Intrauterine Devices (IUDs)

Unit 1: An Overview of the IUD
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2 Types of IUDs
3 Advantages and disadvantages of the IUD
4 Indications for using the IUD
5 Eligibility criteria for IUD use
6 Rumors and misconceptions
7 Six key steps of counseling
8 Screen for IUD insertion
9 When to insert and remove an IUD
10 Insertion and removal procedures
11 Side effects and warning signs

Unit 2: Providing Services
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3 Loading the TCu 380A inside the sterile package
4 Performing the steps in IUD insertion
5 Recommended infection prevention practices
6 Follow-up management of the IUD client
7 Minimum clinic requirements and recordkeeping tasks necessary for IUD services
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Describe the IUD insertion and removal procedures to clients.

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**Unit 2: Providing Services**

Introduction to Unit 2

Demonstrate effective IUD counseling through role-playing.

Use standard checklists to take a limited history and perform a limited physical exam in order to advise, screen, and select clients who request IUDs.

Load the TCu 380A while it is still inside sterile package, without touching it directly.

Perform all steps in safe and gentle IUD insertion and removal efficiently and in correct sequence, according to written standardized technique for TCu 380A IUDs.

Describe recommended infection prevention practices in the provision of IUD services to minimize risk to client and provider.

Provide follow-up management of the IUD client, including appropriate management of common side effects and referrals for complications.

Describe the minimum clinic requirements and recordkeeping tasks necessary for IUD services.

**Trainer’s Tools**

Transparencies

Options for Ice Breakers

Pre/Post-Test Answer Key Unit 1

Pre/Post-Test Answer Key Unit 2

Evaluation

References
Notes to the Trainer

Purpose

This training manual was developed for use in training physicians, nurses, and midwives. It is designed to actively involve the participants in the learning process. Sessions include simulation skills practice, discussions, case studies, role plays and clinical practice, using objective knowledge, attitude, and skills checklists.

At the end of this course, the participant will be able to describe the IUD as an effective family planning method, counsel and screen clients seeking IUDs, respond to rumors and misconceptions about the IUD, provide insertion and removal services for IUD clients, recognize common side effects and complications, and provide follow up care for IUD acceptors.

The manual includes a set of knowledge assessment questions, skills checklists, trainer resources, participant materials, training evaluation tools, and a bibliography.

Suggestions for Use

The manual is designed to provide flexibility in planning, conducting, and evaluating the training course. The curriculum is designed to allow trainers to formulate their own training schedule, based on results from training needs assessments. The manual can be adapted for different cultures by reviewing case studies and using only the ones that are appropriate. Additional case studies can be devised based on local statistics, cultural practices, social traditions, and local health issues.

The curriculum can also be lengthened or shortened depending on the level of training and expertise of the participants. The timing of each exercise assumes that there will be no more than 20 participants. To foster changes in behavior, learning experiences must be in the areas of knowledge, attitudes, and skills. For each session, the overall objective, general objective, and specific objectives are presented in terms of achievable changes in these three areas. Training references and resource materials for trainers and participants are identified.

This module is divided into two volumes, a Trainer’s Guide and Participant’s Guide. The Trainer’s Guide contains the main portion as well as a Trainer’s Tools section, which contains transparencies, options for ice breakers, and Pre- and Post-Test answer keys.

The Trainer’s Guide presents the information in two columns:
1. Content: This column contains the necessary technical information.
2. **Methodology:** This column contains the training methodology (lecture, role play, discussion, etc.) by which the information should be conveyed and the time required to complete each activity.

The *Trainer's Guide* is divided into two units. Unit 1 provides the latest technical information about the IUD. Unit 2 covers the clinical procedure. A training design section is included at the beginning of each unit. It includes the following: an introduction to the unit, the unit training objectives, specific learning objectives, a simulated skills practicum section, clinical practicum objectives, the training/learning methodology, training materials, resource requirements, evaluation methods, time required, and what materials need to be prepared in advance.

The *Participant's Manual* is also divided into two units and contains:
- Participant Handouts
- Pre- and Post-Tests (Participant Copy)
- Participant Evaluation Form

The *Participant Handouts* are referred to in the Methodology sections of the curriculum and include a number of different materials and exercises, ranging from recapitulations of the technical information from the content of the module, to role play descriptions, skills checklists, and case studies.

The *Participant Handouts* should be photocopied for the trainees and distributed to them in a folder or binder to ensure that they are kept together as a technical resource after the training course has ended. Transparency masters have been prepared where called for in the text. These should be copied onto clear overhead sheets for display during the training sessions. The Participant Evaluation form should also be copied to receive the trainees' feedback in order to improve future training courses. The Methodology section is a resource for trainers for the effective use of demonstration/return demonstration in training.

To ensure appropriate application of learning from the classroom setting to clinical practice, clinical practicum sessions are an important part of this training. Refer to Pathfinder’s *Infection Prevention* training module for thorough information on necessary infection prevention procedures.
For consistency in the philosophy of client’s rights, the following should be shared with participants, in preparation for their clinical practicum experiences:

**Informed Choice**

Informed choice is allowing a client to freely make a thought-out decision about family planning, based on accurate, useful information. Counseling provides information to support the client in making informed choices.

“**Informed**” means that:

- **Clients have the clear, accurate, and specific information that they need to make their own reproductive health choices.** Service providers should provide the information on each available and appropriate method of family planning and help clients use the method effectively and safely.

- **Clients understand their own needs.** They have thought about their own situation and service providers can support them in matching methods of family planning to their own needs.

“**Choice**” means that:

- **Clients have a range of family planning methods to choose from.** Programs should offer a variety of different methods to suit people’s different needs. If a method is not available at a particular center, clients should be referred to the nearest facility providing the service.

- **Clients make their own decisions.** Clients always select from the available methods for which they are medically eligible. Service providers should not pressure clients to make a certain choice or to use a certain method.

**Client’s Rights During Clinical Training**

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

The client’s permission must be obtained before having a clinician-in-training observe, assist with, or perform any services. **The client should understand that she or he has the right to refuse care from a clinician-in-training/participant.** Furthermore, a client’s care should not be rescheduled or denied if s/he does not permit a clinician-in-training to be present or provide services. In such cases, the clinical trainer or other staff member should perform the procedure. Finally, the clinical trainer should be present during any client contact in a training situation.
Clinical trainers must be discreet in how coaching and feedback are given during training with clients. Corrective feedback in a client situation should be limited to errors that could harm or cause discomfort to the client. Excessive negative feedback can create anxiety for both the client and clinician-in-training.

The confidentiality of any client information obtained during counseling, history-taking, physical examinations or procedures must be strictly observed. Clients should be reassured of this confidentiality. It can be difficult to maintain strict client confidentiality in a training situation when specific cases are used in learning exercises such as case studies and clinical conferences. Such discussions always should take place in a private area, out of hearing of other staff and clients, and be conducted without reference to the client by name (AVSC, “Tips for Trainers-8,” September 1994; NSV Trainer’s Manual).

Clients should be chosen carefully to ensure that they are appropriate to participate in clinical training. For example, until participants are proficient in performing the procedure, they should not practice with “difficult” clients. Clients have the right to comfort during clinical training. They have the right to feel comfortable during the time they are receiving services. It is the responsibility of clinical trainers to ensure that clinicians-in-training do not cause additional discomfort.

**Demonstration Technique**

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

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

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

3. **Trainer/Participant Talk-Through:** The trainer performs the procedure again while the participant verbally repeats the step-by-step procedure. **Note:** The trainer does not demonstrate
the wrong procedure at any time. The remaining participants observe the learning participant and ask questions.

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

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

**Guide To Symbols**

References to participant handouts, transparencies, and trainer’s tools occur as both text and symbols in the Methodology section. The symbols have number designations that refer to specific objectives and the sequence within the specific objectives. Handouts, transparencies, and trainer’s tools are arranged in chronological order and correspond to the numbered symbols in the Methodology section.

![Trainer’s Tool](image1)

![Transparency](image2)

![Participant Handout](image3)
Dos and Don’ts of Training

The following “dos and don’ts” should ALWAYS be kept in mind by the trainer during any learning session.

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

**DON’TS**
- Don’t talk to the flip chart.
- Don’t block the visual aids.
- Don’t stand in one spot—move around the room.
- Don’t ignore the participants’ comments and feedback (verbal and nonverbal).
- Don’t read from curriculum.
- Don’t shout at participants.
Introduction to Training

Introduce the trainers and participants to each other.

CONTENT

Introducing Trainers and Participants

Establishing norms and housekeeping.

METHODOLOGY

Introduction (30 min.):

Note to trainer: If this module is part of a comprehensive course you may skip most of the introduction and go straight to the objective of the course.

The trainer should:

* Greet Participants (Px) and introduce herself/himself.
* Use Options for Ice Breakers found in the Trainer’s Tools at the back of this manual to choose an exercise to introduce trainers and Px to each other.

Norms and housekeeping (15 min.)

The trainer should:

Ask Px to brainstorm norms for the course. These should include times for breaks and lunch and starting and ending times. Write a list of norms like respecting others’ opinions, active participation, etc.

Divide Px into 5 small groups. Assign each group to be responsible for one day of the training. Explain that on the day they are responsible, they will be expected to get Px back from breaks and lunch on time, collect feedback from Px and meet with trainers at the end of the day to review progress and make suggestions for improvement, prepare
energizers for after lunch, conduct the “Where are We” exercise at the beginning of the day, conduct the “Reflections” exercise at the end of the day, and other responsibilities the group suggests.
Provide suggestions for effective participation in the IUD course.

**CONTENT:**

- **Suggestions for making training more effective**

**METHODOLOGY:**

- **Brainstorming (10 min.):**

  The trainer should:
  - Draw a line down the middle of a flip chart. Label the left-hand column “trainer.” Ask Px what a trainer might do to make the training a poor experience for Px. Suggestions might include things like lecturing too much, not giving enough breaks, etc.
  - Label the right-hand column “Participants” and ask Px what things that might do that would contribute to making the training a poor training experience. Suggestions might include things like answering cell phone calls, dominating discussions, or not participating in discussions.
  - Review what might be done by both the trainer and the Px to make the training experience a good one.
  - Review suggestions for effective participation, if these have not been covered. *Px Handout 1.0.1: Suggestions for Effective Participation.*
  - Record these on a flip chart.
  - Ask Px for their expectations of the course and record these on a flip chart.
Review the exercises “Where Are We?” and “Reflections.”

**CONTENT:**

**Where Are We?**

Starting each day with “Where are We?” is our opportunity to share insights, clarify issues, resolve problems, and review important material so that each of us can get the most out of the course and each day’s experiences.

Problems identified during the “Where Are We?” session should be resolved before continuing (whenever possible), since unresolved issues may hinder the learning process for the Px.

**METHODOLOGY:**

**Trainer Presentation (15 min.):**

The trainer should:

- Explain that the training should be interactive and responsive to the needs of the group. Review what went well or didn’t go well at the end of each day in an exercise called “Reflections.” Also, to make sure we are on track, we use an exercise called “Where are We?”

- Explain the “Where are We” exercise. Each morning one Px from the housekeeping team will review the highlights from the day before. This is an opportunity to share insights, clarify issues, resolve problems, or review important material. Problems will be resolved before continuing.

- Provide each Px with 2 pieces of different colored paper. On one, Px write which topic they found most useful from the previous day and how they will apply it to their work. On the other piece they should write a question or concept from the previous day that needs clarification.

- Process the exercise by reviewing and grouping the topics Px found most useful and by answering questions raised or clarifying areas of confusion.

- Explain that “Where Are We?” will be a regular feature of the beginning of each day during the training session. (See Px Handout 1.0.2: Exercises “Where are We?” and “Reflections.”)
Reflections
At the end of each day, take time to look over what we have done to
✧ Examine what it means to us individually, and
✧ Explore how what we have learned can be applied in a broader setting.

Be sure to close each day’s activities with a session of “Reflections” on the day.

Make a note of the Px and trainers’ feedback, and attempt to address ideas and concerns during the discussion and during the following days’ lesson plans.

Trainer Presentation (15 min.):
The trainer should:
✧ Review how the “Reflections” activity will be performed.
✧ Explain that there are many ways to conduct this exercise.
✧ Pass out 2 colored cards to be completed anonymously.
✧ On card 1 Px write what they liked about the day and what went well.
✧ On card 2 Px write things they did not like and that they hope will improve.
✧ The housekeeping team and the training team will review the results. The trainer will announce the results the following day and will explain how the training team responded to the suggestions.
✧ Explain that in addition to the “Reflections” exercise, Px should bring problems or concerns to the attention of the housekeeping team for discussion with the training team at the end of the day.
Trainer Presentation

Trainer Presentation and Questions/Answers (10 min.):

The trainer should:

- Briefly review objectives as shown in Transparency 1.1: Unit One Objectives. Elicit and respond to questions.
- Explain differences between Units 1 and 2:
  - Unit 1 emphasizes technical update, counseling, client screening/selection, referral, and follow up management (i.e., no IUD insertion skills are covered in Unit 1).
  - Unit 2 builds on Unit 1 and provides skills training for provision of full IUD services.
- Explain the purpose of and then administer the pretest for Unit 1. Px Handout 1.0.3: Unit 1 Pretest.
  (Allow 30 minutes for the pretest.)
UNIT 1: An Overview of the IUD

Introduction:
Unit 1 is the theoretical portion of the module. It provides the participant with the latest technical information about the IUD and prepares the participant to be able to explain the IUD as a safe and effective method of contraception.

Unit Training Objective:
To prepare participants to describe the IUD as an effective contraceptive method and counsel, screen, and select, or refer for insertion or removal.

Specific Learning Objectives:
By the end of the unit, participants will be able to
1. Explain key messages related to the IUD as a safe and effective contraceptive method;
2. Describe the types of IUDs available, the mechanism of action, and effectiveness of the IUD;
3. Explain major advantages and disadvantages of the IUD;
4. Describe indications for using the IUD and rationale for each;
5. Identify eligibility criteria for initiating use of the IUD, and explain rationale for each;
6. Respond to rumors and misconceptions about the IUD, raised by clients or service providers;
7. Describe the six key steps of the counseling process using an approach called RESPECT;
8. Screen a potential client for IUD insertion, using an assessment checklist;
9. Discuss when to insert and remove an IUD;
10. Describe IUD insertion and removal procedures to clients; and
11. Recognize IUD side effects and warning signs of complications.

Simulated Skill Practice:
- Discuss and solve IUD case studies related to client selection, screening, and management of common side effects and complications.
- Through role-play exercises using counseling and history checklists, demonstrate method specific counseling of a client, including pre- and post-insertion counseling and instructions, client screening and selection, and counseling when managing a client with common side effects and complications.

Clinical Practicum Objectives:
During the clinical practicum, participants will be able to:
- Counsel potential IUD clients using the IUD counseling skills checklist, including pre- and
post-insertion and follow up counseling;
› Screen potential IUD clients using the History Checklist for IUD Users;
› Manage IUD clients experiencing common side effects or other problems, and refer if necessary; and
› Document counseling services and other pertinent information on IUD clients seen in the clinic.

Note: No minimum number of clients is specified for certification. The number will vary, and the practicum will be considered complete when the trainer and participant are satisfied that the participant is competent.

Training/Learning Methodology:
› Trainer presentations
› Class discussions
› Required reading
› Case studies
› Case history checklist for IUD users
› Learning guide for IUD counseling
› Counseling role-plays
› Clinical practicum

Resource Requirements:
› Hand-held IUD models
› IUD samples
› Flip chart
› Marking pens
› Masking tape
› Overhead projector
› Large picture of female pelvic organs (or Transparency 1.2: Female Pelvic Organs)
› Large picture of female pelvic organs with IUD in place (or Transparency 1.3: Female Pelvic Organs with IUD)
› Life-size pelvic models
› Hand-held uterine models
**Evaluation Methods:**

- Pre- and Post-Test
- Observation and assessment of participant during role-play, utilizing *Learning Guide for IUD Counseling Skills*
- Observation and assessment of participant during clinical practicum, utilizing *Checklist for IUD Counseling and Clinical Skills*
- Trainer administered examination
- Verbal feedback
- Participant reaction questionnaire

**Time Required (assuming there are no more than 20 participants):**

<table>
<thead>
<tr>
<th>Specific Objective</th>
<th>Topics</th>
<th>Time Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>Introducing participants, tips for effective participation, expectations, unit objectives, Pretest Unit 1</td>
<td>2 hours 5 min.</td>
</tr>
<tr>
<td>1</td>
<td>Key messages related to the Intrauterine Device (IUD)</td>
<td>15 min.</td>
</tr>
<tr>
<td>2</td>
<td>Type of IUDs, mechanism of action, effectiveness</td>
<td>20 min.</td>
</tr>
<tr>
<td>3</td>
<td>Advantages and disadvantages of the IUD</td>
<td>30 min.</td>
</tr>
<tr>
<td>4</td>
<td>Indications for Using the IUD</td>
<td>20 min.</td>
</tr>
<tr>
<td>5</td>
<td>Eligibility criteria for initiating the use of the IUD</td>
<td>30 min.</td>
</tr>
<tr>
<td>6</td>
<td>Counteracting rumors and misconceptions about the IUD</td>
<td>1 hour</td>
</tr>
<tr>
<td>7</td>
<td>Key steps in the counseling process</td>
<td>45 min.</td>
</tr>
<tr>
<td>8</td>
<td>Client assessment and screening</td>
<td>1 hour</td>
</tr>
<tr>
<td>9</td>
<td>Timing for IUD insertion and removal</td>
<td>30 min.</td>
</tr>
<tr>
<td>10</td>
<td>Describing IUD insertion to clients</td>
<td>15 min</td>
</tr>
<tr>
<td>11</td>
<td>IUD side effects and warning signs of complications</td>
<td>1 hour 20 min.</td>
</tr>
<tr>
<td></td>
<td>Post-Test</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total Time Required for Unit 1</strong></td>
<td>9 hours 5 min.</td>
</tr>
</tbody>
</table>
Materials for Trainers to Prepare in Advance

1. Unit 1 Transparencies

2. Participant Handouts

3. Samples of IUDs, pelvic models, and uterine models

4. Prepare flip charts on:
   - Key messages
   - Times for IUD insertion
UNIT 1: An Overview of the IUD

Specific Objective #1: Explain key messages related to the IUD as a safe and effective contraceptive method.

**Key Messages**

1. The IUD is a safe, easy to use, reversible, effective long-term method of contraception.

2. IUD users are very satisfied with their IUD. However, the IUD affects menses, which may be a problem for some women.

3. Careful screening and counseling are essential for successful use of an IUD. *(Note: The provider must know if the client should not use the IUD. The client must know how the IUD works, what the side effects might be, and the signs of possible complications. If the client chooses, the provider should show the client how to check for the IUD's strings.)*

4. IUDs can be safely used by breastfeeding women. *(The IUD does not affect breastfeeding.)*

5. IUDs are safe, even for women at risk of Sexually Transmitted Infections (STIs) and HIV or women with STIs other than gonorrhea and Chlamydia. An IUD should not be inserted if a woman has purulent cervicitis, Chlamydia infection, gonorrhea, or is at high risk for either.

**Trainer Presentation (15 min.):**

- The trainer should:
  - Prepare a flip chart in advance with key messages.
  - Explain that these messages relate to the major concepts to be covered in the module.
  - Ask Px to offer rationale for each as presented.
  - Clarify or elaborate as needed.

*(See Px Handout 1.1.1: Key Messages.)*
6. IUDs are safe for AIDS clients controlled with antiretroviral therapy.

7. IUDs can be a good choice for women with Combined Oral Contraceptive (COC) precautions. (The IUD does not affect blood pressure, cause headaches, or affect the rest of the body.)

8. IUDs can remain in from 5 to 12 years. The TCu 380A IUD can be used for 12 years.

9. Good infection prevention practices are necessary.
Specific Objective #2: Describe the types of IUD available, and mechanism of action and effectiveness of the IUD.

**CONTENT:**

**Types of IUDs available**

There are two types of IUDs: medicated (hormone releasing) or unmedicated (inert). The inert IUDs include copper-containing devices in a range of shapes and sizes and a non-medicated polyethylene device.

The hormone-releasing IUDs either release progesterone or levonorgestrel. Almost all IUDs have 1 or 2 strings hanging from them. The Copper-T380A (TCu 380A) is widely available around the world. This training module focuses on the Copper-T380A.

**Copper T 380A (TCu 380A)**

More than 25 million TCu 380A IUDs have been distributed in 70 countries throughout the world. It is made of polyethylene with barium sulphate (for X rays). The TCu 380A is T shaped, with 314 mm of copper wire wound around the vertical stem. Each of the 2 arms of the T has a sleeve of copper measuring 33 mm. The bottom has a clear knotted string, creating a double string effect. The TCu 380A is inserted into the cavity of the uterus by pulling the outer barrel over the plunger (withdrawal technique). It has a life span of 12 years, and the pregnancy rate is less than 1 per 100 women years.

**METHODOLOGY:**

**Trainer Presentation and Discussion (20 min.):**

The trainer should:

- Display Transparencies 1.2: Female Pelvic Organs and 1.3: Female Pelvic Organs with IUD, which show the female pelvic organs and the pelvic organs with a TCU 380A in place, respectively.
- Distribute sample IUDs to Px to examine.
- Briefly review characteristics of the TCu 380A.
- Encourage discussion and questions.
- Ask Px to explain the mechanism of action of copper-bearing IUDs.
- Clarify and elaborate as needed.

(See Px Handout 1.2.1: The IUD as a Method.)

**Question/Answer (10 min.):**

The trainer should:

- Ask Px what they know about IUDs.
- Correct any misunderstandings immediately. For example, many people have heard that the IUD causes an abortion. This is not so, the IUD stops fertilization (conception) from taking place.
Mechanism of Action

The copper-bearing IUDs’ principal mechanism of action is to prevent fertilization by affecting sperm motility and ova development. Research has shown that sperm counts found in cervical mucus and uterine tube are much lower in women using copper-containing IUDs. In addition to its primary mechanism of action on the sperm, the copper-containing IUD also produces an inflammatory environment in the endometrium. There are 2 types of studies that substantiate this mechanism of action: assays for Human Chorionic Gonadotropin (hCG) levels and evaluations of washings from the vagina and cervix. In one study, the serum hCG levels of 30 IUD users were monitored for 30 months; there were no changes in these levels, meaning that there were no signs of early pregnancy. In another study, researchers studied women who were undergoing sterilization in the middle of their menstrual cycle. The women’s fallopian tubes were flushed and the fluid was examined to look for sperm and fertilized eggs. Eggs were recovered in one-half of the women not using contraception. In women using IUDs, no fertilized, normally-dividing eggs were recovered. IUDs that contain progesterone also cause thickening of cervical mucus, which stops the sperm from entering the uterus. IUDs are not abortifacients.

Effectiveness

The IUD is a highly effective form of long-term, reversible contraception, with an associated failure (pregnancy) rate of
Intrauterine Devices (IUDs)

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

Continuation Rates and Client Satisfaction

Continuation rates are also high in IUD users—higher than those of most other reversible methods. Large trials conducted in many developing countries show that approximately 70% to 90% of women are still using their IUDs one year after insertion.

Note: Continuation rates are not effectiveness rates, but do represent user satisfaction with the method.
Specific Objective #3: Explain the major advantages and disadvantages of the IUD.

**CONTENT:**

**Advantages and Health Benefits**

- Highly effective
- Safe for most women
- Reversible and economical
- May be used by lactating and postpartum women
- Good choice for women with COC precautions
- Long duration of use (up to 12 years for TCu 380A)
- One visit for insertion, and minimal follow up required after first 3 to 6 week check-up (unless client has problems)
- Nothing required during sexual intercourse; allows the client privacy and control over her fertility
- Does not interact with medications
- Can be removed at any time
- May have a protective effect against endometrial cancer, and possibly cervical cancer.

**Disadvantages and Health Risks**

- Does not protect against STIs/HIV
- Pelvic Inflammatory Disease (PID) may occur if the woman has Chlamydia or gonorrhea at the time of IUD insertion.
- May expose client to infection

**METHODOLOGY:**

**Brainstorming (30 min.):**

The trainer should:

- Have Px cite advantages and disadvantages.
- List on a flip chart as identified. Add to list as needed.
- Ask Px to explain rationale for selected advantages and disadvantages (i.e., Why is the IUD suitable for a lactating woman? What method does protect from STIs? Why is ectopic pregnancy a disadvantage?).
- Elaborate on advantages and disadvantages as needed and correct any misconceptions immediately.
- Know the cost of IUDs in-country, in case this question is asked.

(See Px Handout 1.3.1: Advantages and Disadvantages.)
Intrauterine Devices (IUDs) during insertion (The risk is minimal with good infection prevention procedures.)

- Trained provider dependent
- Some pain, cramping, minor bleeding on insertion
- Heavier/longer menstrual periods, increased cramping, and bleeding/spotting fairly common in some women during the first three months
- May contribute to anemia if a woman already has low iron blood stores before insertion and the IUD causes heavier monthly bleeding
- Rarely, the wall of the uterus may be punctured during IUD insertion. Unless severe, this usually heals without treatment.
- Serious complications require immediate attention and good back up services.

**Note: IUDs do not increase the risk of ectopic pregnancy.** A WHO multicenter study found that IUD users are 50% less likely to experience an ectopic pregnancy than women using no contraception. However, in the unlikely event of pregnancy in an IUD user, that pregnancy is more likely to be ectopic than would be a pregnancy in a non-user. Still, pregnancy for an IUD user is far more likely to be normal than ectopic: only an estimated 1 in every 13 to 16 pregnancies, or 6% to 8%, is ectopic.
Specific Objective #4: Describe indications for using the IUD and the rationale for each.

**CONTENT:**

**Appropriate Users of IUDs**

IUDs are an appropriate choice for a client who

- Is not pregnant and wants an effective form of contraception;
- Has a healthy reproductive tract, no signs of gonorrhea or Chlamydia, cancer, or reproductive tract abnormalities;
- Is young and nulliparous (only after thorough consideration—infection during insertion should be carefully ruled-out);
- Has completed childbearing and does not want voluntary surgical contraception (IUDs are highly suitable for older women until menopause);
- Wants a long term, easily reversible method (IUDs have an excellent rate of return to fertility);
- Wants an effective method, but precaution(s) exist for hormonal methods such as COCs (IUDs have little or no effect on body systems other than the reproductive tract);
- Is breastfeeding (IUDs do not affect lactation);
- Is immediately postpartum (IUDs may be inserted immediately after the delivery of placenta or within first 48 hours postpartum. This

**GROUP DISCUSSION (20 min.):**

The trainer should:

- Review and discuss each indication and its rationale with Px.
- Trainer should ask Px:
  - What do you need to know about a woman before you give her an IUD?
  - Why do you need to know this?
  - Can nulliparous women receive IUDs?
  - Should young nulliparous women receive IUDs?
  - Let the Px come up with both the information and why it is important.

(See Px Handout 1.4.1: Indications for Using the IUD.)
procedure requires a specially-trained provider.);
- Has successfully used an IUD in the past (users with positive past experience tend to tolerate IUDs well);
- Is in a mutually faithful sexual relationship (IUDs are appropriate for women who are at no or low risk for STIs/HIV. IUD insertion in the presence of gonorrhea or Chlamydia may increase risk for PID, which can lead to chronic pain, ectopic pregnancy, and infertility); and
- An IUD is a safe method even for women who do hard physical work.

**Women can begin using IUDs**
- Without STI testing,
- Without an HIV test,
- Without any blood tests or other routing laboratory tests,
- Without cervical cancer screening, and
- Without a breast examination.

**Summary**
The crucial elements of safe IUD use are
- The client is not pregnant,
- A careful screening and assessment of STI/HIV risk has been given,
- The provider is competent in IUD insertion and infection prevention practices,
- Reliable back up services are available, and
- Careful and complete client counseling has been provided.
Specific Objective #5: Identify eligibility criteria for initiating use of the IUD, and explain the rationale for each.

**CONTENT:**

The World Health Organization (WHO) first issued guidance for health care providers to assist them in determining who can use the different types of contraceptives. The guidelines came to be known as the WHO Medical Eligibility Criteria and were revised in 2000, 2003, and 2004.

The conditions affecting eligibility for the use of each contraceptive method were classified under one of the following four categories:

- **Category 1** means no restrictions.
- **Category 2** implies a condition where the benefits of using the method generally outweigh the theoretical or proven risks.
- **Category 3** means the risks usually outweigh the benefits.
- **Category 4** indicates an unacceptable health risk.

WHO has recommended that where the technical resources necessary for making advanced diagnosis is limited, the four-category classification framework can be simplified into two categories:

- **Yes** (use the method)
- **No** (do not use the method)

**METHODODOLOGY:**

**Lecture (30 min.):**

Give a mini-lecture on conditions that affect eligibility for the use of IUDs and the rationale for each.

See *Px Handout 1.5.1: Eligibility Criteria.*
In most facilities where Pathfinder works, the technology is not available to diagnose conditions like thrombogenic mutations, hyperlipidemia, trophoblast disease, or various cancers. For that reason, we use the simplified two-category system.

Listed below are conditions which could effect the decision to use an IUD, followed by the recommendation of whether or not it should be used in that instance.

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES (use the method)</th>
<th>NO (don’t use the method)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Postpartum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Less than 48 hours</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• 48 hours to four weeks</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• Four weeks or longer</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• Puerperal sepsis</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Postabortion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• First trimester</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Second trimester</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• Postseptic abortion</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Menarche to 20 years</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• 20 years or older</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Essential hypertension</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>History of preeclampsia</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Condition</td>
<td>YES (use the method)</td>
<td>NO (don’t use the method)</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>----------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Diabetes</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Deep venous thromboembolism</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Pulmonary embolism</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Superficial venous thrombosis</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Current and history of ischemic heart disease</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Known hyperlipidaemias</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Valvular heart disease</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Irregular vaginal bleeding</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Unexplained vaginal bleeding before evaluation</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Breast disease</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Cervical intraepithelial neoplasia</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Cervical cancer (awaiting treatment)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Cervical ectropion</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Pelvic inflammatory disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Past</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Current</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
### Condition

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES (use the method)</th>
<th>NO (don’t use the method)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STIs</strong>¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Current purulent cervicitis or chlamydial infection or gonorrhea</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• Vaginitis without purulent cervicitis</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Increased risk of STIs</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>HIV/AIDS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• HIV infected</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• AIDS (not on antiretroviral therapy)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• Clinically well on antiretroviral therapy</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• High risk of HIV²</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Biliary tract disease</strong></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>History of cholestasis</strong></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Viral hepatitis</strong></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Cirrhosis</strong></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Liver tumors</strong></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Uterine fibroids</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Without distortion of the uterine cavity</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• With distortion of the uterine cavity</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>Past ectopic pregnancy</strong></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Obesity</strong></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Thyroid problems</strong></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Thalassemia</strong></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>YES (use the method)</td>
<td>NO (don’t use the method)</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Trophoblast disease</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Sickle cell disease</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Iron deficiency anemia</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Schistosomiasis</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Malaria</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Drug interactions</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Nulliparous</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Distorted uterine cavity</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Severe dysmenorrhea</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nonpelvic</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Pelvic</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Endometriosis</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Benign ovarian tumors</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>History of pelvic surgery</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

1 **Note:** If the woman has a very high individual likelihood of exposure to gonorrhea or chlamydial infection, don’t initiate use of the IUD. “There is no universal set of questions that will determine if a woman is at very high individual risk for gonorrhea and chlamydia. Instead of asking questions, providers can discuss with the client the personal behaviors and the situations in their community that are most likely to expose women to STIs.” (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. 138)
2 Note: IUDs do not protect against STIs/HIV. If there is a risk of STIs/HIV, the correct and consistent use of condoms is recommended.

Specific Objective #6: Respond to rumors and misconceptions about the IUD raised by clients or service providers.

**CONTENT:**

### Rumors and Misconceptions

**Rumors** are unconfirmed stories that are transferred from person to person by word of mouth. In general, rumors arise when:

- An issue or information is important to people, but it has not been clearly explained.
- There is no one available who can clarify or correct the incorrect information.
- The original source is perceived to be credible.
- Clients have not received complete and accurate information and had not been given enough time to internalize the benefits and limitations of contraceptive options.
- People have been motivated to spread them for political reasons.

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

Unfortunately, rumors or misconceptions are sometimes spread by health workers who may be misinformed about certain methods.

**METHODOLOGY:**

### Trainer Presentation and Group Discussion (60 min.):

The trainer should:

- Ask Px to explain the differences between a rumor and a misconception.
- Write their responses on the board and correct any wrong answers.
- Cite reasons why rumors and misconception might be believable.
- Explain that rumors and misconceptions don't always come from clients or their families. They may sometimes come from service providers themselves.
- Ask Px to list some of the most common rumors or misconceptions they have heard about the IUD; write their responses on the board, under the headings RUMORS or MISCONCEPTIONS.
- Have Px identify the underlying and immediate causes of some of the rumors they have identified.
- Ask Px for examples of strategies to counteract rumors and misconceptions. Supplement their answers if necessary.
- Explain the importance of knowing the underlying reasons for rumors and misconceptions.

(See Px Handout 1.6.1: Rumors and Misconceptions.)
or who have religious or cultural beliefs pertaining to family planning which they allow to impact on their professional conduct.

The underlying causes of rumors have to do with people's knowledge and understanding of their bodies, health, medicine, and the world around them. Often, rumors and misconceptions about contraception make rational sense to clients and potential clients.
Specific Objective #7: Describe the six key steps of the counseling process using an approach called RESPECT.

**CONTENT:**

**Key IUD Information and Messages**

When introducing the IUD to the client, effective client-centered counseling is key to successful, ongoing IUD use and effectiveness. Quality counseling at this point can ensure client ownership, which promotes commitment to careful and continued use, demonstrating client satisfaction. The client may come to the session with preconceptions that pose barriers to accepting the IUD. Good client-centered counseling can earn the client’s trust by encouraging her to share information about her home relationships, social context, and concerns she may have about contraception in general or the IUD in particular. The counseling session should assist the client to develop her own expectations and make her own well-considered, informed, and voluntary decisions.

Many women come to receive services cautiously, awed by the provider’s social/educational position and inclined to be reserved and withdrawn. Here the provider is especially challenged to put the client at ease and make her comfortable with sharing personal information. The provider must be aware of his or her personal

**METHODOLOGY:**

**Trainer Presentation (15 min.):**

The trainer should:

- Give a brief presentation on key IUD information and messages
- Review each step in RESPECT using a prepared flip chart and provide examples of tasks typically conducted under each element or step.

(See Px Handouts 1.7.1: The Six-Step Counseling Model (RESPECT) and 1.7.2: Key Elements in IUD Counseling.)

**Group Exercise (30 min.):**

The trainer should:

- Write each of the key elements of counseling on a slip of paper. Depending on the number of Px, give 1 slip of paper to each Px or to each pair or triad of Px.
- Ask each to describe how they would put their assigned key element of counseling into practice in their own work situation.
- Ask Px to add ideas to each presentation.
- Provide additional examples not mentioned by the Px, if necessary.
- Complete the exercise by explaining that all of the elements discussed are necessary for successful counseling. Successful counseling results in a well-informed decision and a satisfied client. Effective counseling takes knowledge, skill, sensitivity, and tolerance toward the needs and differences of all clients.
presentation and attitude and how the client responds, adjusting his or her style to the situation. Listening skills are essential.

The focus is on RESPECT:
the provider establishes Rapport,
demonstrates Empathy,
Supports the client,
creates a Partnership with the client,
provides comprehensive Explanations about methods,
displays Cultural sensitivity,
and builds Trust.

The key to demonstrating respect is remembering that although the provider is the expert in health care, the client is the foremost expert on her health needs, her social and economic circumstances, and her traditional values and expectations. These forces weigh heavily on her adoption or rejection of a family planning method and her ongoing investment in making the method work for her.

The Key Elements in IUD Counseling are:

- Privacy and patience;
- Building knowledge and trust;
- Reassuring the client of confidentiality;
- Answering all questions and concerns;
- Using language that is clear and easy to understand;
- Assessing the client’s individual risk for STIs with sensitivity;
- Providing detailed information about dual protection;
Providing comprehensive information about how the IUD works, IUD safety, effectiveness, correct use, what to expect after IUD insertion, possible side effects, warning signs and complications, as well as where and when to return and the fact that it does not protect against STIs and HIV;

Informing the client about when to return for the follow-up visit; and

Giving the client the message that she should return any time that she has any questions or concerns.
Specific Objective #8: Screen a potential client for IUD insertion, using an assessment checklist.

CONTENT:

Key Client Assessment Questions

The IUD is more appropriate for some women than for others. Careful screening is crucial for successful IUD use. Some serious side effects can be prevented by thorough screening.

Why screen?

- To determine indications for use
- To identify precautions
- To identify other health or special problems

Using a screening checklist helps clinicians obtain information systematically and completely.

Using the IUD screening checklist

Refer to Px Handout 1.8.1: Client Assessment Checklist for Small Group Exercise.

METHODOLOGY:

Trainer Presentation and Small Group Exercise (60 min.):

The trainer should:

- Divide Px into groups of 3.
- Hand out to each group a copy of Px Handout 1.8.1: Client Assessment Checklist for Small Group Exercise. Before the class, check off “yes” responses to different screening questions on each copy.
- Explain that the purpose of this exercise is to familiarize Px with essential screening questions and the rationale for each.
- It also serves to strengthen Px’ analytic and problem solving skills when screening IUD clients.
- Finally, it encourages them to get into the habit of referring to the checklist when dealing with IUD clients.
- Instruct each group to look up the rationale for asking the question with the “yes” response checked in Px Handout 1.8.2: Recommendations for Updating Selected Practices in IUD Insertion and Removal.
- Ask them to fill in the column marked “rationale for question.” Then, depending on the “yes” response checked off, each group will fill in the “Action/Plan” column with their recommendation on how to manage the client.
Give the Px 15 minutes in their small group, encourage them to ask questions if they have problems.

When the Px have filled in the rationales and action plans, ask each small group to present their cases to the larger group.

They should state the problem or “yes” response, the rationale for asking the question, and the plan for managing the client.

The trainer may guide group discussion and encourage Px to offer each other solutions and constructive feedback.
Specific Objective #9: Discuss when to insert and remove an IUD.

**CONTENT:**

**Timings for IUD Insertion**

1. **Having menstrual cycle**
   - A woman can have an IUD inserted at any time **within the first 12 days** after the start of menstrual bleeding, at her convenience, not just during menstruation. No additional contraceptive protection is needed.
   - The IUD can also be inserted at any other time during the menstrual cycle, at her convenience, if it is reasonably certain that she is not pregnant. No additional contraceptive protection is needed.

   *Note: See Px Handout 2.2.2 Client Assessment Checklist for assistance in ruling out pregnancy for nonmenstruating family planning clients.*

2. **Switching from another method**
   - She can have the IUD inserted immediately, if it is reasonably certain that she is not pregnant. There is no need to wait for her next menstrual period. No additional contraceptive protection is needed.

3. **Postpartum**
   - Immediately postpartum (within 10 minutes) following delivery of the

**METHODODOLOGY:**

**Trainer Presentation (30 min.):**

**The trainer should:**

- List on a flip chart these times for IUD insertions:
  - Anytime during the menstrual cycle if you reasonably certain client is not pregnant.
  - Immediately postpartum.
  - Around 4 to 6 weeks postpartum, and
  - Immediately postabortion up to 7 days.
- Ask the Px why each of these are the best times.
- Describe when the IUD should not be inserted immediately postabortion.
- Again, have the Px tell you under which conditions they would not insert the IUD postabortion.
- For example, you may say, “Why wouldn’t you insert an IUD postabortion if the pregnancy had been 16 weeks or greater?”
- Then review the follow up schedule for IUD clients.
- Again, you may ask the Px why they should schedule these follow up visits.
- Finally, list the best times for IUD removals and have the Px explain why to remove at these times.
Intrauterine Devices (IUDs)

placenta, during or immediately after a cesarean section. This requires special training.

- Within the first 48 hours postpartum. Expulsion rates may be higher for IUDs inserted during this time. Insertions after one week and before four weeks should be avoided because of the higher risk of complications including infection uterine perforation.

**Note:** IUD insertion at immediate or 48 hours postpartum requires special training and should not be attempted without having received the required training.

- As early as 4 to 6 weeks postpartum for those who come for routine postpartum care and who request an IUD. Copper IUDs may be safely inserted at this time.

4. Immediately Postabortion

- The IUD may be inserted immediately postabortion (spontaneous or induced) if the uterus is not infected, or during the first 7 days postabortion (or anytime you can be reasonably sure that the client is not pregnant).

IUDs should **not** be inserted immediately postabortion in the following situations:

- Signs of unsafe or unclean induced abortion, signs of infection, or an inability to rule out infection, do not insert an IUD. Do not insert IUD until risk of infection has been ruled out or infection has fully resolved.

(See Px Handout 1.9.1: Timing of IUD Insertion and Removal.)
Serious trauma to the genital tract (uterine perforation, serious vaginal or cervical trauma, chemical burns). Do not insert IUD until healed.

Hemorrhage and physical signs of severe anemia, inert or copper bearing IUDs are not advised until hemorrhage or severe anemia is resolved. Progestin releasing IUDs decrease menstrual blood loss and can be used in cases of severe anemia.

Immediate postabortion IUD insertion after 16 weeks’ gestation requires special training. If the pregnancy went beyond 16 weeks, delay insertion for 6 weeks postabortion.

Follow-up schedule after IUD insertion

a) There should be one follow up visit **approximately** 3 to 6 weeks after insertion. Thereafter, there is no need for a fixed follow up schedule.

b) The client should be strongly encouraged to come to the clinic anytime she has questions or problems, particularly if she has:

- Late period (possible pregnancy);
- Prolonged or excessive abnormal spotting or bleeding;
- Abdominal pain or pain during intercourse;
- Infection exposure (such as gonorrhea), abnormal vaginal discharge, or pelvic pain, especially with fever; or
- String missing or change in length.

c) Encourage clients to come in for other preventive reproductive health care if available, including provision of condoms.
Timings and reasons for IUD Removal

- The IUD may be removed at any time during the menstrual cycle. Some clinicians prefer to remove IUDs during menses because the os may be slightly open and the client will not be concerned if she has any bleeding.
- Anytime the client requests—for any stated reason, or for no reason at all.
- Evidence of IUD perforation.
- Known or suspected pregnancy.
- Partial expulsion—the old IUD may be removed and replaced with a new one.
- Persistent side effects unacceptable to client.
- Client is now at risk for STIs.
- When IUD has been in uterus for its effective life—a new IUD may be inserted immediately if no precautions are present.
- Severe pain or severe bleeding with evidence of marked anemia that is getting worse.

Note: In most cases, if PID is known or suspected, the client should be treated with antibiotics, counseled, and the IUD left in place.
Specific Objective #10: Describe the IUD insertion and removal procedure to clients.

CONTENT:

**Suggested Simple Explanation**

One could say:

“The IUD is a small device made of plastic and copper. It is placed in the uterus through the vagina and the opening of the uterus using a small applicator. It has 2 thin strings attached, which hang down into the vagina. If you feel comfortable doing so, these strings allow you to check that the IUD is still in place each month after your menstrual period and that you are still protected from getting pregnant. The strings are also used to remove the IUD. Removing the IUD takes only a few minutes and is usually not painful. When you want the IUD removed a doctor or trained health worker must do it.

“Inserting the IUD is simple. You may feel uncomfortable for a few minutes. Most women, however, say that it is not too painful and compare the feeling to having heavy menstrual cramps. Before I insert the IUD, I will need to ask you some questions about your medical history, and perform a pelvic examination to make sure the IUD is right for you.”

METHODOLOGY:

**Demonstration and Group Discussion (15 min.):**

The trainer should:

- Use a modified role play approach, to demonstrate how to explain the insertion and removal procedure to client with a volunteer Px. Important points:
  - Use hand held model (or local flip chart) to demonstrate insertion and removal.
  - Let the client feel and hold the IUD. (It is a good idea for Px to keep an outdated IUD on their desk for this purpose).
  - Encourage Px to use simple/local words for “uterus,” “vagina,” etc.
  - Keep description simple and ask client if she has questions after explanation has been given.

(See Px Handout 1.10.1: Describing IUD Insertion and Removal to Clients.)
Specific Objective #11: Recognize IUD side effects and warning signs of complications.

**CONTENT:**

**Common side effects and their management**

As with most contraceptive methods, IUDs are associated with certain common side effects. Most are not serious and can be handled by the provider or practitioner. Some may need referral to a specialist.

**Possible side effects include:**
- Bleeding or spotting for the first few days following insertion,
- Heavier menses, and
- More cramping for the first few periods.

**Signs of possible complications include:**
- Syncope/bradycardia, vasovagal episode during insertion (fainting, becoming dizzy, or lowered heart rate during insertion);
- Abnormal bleeding: no period, heavy bleeding, abnormal spotting;
- Purulent or foul smelling discharge;
- Fever, (a possible sign of pelvic infection);
- Abdominal pain or pain during intercourse; and
- An IUD string that becomes shorter, longer, or missing.

**METHODOLOGY:**

**Trainer Presentation (30 min.):**

The trainer should:
- Ask Px to identify side effects and list them on a flip chart.
- Describe warning signs of possible complications and ask Px to suggest what possible complication may be indicated by each sign.
- List these on a flip chart.
- Elaborate and clarify, as needed.
- Discuss with Px how to prepare a local referral system for their clients with complications. This list should include:
  - To whom to make referrals.
  - How to ensure that client will be seen promptly, and
  - How to get feedback from a specialist on diagnosis/treatment and necessary follow up of the client.
- Review the warning signs of serious side effects and complications.
- Review Px Handout 1.11.1: Common Side Effects and Warning Signs of Possible Complications.
- When discussing more complex side effects or complications, stress need for Px to refer immediately to an Ob/Gyn specialist and to ensure that client is seen immediately.
Summary and Closure (20 min.):
The trainer should:

- Briefly summarize major concepts covered in the unit, and review overall learning objectives.

Administer Post-Test (30 min.):
The trainer should:

- Administer the Post-Test for Unit 1. *Px Handout: 1.12.1: Unit 1 Post-Test.*
Unit 2: Providing Services
UNIT 2: Providing Services

Introduction:
Unit 2 focuses on competency-based clinical skills training that builds on the essential IUD knowledge base that participants acquired in Unit 1 of this module.

Before advancing to the clinical practicum, the trainee must demonstrate

- Basic IUD technical knowledge as assessed by a written test; and
- Clinical and counseling skill competency in simulated situations (i.e., counseling role play, IUD insertion and removal in anatomical models, and infection prevention practices demonstration).

Note: These will be assessed through direct observation by a trainer, using standardized skills assessment checklists from the appendix.

After the clinical practicum, the participant will be certified as a provider when the trainer is satisfied with her or his competency in all aspects of IUD service delivery. Upon completion of this module and certification of proficiency as described above, the participant will be qualified to offer high-level IUD services in her or his clinic setting, which must fulfill minimum standard criteria explained in this unit. The participant also must agree to be interviewed and possibly observed by a program-designated monitor while delivering IUD services, six to twelve months after completing certificate course requirements. The purpose of these visits is to monitor and provide ongoing improvements in the training of subsequent generations of trainees, as well as to help the trained provider solve any problems encountered and upgrade her or his practical skills.

Unit Training Objective:
To prepare the participants to insert and remove IUDs competently; to provide high-quality IUD services, including counseling, screening, and selecting clients; and to manage and provide follow-up for clients who choose an IUD.

Specific Learning Objectives:
By the end of the unit, participants will be able to:
1. Demonstrate effective IUD counseling through role-playing;
2. Use standard checklists to take a limited history and perform a limited physical exam in order to advise, screen, and select clients who request IUDs;
3. Load the TCu 380A while it is still inside the sterile package, without touching it directly;
4. Perform all steps in safe and gentle IUD insertion and removal, efficiently and in the correct sequence, according to written standardized technique for TCu 380A IUDs;
5. Describe recommended infection prevention practices in the provision of IUD services, in order to minimize risk to client and provider;

6. Provide follow-up management of the IUD client, including appropriate management of common side effects and referrals for complications; and

7. Describe the minimum clinic requirements and recordkeeping tasks necessary for IUD services.

Simulated Skill Practice:
- Using a pelvic model, practice and demonstrate speculum and bimanual pelvic exams.
- Using a pelvic model, practice and demonstrate IUD insertion and removal.
- Observe and demonstrate exam-room set-up and infection prevention practices including decontamination, cleaning, High-Level Disinfection (HLD) or sterilization, and waste disposal.

Clinical Practicum Objectives:
During the clinical practicum, participants will be able to
- Counsel IUD clients in initial, method-specific, pre- and post-insertion, and follow-up visit sessions;
- Assess and screen potential IUD clients;
- Perform IUD insertions and removals;
- Provide follow-up care to IUD clients;
- Manage IUD clients experiencing side effects and other problems, if available;
- Practice infection prevention activities in the clinical setting; and
- Using a standard form, document history, physical findings, and other pertinent information.

Note: In many programs where new service providers are being trained, each participant is expected to provide IUD services to at least five to ten clients. In determining competence, the judgment of a skilled clinical trainer is the most important factor. Thus, in the final analysis, the level of demonstrated competence carries more weight than the number of performed insertions.

Training/Learning Methodology:
- Lecture
- Video
- Discussion
- Required reading
- Role-plays
- Case studies
Simulated practice on models
• Demonstration
• Clinical practicum
• Use of checklists and learning guides

**Resource Requirements:**
• Hand-held IUD models
• IUD samples
• Flip chart
• Marking pens
• Masking tape
• Overhead projector
• Large picture (or transparency) of female pelvic organs
• Large picture (or transparency) of female pelvic organs with IUD in place
• Life size pelvic models
• Infection prevention supplies
• Speculum and other IUD insertion equipment, light source
• Notebooks for use by participants to record results of clinical practicum
• Materials necessary for infection prevention: leak-proof container with tight-fitting lid or plastic bag, plastic bucket, chlorine, gloves (either single-use or reusable), detergent, soft brush, HLD container, cooker pot, forceps

**Evaluation Methods:**
• Pre/Post-Test
• Observation and assessment of participant during simulated practice, utilizing IUD Counseling and Clinical Skills Learning Guide
• Observation and assessment of participant during clinical practicum, utilizing IUD Counseling and Clinical Skills Learning Guide
• Trainer administered examination
• Verbal feedback
• Participant Evaluation Form
Time Required:

<table>
<thead>
<tr>
<th>Specific Objective</th>
<th>Topics</th>
<th>Time Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Review of six step counseling process and key elements of IUD counseling, counseling role-play, unit 2 pre-test</td>
<td>2 hours 10 min.</td>
</tr>
<tr>
<td>2</td>
<td>Screening checklists, checklists to rule out pregnancy, bimanual examination demonstration and skills practice</td>
<td>3 hours</td>
</tr>
<tr>
<td>3</td>
<td>Loading the TCu380A in the sterile package, demonstration and skills practice</td>
<td>45 min.</td>
</tr>
<tr>
<td>4</td>
<td>Demonstration and return demonstration of sounding the uterus and inserting the IUD on a pelvic model, observing a video</td>
<td>4 hours</td>
</tr>
<tr>
<td>5</td>
<td>Infection prevention in IUD insertion and removal</td>
<td>2 hours</td>
</tr>
<tr>
<td>6</td>
<td>Management of side effects and complications</td>
<td>3 hours 15 min.</td>
</tr>
<tr>
<td>7</td>
<td>Minimum criteria for IUD services, record keeping, course evaluation, post-test</td>
<td>1 hour 30 min.</td>
</tr>
</tbody>
</table>

**Total Time Required**: 12 hours 30 min.

Workshop/simulated practice: 11.5 hours
Clinical practicum: time depends on availability of clients and experience of participants

**Materials for Trainers to Prepare in Advance**

1. Unit 2 Transparencies

2. Participant Handouts

3. Samples of IUDs, life-sized pelvic models, uterine models, IUD insertion equipment including light source and other supplies

4. Video player and required videos
UNIT 2: Providing Services

Specific Objective #1: Demonstrate effective IUD counseling through role-playing.

CONTENT

Six Steps of the Counseling Process

RESPECT
- The provider establishes Rapport,
- Demonstrates Empathy,
- Supports the client,
- Creates a Partnership with the client,
- Provides comprehensive Explanations about the method,
- Displays Cultural sensitivity, and
- Builds Trust.

Key Elements in IUD Counseling
The key elements in IUD counseling are:
- Privacy and patience;
- Building knowledge and trust;
- Reassuring the client of confidentiality;
- Answering all questions and concerns;
- Using language that is clear and easy to understand;
- Assessing the client’s individual risk for STIs with sensitivity;
- Providing detailed information about dual protection;
- Providing comprehensive information about IUD safety, effectiveness, correct use, what to expect following insertion, possible side effects, warning signs and complications, as well as where and when to return and the fact that it does

METHODODOLOGY

The trainer should:
- Display Transparency 2.1: Unit 2 Objectives and discuss.
- Administer Px Handout 2.1.0: Unit 2 Pretest. (Allow 30 minutes.)

Trainer Presentation (10 min.):
The trainer should:
- Briefly review the 6 steps of the counseling process and the key elements in IUD counseling.

Role Play Exercise (1 hr. 30 min.):
The trainer should:
- Divide the Px into groups of 3. One person to play the client, one the counselor, and the third to observe, using the observer’s role-play checklist.
- Assign each team one of the role plays in Px Handout 2.1.1: Role-Play Situations. Only allow the “client” to see the case study.
- Distribute copies of Px Handout 2.1.2: Competency-Based Checklist for IUD Counseling Skills to each Px.
- Ask the “client” and “counselor” to role-play the counseling session and the observer to comment on the role-play using Px Handout 2.1.3: The Observer’s Role-Play Checklist for IUD Counseling Skills. Refer to this
Intrauterine Devices (IUDs)

- Not protect against STIs and HIV;
- Informing the client about when to return for the follow-up visit; and
- Telling the client that she should return any time that she has any questions or concerns.

Handout for supplemental information on counseling.

- The “counselor” demonstrating respect, caring, honesty, and confidentiality must identify the client’s feelings to assist in the decision-making process.
- The “client” and “counselor” should give their impressions and/or reactions and the observers should comment on their observation of the case studies.
- Reassign the role-plays, having “observers,” “counselors,” and “clients” switch roles.
- Interrupt role-plays at key moments to point out problems to the Px, and to identify possible solutions.
- To summarize the session, remind the Px that, “the counselor must recognize and respond to each client as a unique person with attitudes, values, and experiences reflected in his or her personal situation. The counselor must recognize the individual needs of each client.”
- Analyze the role-play by asking the following questions:
  - What were the dynamics between “counselor” and “client?”
  - Did the counselor listen actively?
  - Did the counselor respond to questions appropriately?
  - Did the counselor ignore nonverbal cues?
  - Did the counselor convey negative/positive cues?
  - Was the information given too technical, or did the counselor use language the client could understand?
  - Was the information accurate and complete?
Specific Objective #2: Use standard checklists to take a limited history and perform a limited physical exam to advise, screen, and select clients who request IUDs.

**CONTENT:**

**Key Concepts of History Taking and Physical Examination**

Once a client has made the decision to use an IUD based on complete general method counseling, she must receive IUD method-specific counseling (as covered in the previous objective and Unit 1 of this module). Before you can assure her that the IUD is an appropriate choice for her, you must take a limited history and perform a physical exam to rule out conditions that might affect eligibility, including the possibility of pregnancy, genital tract abnormalities, pelvic TB infection, or high risk of STIs.

To aid the practitioner in obtaining client history and giving rationale for asking each question (as well as aiding decision-making in case of a precaution), practitioners may use checklists such as Px Handout 2.2.2: Client Assessment Checklist. **Note:** Microscopic examination of vaginal secretions is not necessary for IUD insertion.

Once the practitioner has completed the checklist, he or she should perform a complete pelvic exam to

- Determine position and size of uterus;
- Rule out likelihood of pregnancy; and

**METHODOLOGY:**

**Trainer Presentation/ Discussion (3 hours):**

The trainer should:

- Discuss key concepts.
- Describe the pelvic exam in detail.
- Introduce and review Px Handouts 2.2.1: IUD Screening, 2.2.2: Client Assessment Checklist, and 2.2.3 Pelvic Bimanual and Speculum Exam Checklist.
- Review each of the screening checklists in detail.
- Review the checklists to rule out pregnancy. Go over the checklists 1 item at a time and ask Px to explain why each item is included in the checklist.
- Ask Px to discuss the meanings of various positive checklist findings and management options for each.
- Use brainstorming approach as a way to assess the knowledge learned in Unit 1 of this module.

If available, show the JHPIEGO video on insertion and removal of the TCu 380A IUD.
Intrauterine Devices (IUDs)

Rule out presence of visible and/or palpable abnormalities, including infections, masses, tumors, etc.

If any of these are present, an IUD should not be inserted until the problem is investigated and resolved. Again, the trainer and practitioner can use Px Handout 2.2.3: Pelvic Bimanual and Speculum Checklist.

Simulated Demonstration of Pelvic Exam and Simulated Practice:

After presenting the content, the trainer should:

- Get a sense of the knowledge and Px’s skill levels from the pretest and other means.
- Some Px will have no experience in performing a pelvic exam, others may have a lot.
- Some Px may have learned habits which must be unlearned.
- Before Px practice on the life-size pelvic model, the trainer should demonstrate on the model, pointing out its parts and how to use them.
- After demonstrating a pelvic exam on the model, the trainer will allow each Px to do the same, while being coached by the trainer at first and then by a fellow Px who will use Px Handout 2.2.3.
- The trainer will then assess the skills of the Px in distinguishing an anteverted from a retroverted uterus, a non-pregnant from a pregnant uterus, and an abnormal from a normal cervix (done by trainer changing optional organs in the pelvic model without Px observing).
- Throughout the simulated practice, Px should practice her or his role as clinician by talking to the “client” while performing the exam, explaining what is taking place and why, what sensations the client might be feeling, and what the findings are.
Specific Objective #3: Load the TCu 380A while it is still inside sterile package, without touching it directly.

**CONTENT:**

## Reasons to load the TCu 380A in the Sterile Package

There are at least 2 reasons to load the TCu 380A inside the sterile package instead of using sterile gloves to load the IUD outside the package.

- Not touching the IUD directly will ensure its sterility, thus avoiding the risk of PID.
- Loading the TCu 380A while it is in the package eliminates the need to use sterile or HDL gloves. Gloves are frequently inadvertently contaminated by inexperienced practitioners, and will need to be changed before continuing with the insertion, if contaminated.

At first, loading the TCu 380A inside the sterile package may appear awkward and time-consuming, however, with help from the trainer and some practice, the Px will be able to perform this maneuver in less than 20 seconds.

**METHODOLOGY:**

## Demonstration and Practice (45 min.)

The trainer should:

- Discuss the reasons for loading the TCu 380A in the sterile package.
- Have sample IUDs on hand, some out of the package and some still inside of the sterile package.
- Distribute 1 or 2 TCu 380As in sealed packages to each Px (expired IUDs may be used).
- Display Transparency 2.2: The TCu 380A IUD. Always use the same name for the parts of the IUD.
- Ask the Px to point to the following parts in the packages they are holding: arms, stem, inserter tube, blue depth gauge, ID card, white rod, thumb grip.
- Name the parts of the IUD package—the clear plastic and the white backing flap.
- Demonstrate the steps needed to load the TCu 380A in the sterile package.
- Observe Px as she or he follows the steps in order. (See Px Handout 2.3.1: Instructions for Loading the TCu 380A in the Sterile Package.)
- Allow the Px to practice until competent; alternatively, she or he may choose to practice at home or work and then demonstrate the skill, once acquired, to the trainer.
Specific Objective #4: Perform all steps in safe and gentle IUD insertion and removal, efficiently and in the correct sequence, according to written standardized technique for TCu 380A IUDs.

**CONTENT:**

Px will achieve this objective through a variety of training methodologies.

Throughout insertion and removal training, **certain basic principles** are to be emphasized.

- **Gentle techniques** to minimize discomfort and emotional trauma to the client. In order to perform a comfortable IUD insertion, force is neither necessary nor desirable.
- **No-touch technique** in which the tip of the uterine sound that will touch the upper genital tract will not have previously touched any unsterile surface: hands, speculum, vagina, table top, etc.
- TCu 380A is loaded inside package, as already indicated in Specific Objective #3.
- The cervix and vagina should be thoroughly prepped with antiseptic. Use a water-based antiseptic such as an iodophor (Betadine or Povidone Iodine) or Chlorhexidine (Hibitane)

**Note:** *If an Iodophor is used, wait 1 or 2 minutes before proceeding because Iodophors take up to 2 minutes of contact time to release free iodine.*

- The uterine cavity should always be sounded to confirm the position of the uterus and the depth of the

**METHODOLOGY:**

**Discussion/Video (Up to 4 hours depending on the availability of models and the number of Px)**

The trainer should:

- Provide a brief review of key performance features of TCu 380A, referring back to Unit 1.
- Use the JHPIEGO video and/or slide set to describe standard insertion and removal techniques.
- Demonstrate insertion and removal both on the hand-held and life-size pelvic models.
- During this demonstration, role-play a provider, speaking to the “client.”
- Demonstrate insertion and removal exactly, and in the same order, as in Px Handouts 2.4.1: Basic Principles for IUD Insertion and Removal, 2.4.2: Passing a Uterine Sound, and 2.4.3: Inserting the Loaded TCu 380A IUD
- Divide the Px into pairs and distribute Px Handouts 2.4.2 and 2.4.3.
- Have one Px use the guide to coach the other Px, step-by-step, in the insertion technique.
- Each Px will have a chance both to coach a colleague and to insert and remove the IUD on the model under observation by trainer.
- The rest of the Px may spend this time working with hand-held models,
Intrauterine Devices (IUDs)

- Set the depth gauge on the IUD to the level on the uterine sound.
- Insert the IUD high in the fundus of the uterus by withdrawal technique, as there is less risk of expulsion.

- Practicing loading the TCu 380A inside the package, or viewing slides or video, etc.

**Insertion Practice:**

The trainer should:

- Be available after this activity, as Px will need access to the life-size pelvic model to practice until they feel ready for competency-based evaluation by trainer.
- The trainer needs to be available at preset times to meet with Px and correct any misinformation or steps not performed correctly, etc.
- The time required per Px will vary and is defined only by the time necessary for trainer and Px to be satisfied with skill competency (i.e., the Px will perform all key steps of IUD insertion and removal in correct manner and in correct order, as determined by the trainer, using Px Handout 2.4.4: Using the Clinical and Counseling Skills Checklist and 2.4.5: Checklist for IUD Counseling and Clinical Skills).

**Note:** This competency-based checklist also includes counseling skills. Although these do not have to be demonstrated for the purpose of this session, the complete checklist will be used during the clinic practicum.

- At the skills acquisition stage, Px may also spend time observing IUD insertions and removals in clients by the trainer or training-center staff and obtaining more experience in pelvic examination.
Clinical Practicum: (Time: depends on availability of clients and experience of Px.)

The trainer should:

- Permit Px to do clinical practicum once certified competent to insert and remove IUDs in the simulated-practice setting.
- Accompany all Px and observe their interpersonal communication with clients, infection-prevention precautions, and other necessary skills.
- Remind Px of any forgotten key steps, monitor the practice of gentle and no-touch techniques, suggest improvements and, if necessary, replace Px if clients may suffer injury or risk without her or his intervention.
- As in Learning Objective #1, discuss each case with the Px and sign off each case in the Px's client record notebook.
- When confident of Px's competency (evaluated using checklists), certify Px as capable of delivering IUD services in her or his clinic.

Note: Final certification cannot take place until all Learning Objectives have been achieved.
Specific Objective #5: Describe recommended infection prevention practices in the provision of IUD services to minimize risk to client and provider.

**CONTENT:**

**Infection Prevention Guidelines for IUD Insertion or Removal**

**Decontamination**

1. While still wearing gloves, dispose of contaminated objects (gauze, cotton, etc.) in a properly marked, leak-proof container or plastic bag.

2. Fully immerse all metal instruments in a plastic bucket containing 0.5% chlorine solution (bleach) for 10 minutes before allowing staff and cleaning personnel to handle or clean them. (This prewash soak kills most microorganisms, including HBV and HIV.)

3. All surfaces (such as the procedure table or the instrument stand) that could have been contaminated by blood or mucus should also be wiped with chlorine solution.

4. If single-use (disposable) gloves were used, carefully remove them by inverting and place in the leak-proof waste container. If gloves are reusable, first briefly immerse both gloved hands in bucket containing chlorine solution and then carefully remove by inverting. Deposit gloves in chlorine solution.

**METHODOLOGY:**

**Lecture, Discussion and Demonstration: (2 hours)**

The trainer should:

- Pass out 4-5 index cards to each Px.
- Ask Px to think of possible ways that infection may be spread in connection with IUD insertion or removal procedures.
- Collect all of the index cards.
- Organize them according to various phases in the IUD insertion and removal process. Use this exercise as a way to introduce the topic.
- Review infection prevention guidelines for IUD insertion or removal and infection prevention tips for both IUD insertion and removal as seen in the content column.
- Set up a demonstration area with the following supplies:
  - Leak-proof container or plastic bag
  - Plastic bucket
  - Chlorine
  - Gloves—either single-use or reusable
  - Detergent
  - Soft brush
  - 2% glutaraldehyde or 8% formaldehyde solution
Cleaning and Rinsing

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

High-Level Disinfection

High-Level Disinfection (HLD) through boiling or the use of chemicals is recommended. Surgical (metal) instruments and reusable gloves should be boiled for 20 minutes. **Begin timing when boiling action starts.** Alternatively, instruments can be soaked for 20 minutes in a 2% glutaraldehyde or 8% formaldehyde solution. After cooling (if boiled) or rinsing in boiled water (if chemical disinfectants used) and drying, instruments are ready to use. Use immediately or store for up to one week in a clean, dry, HLD container with a tight-fitting lid or cover.

Sterilization

Alternatively, instruments and reusable gloves used for IUD insertion and removal can be sterilized by autoclaving (121°C [250°F] and 106 kPa [15 lb/in2] for 20 minutes if unwrapped and 30 minutes if wrapped).

**Note:** Dry heat sterilization (170°C [340°F] for 60 minutes) can be used only for metal or glass instruments.
Storage
Unwrapped instruments must be used immediately. Wrapped instruments, gloves, and drapes can be stored for up to 1 week if the package remains dry and intact, 1 month if sealed in a plastic bag.

Infection Prevention Tips: IUD Insertion
To minimize the client’s risk of post-insertion infection, clinic staff should strive to maintain an infection-free environment. To do this:

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

When these tips are followed, post-insertion infection rates are low; therefore, use of prophylactic antibiotics is **not** recommended.
Infection Prevention Tips: IUD Removal

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

- Wash hands thoroughly with soap and water **before** and **after** each procedure.
- When possible, have the client wash her genital area **before** doing the screening pelvic examination.
- Use **clean, HLD** (or sterilized) instruments and gloves (**both hands**) or use disposable (single-use) examination gloves.
- Apply antiseptic solution several times to the cervix and vagina before beginning the procedure.
- Properly dispose of waste material after removal.
- Decontaminate instruments and reusable items **immediately** after using them.
Specific Objective #6: Provide follow-up management of the IUD client, including appropriate management of common side effects and referrals for complications.

**CONTENT:**

**Post-Insertion Follow-up**

Follow-up management of the IUD client involves routine follow-up visits as well as problem visits and management of common side effects. Routine follow-up visits should include at least a first check-up 3 to 6 weeks after IUD insertion.

The client can return for a visit to have the IUD removed when it has been in place for the recommended number of years (12 years for the TCu 380A) or when client wishes to have it removed for any reason. (The latest scientific evidence shows that the TCu 380A is effective for at least 12 years.) In addition, the client should be able to return for a visit if she has questions, concerns, or any signs or symptoms she thinks may be caused by the IUD. If facilities are available, it is also recommended that clients have yearly routine gynecological checkups, but these are not a necessary part of IUD management.

Remember to teach her the warning signs. If she has any of these signs she must return for a visit immediately.

- Fever (a possible sign of infection);
- Abdominal pain, or pain during intercourse;
- Purulent or foul smelling discharge;

**METHODOLOGY:**

**Question/Answer: (2.5 hours)**

The trainer should:

- Review post-insertion follow-up, using the content found on the left-hand side of the page and **Px Handout 2.6.1: IUD Follow-Up Care**.
- Review **Px Handouts 2.6.2: IUD Post-Insertion Follow-Up Care, 2.6.3: Management of Complications, and 2.6.4: Management of Side Effects and Complications**.
- Discuss the management of each of the IUD related problems found in **Px Handouts 2.6.4, 2.6.5: Managing Severe Cramping, 2.6.6: Managing Amenorrhea, 2.6.7: Managing Expelled IUD, 2.6.8: Managing Missing Strings, and 2.6.9: Managing Irregular or Heavy Bleeding**.

**Case Study Exercise (45 min.):**

The trainer should:

- Divide the Px into 4 groups.
- Distribute the case studies on IUD complications found in **Px Handouts 2.6.10: Case Study #1, 2.6.11, Case Study #2, 2.6.12: Case Study #3, and 2.6.13: Case Study #4**. Give 1 to each group.
- Each group should discuss the material and develop a course of action based on the study. Allow 20
An IUD string that becomes shorter, longer, or missing.

When a client comes for follow-up care, follow recommendations in Px Handout 2.6.1. For problem visits and management of side effects and complications, follow protocols and recommendations in the Px Handout 2.6.2 and 2.6.3.

If a complication such as PID, pregnancy with IUD, perforation, difficulty in IUD removal, or missing strings is suspected, thePx should be instructed to refer the client to an Ob/Gyn or specialist (trainer) for management.

Reconvene the large group and discuss the case studies.

Finally, have Px help compile a definitive list of local specialists or clinics to which clients may be referred, procedures for referral, and ways to obtain information back from the specialist.

During clinical practicum, Px will participate in management of clients with side effects or complications.
Specific Objective #7: Describe the minimum clinic requirements and recordkeeping tasks necessary for IUD services.

To offer quality IUD services, the provider needs to meet minimum criteria of space, privacy, equipment, supplies, recordkeeping, and availability of referrals.

The minimum clinic requirements are:

- Space, separate from waiting area for counseling, which ensures privacy for client;
- Examination table and procedure area which ensures client privacy;
- Supply cabinet to store instruments and IUDs;
- Water, adequate light, and toilet facility in or very near office; and
- Basic standardized equipment and supplies sufficient for 2 IUD insertions:
  - 2 specula,
  - 2 tenacula,
  - 2 uterine sponge forceps,
  - 2 pairs of scissors,
  - 2 uterine sounds,
  - 2 utility forceps,
  - Cotton or gauze,
  - Antiseptic,
  - Covered instrument trays,
  - 6 pairs of reusable gloves or 1 box of disposable gloves,
  - Client record forms,
  - Cooker or stove,
  - Fuel supply,
  - Glutaraldehyde or 8%

**Lecture/Discussion (1 hour)**

The trainer should:

- Discuss how to set up the procedure room for IUD insertion and how to organize client flow throughout the clinic.
- Discuss the minimum criteria needed to give quality IUD services. (See Px Handout 2.7.1: Minimum Standards for IUD Services.)
- Ask Px how their client records are currently stored.
- Discuss effective ways of storing and retrieving client records.
- Brainstorm what should be included in the client record for IUD clients.
- Thank Px for their participation in the course. Ask for comments or questions.
- Pass out the course evaluation form.
- Allow Px 15 min to complete the course evaluation form.
- Pass out the post-test for Unit 2, Px Handout 2.7.2: Unit 2 Post-Test.
- Allow Px 30 min to complete the test.
formaldehyde solution,
> Chlorine solution (bleach), and
> Decontamination bucket.

**Client Records**

Client records should be stored in a way that facilitates easy retrieval. Each IUD client record should include the following:

> The date of the consultation and the name of the provider,
> The medical and menstrual history (anything unusual should be noted),
> A record of the physical examination (anything unusual should be noted),
> Any laboratory tests performed,
> A record of the counseling session and information provided,
> Any medications given, and
> Detailed notes of the follow-up visit.

Written informed consent is not necessary for IUD insertion, unless required in national clinical standards and guidelines.

The trained provider will also establish a routine for receiving and serving IUD clients: referring them when necessary, and training her or his support staff in infection prevention, waste disposal, etc. Client information materials about the IUD should be made available to clients and families.
Trainer’s Tools
Transparency 1.1: Unit 1 Objectives

By the end of this unit participants will be able to:
1. Explain key messages related to the IUD as a safe and effective contraceptive method;
2. Describe the types of IUDs available, the mechanism of action, and effectiveness of the IUD;
3. Explain major advantages and disadvantages of the IUD;
4. Describe indications for using the IUD and rationale for each;
5. Identify eligibility criteria for initiating use of the IUD, and explain rationale for each;
6. Respond to rumors and misconceptions about the IUD, raised by clients or service providers;
7. Describe the six key steps of the counseling process, using an approach called RESPECT;
8. Screen a potential client for IUD insertion, using an assessment checklist;
9. Discuss when to insert and remove an IUD;
10. Describe IUD insertion and removal procedures to clients; and
11. Recognize IUD side effects and warning signs of complications.
Transparency 1.2: Female Pelvic Organs
Transparency 1.3: Female Pelvic Organs with IUD
Transparency 2.1: Unit 2 Objectives

By the end of this unit participants will be able to:

1. Demonstrate effective IUD counseling through role-playing;

2. Use standard checklists to take a limited history and perform a limited physical exam in order to advise, screen, and select clients who request IUDs;

3. Load the TCu 380A while it is still inside the sterile package, without touching it directly;

4. Perform all the steps in safe and gentle IUD insertion and removal, efficiently and in correct sequence, according to written standardized protocols for TCu 380A;

5. Describe recommended infection prevention practices in the provision of IUD services, in order to minimize risk to client and provider;

6. Provide follow-up management of the IUD client, including appropriate management of common side effects and referrals for complications; and

7. Describe the minimum clinic requirements and recordkeeping tasks necessary for IUD services.
Intrauterine Devices (IUDs)

Transparency 2.2: The TCu 380A IUD
Options for Ice Breakers

1. Lifelines
Purpose: To help participants get to know each other
Time Required: 20 – 30 minutes
Materials Required: Flip chart paper and markers
Description: Ask participants to draw a line on a piece of flip chart paper turned sidewise. If needed, they may use additional paper. At one end is their date of birth. Along the line participants should record the important events in their life that “shaped” the person they have become today. The events may be personal, professional, or simply interesting.

After each participant completes their “lifeline” they should explain it to the group.

2. What’s Your Name?
Purpose: To help participants and the trainer to learn each other’s name.
Time Required: 15-20 minutes
Materials Required: None
Description: Ask each participant to introduce themselves to the group by giving their name and one unusual thing about themselves. For example, “My name is Elizabeth and I drove a tank.” The next person repeats the name and information about the first person and adds his or her own name and fact. Each person follows the same procedure, recalling all of the names and facts.

3. Shout, Whisper, Sing
Purpose: To help participants remember new names.
Time Required: 10 minutes
Materials Required: None
Description:
- Ask participants to stand in a circle.
- Explain that you are going to call out someone’s name as you cross the circle towards him or her. The person whose name you called should then take your place in the center of the circle.
- The person who is now in the center should call out someone else’s name and that person moves to the center.
- When your name is called again, continue the game, but this time everyone must whisper the person’s name.
- Finally when your name is called out again, continue the game, but this time everyone must sing the person’s name.
4. The Interview
Purpose: To introduce participants and learn something about them.
Time Required: 20-30 minutes
Materials Required: Pen and paper for note taking
Description: Ask participants to choose a partner they don’t know.
  - Give five minutes for each person to interview their partner. Instruct them to find out as much about their partner as possible. Notes may be taken.
  - After the interviews ask each person to introduce their partner to the rest of the group.

Note: This introduction works best when the group is less than 20 people.

5. The Cocktail Party
Purpose: For larger groups to get acquainted with as many people in the group as possible.
Time Required: This is up to the trainer. Each introduction takes one minute.
Materials Required: None
Description: Ask each person to introduce themselves to someone and spend a minute learning about each other.
  - After one minute ask everyone to find a new person to get acquainted with for one minute.
  - Continue changing every minute as long as you have time. The longer you spend at the exercise the more people each person will met.

6. Common Ground
Purpose: This introduction works for small groups, especially for a small group working as a team. It also works well when there are several small groups that make up a larger group.
Time Required: 10-15 minutes
Materials Required: Pen and paper
Description: Instruct each group to list everything they can find that they have in common. Give them a time limit (five minutes or so) and tell them to avoid the obvious things like, we are all in this work shop, etc.
  - Ask each group to assign one person to write down the things the group has in common.
  - When the time is up, ask each group to read the things on their list.

7. Who is Who?
Purpose: To help participants and the trainer to learn something about each other. This exercise works best when people already know each other, at least by name.
Time Required: 20 minutes
Materials Required: A slip of paper for each participant and a bowl
Intrauterine Devices (IUDs)

Description:
- Hand out a slip of paper to each participant
- Ask each participant to write several things about themselves that would help other participants recognize them such as tall or thin, hair, glasses, etc.
- Ask participants to fold the slips of paper and put them into a bowl
- Ask each participant to pick a slip of paper from the bowl
- One at a time ask participants to identify the person described on their slip of paper

8. Catch the Ball!
Purpose: To help participants learn each others names
Time Required: 30 minutes
Materials Required: A ball, preferably large and easy to catch
Description:
- Have participants form a circle.
- Begin the exercise by throwing the ball to someone else in the circle.
- The person who catches the ball must name the person who threw it.
- The person who caught the ball throws it to another person who names him or her and the game continues.

Variation: With small groups it is possible for each person who catches the ball to recite the names of all the people who have already thrown the ball.

9. Pass the Fruit
Purpose: To help participants learn something about each other
Time Required: 20 minutes depending on the size of the group
Materials Required: A piece of fruit big enough for participants to pass to each other without using their hands.
Description:
- Arrange participants in a circle.
- Give the first person a piece of fruit and ask him or her to pass the fruit to the next person without using his or her hands.

10. Two Truths and a Lie
Purpose: To help participants who already know each other get to know more about each other.
Time Required: 12-30 minutes, depending on the number of participants.
Materials Required: One small prize
Description:

- Explain the introductory exercise “Two Truths and a Lie.”
- Each participant should first give their name and designation and then tell the rest of the group three interesting things about themselves. The facts should be things the rest of the participants are not likely to know.
- The group has to decide which piece of information is the lie.
- After everyone has introduced themselves and their lie, ask the group to vote on the best or most imaginative lie.
- Give the person who wins a small prize.

11. Two Loves and One Hate

Purpose: To help participants who already know each other get to know more about each other.

Time Required: 12-30 minutes, depending on the number of participants.

Materials Required: One small prize

Description:

- Ask participants to write down two things they really love and one thing they really hate on a piece of paper. Encourage participants to write unusual things, not ordinary everyday things.
- Instruct participants to put their paper face down and not show other participants.
- Ask each person to take a turn reading their two loves and one hate to the rest of the group. Participants should present each item by saying “The first thing I love or hate is—”
- Ask the rest of the group to guess which things the person loves and what is the one thing the person hates. At the same time the person tells the things they love and hate, they should also briefly introduce themselves to the other participants.
- At the end of the exercise ask participants to vote on which was the most interesting or outrageous “hate” and give a prize.

12. Mix and Match

Purpose: To match up participants for mutual introductions.

Time Required: 30 minutes

Materials: Whatever you use, you will need one for each pair of participants. You may use holiday greeting cards or IEC, or BCC material related to the course.

Description:

- Collect the holiday greeting cards or IEC or BCC material you have decided to use.
- If you use greeting cards, cut off everything except the first page with the picture on it. Whatever you use, you will need one picture for each pair of participants. Each pair should
have a different picture if possible.

- Cut each picture in half. If you don’t have a different picture for each pair of participants, then cut the pictures in half in different ways.
- Distribute one half of a picture to each participant.
- Instruct participants to mix with each other until they find the person holding the other half of their picture.
- When they find a partner, each person should find out enough interesting information about their partner to introduce their partner to the rest of the group.
- Gather the group together and have each pair introduce their partner to the rest of the group.

13. The Walking Billboard

Purpose: To provide an interesting way of having a new group of participants mix with each other and share information about themselves.

Time Required: 30 minutes

Materials Required: A half of a piece of flip chart paper for each participant, masking tape, markers for each participant

Description:

- Ask participants to think of some things they would like to learn about other participants.
- Write these on a flip chart. These might include things like where they work, favorite food, how many children they have, hobbies, etc.
- Have the group agree on five or six favorite items.
- Ask them to take the flip chart paper they have been given, write their name on the top and then answer the questions about themselves.
- Now, ask them to take their flip chart paper and attach it to their back using masking tape.
- Ask them to walk around the room and discover who everyone is.

14. Self-Disclosure

Purpose: To introduce participants to each other. It is useful as an opening exercise for participants who already know each other.

Time Required: Two minutes for each person

Materials: None

Description:

- Ask each person to take two items from their purse or pocket. Suggest that they take out things that are important to them for some reason or another.
- Ask each person to introduce themselves and explain why the item is important to them.

Note: You can also relate this exercise to a specific training. For example, ask “How does this item relate to you as a potential trainer?”
The IUD: An Overview
Pre/Post-Test Answer Key
UNIT 1

Participant Name_________________________________________________

Instructions: Circle the letter(s) that correspond to the correct answer(s). Some questions may have more than one correct answer.

1. Who is the best-qualified person to choose a contraceptive method for a woman in good health?
   a. a trained physician
   b. a woman's mother in law
   c. the woman herself
   d. the person who counseled her

2. Women who are not in a mutually faithful relationship (i.e., she or her partner have other sexual partners) may be at increased risk of
   a. uterine perforation with IUD insertion
   b. Sexually Transmitted Infections (STIs)
   c. ovarian cancer
   d. all of the above

3. The IUD not only protects a woman from undesired pregnancy, but also from
   a. developing fibroids
   b. HIV infection
   c. anemia
   d. all of the above
   e. none of the above

4. When an IUD client presents with a late period, you should rule out
   a. allergy to copper
   b. pregnancy
   c. cervical cancer
   d. PID
5. Following the insertion of an IUD, you should recommend that the client, even if she has no problems, have it checked after
   a. three days
   b. one week
   c. **three to six weeks**
   d. three to six months

6. The most likely mechanism of action of the IUD is that
   a. it interferes with implantation
   b. **it interferes with fertilization**
   c. it interferes with ovulation
   d. it acts as a barrier to prevent sperm from entering uterus

7. The IUD is NOT an appropriate contraceptive method for a woman who
   a. is taking rifampin
   b. is not sure she wishes to have a tubectomy
   c. **has unexplained vaginal bleeding**
   d. **gave birth three weeks ago**

8. During counseling on the IUD, a client should be informed that common side effects of the IUD may include
   a. nausea
   b. headaches
   c. **mild cramping and light spotting**
   d. heavy vaginal discharge

9. The IUD is
   a. 90-95% effective
   b. **greater than 99% effective**
   c. 100% effective
   d. none of the above
10. Correctly loading the TCu 380A IUD in the sterile package:
   a. should be done only if sterile gloves are available
   b. assures that the IUD will remain sterile until it is removed from the package
   c. is not necessary for physicians
   d. all of above

11. List the five warning signs that alert the client that something is wrong:

   Abnormal bleeding: (no period, heavy bleeding, abnormal spotting)

   Abnormal discharge

   Pain/dyspareunia

   Fever

   String missing or shorter or longer

12. TRUE or FALSE. Mark “T” or “F” in the blank to indicate true or false.

   a. T Counseling should be integrated into each and every interaction with a FP client.
   b. F Following IUD insertion, heavy, yellow vaginal discharge is common.
   c. F An IUD should only be removed during menstruation.
   d. T An IUD may be inserted at any time during the menstrual cycle, if the provider is reasonably certain that the client is not pregnant.
   e. F After an IUD is removed, a healthy woman may expect several months’ delay in return to fertility.
   f. F It is better to change all IUDs after two years, because leaving them in the uterus for a longer period may lead to development of complications.
   g. F IUDs increase the risk of ectopic pregnancy.
The IUD: Providing Services
Pre/Post-Test Answer Key
UNIT 2

Participant Name __________________________________________________________

Instructions: Circle the letter(s) that correspond to the correct answer(s). Some questions may have more than one correct answer.

1. In counseling a woman about the advantages of the TCu 380A IUD, you would inform her that the IUD
   a. is permanent
   b. is highly effective
   c. has few side effects for most women
   d. does not interfere with sexual intercourse
   e. is effective in preventing anemia.

2. Which of the following conditions are precautions, which influence the suitability of IUD for a particular woman?
   a. pregnancy
   b. three or more children
   c. at risk for STIs
   d. history of candidiasis
   e. retroverted uterus
   f. current pelvic infection

3. Prior to IUD insertion, a pelvic exam is performed to
   a. determine uterine position and size
   b. rule out anteflexion
   c. rule out pregnancy
   d. rule out presence of infection, masses, and tumors

4. Prior to an IUD insertion all metal instruments used should be
   a. decontaminated with soap and water
   b. decontaminated in 0.5% chlorine solution for 10 minutes
c. cleaned with formaldehyde and water  
d. cleaned with detergent and water  
e. high level disinfected by boiling in a covered pot for 20 minutes  
f. high level disinfected by autoclaving (unwrapped) for 20 minutes at 106kPa pressure at 1210 degrees

5. Key infection prevention activities for IUD insertion include  
   a. washing hands carefully  
   b. cleaning the cervix and vagina with an antiseptic solution  
   c. decontaminating, cleaning and high level disinfecting or sterilizing all instruments used  
   d. proper contaminated waste disposal  
   e. training and supervision of cleaning staff in infection prevention

6. Reasons for follow up visits after an IUD insertion can include  
   a. first check up one week after insertion  
   b. first check up three to six weeks after insertion  
   c. client wants device removed because she doesn't like it  
   d. removal when the IUD has been in place for one year

7. The following are warning signs that you should teach to an IUD client, which indicate that she may be having a problem with her IUD and should seek medical attention:  
   a. cramping with menses  
   b. increased length of menstrual cycle  
   c. sexual partner has abnormal penile discharge  
   d. string is longer than usual  
   e. pain with intercourse

8. IUD clients should be counseled  
   a. before the insertion  
   b. after insertion  
   c. during each follow up visit  
   d. all of the above
True or False: Mark “T” or “F” in the blank to indicate true or false.

9. **T** A woman herself is best at selecting her own contraceptive method.
10. **F** Douching daily after an IUD infection is recommended to prevent PID.
11. **T** A physical exam for an IUD client must include abdominal, speculum, and bimanual exams.
12. **F** You must use high level disinfected or sterile gloves to place a copper IUD in its inserter.
13. **T** A tarnished IUD in a sealed, undamaged package can be used.
14. **T** An IUD can be inserted in a woman who is ovulating.
15. **F** The “push” technique should be used when inserting TCu 380A IUDs.
16. **T** The “no touch” technique should be used when inserting IUDs.
17. **F** An IUD client who has moderate bleeding for seven to ten days after insertion should have the IUD removed immediately.
18. **T** If PID is diagnosed in a woman with an IUD; the IUD should be removed, antibiotic treatment should be started and she should be counseled on and provided with an alternative contraceptive.
19. **T** If an IUD is partially expelled, it should be removed, and a new IUD can be inserted immediately.
20. **F** If a woman becomes pregnant with an IUD, it should be left in place unless a problem develops.
IUD Training Course
Participant Evaluation

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

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

Course Materials
I feel that:
• The objectives of the module were clearly defined.  5
• The material was presented clearly and in an organized fashion.  5
• The pre-/post-test accurately assessed my course learning.  5
• The competency-based performance checklists were useful.  5

Technical Information
• I learned new information in this course.  5
I will now be able to:
• Provide appropriate counseling to women considering the IUD as a contraceptive method.  5
• Screen clients to determine if the IUD is a good method for them.  5
• Provide safe IUD insertion and removal services.  5
• Manage side effects and complications of IUDs.  5

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

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

Suggestions

What was the most useful part of this training?

What was the least useful part of this training?

What suggestions do you have to improve the module? Please feel free to reference any of the topics above.
Major References and Training Materials

Introduction to Training:

Unit 1
Intrauterine Devices (IUDs)

- JHUCCP. *WHO Updates Medical Eligibility Criteria for Contraceptives*. Info Reports, Issue 1, August 2004.

**Unit 2**


Participant Handout 1.8.1


Mishell DR, Roy S. *Copper intrauterine contraceptive device event rates following insertion 4 to 8 weeks postpartum.* American Journal of Obstetrics and Gynecology 143(1): 29-33 (1982).


**Participant Handout 1.8.3**

Participant Handout 2.2.2

- Family Health International. *Checklist for Screening Clients who Want to Initiate Use of the Copper IUD* 2006

Participant Handout 2.2.3


Participant Handout 2.3.1


Participant Handout 2.4.2


Participant Handout 2.4.3


Participant Handout 2.5.1


Participant Handout 2.6.2

Participant Handout 2.6.3


Participant Handout 2.6.4


Transparency 1.2


Transparency 1.3


Transparency 2.2

Acknowledgements

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Unit 1:
An Overview of the IUD
Participant Handout: 1.0.1: Suggestions for Effective Participation

DO

- Ask a question when you have one.
- Feel free to share an illustration.
- Request an example if a point is not clear.
- Search for ways in which you can apply a general principle or idea to your work.
- Try to evaluate how you are already performing a skill based on new techniques you are learning.
- Think of ways you can pass on ideas to your subordinates and coworkers.
- Be skeptical—don’t automatically accept everything you hear.
- Feel free to ask for clarification.
- Respect the ideas of other participants.

DON’T

- Try to develop an extreme problem just to prove the trainer doesn’t have all the answers. (The trainer doesn’t.)
- Close your mind by saying, “This is all fine in theory, but...”
- Assume that all topics covered will be equally relevant to your needs.
- Take extensive notes; the handouts will satisfy most of your needs.
- Don’t monopolize class time by trying to show how much you know.
- Engage in side talk.
- Interrupt others.
Participant Handout: 1.0.2: Exercises: “Where are we?” and “Reflections”

Where Are We?
Starting each day with “Where are We?” is our opportunity to share insights, clarify issues, resolve problems, and review important material so that each of us can get the most out of the course and each day’s experiences.

Problems identified during the “Where Are We?” session should be resolved before continuing (whenever possible), since unresolved issues may hinder the learning process.

Each participant will be given two pieces of different colored paper. On one, participants write which topic they found most useful from the previous day and how they will apply it to their work. On the other piece they should write a question or concept from the previous day that needs clarification.

The trainer will process the exercise by reviewing and grouping the topics participants found most useful and by answering questions raised or clarifying areas of confusion.

Reflections
At the end of each day, take time to look over what we have done to
• Examine what it means to us individually, and
• Explore how what we have learned can be applied in a broader setting.

Be sure to close each day’s activities with a session of “Reflections” on the day.

There are many ways to conduct this exercise. One way is to pass out two colored cards to be completed anonymously. On one card, participants write what they liked about the day and what went well. On the other card, participants write things they did not like and that they hope will improve.

The housekeeping team and the training team will review the results. The trainer will announce the results the following day and will explain how the training team responded to the suggestions.

In addition to the “Reflections” exercise, participants should bring problems or concerns to the attention of the housekeeping team for discussion with the training team at the end of the day.

Make a note of the participants’ and trainer’s feedback, and attempt to address ideas and concerns during the discussion and during the following days’ lesson plans.
Participant Handout 1.0.3:  
Unit 1 Pretest

Participant Name_________________________________________________

Instructions: Circle the letter(s) that correspond to the correct answer(s). Some questions may have more than one correct answer.

1. Who is the best-qualified person to choose a contraceptive method for a woman in good health? 
   a. a trained physician 
   b. a woman’s mother in law 
   c. the woman herself 
   d. the person who counseled her 

2. Women who are not in a mutually faithful relationship (i.e., she or her partner have other sexual partners) may be at increased risk of 
   a. uterine perforation with IUD insertion 
   b. Sexually Transmitted Infections (STIs) 
   c. ovarian cancer 
   d. all of the above 

3. The IUD not only protects a woman from undesired pregnancy, but also from 
   a. developing fibroids 
   b. HIV infection 
   c. anemia 
   d. all of the above 
   e. none of the above 

4. When an IUD client presents with a late period, you should rule out 
   a. allergy to copper 
   b. pregnancy 
   c. cervical cancer 
   d. PID
5. Following the insertion of an IUD, you should recommend that the client, even if she has no problems, have it checked after
   a. three days
   b. one week
   c. three to six weeks
   d. three to six months

6. The most likely mechanism of action of the IUD is that
   a. it interferes with implantation
   b. it interferes with fertilization
   c. it interferes with ovulation
   d. it acts as a barrier to prevent sperm from entering uterus

7. The IUD is NOT an appropriate contraceptive method for a woman who
   a. is taking rifampin
   b. is not sure she wishes to have a tubectomy
   c. has unexplained vaginal bleeding
   d. gave birth three weeks ago

8. During counseling on the IUD, a client should be informed that common side effects of the IUD may include
   a. nausea
   b. headaches
   c. mild cramping and light spotting
   d. heavy vaginal discharge

9. The IUD is
   a. 90 - 95% effective
   b. greater than 99% effective
   c. 100% effective
   d. none of the above

10. Correctly loading the TCu 380A IUD in the sterile package
    a. should be done only if sterile gloves are available
    b. assures that the IUD will remain sterile until it is removed from the package
    c. is not necessary for physicians
    d. all of above
11. List the five warning signs that alert the client that something is wrong:

12. TRUE or FALSE. Mark “T” or “F” in the blank to indicate true or false.

a. ___ Counseling should be integrated into each and every interaction with a family planning client.

b. ___ Following IUD insertion, heavy, yellow vaginal discharge is common.

c. ___ An IUD should only be removed during menstruation.

d. ___ An IUD may be inserted at any time during the menstrual cycle, if the provider is reasonably certain that the client is not pregnant.

e. ___ After an IUD is removed, a healthy woman may expect several months’ delay in return to fertility.

f. ___ It is better to change all IUDs after two years, because leaving them in the uterus for a longer period may lead to development of complications.

g. ___ IUDs increase the risk of ectopic pregnancy.
Participant Handout 1.1.1: Key Messages

Key Messages

1. The IUD is a safe, easy to use, reversible, effective, long-term method of contraception.

2. IUD users are very satisfied with their IUD. However, the IUD affects menses, which may be a problem for some women.

2. Careful screening and counseling are essential for successful use of an IUD. *(The provider must know if the client should not use the IUD. The client must know how the IUD works, what the side effects might be, how to check for strings, and what the warning signs are.)*

3. IUDs can be safely used by breastfeeding women. *(The IUD does not affect breastfeeding.)*

4. IUDs are safe, even for women at risk of Sexually Transmitted Infections (STIs) and HIV or women with STIs other than gonorrhea and Chlamydia. An IUD should not be inserted if a woman has purulent cervicitis, Chlamydial infection, or gonorrhea or is at high risk for either.

5. IUDs are safe for AIDS clients controlled with Antiretroviral Therapy (ART).

6. IUDs can be a good choice for women with Combined Oral Contraceptive (COC) precautions. *(The IUD does not affect blood pressure, cause headaches, or affect the rest of the body.)*

7. IUDs can remain in for 5 to 12 years, depending on the type. *The latest scientific evidence shows that the Copper T 380A (TCu 380A) is effective for at least 12 years.*

8. Good infection prevention practices are necessary during insertion and removal to safeguard the client and possibly the practitioner from infection.
Participant Handout 1.2.1: The IUD as a Method

Types of IUDs available
There are two types of IUDs: medicated (hormone releasing) or unmedicated (inert). The inert IUDs include copper-containing devices in a range of shapes and sizes and a non-medicated polyethylene device. The hormone releasing IUDs either release progesterone or levonorgestrel. Almost all IUDs have one or two strings hanging from them. The TCu 380A is widely available around the world. This training module focuses on the TCu 380A.

TCu 380A
More than 25 million TCu 380A IUDs have been distributed in 70 countries throughout the world. This model is made of polyethylene with barium sulphate (for X rays). The TCu 380A is T shaped, with 314mm of copper wire wound around the vertical stem. Each of the two arms of the T has a sleeve of copper measuring 33mm. The bottom has a clear knotted string, creating a double string effect. The TCu 380A is inserted into the cavity of the uterus by pulling the outer barrel over the plunger (withdrawal technique). It has a lifespan of 12 years, and pregnancy rate is less than 1 per 100 women years.

Mechanism of Action
The copper bearing IUD’s principal mechanism of action is to prevent fertilization by affecting sperm motility and ova development. Research has shown that sperm counts found in cervical mucus and the uterine tube are much lower in women using copper-containing IUDs. In addition to its primary mechanism of action on the sperm, the copper-containing IUD also produces an inflammatory environment in the endometrium. There are two types of studies that substantiate this mechanism of action: assays for Human Chorionic Gonadotropin (hCG) levels and evaluations of washings from the vagina and cervix. In one study, the serum hCG levels of 30 IUD users were monitored for 30 months; there were no changes in these levels, meaning that there were no signs of early pregnancy. In another study researchers studied women who were undergoing sterilization in the middle of their menstrual cycle. The women’s fallopian tubes were flushed and the fluid was examined to look for sperm and fertilized eggs. Eggs were recovered in half of the women not using contraception. In women using IUDs, no fertilized, normally-dividing eggs were recovered. IUDs that contain progesterone also cause the thickening of cervical mucus, which stops the sperm from entering the uterus. IUDs are not abortifacients.

Effectiveness
The TCu 380A is a highly effective form of long-term, reversible contraceptive with an associated failure rate of 0.8 percent in the first year of use (Trussell, 2004). In a long-term international comparative trial sponsored by the World Health Organization (WHO), the average annual failure rate was 0.4 percent or less, and after 12 years of use the cumulative failure rate for women using the TCu 380A IUD was 2.2 percent, which is comparable to that of female sterilization (United Nations Development Programme et al., 1997).
Continuation Rates and Client Satisfaction
Continuation rates are also high in IUD users—higher than those of most other reversible methods. Large clinical trials conducted in many developing countries show that approximately 70% to 90% of women are still using their IUDs one year after insertion.

*Note:* Continuation rates are not effectiveness rates, but do represent user satisfaction with the method.
Participant Handout 1.3.1: Advantages and Disadvantages

Advantages and Health Benefits

• Highly effective.
• Safe for most women.
• Reversible and economical.
• May be safely used by lactating and postpartum women.
• Good choice for older women with COC precautions.
• Long duration of use. The latest scientific evidence shows that the TCu 380A is effective for at least 12 years.
• One visit for insertion and minimal follow up is required after first three to six week checkup (unless the client has problems).
• Because nothing is required during sexual intercourse, IUDs allow women privacy and control over their fertility.
• Does not interact with medications.
• Can be removed whenever the client chooses.

Disadvantages and Health Risks

• Does not protect against STIs/HIV.
• Pelvic Inflammatory Disease (PID) may occur if the woman has Chlamydia or gonorrhea at the time of IUD insertion.
• May expose client to infection during insertion if infection prevention practices are not followed (this is minimal with good infection prevention procedures).
• Trained provider dependent.
• Some pain, cramping, minor bleeding on insertion.
• Heavier/longer menstrual periods, increased cramping, and bleeding/spotting fairly common in some women during the first three months.
• May contribute to anemia if a woman already has low iron blood stores before insertion and the IUD causes heavier monthly bleeding.
• Rarely, the wall of the uterus may be punctured during IUD insertion. Unless severe, this usually heals without treatment.
• Serious complications require immediate attention and good back up services.

Note: IUDs do not increase the risk of ectopic pregnancy. A WHO multicenter study found that IUD users are 50% less likely to experience an ectopic pregnancy than are women using no contraception. However, in the unlikely event of pregnancy in an IUD user, that pregnancy is more likely to be ectopic than would be a pregnancy in a non-user. Still, pregnancy for an IUD user is far more likely to be normal than ectopic: only an estimated 1 in every 13 to 16 pregnancies, or 6% to 8%, is ectopic.
Participant Handout 1.4.1: Indications for Using the IUD

Appropriate Users of IUDs
IUDs are an appropriate choice for a client who:
• Is not pregnant and wants an effective form of contraception;
• Has no signs of gonorrhea, Chlamydia, cancer, or reproductive tract abnormalities that would make insertion difficult;
• Is nulliparous (only after thorough consideration—infecion at a time of insertion should be carefully ruled-out);
• Has completed childbearing and does not want voluntary surgical contraception (IUDs are highly suitable for older women until menopause—the IUD is as effective as female sterilization, which has a failure rate of 0.5 per 100 women in the first year);
• Wants a long term, easily reversible method (IUDs have an excellent rate of return to fertility);
• Wants an effective method, but precautions exist for hormonal methods such as COCs (IUDs have little or no effect on body systems other than the reproductive tract);
• Is breastfeeding (IUDs do not affect lactation);
• Is immediately postpartum (IUDs may be inserted immediately after the delivery of placenta or within first 48 hours postpartum. This procedure requires a specially trained provider.);
• Has successfully used an IUD in the past (users with positive past experience tend to tolerate IUDs well); and
• Is in a mutually faithful sexual relationship (she is only having sexual intercourse with one person who is only having sexual intercourse with her). IUDs are appropriate for women who are at no or low risk for STIs and HIV. IUD insertion in a presence of gonorrhea or Chlamydia may increase risk for PID, which can lead to chronic pain, ectopic pregnancy, and infertility.
• An IUD is a safe method even for women who do hard physical work.

Women can begin using IUDs
• Without STI testing,
• Without an HIV test,
• Without any blood tests or other routing laboratory tests,
• Without cervical cancer screening, and
• Without a breast examination.

Summary
Crucial elements of safe IUD use are:
• The client is not pregnant,
• A careful screening and assessment of STI/HIV risk has been given,
• The provider is competent in IUD insertion and infection prevention practices,
• Reliable back up services available, and
• Careful and complete client counseling has been provided.
Participant Handout 1.5.1: Eligibility Criteria

Certain conditions make the use of an IUD inappropriate. Listed below are conditions which could effect the decision to use an IUD, followed by the recommendation of whether or not it should be used in that instance.

_Note: These recommendations are based on the WHO Medical Eligibility Criteria Classifications, Third Edition, 2004. This interpretation is for use when clinical judgment is limited. For more detailed classification (categories 1-4) refer to the WHO Medical Eligibility Criteria for Contraceptive Use._

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<th>YES (use the method)</th>
<th>NO (don't use the method)</th>
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<td>X</td>
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<tr>
<td>Postpartum</td>
<td></td>
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<tr>
<td>• Less than 48 hours</td>
<td>X</td>
<td></td>
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<tr>
<td>• 48 hours to four weeks</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• Four weeks or longer</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• Puerperal sepsis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postabortion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• First trimester</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Second trimester</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Postseptic abortion</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Menarche to 20 years</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• 20 years or older</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Essential hypertension</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>History of preeclampsia</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Deep venous thromboembolism</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Pulmonary embolism</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Superficial venous thrombosis</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Current and history of ischemic heart disease</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Known hyperlipidaemias</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Valvular heart disease</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Irregular vaginal bleeding</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>YES (use the method)</td>
<td>NO (don’t use the method)</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Unexplained vaginal bleeding, before evaluation</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Breast disease</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Cervical intraepithelial neoplasia</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Cervical ectropion</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Pelvic inflammatory disease</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• Past</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Current</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>STIs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Current purulent cervicitis or chlamydial infection or gonorrhea</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• Vaginitis without purulent cervicitis</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• Increased risk of STIs&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• HIV infected</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• AIDS (not on antiretroviral therapy)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• Clinically well on antiretroviral therapy</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• High risk of HIV&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Biliary tract disease</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>History of cholestasis</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Viral hepatitis</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Cirrhosis</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Liver tumors</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Uterine fibroids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Without distortion of the uterine cavity</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• With distortion of the uterine cavity</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Past-ectopic pregnancy</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Obesity</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Thyroid problems</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Thalassemia</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

<sup>1</sup> Note: If the woman has a very high individual likelihood of exposure to gonorrhea or Chlamydial infection, don’t initiate use of the IUD. “There is no universal set of questions that will determine if a woman is at very high individual risk for gonorrhea and chlamydia. Instead of asking questions, providers can discuss with the client the personal behaviors and the situations in their community that are most likely to expose women to STIs.” (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. 138)

<sup>2</sup> Note: IUDs do not protect against STIs or HIV. If there is a risk of STIs or HIV, the correct and consistent use of condoms is recommended.
<table>
<thead>
<tr>
<th>Condition</th>
<th>YES (use the method)</th>
<th>NO (don’t use the method)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trophoblast disease</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Sickle cell disease</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Iron deficiency anemia</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Schistosomiasis</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Malaria</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Drug interactions</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Nulliparous</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Distorted uterine cavity</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Severe dysmenorrhea</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nonpelvic</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Pelvic</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Endometriosis</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Benign ovarian tumors</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>History of pelvic surgery</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

For additional information on any of these eligibility criteria, please refer to: World Health Organization. Medical Eligibility Criteria for Contraceptive Use, Third Edition 2004
Participant Handout 1.6.1: Rumors and Misconceptions

Rumors are unconfirmed stories that are transferred from one person to another by word of mouth. In general, rumors arise when:
- An issue or information is important to people, but it has not been clearly explained;
- There is no one available who can clarify or correct the incorrect information;
- The original source is perceived to be credible;
- Clients have not received complete and accurate information and had not been given enough time to internalize benefits and limitations of contraceptive options; and
- People are motivated to spread them for political reasons.

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

Despite much scientific evidence about the IUD, rumors or misconceptions still persist among the general population and unfortunately they are sometimes spread by health workers who may be misinformed about certain methods or who have religious or cultural beliefs pertaining to family planning which they allow to affect their professional conduct.

The underlying causes of rumors have to do with people's knowledge and understanding of their bodies, health, medicine, and the world around them. Often, rumors and misconceptions about the IUD make rational sense to clients, or potential clients.

Methods for Counteracting Rumors and Misconceptions
1. When a client mentions a rumor or misconception, always listen politely. Don't laugh.
2. Define what a rumor or misconception is.
3. Find out where the rumor came from and talk with the people who started it or repeated it. Find out if there is some basis for the rumor.
4. Explain the facts.
5. Use strong scientific facts about the IUD to counteract misinformation.
6. Always tell the truth. Never try to hide side effects or problems that might occur with the IUD.
7. Clarify information with the use of demonstrations and visual aids.
8. Give examples of people who are satisfied users of the IUD (only if they are willing to have their names used). This kind of personal testimonial is most convincing.
9. Reassure the client by examining her and telling her your findings.
10. Counsel the client about the possible side effects of the IUD and prepare her to recognize signs of a possible complication. Clients uneducated about possible side effects can become the source of rumors, rather than satisfied clients.
11. Reassure the client and let her know that you care by encouraging her to return if she has any questions or concerns about her IUD.
## Rumors and Misconceptions about IUDs

<table>
<thead>
<tr>
<th>Rumor or Misconception</th>
<th>Facts &amp; Realities: Information to Combat Rumors</th>
</tr>
</thead>
<tbody>
<tr>
<td>The thread of the IUD can trap the penis during intercourse.</td>
<td>The strings of the IUD are soft and flexible, cling to the walls of the vagina and are rarely felt during intercourse. If the string is felt, it can be cut very short, (leaving just enough string to be able to grasp with a forceps). The IUD cannot trap the penis, because it is located within the uterine cavity and the penis is positioned in the vagina during intercourse. The string is too short to wrap around the penis and cannot injure it. (For greater reassurance, use a pelvic model to show how an IUD is inserted or demonstrate with your fingers how it would be impossible for the IUD to trap the penis.)</td>
</tr>
<tr>
<td>A woman who has an IUD cannot do heavy work.</td>
<td>Using an IUD should not stop a woman from carrying out her regular activities in any way. There is no correlation between the performance of chores or tasks and the use of an IUD.</td>
</tr>
<tr>
<td>The IUD might travel inside a woman’s body to her heart or her brain.</td>
<td>There is no passage from the uterus to the other organs of the body. The IUD is placed inside the uterus and unless it is accidentally expelled, stays there until it is removed by a trained health care provider. If the IUD is accidentally expelled, it comes out of the vagina, which is the only passage to the uterus. The provider can teach the client how to feel for the string, if the client is comfortable doing so.</td>
</tr>
<tr>
<td>A woman can’t get pregnant after using an IUD.</td>
<td>A woman’s fertility returns to normal very soon after the IUD is removed. Studies have shown that most women who discontinue the IUD become pregnant as rapidly as those who have never used contraception.</td>
</tr>
<tr>
<td>A woman who was wearing an IUD became pregnant. The IUD became embedded in the baby’s forehead.</td>
<td>The baby is very well-protected by the sac filled with amniotic fluid inside the mother’s womb. If a woman gets pregnant with an IUD in place, the health provider will remove the IUD immediately due to the risk of infection. If for some reason the IUD is left in place during a pregnancy, it is usually expelled with the placenta or with the baby at birth.</td>
</tr>
<tr>
<td>The IUD rots in the uterus after prolonged use.</td>
<td>Once in place, if there are no problems, the IUD can remain in place up to 12 years. The IUD is made up of materials that cannot deteriorate or “rot.” It simply loses its effectiveness as a contraceptive after 12 years.</td>
</tr>
<tr>
<td>Rumor or Misconception</td>
<td>Facts &amp; Realities: Information to Combat Rumors</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------------------------</td>
</tr>
</tbody>
</table>
| **An IUD can’t be inserted until 12 weeks postpartum.** | If health-care providers are specially trained, the IUD can be inserted immediately after the delivery of the placenta or immediately following a Cesarean section, or up to 48 hours following delivery. Expulsion rates for postpartum insertion vary greatly, depending on the type of IUD and the provider’s technique. Current information indicates that expulsion rates may be higher during the period from 10 minutes to 48 hours after delivery, as compared with the first 10-minute period. To minimize the risk of expulsion, only properly trained providers should insert IUDs postpartum. Use of an inserter for IUD insertion tends to reduce the expulsion rate.  
After the 48 hour postpartum period, a TCu 380A may be safely inserted at four or more weeks postpartum.  
The withdrawal technique for TCu 380A insertion helps minimize perforations when inserting IUDs four to six weeks postpartum. Other types of IUDs may have different perforation rates.  
It has been shown that IUDs do not affect breast milk and can be safely used by breastfeeding women postpartum. |
<p>| <strong>The IUD causes ectopic pregnancy.</strong> | There is no evidence that the use of an IUD increases the risk of an ectopic pregnancy. One study (Vessey, et. al., 1979) showed the risk of ectopic pregnancy to be the same for all women (with or without an IUD). Both the copper and levonorgestrel-releasing contraceptives reduce the risk of ectopic pregnancy, when compared with no use of contraception. (Sivin et al 1991 and Ory 1981). In WHO trials, the 12-year cumulative discontinuation rate for ectopic pregnancy was only 0.4 per 100 women. (WHO, 1997) |
| <strong>In IUD that is discolored in the package is dangerous and can't be used.</strong> | The copper on IUDs sometimes changes color in the package as it oxidizes (reacts to air). The IUD can still be used and is safe as long as the package is not torn or broken open and as long as it is not past the expiration date printed on the packaging. |
| <strong>Women who have never given birth cannot use an IUD.</strong> | Uterine enlargement by pregnancy, even when the pregnancy ends in abortion or miscarriage promotes successful IUD use. WHO carefully reviewed all of the literature before listing nulliparity as Category 2, (generally use, some follow-up may be needed). However, women who have never been pregnant have an increased rate of expulsion. |</p>
<table>
<thead>
<tr>
<th>Rumor or Misconception</th>
<th>Facts &amp; Realities: Information to Combat Rumors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women infected with HIV cannot use an IUD.</td>
<td>IUD use appears to be safe for HIV-infected women who are well and for women with AIDS who remain well on antiretroviral treatment. A cohort study of IUD use among HIV-infected women in Nairobi showed no significant increase in the risk of complications, including infection, in early months of use. Also, viral shedding did not increase among these users.</td>
</tr>
<tr>
<td>IUDs increase the risk of Pelvic Inflammatory Disease (PID) and must be removed when it occurs.</td>
<td>Many studies have confirmed that the risk of infection and infertility among IUD users is very low (Hatcher, 2004). However, studies also indicate that the insertion process and not the IUD or its strings, pose the temporary risk of infection. Good infection prevention procedures should be practiced. Antibiotic prophylaxis should not be used routinely prior to insertion. The risk of infection following IUD insertion returns to a very low or normal level after 20 days (Farley et al., 1992).</td>
</tr>
</tbody>
</table>
Participant Handout 1.7.1: The Six-Step Counseling Model (RESPECT)

Upon introducing a client to any contraceptive method, effective client-centered counseling is the key to successful, ongoing contraception use and effectiveness. This takes time; the client-centered counseling relationship should never be a hurried conversation. Combined ignorance, misinformation, and conservative resistance to change place a burden on the provider to earn each client’s trust. The counseling provider must be aware of her or his demeanor and how the client responds, adjusting her or his style to the situation. Listening skills are essential. Bearing in mind the six steps in the counseling process (“RESPECT”) the following points should be taken into consideration:

Rapport: the provider establishes a rapport with the client by being friendly and respectful, and avoiding making negative judgments and assumptions.

Empathy: the provider demonstrates empathy through active listening and identifying with the client’s needs, wishes and concerns. Use positive body language and other strategies to demonstrate nonjudgmental acceptance of the client’s ideas and feelings, and verbally acknowledge the client’s feelings and expresses understanding.

Support: the provider asks about and acknowledges the barriers to care and compliance, offers the client concrete ways to overcome barriers, involves family members when appropriate, and reassures the client that she or he is there to help.

Partnership: the provider is flexible, and stresses that the client and provider are working together to help the client make her own choices. The provider should always make plans for the client’s return visit and help her weigh her options around discontinuing or switching methods.

Explanations: the provider provides clear explanations of all advantages, disadvantages, and possible side or adverse effects of various methods, according to the expressed needs and preconceptions of the client. The provider explains how to use methods successfully, what to do if the client encounters problems, and asks the client to repeat these instructions.

Cultural sensitivity: the provider displays cultural sensitivity while counseling the client, and understands that both the provider and client view each other through ethnic or cultural stereotypes. The provider should be aware of own biases and preconceptions, and know his or her limitations in addressing counseling and medical issues across cultures.

Trust: Because it is difficult for the client to speak about personal health issues, the provider spends time building the client’s trust for effective counseling.

Remember that although the provider is the expert in health care, the client is the foremost expert on her health needs, her social and economic circumstances, and her traditional values and expectations. This is key in demonstrating respect. These forces weigh heavily in the acceptance or rejection of family planning methods, as well as ongoing compliance.
Participant Handout 1.7.2: Key Elements in IUD Counseling

Client-centered counseling sessions should be private and never hurried. Time is well spent in building knowledge and trust in the initial interview, and each conversation should be responsive to the circumstances and needs of the individual client. From initial contact, the client should be actively reassured that all aspects of her relationship with the provider and visits to the clinic will be kept confidential. The client and all of her questions and concerns about the use of IUDs (or any other method) must remain central, and as much time as is needed should be allowed for her to become comfortable with the information. Her cultural and traditional beliefs should be explored, respected, and taken into consideration. Language must be clear and easy to understand; a confused look should be queried.

Counseling must cover key issues in logical sequence. For new clients with no method in mind, the full range of appropriate and available contraceptive methods should be explained in enough detail to allow the client to make an informed decision. The provider must help the client identify her priorities and limitations (e.g., long-lasting versus something taken daily, or a concern about bleeding). If the client has a method in mind, it should be explored first, but other contraceptive options should also be explained sufficiently to allow the client to make an informed choice.

Information to Include

- Effectiveness of the IUD
- Mechanism of action
- Lasts 12 years
- Safety (complications are rare)
- Health benefits and potential risks
- Rapid return to fertility
- Side effects
- Warning signs
- Need for protection against STIs/HIV

Client choices are made easier if the provider can highlight the significance of different options in light of the client’s personal circumstances. This should include an assessment of her individual risk for STIs, which can influence the choice of method. Such a conversation may be difficult, and the provider needs to be comfortable and professional with helping the client honestly address these important issues. Detailed information must be shared about which forms of contraception protect against STIs and HIV, and which do not.

If the client decides to use an IUD, clear and comprehensive information should be given about its safety, effectiveness, correct use, what to expect after IUD insertion, possible side effects, warning signs and complications, where and when to return, and the fact that it does not protect against STIs and HIV.

Side Effects vs. Complications

Failure to prepare clients to distinguish between normal side effects and more serious complications, and the appropriate response in either case, is the most common reason why women reject specific family planning methods or discontinue their use. This is an area of enormous misinformation and suspicion, and the provider must spend as much time as needed to

Possible side effects include:

- Bleeding or spotting for the first few days following insertion,
- Heavier menses, and
- More cramping for the first few periods.

Signs of possible complications include:

- Fever (a possible sign of infection);
- Abdominal pain or pain during intercourse;
- Purulent or foul smelling discharge; and
- An IUD string that becomes shorter, longer, or missing.
allay the client’s fears, clarify exactly what is normal and what is problematic, and encourage a decision with which she is comfortable. Possible side effects such as bleeding or spotting for the first few days following IUD insertion, heavier menses, and/or possibly more cramping for the first few periods must be spelled out clearly. The client should be reassured that these side effects are experienced by many, are harmless, and that she can come back any time she has concerns.

Possible complications and their warning signs should be thoroughly explained and differentiated from the side effects. It is useful at this point to personalize the information for the client, helping her compare the risks of using a method with those of becoming pregnant.

Once the client has selected an IUD, the provider should give complete and accurate information on exactly when and why the client should return for the follow-up visit, which should be three to six weeks following insertion. This should be coupled with the message that she should return any time that she has any questions or concerns about side effects, possible complications, or using the IUD. Counseling should also help the client identify any potential barriers to the implementation of her decision to use the IUD, such as partner resistance, not being able to cope with side effects, difficulty accessing care and services, etc. The provider should help the client develop strategies and acquire skills to overcome these barriers.

Returning clients should be asked about their satisfaction with the IUD. Complaints of side effects, concerns, misconceptions and other related or unrelated problems raised by the client should be taken seriously and addressed (including appropriate counseling and management of side effects). Client’s changing circumstances should be explored and addressed as needed (like a developing health condition, a change in individual risk for STIs, etc.).

Effective counseling offers clients important guidance in identifying and articulating their personal health-care needs. The effective provider-counselor plays an important role in enabling people unused to health care to assert themselves, identify their priorities, and participate in their own healthcare management. No amount of professional prevention is as effective as an informed client working for her own health.
Intrauterine Devices (IUDs)

Participant Handout 1.8.1: Client Assessment Checklist for Small Group Exercise

Key History Screening Questions
The IUD is more appropriate for some women than for others. Careful screening is crucial for successful IUD use. Some serious side effects can be prevented by thorough screening.

Why screen?
• To determine indications for use
• To identify precautions
• To identify other health or special problems

Using a screening checklist helps clinicians obtain information systematically and completely.

Client Assessment Checklist for Small Group Exercise

*Note: Ask the client the questions below about known medical conditions. If she answers “no” to all of the questions, then she can have an IUD inserted if she wants.*

<table>
<thead>
<tr>
<th>Clinician's Questions</th>
<th>Rationale for Question</th>
<th>Client Response</th>
<th>Recommended Action/Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did you give birth more than 48 hours ago but less than 4 weeks ago?</td>
<td></td>
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<tr>
<td>2. Have you had a miscarriage or an abortion with an infection, within the past 4 weeks?</td>
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<tr>
<td>3. Has it been more than 12 days since the first day of your last menstrual period?</td>
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<tr>
<td>4. Is there a chance that you could be pregnant? Is your period late or have you missed a recent period?</td>
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<tr>
<td>5. Do you consider the bleeding during your menstrual periods to be unusually heavy? Heavier than other women? How many days? How often must you change pads/cloths?</td>
<td></td>
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</tr>
<tr>
<td>6. Do you often experience menstrual pains (cramps) severe enough to limit your daily activities?</td>
<td></td>
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</tr>
<tr>
<td>7. Over the past 3 months, have you had any abnormally heavy periods or bleeding between periods or after intercourse?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>8. Do you have any female conditions or problems (gynecologic or obstetric conditions or problems)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Do you have any other medical conditions that you think are important to tell me?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinician’s Questions</td>
<td>Rationale for Question</td>
<td>Client Response</td>
<td>Recommended Action/Plan</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>-----------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>(Assure client of confidentiality before asking questions 10-13)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Is there any possibility that you or your partner have sex partner(s) outside the relationship?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>11. Are you at risk for STIs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Have you had an STI or PID within the past 3 months? Do you have an STI or PID or any other infection of the female organs now?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>13. Are you concerned that you might have AIDS? If yes, are you being treated with ARVs?</td>
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Q.1. When can an IUD be inserted (interval)?

**Recommendations**

a) The IUD may be inserted at anytime during the first 12 days after the start of menstrual bleeding or anytime during the menstrual cycle, at the client’s convenience, when you can be reasonably sure she is not pregnant. The IUD is effective immediately.

**Rationales**

a) The IUD prevents pregnancy if inserted before implantation.


Q.2. When can an IUD be inserted postpartum?

**Recommendations**

An IUD may be inserted:

a) Immediately post-placental, or during or immediately after a Cesarean section (special training required).

b) Prior to hospital discharge, up to 48 hours after delivery (special training required).

c) As early as four- to six-weeks postpartum, to accommodate women who come to the clinic for routine postpartum care and who request an IUD. Copper T IUDs may be safely inserted at this time. For other types of IUDs, it may be prudent to wait until six-weeks postpartum.

d) While women continue to breastfeed.

**Rationales**

a-b) With the appropriate technique, IUDs inserted immediately after placental delivery or Cesarean section can be safe and effective. Expulsion rates for postpartum insertion vary greatly depending on both the IUD type and provider’s technique. Current information indicates that the expulsion rates may be higher from 10 minutes to 48 hours after delivery than in the first 10 minute period. To minimize risk of expulsion, only properly trained providers (according to relevant national or institutional standards) should insert IUDs postpartum. Use of an inserter for IUD placement tends to reduce expulsion risk. Clients should be counseled that expulsion rates are higher postpartum than for interval insertion and should be carefully trained to detect expulsions.

c) A TCu 380A may be safely inserted at 4-weeks postpartum. The withdrawal technique for TCu 380A insertion presumably helps minimize perforations when inserting IUDs at the routine 4- to 6-week postpartum visit. Other IUDs that have a different profile or a push insertion technique might have different perforation rates. Given the relative lack of information on other IUDs at four- to six-weeks postpartum, it is prudent to wait until six weeks for the insertion of IUDs other than Copper Ts.


d) It has been shown that IUDs can be safely used in breastfeeding women.


**Q.3. Can an IUD be inserted immediately postabortion?**

**Recommendations**

a) Yes, the IUD may be inserted immediately postabortion (spontaneous or induced) if the uterus is not infected, or during the first seven days postabortion, (or anytime you can be reasonably sure the woman is not pregnant).

b) IUDs should not be inserted in the following situations:

- With confirmed or presumptive diagnosis of infection (sign of unsafe or unclean induced abortion, signs and symptoms of sepsis or infection, or inability to rule out infection), do not insert an IUD until the risk of infection has been ruled out or the infection has been fully resolved (approximately three months).

- With serious trauma to the genital tract (uterine perforation, serious vaginal or cervical trauma, chemical burns), do not insert an IUD until the trauma has healed.

- With hemorrhage and severe anemia, inert or copper-bearing IUDs are not advised until hemorrhage or severe anemia is resolved. However, progestin-releasing IUDs decrease menstrual blood loss and can be used with severe anemia.

- Postabortion IUD insertion after 16 weeks gestation requires special training of the provider for correct fundal placement. If this is not possible, delay insertion for six weeks.

**Rationales**

a) With appropriate technique, IUDs can be safely inserted postabortion (spontaneous or induced). Expulsion rates vary greatly depending on both the IUD type and provider. To minimize risk of expulsion, only providers with proper training (according to relevant national or institutional standards) and experience should insert IUDs. Clients should be carefully trained to detect expulsions.

Fertility returns almost immediately postabortion (spontaneous, or induced): within two weeks for first trimester abortion and within four weeks for second trimester abortion. Within six weeks of abortion, 75% of women have ovulated.
b) After 16 weeks gestation, the uterine cavity will be too enlarged for postabortion IUD placement to be accomplished by routine IUD insertion techniques. Only providers trained to do postpartum IUD insertion should perform immediate postabortion IUD insertion for postabortion clients after 16 weeks gestation.

Q.4. What is an appropriate follow-up schedule after IUD insertion?

Recommendations

a) There should be one follow-up visit approximately three to six weeks after insertion; thereafter, there is no need for a fixed follow-up schedule.

b) The client should be strongly encouraged to come to the clinic anytime she has questions or problems, particularly if she has

- A late period (possible pregnancy);
- Prolonged or excessive abnormal spotting or bleeding;
- Abdominal pain or pain with intercourse;
- Infection exposure (such as gonorrhea), abnormal vaginal discharge, or pelvic pain especially with fever; or
- A string missing or a string that seems shorter or longer.

c) Visits are encouraged for other preventive reproductive health care as available, including provision of condoms.

Rationales

a-c) A follow-up visit at three to six weeks is prudent as the peak incidence of PID post-IUD insertion is at one month. The best quality of care is to focus clinic resources and attention to women who come back to the clinic with complaints or problems.
Q. 5. Is there a need for a routine pre-exam (a separate visit) before IUD insertion?

Recommendations
a) No. If at all possible, handle all counseling and screening the same day as the insertion.

Rationales
a) There is no medical need for a pre-exam; it may be difficult for a woman to make two visits, and she may be at risk of pregnancy during this interval.

Q.6. Is there a minimum or maximum age to receive IUDs?

Recommendations
a) No. An IUD can be used from menarche until menopause.

Rationales

b) IUDs can generally be used by young women between menarche and 20 years of age. However, there is some concern about both the risk of expulsion due to nulliparity and the risk of STIs due to sexual behavior in younger age groups (World Health Organization. Medical Eligibility Criteria for Contraceptive Use. Third Edition. Geneva, Switzerland: World Health Organization, 2004.).

Q.7. a) Is there a need for a “rest period” with IUDs after a certain period of use?

b) Are there medical reasons for removal of an IUD?

Recommendations
a) If a woman wants a new IUD when an old one has expired, no rest period is needed.

b) IUD removal is indicated if
   • The woman requests removal,
   • The woman develops precautions/contraindications, or
   • The effective life of the IUD is reached. (The latest scientific evidence shows that the TCu 380A is effective for at least 12 years.)

Rationales
a-b) The removal and reinsertion of an IUD exposes a woman to a small risk of introduction of
vaginal or endocervical canal microorganisms into the upper genital tract. For this reason, long-
acting IUDs are preferred. The TCu 380A has been shown to be effective for at least 12 years.

Q.8. Following removal of an IUD for reasons of partial expulsion without infection, or
expiration of the IUD, should one wait to insert another?

Recommendations
a) If the client wants to continue the method, do not wait to reinsert a new IUD, provided
pregnancy has been ruled out and no new precautions or contraindications have developed (see
Q.1).
b) Make sure removal of the first IUD is indicated (e.g., for reasons of partial expulsion without
infection or expiration of the IUD).

Rationales
a-b) Even with proper technique, the removal and reinsertion of an IUD exposes a woman to the risk
of introduction of vaginal and endocervical canal microorganisms into the upper genital tract.
Therefore, removal and insertion at the same time avoids two separate exposures.


In an interval between removal of one IUD and insertion of another, the woman will not be
protected against pregnancy by the contraceptive method of her choice.

Q.9. If a woman is at low risk of STIs based on history, may an IUD be inserted without any
lab tests if there is no mucopurulent endocervical discharge or clinically apparent PID or
cervicitis?

Recommendations
a) Yes, if the woman has no current risk factors for STIs (by history and on exam) and she has no
apparent clinical signs or symptoms of infection (including normal bimanual exam).
b) If PID, mucopurulent endocervical discharge, cervicitis, Chlamydial infection, or gonorrhea is
present, do not insert the IUD, but treat for infection. Consider other contraceptive methods, if
a STI is suspected.

Note: Not all clinically-apparent vaginal infections are due to STIs.

Rationales
a-b) Lab tests may be impractical and often unaffordable (even in the developed world) to rule out
gonorrhea and Chlamydia, the main causes of PID. Most Chlamydia tests are only 80% to 90%
sensitive, tests for mycoplasma and ureaplasma are not routinely available, and cervical gram
stain is less sensitive for gonorrhea. However, where gonorrhea culture and Chlamydia tests are
affordable, negative test results provide reassurance to corroborate the woman’s history.
Q.10. Should an IUD be removed if the partner complains about the string?

Recommendations

a) Not necessarily. Explain to the woman and/or her partner what the partner is feeling and recommend they try again.

b) Describe other options (and their disadvantages) to the client:

- The string can be cut short so that it does not protrude from the cervical os; inform the woman that she would not be able to feel the string and that, at the time IUD removal, narrow forceps will be needed to remove the IUD (this entails a small additional infection risk). If a string is cut flush with the cervix, record in the chart, and tell the women that the string is located at the opening of the os for future removal.

- Offer to remove the IUD, if other options are not acceptable.

c) If partner complaints occur frequently, the service provider’s technique should be reviewed. Strings should be cut approximately three centimeters from the external os.

Rationales

a-c) For IUD services, the woman’s preferences are the service provider’s appropriate focus.

Q.11. If the cervix is red due to eversion of the squamocolumnar junction (ectopy/ectropion), may the IUD be inserted without further investigation?

Recommendations

a) Yes, the IUD may be inserted for clients with cervical ectopy/ectropion, if not at risk of STIs and the pelvic exam is normal (no cervicitis).

Rationales

a) Cervical ectropion (the presence on the ectocervix of columnar epithelial cells from the endocervix) is a normal condition, particularly in adolescents and in pregnancy, and is distinct from the cervical infection.

b) IUD insertion and continued use of the IUD have no relation to risk of cervical carcinoma.


c) Since Chlamydia is an intracellular parasite of columnar epithelial cells, women with ectropion may be more at risk of infection when exposed to Chlamydia.


Q.12. If a women complains of heavier menses or bleeding between menses, is there a medical basis for the IUD to be removed?

Recommendations

a) Not necessarily. As in premethod choice counseling, women should be informed that menses are normally heavier with the IUD and intermenstrual bleeding may occur, especially in the first few months. Inert IUDs should not be the first choice for this reason. Give nutritional advice on the need to increase the intake of iron-containing foods.

b) For mild to moderate bleeding and pain in the first month postinsertion, with no evidence of clinically apparent pelvic infection, and if reassurance is not sufficient but the woman wants to keep the IUD, a short course of a nonsteroidal anti-inflammatory agent other than aspirin (e.g., ibuprofen) may be given.

c) Bleeding generally decreases over time. If bleeding is heavy or the woman is anemic, treatment using oral iron can improve hemoglobin levels.

d) If bleeding or pain is severe, or the client wishes to discontinue use, remove the IUD.

e) If suspected, abnormal conditions which cause prolonged or heavy bleeding should be evaluated and treated as appropriate.

f) If pelvic infection is diagnosed, treat the infection with appropriate antibiotics with the IUD in place. If the client wishes to continue using the IUD, it does not need to be removed. If the client wishes to discontinue its use, remove the IUD after antibiotic use has been initiated.

Rationales

a) In general, IUDs (especially inert IUDs) commonly increase the amount of menstrual blood loss, according to IUD type, particularly in the first few months postinsertion.


Copper IUDs may increase normal menstrual blood loss by 50%, which may be clinically significant for women who are already anemic. (Progestin-releasing IUDs decrease menstrual
blood loss; the more progestin an IUD releases, the more effectively it decreases menstrual blood loss.)


b) Nonsteroidal anti-inflammatory drugs (e.g., ibuprofen) decrease uterine bleeding and cramping.


Note: Nonsteroidal anti-inflammatory drugs (e.g., ibuprofen) should be used instead of aspirin because of aspirin's stronger and longer-lasting inhibitory effects on platelet aggregation (aspirin promotes bleeding).


Q.13. Can IUDs be safely inserted by trained nurses and midwives?

Recommendations
a) Yes, IUDs (including immediate postpartum and postabortion insertion) can be safely inserted by nurses and midwives, who are appropriately trained according to relevant national or institutional standards.

Rationales
a) Nurses or midwives have been shown to have equal or superior competence in IUD insertion when compared to doctors.


Q.14. How much time should elapse between STI treatment and IUD insertion? What about previous STI incidence?

Recommendations
a) If the client will not be at high personal risk for gonorrhea or Chlamydia in the future, treat the STI today, and insert the IUD when the infection is resolved (for acute PID, wait three months). If she remains at increased risk of PID, advise against IUD use unless you can rule out infection at the time of insertion.
Rationales

a) PID may take several weeks to resolve clinically and in the case of severe PID, waiting several months, in theory, allows healthy tissues free of microabscesses to form.

Women with prior PID are at increased risk of repeat PID. A woman who has had an episode of upper reproductive tract infection may be at increased risk of repeat episodes of nonsexually transmitted PID regardless of IUD use. Theoretically, a previous episode of upper reproductive tract infection may result in tubal damage increasing susceptibility of the fallopian tubes to opportunistic lower genital tract flora.


Q.15. Should IUDs be provided if infection prevention measures cannot be followed?

Recommendations

a) No. All sites inserting and/or removing IUDs should follow basic infection prevention measures, including:

• Aseptic technique, including appropriate hand washing by the provider and careful preparation of the cervix;
• Sterile (or high-level disinfected) IUDs and equipment;
• Correct decontamination of instruments; and
• Safe disposal of contaminated disposables.

Rationales

a) The potential for infection in IUD users is increased in areas where genital tract infections such as gonorrhea and Chlamydia are prevalent. By following recommended infection prevention processes, however, health workers can minimize the risk of post-IUD insertion infection to clients, and the danger of transmitting infections, even hepatitis B or AIDS, to their clients, their coworkers, or themselves.


Sterilization is the safest and most effective method for processing instruments, which come in contact with the bloodstream, tissue beneath the skin, or tissues which are normally sterile. However, High Level Disaffection (HLD) is a perfectly safe and acceptable alternative. HLD destroys all microorganisms, including viruses causing hepatitis B and AIDS, but does
not reliably kill all bacterial endospores. For example, in family planning facilities, either sterilization or HLD are acceptable for processing instruments and gloves used for pelvic exams and IUD insertion and removal, since problems with endospores (*Clostridia* species) have not been reported with IUD use. Regardless of the method selected however, HLD can only be effective when used or soiled instruments and gloves are first decontaminated, thoroughly cleaned, and rinsed before disaffection.


Contaminated wastes may carry high loads of microorganisms, which are potentially infectious to any person who contacts or handles the waste. Incineration provides high temperatures and destroys microorganisms and is therefore the best method for disposal of contaminated wastes. Incineration also reduces the bulk size of wastes to be buried. If incineration is not possible, all contaminated wastes must be buried as deeply as possible to prevent scattering the waste materials.


**Q. 16. What should be done if a woman using a copper-bearing IUD is diagnosed with Pelvic Inflammatory Disease (PID)?**

**Recommendations**

a) Treat the PID using appropriate antibiotics. There is no need for removal of the TCu 380A if she wishes to continue its use.

b) If she does not want to keep the IUD, remove it *after* antibiotic treatment has been started. If the IUD is removed, she should avoid sex or use condoms and be counseled about other regular contraceptive methods.

c) If the infection does not improve, generally the course would be to remove the IUD and continue antibiotics. If the IUD is not removed, antibiotics should also be continued. In both circumstances, her health should be closely monitored.

d) Provide comprehensive management for STIs, including counseling about condom use.

**Rationale**

a-d) Removing the IUD provides no additional benefit once PID is being treated with appropriate antibiotics.

1) Larsson, B., Wennegren, M., *Investigation of a copper-intrauterine device (Cu-IUD) for possible effect on frequency and


Q.17. What should be done if a woman using a copper-bearing IUD is found to be pregnant?

Recommendations

a) Exclude ectopic pregnancy. Explain that she is at risk of second trimester miscarriage, preterm delivery and infection if the IUD is left in place. The removal of the IUD reduces these risks, although the procedure itself entails a small risk of miscarriage.

b) If the IUD strings are visible or can be retrieved safely from the cervical canal
   • Advise her that it is best to remove the IUD;
   • If the IUD is to be removed, remove it by pulling the string gently; and
   • Explain that she should return promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever.

c) If the IUD strings are not visible and cannot be safely removed
   • Where ultrasound is available, it may be useful in determining the location of the IUD. If the IUD is not located, this may suggest that an expulsion of the IUD has occurred.
   • If ultrasound is not possible or if the IUD is determined by ultrasound to be inside the uterus, explain the risks clearly and advise her to seek care promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever.

Rationale

a-c) Removing the IUD improves pregnancy outcome if the strings are visible or can be removed safely from the cervical canal. The risk of miscarriage, preterm delivery, and infection is substantial if the IUD is left in place.

Participant Handout 1.9.1: Timing of IUD Insertion and Removal

1. Having menstrual cycle
   - A woman can have an IUD inserted at any time within the first 12 days after the start of menstrual bleeding, at her convenience, not just during menstruation. No additional contraceptive protection is needed.
   - The IUD can also be inserted at any other time during the menstrual cycle, at her convenience, if it is reasonably certain that she is not pregnant. A clinician may be “reasonably certain” if the client has not had intercourse since last normal menses, or if she has been using another reliable method since her menses and her pelvic exam does not show any signs of possible pregnancy.
   - Many clinicians prefer to insert during or very soon after the menstrual period since there is little likelihood of pregnancy at that time. Another reason to insert the IUD at this time is that the woman is already bleeding, and the cramping may be less noticeable. Other clinicians prefer to insert mid cycle when the cervical os is a little larger.
   - Note: See Participant Handout 2.2.1: IUD Screening for assistance in ruling out pregnancy for nonmenstruating family-planning clients.

2. Switching from another method
   - She can have the IUD inserted immediately, if it is reasonably certain that she is not pregnant. There is no need to wait for her next menstrual period. No additional contraceptive protection is needed.

3. Postpartum
   - A woman can have an IUD inserted immediately postpartum (within 10 minutes) following delivery of the placenta, or during or immediately after a cesarean section. This requires special training.
   - It can also be inserted within the first 48 hours postpartum.
   - Note: IUD insertion immediately or within 48 hours postpartum requires special training and should not be attempted without having received the required training.
   - Expulsion rates may be higher for IUDs inserted during this time. Insertions after one week and before four to six weeks should be avoided because of the higher risk of complications including infection and uterine perforation.
   - Copper IUDs may be safely inserted as early as four- to six-weeks postpartum for those who come for routine postpartum care and who request an IUD.

4. Immediately Postabortion
   - The IUD may be inserted immediately postabortion (spontaneous or induced)—if the uterus is not infected—during the first seven days postabortion, or anytime you can be reasonably sure that the client is not pregnant.
   - IUDs should not be inserted immediately postabortion in the following situations:
     - When there are signs of unsafe or unclean induced abortion, signs of infection, or inability to
rule out infection, do not insert an IUD. **Do not insert an IUD until the risk of infection has been ruled out** or infection has fully resolved (approximately three months).

- When there is serious trauma to the genital tract such as uterine perforation, serious vaginal or cervical trauma, or chemical burns, do not insert an IUD until healed.
- When there is hemorrhaging and physical signs of severe anemia, inert or copper bearing IUDs are not advised until the hemorrhage or severe anemia is resolved. However, progestin releasing IUDs decrease menstrual blood loss and can be used in cases of severe anemia.

- Immediate postabortion IUD insertion after 16 weeks’ gestation requires special training of the provider. If the pregnancy went beyond 16 weeks, delay insertion for six weeks postabortion.

**Follow up schedule after IUD insertion**

a) There should be one follow up visit **approximately** three to six weeks after insertion; thereafter, there is no need for a fixed follow up schedule.

b) The client should be strongly encouraged to come to the clinic anytime she has questions or problems, particularly if she has

- A late period (possible pregnancy);
- Prolonged or excessive abnormal spotting or bleeding;
- Abdominal pain or pain during intercourse;
- Infection exposure (such as gonorrhea), abnormal vaginal discharge, or pelvic pain, especially with fever; or
- A missing string or the string seems shorter or longer.

c) Encourage clients to come in for other preventive reproductive health care if available, including provision of condoms, when appropriate.

**Timings and Reasons for IUD Removal**

- The IUD may be removed at any time during the menstrual cycle. Some clinicians prefer to remove IUDs during menses because the os may be slightly open and the client will not be concerned if she has any bleeding.
- Anytime the client requests—for any stated reason, or for no reason at all.
- There is evidence of IUD perforation.
- She has a known or suspected pregnancy.
- There has been partial expulsion—the old IUD may be removed and replaced with a new one.
- She has persistent, unacceptable side effects.
- When IUD has been in utero for its effective life a new IUD may be inserted immediately if no precautions are present.
- She has severe pain, or severe bleeding with evidence of marked anemia that is getting worse.
- Many complications may be treated with the IUD in place. There is no need to remove it in most cases.

*Note: In most cases of known or suspected PID, the client should be treated with antibiotics, counseled, and the IUD left in place.*
A health worker could explain the Copper T IUD and its insertion to her client like this:

“The TCu 380A IUD is a small flexible, device made of plastic and copper. It works mainly by stopping the sperm from meeting the egg. It is very effective, with little to remember. The latest scientific evidence shows that the TCu 380A is effective for at least 12 years. You can become pregnant again as soon as it is taken out.

“It is placed in the uterus through the vagina and the opening of the uterus, using a small applicator. It has two thin strings attached, which hang down into the vagina. These strings allow you to check each month after your menstrual period that the IUD is still in place and that you are still protected from getting pregnant. The strings are also used to remove the IUD. Removing the IUD takes only a few minutes and is usually not painful. When you want the IUD removed, it must be done by a doctor or trained health worker.

“Inserting the IUD is simple. You may feel uncomfortable for a few minutes. Most women, however, say that it is not too painful and compare the feeling to having heavy menstrual cramps. Before I insert the IUD, I will need to ask you some questions about your medical history, and perform a pelvic examination to make sure the IUD is right for you.”
Participant Handout 1.11.1: Common Side Effects and Warning Signs of Possible Complications

As with most contraceptive methods, IUDs are associated with certain common side effects. Most are not serious and can be handled by the provider or practitioner. Some may need referral to a specialist.

Side effects may include:
• Bleeding or spotting for the first few days following insertion,
• Heavier menses, and
• More cramping for the first few periods.

Warning signs of possible complications include:
• Syncope/bradycardia, vasovagal episode during insertion (fainting, becoming dizzy, or lowered heart rate during insertion);
• Abnormal bleeding (no period, heavy bleeding, abnormal spotting);
• Purulent or foul smelling discharge;
• Fever, (a possible sign of pelvic infection);
• Abdominal pain or pain during intercourse; or
• An IUD string that becomes shorter, longer, or is missing.
Participant Name_________________________________________________

Instructions: Circle the letter(s) that correspond to the correct answer(s). Some questions may have more than one correct answer.

1. Who is the best-qualified person to choose a contraceptive method for a woman in good health?
   a. a trained physician
   b. a woman’s mother in law
   c. the woman herself
   d. the person who counseled her

2. Women who are not in a mutually faithful relationship (i.e., she or her partner have other sexual partners) may be at increased risk of
   a. uterine perforation with IUD insertion
   b. Sexually Transmitted Infections (STIs)
   c. ovarian cancer
   d. all of the above

3. The IUD not only protects a woman from undesired pregnancy, but also from
   a. developing fibroids
   b. HIV infection
   c. anemia
   d. all of the above
   e. none of the above

4. When an IUD client presents with a late period, you should rule out
   a. allergy to copper
   b. pregnancy
   c. cervical cancer
   d. PID
5. Following the insertion of an IUD, you should recommend that the client, even if she has no problems, have it checked after
   a. three days
   b. one week
   c. three to six weeks
   d. three to six months

6. The most likely mechanism of action of the IUD is that
   a. it interferes with implantation
   b. it interferes with fertilization
   c. it interferes with ovulation
   d. it acts as a barrier to prevent sperm from entering uterus

7. The IUD is NOT an appropriate contraceptive method for a woman who
   a. is taking rifampin
   b. is not sure she wishes to have a tubectomy
   c. has unexplained vaginal bleeding
   d. gave birth three weeks ago

8. During counseling on the IUD, a client should be informed that common side effects of the IUD may include
   a. nausea
   b. headaches
   c. mild cramping and light spotting
   d. heavy vaginal discharge

9. The IUD is
   a. 90 - 95% effective
   b. greater than 99% effective
   c. 100% effective
   d. none of the above

10. Correctly loading the TCu 380A IUD in the sterile package
    a. should be done only if sterile gloves are available
    b. assures that the IUD will remain sterile until it is removed from the package
    c. is not necessary for physicians
    d. all of above
11. List the five warning signs that alert the client that something is wrong:

12. TRUE or FALSE. Mark “T” or “F” in the blank to indicate true or false.

a. ___ Counseling should be integrated into each and every interaction with a family planning client.

b. ___ Following IUD insertion, heavy, yellow vaginal discharge is common.

c. ___ An IUD should only be removed during menstruation.

d. ___ An IUD may be inserted at any time during the menstrual cycle, if the provider is reasonably certain that the client is not pregnant.

e. ___ After an IUD is removed, a healthy woman may expect several months’ delay in return to fertility.

f. ___ It is better to change all IUDs after two years, because leaving them in the uterus for a longer period may lead to development of complications.

g. ___ IUDs increase the risk of ectopic pregnancy.
Unit 2: Providing Services
Participant Handout 2.1.0:  
Unit 2 Pretest

Participant Name ________________________________________________

Instructions: Circle the letter(s) that correspond to the correct answer(s). Some questions may have more than one correct answer.

1. In counseling a woman about the advantages of the TCu 380A IUD, you would inform her that the IUD
   a. is permanent
   b. is highly effective
   c. has few side effects for most women
   d. does not interfere with sexual intercourse
   e. is effective in preventing anemia

2. Which of the following conditions are precautions which influence the suitability of IUD for a particular woman?
   a. pregnancy
   b. three or more children
   c. at risk for STIs
   d. history of candidiasis
   e. retroverted uterus
   f. current pelvic infection

3. Prior to IUD insertion, a pelvic exam is performed to
   a. determine uterine position and size
   b. rule out anteflexion
   c. rule out pregnancy
   d. rule out presence of infection, masses, and tumors
4. Prior to an IUD insertion all metal instruments used should be
   a. decontaminated with soap and water
   b. decontaminated in 0.5% chlorine solution for 10 minutes
   c. cleaned with formaldehyde and water
   d. cleaned with detergent and water
   e. high level disinfected by boiling in a covered pot for 20 minutes
   f. high level disinfected by autoclaving (unwrapped) for 20 minutes at 106 kPa pressure at 1210 degrees

5. Key infection prevention activities for IUD insertion include
   a. washing hands carefully
   b. cleaning the cervix and vagina with an antiseptic solution
   c. decontaminating, cleaning, and high-level disinfecting, or sterilizing all instruments
   d. proper contaminated waste disposal
   e. training and supervision of cleaning staff in infection prevention

6. Reasons for follow up visits after an IUD insertion can include
   a. first check up one week after insertion
   b. first check up three to six weeks after insertion
   c. client wants device removed because she doesn’t like it
   d. removal when the IUD has been in place for one year

7. The following are warning signs that you should explain to an IUD client, which indicate that she may be having a problem with her IUD and should seek medical attention:
   a. cramping with menses
   b. increased length of menstrual cycle
   c. sexual partner has abnormal penile discharge
   d. string is longer than usual
   e. pain with intercourse

8. IUD clients should be counseled
   a. before the insertion
   b. after insertion
   c. during each follow up visit
   d. all of the above
True or False: Mark “T” or “F” in the blank to indicate true or false.

9. ___ A woman herself is best at selecting her own contraceptive method.
10. ___ Douching daily after an IUD infection is recommended to prevent PID.
11. ___ A physical exam for an IUD client must include abdominal, speculum, and bimanual exams.
12. ___ You must use high level disinfected or sterile gloves to place a copper IUD in its inserter.
13. ___ A tarnished IUD in a sealed, undamaged package can be used.
14. ___ An IUD can be inserted in a woman who is ovulating.
15. ___ The “push” technique should be used when inserting copper T IUDs.
16. ___ The “no touch” technique should be used when inserting IUDs.
17. ___ An IUD client who has moderate bleeding for seven to ten days after insertion should have the IUD removed immediately.
18. ___ If PID is diagnosed in a woman with an IUD; the IUD should be removed, antibiotic treatment should be started and she should be counseled on and provided with an alternative contraceptive.
19. ___ If an IUD is partially expelled, it should be removed and a new IUD can be inserted immediately.
20. ___ If a woman becomes pregnant with an IUD, it should be left in place unless a problem develops.
Participant Handout 2.1.1: Role-Play Situations

A. General Counseling Role-Play
Participants should be able to demonstrate key messages about the IUD. Practice telling the key messages to:
• A very young woman,
• A woman much older than you are,
• Someone who is related to you, and
• Someone who believes her husband has another partner.

The person playing the client should act out reactions to these situations, and the person playing the provider should demonstrate the ability to talk to different people with different levels of education, status, age, etc.

B. Deciding to choose an IUD - Client Assessment and Counseling Role-Plays
Role-play counseling for each of the situations below. What advice would you give to the client?
• A 17 year-old woman with no children who wants to become pregnant in two years.
• A 35 year-old woman with four children who has regular periods and does not want any more children.
• A 27 year-old woman with two children who has had PID once since the birth of her last child and wants more children in the future.
• A 20 year-old woman who is fully nursing a four week-old baby.
• A 40 year-old woman who has had all the babies she wants, but is still having regular bleeding; she has severe diabetes and must inject herself with insulin.
• A 19 year-old sex worker who has four children, a history of recurrent PID, hepatitis, and is HIV infected.
• A 32 year-old woman with two children who has heavy periods (she needs to change her pads every two hours, she bleeds for eight days) and on the first two days her cramps are so strong that she cannot go to her job.
• A 27 year-old woman with six children; she is very pale with light conjunctiva. She says that after her last baby was born, six months ago, she bled so much she had to go to the hospital. She complains that she has no strength. She does not want any more children.
• A 30 year-old woman with four children; she is not sure if she wants any more children. She is in a mutually monogamous relationship.
• A 30 year-old woman with four children. She is not sure if she wants any more children. Her husband travels for work and she thinks he may be having a relationship with a woman in another town.
• A 26 year-old woman with three children. Her husband is a transport worker and HIV infected. She has AIDS, but is currently being treated with ARVs and appears healthy. He left her and took the two older children when she became ill.
C. Findings on Pelvic Exam
Role-play what you would do if you encountered each of these scenarios and what you would say to the client.

- A 25 year-old woman with three children states no problems during her medical history. On speculum exam you see that her cervix is red, with a bubbly green/gray discharge. What do you tell her? What do you do?
- Same history. You find a painless lesion on her vulva.
- Same history. Pelvic exam normal. When sounding her uterus you find it is deeper than 10 cm. What do you do? Why?

Note: The first two role-plays above are STI risks and client should use condoms.

D. Post-Insertion Role-Plays
Role-play telling the client the kind of IUD she has, when it has to be replaced, when she needs to come back, the danger signs, when the IUD becomes effective, how to check the strings, why the strings need to be checked, when and what changes she might expect with her period, how to protect herself from Genital Tract Infections (GTIs) and STIs, and reasons why she can have her IUD replaced. Practice telling this to:
- A very young woman,
- A woman much older than you are,
- Someone who is related to you, and
- Someone who believes her husband has another partner.

The person playing the client should act out reactions to these situations, and the person playing the provider should demonstrate the ability to talk to different people with different levels of education, status, age, etc.

E. Removal Role-Plays
Role-play counseling for each situation, including what to tell any woman having her IUD removed, what to expect, when she can become pregnant again, how she can protect against pregnancy and STIs, etc.

- A 30 year-old woman with three children; she does not want any more children. Her periods are normal and she has had no problem with the IUD, which she has been using for six years. Her mother-in-law told her that this is too long to have the IUD. She is worried and she wants the IUD taken out so she can give her body a rest.
- Same situation, but she really doesn’t want to take a rest. She is telling you this story because she knows her husband has another sexual partner. She is worried that she is at risk for GTIs and STIs, but is ashamed to tell you.
- A 26 year-old with five children has decided that she wants the IUD removed because she is ready to have another child.
- A 35 year-old woman with four children doesn’t want any more children. She has had the IUD in place for 10 years and has come in to have it replaced.
- A 45 year-old woman has had an IUD in place for three years. Her menstruation is sometimes irregular and her friends have told her she is probably going through menopause and should have her IUD removed.
Participant Handout 2.1.2: Competency-Based Checklist for IUD Counseling Skills

Note: For a more detailed counseling checklist and the RESPECT counseling model, refer to Participant Handout 1.7.1.

Instructions: Rate the performance of each task/activity observed using the following rating scale:

1. Needs Improvement: Step not performed correctly and/or out of sequence (if required) or is omitted.

2. Competently Performed: Step performed correctly in proper sequence (if required) but lacks precision, and/or the trainer/coach/supervisor needed to assist or remind the participant in a minor way.

3. Proficiently Performed: Step performed correctly in proper sequence (if required) and precisely without hesitation or need for any assistance.

4. Not Observed: Step not performed by participant during observation by trainer/observer.

Participant: ________________________        Course Dates: ________________________

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insertion Counseling</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Initial Interview (Private Area)</strong></td>
<td></td>
</tr>
<tr>
<td>Greets client in friendly and respectful manner.</td>
<td></td>
</tr>
<tr>
<td>Ensures necessary privacy.</td>
<td></td>
</tr>
<tr>
<td>Establishes purpose of visit and answers questions.</td>
<td></td>
</tr>
<tr>
<td>Provides general information about family planning.</td>
<td></td>
</tr>
<tr>
<td>Explains what to expect during clinic visit.</td>
<td></td>
</tr>
<tr>
<td>Asks client about her reproductive goals (i.e., does she want to space or limit births?).</td>
<td></td>
</tr>
<tr>
<td>Explores any attitudes or religious beliefs that either favor or rule out one or more methods.</td>
<td></td>
</tr>
<tr>
<td>Gives the client information about the contraceptive choices available and the risks and benefits of each.</td>
<td></td>
</tr>
<tr>
<td>Helps the client begin to choose an appropriate method.</td>
<td></td>
</tr>
</tbody>
</table>

| Method-Specific Counseling if a Client Chooses an IUD |       |
| Obtains biographical information (name, address, etc.). |       |
| Provides detailed information about the IUD. |       |
| • Shows where and how the IUD is used. |       |
| • Gives the client a sample IUD to hold. |       |
| • Explains how it works and its effectiveness. |       |
| • Explains possible side effects and other health problems. |       |
| • Explains benign nature of the most common side effects and that they usually get better after three months. |       |
| • Explains that the TCu 380A lasts for 12 years. |       |
| • For older women, explains that it can be removed 1 year after her menstruation ends. |       |
| • Explains that client can soon become pregnant when IUD is removed. |       |
### IUD Screening

- Screens the client carefully to make sure there is no medical condition that would be a problem (completes Client Assessment Checklist).
- Reviews potential side effects and possible complications and makes sure that they are fully understood.

### Pre-Insertion Counseling (Examination/Procedure Area)

- Reviews the Client Assessment Checklist to determine if the client is an appropriate candidate for the IUD and if she has any problems that should be monitored while the IUD is in place.
- Informs client about required physical and pelvic examinations.
- Prepares the client for the examination while ensuring dignity and privacy.
- Checks that client is within 12 days of her last menstrual period.
- Rules out pregnancy if beyond day 12 (refers for medical care, if nonmedical counselor).
- Describes the insertion process and what the client should expect during and after the procedure.
- Inserts the IUD while maintaining sterile no-touch technique.

### Post-Insertion Counseling

- Completes client record.
- Teaches client how and when to check for strings.
- Explains the importance of also using condoms for STI and HIV/AIDS protection.
- Discusses what to do if the client experiences any side effects or problems.
- Provides follow-up visit instructions.
- Reminds the client that the TCu 380A can be left in for 12 years.
- Assures the client that she can return to the same clinic at any time to receive advice, medical attention, and, if desired, to have the IUD removed.
- Asks the client to repeat instructions.
- Answers the client’s questions.
- Observes the client for at least 15 minutes before sending her home.

### Follow-Up Counseling

- Greets the client in friendly and respectful manner.
- Ensures privacy.
- Asks the following questions:
  - Have you been happy using the IUD?
  - Have you had any concerns or problems?
  - Has your health changed in any way since you had your IUD inserted?
  - Do you have any questions you would like me to answer?
  - How are you protecting yourself from STIs? (Explains dual protection.)
  - Do you need some condoms?
  - May I examine you?

### Follow-Up Examination (3-6 weeks after insertion)

- Explains to the client why and how she will do the pelvic examination.
### Intrauterine Devices (IUDs)

#### Task/Activity

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepares the client while ensuring dignity and privacy.</td>
<td></td>
</tr>
<tr>
<td>Performs a pelvic examination and checks to make sure the string is visible and that there is no partial or complete expulsion.</td>
<td></td>
</tr>
<tr>
<td>Checks for pelvic infection.</td>
<td></td>
</tr>
<tr>
<td>Explains findings and reassures the client.</td>
<td></td>
</tr>
</tbody>
</table>

#### Removal Counseling

**Pre-Removal Counseling (Client Reception Area)**

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greets the client in friendly and respectful manner.</td>
<td></td>
</tr>
<tr>
<td>Establishes the purpose of the visit.</td>
<td></td>
</tr>
<tr>
<td>Asks the client her reason for removal and answers any questions.</td>
<td></td>
</tr>
<tr>
<td>Asks the client about her present reproductive goals (e.g., does she want to continue spacing or limiting births?).</td>
<td></td>
</tr>
<tr>
<td>Describes the removal process and what she should expect during the removal and afterwards.</td>
<td></td>
</tr>
</tbody>
</table>

**Post-Removal Counseling**

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discusses what to do if the client experiences any problems (e.g., prolonged bleeding or abdominal or pelvic pain).</td>
<td></td>
</tr>
<tr>
<td>Asks the client to repeat the instructions.</td>
<td></td>
</tr>
<tr>
<td>Answers any questions.</td>
<td></td>
</tr>
<tr>
<td>Reviews general and method-specific information about family planning methods, if the client wants to continue spacing or limiting births.</td>
<td></td>
</tr>
<tr>
<td>Assists the client in obtaining a new contraceptive method or provides a temporary method (barrier) until her method of choice can be started.</td>
<td></td>
</tr>
<tr>
<td>Observes the client for five minutes before sending her home.</td>
<td></td>
</tr>
</tbody>
</table>
Participant Handout 2.1.3: Observer’s Role-Play Checklist for IUD Counseling Skills

Instructions: Use the checklist to record your observations of the role-play. Observe the counseling process as well as its content. Note whether the doctor applies the steps in the RESPECT counseling process (as appropriate to the role-play). Does the counselor address the problem adequately? Does she or he address the client’s concerns? Is the information given correct and complete? What is the client’s behavior? How does the counselor behave? What nonverbal messages are communicated by client or counselor?

<table>
<thead>
<tr>
<th>Task</th>
<th>Performed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Service Provider’s Nonverbal Communication</strong></td>
<td></td>
</tr>
<tr>
<td>Friendly/welcoming/smiling</td>
<td></td>
</tr>
<tr>
<td>Nonjudgmental/receptive</td>
<td></td>
</tr>
<tr>
<td>Makes eye contact with the client, if culturally appropriate.</td>
<td></td>
</tr>
<tr>
<td>Faces the client directly.</td>
<td></td>
</tr>
<tr>
<td>Listens attentively/nods head to encourage and acknowledge the client’s responses.</td>
<td></td>
</tr>
<tr>
<td>Shows positive regard for the client as a person.</td>
<td></td>
</tr>
<tr>
<td>Ensures the client’s privacy/confidentiality without having to be asked.</td>
<td></td>
</tr>
<tr>
<td>Remains patient/allows the client time to ask all questions.</td>
<td></td>
</tr>
<tr>
<td>Does not interrupt the client.</td>
<td></td>
</tr>
<tr>
<td><strong>Service Provider’s Verbal Communication</strong></td>
<td></td>
</tr>
<tr>
<td>Phrases questions clearly and appropriately. Uses non-technical terms.</td>
<td></td>
</tr>
<tr>
<td>Uses a friendly tone of voice.</td>
<td></td>
</tr>
<tr>
<td>Listens to the client’s responses closely.</td>
<td></td>
</tr>
<tr>
<td>Answers the client’s questions clearly and completely.</td>
<td></td>
</tr>
<tr>
<td>Uses language the client can understand.</td>
<td></td>
</tr>
<tr>
<td><strong>RESPECT Model Process and Content</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Rapport</strong></td>
<td></td>
</tr>
<tr>
<td>• Understands the client’s point of view.</td>
<td></td>
</tr>
<tr>
<td>• Is friendly and respectful.</td>
<td></td>
</tr>
<tr>
<td>• Assures privacy and confidentiality.</td>
<td></td>
</tr>
<tr>
<td>• Doesn’t judge the client.</td>
<td></td>
</tr>
<tr>
<td>• Doesn’t argue with the client or act superior.</td>
<td></td>
</tr>
<tr>
<td>• Doesn’t scold the client.</td>
<td></td>
</tr>
<tr>
<td>• Recognizes and doesn’t make assumptions about the client.</td>
<td></td>
</tr>
<tr>
<td><strong>Empathy</strong></td>
<td></td>
</tr>
<tr>
<td>• Remembers that the client has come for help.</td>
<td></td>
</tr>
<tr>
<td>• Tries to understand the client’s reason for his or her behavior/ideas.</td>
<td></td>
</tr>
<tr>
<td>• Uses positive body language and other strategies to demonstrate nonjudgmental acceptance of the client’s ideas and feelings.</td>
<td></td>
</tr>
<tr>
<td>• Verbally acknowledges the client’s feelings and expresses understanding.</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Performed</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>Support</strong></td>
<td>Yes</td>
</tr>
<tr>
<td>• Asks about and acknowledges the barriers to care and compliance.</td>
<td>No</td>
</tr>
<tr>
<td>• Offers the client concrete ways to overcome barriers.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Involves family members when appropriate.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Reassures the client that she or he is there to help and answer questions.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Encourages the client to return to the clinic if she has any concerns.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Partnership</strong></td>
<td>Yes</td>
</tr>
<tr>
<td>• Is flexible.</td>
<td>No</td>
</tr>
<tr>
<td>• Acknowledges the client’s needs.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Stresses that the client and provider are working together.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Lets the client know she has options and can make her own choices.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Makes a plan for the client to continue to return to the clinic for follow-up.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Helps returning clients weigh options of continuing or switching methods.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Explanations</strong></td>
<td>Yes</td>
</tr>
<tr>
<td>• Gives information about available methods.</td>
<td>No</td>
</tr>
<tr>
<td>• Asks which method interests the client.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Asks what the client knows about the method.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Corrects myths/rumors/incorrect information.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Describes how the method works and its effectiveness.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Uses audio-visual aids during counseling.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Describes the benefits and risks.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Describes potential side effects and warning signs.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Offers clear action steps to respond to side effects and warning signs.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Explains clearly what the client has to do to use the method successfully.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Asks the client to repeat back instructions.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Reminds the client again of danger signs.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Answers the client’s questions clearly.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Encourages the client to return with problems or concerns.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Cultural Sensitivity</strong></td>
<td>Yes</td>
</tr>
<tr>
<td>• Respects the client’s life style, cultural, and religious beliefs.</td>
<td>No</td>
</tr>
<tr>
<td>• Helps the client understand how these may influence family planning and other reproductive health choices.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Understands that the client’s view of the provider may be defined by ethnic or cultural stereotypes.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Is aware of his or her own cultural biases and preconceptions.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Knows his or her own limitations in addressing counseling and medical issues across cultures.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Can explore cultural influences on attitudes and beliefs without disapproval. Can help the client explore these issues as well.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Trust</strong></td>
<td>Yes</td>
</tr>
<tr>
<td>• Recognizes that it may be difficult for clients to share personal information.</td>
<td>No</td>
</tr>
<tr>
<td>• Effective at gradually developing a trusting relationship.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Consciously works to establish trust.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Responds to the client’s concerns, including rumors, respectfully and constructively.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Respect the client’s choice of family planning methods.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Activity

<table>
<thead>
<tr>
<th>Problem Solving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does service provider respond appropriately to the client’s needs and problems?</td>
</tr>
<tr>
<td>Is the service provider convincing when giving advice?</td>
</tr>
<tr>
<td>Is the advice given/method provided appropriate?</td>
</tr>
<tr>
<td>Is the counseling</td>
</tr>
<tr>
<td>• Provider-controlled?</td>
</tr>
<tr>
<td>• Client-controlled?</td>
</tr>
<tr>
<td>• Balanced?</td>
</tr>
</tbody>
</table>

What did you learn from observing this role-play?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please record your comments/observations for feedback to participants (both positive and negative):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Participant Handout 2.2.1: IUD Screening

Once a client has made the decision to use an IUD based on complete general method counseling, she needs to have IUD method-specific counseling (as covered in the previous objective and in Unit 1 of this module). Before you can assure her that the IUD is an appropriate choice for her, you should perform a limited history interview and physical exam to rule out conditions which might affect eligibility, including the possibility of pregnancy, genital tract abnormalities, pelvic tuberculosis, unexplained vaginal bleeding, uterine or cervical malignancy, or infection.

To aid the practitioner in obtaining the client’s history and giving a rationale for asking each question (as well as aiding decision making in case of a precaution), practitioners may use checklists such as Participant Handout 2.2.2: Client Assessment Checklist.

Note: Microscopic examination of vaginal secretions is not necessary for IUD insertion.

Finally, the practitioner should perform a complete pelvic exam to:
• Determine position and size of uterus;
• Rule out likelihood of pregnancy; and
• Rule out presence of visible and/or palpable abnormalities, including infections, masses, tumors, etc.

If any of these are present, an IUD should not be inserted until the problem is investigated and resolved. The trainer and practitioner can use Participant Handout 2.2.3: Pelvic Bimanual and Speculum Checklist for guidance.
**Participant Handout 2.2.2: Client Assessment Checklist**

**Note:** Ask the client the questions below about known medical conditions. If she answers “no” to all of the questions, then she can have an IUD inserted.

<table>
<thead>
<tr>
<th>Service Provider’s Questions</th>
<th>NO</th>
<th>YES</th>
<th>Service Provider’s Instructions (and Rationale)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask the client the following questions:</td>
<td></td>
<td></td>
<td>If the client’s response falls in the “YES” column, follow the instructions below:</td>
</tr>
<tr>
<td>1. Did you give birth more than 48 hours ago but less than 4 weeks ago?</td>
<td>NO</td>
<td>YES</td>
<td>Do not insert. It is not advisable to insert an IUD after the first 48 hours postpartum until 4 weeks postpartum. During this time, the risk of uterine perforation is greater due to the rapidly involuting (shrinking) uterus.</td>
</tr>
<tr>
<td>2. Have you had a miscarriage or an abortion, with an infection within the past 4 weeks?</td>
<td>NO</td>
<td>YES</td>
<td>Women who have recently had a miscarriage or abortion can have an IUD inserted if there is no sign of infection on pelvic examination. If you are unsure, make an appropriate referral.</td>
</tr>
<tr>
<td>3. Has it been more than 12 days since the first day of your last menstrual period?</td>
<td>NO</td>
<td>YES</td>
<td>If it has been fewer than 12 days since the beginning of menstruation you can be certain that the woman is not pregnant. If it has been more than 12 days, you must be sure that the woman is not pregnant.</td>
</tr>
<tr>
<td>4. Is there a chance that you could be pregnant; is your period late or have you missed a recent period?</td>
<td>NO</td>
<td>YES</td>
<td>Do not insert the IUD if there is any chance that the client is pregnant. Perform a pelvic exam and a urine pregnancy test, if available. If you are unsure if she is pregnant, have the client use a barrier method and return in four weeks or upon beginning her menses. Note: Use following checklist on “How to be Reasonably Sure a Client is not Pregnant.”</td>
</tr>
<tr>
<td>5. Do you consider the bleeding during your menstrual periods to be unusually heavy? Heavier than other women? How many days? How often must you change pads/cloths? Do you often experience menstrual pains (cramps) severe enough to limit your daily activities?</td>
<td>NO</td>
<td>YES</td>
<td>If answer is “yes” to either question, encourage the client to consider another effective method. Explain to her that the IUD may make her bleeding even heavier. The IUD could also make her cramps worse. If she still prefers the IUD, insert it and ask her to come back if her bleeding or cramps become heavier.</td>
</tr>
<tr>
<td>6. Over the past 3 months, have you had any abnormally heavy periods or bleeding between periods or after intercourse?</td>
<td>NO</td>
<td>YES</td>
<td>These symptoms may indicate a health problem, such as cervicitis, cervical polyps, or, rarely, cancer. Look for signs of these problems when you do the speculum and bimanual examination.</td>
</tr>
<tr>
<td>7. Over the past 3 months, have you had fever or chills accompanied by pain in the lower abdomen?</td>
<td>NO</td>
<td>YES</td>
<td>These symptoms may indicate PID. Look for signs of tenderness, discharge, or guarding during pelvic examination. If you think infection is present, do not insert the IUD.</td>
</tr>
<tr>
<td>8. Have you recently had severe pelvic infection (with fever, chills, pain in the womb and/or discharge)? Or have you had problems with recurrent PID?</td>
<td>NO</td>
<td>YES</td>
<td>Do not insert the IUD. If the client currently has PID treat with antibiotics. If she has recurrent PID, help client make an informed choice of another effective contraceptive method. Discuss using condoms as her primary method of contraception or as a backup method to prevent PID.</td>
</tr>
</tbody>
</table>
Assure the client of confidentiality before asking the following questions:

<table>
<thead>
<tr>
<th>Ask the client the following questions:</th>
<th>NO</th>
<th>YES</th>
<th>If the client’s response falls in the “YES” column, follow the instructions below:</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. As far as you know, does your sex partner have other sex partners besides yourself?</td>
<td></td>
<td></td>
<td>If “yes” to one or both questions, client needs to be screened for possible GTIs or STIs. Counsel the client on risks associated with HIV, GTIs, and STIs. If the client has current purulent cervicitis, Chlamydia infection, or gonorrhea, help her choose another contraceptive method, and advise her to use condoms and/or spermicide to protect herself against these diseases. If the client has other STIs (excluding HIV and hepatitis) or vaginitis (including trichomonas vaginalis and bacterial vaginosis) you may insert the IUD.</td>
</tr>
<tr>
<td>Do you have more than one sex partner?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Do you have AIDS?</td>
<td></td>
<td></td>
<td>If the client has AIDS, or is being treated with any medicines that make her body less able to fight infections, do not insert the IUD. Help her choose another effective method. However, if she is clinically well on ARV therapy, you may insert the IUD. Whatever method she chooses, urge her to use condoms. A woman infected with the HIV virus, but clinically well, may have an IUD inserted.</td>
</tr>
<tr>
<td>11. Do you have any cancer in the female organs or pelvic tuberculosis?</td>
<td></td>
<td></td>
<td>Known cervical, endometrial, or ovarian cancer; benign or malignant trophoblast disease; pelvic tuberculosis: do not insert the IUD. Treat or refer for care as appropriate. Help her choose another effective method.</td>
</tr>
<tr>
<td>12. Are you currently taking any medications, such as high dose corticosteroids, immunosuppressive therapy, anticoagulant therapy, or receiving radiation therapy?</td>
<td></td>
<td></td>
<td>People using high dose corticosteroids or immunosuppressive drugs or receiving radiation therapy are at higher risk of infection. Also, anticoagulant therapy may increase blood loss. Do not insert the IUD. Help her to choose another effective method.</td>
</tr>
</tbody>
</table>
**Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD**

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

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

If the client answered **YES** to any one of questions 1–6 and is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. Proceed to questions 7–13. However, if she answers **YES** to question 1, the insertion should be delayed until 4 weeks after delivery. Ask her to come back at that time.

To determine if the client is medically eligible to use an IUD, ask questions 7–13. As soon as the client answers **YES** to any question, stop, and follow instructions below.

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

If the client answered **NO** to all of questions 1–6, pregnancy cannot be ruled out. The client should await menses or use a pregnancy test.

During the pelvic exam, the provider should determine the answers to questions 14–20.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Is there any type of ulcer on the vulva, vagina, or cervix?</td>
<td>YES</td>
</tr>
<tr>
<td>15. Does the client feel pain in her lower abdomen when you move the cervix?</td>
<td>YES</td>
</tr>
<tr>
<td>16. Is there adnexa tenderness?</td>
<td>YES</td>
</tr>
<tr>
<td>17. Is there purulent cervical discharge?</td>
<td>YES</td>
</tr>
<tr>
<td>18. Does the cervix bleed easily when touched?</td>
<td>YES</td>
</tr>
<tr>
<td>19. Is there an anatomical abnormality of the uterine cavity that will not allow appropriate IUD insertion?</td>
<td>YES</td>
</tr>
<tr>
<td>20. Were you unable to determine the size and/or position of the uterus?</td>
<td>YES</td>
</tr>
</tbody>
</table>

If the answer to all of questions 14–20 is **NO**, you may insert the IUD.

If the answer to any of questions 14–20 is **YES**, the IUD cannot be inserted without further evaluation. See explanations for more instructions.
### Service Provider’s Observations

<table>
<thead>
<tr>
<th>Service Provider’s Observations</th>
<th>NO</th>
<th>YES</th>
<th>Service Provider’s Instructions (and Rationales)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Look for the abnormalities listed below.</strong></td>
<td></td>
<td></td>
<td><strong>If a response falls in the “YES” column, follow the instructions below.</strong></td>
</tr>
<tr>
<td>1. Is there marked tenderness of cervix, uterus, or adnexal area?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> This suggests PID or cervicitis. Help the client make an informed choice of another effective method. Encourage the client to use condoms and/or spermicide to protect against GTIs and other STIs, including AIDS.</td>
</tr>
<tr>
<td>2. Is the cervix immobile, or is there a palpable mass or ulcer?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> These abnormalities may indicate a tumor or, rarely, cervical cancer. Help the client make an informed choice of another method, and refer for further evaluation.</td>
</tr>
<tr>
<td>3. Are you unable to determine the position of the uterus?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> If you are unsure of the position of the uterus after bimanual palpation, seek consultation or refer for further evaluation.</td>
</tr>
<tr>
<td>4. Is the uterus enlarged, soft, and smooth?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> If the woman has also missed a period, she is likely to be pregnant. If you are certain she is not pregnant, an IUD may be inserted.</td>
</tr>
<tr>
<td>5. Is the uterus enlarged, firm, and/or irregular?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> This may indicate uterine fibroids which can change the shape of the uterine cavity. Attempt to insert the IUD only if you are experienced; otherwise, refer or help her to choose another method. If you refer, help her choose another method to use until she gets her IUD.</td>
</tr>
<tr>
<td>6. Is there a palpable mass in the adnexal area?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> This may indicate PID or a tumor of the ovary or tube. Help the client make an informed choice of another nonhormonal method until problem is solved. Make appropriate referral.</td>
</tr>
<tr>
<td>7. On sounding, is the uterine cavity irregular or deeper than 10 cm?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> This may mean that she has fibroids, is pregnant, or the uterus was perforated by the sound. If perforation is suspected, observe the client for evidence of intra abdominal bleeding: decreased blood pressure, rising pulse and/or syncope.</td>
</tr>
<tr>
<td>8. Check for purulent vaginal discharge, lesions or sores.</td>
<td></td>
<td></td>
<td>Although ulcerative STIs are not a contraindication for initiating IUD, coinfection with gonorrhea and Chlamydia should be ruled out prior to insertion.</td>
</tr>
<tr>
<td>9. Is there discharge from the cervical canal?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> This suggests cervicitis. Diagnose and treat cervicitis. Help client make an informed choice of another method. Encourage her to use condoms and/or spermicide to protect against STIs, including AIDS.</td>
</tr>
<tr>
<td>10. Is there a mass, ulcer, or bleeding on contact with the cervix?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> This suggests possible cervical polyp, severe cervicitis or, rarely, cervical cancer. Help client make informed choice of another method. Refer if necessary for further evaluation.</td>
</tr>
<tr>
<td>11. If findings on the bimanual examination are unclear, (position or size of uterus can’t easily be determined) perform a rectovaginal examination.</td>
<td></td>
<td></td>
<td><strong>Do not insert IUD if any cul-de-sac mass or tenderness are found. Investigate further.</strong></td>
</tr>
</tbody>
</table>
Participant Handout 2.3.1: Instructions for Loading the TCu 380A in the Sterile Package

How to Load the TCu 380A

Do not open the sterile package containing the IUD or load it until the final decision to insert an IUD has been made (i.e., after the pelvic examination, including both speculum and bimanual exams, has been performed). In addition, do not bend the arms of the “T” into the inserter tube (as instructed below) more than five minutes before it is introduced into the uterus. If the arms are left in the inserter tube too long, they will not straighten as easily.

Step 1: Make sure that the vertical stem of the T is fully inside the inserter tube (the T can be shifted through the unopened package) and that the end of the inserter tube opposite the T is close to the seal at the end of the package.

Step 2: Place the package on a clean, hard, flat surface with the clear plastic side up. Partially open the end of the package farthest from the IUD. Open the package approximately halfway to the blue depth gauge.

Step 3: Pick up the package, holding the open end up towards the ceiling so that the contents do not fall out. Bend the clear plastic cover and white backing “flap” at the open end of the package away from each other. (This will help maintain sterility of the white rod during loading.) Using your free hand, grasp the white rod, which is behind the I.D. card, by the thumb grip and remove it from the package. Be careful not to touch the tip of the white rod or brush it against another surface. Put the white rod inside the inserter tube and gently push the rod up into the inserter tube until it almost touches the bottom of the T.

Step 4: Release the white backing flap so that it is flat, and place the package on a flat surface with the clear plastic side up.

Step 5: Through the clear plastic cover, place your thumb and index finger over the ends of the horizontal arms of the T and hold the T in place. At the open end of the package, use your free hand to push the I.D. card so that it slides underneath the T and stops at the top seal of the package. While still holding the tips of the horizontal arms of the T, use your free hand to grasp the inserter tube against the arms of the T, as indicated by the arrow in the figure below. This will start the arms of the T bending downward, towards the stem of the T, as indicated in the drawing on the I.D. card.
Step 6: Continue bending the arms of the T by bringing the thumb and index finger together. When the arms have folded enough to touch the sides of the inserter tube, pull the inserter tube out from under the tips of the arms. Then push and rotate the inserter tube onto the tips of the arms so that the arms become trapped inside the inserter tube next to the stem. Insert the folded arms into the tube only as far as necessary to ensure retention of the arms. **Do not try to push the copper bands on the arms into the inserter tube; they will not fit.**

Step 7: The blue depth gauge on the inserter tube is used to mark the depth of the uterus and to show the direction in which the arms of the T will unfold once they are released from the inserter tube. Holding the blue depth gauge in place through the clear plastic wrapper, grasp the inserter tube at the open end of the package with your free hand.

Pull the inserter tube gently until the distance between the top of the folded T and the edge of the blue depth gauge closest to the T is equal to the depth of the uterus as measured on the uterine sound. Rotate the inserter tube so that the long axis of the blue depth gauge is on the same horizontal plane as the arms of the T.
**Step 8:** The IUD is now ready to be placed in the woman’s uterus. Carefully peel the clear plastic cover of the package away from the white backing. Lift the loaded inserter, keeping it horizontal, so that the T or white rod doesn’t fall out. Be careful not to push the white rod towards the T until you are ready to release the T in the fundus. **Do not let the inserter tube or the tip of the IUD touch any unsterile surfaces. If it touches any unsterile surfaces it must not be inserted in the uterus. Throw it away and get another one.**
Participant Handout 2.4.1: Basic Principles for IUD Insertion and Removal

Participants will achieve this objective through a variety of training methodologies. The step-by-step IUD insertion and removal sequence is found in Participant Handout 2.4.3: Inserting the Loaded TCu 380A IUD. The JHPIEGO video on IUD insertion and removal also details the procedure.

Throughout the IUD insertion and removal training, certain basic principles are to be emphasized.

- Talk with the client before and during the procedure.
- Explain the procedure.
- Tell her she will experience some discomfort or cramping during the procedure.
- Ask her to tell you whenever she feels discomfort or pain.
- Tell her what is happening step-by-step.
- Provide reassurance.
- Alert her before any step that might cause pain.
- **Gentle techniques** minimize discomfort and emotional trauma to the client. In order to perform a comfortable IUD insertion, force is neither necessary nor desirable.
- **No-touch technique**, in which the tip of the uterine sound (and the loaded IUD) that will touch the upper genital tract will not have previously touched anything that may contaminate it: hands, speculum, vagina, table top, etc.
- As already indicated in Specific Objective #2, the TCu 380A is loaded using the no-touch technique, inside the package.
- The cervix and vagina should be thoroughly prepped with antiseptic. Use a water-based antiseptic such as an iodophor (Betadine® or Povidone Iodine) or Chlorhexidine (Hibitane®). **Note: If an iodophor is used, wait one or two minutes before proceeding because iodophors take up to two minutes contact time to release free iodine.**
- The uterine cavity should always be sounded to confirm the position of the uterus and the depth of the cavity.
- Set the depth gauge on the IUD to the level on the uterine sound.
- Insert the IUD high in the fundus of the uterus by withdrawal technique, as there is less risk of expulsion.
Participant Handout 2.4.2: Passing a Uterine Sound

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

**Purpose of Sounding the Uterus**
- To check the position of the uterus (to confirm findings of the pelvic exam) and check for obstructions in the cervical canal.
- To measure the direction of the cervical canal and uterine cavity, so that the inserter can be positioned appropriately to follow the canal.
- To measure the length from external cervical os to the uterine fundus so that the blue depth gauge on the insertion tube (TCu 380A IUD) can be set at the same distance, so that the IUD will be placed high in the uterine fundus.

**Procedure for Sounding the Uterus**
Use gentle, no touch (aseptic) technique throughout.

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

**Step 1:** Put on HLD or sterile gloves.

**Step 2:** Insert the speculum. Thoroughly clean the cervix with an antiseptic solution e.g., Chlorhexidine Gluconate (Hibiclens®, Hibiscrub®, Hibtane® or Savlon® note: concentration of Savlon® may vary) or iodophors (Povidone Iodine, Betadine®, Wesodyne®).

**Step 3:** Apply the HLD or sterile tenaculum at the 10 o’clock and 2 o’clock positions on the cervix. Close the tenaculum **one notch at a time**, slowly, and no further than necessary.

**Step 4:** Pick up the handle of the sound, do not touch the tip. Turn the sound so that it is in the same direction as the uterus. Gently pass the HLD or sterile tip of the uterine sound into the cervical canal. At the same time, keep a firm grip with the tenaculum. (Be careful not to touch the walls of the vagina with tip of sound.)

Carefully and gently, insert the uterine sound in the direction of the uterus while gently pulling steadily downwards and outward on the tenaculum. If there is resistance at the internal os, use a smaller sound, if available. Do **not** attempt to dilate the cervix unless well qualified. **Gentle** traction on the tenaculum may enable the sound to pass more easily. **If client begins to show symptoms of fainting or pallor with slow heart rate, STOP.**

**Step 5:** Slowly withdraw the sound, it will be wet and darker where it was in the uterus. Place the sound next to the IUD and set the blue depth gauge at the depth of the uterus. Determine the length of the uterus by noting the mucus and or blood on the sound. The average uterus will sound to a depth of six to eight centimeters. **Do not attempt to insert an IUD into a uterus that measures 6.5 cm or less in depth because there is more risk of expulsion.**
**Note:** If the uterus sounds to a depth of 10 cm or more, the sound may have perforated the uterus, or the uterus may be enlarged due to tumors or pregnancy. **DO NOT** insert an IUD. If perforation is suspected, observe the client in the clinic carefully.

a) For the first hour, keep the woman in bed and check the pulse and blood pressure every 5 to 10 minutes.

b) If the woman remains stable after one hour, check the hematocrit/hemoglobin if possible, allow her to walk, check vital signs as needed, and observe for several more hours. If she has no signs or symptoms, she can be sent home, but should avoid intercourse for two weeks. Help her make an informed choice about a different (back up) contraceptive.

c) If there is a rapid pulse and falling blood pressure, or new pain or increasing pain around the uterus, hospitalization is needed.
Participant Handout 2.4.3: Inserting the Loaded TCu 380A IUD

Step 1: Grasp the tenaculum (which is still in place on the cervix after sounding the uterus) and pull firmly to pull the uterine cavity and cervical canal in line with the vaginal canal. Gently place the loaded inserter tube through the cervical canal. Keep the blue depth gauge in a horizontal position.

Advance the loaded IUD until the blue depth gauge touches the cervix or resistance of the uterine fundus is felt. Keep the blue depth gauge in a horizontal position.

Step 2: Hold the tenaculum and the white rod in place in one hand. With your other hand, withdraw (pull toward you) the inserter tube until it touches the thumb grip of the white rod. This will release the arms of the TCu 380A high in the uterine fundus.

Step 3: Once the arms have been released, again very gently and carefully, push the inserter tube upward, toward the top of the uterus, until you feel a slight resistance.

This step ensures that the arms of the T are as high as possible in the uterus.

Hold the inserter tube still while removing the white rod.

Step 4: Gently and slowly withdraw the inserter tube from the cervical canal. The strings should be visible protruding from the uterus. Cut the strings so that they protrude only three to four centimeters into the vagina.

Remove the tenaculum. If the cervix is bleeding from the tenaculum site, press a swab to the site, using clean forceps, until the bleeding stops.

Step 5: Gently remove the speculum and put all of the instruments used in 0.5% chlorine solution for 10 minutes for decontamination.
**Step 6:** Help the client get up from the table very slowly. Watch her in case she becomes dizzy or feels faint. Teach her how and when to check the strings. Ask her to check the strings now. Ask her if she has any questions and answer them in simple words she can understand. Tell her to return in three to six weeks. If she can read, give her written instructions or tell her the warning signs of problems and how to get help if she needs it.

Participant Handout 2.4.4: Using the Clinical and Counseling Skills Checklist

The Checklist for IUD Counseling and Clinical Skills is used by the trainer to certify each participant’s competency in providing IUD services (i.e., counseling, infection prevention practices, insertion or removal, and follow up care). The checklist focuses only on key steps in the entire process.

The trainer uses this checklist to evaluate the performance of each participant for certification as she or he provides IUD services to one or more clients. Criteria for satisfactory performance by the participant are based on the knowledge, attitudes, and skills set forth in the module.

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

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

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

In preparing for formal evaluation (certification) by the trainer(s), participants may familiarize themselves with the content of the checklist by using it to critique each others counseling skills (role-play or with a client) and clinical skills (using a pelvic model or with a client).

In general, a participant is expected to demonstrate satisfactory counseling skills and to perform at least 5 to 10 insertions satisfactorily in clients before being certified as competent. When determining competence, the judgment of a skilled trainer is the most important factor. In order to enable every participant to achieve competency, additional training in counseling techniques, insertion, or both may be necessary.

It is recommended that, if possible, participants who have been certified later be observed and evaluated in their own clinic by a course trainer, using the same checklist, within three to six months of certification. At a minimum, the graduate should be observed by a skilled provider soon after completing training. This post-course evaluation is important for several reasons. First, it provides the graduate with experience in handling direct constraints to service delivery (e.g., lack of instruments, supplies, or support staff). Second, and equally important, it provides the training center, via the trainer, with key information on the adequacy of the training and its appropriateness to local conditions. Without this type of feedback, training can easily become routine, stagnant, and irrelevant to service delivery needs.
Participant Handout 2.4.5: Checklist for IUD Counseling and Clinical Skills

Date of Assessment ___________________ Dates of Training ___________________
Place of Assessment: Clinic _______________ Classroom____________________
Name of Clinic Site ____________________________
Name of the Service Provider ___________________________
Name of the Assessor ____________________________

This assessment tool contains the detailed steps for IUD counseling and IUD insertion or removal. The checklist may be used during training to monitor the progress of the trainee as s/he acquires the new skills and during the clinical phase of training to determine whether the trainee has reached a level of competence in performing the skills. The checklist may also be used by the trainer or supervisor when following up or monitoring the trainee. The trainee should always receive a copy of the assessment checklist so that s/he may know what is expected of her/him.

Instructions for the Assessor
Always explain to the client what you are doing before beginning the assessment. Ask for the client’s permission to observe.
Begin the assessment when the trainee greets the client.
Use the following rating scale:
2 = Done according to standards
1 = Needs improvement
N/O = Not observed

Continue assessing the trainee throughout the time s/he is with the client, using the rating scale. Only observe. Do not interfere unless the trainee misses a critical step or compromises the safety of the client. Fill in the form using the rating numbers. Write specific comments when the task is not performed according to standards. Use the same form for one trainee for at least three observations. When you have completed the observation, review the results with the trainee. Do this in private, away from the client or other trainees.

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friendly/welcoming/smiling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonjudgmental/receptive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makes eye contact with the client, if culturally appropriate.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faces the client directly.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listens attentively/nods head to encourage and acknowledge the client’s responses.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shows positive regard for the client as a person.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures the client’s privacy/confidentiality without having to be asked.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remains patient/allows the client time to ask all questions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not interrupt the client.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Service Provider’s Verbal Communication**
Phrases questions clearly and appropriately.
**Intrauterine Devices (IUDs)**

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uses non-technical terms.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses a friendly tone of voice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listens to client’s responses closely.</td>
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<tr>
<td>Answers client’s questions clearly and completely.</td>
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<tr>
<td>Uses language the client can understand.</td>
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</tbody>
</table>

**RESPECT Model Process and Content**

**Rapport**
- Understands the client’s point of view.
- Is friendly and respectful.
- Assures privacy and confidentiality.
- Doesn’t judge the client.
- Doesn’t argue with the client or act superior.
- Doesn’t scold the client.
- Recognizes and doesn’t make assumptions about the client.

**Empathy**
- Remembers that the client has come for help.
- Tries to understand the client’s reason for his or her behavior/ideas.
- Uses positive body language and other strategies to demonstrate nonjudgmental acceptance of the client’s ideas and feelings.
- Verbally acknowledges the client’s feelings and expresses understanding.

**Support**
- Asks about and acknowledges the barriers to care and compliance.
- Offers the client concrete ways to overcome barriers.
- Involves family members when appropriate.
- Reassures the client that s/he is there to help and answer questions.
- Encourages the client to return to the clinic if s/he has any concerns.

**Partnership**
- Is flexible.
- Acknowledges the client’s needs.
- Stresses that the client and provider are working together.
- Lets the client know she has options and can make her own choices.
- Makes a plan for the client to continue to return to the clinic for follow-up.
- Helps returning clients weigh options of continuing or switching methods.

**Explanations**
- Gives information about which methods are available.
- Asks which method interests the client.
- Asks what the client knows about method.
- Corrects myths/rumors/incorrect information.
- Describes how the method works and its effectiveness.
- Uses A/V aids during counseling.
- Describes benefits and risks.
- Describes potential side effects and warning signs.
- Offers clear action steps to respond to side effects/warning signs.
- Explains clearly what the client has to do to use the method successfully.
- Asks the client to repeat back instructions.
- Reminds the client again of danger signs.
- Answers the client’s questions clearly.
- Encourages the client to return with problems or concerns.
<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cultural Sensitivity</strong></td>
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<tr>
<td>• Respects the client's life style and cultural and religious beliefs.</td>
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<tr>
<td>• Helps the client understand how these may influence family planning and other reproductive health choices.</td>
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<tr>
<td>• Understands that the client's view of the provider may be defined by ethnic or cultural stereotypes.</td>
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<tr>
<td>• Is aware of his or her own cultural biases and preconceptions.</td>
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<tr>
<td>• Knows his or her own limitations in addressing counseling and medical issues across cultures.</td>
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<tr>
<td>• Can explore cultural influences on attitudes and beliefs without disapproval.</td>
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<tr>
<td>• Can help the client to explore these issues as well.</td>
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<tr>
<td><strong>Trust</strong></td>
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<tr>
<td>• Recognizes that it may be difficult for clients to share personal information about themselves.</td>
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<tr>
<td>• Effective at gradually developing a trusting relationship.</td>
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<tr>
<td>• Consciously works to establish trust.</td>
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<tr>
<td>• Responds to the client’s concerns, including rumors, respectfully and constructively.</td>
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<tr>
<td>• Respects the client’s choice of family planning methods.</td>
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<tr>
<td><strong>Problem Solving</strong></td>
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<tr>
<td>Responds appropriately to the client’s needs and problems.</td>
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<tr>
<td>Service provider is convincing when giving advice.</td>
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<tr>
<td>The advice given and method provided are appropriate.</td>
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<tr>
<td><strong>Pre-Insertion Tasks</strong></td>
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<tr>
<td>Obtains or reviews brief reproductive health history.</td>
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<tr>
<td>Washes hands with soap and water.</td>
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<tr>
<td>Asks the client if she has emptied her bladder.</td>
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<tr>
<td>Palpates abdomen and checks for suprapubic or pelvic tenderness and adnexal abnormalities.</td>
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<tr>
<td>Tells the client what is going to be done and encourages her to ask questions.</td>
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<tr>
<td>Puts new examination (disposable) or HLD or sterile (reusable) gloves on both hands.</td>
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<tr>
<td>Performs speculum examination.</td>
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<tr>
<td>Collects specimens of vaginal and cervical secretions, if indicated.</td>
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<tr>
<td>Performs bimanual examination.</td>
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<tr>
<td>Performs rectovaginal examination, if indicated.</td>
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<tr>
<td>Removes gloves and properly disposes (single use) or immerses (reusable) in chlorine solution.</td>
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<tr>
<td>Performs microscopic examination, if indicated (and if equipment is available).</td>
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<tr>
<td>Washes hands thoroughly with soap and water and dries with clean cloth or allows to air dry.</td>
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<tr>
<td>Loads TCu 380A inside the sterile package.</td>
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<tr>
<td><strong>IUD Insertion</strong></td>
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<tr>
<td>Puts new examination (disposable) or HLD or sterile (reusable) gloves on both hands.</td>
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<tr>
<td>Inserts vaginal speculum (and vaginal wall elevator if using single valve speculum).</td>
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<tr>
<td>Task/Activity</td>
<td>1</td>
<td>2</td>
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<td>Comments</td>
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<tr>
<td>Swabs cervix and vagina with antiseptic at least twice. Waits for two minutes if using an iodophor.</td>
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<tr>
<td>Gently grasps cervix with tenaculum or Vulsellum Forceps.</td>
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<tr>
<td>Sounds uterus using no touch technique</td>
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<tr>
<td>Sets blue depth gauge on the loaded IUD inserter to the depth on the sound.</td>
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<tr>
<td>Inserts the IUD using the withdrawal technique.</td>
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<tr>
<td>Cuts strings and gently removes tenaculum.</td>
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</table>

**Post-Insertion Tasks**

- Places used instruments in chlorine solution for decontamination.
- Disposes of waste materials according to guidelines.
- Removes reusable gloves and places them in chlorine solution.
- Washes hands with soap and water.
- Completes the client record.

**Post-Insertion Counseling**

- Teaches client how and when to check for strings.
- Discusses what to do if the client experiences any side effects or problems.
- Assures the client that she can have the IUD removed at any time.
- Observes the client for at least 15 minutes before sending her home.

**Follow-Up Counseling**

- Greets the client in friendly and respectful manner.
- Ensures privacy.
- Asks the following questions;
  - Have you been happy using the IUD?
  - Have you had any concerns or problems?
  - Has your health changed in any way since you had your IUD inserted?
  - Do you have any questions you would like me to answer?
  - How are you protecting yourself from STIs? (Explains dual protection)
  - Do you need some condoms?
  - May I examine you?

**Follow Up Examination (3-6 weeks after insertion)**

- Explains to the client why and how she will do the pelvic examination.
- Prepares the client while ensuring dignity and privacy.
- Performs a pelvic examination and checks to make sure the string is visible and that there is no partial or complete expulsion.
- Explains findings and reassures the client.

**Pre-Removal Counseling**

- Greets the client in friendly and respectful manner.
- Asks the client her reason for removal and answers any questions she may have.
- Reviews the client’s present reproductive goals.
- Describes the removal procedure and what to expect.

**Removal of IUD**

- Washes hands thoroughly with soap and water and dries with a clean cloth or allows to air dry.
<table>
<thead>
<tr>
<th>Task/Activity</th>
<th></th>
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<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puts new examination (disposable) or HLD or sterile (reusable) gloves on both hands.</td>
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<tr>
<td>Performs bimanual exam.</td>
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<tr>
<td>Inserts vaginal speculum and looks at length and position of strings.</td>
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<tr>
<td>Swabs cervix and vagina with antiseptic.</td>
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<tr>
<td>Grasps strings close to the cervix and pulls gently but firmly to remove the IUD.</td>
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<tr>
<td><strong>Post-Removal Tasks</strong></td>
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</tr>
<tr>
<td>Places used instruments in chlorine solution for decontamination.</td>
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<td></td>
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</tr>
<tr>
<td>Disposes of waste materials according to guidelines.</td>
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<tr>
<td>Removes reusable gloves and places them in chlorine solution.</td>
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<tr>
<td>Washes hands with soap and water.</td>
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<tr>
<td>Records IUD removal in client record.</td>
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</tr>
<tr>
<td><strong>Post-Removal Counseling</strong></td>
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<tr>
<td>Discusses what to do if the client experiences any problems.</td>
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<tr>
<td>Counsels the client regarding new contraceptive method, if desired.</td>
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<tr>
<td>Assists the client in obtaining new contraceptive method or provides temporary (barrier) method until method of choice can be started.</td>
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</table>

Comments (summary):

Recommendations:

Certified (If not, why):

Trainer’s Signature__________________________ Date______________________ Participant
Handout 2.5.1: Infection Prevention for IUDs

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

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

High-Level Disinfection
High-Level Disinfection (HLD) through boiling or the use of chemicals is the recommended method of cleaning and disinfection. Surgical (metal) instruments and reusable gloves should be boiled for 20 minutes. **Begin timing when the boiling action starts.** Alternatively, instruments can be soaked for 20 minutes in a 2% glutaraldehyde or 8% formaldehyde solution. After cooling (if boiled) or rinsing in boiled water (if chemical disinfectants used) and drying, instruments are ready to use. Use immediately or store for up to one week in a clean, dry, HLD container with a tight-fitting lid or cover.

Sterilization
Alternatively, instruments and reusable gloves used for IUD insertion and removal can be sterilized by autoclaving (121°C [250°F] and 106 kPa [15 lb/in2]) for 20 minutes if unwrapped and 30 minutes if wrapped.

**Note:** **Dry heat sterilization (170°C [340°F] for 60 minutes) can be used only for metal or glass instruments.**

Storage
Unwrapped instruments must be used immediately. Wrapped instruments, gloves, and drapes can be stored for up to one week if the package remains dry and intact, one month if sealed in a plastic bag.
Infection Prevention Tips: IUD Insertion

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

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

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

Infection Prevention Tips: IUD Removal

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

- Wash hands thoroughly with soap and water before and after each procedure.
- When possible, have the client wash her genital area before doing the screening pelvic examination.
- **Use clean, HLD** (or sterilized) instruments and gloves (on both hands) or use disposable (single-use) examination gloves.
- After inserting the speculum and while looking at the cervix, before beginning the procedure, apply antiseptic solution several times to the cervix and vagina.
- Properly dispose of waste material (gauze, cotton, the IUD, and disposable gloves) after removal.
- Decontaminate instruments and reusable items immediately after using them.
Participant Handout 2.5.2: Competency-Based Skills Checklist for Infection Prevention

Date of Assessment ____________________ Dates of Training ____________________
Place of Assessment: Clinic____________ Classroom___________________________
Name of Clinic Site ___________________________________________________________
Name of the Service Provider __________________________________________________
Name of the Assessor___________________________________________________________

This assessment tool contains the detailed steps in infection prevention that a service provider should accomplish when performing IUD insertion or removal. The checklist may be used during training to monitor the progress of the trainee as s/he acquires the new skills and during the clinical phase of training to determine whether the trainee has reached a level of competence in performing the skills. The checklist may also be used by the trainer or supervisor when following up or monitoring the trainee. The trainee should always receive a copy of the assessment checklist so that s/he may know what is expected of her/him.

**Instructions for the assessor**
Always explain to the client what you are doing before beginning the assessment. Ask for the client’s permission to observe. Begin the assessment when the trainee greets the client.
Use the following rating scale:
2 = Done according to standards
1 = Needs improvement
N/O = Not observed

Continue assessing the trainee throughout the time s/he is with the client, using the rating scale. Only observe. Do not interfere unless the trainee misses a critical step or compromises the safety of the client. Fill in the form using the rating numbers. Write specific comments when the task is not performed according to standards. Use the same form for one trainee for at least three observations. When you have completed the observation, review the results with the trainee. Do this in private, away from the client or other trainees.

### CBT Skills Assessment Checklist for Infection Prevention Related to IUD Insertion or Removal

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Cases</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
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<tr>
<td><strong>Prior to IUD Insertion</strong></td>
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<tr>
<td>Prepare a bucket containing 0.5% chlorine solution for decontaminating instruments</td>
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<tr>
<td>Wash hands thoroughly and dry them</td>
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<tr>
<td>Put new examination or HLD surgical gloves on both hands</td>
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<td></td>
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<tr>
<td>Arrange instruments and supplies on HLD disinfected or sterile tray</td>
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<tr>
<td>Task/Activity</td>
<td>Cases</td>
<td>Comments</td>
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<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>During Client Assessment and IUD Insertion</strong></td>
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<tr>
<td>If rectovaginal exam is performed: immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out and dispose of them properly</td>
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<tr>
<td>Puts on gloves correctly</td>
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<tr>
<td>Load TCu 380A in sterile package</td>
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<tr>
<td><strong>Following IUD Insertion</strong></td>
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<tr>
<td>Places all instruments in 0.5% chlorine solution for only 10 minutes immediately following the procedure</td>
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<tr>
<td>Reusable gloves are decontaminated in 0.5% chlorine for 10 minutes</td>
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<tr>
<td>Wipes down exam table with chlorine between clients</td>
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<tr>
<td><strong>Cleaning Instruments</strong></td>
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<tr>
<td>Collects all supplies needed, including large and small brushes, detergent, and large basin</td>
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<tr>
<td>Wears utility gloves</td>
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<tr>
<td>Completely disassembles instruments and/or opens jaws of jointed items</td>
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<tr>
<td>Washes all surfaces with a brush or cloth until visibly clean</td>
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<tr>
<td>Thoroughly cleans serrated edges</td>
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<tr>
<td>Rinses all surfaces with clean water</td>
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<tr>
<td>Dries by air or towels before further processing</td>
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<tr>
<td><strong>High-Level Disinfection of Instruments by Boiling</strong></td>
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<tr>
<td>Completely submerges items in water</td>
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<tr>
<td>Starts timing when boiling begins</td>
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<tr>
<td>Keeps at rolling boil for 20 minutes</td>
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<tr>
<td>Air dries equipment</td>
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<tr>
<td>Boiled items removed using HLD forceps</td>
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<tr>
<td><strong>High-Level Chemical Disinfection</strong></td>
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<tr>
<td>Uses one of the following:</td>
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<tr>
<td>Chlorine 0.5% for 20 minutes</td>
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<tr>
<td>One part 35%-40% formaldehyde to four parts water) for 20 minutes</td>
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<tr>
<td>Glutaraldehyde (Cidex) for 20 minutes</td>
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<tr>
<td>Hydrogen peroxide 6% (one part 30% to four parts water) for 20 minutes</td>
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<tr>
<td>Prepares fresh solution</td>
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<tr>
<td>Immerses items completely</td>
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<tr>
<td>Rinses items with boiling water and allows to air dry</td>
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<tr>
<td>Stores items in HLD container</td>
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<tr>
<td>Task/Activity</td>
<td>Cases</td>
<td>Comments</td>
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</tr>
<tr>
<td><strong>Sterilization by Autoclave</strong></td>
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</tr>
<tr>
<td>Decontaminates, cleans, and dries instruments</td>
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<td></td>
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<tr>
<td>Disassembles items</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wraps instruments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arranges packs loosely in autoclave</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puts holes in drums in open position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heats water until steam escapes from pressure valve only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follows directions for operating autoclave</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterilizes for 30 minutes for wrapped items and 20 minutes for unwrapped items at 121°C (250°F) and 106 kPa (15 lbs/in²)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After autoclaving, opens the lid and lets instruments dry for 30 minutes before removing</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sterilization by Dry Heat</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decontaminates, cleans, and dries instruments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puts instruments on traps or wraps loosely</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Begins timing after temperature has been reached</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 170°C (340°F): 60 minutes</td>
<td></td>
<td></td>
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<tr>
<td>• 160°C (320°F): 120 minutes</td>
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<td></td>
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<tr>
<td>• 150°C (300°F): 150 minutes</td>
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<td></td>
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<tr>
<td>• 140°C (285°F): 180 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 121°C (250°F): over night</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After cooling, removes instruments with HLD forceps</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chemical Sterilization</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has 2% glutaraldehyde freshly made</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soaks in covered container eight to ten hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rinses items with sterile water</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Air dries instruments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stores items in a sterile covered container</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Handles items with HLD forceps</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Waste Disposal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needles are disposed of in a separate container filled with 0.5% chlorine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical waste is removed daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical waste is destroyed by burning</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sum/Total</strong></td>
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</tr>
</tbody>
</table>
Participant Handout 2.6.1: IUD Follow-Up Care

Follow-up management of the IUD client involves routine follow-up visits, problem visits, and management of common side effects. Routine follow-up visits should include at least a first check-up three to six weeks after IUD insertion.

The client can return for a visit to have the IUD removed when it has been in place for the recommended number of years, (12 years for the TCu 380A) or when client wishes to have it removed for any reason. (The latest scientific evidence shows that the TCu 380A is effective for at least 12 years.) In addition, the client should be able to return for a visit if she has questions, concerns, or any signs/symptoms she thinks may be caused by the IUD. If facilities are available, it is also recommended that clients have yearly routine gynecological checkups, but these are not a necessary part of IUD management.

Remember to teach her the warning signs. If she has any of these signs she must return for a visit immediately:
• Fever (a possible sign of infection);
• Abdominal pain, or pain during intercourse;
• Purulent or foul smelling discharge; or
• An IUD string that becomes shorter, longer, or missing.

When a client comes for follow-up care, follow the recommendations in this handout. For problem visits and management of side effects and complications, follow protocols and recommendations in the Participant Handout 2.6.2: IUD Post-Insertion Follow-Up Care.

If a complication such as PID, pregnancy with IUD, perforation, difficulty in IUD removal, or missing strings is suspected, refer the client to an Ob/Gyn or specialist (trainer) for management.
Participant Handout 2.6.2: IUD Post-Insertion Follow-Up Care

Background
Long term success, as defined by satisfied clients and high continuation rates, will take place only if service providers recognize the importance of providing follow up care (including counseling) and prompt management of side effects and other problems should they occur.

Most clients will not experience problems immediately following IUD insertion. When they do occur however, immediate problems may include:

- Nausea;
- Mild to moderate lower abdominal pain (cramping); and
- Syncope (fainting), rarely.

Because of these potential problems, it is recommended that all clients remain at the clinic for 15 or 30 minutes before being discharge.

Note: This time can be put to productive use by further counseling of the patient.

Client Instructions
Telling a client about common IUD side effects and what to do if certain problems occur promotes continued use. In particular, she should know

- **What kind of IUD she has and when it needs to be replaced**: Following insertion, the effective life of the TCu 380A IUD is 12 years. (The latest scientific evidence shows that the TCu 380A is effective for at least 12 years.) The provider should give her a card with the date of insertion and the IUD’s effective life.

- **The IUD provides no protection against HIV or other STIs**: The provider should remind the client to use a condom for protection from HIV or STIs if she thinks that she or her partner could be at risk of exposure to HIV or STIs.

- **When to come back for a check up**: Normally, clients should return for a routine visit after the first post-insertion menses (three to six weeks) but not later than three months after insertion. (Give her a follow up appointment before she leaves.)

- **What are the health risks with IUDs?**
  - IUDs do not completely protect the user from having an ectopic (outside the uterus) pregnancy.
  - A woman who has an IUD is at a somewhat greater risk of developing infections in the uterus and/or fallopian tubes during the first month following insertion. These infections are known as Pelvic Inflammatory Disease (PID). Thereafter, unless she is at risk for STIs (e.g., either she and/or her partner has more than one sexual partner), it is unlikely that she will get a pelvic infection. Also, a woman who has an IUD should avoid douching if possible, as douching may increase the chance of infection.
  - IUDs, although extremely effective, may fail, even if they are correctly in place. **If a woman who has an IUD thinks she is pregnant, she should go to the clinic as soon as possible for a check up.** If she is pregnant, the IUD should be removed, because there is a greater chance of miscarriage and the possibility of developing a pelvic infection.
• **How can she tell if she has one of these health problems?:** A woman with an IUD should come to the clinic as soon as possible if any of the following occur:
  o Late period with pregnancy symptoms (nausea, breast tenderness, etc.);
  o Persistent or crampy lower abdominal pain, especially if accompanied by nausea, fever, or chills (these symptoms suggest possible pelvic infection);
  o Strings missing or the plastic tip of the IUD can be felt when checking for the strings; or
  o Either the client or her partner begins having sexual relations with more than one partner
  IUDs do not protect against sexually transmitted infections, including hepatitis B and HIV.

• **How soon after insertion is the IUD effective?** It is effective immediately, and unless she has just had a baby, she can have sex as soon as she wants. **The client should be told that there might be some bleeding or spotting during the first few days after insertion.** She should not worry if this happens.

• **Should the client check to see if the IUD has remained in place?:** In the past, providers were expected to counsel women about checking the IUD strings to make sure the IUD remained in place. The thinking on this issue has shifted. Many women were reluctant to put their fingers in their vagina to check the position of the string. But, it is important to remind women that if they suspect that their IUD has come out or shifted in position they should begin using a back-up contraceptive method and return to the clinic immediately. Advise women to pay special attention during their first few periods following insertion. Advise the woman to check her menstrual pad or cloth, as well as the toilet or latrine during menstruation during her first several periods following IUD insertion. If the client is comfortable doing so, the provider should show her how to check for the strings. She should return to the provider if she feels any of the following, which suggest that the IUD is being expelled:
  o Cramping in the lower part of the abdomen,
  o Spotting between periods or after intercourse,
  o Pain after intercourse or if her husband or partner experiences discomfort during sex, or
  o If the hard part of the IUD is felt in the vagina or if she notices that the string becomes longer.

• **What to do if there are changes in her menstrual periods:** For most women, the first few periods will be heavier, last longer, and involve more cramping. This is not harmful. However, if the bleeding lasts twice as long as usual or if she uses twice as many pads, cloths, or tampons, she should see a health care provider.

• **When to have the IUD removed:** The IUD should be removed
  o If the client desires,
  o If the client wants to get pregnant,
  o If she experiences persistent side effects or other health problems, or
  o At the end of the effective life of the IUD. The TCu 380A should be removed after 12 years. (The latest scientific evidence shows that the TCu 380A is effective for at least 12 years.)

To have the IUD removed, the woman should return to the clinic. She should **never** try to remove the IUD herself or ask an untrained person to remove the IUD. Normal fertility returns soon after IUD removal. If the client does not want to become pregnant, another IUD can be inserted.
immediately. There is no need for a “rest period” before inserting another IUD. Finally, remember to tell the client that she can have the IUD removed at any time for any reason and choose another contraceptive method. To help the client understand and remember the most important points, be sure to explain them to her clearly and simply, and repeat them several times. It is also useful to give the client printed material, if available, with the name and a picture of the IUD as well as the date of insertion and time for removal.

- **Follow-Up Care**: Normally, clients should return after the first post-insertion menses (three to six weeks), but not later than three months, for their first check up. At the first regular check up:
  - Inquire about problems, questions, complications, or side effects;
  - Answer the client’s questions or concerns; and
  - Perform a speculum and bimanual exam to
    - See the strings,
    - Check for vaginal discharge or cervicitis suggestive of a GTI,
    - Gently palpate the cervical os for any plastic which might indicate that the IUD is dislodged from the fundus (partially expelled), and
    - Check for uterine and adnexal tenderness or other signs of infection.

Provide oral iron supplementation if she appears to be anemic (e.g., Hgb. less than 9 gm/dl or Hct. less than 30; conjunctiva (inside of eyelids) or nail beds look pale).

If the client is satisfied with the IUD, and there are no precautions for continued use
- Remind her about the warning signs. Tell her if she has any of the warning signs to come back immediately. Warning signs include:
  - Fever (a possible sign of infection);
  - Abdominal pain, or pain with intercourse;
  - Purulent or foul smelling discharge; and
  - Signs that the IUD has been expelled.
- Schedule her for a return visit in about 12 months.
- Remind her at each annual visit of the date (month/year) her IUD needs to be removed or replaced.

IUD users normally need follow up visits only once a year.

It is important to remember that successful IUD programs require well trained providers who exhibit
- Good clinical judgment in selecting acceptors;
- Care, sensitivity, and thoroughness in informing the user about IUDs and common side effects;
- Skill in inserting and removing the IUD;
- Knowledge of and ability to recognize real or potential problems; and
- Ability to take clinical action for these problems, including knowing when and where to refer clients with serious complications.

Long term success, as defined by satisfied clients and high continuation rates, will only take place if the provider can recognize the importance of providing follow up care.
Participant Handout 2.6.3: Management of Complications

Background
Most side effects and other health problems associated with the use of IUDs are not serious. Changes in menstrual bleeding patterns are the most common adverse side effects. In addition, during the first few menstrual cycles, clients may experience increased discomfort with their menses (dysmenorrhea).

In this handout there is more information on the most important health problems and serious side effects associated with IUD use. These include:
• Management of early pregnancy with an IUD in place,
• Extrapletal (ectopic) pregnancy,
• Pelvic Inflammatory Disease (PID), and
• Management of uterine perforation.

Finally, also included in this handout is a Problem Assessment and Management Chart, which outlines the steps in evaluating and managing most common side effects and other problems.

Pregnancy
Approximately one third of IUD related pregnancies are due to undetected partial or complete expulsion of the IUD. Pregnancies may occur, however, even if the IUD is correctly in place. There is an increased risk of septic abortion, which can result in septicemia, septic shock, and death in clients becoming pregnant with an IUD in place. For this reason it is preferable that the IUD is removed if pregnancy is diagnosed.

• If the strings are visible and the pregnancy is less than 13 weeks (first trimester), the IUD should be removed. If the IUD is removed within this period, there should be no adverse effect other than a slightly increased risk of spontaneous abortion. If the client consents, remove the IUD with gentle traction. Ask her to return if she experiences bleeding, cramping, or signs of infection.
• If you cannot see the strings, find them behind the cervix, or the pregnancy is beyond the 1st trimester, removal is more difficult. If this is the case, carefully discuss all options with the client.
• If the client wants to continue her pregnancy but does not want her IUD removed, advise her that there is an increased risk of spontaneous abortion and infection. She should be watched closely during her pregnancy, and she should come in immediately if she has fever, lower abdominal pain, and/or vaginal bleeding.

Extraterine (Ectopic) Pregnancy
IUDs provide protection against both intrauterine and extraterine pregnancies, but because IUDs provide less protection against extraterine pregnancies than intrauterine pregnancies, a pregnancy that occurs while a woman is using an IUD is somewhat more likely to be extraterine. Therefore, those clients who become pregnant should be carefully evaluated for an ectopic pregnancy.
Pelvic Inflammatory Disease (PID)
Uncovered PID with an IUD in place can cause serious complications, which may lead to loss of fertility. According to WHO, there was no difference in clinical course if the IUD was removed or left in place among IUD users treated for PID. The symptoms of PID include abnormal vaginal discharge, abdominal or pelvic pain, pain with sexual intercourse (dyspareunia), fever, and chills. If these symptoms occur during the first cycle, they may be due to infection at the time of insertion. If symptoms occur after several cycles, they are more likely due to a STI. The practitioner should perform speculum and bimanual exams and testing of cervical discharge for genital tract infections, when possible.

If she does not have cervical tenderness, leave the IUD in place and begin doxycycline (100 mg twice a day for 14 days).

If the woman has a tender uterus and pain when the cervix is touched, she may have PID. Start her on one of the following antibiotics:
- Cefoxitin (2g IM) plus probenecid (1g orally), or
- Ceftriaxone (250 mg IM) plus doxycycline (100 mg orally twice a day) for 14 days.

According to the WHO, there is no need to remove the IUD. If there is no improvement in 24-48 hours, the client should be referred to a facility where she can receive intravenous antibiotics.

Uterine Perforation, Embedding, and Cervical Perforation
The IUD can perforate (go through) the uterus. This mostly happens during the insertion. If a client complains of a sharp, significant pain during the procedure, stop the procedure and remove the IUD. Observe for signs of intra-abdominal bleeding (e.g., falling blood pressure, rising pulse, severe abdominal pain, tenderness, guarding and rigidity).

Take the client’s blood pressure and pulse every 15 minutes for 90 minutes. Have her sit up rapidly from a resting position. If her pulse is greater than 120/min or she becomes dizzy (light-headed) on sitting up, manage or refer for further evaluation of possible intra-abdominal bleeding. If there are no signs of intra-abdominal bleeding after two hours, discharge with instructions for warning signs that require immediate return to clinic. Schedule return checkup in one week. Provide backup contraception and help the client choose another method.

The IUD sometimes will perforate the uterus later on, and may be “silent,” with no symptoms of bleeding or pain. The IUD may also perforate the cervix--this may happen if the IUD comes out by itself. The IUD may be embedded (stuck) in the wall of the uterus, and part of it may perforate the cervix. Only an experienced clinician should attempt to remove an IUD that is perforating the cervical wall. (To remove it, grasp the exposed tip with an alligator or Bozeman forceps, push it back up into the uterine cavity, and then gently remove it in the usual manner.)

Signs of uterine perforation are missing IUD strings, inability to withdraw the IUD if the strings are still present, and seeing the IUD in a x-ray or ultrasound. Ultrasound can find Copper IUDs in the pelvis, but can’t find IUDs that have moved into the abdomen. X-rays are better for finding lost IUDs.
Removal of an IUD in the abdomen should be done only if the perforation is found within the first few days (or weeks) after insertion. Removal should be performed only by a surgeon experienced in removing IUDs by laparoscopy; otherwise, leave it in place.

### Participant Handout 2.6.4: Management of Side Effects and Complications

<table>
<thead>
<tr>
<th>Side Effect or Problem</th>
<th>Assessment</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amenorrhea</td>
<td>Ask client • When she had her Last Menstrual Period (LMP), • When she last felt the strings, and • If she has any symptoms of pregnancy. If necessary, do a speculum and bimanual examination to rule out pregnancy.</td>
<td>If pregnancy is less than 13 weeks (by LMP) and strings are visible, explain that the IUD should be removed to minimize risk of pelvic infection. Do not attempt to remove if • Strings are not visible, or • Pregnancy is greater than 13 weeks (by LMP). A woman who has these signs is at risk of spontaneous abortion and sepsis and must be followed closely.</td>
</tr>
<tr>
<td>Cramping</td>
<td>Do abdominal and pelvic (speculum and bimanual) exams to check for PID and other causes of cramping, such as partial expulsion of the IUD, cervical or uterine perforation, or ectopic pregnancy.</td>
<td><strong>Client has had IUD less than three months</strong> • If no cause is found and cramping is not severe, reassure the client, and provide aspirin or a similar analgesic. • If no cause is found but cramping is severe, remove the IUD (if client finds cramping unacceptable). Replace with a new IUD or help the client choose another method. <strong>Client has had IUD more than three months</strong> • If no cause found, remove IUD. If there is no evidence of infection, replace with a new IUD or help the client choose another method.</td>
</tr>
<tr>
<td>Ectopic Pregnancy</td>
<td>Irregular bleeding with or without symptoms of pregnancy or infection, pelvic pain or tenderness, or palpable adnexal mass.</td>
<td><strong>Refer to appropriate facility for complete evaluation.</strong></td>
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</table>

*Remember: Some cramping pain is common in the first 24-48 hours after IUD insertion.*
<table>
<thead>
<tr>
<th>Side Effect or Problem</th>
<th>Assessment</th>
<th>Management</th>
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</table>
| Irregular or Heavy Bleeding  | Perform speculum and bimanual exams to ensure that there is neither cervical pathology nor evidence of intrauterine or ectopic pregnancy or spontaneous abortion. How much has she bled? • Check for signs of marked anemia (pale conjunctivae or nail beds, low hemoglobin or hematocrit). | **Client has had IUD less than three months:** • If exam is normal, reassure and give iron tablets (one tablet daily for one to three months). Ask client to return in three months for another check. Use locally approved drugs, such as ibuprofen, during the bleeding episode, if available. • If bimanual exam shows enlarged or irregular uterus due to fibroids, inform client of the problem. Remove the IUD if the client is anemic or requests removal, and help her select another method.  

**Client has had IUD more than three months:** • If the exam is negative and bleeding intervals are short (less than three weeks), suspect anovulation; if bleeding intervals are longer (more than six weeks) suspect delayed ovulation; if with hot flashes, suspect menopause (if age over 35) or gynecologic endocrine problem. Refer to specialist.  

Recommend removal if severe anemia is present (e.g., less than 9 g/dl Hgb or 30% Hct) and help client choose another method. If the IUD is inert (Lippes Loop) and the client chooses to continue use of the IUD, remove current IUD and insert a new IUD; give three more months of iron tablets and reexamine in three months. If the client already has a copper IUD, remove the IUD and help the client select another method. |


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<thead>
<tr>
<th>Side Effect or Problem</th>
<th>Assessment</th>
<th>Management</th>
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</table>
| Missing Strings                        | Ask the client whether she knows if the IUD has come out. If the client does not know if the IUD was expelled, ask her  
• When she had her LMP,  
• When she last felt the strings,  
• If she has any symptoms of pregnancy, and  
• If she used a back up method (e.g., condom) from the time she noticed the missing strings.  
  Do speculum and bimanual examination. Check for signs of pregnancy.  
  If she comes back while having her period, do a speculum examination.  
  If strings are still not seen, rule out perforation.  
  If she comes back with delayed (greater than four weeks) menses, check for pregnancy. | If the client knows the IUD fell out, check for pregnancy, provide back up method, and reinsert IUD during her next period, if she desires.  
  Perform a vaginal examination.  
  • If the exam reveals suspected pregnancy, refer her to an appropriate facility for complete evaluation.  
  • If no strings are seen during the vaginal exam, it may mean that the IUD has fallen out or strings may be in the cervical canal (not visible), or high in the vagina.  
  • If strings are not found by carefully probing the cervical canal, the client should use a nonhormonal method of family planning and return with menses or in four weeks if her period does not start.  
  The strings may come down with menses. If strings are seen, reassure client that strings are present, and help her feel them.  
  Refer to check for IUD. It can be located either by carefully sounding the uterus, X-ray, or ultrasonography.  
  • If the IUD is not found on referral, it may have been expelled without being seen. Insert another IUD or help client choose another method.  
  If pregnant, see “Amenorrhea” above. |
<p>| Partner complains about strings         | Check to be sure that the IUD is in place and not partially expelled.                                                                                                                                       | Counsel the client that there are several options. One option is to explain to her partner what he is feeling and see if he is willing to tolerate it or cut the string to a length even with the cervical os (inform the client that she will no longer be able to feel string,) and record in chart that string has been cut evenly with cervix for future removal. |</p>
<table>
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<tr>
<th>Side Effect or Problem</th>
<th>Assessment</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pelvic Infection</td>
<td>Perform abdominal and pelvic (speculum and bimanual) exams and GTI testing if available. If urethritis or cervicitis (purulent discharge or beefy red cervix) is present, check Gram stain of cervical discharge.</td>
<td>If abdominal and pelvic exams confirm uterine and/or adnexal tenderness or pain when moving the cervix and uterus during pelvic examination, and/or microscopic testing supports the diagnosis of PID: • Treat with antibiotic, or immediately refer for treatment. Carefully observe the results of antibiotic treatment. If the woman does not improve in two to three days after starting treatment, refer her to a hospital. Her sex partner should be checked for an STI.</td>
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<tr>
<td>Suspected Uterine Perforation At time of insertion</td>
<td>When sounding the uterus • Stop the procedure. Gently remove the instrument that may have perforated the uterus. If resistance is encountered stop immediately and ask for an evaluation by a qualified surgeon. Observe for signs of intra-abdominal bleeding (i.e., failing blood pressure, rising pulse, severe abdominal pain, tenderness, guarding, and rigidity). • Take blood pressure and pulse every 15 minutes for 90 minutes. From resting position, have client sit up rapidly. Observe for syncope or pulse greater than 120/min. • If negative after two hours, discharge with instructions for warning signs that require immediate return to clinic. Have client return after one week for check up. • If complete perforation is suspected, stabilize the woman and do an ultrasound or x-ray to see where the IUD is.</td>
<td>When inserting the IUD (complete or partial) • Stop the procedure. Remove the IUD and initiate steps as above.</td>
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According to recent research, the risk of infection following IUD insertion is very low, but highest the first 20 days following insertion. Cramping accompanied by abdominal tenderness, fever, flu like symptoms, headache, chills, nausea or vomiting, vaginal discharge, painful intercourse, and/or palpable pelvic mass.
<table>
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<tr>
<th>Side Effect or Problem</th>
<th>Assessment</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syncope, bradycardia, vasovagal episode during IUD insertion or removal</td>
<td>Is woman anxious? Does she have a small uterus or relative cervical stenosis? (These characteristics increase risk for syncope and/or vasovagal reaction.)</td>
<td>Everything done at time of IUD insertion and removal should be done slowly and gently. • Maintain a calm, relaxed, unhurried atmosphere with a gently reassuring approach to the client. • At the earliest sign of fainting, stop the insertion. • Put a cool, wet cloth to the client’s forehead. • If severe pain occurred as the IUD was being inserted through the cervical canal, leave the IUD in place and allow the patient to rest. Keep the client supine, the head lowered, and legs elevated, to ensure adequate blood flow. • Avoid overtreatment; observation and support are usually all that is required. Use analgesics (paracetamol or ibuprofen) for abdominal pain or cramping. • Remove IUD if pain persists and is not relieved by analgesics or if client requests removal. Help her choose another method.</td>
</tr>
<tr>
<td>Vaginal Discharge</td>
<td>Check history for GTIs or other STI exposure and examine for vaginitis or purulent cervicitis or beefy red cervix. Examine saline and KOH wet mounts of vaginal discharge for trichomonas, monilia (candida), gardnerella. Prepare Gram stain of vaginal or cervical discharge. Observe for Gram negative intracellular diplococci (GNID) and WBC (PMNs).</td>
<td>If saline or KOH wet mounts are positive, treat for specific organism. If positive for GNID, treat for GC. If negative for GNID and purulent cervicitis or beefy red cervix is present, treat for Chlamydia. Do GC culture if available.</td>
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</tbody>
</table>
Participant Handout 2.6.5: Managing Severe Cramping

Investigation Steps
A) Has client had the IUD less than three months? Remember: some cramping pain is common during the first 24-48 hours after insertion.

Management
A-1) Speculum and bimanual exams are needed in order to rule out PID and other causes of cramping, such as partial expulsion of the IUD, perforation of the uterus or cervix, or ectopic pregnancy. If there are signs of any of these conditions, go to the section on managing these complications.
A-2) If no cause is found, provide an analgesic such as paracetamol.
A-3) If no cause is found but the cramping is not acceptable to the woman, remove the IUD. Counsel the woman to use another method, tell her the IUD is not for her.

Note: If progestin containing IUDs are available, they would be a better choice, since they cause less cramping than IUDs without progestin.

Investigation Steps
B) Has she had the IUD more than three months?

Management
B-1) If the IUD has been in place more than three months and cramping is new, examine the client for other causes of cramping, such as PID, perforation, or pregnancy. In such cases go to the section on managing these complications.
B-2) If no cause is found and the cramping is very mild and occurs only around menses, provide an analgesic such as paracetamol.
B-3) If no cause is found but the cramping is severe and not due to menses and unacceptable to the woman, remove the IUD. Counsel the woman to use another method, tell her the IUD is not for her.
Participant Handout 2.6.6: Managing Amenorrhea

Investigation Steps
A) Ask the client
   • When she had her last menstrual period,
   • When she last felt the strings, and
   • If she has symptoms of pregnancy.

B) Perform speculum and bimanual exams to check for strings and rule out pregnancy. Have her take a pregnancy test if available.

Management
If exam, or pregnancy test where available, shows that client is pregnant:
B-1) Rule out ectopic pregnancy. If the pregnancy is ectopic, refer her immediately to a hospital with surgical facilities.
B-2) Explain to the client that because she is pregnant with an IUD in place, miscarriage and infection are quite likely.
B-3) Have her return to the clinic if she has excessive bleeding, cramping, pain, foul discharge, or fever. If strings are visible and she is less than 13 weeks pregnant, remove the IUD. Explain that there is a small risk of miscarriage associated with the removal procedure.
B-4) If the strings cannot be located at the cervical os and/or the pregnancy is beyond the first 13 weeks, removal is more difficult. Remind the client that if she is pregnant with an IUD in place, there is a high risk of spontaneous abortion and infection. Counsel the client as to all available options.
B-5) If the woman wants to, or must continue her pregnancy, but does not want her IUD removed, advise her that there is an increased risk of spontaneous abortion and infection and that the pregnancy should be followed closely. Stress the importance of reporting all abnormal symptoms immediately. Tell her to report any sign of infection immediately. She should be watched closely during her pregnancy. Refer her to a specialist for her pregnancy care.
Participant Handout 2.6.7: Managing Expelled IUD

Investigation Steps

A) Ask the client if she saw the IUD fall out.

Management:

A-1) If the client saw the IUD fall out, rule out pregnancy. If she is not pregnant and wants another IUD, insert a new IUD.
Participant Handout 2.6.8: Managing Missing Strings

Investigation Steps
A) Ask the client
   • When she last felt the strings,
   • If she has any symptoms of pregnancy,
   • If she used a back up method (such as condoms) from the time she noticed the missing strings, and
   • When she had her last menstrual period.

Management
A-1) Perform a speculum and bimanual exam. Strings may be high up in the vagina or hidden in a fold of the cervix. Take a sterile cotton swabstick and gently probe the folds of the cervical canal.
A-2) Check for signs of pregnancy. Rule out ectopic pregnancy. (IUDs do not prevent ectopic pregnancy as well as they prevent intrauterine pregnancy.) If exam shows an ectopic pregnancy, refer immediately to a hospital with surgical facilities.
A-3) If exam shows intrauterine pregnancy and the strings are visible, explain to the client that the risk of miscarriage with infection is very high if the IUD is left in place and the IUD should be removed to protect her health. Pregnancy is twice as likely to succeed if the IUD is removed, although miscarriage may still occur. Refer for IUD removal, or remove the IUD yourself, according to local clinic guidelines.
A-4) If the exam reveals pregnancy and the strings are not visible, refer with a letter stating that the client is pregnant and that the IUD may still be in place.

Investigation Steps
B) If no strings are visible on vaginal exam and the client is not pregnant, it may mean that
   • The IUD has moved higher up in the uterus, or
   • The IUD has fallen out.

Management
B-1) It is possible that strings will be felt in the cervical canal. If the strings are not felt, the client should use a nonhormonal method (such as condoms and/or spermicide) and return during menses, or in four weeks if her period does not start. The strings may come down with menses.

Investigation Steps
C) If the client comes back while having her period, a speculum exam will show whether strings are now visible.

Management
C-1) If the strings came down with menses, reassure the client that the strings are present, and help the client feel them.
Investigation Steps
D) If she comes back while having her period and strings are still not visible:

Management
D-1) Rule out infection. IUD perforations are uncommon but can cause acute abdominal infections. If infection is present, treat as for PID and promptly refer client to hospital.
D-2) Rule out pregnancy by means of history and pelvic exam. If the client is pregnant, see “A” above. If she is not pregnant:
D-3) Refer her for X ray or ultrasound, depending on which is available; X ray may provide more information. If the IUD is seen on the X ray, it may be in the uterus or may have perforated the uterus; refer her to a hospital for treatment. If the IUD has been in the abdominal cavity for six to eight weeks or more, and the client has no symptoms, it may be best to leave the IUD in place. However, the multiload and all ring shaped devices should be removed if a skilled laparoscopist is available, since these IUDs can cause blockage of the bowel.
D-4) The IUD may have been expelled without having been seen. If X ray or ultrasound is negative, and history and physical exam give no evidence of PID, infection, or pregnancy, insert a new IUD, or help the client make an informed choice about another method of family planning.

Investigation Steps
E) If she comes back without menses, rule out pregnancy.

Management
E-1) Rule out pregnancy by means of history, speculum, and bimanual exams, or laboratory test if available and affordable. See if the strings have come down.

If the client is pregnant, see “A-3” and “A-4” above. If she is not pregnant, see “D-3” and “D-4” above.
Participant Handout 2.6.9: Managing Irregular or Heavy Bleeding

Investigation steps
A) Has client had the IUD less than three months?

Management
A-1) Perform speculum and bimanual exams to look for obvious cervical disease or evidence of intrauterine or ectopic pregnancy.
A-2) If the exam is normal, reassure the client and give her iron tablets (ferrous sulfate up to 200mg, three times daily for three months). Ask her to return in three months for another check up.

Investigation Steps
B) How much has she bled?

Management
B-1) Check for signs of marked anemia (pale conjunctivae or nail beds, hemoglobin less than 9). Recommend IUD removal if severe anemia present or getting worse, and help the client make an informed choice about another method.

Note: If progestin containing IUDs are available, they should be used for clients with severe anemia to decrease blood loss.

Investigation Steps
C) Has she had the IUD more than three months?

Management
C-1) Perform speculum and bimanual exams to rule out cervical pathology or intrauterine or ectopic pregnancy.
C-2) If the bimanual exam shows an enlarged uterus due to new fibroids, tell the client the problem and refer her as appropriate for evaluation. Do a bimanual (and speculum) exam every six months to rule out rapid growth. Remove the IUD if bleeding worsens or if the client requests it.
C-3) If the client has prolonged intervals between very heavy periods, suspect endometrial hyperplasia (overgrowth of the uterine lining), beginning of menopause, or other gynecological problem. Refer her as appropriate. A change of method is not necessary unless the client is uncomfortable, has reached menopause (one year without menses), or a gynecologic cancer is found.
Case Study 1: Woman requests IUD and is not having her menses

Problem: Woman is not having her menses or is not within a few days of her menses. Could this woman be pregnant?

Subjective: A 21 year-old woman had normal delivery of her second child eight weeks ago. She is fully breastfeeding. She has not had a menstrual period since delivery. She used an IUD between her two pregnancies and was happy with it. She has had intercourse in the last month. She has no primary or secondary precautions.


Questions for Discussion:
1. Is it appropriate to insert an IUD in this client today? Discuss the pros and cons.
2. If you do not provide her with an IUD today, what information will you give her?
3. Under what circumstances is it appropriate to go ahead with an IUD insertion in a client who is not during or just after her menstrual period?

Discussion: It is important that the practitioner be “reasonably certain” that the client is not pregnant. In this example the woman had her baby eight weeks ago and is fully breastfeeding, which is a reliable form of contraception (LAM). Her pelvic exam is normal. If it is possible, a pregnancy test could rule out pregnancy. However, even if no pregnancy test is done, this client should be provided with an IUD if she has no other precautions.

It is appropriate to insert an IUD in a client who is not during or just after her menstrual period if:
• She is less than 48 hours postpartum,
• She is more than four weeks postpartum and has not had intercourse,
• She is more than four weeks postpartum and has had intercourse, but has used a reliable method of contraception,
• She is less than seven days postabortion and the uterus is not infected,
• She is less than six months postpartum, fully breastfeeding, and has no menses, or
• At any time in the menstrual cycle as long as the practitioner is “reasonably certain” that she is not pregnant.
Participant Handout 2.6.11: Case Study #2

Case Study 2: Pregnancy with IUD

Problem: Sometimes the IUD does not prevent pregnancy (less than 1% of the time with the TCu 380A). How will you manage a woman who has an intrauterine pregnancy with an IUD?

Subjective: Two years ago a 28 year-old para II, had a TCu 380A inserted at six weeks postpartum. Her menses were regular until two months ago, when she had a very heavy period. She has not had a menstrual period since then and she tells you she now feels pregnant.

Objective: Client is anxious and upset. Her blood pressure is 126/84. Breasts are enlarged. Pelvic exam reveals a normal vagina, a slightly bluish cervix with IUD string protruding, a soft, somewhat enlarged nontender uterus, and normal adnexa.

Questions for Discussion:
1. What are some of the complications of pregnancy that may occur with an IUD in place?
2. Should the practitioner strongly recommend removal of all IUDs when strings are visible?
3. What should the practitioner do if the strings are not visible?
4. What might have caused this client to become pregnant after two years of using the IUD successfully?
3. How should the service provider manage such a case?

Discussion: Pregnancy with an IUD in utero will terminate in spontaneous abortion in 50% of cases. Occasionally, these will be septic abortions, which place the woman at risk of severe morbidity and mortality. Most experts agree that an IUD should be removed if the strings are visible. IUD removal is associated with spontaneous abortion in 25% of cases. If the strings cannot be found and/or the pregnancy is beyond the first trimester, the IUD should be left in place, the client counseled about complications (excessive bleeding, cramping, pain, abnormal vaginal discharge, fever) and the pregnancy should be observed closely. Note: where ultrasound is available, it may be useful in determining the location of the IUD. If the IUD is not located, this may suggest that an expulsion of the IUD has occurred.

One third of IUD related pregnancies are due to undetected partial or complete expulsion. Partial expulsion may occur if the IUD is not inserted to the fundus of the uterus, or sometimes with an unusually heavy period. When a woman using an IUD becomes pregnant, it is important to rule out ectopic pregnancy.

Diagnosis: Pregnancy with IUD in place; eight weeks gestation with possible ectopic pregnancy.

Plan: Counsel client about all her options and potential consequences for each course of action. If she wishes to continue the pregnancy, she should be referred promptly to an MD Ob/Gyn specialist for IUD removal, ruling out of ectopic pregnancy, and further observation and management.
Participant Handout 2.6.12: Case Study #3

Case Study 3: PID with IUD

Problem: A client who was at risk for developing an STI was not screened adequately. She has now developed PID.

Subjective: A 20 year-old para I has been using the COC for one year, but recently she has developed severe migraine like headaches, and you have recommended that she discontinue the pills because the headaches may be caused or aggravated by estrogen. She has chosen to try an IUD and had a TCu 380A inserted five months ago. She has returned and she tells you that she noted a yellowish, bloody discharge and pain with intercourse starting three weeks ago.

Objective: Temp: 37 degrees; BP: 120/75; young woman does not appear to be in any discomfort. Abdominal exam shows no upper abdominal pain or guarding; lower abdomen slightly tender to pressure, no guarding. Pelvic exam normal. External genitalia and vagina: IUD string protruding from os; a mucopurulent discharge is seen emanating from the cervix. Bimanual exam elicits tenderness on cervical motion in any direction. Adnexa are also tender to pressure, but no mass is noted. Uterus is midposition, firm, tender to pressure, fairly mobile.

Questions for Discussion:
1. Do IUDs cause PID?
2. What might the service provider have overlooked in this client’s history that may explain her problem?
3. What practices in the standard IUD insertion protocol are specifically designed to prevent infections? (Use Clinical and Counseling Skill Learning Guides as aids in answering this question.)
4. How will you manage her case?

Discussion: The IUD does not cause PID. However, it does increase the risk of infection if the woman had an STI at the time of insertion. An infection in the first three weeks after insertion may be due to poor infection prevention procedures at the time of insertion or presence of cervical STI at a time of insertion. If the infection develops after three months or more postinsertion, it is probably due to new exposure to infection. Before selecting an IUD the client should be asked about the number of sexual partners, if her sexual partner(s) has other sexual partners, and her history of STIs.

Plan: If the client does get an infection, do not remove the IUD, but treat the infection. If the patient only has uterine tenderness, she should get doxycycline 100mg twice daily for 14 days. If she also has cervical motion tenderness (as this client does), she needs cefoxitin (2g IM) plus probenecid (1g orally) OR ceftriaxone (250mg IM) plus doxycycline (100mg twice a day) orally for 14 days. She should be counseled about how to avoid STIs, advised to use condoms, and to get her partner seen for treatment. If the client wants the IUD removed, treat the infection first and remove the IUD later.
Case Study 4: Missing Strings

Problem: “I can’t feel the strings of my IUD.” The client’s inability to locate her IUD strings during a routine self check may indicate one of several possible problems.

Subjective: A 28 year-old para I, who wishes to delay her next pregnancy for two to three years, had a TCu 380A inserted six months ago. The insertion was very painful, and the pain persisted for several hours. She has had no problems since then and has been able to feel the strings herself.

The client’s last menses started two weeks ago and it was normal; but since her menses, she has not been able to feel the IUD strings. She did not see the IUD come out during her period.

Objective: Abdominal exam and pelvic exam are normal; the uterus is retroverted, small, firm, nontender. Adnexa are nontender, and no masses or swelling are noted. The cervix is normal in appearance. No IUD strings are visible.

Questions for Discussion:
1. What are the possible reasons for the missing strings?
2. What will you recommend as a management plan for this woman?

Discussion: If a client can not feel the strings of her IUD, it could mean that the IUD has perforated the uterus or that it has come out with the menses. In this case either could have happened. The fact that she had a lot of pain on insertion, may mean that the IUD was placed so high in the fundus that it later became embedded (stuck) in the uterus. On the other hand, the fact that she had no problem feeling her strings for the first six months and then stopped being able to feel them after her period may mean that the IUD came out with her period (even if she did not see it come out).

Plan: If strings are not noted on exam and client is not pregnant, see if strings can be located with gentle exploration of lower cervical canal with (sterile or HLD) narrow sponge forceps. If you are not able to locate strings, refer the client to Ob/Gyn for further management. Before the client leaves your office, provide her with a supply of condoms to protect her from pregnancy in case the IUD is not in the uterus.
Participant Handout 2.7.1: Minimum Standards for IUD Services

In order to offer quality IUD services, the provider needs to meet minimum criteria of space, privacy, equipment, supplies, recordkeeping, and availability of referrals.

The minimum clinic requirements are:

- Space for counseling that ensures privacy for clients, separate from the waiting area;
- Examination table and procedure area that ensures client privacy;
- Supply cabinet to store instruments and IUDs;
- Water, adequate light, and toilet facility in or very near office;
- Basic standardized equipment and supplies sufficient for two IUD insertions; and
  - 2 specula,
  - 2 tenacula,
  - 2 uterine sponge forceps,
  - 2 pair scissors,
  - 2 uterine sounds,
  - 2 utility forceps,
  - Cotton or gauze,
  - Antiseptic,
  - Covered instrument trays,
  - Six pair reusable gloves or one box disposable gloves,
  - Client record forms,
  - Cooker or stove,
  - Fuel supply,
  - Glutaraldehyde or 8% formaldehyde solution,
  - Chlorine solution, and
  - A decontamination bucket.

The trained provider will also establish a routine for receiving and serving IUD clients, referring them when necessary and training her or his support staff in infection prevention and waste disposal. In addition, client information materials should be made available to clients and families.

Trainer Summary
Each participant will need to demonstrate skill proficiency in counseling, IUD insertion/removal, case management, and infection prevention in order to be certified by trainer.
Participant Handout 2.7.2:  
Unit 2 Post-Test

Participant Name ________________________________________________

Instructions: Circle the letter(s) that correspond to the correct answer(s). Some questions may have more than one correct answer.

1. In counseling a woman about the advantages of the TCu 380A IUD, you would inform her that the IUD
   a. is permanent
   b. is highly effective
   c. has few side effects for most women
   d. does not interfere with sexual intercourse
   e. is effective in preventing anemia

2. Which of the following conditions are precautions which influence the suitability of IUD for a particular woman?
   a. pregnancy
   b. three or more children
   c. at risk for STIs
   d. history of candidiasis
   e. retroverted uterus
   f. current pelvic infection

3. Prior to IUD insertion, a pelvic exam is performed to
   a. determine uterine position and size
   b. rule out anteflexion
   c. rule out pregnancy
   d. rule out presence of infection, masses, and tumors
4. Prior to an IUD insertion all metal instruments used should be
   a. decontaminated with soap and water
   b. decontaminated in 0.5% chlorine solution for 10 minutes
   c. cleaned with formaldehyde and water
   d. cleaned with detergent and water
   e. high level disinfected by boiling in a covered pot for 20 minutes
   f. high level disinfected by autoclaving (unwrapped) for 20 minutes at 106 kPa pressure at 1210 degrees

5. Key infection prevention activities for IUD insertion include
   a. washing hands carefully
   b. cleaning the cervix and vagina with an antiseptic solution
   c. decontaminating, cleaning, and high-level disinfecting, or sterilizing all instruments
   d. proper contaminated waste disposal
   e. training and supervision of cleaning staff in infection prevention

6. Reasons for follow up visits after an IUD insertion can include
   a. first check up one week after insertion
   b. first check up three to six weeks after insertion
   c. client wants device removed because she doesn’t like it
   d. removal when the IUD has been in place for one year

7. The following are warning signs that you should explain to an IUD client, which indicate that she may be having a problem with her IUD and should seek medical attention
   a. cramping with menses
   b. increased length of menstrual cycle
   c. sexual partner has abnormal penile discharge
   d. string is longer than usual
   e. pain with intercourse

8. IUD clients should be counseled
   a. before the insertion
   b. after insertion
   c. during each follow up visit
   d. all of the above
True or False: Mark “T” or “F” in the blank to indicate true or false.

9. ___ A woman herself is best at selecting her own contraceptive method.
10. ___ Douching daily after an IUD infection is recommended to prevent PID.
11. ___ A physical exam for an IUD client must include abdominal, speculum, and bimanual exams.
12. ___ You must use high level disinfected or sterile gloves to place a copper IUD in its inserter.
13. ___ A tarnished IUD in a sealed, undamaged package can be used.
14. ___ An IUD can be inserted in a woman who is ovulating.
15. ___ The “push” technique should be used when inserting copper T IUDs.
16. ___ The “no touch” technique should be used when inserting IUDs.
17. ___ An IUD client who has moderate bleeding for seven to ten days after insertion should have the IUD removed immediately.
18. ___ If PID is diagnosed in a woman with an IUD; the IUD should be removed, antibiotic treatment should be started and she should be counseled on and provided with an alternative contraceptive.
19. ___ If an IUD is partially expelled, it should be removed and a new IUD can be inserted immediately.
20. ___ If a woman becomes pregnant with an IUD, it should be left in place unless a problem develops.
Appendix
IUD Training Course
Participant Evaluation

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

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

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

Technical Information
• I learned new information in this course. 5 4 3 2 1
I will now be able to:
• Provide appropriate counseling to women considering the IUD as a contraceptive method. 5 4 3 2 1
• Screen clients to determine if the IUD is a good method for them. 5 4 3 2 1
• Provide safe IUD insertion and removal services. 5 4 3 2 1
• Manage side effects and complications of IUDs. 5 4 3 2 1

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

5  4  3  2  1

Training Location and Schedule

The training site and schedule were convenient.  

5  4  3  2  1
The necessary materials were available.  

5  4  3  2  1

Suggestions

What was the most useful part of this training?

What was the least useful part of this training?

What suggestions do you have to improve the module? Please feel free to reference any of the topics above.
Major References and Training Materials

Introduction to Training:


Unit 1

- JHUCCP. *WHO Updates Medical Eligibility Criteria for Contraceptives.* Info Reports, Issue 1, August 2004.

**Unit 2**


Participant Handout 1.8.1


**Participant Handout 1.8.3**


**Participant Handout 2.2.2**


Family Health International. *Checklist for Screening Clients who Want to Initiate Use of the Copper IUD* 2006

**Participant Handout 2.2.3**


**Participant Handout 2.3.1**


**Participant Handout 2.4.2**


**Participant Handout 2.4.3**


**Participant Handout 2.5.1**


**Participant Handout 2.6.2**


**Participant Handout 2.6.3**

Participant Handout 2.6.4


Transparency 1.2


Transparency 1.3


Transparency 2.2
