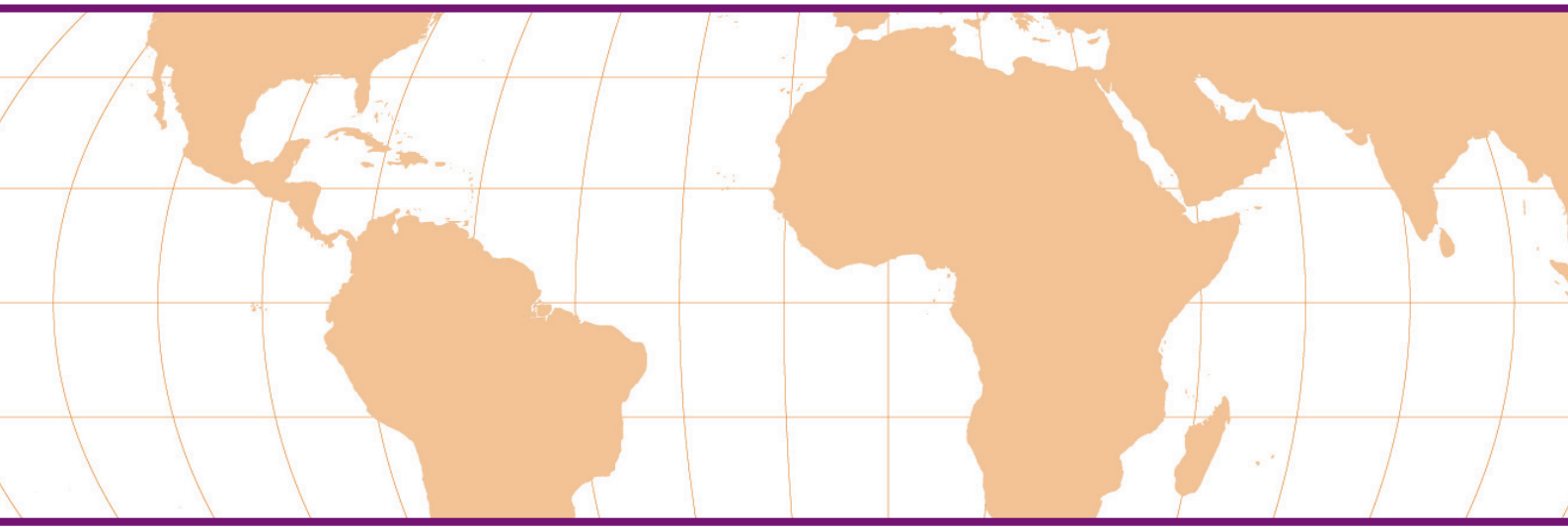
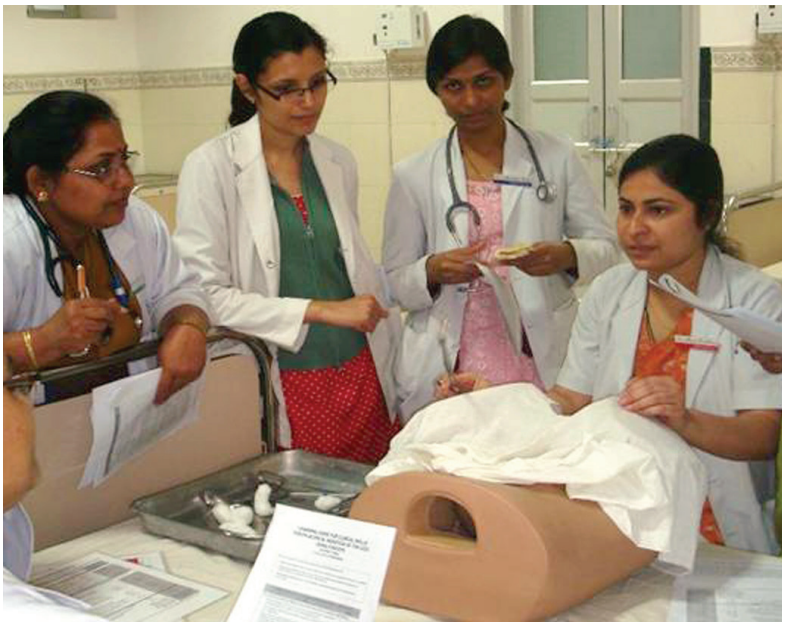


Postpartum Intrauterine Contraceptive Device (PPIUD) Services



A Reference Manual for Providers

USAID
FROM THE AMERICAN PEOPLE

access
Family Planning Initiative
Addressing unmet need for postpartum family planning

Postpartum Intrauterine Contraceptive Device (PPIUD) Services

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ACCESS-FP is an associate award under the ACCESS Program, Associate Cooperative Agreement #GPO-A-00-05-00025-00, Reference Leader Cooperative Agreement #GHS-A-00-04-00002-00. ACCESS-FP focuses on meeting the family planning and reproductive health needs of women in the postpartum period. Interventions are designed to complement those of the ACCESS Program in the promotion and scale-up of postpartum family planning through community and clinical interventions. ACCESS-FP seeks to reposition family planning through integration with maternal, newborn and child health programs, including the prevention of mother-to-child transmission of HIV. For more information about ACCESS-FP, please contact Catharine McKaig, ACCESS-FP Program Director, at cmckaig@jhpiego.net.

Jhpiego is an international, non-profit health organization affiliated with The Johns Hopkins University. For more than 36 years, Jhpiego has empowered front-line health workers by designing and implementing effective, low-cost, hands-on solutions to strengthen the delivery of health care services for women and their families. By putting evidence-based health innovations into everyday practice, Jhpiego works to break down barriers to high-quality health care for the world's most vulnerable populations.

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Postpartum Intrauterine Contraceptive Device (PPIUD) Services:
A Reference Manual for Providers

Abbreviations and Acronyms

AMTSL	Active management of the third stage of labor
ANC	Antenatal care
ARHP	Association of Reproductive Health Professionals
ARV	Antiretroviral [medications/therapy]
BPM	Beats per minute
CBC	Complete blood count
HLD	High-level disinfected
IP	Infection prevention
IUD/IUCD	Intrauterine contraceptive device
LAM	Lactational amenorrhea method
MEC	Medical Eligibility Criteria
MNCH	Maternal, newborn and child health
NSAID	Nonsteroidal anti-inflammatory drug
PID	Pelvic inflammatory disease
PPC	Postpartum care
PPFP	Postpartum family planning
PPIUD	Postpartum intrauterine contraceptive device
PROM	Prolonged rupture of membranes
STI	Sexually transmitted infection
USAID	United States Agency for International Development
USG	Ultrasonography
WHO	World Health Organization

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The computer video featured in this package, *Immediate Postpartum IUCD Insertion: Computer Simulation to Train Doctors and Paramedical Staff to Develop Skills in Postpartum IUCD Insertion Technique*, was produced by ZMQ Software Systems, India (www.zmqsoft.com), with content provided by Jhpiego and funding provided as detailed above for the India materials.

Preface

Postpartum family planning (PPFP) saves lives. Family planning is a key intervention in reducing maternal, newborn and child mortality and morbidity through preventing unintended pregnancies, as well as those that are spaced too closely together. The postpartum period represents a critical window of opportunity for women to receive family planning services because many will access health services during pregnancy and childbirth—at which point they can be introduced to and linked with PPFP services. Moreover, during the postpartum period, many women:

- Are not aware of their risk for pregnancy;
- Want to either space or limit subsequent births and would like to use contraception; and
- Are not likely to otherwise access family planning, or even postpartum, services because they are busy and tend to put the needs of their families before their own.

The postpartum intrauterine contraceptive device (PPIUD)—inserted immediately following delivery of the placenta or up to 48 hours after the birth—is a good choice for postpartum women who are breastfeeding, as well as those who are not breastfeeding. Because it is inserted soon after birth, it is *best* to provide PPIUD counseling to women during the antenatal period, when possible—well before labor and delivery. The PPIUD enables women to leave the birth facility with a safe and extremely effective, long-acting, reversible contraceptive method already in place. And although the IUD will protect her against pregnancy for 12 years (with the Copper T 380A), she can have it removed at any time, for any reason, with immediate return to fertility.

In line with our goal of responding to the significant unmet needs for family planning among postpartum women, ACCESS-FP is proud to present this global *Postpartum Intrauterine Contraceptive Device (PPIUD) Services* learning resource package. In the hands of capable trainers and learners, these materials will serve to prepare service providers to provide high-quality, comprehensive postpartum IUD services, and thus broaden the range of family planning options available to postpartum women. While postpartum insertion of the IUD requires different skills than interval insertion, these skills can be learned by experienced IUD service providers, as well as by maternal, newborn and child health or family planning providers who have not had experience with this method.

Our hope is that providers all over the world will embrace the tremendous opportunity—represented by PPFP and the PPIUD—to save and improve countless lives, by:

- **Taking time to educate and counsel women about the PPIUD, among other PPFP methods available to them; and**
- **Spending a few extra minutes—particularly during the immediate postpartum period—to provide the IUD to postpartum women who choose this method.**

For providers and facilities aiming to establish or greatly strengthen PPFP/PPIUD programs, the two following ACCESS-FP publications provide a wealth of information and guidance to support such efforts:

Blanchard H and Deller B. (ACCESS-FP). 2008. *Workshop on Comprehensive Postpartum Family Planning Care* (learning resource package). Jhpiego: Baltimore, Maryland.

Anthony Kouyate R and Nash-Mercado A (ACCESS-FP). 2010. *A Guide for Developing Family Planning Messages for Women in the First Year Postpartum*. Jhpiego: Baltimore, Maryland.

1. Introduction

The period of time preceding and immediately following the birth of a woman's child represents a valuable opportunity for the woman or couple to learn about and take advantage of family planning services. These are times when women are most likely to access formal health care—through antenatal care (ANC) visits and skilled birth attendance—and they are *motivated* to space or limit subsequent pregnancies.

The extended postpartum period, however, poses a challenge for women, especially in developing countries, because postpartum women are unlikely to be using contraception and are vulnerable to unintended pregnancy. A study of postpartum women in 27 Demographic and Health Surveys (DHS) for 6 years[1] shows that 40% of women who intend to use a contraceptive during the first year postpartum are not; moreover, although only a small percentage of women (3%–8%) want another child within 2 years of their last birth, 35% have children within this timeframe.

Some reasons for these statistics are the unpredictability of return to fertility, resumption of sexual activity and ongoing confusion among providers and clients regarding the contraceptive effects of breastfeeding—breastfeeding is **not** the same thing as the lactational amenorrhea method (LAM). In addition, women are not likely to access services for themselves during the postpartum period[2]; whereas a majority of women receive at least some ANC, and an increasing number in some countries are getting delivery care, a much smaller proportion seek postpartum services.

The **intrauterine contraceptive device (IUD)** is a highly effective, long-acting, reversible family planning method that is safe for use by most postpartum women—including those who are breastfeeding. It is also relatively inexpensive and convenient and has a very low rate of complications. The **postpartum IUD (PPIUD), inserted within 10 minutes or up to 48 hours after birth:**

- Is readily accessible for women who deliver at health care facilities;
- Has no effect on the amount or quality of breast milk;
- Is safe for use by HIV-positive women;
- Is reversible and can be removed at any time (with immediate return to fertility)—should the woman's contraceptive or reproductive desires change;
- Does not require any daily action on the part of the user to be effective; and
- Does not require a separate visit to the facility or, if inserted within 10 minutes of the birth, a separate procedure.

A postpartum woman who chooses the PPIUD can leave the facility, after having her baby, with reliable contraception **already in place**—enabling her to gain control over her fertility throughout the postpartum period and for however long she chooses (up to 12 years for the Copper T 380A). And again, this is especially critical in developing countries, where *if women seek services for themselves at all, it may only be when they are pregnant or about to give birth*.

Did you know that many postpartum women:

- Want to limit their pregnancies or delay the next pregnancy for at least 2 years
- Want to use contraception and plan to start it after their menses return
- Will become fertile again (ovulate) **before** their menses return, as early as 4 to 6 weeks postpartum
- Will resume sexual activity within the first few months postpartum
- Mistakenly believe that as long as they breastfeed their baby, they are protected from pregnancy
- Have many demands on their time and, especially in developing countries, are not likely to return to the facility for postpartum care or family planning
- Do not want to be perceived as needing contraception during the postpartum period—in cultures where postpartum abstinence is customary—for fear of being judged
- End up not using contraception at all, especially in developing countries, and become pregnant too soon after the last birth, increasing their and their children's risk for poor health outcomes
- Can prevent death and disability, for themselves and their children, through PPFP

What you can do: *It takes only* ***a few additional minutes****, immediately after the delivery of the placenta, to give postpartum women who choose the PPIUD* ***safe and effective contraceptive protection for up to 12 years****.*

By enabling women/couples to space their pregnancies or prevent unintended pregnancy, family planning, including postpartum family planning (PPFP), helps to ensure maternal and newborn survival and health. Maternal, newborn and child health (MNCH) service providers (midwives, nurse-midwives, doctors, etc.) have many opportunities—in the course of caring for women and their children—to introduce and counsel the woman about the PPIUD, among other PPFP options.

This manual and the accompanying materials are intended to help prepare MNCH providers, along with health educators and counselors, to deliver high-quality PPIUD services to their clients, as part of a comprehensive PPFP program.

2. Need for Postpartum Family Planning

Multiple studies performed around the world have shown that adverse maternal, perinatal and infant outcomes are related to pregnancies spaced too closely together. The risks are particularly high for women who become pregnant very soon after a previous pregnancy, miscarriage or abortion. Table 1 presents a summary of findings.[3]

The good news is that family planning/PPFP enables women/couples to achieve healthy intervals between births—potentially averting 25% to 40% of maternal deaths[4] and reducing child mortality by an estimated 10%.[5]

Table 1. Risks of Adverse Health Outcomes after Very Short Interval Pregnancy[6–11]

Increased Risks when Pregnancy Occurs 6 Months after a Live Birth		
Adverse Outcome	**Increased Risk**	
Induced abortion	650%	
Miscarriage	230%	
Newborn death (<9 months)	170%	
Maternal death	150%	
Preterm birth	70%	
Stillborn	60%	
Low birth weight	60%	
Increased Risks when Pregnancy Occurs Less than 6 Months after an Abortion or Miscarriage		
Increased Risk	**With 1–2 Month Interval**	**With 3–5 Month Interval**
Low birth weight	170%	140%
Maternal anemia	160%	120%
Preterm birth	80%	40%

Healthy Spacing of Pregnancies

In June 2005, the World Health Organization (WHO) brought together over 30 technical experts to review the available global scientific evidence regarding healthy intervals between pregnancies. The following recommendations are based on the results of this technical consultation:[12]

1. **After a live birth,** a woman should **wait at least 24 months** (but not more than 5 years) before attempting the next pregnancy to reduce the risk of adverse maternal, perinatal and infant outcomes. Women should plan a healthy birth-to-birth interval of about 36 months, or 3 years, between children.
2. **After a miscarriage or induced abortion,** a woman should **wait at least 6 months** before attempting the next pregnancy to reduce the risk of adverse maternal, perinatal and infant outcomes.
3. **Adolescents should delay first pregnancy until at least 18** years of age to reduce the risk of adverse maternal, perinatal and infant outcomes.

Every woman and every maternal/newborn health or family planning worker should know and understand the key recommendations for healthy spacing of pregnancies. (Specific messages related to the healthy spacing of pregnancies are presented in Appendix A.)

Key Terminology: To be able to counsel women and families effectively about healthy spacing of pregnancies, providers must clearly understand several terms.

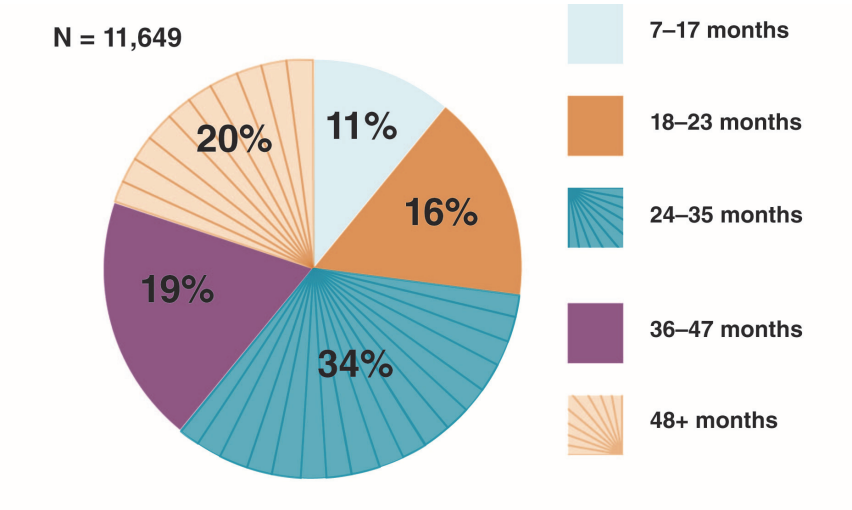
- **Birth-to-pregnancy interval:** Time period between a *live birth* and *start* of the next pregnancy.
- **Birth-to-birth interval:** Time period between a *live birth* and the *next live birth.*

When reviewing scientific studies or technical messages, health professionals can convert a birth-to-pregnancy interval to a birth-to-birth interval by adding 9 months to a year.

Unmet Need for PPFP

Despite the adverse health outcomes associated with short birth intervals, a significant proportion of births are spaced too closely together. In India, for example (Figure 1), approximately 61% of births occur at intervals shorter than the recommended birth-to-birth interval of approximately 36 months. And in many developing countries, the situation is comparable to that in India[a]—which adds to the myriad health challenges and risks that these mothers and babies must face.

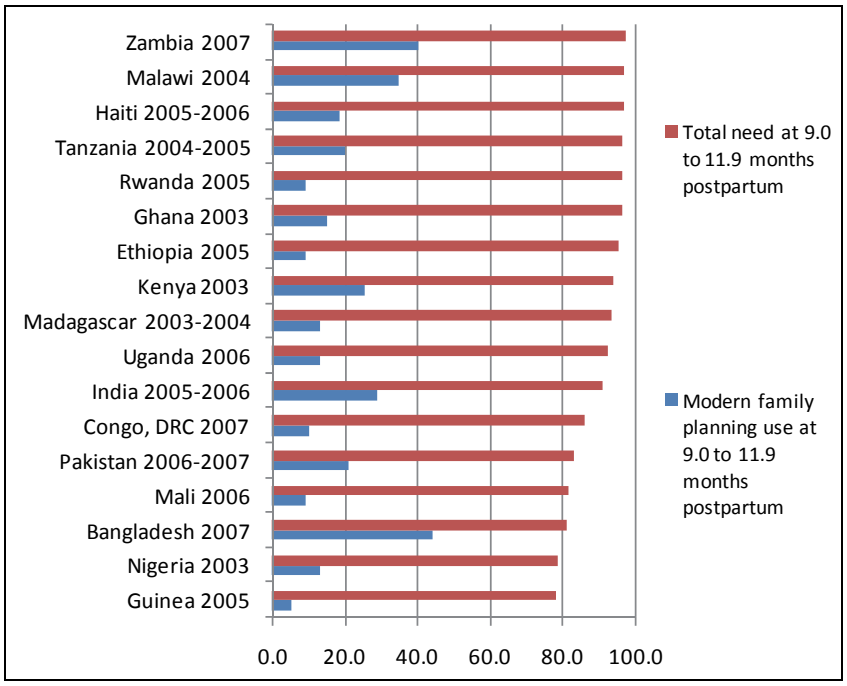
Figure 1. Birth Spacing Among All Women in India—All Births in Last 5 Years[13]



Family planning during the first year postpartum has the potential to reduce a significant proportion of these unintended pregnancies because, as research has demonstrated, women experience a large "unmet need" for family planning during this time.[1] **Loosely defined, unmet need refers to the percentage of women who do not wish to become pregnant but are not currently using a contraceptive.** In a recent study, women in 14 of 17 countries were less likely to be using family planning by the end of the extended postpartum period (11.9 months) than married women in the general population. Those *using* contraception made up only a small proportion of those *needing* it (Figure 2).[14]

[a]According to the last available DHS (2003–2006) in seven African countries (Kenya, Malawi, Mali, Nigeria, Senegal, Tanzania and Uganda), 68% of women age 20–29 years reported that they became pregnant 26 months or less after their last birth.

Figure 2. Percentage of Women 9.0–11.9 Months Postpartum Who Are Using Family Planning versus Those Who Need It, DHS 2003–2007



Factors That Contribute to Short Birth Intervals

Given the unmet need for family planning and prevalence of shorter-than-recommended birth intervals, women and their health care providers should understand the factors that contribute to the high risk of unintended pregnancy among postpartum women.

Return to Fertility

- **Postpartum women are frequently fertile again before they realize it.** A woman will ovulate before she begins regularly menstruating again. And the chance of a woman's fertility returning before menstruation resumes increases as the postpartum period extends.[15]
- **An individual woman's return to fertility cannot be predicted.** Most non-breastfeeding women experience menses return within 4 to 6 weeks. Breastfeeding delays the resumption of ovulation and the return of menses, but it cannot be relied upon for contraceptive protection unless the woman is practicing LAM (further discussed on the following page).
- **Women often initiate family planning after their menstruation resumes.** Individual studies appear to draw a correlation between return of menses and initiation of contraceptive use and suggest that family planning—if used at all during the postpartum period—is most likely to be initiated in the month following the return of menses, which is often too late.[1,16] And in one study, 8%–10% of women who were still experiencing postpartum amenorrhea conceived.[17]

Resumption of Sexual Activity

- **Reported return to sexual activity after a birth varies greatly.** A recent study of 17 developing countries looked at percentages of couples returning to sexual activity by 3 to 5.9 months. At one end of the range is Guinea, where about 10% of women have resumed sexual activity within that timeframe; at the other end are Bangladesh and Rwanda, where almost 90% of women are having sex again by 6 months.[14]

- **Postpartum abstinence, in countries that practice it, is not always strictly observed.** Qualitative research has indicated that even among those countries practicing postpartum abstinence, sexual activity may occur irregularly early on, gradually progressing to more regular activity.[18]
- **Women may be unwilling to ask for contraception "too soon" after birth.** If a woman resumes sexual activity sooner after the birth than is deemed appropriate in her culture, she may assume that the provider will judge her if she asks for contraception. As a result, the woman may forego contraception even though this will put her at risk for unintended pregnancy.

Breastfeeding versus LAM

- **Breastfeeding ≠ LAM.** To prevent unintended pregnancy, breastfeeding women must use a method of contraception (breastfeeding is not a contraceptive). One option is LAM, which is 98.5% effective for up to 6 months postpartum—provided that the woman exclusively breastfeeds her baby on demand (whenever the baby wants, day or night; no other food or other fluids in between), and her menses have not returned. As effective and convenient as LAM is, it still is not widely practiced.
- **LAM is effective only for 6 months.** For women using LAM, it is likely their fertility will return (often before menstruation resumes) after 6 months, even if they continue to breastfeed. This is why women practicing LAM must transition to another method as soon as any of the three LAM criteria is no longer being met.
- **Exclusive breastfeeding drops off after 3 months.** Although many women exclusively breastfeed their babies in the first few months following delivery, the rate drops off significantly after 3 months—which leads to return of fertility.

Implications for Family Planning Programming

In addition to ensuring that high-quality PPFP services are available, the objective of PPFP programs is to help women and couples understand their risk of unintended pregnancy, as well as the maternal and newborn benefits of spacing pregnancies at healthy intervals (or limiting pregnancy, if desired). Linkage of MNCH and family planning services is critical to achieving pregnancy-spacing recommendations and to addressing unmet need for family planning.

Information on healthy spacing of pregnancies should be incorporated into health education, counseling and service delivery for women and their families wherever they receive medical care. Suggested service delivery approaches include:

- Giving clients complete information about the benefits of and recommendations for healthy spacing of pregnancies as a part of routine family planning services, during both general and method-specific education and counseling.
- Emphasizing the importance of timely initiation of a family planning method after childbirth, miscarriage or abortion (and a "transition" method after LAM) as a part of routine antenatal, postpartum and postabortion care.
- Providing family planning services to women while they are still in the health care facility, following a facility-based delivery.

- Integrating family planning services with other health services, such as immunization and newborn or child care services.
- Helping clients to exercise their right to make a free and informed choice regarding family size, fertility goals and contraceptive options.

Remember: The right contraceptive for a woman **is the one she chooses for herself**, provided there are no medical reasons why the method should be withheld. As providers, we can give the woman the information she needs to make a suitable choice, but the choice is hers to make.

3. The PPIUD—An Overview

For more than 30 years, women throughout the world have been using the IUD as their primary method of contraception. It is, in fact, the most commonly used reversible method among married women of reproductive age worldwide. According to recent estimates, almost one in five (or 153 million) married contraceptive users is currently using the IUD.[19]

In a U.S.-based study, women who use the IUD are more satisfied with their choice of contraception than those using other reversible methods (e.g., 99% versus 91% for pill users).[20] Moreover, the advantages of IUD use outweigh the risks for the vast majority of women, even in the presence of many conditions previously thought to preclude IUD use, such as HIV/AIDS, history of pelvic inflammatory disease (PID) and history of ectopic pregnancy.

Postpartum insertion of an IUD, within 10 minutes or up to 48 hours after birth, has been shown to be safe, effective and convenient for women[21]—like the regular or "interval" IUD. (*Interval* refers to IUDs inserted at any time between pregnancies, at or after 4 weeks postpartum, or completely unrelated to pregnancy.) For many women who rarely access health care services, the insertion of an IUD immediately postpartum presents a unique opportunity for them to initiate a long-acting and reversible method of family planning. The popularity of the PPIUD in countries as diverse as China, Mexico and Egypt supports the feasibility and acceptability of this approach.[22]

What Is the IUD?

The IUD is a small, flexible frame generally made of plastic in the shape of a "T," which is inserted into the uterine cavity by a trained service provider. Almost all types of IUDs have one or two monofilament (single-strand) strings that extend, through the cervix, from the uterus into the vagina.

Types of IUDs

Common types of IUDs available worldwide are:

- **Copper-bearing:** Copper T 380A (TCu 380A, TCu 380A with Safe Load) and TCu 200C, the Multiload (MLCu 250 and Cu375) and the Nova T
- **Hormone-releasing:** Mirena® and the levonorgestrel-releasing intrauterine system (LNG-IUS®)

For programs and providers who wish to offer the IUD in the postpartum period, the use of the Copper T 380A is recommended at this time. With additional evidence and experience, this recommendation may be revised.

Mechanism of Action

Copper-bearing IUDs like the Copper T 380A act by preventing fertilization.[23] Copper ions decrease sperm motility and function by altering the uterine and tubal fluid environment, thus preventing sperm from reaching the fallopian tube and fertilizing the egg. These actions are largely local with no measurable increase in the woman's serum copper level. And because there are no effects on the quantity or quality of breast milk, copper-bearing IUDs can be used immediately after delivery regardless of whether the woman is breastfeeding.

Duration of Action

The latest scientific evidence shows that the Copper T 380A is effective for at least 12 years.[24] Clients who have had a Copper T inserted should be advised that it be replaced or removed 12 years from the date of insertion. The contraceptive effects of the Copper T stop as soon as it is removed, with immediate return to fertility.

A Word about Shelf Life and Tarnishing: Unless the package is damaged or torn, an IUD is safe to insert up to the day before the package expiration date (even if the IUD is tarnished/darkened). The expiration date refers to the **sterility** of the contents of an intact IUD package, which is maintained until that date; it does not refer to the effectiveness of the IUD. **The IUD is effective for 12 years from the date of insertion, not from the expiration date.**

Effectiveness

The IUD is one of the most highly effective methods of long-acting, reversible contraception. Its effectiveness is essentially equivalent to the effectiveness of hormonal implants or male or female sterilization. For example, if 1,000 women use the Copper T 380A IUD, only six to eight would become pregnant over the first year of use, meaning it is more than 99% effective.

While the effectiveness of the Copper T with **correct use** is the same, whether it is used as a PPFP method or as an interval method, the **typical-use** effectiveness is influenced by a slightly higher expulsion rate of IUDs inserted in the postpartum period.[b] Several factors appear to influence the risk of expulsion postpartum. Proper insertion to achieve high fundal placement of the IUD (more easily done immediately postpartum) is essential to ensuring IUD retention.

Side Effects

Side effects that copper-bearing IUD users may experience are described in the box on the following page. There is no evidence to suggest that the PPIUD (compared to the interval IUD) increases the frequency or severity of these side effects. In fact, some studies suggest that the PPIUD, when successfully inserted, may be better tolerated than the interval IUD. This is because many IUD-related side effects are similar to the bleeding and cramping typically encountered during this time, as a normal part of recovery. Therefore, they may simply be less noticeable to postpartum women, which is a considerable advantage of the PPIUD.

[b]Correct use refers to what can be expected under ideal circumstances (e.g., the IUD is inserted properly, is not expelled), whereas typical use refers to what may happen in real life (e.g., the IUD is not inserted properly, is expelled).

The most common side effects associated with the copper-bearing, interval IUD are as follows:

- A change in the amount and duration of menstrual flow and an increase in the amount of menstrual cramping—this is the most common reason for removal[25];
- Changes in bleeding patterns, such as spotting/light bleeding (between periods), in the first few weeks; and
- Discomfort or cramping during IUD insertion[26] and for the next several days.

All women should be advised of common side effects before IUD insertion, assessed for conditions that may make the IUD a poor choice given such side effects (e.g., history of severe dysmenorrhea, severe anemia or current pelvic pain) and counseled about side effects as needed during follow-up. Nonsteroidal anti-inflammatory drugs (NSAIDs) can lessen symptoms of pain[27], and good counseling can encourage continued use of the method.[28,29]

Timing of PPIUD Insertion

PPIUD insertion refers only to those IUDs placed during the immediate or early postpartum period (within 10 minutes or up to 48 hours after birth)**. IUDs inserted during the immediate postpartum period (i.e., postplacental and intracesarean) have the highest rates of retention,** but the IUD can be safely inserted at any time during the early postpartum period, that is, within the first 48 hours after the birth. The three types of PPIUD insertion are:

- **Postplacental:** *Immediately* following the delivery of the placenta (active management of the third stage of labor [AMTSL]) in a vaginal birth, the IUD is inserted with an instrument or manually before the woman leaves the delivery room.
- **Intracesarean:** *Immediately* following the removal of the placenta during a cesarean section, the IUD is inserted manually before closure of the uterine incision, before the woman leaves the operating theater.
- **Early postpartum:** Not immediately following the delivery/removal of the placenta but within 2 days/48 hours of the birth (preferably within 24 hours, such as on the morning of postpartum Day 1), the IUD is inserted with an instrument during a separate procedure.

The IUD **should not be inserted between 48 hours and 4 weeks postpartum** because of an overall increase in the risk of complications, especially infection and expulsion. IUDs inserted at 4 weeks postpartum and beyond are considered interval IUDs, rather than PPIUDs, because the same technique and services are required.

Key Differences and Characteristics of the PPIUD

PPIUD Advantages

Safety: The safety profile of PPIUDs is similar to that of interval IUDs. Insertion postpartum appears to have a **lower rate of uterine perforation**, possibly because the insertion instrument used is blunter and the wall of the uterus is thicker just after pregnancy. The provider can also be **certain that the woman is not pregnant** at the time of immediate (postplacental, intracesarean) and early postpartum insertion.

Access to services: The integration of PPIUD with labor and delivery services overcomes multiple barriers to service provision. Access to services for long-acting and permanent methods of family planning is generally limited for a number of reasons, including a lack of trained providers and adequately equipped and accessible facilities. Also, returning for services often poses a challenge to postpartum women, who have many competing demands on their time.

Cost-effectiveness: A study conducted in Peru[30] compared the cost of providing IUDs while the woman was in the hospital during the postpartum period versus when she returned to an outpatient facility later. The cost of providing PPIUD services immediately after delivery ($9) was found to be significantly less than when provided on an outpatient basis ($24). This reduced cost may make the PPIUD more feasible for many women.

Time and service efficiency: Inserting the IUD in the immediate postpartum period (postplacental, intracesarean) saves time for both the woman and provider—because the procedure is conducted in the same setting and involves only a few minutes of additional time. Although inserting the IUD in the early postpartum period (first 48 hours) does require a separate clinical procedure, it does not require an additional visit—which increases the likelihood that the woman will have it done. Providing PPFP services at the birth facility also helps to relieve overcrowded outpatient facilities, allowing more women to be served.

Postpartum Insertion versus Interval Insertion: Challenges and Considerations

In a study done in Egypt in 2004[31], women were provided with family planning counseling during the antenatal and immediate postpartum periods. Of those counseled, 28.9% chose the PPIUD as their method of family planning. If the woman requested immediate or early insertion of the IUD while still in the hospital postpartum, she was much more likely to have an IUD inserted (71.2%) than those who elected to wait until 6 or more weeks postpartum for IUD insertion (7.1%).

This 10-fold difference in provision of the method when women chose immediate/early postpartum versus delayed (interval) insertion could reflect the level of commitment of the women to their choice of method (i.e., they were more certain of their choice than those who chose to delay insertion). Or, it may reflect the reality that—given all they have to manage in their lives—women may find it difficult to return for the IUD in a timely manner.

In any case, the findings underscore the responsibility of the clinician to help women anticipate and overcome barriers to achieving their reproductive goals and protecting their health and that of their families. If it is far less likely that a woman who declares her desire for a method will be able to return for that method after she has left the hospital, then service providers should make an extra effort to provide it for her during her hospitalization, if that is her desire.

PPIUD Limitations

Limitations of the PPIUD are minimal and basically the same as for the interval IUD. Regardless of when an IUD is inserted, it will not protect against HIV or other sexually transmitted infections (STIs). Menstrual changes are a common side effect of the IUD, but again, these may be less bothersome for postpartum women. All women who have had an IUD inserted may be able to better able to tolerate such side effects when properly counseled and reassured that these symptoms are not harmful to their health. Having an IUD inserted, or removed, always requires a procedure performed by a specially trained provider in a clinical setting; however, having the device inserted postpartum will not require a separate visit or—when done immediately after the placenta—a separate procedure.

A limitation unique to the PPIUD is that the strings will not be initially visible after postpartum insertion, because of the length of the string compared to the length of the postpartum uterus. Usually the strings will descend through the cervix and into the vagina by the time of the first PPIUD follow-up visit (at 4 to 6 weeks). This occurrence, however, may be delayed. Although lack of the strings' descending will not adversely affect the efficacy of the device, it may require some additional follow-up or investigation to reassure the woman or the provider that the IUD has not fallen out.

PPIUD Health Risks

There are few potential health risks associated with the PPIUD. However, the lack of well-designed, peer-reviewed studies of the PPIUD leaves important questions unanswered about exact complication rates and such variables as timing and technique of insertion; these are the subject of ongoing research. Still, conclusions about the following complications can be drawn based on consistent findings across countries, clinical sites and provider type—from nurses to midwives to physicians.

- **Uterine perforation—In a recent systematic review of the literature regarding PPIUD insertion, there were no reported cases of uterine perforation during PPIUD insertion in any of the studies reviewed.**[32] Perforation of the uterine wall during interval IUD insertion is rare. When it does occur, it is most often caused by the instrument used to "sound" the uterus, which is not involved in postpartum IUD insertion.
- **Infection—Postpartum insertion appears to have no significant effect on the risk of genital tract infection, which is very low in interval IUD insertion as well.** Among continuing users of the IUD, the risk of upper genital tract infection, such as endometritis or salpingitis, is less than 1%, which is much lower than previously thought. This minimal risk is highest within the first 20 days after IUD insertion, and is thought to be related to either insertion technique (due to lack of proper infection prevention practices) or pre-existing infection, rather than to the IUD itself. After the first 20 days, the risk of infection among IUD users appears to be comparable to that among non-IUD users.[33]
- **Expulsion**—IUD failure is rare, but the most common cause is spontaneous expulsion of the IUD from the uterus.[34] Rates of spontaneous expulsion appear to be higher with the PPIUD than with interval IUD insertions. **Immediate postpartum insertion (within 10 minutes) is associated with a lower risk of expulsion than early postpartum insertion (up to 48 hours).**[32] Interval insertion at 4 weeks after delivery and beyond is associated with the lowest risk of expulsion postpartum. All women who have an IUD inserted should be aware of this risk and the fact that most expulsions occur within the first 3 months after insertion.[35]

Timing, Technique, Training—Key Factors in PPIUD Expulsion[36]

Although individual risk estimates of expulsion vary between studies, a consistent relationship among **the timing of PPIUD insertion, the technique used** and respective expulsion rates has emerged, regardless of country, clinical site or type of provider.

Clinical trials have shown that there is a lower expulsion rate with immediate postpartum (postplacental, intracesarean) insertion than with early postpartum insertion (within 48 hours). This is likely because reliably reaching the uterine fundus (which is critical to retention) is easier during immediate insertion, whereas the uterus begins to contract and regain its firmness immediately thereafter—which makes insertion more difficult during the early postpartum period.

In several clinical studies, expulsion rates varied greatly among clinical sites. This variation has been attributed to **lack of provider skill and consistency in insertion techniques**, which underscores the importance of standardized training to minimize expulsion rates.

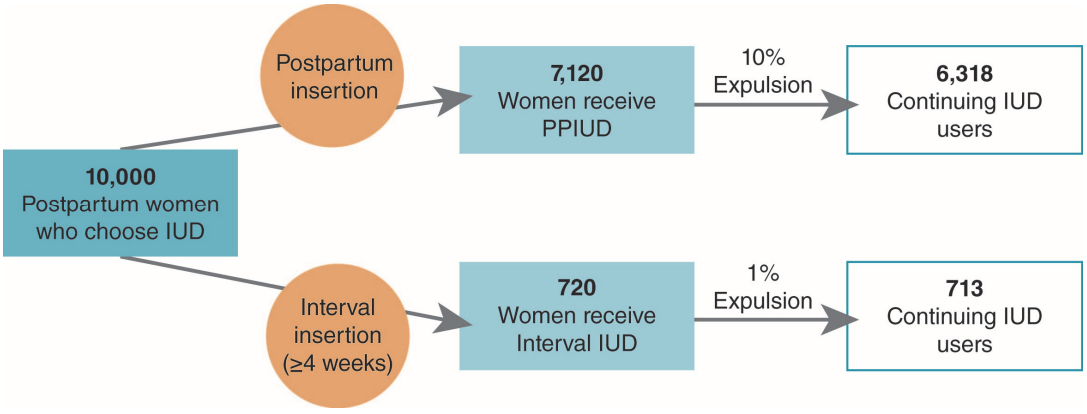
Public Health Approach to the Issue of Spontaneous Expulsion

Although the PPIUD expulsion rate may be as high as 10%–15%[c], the retention rate is more than 85%–90%—which, which from a public health perspective, may be an acceptable rate. And in situations where access to health care is limited or use of postpartum follow-up services is infrequent, this potential for continued use of contraception is an important consideration.

[c]**Postpartum expulsion rates may be reduced to 4%–5% through proper insertion technique.**

Using data from a 2003 study done in Egypt[31], it is possible to estimate the magnitude of the difference that can be made by offering immediate postpartum IUD insertion. In the study by Mohamed et al., 71.2% of the women who requested immediate postpartum IUD insertion were able to have one inserted. In cases where they requested immediate postpartum insertion, but were told to return at 6 weeks to the outpatient department for the procedure, only 7.2% ultimately had an IUD inserted. This suggests that women who request the IUD and are provided it immediately have perhaps a 10-fold greater chance of receiving it than those who are told to return for later insertion. Therefore, given that provision of the IUD in the immediate postpartum period is Category 1 according to WHO's Medical Eligibility Criteria [MEC], all women who request immediate postpartum insertion, and have been properly counseled and evaluated for its safe provision, should be provided the method at the time of their choosing.

Figure 3. Public Health Approach to PPIUD



4. PPIUD Services in Context

As part of a comprehensive family planning/PPFP program, PPIUD services should be fully integrated with MNCH services—from ANC, through intrapartum and postpartum/newborn care. Done correctly, insertion of an IUD postpartum will not interfere with the conduct of routine care. And the PPIUD must never take precedence over prompt, proper treatment of life-threatening conditions that may arise during labor, delivery and the postpartum/newborn period—because insertion can easily be deferred until an appropriate time when the mother and newborn are medically stable. Sound clinical judgment should always prevail.

The services themselves must take into account the ongoing needs of the woman and her child during this critical time, as well as accommodate the transformation the woman's body is undergoing. The recommended technique for, as well as timing of, PPIUD insertion directly address the dramatic changes that take place in the woman's cervix and uterus during the immediate/early postpartum period. These simple adjustments to the technique used for interval IUD insertion are essential to achieve proper placement of the device in the uterine fundus, and thus minimize the risk of expulsion.

Finally, although it is up to the woman whether and when to have a PPIUD inserted, the provider can and should make recommendations based on which practices have been shown to lead to the best outcomes for potential PPIUD users. This "optimal PPIUD service scenario" (further discussed on page 29) is one of several possible service scenarios.

Remember: PPIUD services are not only about the PPIUD: they are about choice. If the woman expresses interest in a long-acting method, then the PPIUD may be a good choice for her. But it must be presented as one in a range of contraceptive options that are available to her.

PPIUD and Other Intrapartum/Postpartum Services

PPIUD services are readily integrated with other elements of essential maternal and newborn care, including:

- Managing normal birth based on the latest recommendations—such as use of a partograph, performing AMTSL (see box, below), etc.;
- Providing essential newborn care;
- Conducting a postpartum examination and ongoing monitoring;
- Facilitating early and exclusive breastfeeding, as appropriate;
- Delivering effective postpartum/newborn counseling, which will include specific messages regarding proper use of the PPIUD; and
- Screening for and identifying complications or conditions that require prompt management or referral.

AMTSL, an obstetric "best practice," has been shown to prevent postpartum hemorrhage and maternal death. It should be offered to every woman during every birth because of the unpredictability of this life-threatening complication.

- There have been no clinical trials to assess the interaction between AMTSL and immediate postplacental insertion of the IUD. However, an expert panel was convened by WHO in 2004 to discuss the issue and concluded that **there is no interaction between AMTSL and postpartum insertion of the IUD and the two practices do not interfere with each other.**
- **Postpartum insertion of the IUD should not be deferred or** delayed in a woman who has undergone AMTSL.
- Likewise, **do not delay administration of oxytocin, as part of AMTSL, because of concerns about IUD expulsion**. There is no evidence to suggest that the contractions resulting from the uterotonic drug will push the IUD out once it is placed at the fundus; in fact, it is likely to be held there, rather than being pushed out, by the ongoing contractions. This is because postpartum contractions are strong and uniform, whereas labor contractions emanate from the uterine fundus and proceed downward like a wave—from the top to the bottom of the uterus—causing cervical dilation and fetal descent.

All three steps of AMTSL—injection of a uterotonic, controlled cord traction to aid in removal of the placenta and (initial) fundal massage—**should be successfully completed before PPIUD insertion.**

Importance of Proper Technique in PPIUD Insertion

The single most important way to reduce the expulsion rate of IUDs that are inserted in the postpartum period is to ensure proper insertion of the device. An understanding of what is happening in the woman's body during the postpartum period is critical to mastering the proper insertion technique for the PPIUD.

Immediate and Early Postpartum Changes and Recommendations

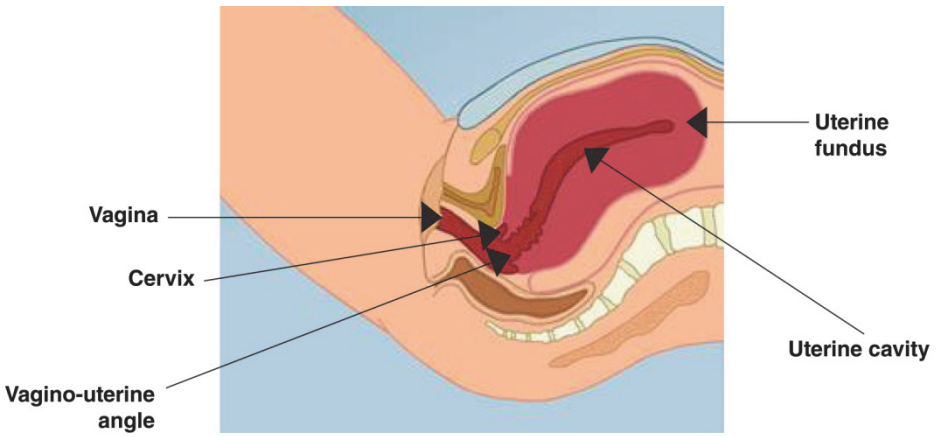
During the first 48 hours after the delivery of the placenta, the state of the uterus and cervix are favorable for quick, easy placement of the IUD.

- The **uterus** is approximately the size of a 5-month pregnancy, about 1 kg in weight and 30 cm in length. Generally, the fundus (top of uterus) can be felt through the abdominal wall,

just below the umbilicus. The anterior and posterior walls of the uterine body are close together, each about 4 to 5 cm in thickness. The lower uterine segment of the uterus is stretched thin and is extremely floppy—adding to the marked mobility of the body of the uterus, which is usually tilted forward. This disparity in consistency and weight between the body of the uterus and the lower uterine segment creates a sharp angle between the vagina and the uterus (Figure 4), which must be effectively negotiated by the provider during insertion. Within 48 hours, the uterus may decrease slightly in length, but it is still floppy enough to be manipulated and thus is conducive to the procedure.

- Like the lower uterine segment, the **cervix** is stretched thin and is floppy. The cervical opening is large; its outer margins are ragged and extremely soft. For the first 10 minutes after birth, the cervix can generally stretch enough to admit either a small hand or long placental forceps with a fenestrated end, which makes either manual or instrumental insertion an easy option. Beyond 10 minutes and up until 48 hours after birth, however, the cervix is no longer stretched open enough for manual insertion, but insertion with fenestrated forceps is still generally possible.

Figure 4. Anatomy of Postpartum Uterus



With minor adjustments to the interval IUD technique as well as the instruments used (see box on the following page), proper placement of the device at the fundus can be readily achieved and the risk of IUD expulsion can be minimized.

Key Adjustments in PPIUD Insertion Technique

- **"Elevating" the uterus** using a specific hand maneuver to straighten the lower segment of the uterus.
- **Negotiation of the vagino-uterine angle** with the hand or forceps to ensure that the IUD will be deposited at the fundus, rather than midcavity.
- **Use of an alternative method of insertion**, either long forceps with a fenestrated end or a hand, rather than the inserter tube used in interval insertions (which is not long enough or rigid enough).
  - **Kelly placental forceps, or other similar long instrument, are long enough to reach the fundus and rigid enough to negotiate the vagino-uterine angle.** There has not been a clinical trial to determine whether using Kelly placental forceps versus ring/sponge-holding forceps results in a lower expulsion rate. But experience suggests that because Kelly forceps are longer, they may allow the fundus to be more easily reached. Also, the slight curve at the end of the forceps may prevent the strings from getting caught in the instrument, which may decrease the risk of displacing the IUD during forceps withdrawal.
  - Numerous clinical trials have found that manual postplacental insertion and instrumental (using ring forceps) postplacental insertion techniques are equivalent in terms of expulsion rates.[22]
- **Careful confirmation of fundal placement** using specific criteria: for instrumental insertion, resistance to the IUD-holding forceps is felt at the fundus (may also be felt through the abdomen at the fundus) and most of the forceps is inside the woman's body (i.e., the hand holding the forceps is very close to the perineum); and no part of the IUD, including the strings, is visible at the cervix or in the vagina.

Later Postpartum Changes and Recommendations

Between 48 hours and 4 weeks after birth, the uterus becomes smaller (involutes) and begins to resume its anteverted or retroverted position, making it harder to reach the fundus. In this situation, it is common for the provider to think that she/he has reached the fundus, and to release the IUD in the midportion of the cavity. This leads to high rates of expulsion, as well as discouragement for both providers and clients.[35] During this time, the cervix closes and becomes firmer, making the passage of any instrument through its opening more difficult. For these reasons, **insertion of the IUD between 48 hours and 4 weeks after birth is not recommended.**[37] At after 4 weeks from birth, the uterus and cervix have mostly returned to their pre-pregnant state; at this time, the typical interval IUD insertion approach (using the standard inserter tube and instruments) is recommended. This procedure is covered elsewhere.[38]

PPIUD Services—Key Elements

Key elements of PPIUD services are as follows (some may happen in a different order or overlap with others):

- **PPFP education/counseling:** The woman receives basic information about healthy spacing of pregnancies (and limiting, if desired) and the PPFP methods available to her (e.g., effectiveness, duration of protection); the woman's fertility goals and individual circumstances are discussed to help her choose a method that is well-suited to her needs.
- **Method-specific counseling:** Women interested in a certain method, such as the PPIUD, are provided more specific information about the method (e.g., side effects, warning signs).
- **Annotation of the woman's PPFP choice on her record:** If a woman has chosen a method, her choice is documented prominently at the top of her medical record—to inform other providers of her decision. This may be done some time after counseling, after the woman has had a chance to discuss the issue with her partner or others.

- **Initial screening:** A woman who chooses the PPIUD is screened for existing characteristics/conditions (according to WHO's MEC for IUDs) that would make the IUD a poor choice for her, or medical reasons why the method should be withheld.
- **First confirmation of the woman's choice of the PPIUD:** When the woman presents for delivery, the provider confirms that she still wants an IUD and when she wants it inserted. The provider reassures or counsels the woman, as needed. (Again, though, PPFP/PPIUD counseling should occur during the antenatal period, whenever possible.)
- **Ensuring that supplies and instruments are available and ready for use:** The provider then ensures that a sterile Copper T IUD and the supplies/instruments and light source needed are available and ready for use.
- **Managing labor and delivery:** Including using a partograph, performing AMTSL and addressing any problems that may arise, obstetric care is integrated with PPIUD services and takes precedence when appropriate.
- **Second screening:** After the birth, the woman is screened for conditions resulting from labor and delivery that would make the IUD a poor choice for her, or medical reasons why the method should be withheld.
- **Second confirmation of the woman's choice of the PPIUD:** Immediately before the PPIUD is inserted, the provider tells the woman she/he is about to insert the IUD if the woman is ready. This helps prepare the woman and reconfirms her choice.
- **Insertion of the PPIUD:** After the final determination has been made that the woman will have an IUD inserted, the supplies/instruments are arranged and the IUD is removed from the package using the "no-touch" technique (described on page 29). The IUD is then gently inserted according to recommended practices, either immediately postpartum (postplacental, intracesarean) or early postpartum (up to 48 hours).
- **Post-insertion counseling:** The woman receives information about side effects, warning signs and when to return to the clinic for follow-up. This should be integrated with routine postpartum/newborn care.
- **Follow-up:** At 4 to 6 weeks after the birth, the woman returns for routine PPIUD follow-up. She is screened for potential problems related to the IUD; any problems are managed or referred.

Throughout all high-quality services:

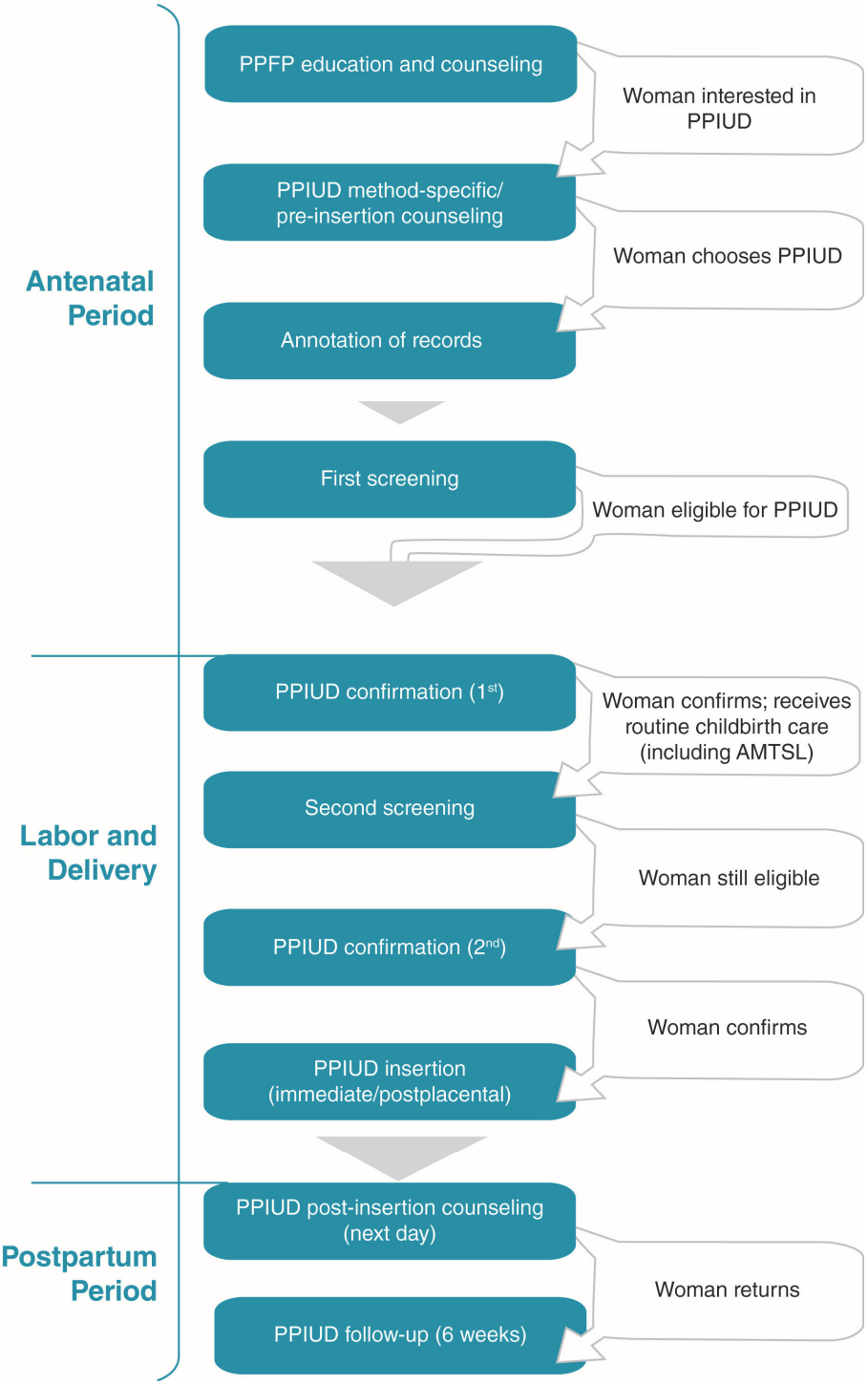
- **Clients are treated with kindness, courteousness and respect;** the woman who chooses the PPIUD should do so freely and should be provided that method, if appropriate, in accordance with the latest evidence-based recommendations and global standards of care.
- **Providers and other health staff employ infection prevention practices as appropriate,** in accordance with global standards.

PPIUD Service Scenarios

Whether a woman is counseled on and chooses the PPIUD during the antenatal period, in the early stage of labor or after the baby is born has a direct effect on how services will be provided, creating different "PPIUD service scenarios." These different scenarios are described/illustrated on the following page.

- **Antenatal introduction to the PPIUD:** This allows more time for counseling, for the woman to consider her PPFP options and freely choose the PPIUD, and for the provider to conduct the initial screening. It may also make immediate postpartum insertion, which is associated with higher IUD retention rates, more likely. Figure 5 presents this "optimal PPIUD service scenario."

Figure 5. "Optimal PPIUD Service Scenario"—Antenatal Introduction to the PPIUD with Immediate Postpartum Insertion



- **Intrapartum introduction to the PPIUD:** Services can be compressed, if needed, to enable a woman who chooses the IUD in the early/inactive stage of labor to have one inserted postpartum. However:
  - This leaves less time for counseling, which may cause the woman to delay the insertion to the early postpartum period—which is associated with higher expulsion rates and requires a separate procedure—or even later. A woman in this situation should be counseled on the benefits of immediate insertion and reminded that she can change her mind or have the IUD removed at any time for any reason.
  - It also leaves less time for initial screening; although if the woman has a normal vaginal delivery, it is unlikely that she has certain conditions (e.g., distorted uterus) that would make the IUD a poor choice for her, or that there are medical reasons why the method should be withheld.
- **Postpartum introduction of the PPIUD:** Services can be initiated after the baby is born, even in the postpartum ward, so that the woman who chooses the PPIUD can have one inserted before she leaves the facility (within 48 hours of the birth).
  - The higher risk of expulsion for IUDs inserted during the early postpartum period, versus the immediate postpartum period, can be minimized by performing the procedure within the first 24 hours (e.g., on the morning of Day 1 postpartum).
  - Although this scenario requires a separate procedure, it is still more convenient and cost-effective—and more likely to result in an actual IUD insertion—than if the woman is expected to return for the procedure after she has left the birth facility.

Introduction to the PPIUD is not recommended during active labor because the woman is likely to be exhausted and unable to concentrate, and should not be asked to make important decisions at this time.

5. Counseling and Initial Screening of Potential PPIUD Users

In counseling for PPFP services, a trained and skilled counselor or service provider explicitly and purposefully gives his/her time, attention and skills to assist clients in:

- Understanding the benefits of healthy spacing of pregnancy;
- Exploring their future reproductive intentions;
- Identifying and acting upon contraceptive solutions that are realistic and well-suited to their needs, goals and life situation (access to services, resources available, etc.); and
- Being prepared for return to fertility.

In settings where women lack awareness about IUDs or where misinformation about the method is very prevalent, quality education and counseling are critical to overcoming barriers to IUD use.

For potential PPIUD users (women who are interested in or have chosen the method), **method-specific counseling** consists of:

- Ensuring that the IUD is a good choice for the woman/couple and offers what they seek in a contraceptive; and

- Discussing the "optimal PPIUD service scenario" (the benefits of immediate postpartum insertion).

For women who have chosen the PPIUD, the **initial screening** determines whether they can have a PPIUD inserted based on the WHO MEC for contraceptives. This can be done as part of individual counseling because it does not involve any physical examination, only a series of questions regarding the woman's medical history.

All providers should keep in mind that although all methods of family planning have some associated risks, the risks to a woman and her family's health may be greater if she uses no method at all and has an unintended or badly timed pregnancy. When a provider counsels and screens a woman properly, that woman is more likely to:

- Make a reasonable contraceptive choice for achieving her reproductive health goals;
- Be satisfied with her chosen method; and
- Use her chosen method correctly and for a longer time.

Rushing or bypassing either of these processes, counseling or screening, may cause a woman to choose a method that is not right for her or avoid choosing any method at all, leaving her more likely to have unprotected sex and more vulnerable to unintended pregnancy and other health consequences.

PPIUD Counseling

Ideally, PPIUD counseling should begin during the antenatal period and occur in stages:

- First, as **part of general health education** (often group-based) about the benefits of healthy spacing of pregnancies (and limiting, if desired) and about the PPFP methods available to women in the community. At this stage, the counselor/provider may offer very basic information about the PPIUD, among other methods.
- This should be followed by **individual counseling about PPFP methods**, in which a woman is provided with more detailed information about a particular method (or methods) and is supported in making an informed choice about a method that is well-suited to her individual needs and circumstances in the postpartum period. Often a woman will take time to discuss her options with her partner or others before making a final decision.
- Then, as the **focus of method-specific counseling about the PPIUD:**
  - For those women who have chosen the IUD for postpartum insertion, pre-insertion counseling provides more detailed information about the insertion procedure and other attributes of the method. Again, this is also an ideal opportunity for initial screening.
  - And finally, for women who have had the IUD inserted postpartum, post-insertion counseling provides information about returning for follow-up, recognizing warning signs and what to do if they occur, and managing side effects. (See Chapter 6.)

Key messages about healthy spacing of pregnancies are summarized in Appendix A. Job aids for PPFP counseling are presented in Appendix B. General counseling techniques and approaches for effective health education and counseling on family planning and PPFP are presented in great detail elsewhere.[38–40]

Remember: All individuals and couples have a right to make their own decisions about family planning. They also have a right to the accurate, up-to-date information they need to make those decisions responsibly, as well as access to a full range of safe and reliable contraceptive options. Family planning education and counseling play a central role in empowering clients to exercise these and other basic rights and should be conducted at a time and in a manner that aids client choice, and does not persuade, pressure or induce a person to use a particular method.

Content of Method-Specific PPIUD Counseling

Once a woman has chosen the PPIUD and a level of confidence and trust has been established between her and the counselor/provider, the **method-specific portion of counseling** can begin. This counseling should include more detailed messages about the method, such as those shown in the table below, and should be tailored to the woman's/couple's individual needs, concerns and circumstances.

Table 2. Client Messages about Basic Attributes of the IUD and PPIUD

	Basic Attributes	Messages
General Information	**What it is**	• The IUD is a small plastic device that is inserted into the uterus.
	Effectiveness	• The IUD is more than 99% effective at preventing pregnancy, which makes it one of the most effective contraceptive methods currently available.
	Mechanism of action	• The IUD prevents pregnancy by preventing the sperm from fertilizing the egg.
	When it is inserted	• For interval IUD insertion, the device can be inserted any time it is reasonably certain the woman is not pregnant—including during menstruation. • **The PPIUD can be inserted either immediately after the placenta comes out (after a vaginal birth or during a cesarean section) or in the early postpartum period (not immediate but up to 48 hours after delivery).** • **Postplacental/immediate IUD insertion is preferred because it has a lower rate of expulsion than early postpartum (not immediate but up to 48 hours) insertion, and it is easier/more convenient for both the woman and provider.**
	Duration of protection	• The IUD begins to work immediately and the Copper T is effective for up to 12 years. • It can be removed at any time, for any reason, with immediate return to fertility—which means it is a long-acting but reversible method of family planning. • **Women who have the IUD inserted postpartum will have contraceptive protection in place even before they leave the birth facility.**

	Basic Attributes	Messages
Screening-Related Information	**Who can use it**	• Most women can use the IUD, including those who are young/ nulliparous, are **postpartum and breastfeeding**, or do hard work—as well as those who have certain medical conditions such as HIV or diabetes. It is especially well-suited to women who think they are finished having children, but want to delay sterilization until they are certain.
	Who cannot use it	• Some women who should not use the IUD include those who have a misshapen uterus (e.g., from fibroids), a high personal risk of STIs or current pelvic infection, PID, gonorrhea or chlamydia. • **Sometimes women develop an infection during the time of birth. These women should wait until after the infection has been treated to have the IUD inserted.** (Pages 23–25 present guidance on initial assessment; Appendix C provides a complete listing of exclusion criteria.)
	Breastfeeding	• **Women who are breastfeeding can safely use the IUD. Using the IUD postpartum will not affect the amount or quality of breast milk.**
	Protection against HIV and other STIs	• The IUD offers no protection against HIV or other STIs. Only barrier methods (e.g., the condom) help protect against exposure to HIV and other STIs. If a woman thinks she has a "very high personal risk" for certain STIs, she should not use the IUD.

Other Considerations	**Limitations and risks**	• The IUD must be inserted and removed by a skilled provider. **The PPIUD is more convenient than interval IUD because it will not require a separate visit or (if postplacental) a separate procedure.**
		• The IUD has some associated risks/complications but they are rare and few, all of which can be virtually eliminated through proper screening and insertion technique:
		  ◦ Uterine perforation is a rare occurrence and infection occurs in less than 1% of cases (**both risks may be even lower in PPIUD**).
		  ◦ Although it is not a problem for most women, expulsion of the IUD is the main risk. Risk of expulsion is higher for PPIUD insertion than for interval IUD insertion. When the IUD is inserted postpartum, about 5 to 10 women out of 100 will find that the IUD has fallen out during the first 3 months. (Fewer IUDs inserted during the immediate postpartum period [postplacental, intracesarean] are expelled than those inserted within 24 to 48 hours after birth.) If the IUD is expelled, the woman should return to the clinic and have another IUD inserted to continue protection against pregnancy.
		• **Strings may not be visible initially after postpartum insertion, which might require some additional follow-up or investigation to ensure that the IUD has not fallen out.**

	Advantages and benefits	• **Safe and effective:** The IUD is safe and effective, with a very low rate of complications. • **Cost-effective and convenient:** Once it is inserted until it must be removed, it requires no additional actions, supplies or costs on the part of the woman. In most cases, only one follow-up visit to the clinic is required (at 4 to 6 weeks). **Getting a PPIUD is especially cost-effective and convenient. The device will be placed before the woman leaves the health care facility (will not require a separate visit nor [if immediate postpartum] a separate procedure).** • **Versatile and quick-acting:** It is both long-acting and reversible–can be used to prevent pregnancy for a short time or as long as 12 years, and fertility returns as soon as it is removed. It also begins preventing pregnancy immediately upon insertion. • **Reduces overall risk of ectopic pregnancy (IUD users are much less likely to have an ectopic pregnancy than non-contraceptive users);** however, if a woman becomes pregnant with an IUD in place, she has an increased risk of ectopic pregnancy.

	Basic Attributes	Messages
User Information/Instructions	**Side effects**	• Copper-bearing IUDs (e.g., the Copper T) have no "hormonal side effects" (such as those associated with DMPA injections, implants, the pill), but sometimes cause an increase in the amount, duration and painfulness of menstrual periods. These symptoms usually lessen or go away during the first few months after insertion. • **Often these symptoms are not noticed by postpartum women because they are still recovering from pregnancy and childbirth. And women who are breastfeeding may not yet have resumed their menstrual periods.** • If side effects become very bothersome to the woman, she should return to the facility for care.
	Warning signs	Warning signs for IUD users, as follows, indicate that the woman should return to the facility as soon as possible for urgent attention and care: • Foul-smelling vaginal discharge **(different from the usual postpartum lochia)** • Lower abdominal pain, especially if accompanied by not feeling well, fever or chills • Concerns that the IUD has fallen out • Signs of pregnancy
	Removal	• The woman can have the IUD removed at any time for any reason by a skilled provider. She should return to the facility to have it removed no later than 12 years after insertion. A new IUD can be inserted at this time, if the woman desires.

Service Delivery Tips for Method-Specific PPIUD Counseling

Who should do it/when:

To be most effective, method-specific should be carried out (as a follow-on to PPFP education/ counseling) with the pregnant woman during the antenatal period if possible, as part of routine care, by a trained counselor or her ANC provider. This is especially advantageous for women who have chosen contraceptives that are initiated during the immediate or early postpartum period, such as PPIUD, LAM or tubal ligation. This allows:

- Multiple opportunities (potentially) to address the woman's concerns and answer her questions before she makes a decision;
- A chance for the woman to discuss her choice with her partner, as well as for counseling to be extended to her partner and/or other family members (if the provider or woman considers this to be important); and
- Ample time for initial screening.

Other opportunities:

- **For a woman who presents at the facility for non-routine care:** If a woman is undergoing evaluation or treatment for an antenatal complication or other concern, she may be counseled for PPFP/PPIUD. This is actually a good time to discuss the health benefits of pregnancy spacing (or limiting, if desired) for both the mother and her children. The woman/couple may be especially interested in ways to increase the likelihood of a positive health outcome for a future pregnancy.
- **For a woman who presents at the facility for delivery care:** If a woman is in the early/inactive stage of labor and has not been counseled, the PPIUD is still an option if a counselor or the clinician can provide adequate PPFP counseling. Because choosing a

contraceptive is an important decision to make on such short notice, it is important that a woman interested in the PPIUD understands that it is non-permanent and can be removed whenever she wants—and that she can change her mind at any time.

- In general, **a woman should NOT be counseled for the first time about PPIUD during active labor**. The stress of labor makes this a difficult time for a woman to focus sufficiently on the information provided and make an informed choice about contraception.

After counseling:

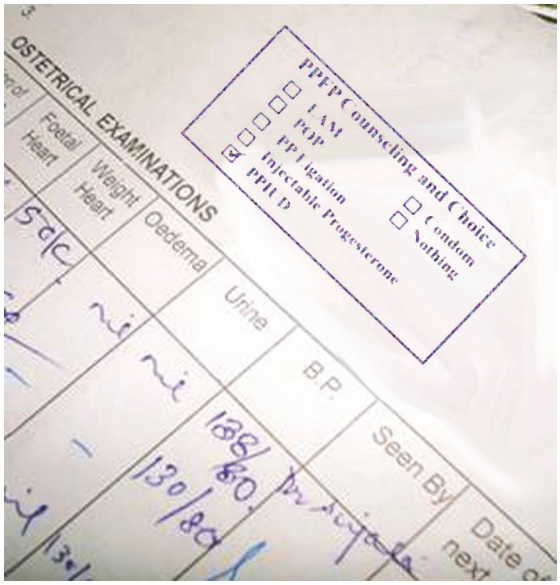
A woman's **choice about PPFP should be clearly documented** on her antenatal card or medical record (as shown in Figure 6). This is especially critical for women who choose the PPIUD (or other labor/delivery-related methods) during the antenatal period—alerting labor and delivery room staff so that preparations can be made to provide the method immediately following delivery of the placenta (or in the early postpartum period). The annotation should be obvious and noticeable enough to serve as a reminder to all MNCH providers.

Assessment of the Potential IUD User

Assessment for provision of PPIUD services should occur in **two phases** (Figure 7).

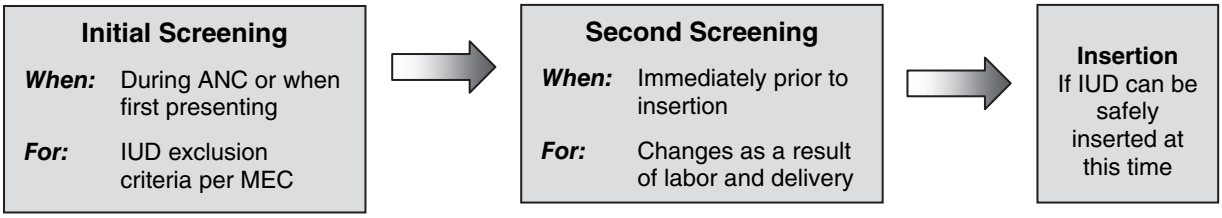
- The **initial screening** is a general review of the woman's medical history to identify specific *existing* characteristics and conditions and determine her eligibility for the method.
- A **second screening** is done immediately prior to insertion (following delivery of the placenta or within 48 hours after birth) to assess for conditions *resulting* from labor and delivery that may have an impact on whether an IUD can be safely inserted at this time. (See Chapter 6.)

Figure 6. Documentation of Woman's PPFP Choice in Medical Record



If any such characteristics/conditions are identified, the provider and client should weigh the risks posed by the IUD against those posed by unintended pregnancy to determine whether an IUD should be inserted at this time.

Figure 7. Assessment Scheme for Women Who Choose the PPIUD



Content of Initial Screening for Potential IUD Users

The WHO MEC form the scientific foundation for client assessment regarding family planning methods.[40] These criteria give detailed guidance regarding whether a woman with a certain condition can safely use a given method of family planning (Appendix C). The MEC has four categories, as shown in Table 3.

Table 3. WHO Medical Eligibility Categories

Category	With Clinical Judgment	With Limited Clinical Judgment
1	Use method in any circumstances	Yes (Use the method)
2	Generally use the method	
3	Use of method not usually recommended unless other more appropriate methods are not available or not acceptable	No (Do not use the method)
4	Method not to be used	

During the initial assessment, the provider is looking for the following conditions, listed in the MEC and relevant to PPIUD services, which make the IUD an unsuitable choice for this woman:

- Known distorted uterine cavity (uterine septum, fibroid uterus, etc.) (Category 4)
- Acute purulent (pus-like) discharge (Category 4)
- High individual likelihood of exposure to gonorrhea or chlamydia (Category 3)
- Malignant or benign trophoblastic disease (Category 4/3)
- AIDS and not clinically well or not on antiretroviral therapy (Category 3)

Service Delivery Tips for Initial Screening of Potential IUD Users

Who should do it/when:

- Again, ideally, the initial screening should be carried out with the pregnant woman during the antenatal period by her ANC provider. However, for women who present at the facility for delivery care, and who have not had a prior screening, the clinician must use her/his clinical judgment about the likelihood of characteristics/conditions that would make the IUD a poor choice for her, or whether there are medical reasons to withhold the method.
- If a woman has just experienced a normal, vertex, full-term vaginal delivery, it is reasonable to assume that she does not have a distorted uterine cavity, have malignant or benign trophoblastic disease, or suffer from acute illness due to unmanaged HIV/AIDS.
- If she does not report purulent cervicitis in the final trimester of pregnancy, it is reasonable to assume that she does not have an undiagnosed chlamydia or gonorrhea. As with screening for the interval IUD, it is reasonable to provide IUDs to women without prior STI testing.

After the initial screening:

- **If NO exclusion criteria are identified**, the provider should advise the woman that it is safe to insert the IUD postpartum, provided that results of the second screening are also favorable. The provider should then:
  - Provide any additional counseling, as appropriate.

- Discuss and decide/confirm the timing of the insertion, reminding the woman that immediate postpartum (postplacental, intracesarean) insertions are associated with fewer problems that those that take place later, within 48 hours.
- Get the woman's verbal consent.
- Answer any questions she may have.

- **If ANY exclusion criteria are identified,** the provider should explain the reason why an IUD cannot be inserted and assist the woman in choosing another method (or for Category 3 conditions, assist her in weighing the pros and cons of using this method versus another method). Appendix B offers additional information about other PPFP options.

6. Postpartum Insertion of the IUD—A Process

The main element of PPIUD services is insertion of an IUD, within 10 minutes of the delivery of the placenta or up to 48 hours after birth. Because PPIUD insertion occurs in the context of other important health events, it is helpful to think of insertion not just as a clinical procedure, but as a process—fully integrated with intrapartum, postpartum and newborn care—that occurs in many stages:

- Beginning with **confirmation** (of *choice*) that the woman still wants the PPIUD;
- Continuing with the **second assessment** of the woman, to ensure that there are no conditions resulting from labor and delivery that make IUD insertion unsafe at this time, followed by another **confirmation** (of *readiness*); and **IUD insertion** in the immediate (postplacental, intracesarean) or early postpartum period, as appropriate; and
- Ending with **post-insertion counseling**.

How and when these different stages of the process are carried out will depend on a variety of factors—including the woman's preferences and what services she has received up to this point, the skills of her provider and the policies and capacities of the health care facility. **Respectful treatment** of the woman and her family and adherence to global **infection prevention standards** are integral to the PPIUD insertion process, regardless of how this process unfolds.

Confirming Choice/Readiness of the Potential PPIUD User

Before the woman has an IUD inserted postpartum, the provider should confirm with her that she still wants one: once before active labor begins, if possible; and again immediately before the procedure.

- The **first confirmation** is especially important if the woman chose the PPIUD *before* presenting for labor and delivery care (i.e., during the antenatal period)—to ensure that she has not changed her mind. In addition, it gives the delivery room staff ample time to prepare for the procedure, for example by ensuring that IUDs are available on the ward and gathering necessary supplies and equipment (Appendix D). Confirming the woman's contraceptive choice is a matter of respect, as well, presenting an opportunity for the woman to ask questions she may still have and for the provider to counsel her as needed.

- The **second confirmation** happens after the second assessment, which follows the birth but immediately precedes insertion of the IUD postpartum. The provider explains that she/he is about to insert an IUD, briefly explains what the procedure will involve and ensures that the woman is ready (thereby confirming that she still wants an IUD).

Second Screening of the Potential PPIUD User

The purpose of the second screening is to ensure that the process of labor and birth has not produced a clinical situation for which insertion of the PPIUD would not be advised. Specifically, after the delivery of the placenta, the woman should be assessed for:

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

Appendix E provides a job aid for the second screening. **It should be noted that the conditions listed below are not represented in the WHO MEC for IUD use; however, they are regarded as exclusions or precautions based on clinical trials and expert opinion.**

1. **Chorioamnionitis** is an infection that may occur when membranes are ruptured and amniotic fluid is leaking. The management principle for this infection is to deliver the fetus, which will clear the infection from the mother. Therefore, antibiotics are administered and the fetus is delivered as quickly as possible. No additional antibiotics are needed after a normal vaginal delivery in a woman with chorioamnionitis because the infection has been addressed; however, IUD insertion is not advised (Category 3) as the woman is at increased risk for puerperal infection.

Diagnosis of Chorioamnionitis

Chorioamnionitis is an intra-amniotic infection of the fetal membranes and amniotic fluids prior to or during labor that is characterized by:

- Temperature of 38°C
- Abdominal pain

PLUS one of the following:

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

2. **Prolonged rupture of membranes (PROM) for more than 18 hours prior to delivery** is listed as an exclusion criterion in most research studies about PPIUDs. Because PROM increases the woman's risk of postpartum uterine infection or puerperal sepsis, IUD insertion is not advised (Category 3). However, there is no strong or definitive evidence for this exclusion criterion, and thus it is open to review.
3. **Unresolved postpartum hemorrhage** may make it physically challenging to insert an IUD; there is also the chance that the flow of the hemorrhage will dislodge the IUD. In addition, the provider should be focused on addressing the cause of the bleeding and stabilizing the woman, rather than inserting an IUD. For these reasons, an IUD should not be inserted

(Category 4). The IUD can be inserted once the hemorrhage is controlled and the woman is in stable condition.

4. **Extensive genital trauma** from the delivery does not mean that a woman cannot have an IUD at this time, but it *will* affect how the provider approaches insertion.
   - If the woman is found to have substantial genital trauma **immediately after delivery of the placenta**, an instrumental or manual insertion is recommended **prior to starting the repair of the lacerations/episiotomy**. In this case, the provider should cover the posterior wall of the vagina with a towel or several gauze sponges to limit the possibility of contamination, and avoid contamination of the IUD while inserting it.
   - If a woman is found to have substantial genital trauma while being evaluated **during the early postpartum period** (within 48 hours of delivery), the provider should take special care in performing the insertion to ensure that any previously made repairs are not disrupted during the insertion.

Who Should Do It/When

The second screening should be done immediately prior to IUD insertion by the person who will perform the procedure (i.e., the provider who managed the birth).

- If a **postplacental insertion** is planned, the second assessment is best carried out during the second stage of labor so that insertion can be performed immediately following AMTSL and the delivery of the placenta without any delay.
- If an **intracesarean insertion** is planned, the second assessment should take place during the pre-operative activities prior to surgery.
- If a **postpartum insertion** is planned for the first day postpartum (or second day, if the first is not possible), the second assessment should take place during the initial postpartum evaluation.

After the Second Screening

- **If NO exclusion criteria are identified**, then the provider should advise the woman that it is safe to insert the IUD and can proceed with preparations for insertion.
- **If ANY exclusion criteria are identified**, the provider should explain the reason why an IUD cannot be inserted and assist the woman in choosing another, *at least temporary* method (or for Category 3 conditions, assist her in weighing the pros and cons of using this method versus another method). Appendix B offers additional information about other PPFP options. **Also:**
  - It should be made clear that the situation identified by the second assessment is a temporary clinical situation, and that if she still would like the IUD as her postpartum method of family planning, it can be provided to her at 4 weeks.
  - She should be scheduled for a postpartum visit at 4 to 6 weeks.

Infection Prevention during PPIUD Insertion[d]

The key objectives of infection prevention during PPIUD insertion are reduction of the risk of infection associated with PPIUD insertion technique and facility-related disease transmission to

[d]Because providers are likely to be well-grounded already in the basic principles of infection prevention, only practices that are essential to the safe delivery of PPIUD services are reviewed here. Appendix F provides additional information about infection prevention.

PPIUD clients, and protection of health care workers at all levels from exposure to disease. To achieve these objectives, service providers and health care staff must:

- Implement standard precautions;
- Use the aseptic/"no-touch" technique (page 29) during every PPIUD insertion; and
- Use high-level disinfected (HLD)/sterilized equipment, with appropriate disposal of waste after every procedure.

These measures are applied—in the appropriate setting, with staff and clients appropriately attired (Table 4)—as described below and summarized in Appendix F.

Table 4. Appropriate Setting and Attire for Infection Prevention during PPIUD Insertion

Timing	Setting	Staff Attire
Postplacental	Delivery room, the same bed used for labor and birth	• Personal protective equipment appropriate for vaginal delivery (e.g., impermeable gowns or long-sleeved gowns with rubber aprons; eye and mouth protection); elbow-length gloves are needed for manual insertion • Sterile gloves do not need to be changed before insertion if not contaminated
Intracesarean	Operating theater, procedure table	• Personal protective equipment • Sterile gloves do not need to be changed before insertion if not contaminated
Early postpartum	Clinical procedure room, procedure table	• The arms of the health care provider covered by a long-sleeved gown • Use of eye and mouth protection is optional • When using "no-touch" technique, use of clean exam gloves is sufficient

Immediately before PPIUD Insertion

- Ensure that instruments and supplies are available and ready for use (Appendix D).
- Ensure that the IUD package is unopened and undamaged and check the expiration date. (Regardless of timing or setting, the IUD package should not be opened until the final decision to insert the IUD has been made.)
- Open and arrange all sterile instruments and supplies onto a dry, sterile surface (sterile field) such as a drape/towel or steel basin. **Particular care is required immediately after delivery to ensure an adequate sterile field. Use of a separate table or stand is recommended to prevent cross-contamination with instruments used during delivery.**
- Keep the IUD to the side of the sterile field.
- For early postpartum insertion, wash or have the woman wash her perineal area with soap and water before prepping the vagina and cervix and beginning insertion. **If immediately after delivery, cleaning the perineal area gently with a sterile gauze or towel is sufficient in the absence of obvious fecal contamination.**

Note: Antiseptic preparation of the vulva, perineum and perirectal area is not required. Moreover, there is no evidence that shaving the genital area for delivery or PPIUD insertion decreases the infection rate.

- Place a dry, sterile cloth on the woman's abdomen, just above the symphysis pubis. This will protect the provider's nondominant hand from contamination as it applies upward pressure to "elevate" the uterus.
- When available, place another dry, sterile cloth between the woman's genital area and the surface of the examination table for patient comfort and to minimize the risk of contamination of sterile instruments and the IUD during insertion.
- Wash hands thoroughly with soap and water; dry them with a clean, dry cloth or allow them to air dry.
- Put HLD or sterile surgical gloves on both hands. **Remember to use elbow-length gloves for manual vaginal (versus intracesarean) insertion.**
- Using sterile gauze and a sterile sponge/ring clamp or its equivalent, apply an appropriate water-based antiseptic agent to the vagina and cervix two or more times before IUD insertion. Cleanse from the inside of the cervical opening outward.
  - The most commonly used lower genital tract antiseptics are: iodophors, such as povidone iodine, and chlorhexidine. If an iodophor is used, allow 1 to 2 minutes before proceeding with the procedure after application. Iodophors such as povidone iodine require "contact time" to act.
  - Do not use alcohol as an antiseptic in the lower genital tract. Not only is it painful for the patient, but it may also actually increase the risk of infection by drying and damaging the vaginal and cervical mucosa.
- If sterile gloves are contaminated during the antiseptic application process, change to a new pair before proceeding with insertion.

During IUD Insertion (as applicable)

- Remember that gloves that have been used to touch the perineum or vagina are contaminated and no longer sterile.
- Beginning with removing the IUD from its sterile package and throughout the procedure, use the "**no-touch**" technique to reduce the risk of contaminating the uterine cavity. Using the no-touch technique during PPIUD insertion means that the IUD is:
  - Touched only by uncontaminated sterile gloves and sterile equipment.
  - Not allowed to touch the buttock drape, the perineum, the vaginal walls or the blades of the speculum (or any other nonsterile surface that may contaminate it)
- If successful fundal placement is not achieved, or if the IUD is dislodged or removed, and a "repeat attempt" is planned, the same IUD can be reinserted unless it has been contaminated. If possible contamination of the IUD has occurred, a new IUD from a sterile package should be used; additional application of antiseptic to the vagina may also be required.

After IUD Insertion

- Before removing your gloves:
  - Place all used instruments in 0.5% chlorine solution for 10 minutes for decontamination, if not already done.

- Dispose of waste materials (e.g., cotton balls and gauze) by placing them in a leak-proof container (with a tight-fitting lid) or plastic bag.
- Immerse both gloved hands in 0.5% chlorine solution.

- Remove gloves by turning them inside out.
- Dispose of gloves by placing them in a leak-proof container or plastic bag.
- Wash hands thoroughly with soap and water; dry them with a clean, dry cloth or allow them to air dry.
- After the client has left, wipe the procedure table with 0.5% chlorine solution to decontaminate.
- Ensure that all instruments, gloves and other reusable items are further processed according to recommended infection prevention practices (Appendix F).

Clinical Technique for Insertion of the PPIUD

This section provides step-by-step guidance on four types of PPIUD insertion: during the immediate postpartum period: postplacental (1) instrumental or (2) manual insertion; (3) cesarean (manual) insertion; and (4) early postpartum (instrumental) insertion.[e] **The goal of all types of insertions is to insert the IUD safely, in a manner that reduces the risk of spontaneous expulsion.**

Tips for Reducing Spontaneous Expulsion

Right Time:

- Recommend postplacental and intracesarean insertions, which have the lowest expulsion rates.

Right Technique/Instrument:

- "Elevate" the uterus to straighten its lower segment.
- Use an instrument that is rigid enough to negotiate the vagino-uterine angle, and long enough to reach the fundus (such as a Kelly or ring forceps).
- If using an instrument:
  - Keep instrument closed until the fundus is reached.
  - Sweep instrument to the side after placing the IUD.
  - Keep instrument open while withdrawing.
- Confirm proper IUD placement.

Postplacental Instrumental Insertion

Postplacental instrumental insertion of the IUD is done immediately following delivery of the placenta, typically within 10 minutes using a Kelly or ring forceps. The woman has been counseled and prepared prior to the start of active labor, preferably during the antenatal period. The woman is in the labor/delivery room and has not yet gotten up from the delivery bed. She is still in the lithotomy position following delivery, or assumes the lithotomy position if an alternative position has been used for delivery. The insertion takes place immediately following AMTSL and the delivery of the placenta. These steps are described in full detail in Table 5 and summarized in Appendix G.

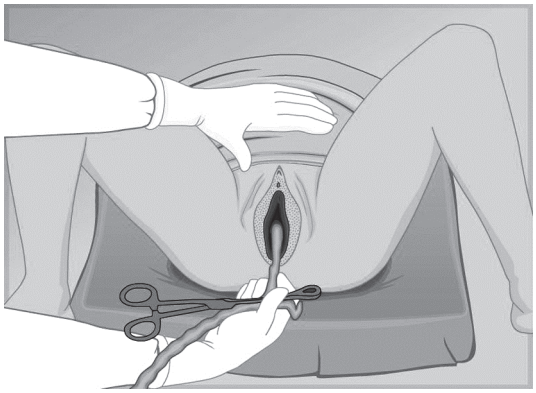
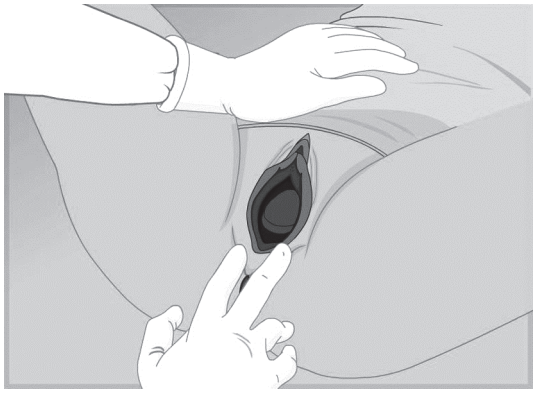
[e] **In the Learning Resource Package that accompanies this manual, checklists are included for each of the insertion procedures, which can be used in learning and assessment exercises.**

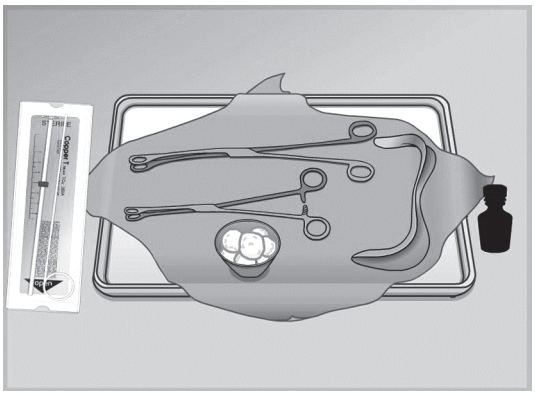
Table 5. Postplacental Insertion of the IUD Using Forceps

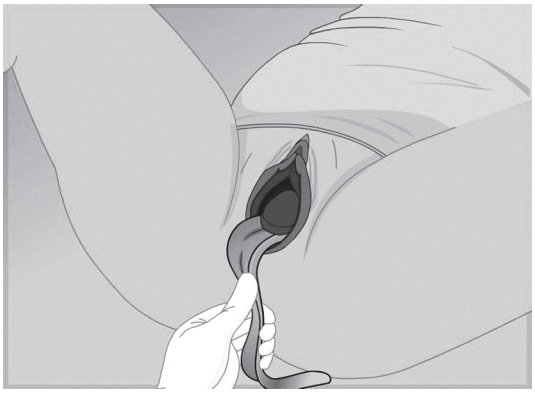
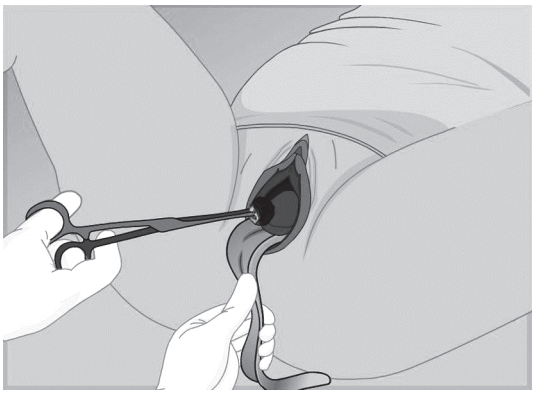
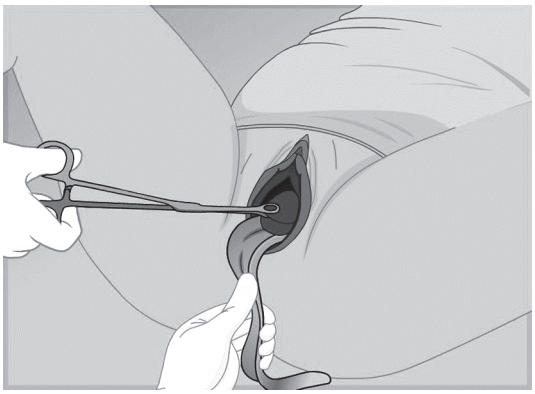
<table>
<tr><th colspan="3">Tasks to Perform before Active Labor and Delivery</th></tr>
<tr><th>No.</th><th>Step</th><th>Explanation/Additional Guidance</th></tr>
<tr><td>Steps 1–5</td><td colspan="2">Ensure that the woman has chosen to have an IUD inserted immediately postpartum, and that it is an appropriate method for her.</td></tr>
<tr><td>1.</td><td>Review the woman's medical record to ensure that she has chosen the PPIUD.</td><td rowspan="2">Before approaching the woman's bedside, the provider reviews the woman's record. If she has chosen the PPIUD, ensure that she has been:
Educated/counseled regarding PPFP and provided in-depth information about the PPIUD.
Screened for characteristics and conditions that would make the IUD a poor contraceptive choice for her (i.e., according to the WHO MEC).</td></tr>
<tr><td>2.</td><td>Ensure that she has been appropriately counseled and screened for PPIUD insertion.</td></tr>
<tr><td>3.</td><td>Greet the woman with kindness and respect.</td><td rowspan="3"> 
Talking to the woman about her choice allows her to ask questions. Women who feel supported in their decision are more likely to use the method correctly and for a longer time.</td></tr>
<tr><td>4.</td><td>Explain that you will insert the IUD immediately following delivery of the baby and placenta (if needed, remind her that this is the best time). Confirm with the woman that she still wants the PPIUD.</td></tr>
<tr><td>5.</td><td>Answer any questions the woman might have; provide reassurance, as needed. (Provide counseling, as needed.[f])

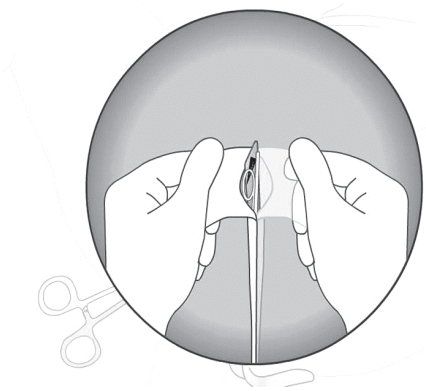
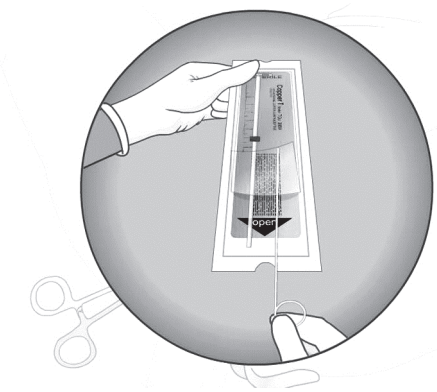
Note: Key messages that may be appropriate at this time are:
Immediate insertion is best.
She can change her mind at any time.
The IUD can be removed at any time with immediate return to fertility.</td></tr>
<tr><td>Steps 6, 7</td><td colspan="2">Ensure that supplies/equipment and sealed IUD are available and ready to use.</td></tr>
<tr><td>6.</td><td>Once the woman has confirmed that she wants the PPIUD, obtain a PPIUD kit/tray (or gather the correct sterile instruments, supplies, light source) for the procedure.</td><td>The provider should ensure that all of the items needed are available and ready to use so that there is no unnecessary delay after the placenta is delivered. Keep the tray wrapped/covered until after the birth of the baby.</td></tr>
<tr><td>7.</td><td>Obtain a sterile IUD; keep the package sealed until immediately prior to insertion.</td><td>The package should be kept sealed to maintain its sterility until it is absolutely certain the IUD will be inserted (i.e., after the woman's second screening and final confirmation).</td></tr>
</table>

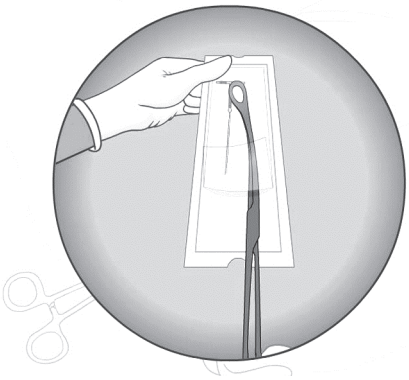
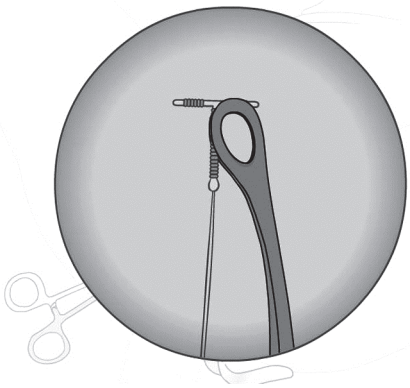
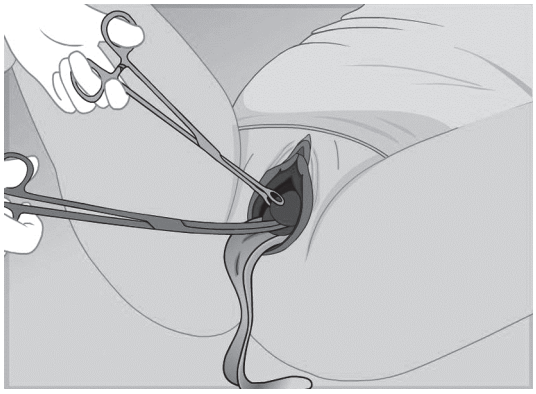
[f] **If the woman has not received an initial screening, she can still have a PPIUD. If the woman has an uneventful pregnancy and birth, it is unlikely that she has any of the conditions that would exclude the IUD as an option. The second screening addresses the most critical concerns.**

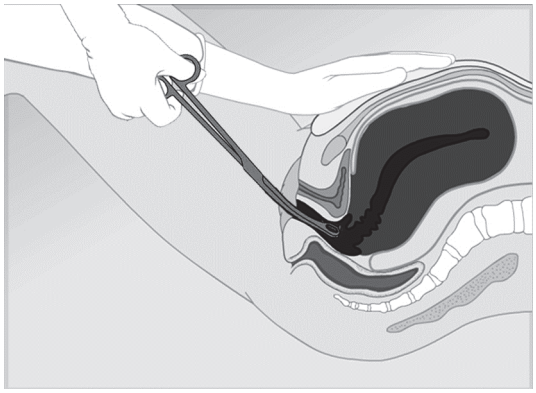
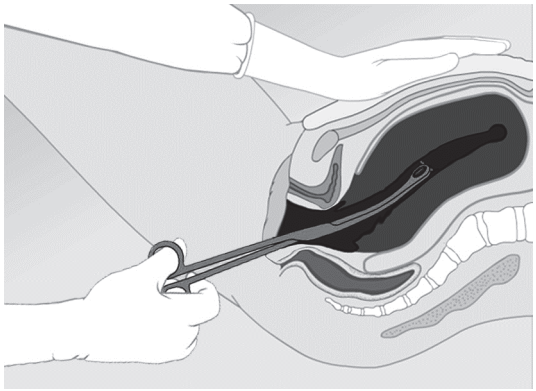
Tasks to Perform before Insertion—Pre-Insertion Tasks		
No.	**Step**	**Explanation/Additional Guidance**
Steps 8–11	***Perform AMTSL and the second screening.***	
8.	After labor and delivery (including performing AMTSL), **screen for delivery-related conditions that preclude insertion** of IUD now: ● Prolonged rupture of membranes for more than 18 hours ● Chorioamnionitis ● Unresolved postpartum hemorrhage [Further discussed on pages 26, 27; see also Appendix G.]	 ***Remember:*** *AMTSL should be performed as usual to prevent postpartum hemorrhage.* ***The processes of AMTSL and postplacental IUD insertion do not interfere with each other.***
9.	Before continuing with the second screening, **perform infection prevention measures** as appropriate: ● The provider who manages the birth and inserts the IUD does not need to change gloves. ● The provider who did not manage the birth but inserts the IUD should ensure that AMTSL has been completed, then perform hand hygiene and put on sterile or HLD gloves.	*If the same provider does the delivery and the IUD insertion, new gloves are not needed because the IUD is grasped with the Kelly forceps inside the wrapper; therefore, the provider never touches the IUD (i.e., the "no-touch" technique is used).* *However, if a different/new provider does the IUD insertion, that provider should perform hand hygiene and put on a new pair of sterile or HLD gloves.*
10.	Inspect perineum, labia and vaginal walls for lacerations. ● If there are lacerations and they are bleeding, *apply a clamp to the bleeding areas to stop the bleeding and* proceed with the IUD insertion procedure. ● Repair lacerations, if needed, after the procedure. [Further discussed on pages 26, 27.]	 *The provider does not need to delay insertion to repair minor lacerations.*
11.	**If any of the conditions exists**, speak with the woman and explain that now is not a safe time for insertion of the IUD. Counsel her and offer her another PPFP method as appropriate.	*Women who cannot receive the IUD now may be able to receive it on postpartum Day 1 or 2. Otherwise, advise the woman to return at 4 weeks postpartum for re-evaluation and possible IUD insertion; and/or assist her in choosing another PPFP method.*

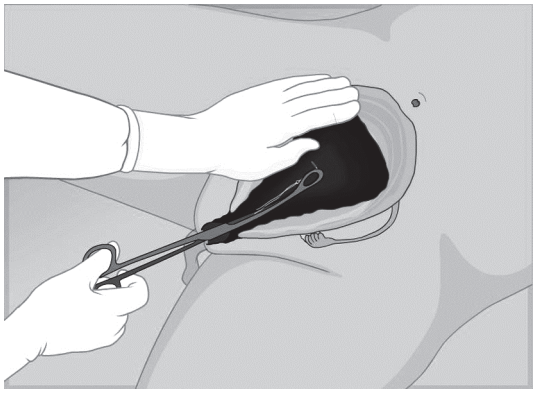
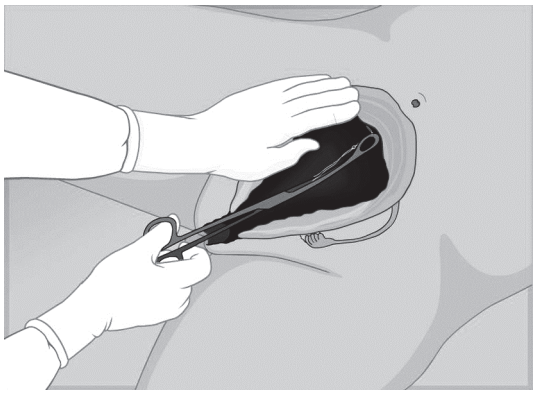
Tasks to Perform before Insertion—Pre-Insertion Tasks		
No.	**Step**	**Explanation/Additional Guidance**
Steps 12, 13	***Let the woman know that you are about to insert the IUD, if that is acceptable to her, and arrange instruments/supplies.***	
12.	If the second screening has revealed no conditions that contraindicate insertion of the IUD at this time, **ensure that the woman is ready to have an IUD inserted**. Answer any questions the woman might have; provide reassurance, as needed.	 *Just as the woman should be talked to and supported during labor and delivery, it is important continue these behaviors throughout the IUD insertion procedure.*
13.	Open the PPIUD kit/tray and **arrange insertion instruments and supplies** in a sterile field. Keep the IUD in its sterile package to side of the sterile field. Place a dry, sterile cloth on the woman's abdomen.	 *To prevent infection, it is critical that all instruments and supplies have been properly processed and are protected in a sterile field. The IUD should be to the side because it is in a package whose exterior is not sterile. The sterile towel on the woman's abdomen will protect the provider's hand from contamination while "elevating" the uterus.*

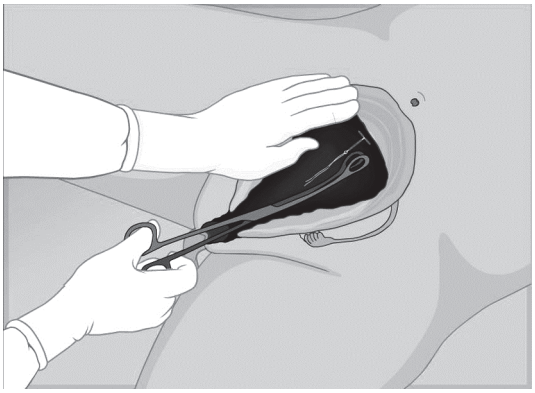
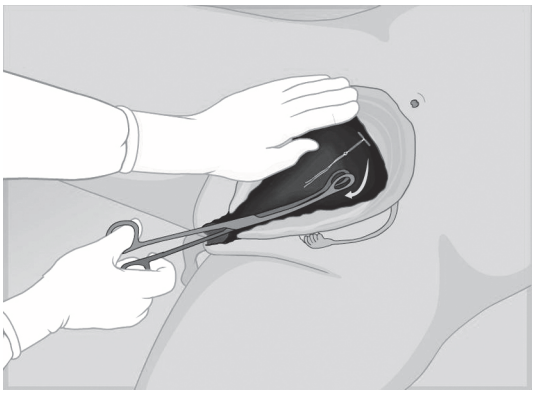
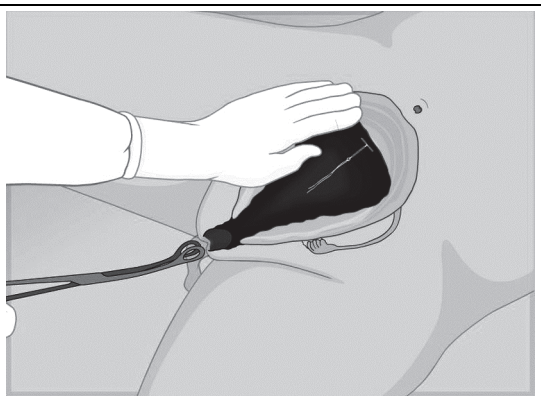
Insertion of the IUD		
No.	**Step**	**Explanation/Additional Guidance**
Steps 14–16	***Prepare the woman's vagina and cervix for insertion.***	
14.	Gently **insert the Simms speculum and visualize the cervix** by depressing the posterior wall of the vagina. (Note: If the cervix is not easily seen, gently apply fundal pressure so that the cervix descends and can be seen.)	 *The provider holds the Simms or other appropriate speculum in her/his left (or nondominant) hand and uses it to visualize the cervix.* *It is usually not necessary to have an assistant hold the speculum in place, but if the provider is having difficulty, an assistant may use the retractor to gently visualize the cervix.*
15.	**Clean the cervix and vagina** with antiseptic solution two times, using two gauzes (a separate gauze each time).	 *Using betadine or chlorhexadine to gently clean the cervix and edges of the vagina helps to prevent infection.*
16.	**Gently grasp the anterior lip of the cervix** with the ring forceps. (The speculum may be removed at this time, if necessary.) Let the forceps out of your hand, keeping them attached to the cervix.	 *The same ring forceps that was used to clean the cervix and edges of vagina can be used to grasp the anterior lip of the cervix and apply gentle traction.*

Insertion of the IUD		
No.	**Step**	**Explanation/Additional Guidance**
Steps 17–19	***Open the IUD package and remove IUD.***	
17.	**Open the sterile package of the IUD** from the bottom, by pulling back the plastic cover approximately one third of the way.	 *The "no-touch" technique for removing the IUD from the package (Steps 17 to 19) helps to ensure that the IUD remains perfectly sterile throughout the insertion procedure.*
18.	**Remove everything except the IUD from the package:** ● Holding the IUD package at the closed end with the nondominant hand, stabilize the IUD in the package by pressing it between the fingers and thumb of the nondominant hand—through the package. ● With the other hand, remove the plunger rod, inserter tube and card from the package.	 *The plunger rod and inserter tube are not needed for the postpartum insertion of the IUD. The card will not be needed until later.*

Insertion of the IUD		
No.	**Step**	**Explanation/Additional Guidance**
Steps 17–19	***Open the IUD package and remove IUD. (cont.)***	
19.	With your dominant hand, use the placental forceps to **grasp the IUD inside the sterile package.**	 *As shown below, the IUD should be held just at the edge of the placental forceps so that the IUD will be easily released from the forceps when they are opened at the uterine fundus.* 
Steps 20, 21	***Insert the IUD gently, using the "no-touch" technique.***	
20.	**Gently lift the anterior lip of the cervix** using the ring forceps, adjusted to one notch.	Lifting the anterior lip opens the cervical os to allow the IUD to pass through.
21.	• **While avoiding touching the walls of the vagina**, insert the placental forceps**—**which are holding the IUD—through the cervix and into the lower uterine cavity. • **Gently move the IUD further into the uterus**, toward the point where slight resistance is felt against the back wall of the lower segment of the uterus. **Be sure to keep the placental forceps firmly closed**. • **Lower the ring forceps and gently remove them from the cervix**; leave them in the sterile field.	 *Limiting the extent to which the IUD comes in contact with the vaginal walls helps to prevent infection. Keeping the placental forceps firmly closed helps avoid dropping the IUD midcavity during insertion. Forceps are placed in the sterile field in case they are needed again.*

Insertion of the IUD		
No.	**Step**	**Explanation/Additional Guidance**
Steps 22–24	***"Elevate" the uterus and advance the placental forceps toward the umbilicus—to negotiate the vagino-uterine angle—until the fundus is reached.***	
22.	**"Elevate" the uterus:** ● Place the base of your nondominant hand on the lower segment of the uterus (midline, just above the pubic bone with the fingers toward the fundus). ● Through the abdominal wall, push the entire uterus superiorly (in the direction of the woman's head). ● Maintain this position to stabilize the uterus during insertion.	*This maneuver, elevating the uterus, is done to smooth out the angle between the uterus and the vagina so that the instrument can easily move upward toward the uterine fundus.*  

Insertion of the IUD		
No.	**Step**	**Explanation/Additional Guidance**
Steps 22–24	***"Elevate" the uterus and advance the placental forceps toward the umbilicus—to negotiate the vagino-uterine angle—until the fundus is reached. (cont.)***	
23.	**Keeping the forceps closed, advance the IUD by:** • Gently moving the IUD upward toward fundus, in an angle toward the umbilicus. • Lowering the dominant hand (the IUD/forceps-holding hand), so that the forceps can pass easily through the vagino-uterine angle. • Following the contour of the uterine cavity. • **If significant resistance is felt before the fundus is reached**, the provider should try repositioning the uterus (again, by gently pushing it upward) and re-attempt to advance the instrument.	 *The provider moves the instrument upward in the uterus, following an arc toward the umbilicus, to negotiate the angle between the vagina and uterus more easily. Even though the angle has been lessened by "elevation" of the uterus (Step 22), insertion still requires careful technique.* ***Note: Throughout this part of the procedure, the provider should (1) take care not to apply excessive force*** *(if not careful, the provider could perforate the back wall of the uterus); and* ***(2) always keep the instrument closed*** *so that the IUD is not inadvertently dropped in the midportion of the uterine cavity.*
24.	**Continue gently advancing the forceps until the uterine fundus is reached**, when you will feel a resistance. Confirm that the end of the forceps has reached the fundus.	 *When the instrument reaches the uterine fundus, the provider will feel resistance. She/he may also be able to feel the instrument at the fundus with her/his nondominant hand through the abdominal wall.* ***Note:*** *An added advantage of the Kelly placental forceps is that the broad ring at the distal end makes it extremely unlikely that the forceps will perforate the uterine fundus.*

Insertion of the IUD		
No.	**Step**	**Explanation/Additional Guidance**
Steps 25–27	***Release the IUD at the fundus and withdraw the forceps, being careful not to dislodge the IUD.***	
25.	While continuing to stabilize the uterus, **open the forceps**, tilting them slightly toward midline, to release the IUD at the fundus.	 *Keep the nondominant hand in position to maintain stabilization of the uterus. This aids in proper placement of the IUD.*
26.	**Keeping the forceps slightly open, slowly remove them from the uterine cavity,** being careful not to dislodge the IUD. Do this by: ● Sweeping the forceps to the side wall of the uterus, and ● Sliding the instrument against the side of the uterine wall.	 *If the forceps close and/or catch the strings of the IUD, the forceps can inadvertently pull the IUD down from its fundal position, and increase the risk of expulsion.*
27.	**Keep stabilizing the uterus until the forceps are completely withdrawn.** Place the forceps aside, in the sterile field.	 *Forceps are returned to the sterile field in case they are needed again.*

Insertion of the IUD		
No.	**Step**	**Explanation/Additional Guidance**
Steps 28, 29	***Examine the cervix and begin processing instruments.***	
28.	**Examine the cervix** to see whether any portion of the IUD or the IUD strings are protruding from the cervix. **If the IUD or the IUD strings are seen protruding from cervix**: ● Remove the IUD using the same forceps used for the first insertion; ● Position the same IUD in the forceps inside the sterile package (as in Steps 18 and 19); and ● Reinsert the device (repeating Steps 20–27).	*It is important to check that the IUD is not visible at the cervical os. If it is visible, or if the strings appear to be very long, then the IUD has not been adequately placed at the fundus and the chance of spontaneous expulsion is higher.* *The same IUD can be reinserted if it has not been contaminated.*
29.	**Remove all instruments and place them in a 0.5% chlorine solution.**	*This is the first step in infection prevention processing. Forceps should be "open"; all instruments should be totally submerged.*
Tasks to Perform after Insertion		
No.	**Step**	**Explanation/Additional Information**
Steps 30–33	***While the woman rests, continue infection prevention measures.***	
30.	**Allow the woman to rest for a few minutes. Support the initiation of routine postpartum care**, including immediate breastfeeding as appropriate.	*The woman should rest on the table for several moments following the insertion procedure. Routine care for the mother and baby become the provider's focus now.*
31.	**Dispose of waste materials** in the appropriate container(s).	*Because this insertion has taken place immediately after a vaginal delivery, the provider should follow all routine delivery-related infection prevention practices, as well as those described earlier in this chapter.*
32.	**Process gloves prior to removal and disposal**. ● Immerse both gloved hands in 0.5% chlorine solution. ● Remove gloves by turning them inside out and properly dispose of them.	
33.	**Perform hand hygiene.**	

Tasks to Perform after Insertion		
No.	**Step**	**Explanation/Additional Information**
Steps 34–36	***Provide post-insertion counseling and update records.***	
34.	**Tell the woman that the IUD has been successfully placed and provide her with post-insertion counseling**, including IUD instructions. Tell her these instructions will be provided again prior to discharge. **Reassure her and answer any questions that she may have.**	 *IUD instructions should be provided again by the staff of the postpartum unit to the woman, and perhaps to her family, to be certain that the instructions are understood. If possible, instructions should also be provided to the woman in writing, for her to take home.*
35.	**Record information in the woman's chart or record. Attach an IUD card** to the chart/record, for the woman to take home with her upon discharge.	*Including essential information regarding the IUD insertion in the woman's record (and on a card she can take with her) helps facilitate appropriate clinical follow-up, including proper timing for removing the IUD and inserting a new one or switching to a different family planning method, as the woman desires.*
36.	**Record information in the procedure room register.**	*Basic information should also be recorded, along with contact information, in a PPIUD register to ensure that the PPFP/PPIUD program is being successfully implemented.*

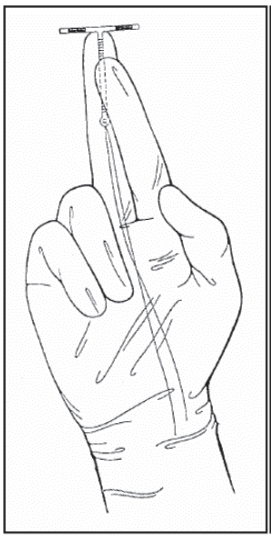
Postplacental Manual Insertion

Following a service delivery scenario similar to that for postplacental instrumental insertion, manual insertion of the IUD—using the provider's own hand—is also done immediately following delivery of the placenta, typically within 10 minutes. Key differences are highlighted in the box below.

For postplacental manual insertion, use elbow-length sterile or HLD gloves and supplement Steps 19 to 27 in the illustrated guide "*Postplacental Insertion of the IUD Using Forceps*" (pages 31–41), with the following:

- Grasp and hold the IUD by gripping its vertical rod between the index and middle fingers of the dominant hand (Figure 8).
- Move the nondominant hand up onto the abdomen. Stabilize and "elevate" the uterus with firm upward pressure through the abdominal wall.
- Slowly insert the IUD-holding hand into the vagina and through the cervix. Limit the extent to which the IUD comes in contact with the vaginal walls.
- Gently move the IUD-holding hand in an upward motion toward the fundus (in an angle toward the umbilicus), taking care to follow the contour of the uterine cavity.
- By feeling the uterus through the abdominal wall, confirm with the abdominal hand that the IUD-holding hand has reached the fundus.
- Release the IUD at the fundus and slowly remove the hand from the uterus. Take particular care not to dislodge the IUD as the hand is removed.
- Keep the nondominant hand in place to stabilize the uterus until the other hand is completely out of the uterus.

Figure 8. Manual IUD Insertion



Intracesarean Insertion

For intracesarean insertion, the woman has been counseled and prepared prior to the start of the operation, preferably during the antenatal period. She will still be in the operating theater, in the lithotomy position on the operating table. Typically, manual insertion is sufficient (as opposed to instrumental insertion) because the provider can easily reach the uterine fundus. After the placenta is removed, the provider:

- Holds the IUD between the index and middle fingers of the hand, passes it through the uterine incision and places it at the uterine fundus;
- Slowly withdraws the hand, ensuring that the IUD remains properly placed; and
- Closes the uterine incision, taking special care not to incorporate the IUD strings into the suture.

Note: The strings can be pointed toward the cervix but should NOT be pushed through the cervical canal. This helps prevent both uterine infection (caused by contamination of the uterine cavity with vaginal flora) and displacement of the IUD from the fundus (caused by drawing the strings downward toward the cervical canal).

Early Postpartum Insertion

Early postpartum insertion is done after the immediate postplacental period has passed but within 48 hours of the birth. If the woman has not yet received counseling, a designated family planning counselor or postpartum caregiver can provide group PPFP education/counseling on the postpartum ward, followed by individual PPIUD counseling to women who are interested in the method. The same postpartum caregiver or another trained provider can insert the IUD in a procedure or examination room on the postpartum ward. It is preferable that postpartum insertion be done within 24 hours of birth—for example, on the morning of postpartum Day 1, rather than Day 2—to reduce expulsion rates and also to avoid logistical issues at the time of postpartum discharge.

Postpartum insertion is essentially the same as postplacental instrumental insertion, but the process of uterine involution is under way and several anatomic changes that may have an influence on the instruments or technique used should be noted:

- **The cervix will have become firmer and will begin to resume its round, tubular shape.** For this reason, manual insertion is not possible and should not be attempted. These changes may also have an impact on which type of forceps works best.
  - Although the ring forceps can still be used to grasp the cervix, slightly more pressure may be required to close them (on the cervix).
  - If the provider notes some difficulty in passing the Kelly placental forceps through the cervix, due to the width of the distal ring of the instrument in relation to the dilation of the cervix, she/he should consider using a second ring forceps to introduce the IUD. The provider should ensure that the ring forceps are long enough to reach the fundus. It is possible that a normal ring forceps will be sufficient, depending on how much involution of the uterus has taken place.
- **The uterus has begun to resume its original anteverted or retroverted position;** therefore, it may become slightly more difficult to advance the instrument through the uterus to the fundus. However, it is still critically important to reach the uterine fundus. Failure to reach the uterine fundus is likely a principal factor in the higher spontaneous expulsion rates that occur following early postpartum insertion compared to immediate postplacental insertion. Additional care should be taken.
  - The provider must ensure that the IUD is placed at the uterine fundus and should visually examine the cervix following insertion.
  - If the IUD is visible, or if the strings seem inappropriately long, the provider should consider whether the IUD is at the fundus. If there is doubt, it is better to remove the IUD and reinsert it.

Immediate Post-Insertion Care and Counseling

After the insertion procedure, global standards/local protocols for postpartum and newborn care should be observed. The woman who has just had an IUD inserted should have additional counseling, focused on correct use of the IUD, timely management of problems that may occur and return for follow-up. (Management of IUD/PPIUD-related problems is covered in the next chapter.) This counseling should be done by the provider who inserted the IUD when the woman is rested and able to concentrate.

- For women who receive a postplacental or an intracesarean insertion, counseling is best done the following day, when the woman has rested and is better able to concentrate.
- If the insertion was done in the early postpartum period (not immediate but within 48 hours), the post-insertion counseling can be done shortly after the insertion.

Immediate Care

The client should be advised to report any of the following, which should be promptly addressed:

- **Increase in vaginal bleeding.** Vaginal hemorrhage related to uterine atony should be managed—per global standards/local protocols—with uterine massage and uterotonics, as necessary. Note that the PPIUD does not increase the risk of uterine atony.

- **Severe uterine cramping.** If this persists after PPIUD insertion, a speculum or bimanual exam should be performed to check for partial or complete expulsion. (See page 48.)
- **Feeling feverish.** Fever should prompt a full clinical evaluation to determine the source. In the presence of presumed endometritis, an accepted antibiotic regimen should be used for treatment. (See page 49.) Note that it is not necessary to remove the IUD while treating presumed endometritis.

Take-Home Messages

Provide reassurance and advise the woman to:

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

When to Return

Before discharge, the following **danger signs** should be highlighted. The client should be advised to call or return to the facility immediately for assessment if any of these signs occur:

- Heavy vaginal bleeding
- Severe lower abdominal discomfort
- Fever
- Not feeling well

The client should also call or come in if any of the following occur:

- Unusual vaginal discharge is present.
- IUD expulsion is suspected—woman can either feel IUD in the vagina or has seen it expelled from the vagina.
- She has any other problems/questions related to her IUD.
- She wants the IUD removed or 12 years have elapsed since IUD insertion.

Reminder Card for the PPIUD Client
If possible, give the client a card with the following information in writing:

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

7. Routine Follow-Up of the PPIUD User and Management of Potential Problems

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

Once the IUD is in place, patient care and advice are almost identical for women who have had an interval or a postpartum insertion. Routine follow-up for many PPIUD users (at 4 to 6 weeks) may involve little more than answering questions and reinforcing key messages. Some users, such as those who are bothered by side effects, may require additional care and support. Serious problems related to IUD use are uncommon, but when they do occur, prompt and appropriate management is essential.

Routine Follow-Up Care for PPIUD Clients

Key objectives of follow-up care are to:

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

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

- Ask the client if she has experienced any problems and if she thinks the IUD has fallen out.
- Do a clinical assessment for anemia if she complains of excessive or prolonged bleeding.
- If possible, perform a speculum examination to see whether the IUD strings have descended into the vagina. If they appear long, trim them so that approximately 3–4 cm of string protrudes from the cervix.

- Conduct a pelvic examination only if the following conditions are suspected: an STI or PID, suspected partial or complete expulsion, pregnancy. Routine pelvic examination at any subsequent follow-up visit is not required.
- Provide counseling and treatment for side effects, as needed.
- Advise the client to return if she is concerned about possible IUD-related problems or if she wants it removed or to change to another family planning method.
- Review danger signs that indicate a need to return to the clinic immediately.
- Remind the client to keep monitoring for possible IUD expulsion during/after her first few menstrual periods.
- Encourage use of condoms for STI protection, as appropriate.

If the IUD has been expelled, offer the client another contraceptive method or plan to insert another IUD, if she wishes. The IUD may be reinserted the same day as expulsion if: there is no sign of infection; pregnancy is not suspected; and it is NOT between 48 hours and 4 weeks after the client's delivery.

If the IUD is in place and the client has no problems, no other follow-up visits are required. Annual checks of the IUD are not necessary. Clients should be advised to return for removal as desired but no later than the recommended length of pregnancy protection (12 years for the Copper T).

Who Should Do It/Where

If possible, the provider who did the insertion should do the clinical follow-up, at the same facility where the insertion was done. This helps to ensure the client continuity of care; it also enables the provider to see the clinical results of his/her care and establish a "personal expulsion rate"—with the aim of strengthening his/her technique as needed. Follow-up also greatly enhances the ability to track a PPFP/PPIUD program's success and make improvements as necessary. Information from the insertion registers should be available during follow-up, so that there can be correlation of findings. (A sample data collection form is included as Appendix K.)

If it is not possible or practical for follow-up to be done by the same provider at the same facility, it can be done by a provider clinically oriented to PPIUD services in a facility that has the minimum set-up needed for conducting counseling and performing pelvic exams—as well as referral capacity for ultrasound, as needed. Ideally, the provider/facility would be able to report back on the findings to the originating PPFP/PPIUD program.

When It Should Be Done

The WHO currently recommends at least one postpartum visit by 6 weeks after delivery.[41] This is a good opportunity for women who have had an IUD inserted in the immediate/early postpartum period to receive PPIUD follow-up services because by 6 weeks postpartum, the uterus has undergone complete involution. In any case, PPIUD follow-up should happen within the first 3 months postpartum, because the majority of expulsions occur during this time.

Identification and Management of Common Side Effects and Potential Problems[42]

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

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

Some problems that may arise, however, require specific management. The purpose of the guidelines provided in Table 6 is to assist the health care provider in providing appropriate support for a woman who experiences such side effects or problems. In most cases, the woman can continue to use the IUD while awaiting or undergoing evaluation. Some of the problems associated with IUD use that require specific management include:

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

General management principles are as follows:

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

Table 6. Identification and Management of Common Side Effects and Problems Encountered at Follow-Up

Problem (Signs/Symptoms)	Explanation	Management
Changes in Menstrual Bleeding Patterns • Increase in amount of menstrual bleeding above what is usually expected in the postpartum period • Increase in duration of menstrual bleeding above what is usually expected in the postpartum period • Spotting/light bleeding between periods once they resume postpartum	Changes in menstrual bleeding patterns are a common side effect among IUD users, regardless of timing of insertion. In the first 6 weeks postpartum, such changes may be masked by the usual irregular bleeding and spotting associated with uterine involution during the postpartum period. Also, for a woman who is exclusively breastfeeding her baby, amenorrhea is likely up to 6 months—whether or not she is using an IUD. Menstrual changes caused by the IUD are usually not harmful to the woman and diminish or disappear within the first few months after IUD insertion. If, however, these symptoms are severe, persistent or accompanied by certain other signs/ symptoms, they require special follow-up.	• Determine severity of symptoms: how much more bleeding than usual; how long have symptoms lasted; when did the symptoms start; are they accompanied by other symptoms (e.g., pain, fever); how well is the woman tolerating them? • If symptoms are mild and consistent with uterine involution, provide reassurance. • Where appropriate, rule out other gynecologic pathology and refer her to a qualified practitioner, if indicated. • Where appropriate, rule out pregnancy by history or available testing. • Where appropriate, check for IUD expulsion: palpate strings on bimanual exam or by using a speculum. • If client desires treatment, offer a short course of NSAIDs, continued for 3 to 5 days. If heavy bleeding is the problem, aspirin should not be used because it has an anti-blood-clotting effect. • If bleeding is persistently heavy and prolonged or associated with clinical or laboratory signs consistent with severe anemia (e.g., pallor, weakness), offer iron replacement therapy and consider IUD removal with the patient's consent. • If client finds bleeding unacceptable, remove IUD and counsel her regarding alternative methods of family planning.
Cramping or Pain • Increased cramping or pain that may or may not be associated with menstruation	Mild intermittent cramping may occur in the first few weeks after IUD insertion, but is generally masked by the usual cramping associated with uterine involution postpartum ("afterpains"). Increased cramping and pain may also be noted with return of menstruation and is a common side effect among IUD users. Special follow-up is needed if symptoms are bothersome, severe or associated with other signs/symptoms.	• Determine severity of symptoms: how severe is pain; how long has pain lasted, when did pain start; is pain accompanied by other symptoms (e.g., bleeding, fever); how well is the woman tolerating the pain? • Perform an appropriate assessment, including: vital signs, abdominal and pelvic examination and appropriate laboratory studies (pregnancy test; complete blood count [CBC], cultures) to rule out other possible causes of pain or infection; partial IUD expulsion, such as: uterine perforation; pregnancy/ectopic pregnancy; urinary tract infection. If appropriate, see section for management of infection (page 49) and pregnancy with the IUD in place (page 51). • If symptoms and physical findings are mild and consistent with postpartum uterine involution, reassure the woman. • Recommend a short course of NSAIDs immediately before and during menstruation to help reduce menstrual pain and cramping that are bothersome to the client. • If cramping or pain is severe, remove the IUD. If the IUD was improperly placed, partly expelled or appeared to be abnormal/distorted, discuss insertion of a new IUD with the client. If the IUD appeared to be normal and in proper position, counsel the woman regarding alternative forms of family planning.

Problem (Signs/Symptoms)	Explanation	Management

Infection
• Lower abdominal pain
• Fever
• Painful intercourse
• Bleeding after sex or between periods once resumption of normal monthly menses has occurred postpartum
• New onset of pain associated with periods
• Abnormal vaginal discharge
• Nausea and vomiting
	Although the risk of infection after interval IUD insertion is very low, it is highest within the first 20 days of insertion and is generally thought to be related to concurrent gonorrhea or chlamydia infection. Similar risk estimates are not available for PPIUD insertion, but studies suggest the risk is very low. Because pelvic infection can lead to infertility and other serious problems, providers should treat all suspected cases. Of note, the IUD should never be inserted when puerperal infection such as chorioamnionitis or endometritis is suspected.	• Perform an appropriate assessment, including: vital signs, abdominal and pelvic examination and appropriate laboratory studies (pregnancy test, CBC, cultures) to rule out other problems, such as: endometritis, appendicitis, partial IUD expulsion, uterine perforation, pregnancy/ectopic pregnancy or urinary tract infection. If appropriate, see section for management of pregnancy with the IUD in place (page 51).
		• Suspect PID if any of the following signs/symptoms are found and no other causes can be identified:
		  • Lower abdominal, uterine or adnexal tenderness (tenderness in the ovaries or fallopian tubes)
		  • Evidence of cervical infection: yellow cervical discharge containing mucus and pus, cervical bleeding when it is touched with a swab, positive swab test
		  • Tenderness or pain when moving the cervix and uterus during bimanual exam (cervical motion tenderness)
		  • Other possible sign/symptoms: purulent cervical discharge, enlargement or hardening (induration) of one or both fallopian tubes, a tender pelvic mass, pain when the abdomen is gently pressed (direct abdominal tenderness) or when gently pressed and then suddenly released (rebound abdominal tenderness)
		• If endometritis or PID is suspected, begin treatment immediately with an appropriate antibiotic regimen per global standards/local protocols for gonorrhea, chlamydia and anaerobic infections. Remove the IUD only in the presence of sepsis or if symptoms do not improve within 72 hours. Studies have not indicated that removing the IUD affects outcomes of PID treatment.[34]
		  • If the woman does not want to keep the IUD in during treatment, remove the IUD 2 to 3 days after antibiotic treatment has begun.
		• Where appropriate and when an STI is suspected, counsel the woman regarding condom use for protection against future STIs and recommend treatment for the partner.

Problem (Signs/Symptoms)	Explanation	Management

IUD String Problems (Missing, Long, Short)	Missing or longer or shorter-than-expected strings may indicate a variety of problems, including pregnancy, IUD expulsion and IUD malpositioning. Sometimes there is no real problem at all—it is simply that the strings have not descended yet. In some circumstances, the IUD strings may never descend through the cervix into the vagina following postpartum insertion.
	
	Because strings are not trimmed at postpartum insertion, they typically extend well into the middle of the vagina and perhaps all the way to the vulva by 4 to 6 weeks postpartum.
	
	Remember: IUD strings are not related to efficacy; their purpose is to facilitate removal and confirmation of intrauterine positioning only.
		Missing Strings (Appendix I presents a job aid for managing missing strings.)
		• Ask the woman if she thinks the IUD has fallen out.
		• Rule out pregnancy by history or laboratory examination.
		• Probe the cervical canal using an HLD or sterile cervical brush or narrow forceps (e.g., Bose, alligator) to locate the strings and gently draw them out so that they are protruding into the vaginal canal.
		• If the strings are not located in the cervical canal, refer the woman for an X-ray or ultrasound to confirm normal intrauterine positioning. Provide a back-up method while waiting for results. Manage as appropriate based on findings:
		  • If the IUD is located inside the uterus and the woman wants to keep the IUD, do not remove it. Explain to her that the IUD is still protecting her from pregnancy but that she will no longer be able to feel the strings. Review signs and symptoms of spontaneous expulsion.
		  • If the IUD is located inside the uterus and the woman wants it removed, refer her for IUD removal by a specially trained provider.
		  • If the IUD cannot be visualized in the uterus or the peritoneal cavity, manage as complete IUD expulsion (below).
		
		Long Strings
		Trim strings, as needed, up to 3–4 cm from cervical os.
		
		Short Strings (if Bothersome to Woman or Partner)
		• Reassure the woman and her partner that the strings are very flexible and not harmful.
		• If it is very bothersome, advise the woman that the IUD strings can be cut shorter, so that the string curves around the cervical lip. Trim as needed.

Problem (Signs/Symptoms)	Explanation	Management

Partial or Complete IUD Expulsion
• New onset of irregular bleeding and/or cramping
• Expelled IUD seen (complete expulsion)
• IUD felt/seen in the vaginal canal (partial expulsion)
• Delayed or missed menstrual period (See **Pregnancy with an IUD in Place,** below.)
• Missing or longer strings (See IUD string problems, page 50.)
	Partial or complete IUD expulsion can occur "silently" (with no signs/symptoms) or it may be associated with other signs/symptoms, such as: missing or longer than expected IUD strings, or a delayed or missed menstrual period. The following guidelines address management of confirmed partial or complete IUD expulsions.	• Conduct an appropriate assessment, including: pelvic examination to rule out other possible causes of symptoms such as infection and pregnancy.
		• When other possible causes of symptoms are ruled out, manage based on findings.
		  • If complete expulsion of the IUD is confirmed (e.g., seen by the woman, confirmed by X-ray or ultrasound): replace IUD immediately, if desired and appropriate (not pregnant or infected), or counsel for alternative family planning method.
		  • If partial IUD expulsion is confirmed (e.g., felt/seen by the woman or clinician): remove the IUD and replace it, if desired and appropriate (not pregnant or infected), or counsel for alternative family planning method.
		  • If the IUD appears to be embedded in the cervical canal and cannot be easily removed in the standard fashion: refer the woman for IUD removal by a specially trained provider.
		• If complete expulsion of the IUD is confirmed and pregnancy diagnosed, manage ANC per national and regional standards.

Pregnancy with an IUD in Place[43]
• Delayed or missed menstrual period
• Other signs/symptoms of pregnancy
• Missing strings
• Strings that are shorter or longer than expected
	Although the IUD is one of the most effective forms of reversible contraception, failures can occur. Approximately one-third of IUD-related pregnancies are due to undetected partial or complete expulsion of the IUD. When pregnancy does occur with an IUD in place, ectopic pregnancy must be ruled out and the IUD should be removed. If the IUD is left in place during pregnancy, there is an increased risk of preterm labor, spontaneous abortion and septic abortion.	• Confirm pregnancy and trimester. If the woman is in her second or third trimester of pregnancy, manage according to global standards/local protocols and refer to an appropriate provider, if needed.
		• Rule out ectopic pregnancy: sharp/stabbing abdominal pain (which is often unilateral), abnormal vaginal bleeding, light-headedness/dizziness, fainting. If ectopic pregnancy is suspected, immediately refer/transport the woman to a facility with surgical capability.
		• When ectopic pregnancy has been ruled out, and if the pregnancy is in the first trimester:
		  • Counsel the woman on the benefits and risks of immediate removal of the IUD. Removing the IUD slightly increases the risk of miscarriage; leaving the IUD in place can cause second trimester miscarriage, infection and preterm delivery.
		  • If the woman requests removal, proceed with immediate removal if the strings are visible and the pregnancy is in the first trimester. If the strings are not visible, do an ultrasound to determine whether the IUD is still in the uterus or has been expelled. If the IUD is still in place, it cannot be safely removed. Follow, as below, with plans to remove the IUD at delivery.
		  • If the woman declines removal, provide support and care per standard global guidelines/local protocols and arrange close monitoring of the pregnancy by a qualified provider. Stress the importance of returning to the clinic immediately if she experiences signs of spontaneous abortion or infection (e.g., fever, low abdominal pain, and/or bleeding) or any other warning signs. Plan to remove the IUD at delivery.

8. PPIUD Clinical Services

Provision of PPIUD services requires careful coordination and collaboration of antenatal, intrapartum and postpartum care services—both in the community and the facilities.

Provision of PPIUD clinical services can only be safely accomplished in a clinical facility that has adequate infrastructure, supplies/equipment and personnel. Although counseling and assessment may take place during normal working hours through the ANC delivery system, insertion of the PPIUD—especially using the postplacental or intracesarean approaches—can take place at any time, day or night. For this reason, PPIUD services must be integrated with the delivery care system for intrapartum care; all personnel of the obstetrics/maternity care team should be oriented to PPIUD service provision. This helps to ensure that counseling messages are uniform and consistent, and that accurate information is disseminated during the period when PPIUD services are being established, both of which are key to generating demand.

Each program and clinical facility will determine which insertion technique is appropriate for implementation based on its staffing and service delivery capacity as well as on national and local norms and policies.

Considerations for Starting a PPIUD Program

Any facility that provides basic obstetric care, including intrapartum care services, can be prepared to offer PPIUD clinical services to women. It is recommended that clinical services be provided by a health care provider—such as a midwife, nurse or doctor—who has been trained to competency in PPIUD service provision.

During the initial analysis of a facility to determine the best way to establish PPIUD services, it is important to review the patterns of care, clinical volume and staff responsibilities. Consider the following factors that will be important to address during program start-up:

- Where are family planning services provided now? Is there an existing mechanism for providing family planning to women in the postpartum ward? How can IUDs be made available on the labor and delivery unit?
- Who currently provides family planning counseling and services? Will different or the same providers provide PPIUD services? What experiences do these providers have in counseling and IUD insertion techniques?
- Where do women who deliver at this facility receive their ANC? Is it in the clinic of this same facility or from an outside network of health centers? How can communication about the woman's postpartum contraceptive choice be communicated to the staff of this facility?
- Do many women who deliver at this facility arrive having received no ANC? Will they be managed or counseled differently from women who have received care at this facility?
- What is the current volume of maternity patients? What is the anticipated number of PPIUD insertions on a monthly basis? If volume is low, how will trained providers maintain their clinical skills in insertion technique?
- How will records be maintained? What is the existing recordkeeping system for deliveries and family planning visits? Are any elements of those recordkeeping systems similar?
- With what information will the woman leave the facility after the postpartum insertion of the IUD?

Careful planning and consideration of these factors will help facility managers to introduce and successfully establish PPIUD services.

PPIUD insertion during cesarean section or immediately following delivery of the placenta is preferred because expulsion rates are lower, and this timeframe is more convenient for the woman. However, certain facilities may be well-equipped to provide these services to clients on the postpartum ward, during the early postpartum period. In this service delivery context, dedicated counselors and service providers can review the situation and family planning needs of women on the postpartum ward and provide care in a planned and directed manner.

Minimum Criteria for PPIUD Service Provision

The **minimum service delivery criteria** for the safe and effective provision of PPIUD services include:

- ***Informed demand:*** This is critical to the success of PPIUD program. Women, families and communities need accurate, understandable and timely information about the PPIUD in order to make an informed choice about PPFP options. Although this information may come through group education and individual counseling targeting PPFP clients, it may also be provided through other health services, mass media campaigns, community health workers/volunteers or peer recommendations. Demand also helps maintain the flow of PPIUD clients, which enables providers to maintain skill competency and develop proficiency.
- ***Infrastructure:*** An outpatient care area for both antenatal screening and counseling as well as postpartum follow-up and evaluation; an intrapartum care area, where deliveries are conducted and postplacental insertions can take place; and an examination/treatment room on or near the postpartum ward, where early postpartum insertions can take place.
- ***Supplies:*** A delivery/examination table with footrests (or an area for the woman to place her feet); insertion instruments such as a Simms speculum, ring forceps and long forceps (e.g., Kelly placental forceps); sterile towels, sterile or HLD gloves (including long gloves if the manual insertion technique is to be practiced); antiseptic solution, such as povidone iodine (i.e., Betadine®) or chlorhexidine gluconate (i.e., Savlon® or Hibiclens®); and IUDs in their sterile packaging.

PPIUD programs will benefit from having "PPIUD insertion kits" already prepared and wrapped in sterile trays. This facilitates both the safety and efficiency of the procedure.

- ***Personnel:*** A clinical service provider, such as a midwife, doctor or nurse, who regularly attends to women in labor and who has been trained to competency in the provision of PPIUD services, including counseling, infection prevention, insertion/removal techniques and management of side effects or complications.
- ***Coordination of care:*** A system of communication and sharing of information between the ANC service, the labor/delivery unit, the postpartum ward and the outpatient postpartum care unit.
- ***Management systems:*** Adequate integration of all of the above so that services are provided in a manner that ensures continuity of care, good counseling, appropriate infection prevention practices and adequate follow-up.

Using Performance Standards for PPIUD Services

Performance standards break down the tasks that a specific skill or skill set comprises into observable steps. Achievement of each standard can be verified by certain verification criteria, using a tool in a modified checklist format. This tool can serve as a self-empowering guide—by service providers, supervisors and program managers—for establishing and maintaining high-quality PPIUD services.

- Service providers can use the PPIUD Performance Standards assessment tool (Appendix J) as a way to develop and assess their or their colleagues' clinical performance. This tool can also be used as a job aid.
- Supervisors can use the assessment tool as a specific and detailed way of providing oversight of PPIUD services. This can allow them to provide specific feedback to providers and managers about what is being done well and the areas that may need additional attention.
- Sequential measurement of performance compared to the standards allows program managers and district/state officials to monitor the quality of service over time and be able to compare performance of facilities in a quantifiable manner.

Recordkeeping

After insertion of the IUD, the provider should make several notations in the woman's record, as well as in a delivery or PPIUD insertion logbook/register. In addition, when the woman returns for follow-up, the provider should make notations; if any problem is identified at this time, the insertion logbook/register should be consulted to identify factors that could have predicted or caused the problem. A sample data collection form is included as Appendix K.

Maintaining careful records is critical to building a successful PPIUD program. This is because client selection criteria and insertion technique are directly related to expulsion rate and, thus, potentially, to overall program success. If it appears that a larger than expected number of clients are returning with partially or completely expelled IUDs, it is helpful to be able to review notations recorded at the time of insertion (e.g., findings from screenings, difficulties faced by the provider). Likewise, follow-up notations can also provide critical insights—into both successful and problematic insertions. Either way, recordkeeping allows program managers and supervisors to observe provider insertion and client assessment practices and to determine whether changes are needed.

Appendix A: Key Messages for Healthy Spacing of Pregnancies

	For clients who desire a next pregnancy after a live birth	For clients who desire a next pregnancy after a miscarriage or induced abortion	For clients who desire a pregnancy and are adolescents (<18 years)
Return to Fertility	If you are not exclusively breastfeeding, return to fertility may occur within 4 to 6 weeks of childbirth. **If you do not want to become pregnant,** start a family planning method of your choice shortly after birth.	Fertility may return as early as 2 weeks after a miscarriage or abortion. **If you do not want to become pregnant,** start a family planning method of your choice immediately after miscarriage or abortion.	
Exclusive Breastfeeding	Exclusive breastfeeding up to 6 months postpartum can prevent fertility from returning. If you are practicing LAM (of which exclusive breastfeeding is just one of three essential criteria), fertility may return when: ● The baby is 6 months of age OR ● You are no longer exclusively breastfeeding OR ● Your menses have returned **If you do not want to become pregnant,** start a family planning method of your choice immediately when any of these criteria are no longer met.		
Pregnancy Spacing	For the health of the woman and the baby, wait at least 24 months, but not more than 5 years, before trying to become pregnant again. **If you do not want to become pregnant,** use a family planning method of your choice during that time.	For the health of the woman and the baby, wait at least 6 months before trying to become pregnant again. **If you do not want to become pregnant,** use a family planning method of your choice during that time.	For your health and your baby's health, wait until you are at least 18 years of age before trying to become pregnant. **If you do not want to become pregnant,** use a family planning method of your choice until you are 18 years old.

Appendix B: PPFP Counseling Job Aids

JOB AID: COUNSELING GUIDE—ATTRIBUTES OF PPFP METHODS			
Methods	**Advantages**	**Limitations**	**Client Assessment/Considerations**

PPIUD	• Available right after delivery—no delay
	• Like interval IUD:
	  • >99% effective
	  • Immediate return of fertility upon removal
	  • Short-acting or long-acting protection
	  • No additional supplies/materials or user action needed (up to 12 years)
	  • Reduces overall risk of ectopic pregnancy (by preventing pregnancy)
		• May have heavier, more painful menses, especially first few cycles; often less noticeable for postpartum women
		• Slightly elevated risk of expulsion
		• Like interval IUD, does not protect against STIs, including HIV
		• Like interval IUD, requires clinical procedure
			• Not appropriate for women who have:
			  • Cervical cancer or trophoblastic disease
			  • Uterine distortion (fibroids, septum)
			  • Increased risk of having gonorrhea/chlamydia
			  • AIDS and not clinically well or not on antiretroviral therapy
			• Not appropriate for postpartum women with certain conditions resulting from labor and delivery
			• Must be inserted within 48 hours of delivery.

Progestin-Only Pills	• More effective if used by women who are also breastfeeding
	• About 99% effective
	• No delay in return of fertility after stopping pills
		• Pill must be taken every day, at the same time
		• Woman may experience bleeding changes
		• Does not protect against STIs, including HIV
			• Not appropriate for women who:
			  • Have cirrhosis or active liver disease
			  • Take medications for tuberculosis or seizures
			  • Have a blood clot in legs or lungs now
			  • Have a history of breast cancer
			• Provide supply before discharge.
			• Woman should start 6 weeks postpartum.

Condom	• Can prevent against pregnancy and some STIs (including HIV) • Can use once couple resumes intercourse	• Must have reliable access to resupply • About 85% effective	• Must be used with EVERY act of sex. • Must be used correctly every time. • A supply can be provided before discharge.
Postpartum Tubal Ligation	• Permanent method of family planning • >99% (not 100%) effective • Simple procedure; serious complications are rare	• Does not protect against STIs, including HIV • Requires surgical procedure	• For women who are certain they want no more children • Hospital must be set up to offer the surgery. • Can be done in first 7 days postpartum.

LAM
 	
Encourage breastfeeding for all women
	• Good for mother and newborn
	• 98.5% effective if all three criteria met
	• No side effects
	• Start immediately after birth
	• No additional supplies/materials
		• Does not protect against STIs, including HIV
		• Short-acting method—reliable for 6 months
			• Effective if ALL three criteria are met:
			  1. Exclusive breastfeeding on demand, day and night, with no food or other fluids given
			  2. Monthly bleeding has not returned
			  3. Baby is less than 6 months old
			• Transition to another contraceptive method if any one of three criteria is not met

Vasectomy	• Permanent method of family planning • >99% (not 100%) effective • Safe, simple procedure; serious complications are rare • Procedure does not require hospitalization	• Does not protect against STIs, including HIV • Requires outpatient surgical procedure	• For couples who are certain they want no more children • 3-month delay in taking effect • Can be done at any time • Does not affect male sexual performance

JOB AID: COUNSELING GUIDE—TIMING OF PPFP METHODS

Appendix C: Medical Eligibility Criteria for IUD/PPIUD Use[g]

CATEGORY 1 CONDITIONS *Use the method in any circumstance*	CATEGORY 2 CONDITIONS *Generally use the method*
• **Immediate postplacental or during cesarean section** • **More than 4 weeks postpartum** • Postpartum <48 hours • Age: >20 years • Parity 1 or more • Irregular menstrual bleeding (metrorrhagia) without heavy menstrual bleeding • History of ectopic pregnancy • Cigarette smoking • Obesity • Cardiovascular disease risk factors • Hypertension or history of hypertension • Thrombembolic disease (past or current) • Hyperlipidemias • Uncomplicated valvular heart disease • Headaches (any type) • Epilepsy • Depression • Benign ovarian tumors • Cervical intraepithelial neoplasia • Benign breast disease or breast cancer • Women taking antibiotics or anticonvulsants • Thyroid, liver or gallbladder disease or diabetes • Malaria • Non-pelvic tuberculosis • History of PID (with subsequent pregnancy) • Previous pelvic surgery, including previous cesarean section	• Age: menarche to <20 years • Nulliparity • Heavy or prolonged vaginal bleeding • Complicated valvular heart disease [**Note**: Use antibiotic prophylaxis prior to insertion in a woman who has complicated valvular heart disease.] • Lupus on immunosuppressive therapy • Endometriosis • History of PID (with subsequent pregnancy) • High risk of HIV • Women who are HIV-positive and on antiretroviral therapy • Anemia (thalassemia or iron-deficiency)

[g]Although the MEC has been updated in recent years to provide clearer guidance on use of the IUD in general, specific information about the PPIUD is limited. Therefore, it is necessary to review the MEC with respect to the use of the IUD in the postpartum period and to expand the list of conditions for which the IUD might or might not be appropriate. Although the focus of the initial screening includes the more established, general criteria for IUD use, the second screening focuses on these expanded criteria (which appear in *bold*).

CATEGORY 3 CONDITIONS *Generally, do not use the method unless other more appropriate methods are not available or not acceptable*	**CATEGORY 4 CONDITIONS** *Do not use the method*
• **Between 48 hours and 4 weeks postpartum** • **Chorioamnionitis** • **Prolonged rupture of membranes (PROM) >18 hours*** • **Extensive genital trauma where insertion may disrupt the repair*** **[Note: This only applies to insertion on postpartum Day 1 or 2]** • AIDS, but no antiretroviral therapy or no access to care • High individual risk of chlamydia and gonococcal infection (partner has current purulent discharge or STI) • Ovarian cancer • Benign trophoblastic disease • Lupus with severe thrombocytopenia	• **Puerperal sepsis** • **Postpartum endometritis** • **Unresolved postpartum hemorrhage*** • Pregnancy (known or suspected) • Unexplained vaginal bleeding • Current PID, gonorrhea, or chlamydia • Acute purulent (pus-like) discharge • Distorted uterine cavity • Malignant trophoblastic disease • Known pelvic tuberculosis • Genital tract cancer (cervical or endometrial)

***These conditions are not specifically mentioned in the WHO MEC; however, their inclusion is considered a prudent interpretation of that publication.**

Appendix D: Supplies and Equipment Needed for PPIUD Services

ANTENATAL CARE/COUNSELING

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

POSTPLACENTAL OR INTRACESAREAN INSERTION[h]

- Counseling materials (as described above), if necessary
- Pre-insertion Screening Job Aid (Appendix E)
- Table or tray for instruments and supplies:
  - Long placental forceps (33 cm) for insertion
  - Ring forceps for grasping the cervix
  - Retractor or Simms speculum
  - Gauze pads/cotton balls
  - Antiseptic solution, such as povidone iodine (i.e., Betadine®) or chlorhexidine gluconate (i.e., Savlon® or Hibiclens®)
- Sterile or HLD gloves
- IUD in its sterile package
- Sterile towels (2)
- Data collection form (Appendix K)
- PPIUD Insertion Register
- PPIUD discharge instructions card to give to the woman

EARLY POSTPARTUM INSERTION

- Counseling materials (as described above), if necessary
- Pre-Insertion Screening Job Aid (Appendix E)
- Table or tray for instruments and supplies (as described above)
- Sterile or HLD gloves
- IUD in its sterile package
- Sterile towels (2)
- Data collection form (Appendix K)
- PPIUD Insertion Register
- PPIUD discharge instructions card to give to the woman

FOLLOW-UP

- Data collection form (Appendix K)
- Follow-Up Register
- Supplies for performing speculum exam as needed:
  - Simms or Cusco or Graves speculum
  - Long forceps
  - Scissors
- Medications for management of common complaints
  - Ibuprofen (400 mg) tablets
  - Iron tablets

[h]**Other standard supplies for labor and delivery are not mentioned here.**

Appendix E: Job Aid for Second PPIUD Screening

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

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

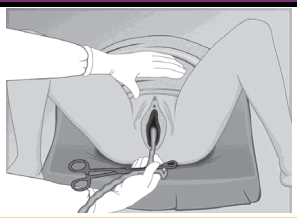
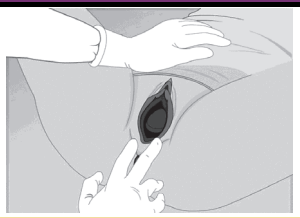
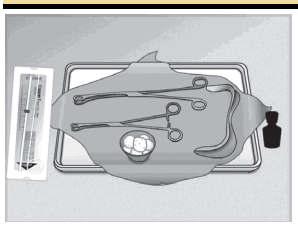
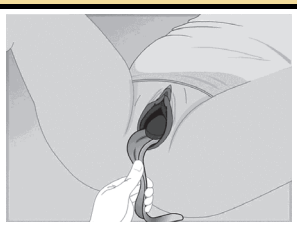
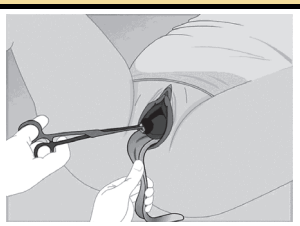
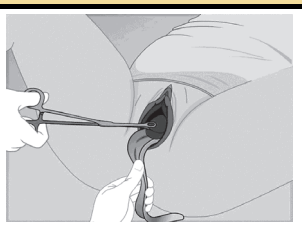
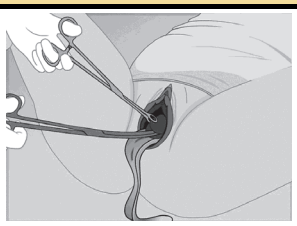
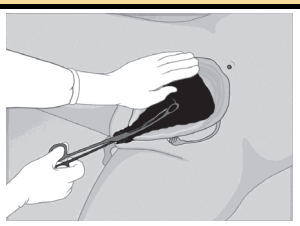
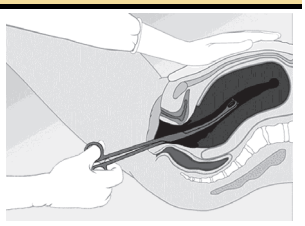
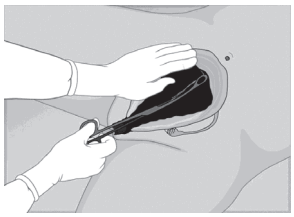
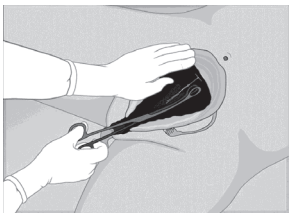
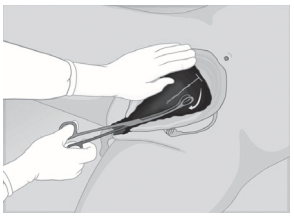
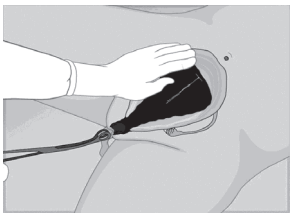
*If correct instruments or sterile IUDs are not available, proceed with IUD insertion if they become available within an appropriate time period.

Appendix F: Summary of Steps for Processing Instruments and Other Items Used in PPIUD Services[44]

Item	Decontamination	Cleaning	HLD	Sterilization
	First Step in Handling Dirty Instruments; Reduces Risk of Hepatitis B and HIV Transmission	Removes All Visible Blood, Body Fluids and Dirt	Recommended Method of Final Processing; Destroys All Viruses, Bacteria, Parasites, Fungi and Some Endospores	Alternative Method of Final Processing; Destroys All Microorganisms Including Endospores
Examination table top and other large surface areas	Wipe off with 0.5% chlorine solution.	Wash with soap and water if organic material remains after decontamination.	Not necessary	Not necessary
Instruments used for IUD insertion or removal (e.g., speculum, placental/ring forceps, retractor/speculum)	Soak in 0.5% chlorine solution for 10 minutes before cleaning. Rinse or wash immediately.*	Using a brush, wash with soap and water. Rinse with clean water. If they will be sterilized, air or towel dry and package.	• Steam or boil for 20 minutes. • Chemically high-level disinfect by soaking for 20 minutes. Rinse well with boiled water and air dry before use or storage.	• Dry heat for 1 hour after reaching 170°C (340°F), or • Autoclave at 121°C (250°F) and 106 kPa (15 lb/in^2) for 20 minutes (30 minutes, if wrapped).
Storage containers for instruments	Soak in 0.5% chlorine solution for 10 minutes before cleaning. Rinse or wash immediately.**	Wash with soap and water. Rinse with clean water, air or towel dry.	Boil container and lid for 20 minutes. If container is too large: • Fill container with 0.5% chlorine solution and soak for 20 minutes. • Rinse with water that has been boiled for 20 minutes and air dry before use.	• Dry heat for 1 hour after reaching 170°C (340°F), or • Autoclave at 121°C (250°F) and 106 kPa (15 lb/in^2) for 20 minutes (30 minutes, if wrapped).

*If unwrapped, use immediately; if wrapped, may be stored up to 1 week before use.
**Avoid prolonged/excessive exposure to chlorine solution (more than 20 minutes, more than 0.5%) to minimize corrosion of instruments and deterioration of rubber or cloth products.

Appendix G: Job Aid for Instrumental PPIUD Insertion Steps

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

*This maneuver will help straighten the lower uterine segment and vagino-uterine angle for ease of insertion.

Appendix H: Guidelines for IUD Removal[38,43]

IUD removal is usually an uncomplicated and relatively painless routine procedure. Unless an IUD is removed for a medical reason or because the woman wishes to discontinue the method, a new IUD can be inserted **immediately** after removing the old one, if she so desires. Appropriate assessment and care, before and after the procedure, depend on the reason for IUD removal, and whether the woman is having another IUD inserted or is starting a different method. Use proper infection prevention practices.

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

Before Removing the IUD

- Ask the woman her reasons for having the IUD removed:
  - If the woman wants her IUD removed for **personal reasons** (or offers **no reason at all**), remove her IUD. The woman has a right to discontinue the method at any time, regardless of the reason.
  - If the woman is having her **IUD replaced** (i.e., at the end of its effective life), ensure that she has undergone appropriate assessment to determine whether she is eligible for IUD reinsertion at this time.
  - If she is having the IUD removed for **medical reasons** (e.g., pregnancy, dangerously heavy menstrual bleeding), ensure that she has undergone the appropriate assessment to determine whether routine IUD removal is safe for her at this time. Refer for special removals, if needed.
  - If she will be **starting a different method**, ask when her last menstrual period began. This will help determine whether she will need to use a back-up method.
- Ensure that she understands the following key points about having her IUD removed, as appropriate:
  - "You can get pregnant again immediately after IUD removal."
  - "If you do not want to become pregnant, you should have another IUD inserted immediately or start another contraceptive method."
  - "No rest period is needed between IUDs."
- Review her reproductive goals and need for protection against STIs.
- Help her choose a different contraceptive method, if appropriate.

Removing the IUD

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

STEP 1: Prepare the client:

- Give the woman a brief overview of the procedure, encourage her to ask questions, and provide reassurance as needed.
- Remind her to let you know if she feels any pain.

STEP 2: Put new/clean examination or HLD surgical gloves on both hands.

STEP 3: Insert an HLD (or sterile) speculum and visualize the cervix and the IUD strings.

- If the strings cannot be seen, **manage as Missing Strings** (Appendix I).

STEP 4: Cleanse the cervix and vagina with an appropriate antiseptic: Thoroughly apply an appropriate antiseptic (e.g., povidone iodine or chlohexidine) two or more times to the cervix (wiping from inside the os outward) and vagina. If povidone iodine is used, ensure that the woman is not allergic to iodine and wait 2 minutes for the solution to act.

STEP 5: Alert the woman immediately before you remove the IUD:

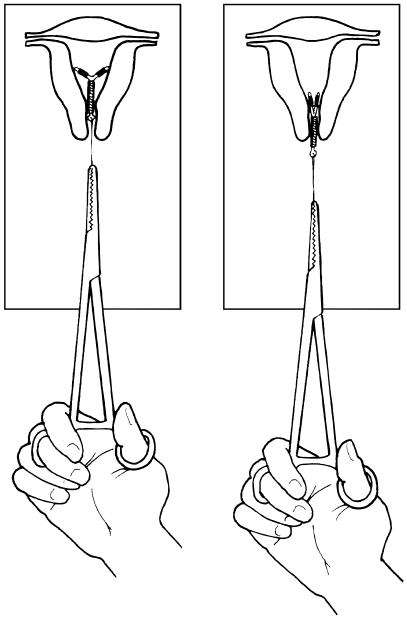
- Ask her to take slow, deep breaths and relax.
- Inform her that she may feel some discomfort and cramping, which is normal.

Do **not** use force at any stage of this procedure.

STEP 6: Grasp the IUD strings and apply gentle traction:

- Grasp the strings of the IUD with a high-level disinfected (or sterile) narrow forceps (Figure I-1, Left panel).
- Apply steady but gentle traction, gently pulling the strings toward you with the forceps (Figure I-1, Right panel). (The device can usually be removed without difficulty.)
  - If the strings break off but the IUD is visible, grasp the device with the forceps and remove it.
  - If removal is difficult, **do not use excessive force!** See box below for guidance on managing this problem.

Figure I-1 Removing the IUD



Guidelines for Difficult IUD Removals

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

- Attempt a gentle, slow twisting of the IUD while gently pulling.
- Continue as long as the woman remains comfortable.
  - If the IUD can still not be removed, refer the woman to a specially trained provider who can dilate the cervix.

If there seems to be a sharp angle between the uterus and cervix:

- Place a high-level disinfected (or sterile) tenaculum on the cervix, and apply gentle traction downward and outward.
- Attempt a gentle, slow twisting of the IUD while gently pulling.
- Continue as long as the woman remains comfortable.
  - If the IUD can still not be removed, refer the woman to a specially trained provider who can dilate the cervix.

STEP 7: Show the woman the IUD, and place it in 0.5% chlorine solution for 10 minutes for decontamination.

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

After Removing the IUD

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

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

  - If the woman is starting a new contraceptive method, it should be provided now—along with a back-up method if needed.

Appendix I: Protocol for Management of Missing PPIUD Strings

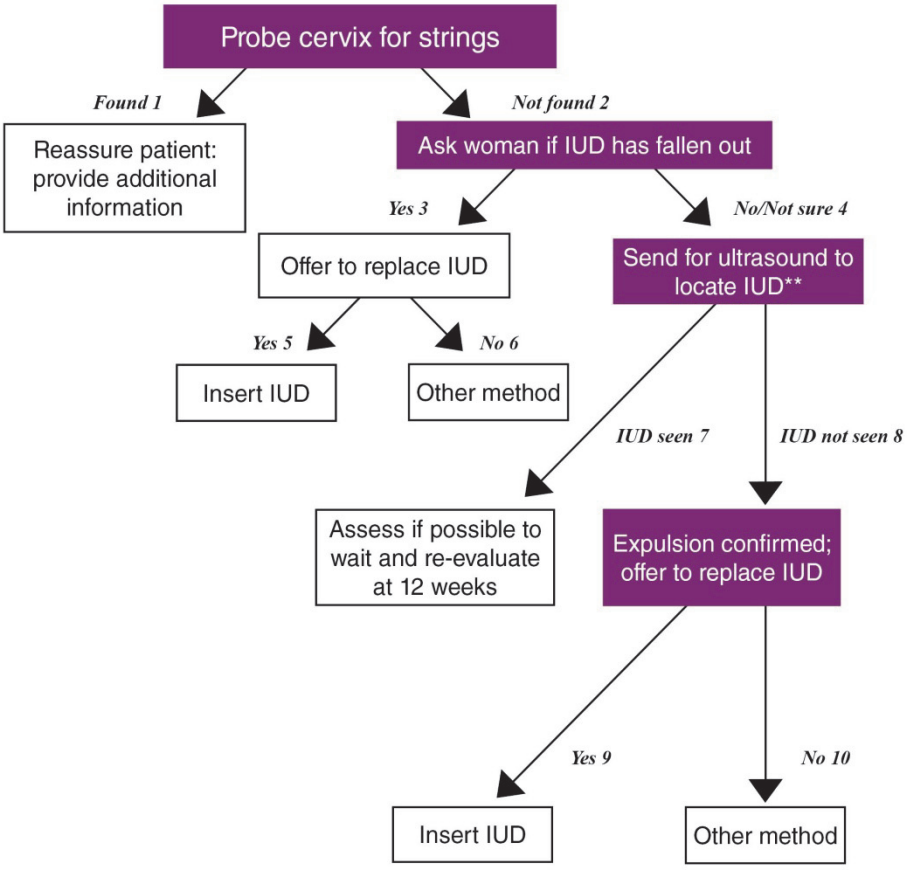
Case # _____
Date _____

Protocol for Management of Missing PPIUD Strings*

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

Check action taken

1 ☐ 2 ☐
3 ☐ 4 ☐
5 ☐ 6 ☐
7 ☐ 8 ☐
9 ☐ 10 ☐
11 ☐
12 ☐
13 ☐



* If strings not seen at 3 months, repeat the protocol from start. If strings still not found, either:
1. Reassure and follow-up *11*
2. Remove IUD with hook and replace *12*

** Consider X-ray of abdomen instead of, or to augment, findings of ultrasound *13*

Appendix J: Performance Standards for PPIUD Counseling and Services[i]

Performance Standards for PPIUD Counseling and Services			
Number	**Area**	**Performance Standards**	
		Number	**Total**
1	PPFP/PPIUD education and counseling and initial client screening during ANC; follow-up care/return visits	**1–8**	**8**
2	PPFP/PPIUD education and counseling and client assessment during early/inactive labor or the postpartum period	**9–3**	**5**
3	IUD insertion	**14–21**	**8**
4	Management of PPIUD services and recordkeeping	**22–26**	**5**

[i]**Sources for these performance standards include the Jhpiego Family Planning Performance Standards for Afghanistan, the WHO/CCP's *Family Planning: A Global Handbook for Providers* and the Postpartum IUD training materials by Acquire/Engender Health.**

FACILITY:_____

ASSESSMENT TEAM:_____ **DATE:**_____

Performance Standards	Verification Criteria	Y/N, N/A[j]	Y/N, N/A	Comments
Area 1: PPFP/PPIUD Education and Counseling and Initial Client Screening during ANC; Follow-Up Care/Return Visits				
Instructions for the Assessor: Observe standards 1–6 in sequence with two women receiving PPFP counseling during an ANC visit. Observe provision of care to at least two women for standards 7 and 8.				
1. Provider/counselor uses recommended counseling techniques for PPFP during ANC.	**Observe in the appropriate clinical services area with client that the provider/counselor:**			
	• Shows respect for the woman and helps her feel at ease.			
	• Encourages the woman to explain needs, express concerns and ask questions.			
	• Includes the woman's husband or an important family member, with the woman's consent.			
	• Listens carefully.			
	• Respects and supports the woman's informed decisions.			
	• Checks to be sure the woman understands PPFP counseling messages.			
2. Provider/counselor provides information on benefits of healthy pregnancy spacing (or limiting, if desired) and explores the woman's knowledge about (postpartum) family planning methods.	**Observe that the provider/counselor:**			
	• Explores woman's knowledge about the benefits of pregnancy spacing.			
	• Asks about previous family planning methods used and knowledge about all family planning methods (LAM, progestin-only pills, postpartum ligation, condoms and the PPIUD).			
	• Addresses any related needs such as protection from STIs, including HIV and support for condom use.			

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

Performance Standards	Verification Criteria	Y/N, N/A[j]	Y/N, N/A	Comments
Use the ***PPFP Counseling Job Aids*** (Appendix B) to facilitate this task.	• Corrects misinformation.			
	• Discusses the woman's situation, her plans and what is important to her about a method.			
	• Helps the woman consider suitable methods. If needed, helps her reach a decision.			
	• Supports the woman's choice.			
3. Provider/counselor does a brief screening to determine whether the IUD is an appropriate method for the woman interested in a PPIUD.	**If the woman is interested in the PPIUD, observe that the provider/counselor:**			
	• Determines that the woman does not have any of the following conditions:			
	• Malignant trophoblastic disease			
	• Cervical, endometrial or ovarian cancer			
	• Abnormalities of the reproductive tract/uterine fibroids that distort the uterine cavity			
	• Pelvic tuberculosis			
	• Increased personal risk of having gonorrhea or chlamydia infection			
	• AIDS and not clinically well or not on antiretroviral therapy			
	• If none of the above conditions are present, tells the woman that she is likely eligible to use the IUD.			
	• Proceeds with method-specific counseling for this method. *[NOTE: The woman will be reassessed immediately postpartum for other conditions resulting from labor/delivery that may make the IUD a poor choice for her at this time.]*			

Performance Standards	Verification Criteria	Y/N, N/A[j]	Y/N, N/A	Comments
4. Provider/counselor gives method-specific information about the IUD.	**Observe that the provider/counselor:**			
	• Uses visual aids (poster, demonstration IUD) during counseling.			
	• Discusses key information with the woman:			
	◦ How effective the IUD is: prevents almost 100% of pregnancies			
	◦ How the IUD prevents pregnancy: causes a chemical change that damages the sperm BEFORE the sperm and egg meet			
	◦ How the IUD is used: inserted after delivery and then requires no additional care (Ensure that the woman knows it can be inserted at other times as well.)			
	◦ How long the IUD prevents pregnancy: up to 12 years (Copper T 380A)			
	◦ How the IUD can be removed at any time by a trained provider and fertility will return immediately			
	• Provides information about when the woman should come back.			

Performance Standards	Verification Criteria	Y/N, N/A[j]	Y/N, N/A	Comments
5. Provider/counselor gives the woman more specific information about the PPIUD (e.g., advantages, limitations, when to return).	**Observe that the provider/counselor:**			
	• Discusses the following advantages:			
	• Immediate placement after delivery			
	• No action required by the woman			
	• Immediate return of fertility upon removal			
	• Does not affect breastfeeding			
	• Long-acting and reversible: can be used to prevent pregnancy for a short time or as long as 12 years.			
	• Discusses the following limitations:			
	• Heavier and more painful menses, especially the first few cycles (may not be as noticeable to the postpartum woman because of the recovery process)			
	• Does not protect against STIs, including HIV			
	• Small risk of perforation			
	• Higher risk of expulsion when inserted postpartum (but this risk can be minimized through immediate [postplacental, intracesarean] insertion, using appropriate technique and instruments)			
	• Discusses the following warning signs and explains that the woman should return to the clinic as soon as possible if she has any of the following:			
	• Foul-smelling vaginal discharge, different from the usual lochia			
	• Lower abdominal pain, especially if accompanied by not feeling well, fever or chills			
	• Concerns that she might be pregnant			
	• Concerns that the IUD has fallen out			

Performance Standards	Verification Criteria	Y/N, N/A[j]	Y/N, N/A	Comments
6. Provider/counselor annotates the woman's medical record to alert other care providers that she has chosen the PPIUD.	**Observe that the provider/counselor:**			
	• Makes a notation of which PPFP method has been chosen.			
	• Documents on ANC record/card that the woman has been counseled and has requested the PPIUD.			
	• Instructs the woman that, when she comes in labor to deliver, she should tell the provider in the facility that she wants an IUD after delivery.			
	• Gives the woman the card that shows she has consented to postpartum insertion of the IUD.			
Note: In reality, between Steps 6 and 7, the women has had her baby, undergone AMTSL (following vaginal delivery), had an IUD inserted and been discharged from the facility with instructions to return at 6 weeks for routine follow-up, or whenever she has problems or concerns.				
7. The provider conducts follow-up care/return visits appropriately.	**Observe that the provider:**			
	• Greets the woman politely.			
	• Identifies the purpose of the visit.			
	• Ensures privacy and confidentiality.			
	• Allows the woman to ask questions.			
	• Asks if the woman has concerns or problems related to the IUD.			
	• Enquires about breastfeeding (if applicable).			
	• Asks the woman whether she has resumed sexual relations and whether she has concerns that she might be at increased risk of exposure to STI/HIV. Describes and offers condoms for dual protection, as appropriate.			
	• Where possible, performs pelvic examination and documents presence and length of string.			
	• Trims string, if appropriate or desired by the woman.			
	• Reminds the woman to return, if needed, and that she can have the IUD removed at any time at her request.			
	• Documents this and other information from visit in the chart.			

Performance Standards	Verification Criteria	Y/N, N/A[j]	Y/N, N/A	Comments
8. The provider identifies women with problems and manages complications, as necessary. A more detailed discussion of management of side effects and complications is found in *Family Planning: A Global Handbook for Providers* (WHO and CCP 2007).	**Observe that the provider:**			
	• Asks the woman if she is experiencing any side effects or problems with the PPIUD.			
	• If side effects and/or problems are identified, conducts brief assessment and provides initial management: (noted here) and either manages accordingly or refers for additional treatment.			
	• *Heavy vaginal bleeding:* provides explanation and reassurance, assesses for anemia, performs pelvic exam, provides NSAIDs (ibuprofen 400 mg twice daily for 5 days), provides iron tablets. Aspirin should not be used because it has an anti-blood-clotting effect.			
	• *Irregular bleeding:* provides explanation and reassurance, provides NSAIDs (ibuprofen 400 mg twice daily for 5 days), provides iron tablets.			
	• *Low abdominal pain or cramping:* assesses for endometritis by palpating abdomen and observing vaginal discharge, provides explanation and reassurance, provides NSAIDs (ibuprofen 400 mg twice daily for 5 days).			
	• *Severe lower abdominal pain:* assesses for ectopic pregnancy or pelvic infection.			
	• *Fever and purulent vaginal discharge:* performs pelvic exam, assesses for pelvic infection. (Note: it is not necessary to remove the IUD during treatment)			
	• *Suspected pregnancy:* performs pelvic exam, assesses for pregnancy.			
	• *Suspected expulsion:* performs pelvic exam: if the IUD is partially expelled, removes and replaces it; if the IUD is not found, asks the woman if the IUD was expelled (offers replacement or another method); if the IUD is not found and the woman is unaware of expulsion, considers X-ray or ultrasound.			
	• *String problems:* too long—trims strings; not found—assesses for expulsion. Considers ultrasound to check location of the IUD.			
	• If initial management approaches are not effective, refers the woman for additional evaluation and management, as necessary.			
	• Offers to remove the IUD for any woman who requests to have it removed.			

Performance Standards	Verification Criteria	Y/N, N/A[j]	Y/N, N/A	Comments
Area 2: IUD Counseling and Client Assessment during Labor or Postpartum Period				
Instructions for the Assessor: Observe provision of service to at least one woman for each of standards 9, 10 and 11. Observe provision of care to at least two women for standards 12 and 13.				
9. The provider re-confirms with the <u>laboring</u> woman that she has chosen the IUD for postpartum family planning.	**Observe that the provider:**			
	• Greets the patient (and her companion, if present) with respect.			
	• Introduces self to the patient (and her companion, if present).			
	• Confirms the patient identifier information (name, date of birth).			
	• If the woman is in labor, is sensitive to the woman's discomfort and pauses the discussion during contractions/labor pains.			
	• Determines, using the ***Pre-Insertion Screening Job Aid***, that the woman meets criteria for postplacental insertion.			
	• Has had family planning counseling when not in active labor.			
	• Has indicated consent.			
	• Insertion can occur immediately following delivery.			
	• Determines that the IUD is appropriate for the woman (see Standard 12) and that she still desires the IUD.			
10. The provider re-confirms with the <u>postpartum</u> woman that she has chosen the IUD for PPFP.	**Observe that the provider:**			
	• Greets the patient (and her companion, if present) with respect.			
	• Introduces self to the patient (and her companion, if present).			
	• Confirms the patient identifier information (name, date of birth).			
	• Determines that the woman meets criteria for postplacental insertion.			
	• Has had family planning counseling when not in active labor.			
	• Has indicated consent.			
	• Determines, using the ***Pre-Insertion Screening Job Aid***, that the IUD is appropriate for the woman (see Standard 12) and that she still desires the IUD.			

Performance Standards	Verification Criteria	Y/N, N/A[j]	Y/N, N/A	Comments
11. The provider counsels and screens a woman who was not identified during ANC for the PPIUD.	**Observe that the provider:**			
	• Identifies laboring and postpartum women who are interested in the PPIUD.			
	• If the woman is in early labor or postpartum, ensures woman is comfortable and capable of making an informed choice.			
	• Performs a brief screening assessment and determines whether the PPIUD is an appropriate method for the woman (see Standard 3).			
	• Provides method-specific information about the PPIUD (see Standards 4 and 5).			
	• Makes a notation in the medical record and notifies other care providers that the woman has chosen postpartum insertion of the IUD.			
	• Where appropriate for the postpartum woman or the woman who has been unable to have postplacental insertion, makes arrangements for early PPIUD insertion before discharge.			
12. The provider ensures the IUD is an appropriate postpartum contraceptive method for a laboring/recently postpartum woman.	**Observe that the provider:**			
	• Uses the ***Pre-Insertion Screening Job Aid*** to ensure that none of the following medical conditions are present:			
	• Postpartum endometritis/metritis			
	• Puerperal sepsis			
	• More than 18 hours from rupture of membranes to delivery of the baby			
	• Unresolved postpartum hemorrhage			
	• Extensive genital trauma where the repair would be disrupted by postpartum placement of the IUD			

Performance Standards	Verification Criteria	Y/N, N/A[j]	Y/N, N/A	Comments
13. The provider demonstrates good client-provider interaction.	**Observe that the provider:**			
	• Uses the patient's name, as appropriate for the setting.			
	• Provides the patient with an opportunity to ask questions; answers the patient's (and if present, her companion's) questions.			
	• Maintains privacy and confidentiality for the woman.			
	• Demonstrates active listening.			
	• Speaks respectfully and professionally with the patient in clear and simple language.			
	• Ensures that the patient understands the information provided.			
Area 3: IUD Service Provision				
Instructions for the Assessor: Observe the provision of IUD services to at least two women each for standards 14–21. If there are no women, have providers demonstrate service provision on anatomic models, AND review the clinical record of the two most recent cases of each type of service provision (postplacental, intracesarean and early postpartum). Cases should not be more than 6 months old.				
Immediate PPIUD Insertion				
14. The provider completes all <u>pre-insertion tasks</u> for postplacental or intracesarean IUD insertion. Use the ***Pre-Insertion Screening Job Aid*** to help facilitate this task.	**Observe that the provider:**			
	• Ensures that the woman has consented to PPIUD insertion.			
	• Ensures that the needed supplies and equipment are available in the room.			
	For postplacental insertion:			
	• Long placental forceps for insertion			
	• Ring forceps for grasping the cervix			
	• Retractor or Simms speculum			
	• Gauze pads/cotton balls			
	• Betadine			
	For intracesarean insertion:			
	• Ring forceps for inserting the IUD			
	• Opens the IUD onto a sterile delivery tray (postplacental) or an instrument tray (intracesarean).			

Performance Standards	Verification Criteria	Y/N, N/A[j]	Y/N, N/A	Comments
15. The provider correctly inserts the IUD within 10 minutes after placental expulsion after a vaginal delivery (instrument insertion). *NOTE: The IUD should be inserted following performance of AMTSL and confirmation that postpartum bleeding is minimal.* 	**Observe that the provider:**			
	• After completing AMTSL, asks the woman if she is ready for IUD insertion and if she has any questions.			
	• Performs hand hygiene; puts on HLD or sterile gloves.			
	• Arranges instruments and supplies on a sterile tray or draped area.			
	• Grasps the IUD with Kelly placental forceps or ring forceps. Leaves aside.			
	• Inspects the perineum, labia and vaginal walls for lacerations. If lacerations are not bleeding heavily, repairs them, if needed, after inserting the IUD.			
	• Gently visualizes the cervix by depressing the posterior wall of the vagina. (Note: If the cervix is not easily seen, applies fundal pressure so that the cervix descends and can be seen.)			
	• Cleans cervix and vagina with antiseptic solution two times using two gauzes.			
	• Gently grasps the anterior lip of the cervix with ring forceps.			
	• Exerts gentle traction on the anterior lip of the cervix using ring forceps.			
	• Inserts IUD into the lower uterine cavity. Avoids touching the walls of the vagina with the IUD.			
	• Stabilizes the uterus by “elevating” it with the palm of the hand against the uterine body.			
	• Gently moves the IUD upward toward the fundus (angle toward umbilicus), following the contour of the uterine cavity. Takes care not to perforate the uterus.			
	• Keeps the forceps closed so the IUD does not become displaced.			
	• Confirms that the end of the placental/ring forceps has reached the fundus.			
	• Opens the forceps and releases the IUD at the fundus.			
	• Sweeps the placental/ring forceps to the side wall of the uterus.			
	• Slowly removes the forceps from the uterine cavity, keeping them slightly open. Takes particular care not to dislodge the IUD as the forceps are removed.			
	• Stabilizes the uterus until the forceps are completely out of the uterus.			

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

Performance Standards	Verification Criteria	Y/N, N/A[j]	Y/N, N/A	Comments
Early PPIUD Insertion				
17. The provider completes all pre-insertion tasks for early PPIUD insertion.	**Observe that the provider:**			
	• Opens HLD instrument pan or sterile pack/container without touching instruments.			
	• Prepares the instrument tray with the following instruments/supplies:			
	◦ Bivalve or Simms speculum			
	◦ Long placental forceps for insertion of the IUD			
	◦ Ring forceps for cleaning and grasping the cervix			
	◦ Galley pot/bowl for antiseptic			
	◦ Gauze pads			
	◦ Sterile gloves			
	• Pours antiseptic solution in a cup.			
	• Opens the IUD onto the sterile instrument tray.			
18. The provider performs a pelvic examination before early postpartum insertion of the IUD.	**Observe that the provider:**			
	• Explains the nature and purpose of the examination to the patient.			
	• Ensures that the woman has recently emptied her bladder.			
	• Helps the woman onto the examination table.			
	• Determines the level of the uterus and that there is good uterine tone.			
	• Places a clean drape over the woman's abdomen and underneath her buttocks.			
	• Performs hand hygiene and puts HLD or sterile gloves on both hands.			
	• Arranges the instruments and supplies on an HLD or sterile tray or draped area.			
	• Grasps the IUD with Kelly or ring forceps. Leaves aside.			
	• Inspects the external genitalia.			
	• Gently inserts the speculum.			
	• Maneuvers the speculum to visualize the cervix.			

Performance Standards	Verification Criteria	Y/N, N/A[j]	Y/N, N/A	Comments
19. The provider correctly inserts IUD during the early postpartum period.	**If the exam is normal, observe that the provider:**			
	• Asks the woman if she is ready for IUD insertion and if she has any questions.			
	• Cleans the cervix and vagina with antiseptic solution two times using two gauzes.			
	• Gently grasps the anterior lip of the cervix with ring forceps.			
	• Exerts gentle traction on anterior lip of the cervix using ring forceps.			
	• Inserts the IUD into the lower uterine cavity. Avoids touching the walls of the vagina.			
	• Releases the hand that is holding the cervix-holding forceps, moves this hand to the abdomen and places this hand on top of the uterine fundus.			
	• Stabilizes the uterus by "elevating" it with the palm of the hand against the uterine body.			
	• Gently moves the IUD upward toward the fundus (angle toward umbilicus), following the contour of the uterine cavity. Takes care not to perforate the uterus. *(Note: Remember that the lower uterine segment may be contracted postpartum and therefore some slight pressure may be necessary to advance the IUD and achieve fundal placement.)*			
	• Keeps the forceps closed so the IUD does not become displaced.			
	• Confirms that the end of the forceps has reached the fundus.			
	• Opens the forceps and releases the IUD at the fundus.			
	• Sweeps the placental/ring forceps to the side wall of the uterus.			
	• Keeping the forceps slightly open, slowly removes them from the uterine cavity. Takes particular care not to dislodge the IUD as the forceps are removed.			
	• Stabilizes the uterus until the forceps are completely out of the uterus.			
	• Examines the cervix to ensure there is no bleeding. If the IUD is seen protruding from the cervix, removes the IUD and reinserts it.			
	• Removes all instruments used and places them in 0.5% chlorine solution.			
	• Allows the woman to rest a few minutes, helps her off the table if necessary.			

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

Performance Standards	Verification Criteria	Y/N, N/A[j]	Y/N, N/A	Comments
Area 4: Management and Recordkeeping				
Instructions for the Assessor: Review the clinical record of the two most recent cases of PPIUD insertion for standard 22. Review the delivery room and procedure room record for standard 23. For standards 24–26 interview the clinic administrator and one service provider, plus review the organization and readiness of the relevant service delivery areas.				
22. The provider records, in the patient's chart, relevant information about the services provided.	**Determine through two record reviews whether the following information is recorded:**			
	• Date of service			
	• Type of insertion (postplacental, intracesarean or early postpartum), if the IUD is chosen			
	• Complications, if they occurred			
	• Follow-up plan			
23. The provider records relevant information about services provided in the register.	**Determine through review of the delivery room register and the procedure room register whether the following information is recorded:**			
	• Patient name, age and parity			
	• Patient address			
	• Delivery and complications			
	• Method of IUD insertion and timing			
	• Complications of the procedure			
	• Follow-up plan			

Performance Standards	Verification Criteria	Y/N, N/A[j]	Y/N, N/A	Comments
24. The facility has adequate supplies and materials for PPFP.	**Determine by interview with a provider or clinic administrator that the facility has:**			
	• A full range of available PPFP options in stock.			
	• Condoms			
	• IUDs			
	• Progestin-only pills			
	• Has a number of postpartum insertion kits equal to 50% of the number of women who deliver on a daily basis.			
	• Has long placental forceps packaged separately for postplacental insertion.			
	• Has postpartum information to distribute to patients.			
	• IUDs available on the labor ward.			
	• IUDs available in the postpartum procedure room.			
25. The provider(s) have the required qualifications.	**Determine by interview with provider or clinic administrator that:**			
	• Providers performing PPIUD insertion have been trained in a competency-based training course and meet facility/institutional/regional proficiency and certification standards for delivery of the service.			
	• Providers are midwives, medical doctors or other health cadres who are able to perform IUD insertion that is consistent with national practice standards.			

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

Summary of Assessment				
Area	**Total Number of Standards**	**Number Observed**	**Number Achieved**	**Percentage**
Area 1: Antenatal Assessment and Return Visits	**8**			
Area 2: Counseling and Assessment during Labor/Postpartum	**5**			
Area 3: IUD Service Provision	**8**			
Area 4: Management and Recordkeeping	**5**			
Overall	**26**			

Appendix K: Sample PPIUD Service Delivery Data Collection Form

Insertion Details			
Serial No. (of IUD):	**Registration No.:**	**Woman's Name:**	**Date of Completing Form:**
Age: ❑ <20 ❑ 20–35 ❑ >35		**Parity:** ❑ 1 ❑ 2–4 ❑ >4	**No. of Living Children:**
Address:		**Phone No.:** **Phone No.:** **Mobile No.:**	
Booked: ❑ Yes ❑ No	**Period of Gestation at Delivery:** ❑ 21–32 Wks ❑ 33–36 Wks ❑ 37–41 Wks	**Time of Counseling:** ❑ ANC ❑ Early Labor ❑ Postpartum	
Type of Insertion: ❑ Postplacental ❑ Intracesarean ❑ Early Postpartum		**Instrument Used for Insertion:** ❑ Sponge Holder ❑ Kelly Forceps ❑ Manual	
Duration of Membrane Rupture: ❑ <6 Hours ❑ 6–12 Hours ❑ 12–18 Hours ❑ >18 Hours		**Perforation during Insertion:** ❑ Yes ❑ No	
Provider Assessment: *On a scale of 1 to 10 (with 10 being easiest)* Ease of Insertion: 1 2 3 4 5 6 7 8 9 10 ❑ could not insert with Kelly forceps ❑ could not insert with sponge holder		**Client's Experience:** *On a scale of 1 to 10 (with 10 being most pain or anxiety)* Pain: 1 2 3 4 5 6 7 8 9 10 Anxiety: 1 2 3 4 5 6 7 8 9 10	
Follow-Up Details (to be completed at follow-up visit)			
Expulsion: ❑ Yes ❑ No ***If yes—*** ❑ <6 weeks ❑ 6 weeks–3 months			
Removal: ❑ Yes ❑ No	**Reason For Removal:** ❑ wants pregnancy ❑ infection ❑ excessive bleeding ❑ pain ❑ partial expulsion ❑ voluntary		
Failure: ❑ Yes ❑ No ***If yes—*** ❑ 0–3 months ❑ >3 months		**Infection:** ❑ Yes ❑ No ***If yes—*** ❑ 1–3 days ❑ 4–7 days ❑ 1–2 wks ❑ >2 weeks	
Strings at Follow-Up: Initial visit: ❑ seen ❑ not seen ❑ need to cut Subsequent visit: ❑ seen ❑ not seen ❑ need to cut		**Action Taken for Strings:** Initial visit: ❑ USG done ❑ Strings pulled down Subsequent visit: ❑ USG done ❑ Strings pulled down	
Client Satisfaction: *"On a scale of 1 to 10 (with 10 being most), how satisfied are you with your IUD overall?"* Initial visit: 1 2 3 4 5 6 7 8 9 10 Subsequent visit: 1 2 3 4 5 6 7 8 9 10			

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TEN KEY POINTS REGARDING PPFP/PPIUD SERVICES

1. **Many women want to delay or limit their pregnancies, and they desire information about family planning (PPFP) methods, as well as a range of methods from which to choose.**

2. **Postpartum women in developing countries are especially vulnerable to unintended pregnancy** because their fertility may return before they realize and most are not using contraception.

3. **There are many opportunities throughout the course of caring for women and children to provide PPFP education and counseling.** A successful PPFP program will employ several strategies for reaching women with key PPFP messages.

4. **When possible, and particularly where the postpartum IUD (PPIUD) or tubal ligation are available, PPFP counseling should be initiated during antenatal care** so that there is ample time for the woman and her partner to consider different options, ask questions and choose the method that is best for them.

5. Whether it is inserted postpartum or during the "interval," **the IUD is a safe, highly effective, long-acting (12 years for the Copper T) but reversible contraceptive, with a high rate of user satisfaction.**

6. If the woman chooses the PPIUD, **her choice should be clearly noted** on her medical record and she should be:
   - **Provided more in-depth information about the method** (e.g., duration of efficacy, side-effects, warning signs), which helps to support correct, continued use; and
   - **Advised on the advantages of having it inserted immediately after delivery of the placenta** (postplacental, intracesarean) versus on Day 1 or 2 postpartum: immediate postpartum insertion is associated with lower rates of expulsion and is more cost-effective and convenient than early postpartum insertion.

7. **The vast majority of women can use the IUD.**
   - An **initial screening**, according to the latest WHO Medical Eligibility Criteria, helps the provider determine whether a woman is a suitable candidate.
   - A **second screening**, immediately after birth, focuses on conditions resulting from labor and delivery that may mean the method should be withheld or delayed.

   Note: In some cases, the provider and woman may need to weigh the risk of not having an IUD inserted against those of having it inserted.

8. **The slightly higher rates of expulsion with the PPIUD (versus interval IUD) can be greatly reduced with proper postpartum insertion technique.** This technique focuses on ensuring high fundal placement of the IUD, which is the most important factor in retention.

9. **The PPIUD does not interfere** with routine intrapartum care, including active management of third stage of labor, which should be performed before the IUD is inserted. It also does not interfere with routine postpartum or newborn care, **nor does it affect breast milk or breastfeeding.**

10. **In general, IUD side effects are temporary (and better tolerated by postpartum women) and complications are rare or uncommon.** Potential problems can be identified and managed at the routine follow-up visit (only one is usually needed). As with all PPFP services, quality follow-up—including treatment, referral and reassurance, as needed—has a strong positive impact on client satisfaction and correct, continued use of the method.