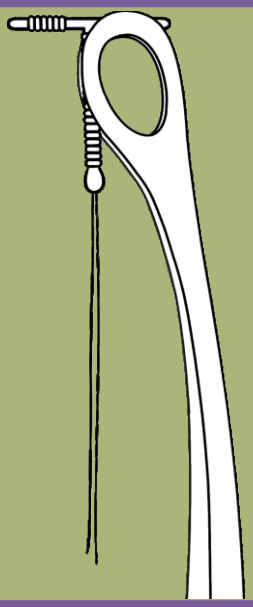
Postpartum IUCD Reference Manual



November 2010

Family Planning Division
Ministry of Health and Family Welfare
Government of India

सत्यमेव जयते

चिकित्सा एवम् स्वास्थ्य विभाग राजस्थान

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

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Ministry of Health & Family Welfare
Government of India,
Nirman Bhawan, New Delhi-110011

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MINISTRY OF HEALTH & FAMILY WELFARE
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PREFACE

National Population Policy of India was formulated in the year 2000 with the long term objective of achieving a stable population by 2045, at level consistent with the requirements of sustainable economic growth and social development. One of the immediate objectives of the policy is to address the unmet needs for contraception.

Providing quality contraception services to women is one of the cornerstones for achieving MDG goals of improved maternal and child health. Unwanted and mistimed pregnancy results in adverse outcomes for both mother and child. A large proportion of women in the postpartum period want to accept a contraceptive method to regulate their fertility, either by spacing or limiting future pregnancies. Accordingly, the postpartum Family Planning services need to be strengthened and the providers updated on recent developments in contraceptive services. Provision of IUCD in the immediate postpartum period offers an effective and safe method for spacing and limiting births.

This Reference manual on PPIUCD developed by Family Planning Division contains the service delivery and training guidelines for immediate post partum insertion of IUCD which will equip the service providers with knowledge and skills to ensure the quality of post partum IUCD services. I hope this will be an important step towards reducing the unmet needs for contraception in the post partum period and for promoting maternal and child health.

Date: 30.11.2010

(K. SUJATHA RAO)

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ACKNOWLEDGEMENT

Access to safe and effective contraceptive services in the postpartum period is of utmost importance for a woman to prevent unwanted /mistimed pregnancy. Immediate Postpartum insertion of IUCD is being seen as an effective and safe contraception which can be accepted by the woman immediately after delivery.

This Reference manual on "**Immediate Postpartum Insertion of IUCD"** is developed for service providers and trainers to facilitate them to provide quality IUCD services as per standard protocols.

Technical support given by Dr. Loveleen Johri, USAID, Dr. Bulbul Sood, Dr. Jeffrey Smith, Dr. Rashmi Asif and Dr. Saswati Das from JHPIEGO is deeply appreciated.

Sincere efforts of Dr. Sushma Dureja, Asst.Commissioner, Family Planning Division, Dr. Jaya Lalmohan and Dr. Amrita Kansal, consultants in the Division are greatly acknowledged.

Dated: 30.11.2010

(Dr.Kiran Ambwani)

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ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
AMTSL	Active Management of Third Stage of Labor
ANC	Antenatal care
BPM	Beats per Minute
CBC	Complete Blood Count
CuT	Copper T
DMPA	Depot Medroxy Progesterone Acetate
FP	Family Planning
HSP	Healthy Spacing of Pregnancy
IUCD	Intra Uterine Contraceptive Device
HIV	Human Immunodeficiency Virus
HLD	High Level Disinfection
IP	Infection Prevention
LAM	Lactational Amenorrhea Method
MCH	Maternal and Child Health
MEC	Medical Eligibility Criteria
NSV	No-Scalpel Vasectomy
OT	Operation Theatre
PID	Pelvic Inflammatory Disease
PNC	Postnatal Care
POP	Progestin-Only-Pills
PPFP	Postpartum Family Planning
PPIUCD	Postpartum Intra Uterine Contraceptive Device
ROM	Rupture of Membranes
STIs	Sexually Transmitted Infections
WHO	World Health Organization

CHAPTER 1
POSTPARTUM FAMILY PLANNING

Background

Postpartum period is one of the critical times when both woman and newborn need a special and integrated package of health services as morbidity and mortality rates are quite high during this period and also the women are vulnerable to unintended pregnancy. Studies show that pregnancies taking place within 24 months of a previous birth have a higher risk of adverse outcomes like abortions, premature labor, postpartum hemorrhage, low birth weight babies, fetal loss and maternal death.

Postpartum Period

The postpartum period has traditionally been understood as the first six weeks after the birth of a child, as by then, the woman's body has largely returned to its pre-pregnancy state. However there is a need to focus on the "extended postpartum period;" i.e., the first 12 months after birth.

Programmatically it is convenient to further define the time periods as the interventions and issues vary during the period of first 6 weeks and beyond up to one year after childbirth.

1. Immediate Postpartum - Postplacental and within 48 hours after delivery

   The immediate postpartum period is an ideal time to educate and counsel a woman on exclusive breastfeeding as a contraceptive method. Counseling on future fertility, birth spacing or limiting intentions, and provision of appropriate family planning methods like IUCD, sterilization should also be provided in this period.

2. Early Postpartum - up to 7days

   Postpartum Sterilization can be performed within this time period. Messages on Lactational Amenorrhea Method (LAM) should be reinforced.

3. Extended Postpartum - 6 weeks to 1 year

   Spacing methods like IUCD and other methods as per the Medical Eligibility Criteria (MEC) can be provided. Laparoscopic/minilap tubal ligation can also be performed during this period.

Women are highly motivated and receptive to accept Family Planning (FP) methods during the postpartum period. Demographic and Health Survey show that 40 percent of women in the first year postpartum intend to use a family planning (FP) method but are not doing so.

Institutional deliveries have increased significantly all across the country, thereby creating opportunities for providing quality postpartum family planning services. The postpartum services need to be strengthened by integrating maternal and child health (MCH) and FP services at each level of health facility from the district hospital to the sub-centre.

Rationale for Postpartum Family Planning

1. Maternal and Child Health

A baby born after a short birth interval has increased chances of:

- being born pre-term
- being small for gestational age
- death during newborn period or childhood

- A woman who becomes pregnant too quickly following a previous birth or spontaneous or induced abortion faces higher risks of:
  - anaemia
  - abortion
  - premature rupture of membranes
  - maternal mortality
- Adolescent reproductive health

  Pregnancy during adolescence poses a higher risk of adverse outcome for the mother and the baby and it is important that she is counseled to delay the childbirth

  - Early pregnancy at age less than 18 years is associated with increased risk of health complications for mothers and newborns compared to women aged 20 to 24 years old.
  - Adolescent mothers aged 15-19 years are twice as likely to die during pregnancy or childbirth as those over 20; girls below the age of 15 are five times more likely to die.

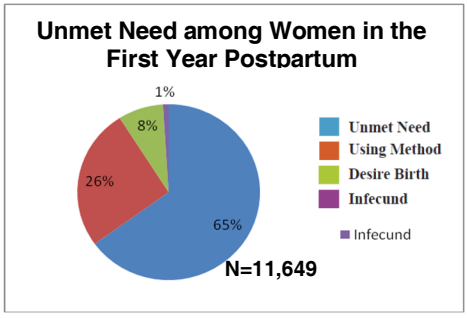
2. Unmet need for birth spacing

In India, 65% of women in the first year postpartum have an unmet need for family planning, as shown in Figure 1.1.

Only 26% of women are using any method of family planning during the first year postpartum.

8% of the women desire to have another child within the next 2 years after giving birth and are vulnerable to the risks of early pregnancy.

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



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

3. Return of fertility

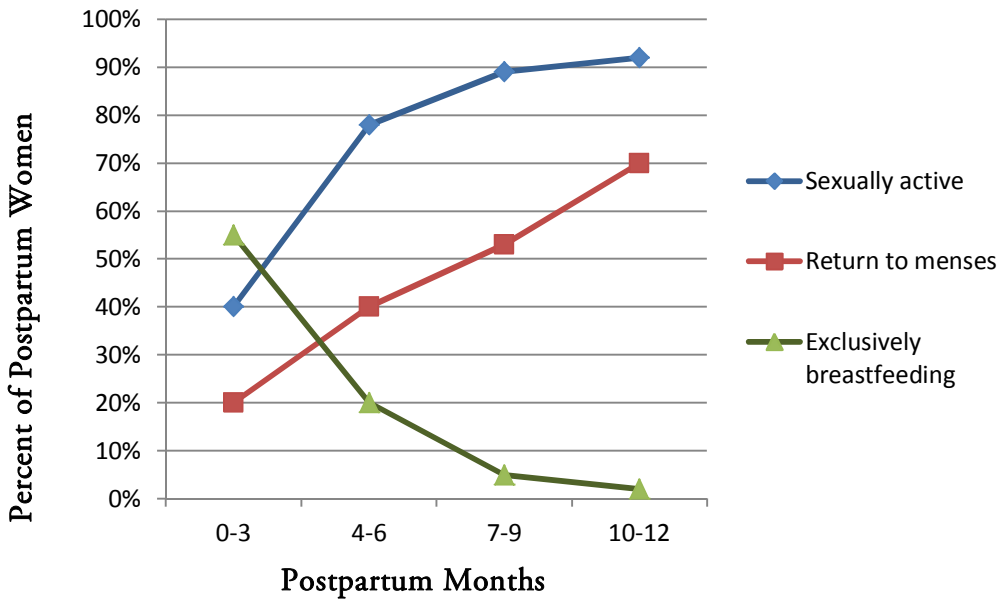
Exclusive breastfeeding-While more than 55% of women exclusively breastfeed their babies in the first three months following delivery, this rate drops to nearly zero by one year as shown in **Figure 1.2** and this exposes them to risk of pregnancy.

Partially breastfeeding or not breastfeeding -Women may resume menses within 4-6 weeks of delivery and first ovulation may occur as early as 45 days postpartum thereby increasing the risk of pregnancy soon after childbirth.

Lactational Amenorrhea–Some women may experience amenorrhoea during breast feeding even if they are not practicing exclusive breast feeding or do not satisfy the three criteria of Lactational

Amenorrhea Method (LAM). There is a probability that ovulation may occur before the return of menstruation. Therefore, amenorrhea after child birth is an unreliable indicator that a woman is protected against pregnancy.

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



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

- **Return to sexual activity-**As in figure 1.2,during the first year postpartum, approximately 40% women return to sexual activity within the first three months and by 10-12 months postpartum 90% have resumed sexual activity which exposes the woman to risk of having an unintended pregnancy.

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

  Following an abortion, a woman's fertility returns within 10–11 days. Women who have experienced a spontaneous or induced abortion should begin use of a contraceptive method within 48 hours to prevent an unintended pregnancy.

Healthy Spacing of Pregnancy (HSP)

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

The **birth-to-pregnancy interval** is the time period between a live birth and the start of the next pregnancy. After a live birth, a woman should wait at least 24 months (but not more than five years) before attempting the next pregnancy.

After a **spontaneous or induced abortion**, a woman should wait at least 6 months before attempting the next pregnancy.

Adolescents should delay first pregnancy until the age 20 years

Elements of Postpartum Family Planning

Helping couples understand their risk of unplanned pregnancy and ensuring high quality postpartum family planning services.

- Information about optimal birth spacing—including the benefits of spacing births—should be provided to the woman /couple at various points of contact like in family planning clinics; antenatal clinics; labor wards/rooms; postpartum and postnatal care facilities; immunization and child health services; and any service or facility where mothers and children receive routine health care.
- Linkage of maternal and newborn health and family planning services at all levels.

CHAPTER 2
POSTPARTUM IUCD

Background

Intrauterine contraceptive devices (IUCDs) have been used by women in India for decades for spacing pregnancies. In some of the health facilities, it has also been provided to women in the immediate postpartum period. Returning to health facilities for postpartum services after delivery is challenging to mothers who have competing demands.

Taking advantage of the immediate postpartum period for counseling on family planning and IUCD insertion, overcomes multiple barriers to service provision. The increased institutional deliveries are the opportunity to provide women easy access to immediate PPIUCD services.

Policy

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

Standards

The following standards of care must be maintained.

1. Woman must be counseled regarding advantages, limitations, effectiveness, side effects and problems related to IUCD.
2. The provider must explain the procedure for insertion and/or removal of the immediate PPIUCD.
3. Woman must be screened for clinical situations as per WHO Medical Eligibility Criteria (MEC). Screening should take place in the antenatal period, as well as immediately prior to insertion, immediate postpartum.
4. The woman must be counseled and offered another suitable postpartum family planning method if her clinical situation does not allow for insertion of the immediate PPIUCD.
5. The provider must insert the IUCD by following all recommended clinical and infection prevention measures for successful insertion.

6. Insertion must be done using a long instrument, such as a placental forceps, to ensure that the IUCD is placed at the fundus.
7. The provider must maintain records regarding PPIUCD insertions and services as per protocol.
8. Woman must be followed up by a provider oriented to PPIUCD services.

Timing of IUCD Insertion

The usual timings are:

- **Immediate Postpartum**:
  - **Postplacental:** Insertion within 10 minutes after expulsion of the placenta following a vaginal delivery on the same delivery table.
  - **Intracesarean:** Insertion that takes place during a cesarean delivery, after removal of the placenta and before closure of the uterine incision.
  - **Within 48 hours after delivery:** Insertion within 48 hours of delivery and prior to discharge from the postpartum ward.
- **Postabortion:** Insertion following an abortion, if there is no infection, bleeding or any other contraindications.
- **Extended Postpartum/Interval:** Insertion any time after 6 weeks postpartum.

The IUCD should NOT be inserted from 48 hours to 6 weeks following delivery because there is an increased risk of infection and expulsion.

Overview of IUCDs

There are **2 types of IUCDs** available in India –

Copper-bearing IUCDs, made of a small inert plastic frame covered with copper sleeves and/or copper wire

Progestin-releasing IUCDs which continuously release a small amount of levonorgestrel.

Among the copper-bearing IUCDs, the CuT-380A is available in the government program and it is used for immediate postpartum insertion. Cu-375 (popular commercial name Multi Load) has been approved for use in the private sector, with planned introduction into the government program (Refer IUCD Reference Manual, Ministry of Health and Family Welfare, Government of India 2006 for details).

Mode of Action

The IUCD interferes with the ability of sperm to survive and to ascend the fallopian tubes where fertilization occurs. It alters or inhibits sperm migration, ovum transport and fertilization. It stimulates a sterile foreign body reaction in endometrium potentiated by copper.

Effectiveness

- The CuT-380A is a highly effective (>99% effective). There are 0.6 to 0.8 pregnancies per 100 women in first year of use.
- The CuT-380A is effective for 10 years of continuous use. It can, however, be used for whatever time period the woman wants, up to 10 years.

Advantages

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

Advantages for the woman:

Convenience; saves time and additional visit.

Safe because it is certain that she is not pregnant at the time of insertion.

High motivation (woman and family) for a reliable birth spacing method.

Has no risk of uterine perforation because of the thick wall of the uterus.

Reduced perception of initial side effects (bleeding and cramping).

Reduced chance of heavy bleeding, especially among lactational amenorrhea method (LAM) users, since they are experiencing amenorrhea.

No effect on amount or quality of breast milk.

The woman has an effective method for contraception before discharge from hospital.

Advantages for the service provider or the service delivery site:

Certainty that the woman is not pregnant.

Saves time as performed on the same delivery table for postplacental/intracesarean insertions. Additional evaluations and separate clinical procedure is not required.

Need for minimal additional instruments, supplies and equipment.

Convenience for clinical staff; helps relieve overcrowded outpatient facilities thus allowing more women to be served.

Limitations

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

Increased risk of spontaneous expulsion. The skilled clinicians with right technique of insertion are associated with lower expulsion rates.

Perforation of the uterus while placing a PPIUCD immediately after delivery of placenta or during cesarean section or during the first 48 hours postpartum is unlikely because of the thickness of the uterine wall in the postpartum period. No such cases are reported in the literature.

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

CHAPTER 3
POSTPARTUM FAMILY PLANNING COUNSELING

Background

Counseling is an ongoing two-way communication process which enables the client to make an **informed choice** of an appropriate contraceptive method. Counseling for PPIUCD placement should take place during regular antenatal visits. A system should be established to determine if women who attend ANC clinic have been counseled and have chosen a postpartum FP method. This is essential so that delivery room staff can be alerted regarding women who have chosen the PPIUCD so that preparations can be made to provide the method immediately following delivery of the placenta.

Immediate Postpartum IUCD counseling occurs in various stages:

- General health education, often group-based, is about immediate postpartum family planning methods and options. Stress on importance of initiating a family planning method soon after childbirth, spontaneous or induced abortion.
- Individual counseling about immediate postpartum methods where a woman/couple considers and makes an informed choice for a method that is well suited to her/their individual needs and circumstances in the postpartum period.
- Method specific counseling about the immediate PPIUCD, for those women who choose IUCD for postpartum insertion. She should be given information regarding advantages, limitations and side effects about the method. Refer Annexure A and B for details.
- Follow-up counseling for woman who has had the IUCD inserted immediate postpartum to help them effectively use the IUCD.

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

Timing of Counseling for Immediate PPIUCD

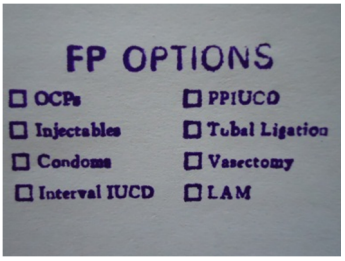
1. During antenatal visits:

Women should be ideally counseled in the antenatal period for immediate PPIUCD insertion. The provider may use the Job-aid for counseling (Annexure C) to address the woman's and her family's concerns and clarify their doubts.

A woman's choice of Family Planning method should be noted clearly on her antenatal card or record. This stamp or specific notation in the ANC record (figure 3.1) will enable the delivery room staff, to be prepared for providing the method immediately following delivery of the placenta.

The labor room staff should check the ANC card for this information when the woman presents for delivery.

Fig 3.1 Prototype of Stamp to be put on ANC Card



2. **During admission**:

   If not counseled during antenatal period, the woman has to be given information about postpartum family planning including PPIUCD as per her need. Those who express interest in the immediate PPIUCD should be provided specific information, as outlined in Annexure A.

3. **During early labor:**

   If a woman presents in early labor (she is relatively comfortable, with infrequent contractions, and able to concentrate on the information being provided), she can be counseled for an immediate PPIUCD.

4. **On the first day of postpartum period:**

   For woman who could not be counseled prior to delivery, she can receive counseling on the first postpartum day.

5. **Prior to scheduled cesarean section:**

   Woman who arrives to the hospital for a scheduled cesarean section, can be counseled prior to the operation about Intra-cesarean IUCD insertion.

> A woman should *NOT* be counseled for the first time about immediate PPIUCD during active labor as she may not be able to make an informed choice due to stress of labor.

Post Insertion Counseling

Following insertion of the IUCD, the provider who has done the insertion should reinforce the key messages related to PPIUCD and inform the woman regarding follow-up visits. A follow up card providing all relevant instructions may be given to her on discharge from the facility.

Points to be stressed are importance of exclusive breastfeeding and assurance that the IUCD does not affect breastfeeding.

To return after six weeks for IUCD/Postnatal Care (PNC)/newborn check-up.

To come back any time if she has any concern or experiences any warning sign or if the IUCD is expelled.

Follow-Up Care and Counseling

Follow-up care of the immediate PPIUCD acceptor is very important to ensure client satisfaction and continuation of the accepted method. It allows the provider to know if the counseling messages were clearly understood by the woman and also to confirm that the IUCD is in place. A woman should come for check-up at 6 weeks and thereafter as and when necessary. If the woman lives far from the facility where the immediate PPIUCD was inserted, ANM/ASHAs, can provide appropriate follow-up counseling.

During the follow-up visit:

Ask the woman if she has any complaints.

Ask if she feels that the IUCD has spontaneously expelled.

Do a clinical assessment for anaemia if she complains of excessive or prolonged bleeding.

Perform a speculum examination on the first visit to assess if the IUCD strings have descended into the vagina. Thereafter, perform a pelvic examination only if necessary.

If the woman does not have any concerns or complaints, she need not have additional follow-up solely related to the IUCD.

Ensure that the woman knows that she can come any time if there is a problem.

If large numbers of women are not returning for follow-up to the site where the IUCD was inserted, consider following-up those women by community health workers through their out-reach services.

While counseling clients, the provider may use Annexure B and C as Counseling Guide.

Key Messages during Family Planning

Importance of initiating a family planning method soon after childbirth, spontaneous or induced abortion for maintaining healthy spacing of at least 3 years between two children.

Fertility may return within four to six weeks for women who are not exclusively breastfeeding and as early as 10-14 days after an abortion.

Women who are practicing LAM should change to another family planning method before the baby is six months old.

CHAPTER 4
INFECTION PREVENTION

Background

Infection prevention practices are an integral part of all clinical procedures to ensure the quality of services. It is mandatory to practice appropriate infection prevention procedures at all times with all clients to decrease the risk of transmissison of infection including HIV, Hepatitis B and Hepatitis C to the acceptor and protect the health workers and other clients from exposure to infection.

The following basic infection prevention processes are to be ensured:

- Consistent implementation of Standard Universal Precautions (SUP).
- Use of aseptic/no-touch technique during every insertion procedure.
- Use of High Level Disinfection (HLD)/sterilized equipment for every procedure with appropriate disposal of waste.

Standard Universal Precautions of Infection Prevention

1. Hand washing:

- Wash hands with soap and water or an appropriate alcohol-based hand rub before performing immediate PPIUCD insertions and after the procedure.
- Hands should be dried with a clean personal towel or air-dried. Towel should not be shared.

2. Self-protection such as wearing gloves and physical barrier:

- Wear gloves on both hands before touching anything such as lower genital tract skin and mucous membranes, blood or other body fluids such as urine or faeces, soiled instruments, and contaminated waste materials or while performing invasive procedures.
- Use protective goggles, face masks and aprons if splashes and spills of blood or other body fluids are possible (e.g. during the procedure itself or when cleaning instruments and other items).

3. Safe work practices and maintaining asepsis:

- Before IUCD insertion, apply a water-based antiseptic to the cervix and vagina two or more times.
- Use aseptic/no-touch technique during every immediate PPIUCD insertion.
- Use only sterile IUCDs that are in intact and undamaged sterile packages and are not beyond expiry date.
- Sterile/HLD gloves or instruments should be used throughout the procedure.
- The IUCD should not touch the perineum, the vaginal walls or any other non-sterile surface that may contaminate it before placement in the uterus.

- Ideally the IUCD should not be passed through the cervical os more than once. However, if the strings are visible after removing the forceps during immediate postplacental insertion, which indicates that IUCD is placed lower than the fundus or displaced while removing the forceps, then the IUCD may be removed and tried **only once** more for fundal placement.

4. Maintain environmental cleanliness:

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

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

Step 1: Decontamination

This step helps prevent transmission of Hepatitis B virus (HBV), Hepatitis C virus (HCV) and HIV. It should be done before the staff is allowed to handle or clean instruments.

- Immediately after use, fully immerse all instruments in a plastic container filled with 0.5% chlorine solution, for 10 minutes. If the instruments are not to be cleaned (refer to Step 2: Cleaning and Rinsing) immediately after decontamination, rinse them with water and dry them with a clean towel to minimize possible corrosion of the instruments due to chlorine. Refer to Annexure D for steps in processing instruments.
- Briefly immerse both gloved hands in the bucket containing the 0.5% chlorine solution and then carefully remove them by turning them inside out. Leave them in the 0.5% chlorine solution for 10 minutes.

> **Preparation of 0.5% Chlorine solution using 30% bleaching powder**
> Mix 15 gms (3 leveled teaspoons) of commercially available bleaching powder in one liter of tap water or make a paste of 15 gms of bleaching powder with very little water in a cup and then pour and mix the paste in one litre of water. Stir well. The solution needs to be changed once in 24 hours or whenever it becomes milky white or red in color.

Step 2: Cleaning and Rinsing: After decontaminating instruments:

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

Step 3

A: High Level Disinfection (HLD) (Recommended for IUCD services if sterilization services are not available)

After decontaminating and cleaning the instruments and surgical gloves, high-level disinfection can be done using one of the following processes:

3 A.1. HLD by boiling:

Fully immerse items in water in a covered container /sterilizer and heat.

Bring water to a rolling/bubbling boil, and boil for **20 minutes**. Do not add any instrument after boiling begins.

Remove items using high-level disinfected forceps, and place in a high-level disinfected container.

Allow items to cool and air dry.

Use objects immediately or store them in a covered airtight, dry high level disinfected container for up to 7 days. If stored in an ordinary covered HLD container, it should be used only up to 24 hours.

3 A.2. HLD by chemical method:

Fully immerse items in an appropriate high-level disinfectant (i.e., 2% glutaraldehyde or 0.1% chlorine solution).

Soak them for 20 minutes.

Remove items using new/clean examination or high-level disinfected gloves, and high-level disinfected forceps.

Rinse items three times with boiled and cooled water.

Place them in a high-level disinfected container and air dry.

Use objects immediately or store them in a covered airtight, dry high level disinfected container for up to 7 days.

B: Sterilization (Not essential for IUCD services):

3 B.1. Sterilization by steam:

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

Sterilized packs can be used up to one week if kept dry and intact and drum is not opened.

Once drum is opened, use instruments within 24 hours.

3 B.2. Sterilization by chemical method

Decontaminated, cleaned and dried items are put in 2% glutaraldehyde solution for at least 8 to 10 hours.

Items such as scissors and forceps should be put into the solution in an open position.

Do not add or remove any items once timing starts.

Items should be rinsed well with sterile water (not boiled water), air-dried and stored in a covered sterile container for up to seven days. (Sterile water can be prepared by autoclaving water for 20 minutes at 15 lb/sq inches in an autoclave).

Refer to Annexure E for additional information on chemicals used for infection prevention processes.

Step 4: Storage:

- Use high-level disinfected or sterilized instruments and gloves immediately, or store them for up to 1 week in a **high-level disinfected** or sterilized container accordingly with a tight-fitting cover.
- If lid is opened then repeat the procedure after 24 hours

  Refer to Annexure D and E for details.

6. Waste disposal:

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

Specific Infection Prevention Steps for the Immediate PPIUCD Procedure

Before insertion

Ensure that HLD /sterilized instruments and supplies are available and ready for use. Open all required HLD/sterile instruments and supplies onto a dry, HLD/sterile surface. IUCD should be placed close by in its sterile unopened packet.

Ensure that the IUCD package is unopened and undamaged and check the expiry date.

For immediate postpartum insertion within 48 hours of delivery, wash or have the woman wash her perineal area with water before preparing the vagina and cervix. If immediately after delivery, in the

absence of frank fecal contamination, cleaning the perineal area gently with a sterile gauze or towel is sufficient.

Hand washing and wearing of gloves should be done appropriately.

Using sterile cotton swab and a sterile sponge/ring forceps ensure that the cervix is cleaned with a water-based antiseptic solution two times.

During insertion (as applicable)

Sterile or HLD gloves are used to stabilize the IUCD in its packet when trying to hold it by the placental forceps while the IUCD is still in its packet.

Throughout the procedure, use "no-touch" technique to reduce the risk of infection. If successful fundal placement is not achieved and the IUCD is dislodged, it may be removed and reinserted once more with all aseptic precautions.

After insertion

Before removing gloves follow all the steps of decontamination (Refer to Annexure D) and waste management as per health facility protocol.

CHAPTER 5
MEDICAL ELIGIBILITY CRITERIA AND CLIENT ASSESSMENT

Medical Eligibiligy Criteria (MEC)

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

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

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

- **Category 1:**
  - Immediate postplacental, immediate postpartum<48 hours or during cesarean section
  - > six weeks postpartum
- **Category 2:** no conditions
- **Category 3:**
  - Between 48 hours and six weeks postpartum
  - Chorioamnionitis
  - Prolonged rupture of membranes (ROM)> 18 hours
- **Category 4:**
  - Puerperal sepsis
  - Unresolved postpartum haemorrhage

Diagnosis of Chorioamnionitis

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

- Temperature of 38°c
- Abdominal pain

PLUS one of the following:

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

The following conditions merit additional discussion:

Unresolved Postpartum Haemorrhage

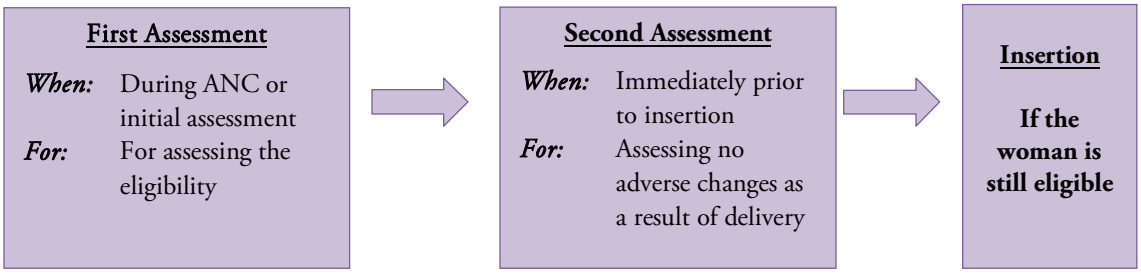
The attention and priority should be on addressing the cause of the bleeding and achieving hemodynamic stability rather than inserting the IUCD.

Once the haemorrhage is controlled, and the woman is stable, the IUCD can be inserted at that time or can be inserted the following day

The IUCD should be inserted prior to starting the repair of the multiple lacerations of the vagina or episiotomy.

Client Assessment

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



First

First Assessment

A **first assessment** should be carried out with the pregnant woman during antenatal care and it must include assessment for the following conditions, listed in the Medical Eligibility Criteria and relevant to immediate PPIUCD services,

- Known distorted uterine cavity (uterine septum, fibroid uterus, etc.)
- Acute purulent discharge
- High individual likelihood of exposure to Gonorrhoea or Chlamydia
- Malignant or benign trophoblastic disease
- Suffering from AIDS and neither clinically well nor on antiretroviral therapy

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

Refer to the Medical Eligibility Criteria table in Annexure F for details.

Second Assessment

A ***second assessment*** should be done immediately prior to insertion by the person who will insert the IUCD.

The purpose of the second assessment is to ensure that the process of labor has not created any clinical situation which may be a contraindication for insertion of the immediate PPIUCD and to rule out the following conditions:

- Chorioamnionitis
- Postpartum endometritis/metritis or puerperal sepsis
- More than 18 hours from rupture of membranes to delivery of the baby
- Unresolved postpartum haemorrhage
- Extensive genital trauma

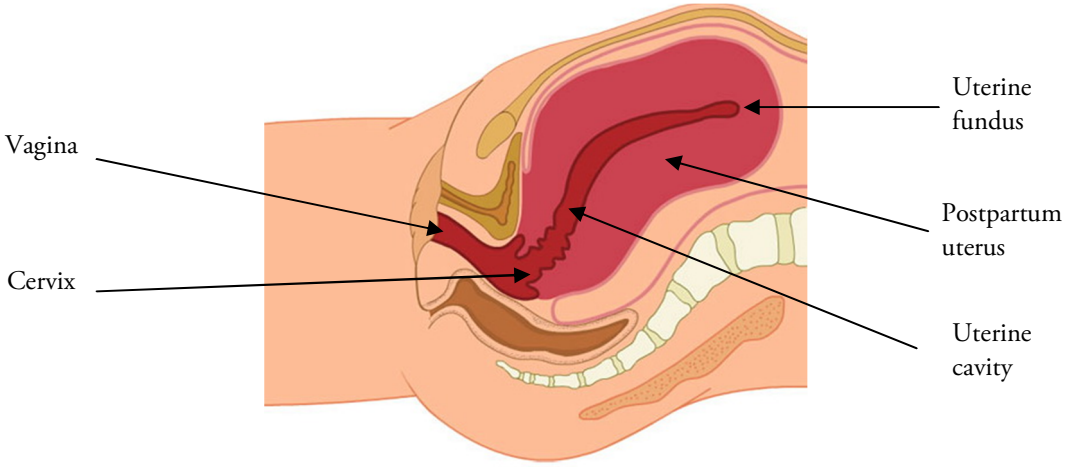
If her clinical condition makes the IUCD unsuitable for her at this time, the reason should be explained to her and she should be offered another method of postpartum family planning. If she prefers IUCD, she may be informed that it can be provided to her after six weeks when she comes for post natal visit.

CHAPTER 6
CLINICAL TECHNIQUE FOR INSERTION OF THE IMMEDIATE POSTPARTUM IUCD

Background

Immediate PPIUCD services are intended to be fully integrated with intrapartum and postpartum care. This chapter describes the changes in the cervix and uterus after birth which influence both the timing as well as the technique for successful IUCD placement in the immediate postpartum period. The timing of insertion in relation to active management of the third stage of labor will also be discussed.

Figure 6.1: Anatomy of Postpartum Uterus



Changes in the Uterus

Immediately after expulsion of the placenta, the fundus or top of the the uterus is just below the umbilicus. It weighs about 1 kg and is approximately the size of a five month pregnancy. It can be palpated easily through the abdominal wall.

The anterior and posterior walls of the body of the uterus are close together, each wall is about four to five centimeters in thickness.

The lower part of the uterus (also called the lower uterine segment) is stretched thin and is extremely floppy adding to the marked mobility of the body of the uterus which is usually tilted forward.

This disparity in consistency and weight between the heavy and thickened body of the uterus and the stretched and folded lower uterine segment contributes to the extreme curvature that can be noted upon manual exploration or bimanual examination. (See Figure 6.1).

Immediately following delivery and active management of third stage of labor, the uterus contracts and is slightly tilted forwards in the lower abdominal cavity.

As shown in Figure 6.1, the axis of the uterine cavity is at about a right angle to the axis of the postpartum vagina. During instrumental insertion of the immediate PPIUCD, this sharp angle can make insertion difficult and can result in a false belief that the provider has reached the fundus.

Over the next 48 hours, the uterus remains approximately the same size and consistency.

Within two weeks however the uterus cannot be felt above the pubic bone as it has almost completely descended into the pelvis. The lower uterine segment can no longer be appreciated, and the uterine cavity straightens and shrinks.

During the process of involution, the uterus normally regains its previous nonpregnant size within five to six weeks postpartum.

Changes in the Cervix

Immediately after completion of the third stage of labor, the cervix and lower uterine segment are thin, collapsed and flabby.

The outer margins of the cervix are often lacerated, and the cervix is extremely soft.

The cervical opening contracts slowly and for a few days after delivery, it readily admits at least two fingers.

By the end of the first week however the cervical canal has re-formed with progressive narrowing of the cervical opening and thickening of the cervical walls.

At the completion of involution, the cervix is firm and tightly closed while retaining permanent changes that characterize a parous cervix.

Importance of Proper Insertion Technique of PPIUCD

For the first 48 hours after birth, the length of the uterus is almost 30 cm. This makes successful fundal placement of the IUCD with a typical interval IUCD inserter tube difficult, as the length of the tube is not sufficient. Instead, either hand or a long placental forceps with a fenestrated end is used for insertion of the immediate PPIUCD to ensure the placement of IUCD at the fundus. Negotiation of the "bend" where the uterine body flops over the lower uterine segment is a common challenge during insertion.

- A common error in insertion technique is to mistake the back or posterior wall of the uterus for the fundus.
- Careful confirmation of fundal placement by manual palpation minimizes the risk of this error which can lead to an increased risk of expulsion.

Between 48 hours and six weeks after birth, perhaps because the uterus is softer and more vascular than in its non-pregnant state, an increase in the perforation and overall complication rate like infection, has been observed. IUCD insertion therefore is not recommended during this period.

Interval insertion using no-touch technique and the traditional inserter tube assembly is recommended for all insertions starting **at six weeks after birth** when the uterus has returned to its pre-pregnant state.

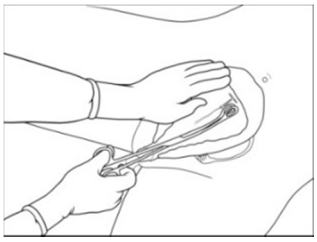
Types of Insertion

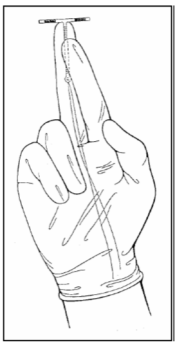
1. **Postplacental:** Postplacental insertion of the IUCD is done immediately following delivery of the placenta, typically within 10 minutes.

   The woman is not yet shifted from the delivery table. The insertion takes place immediately following active management of third stage labor and the delivery of the placenta.

   Postplacental insertion can be done by two techniques:

   A. Instrumental insertion (Using forceps): the IUCD is held in a suitably long forceps without a lock (eg. long placental forceps). The instrument is inserted upto the fundus of the uterus, and the IUCD is released.





   B. Manual postplacental insertion: the IUCD is held in the provider's hand as shown in Fig. and inserted to the uterine fundus. The provider should use long gloves that reach midway up the arm for the protection of both the provider and the woman.

2. **Intracesarean:** the IUCD is introduced through the uterine incision during a caesaren section and placed at the uterine fundus. This is done manually or using a regular ring forceps, since it is not necessary to use a long instrument to reach the fundus.

   After the placenta is removed, the provider inserts the IUCD, and then closes the uterine incision. It is important NOT to attempt to pass the strings of the IUCD through the cervical os before closure of the uterus as this will displace the IUCD and leave it lower down in the uterine cavity. There is no need to fix the IUCD with a ligature.

3. **Immediate postpartum:** the IUCD is inserted within 48 hours following the birth of the baby. The trained provider can insert the IUCD in a procedure or examination room in the postpartum ward even with a regular ring forceps.

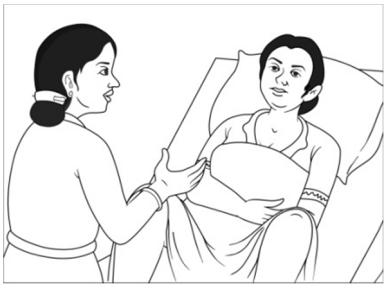
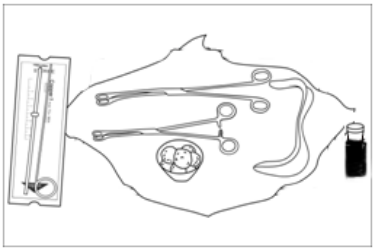
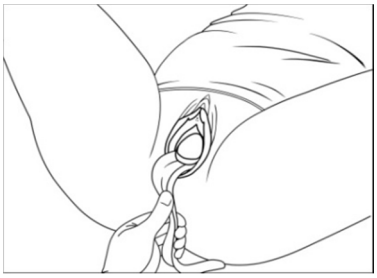
4. **Extended postpartum/Interval IUCD:** women who return for postpartum care at six weeks or later, can receive the IUCD. The technique of insertion and the related precautions are the same as for regular IUCD insertion.

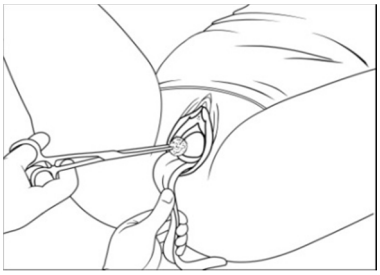
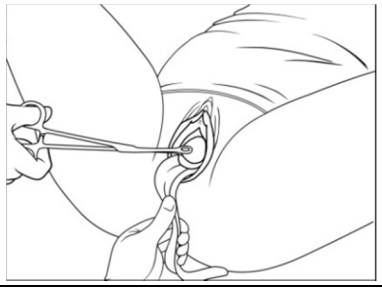
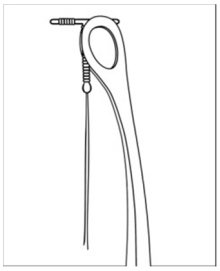
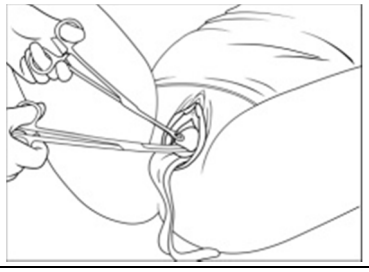
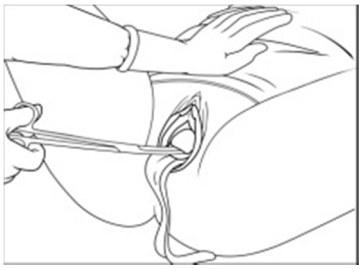
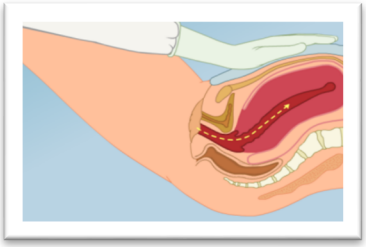
Immediate PPIUCD Insertion and Active Management of Third Stage Labor (AMTSL)

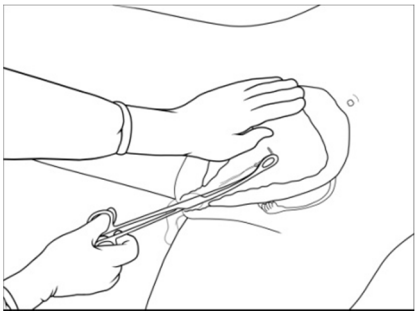
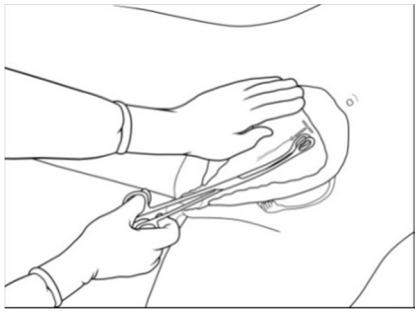
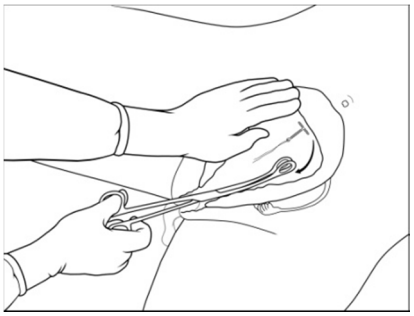
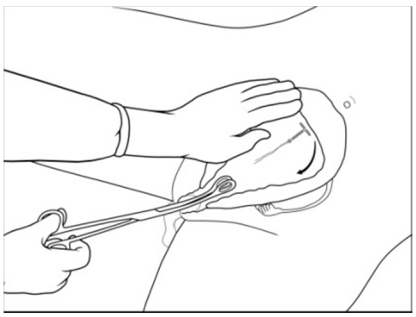
- Insertion of an IUCD immediately postpartum should not interfere with the routine intrapartum and postpartum management protocol.
- Life-threatening medical conditions such as postpartum hemorrhage and pre-eclampsia/eclampsia should be treated as per national guidelines on priority. Sound clinical judgment should always prevail.
- Administration of a uterotonic, controlled cord traction, and uterine massage for active manangement of third stage of labor does not increase the subsequent risk of expulsion of the PPIUCD nor does it make the PPIUCD insertion more difficult.
- No aspect of AMTSL should be modified to accommodate immediate PPIUCD insertion.

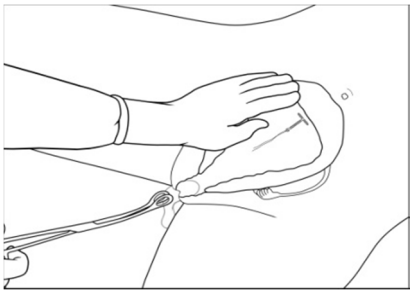
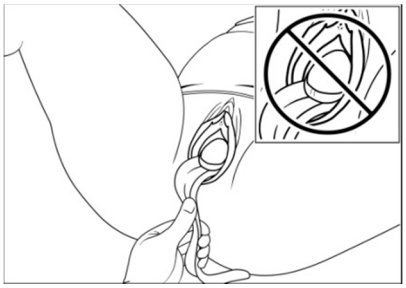
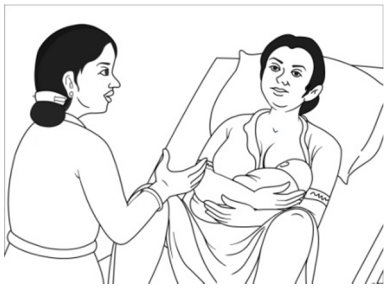
Steps of Postplacental Insertion

The steps described below follow the 'Clinical Skills Checklist for Postplacental Insertion of the IUCD Using Forceps'. The following table gives greater detail about each step of the insertion process. The differences in technique for immediate postpartum insertion and for intracesarean insertion are then explained.

S.No	Steps for insertion of IUCD using placental forceps
1.	Check woman's record to ensure that she is an appropriate client for IUCD and she has given her consent. Using the Job-aid for immediate PPIUCD pre-insertion screening of client (Annexure G), rule out conditions which prevent insertion of IUCD like: • Rupture of membranes for more than 18 hours • Chorioamnionitis • Unresolved postpartum hemorrhage
2.	Confirm that HLD/sterile instruments, supplies and light source are available in the labor room as per annexure M for immediate postplacental insertion. Talk to the woman with kindness and respect. Confirm with the woman whether she still wants IUCD. Explain that you will insert the IUCD following delivery of the placenta. Answer any questions she might have. 
3.	Perform hand hygiene and put on HLD or sterile gloves.
4.	Arrange instruments and supplies on sterile tray or draped area. 
5.	Inspect perineum, labia and vaginal walls for lacerations. If lacerations are not bleeding heavily, insert the IUCD and repair if needed.
6.	Gently visualize cervix by inserting a Sims speculum in the vagina and depressing the posterior wall of the vagina. 

S.No	Steps for insertion of IUCD using placental forceps	
7.	Gently clean cervix with antiseptic solution two times using two separate cotton swabs with Povidone Iodine or Chlorhexidine. Wait for two minutes to allow the antiseptic to work.	
8.	Gently grasp the anterior lip of the cervix with the ring forceps upto the first lock. (The same ring forceps that was used to clean the cervix can be used).	
9.	Grasp IUCD with long placental forceps in the sterile package using a no-touch technique as noted in Figure. It should be held just on the edge of the placental forceps so that it can be easily released from the instrument when opened.	 
10.	Apply gentle traction on the anterior lip of the cervix using the ring forceps and insert IUCD into lower uterine cavity. Avoid touching the walls of vagina. The provider passes the placental forceps with the IUCD carefully into the lower uterine cavity.	
11.	Once the placental forceps is in the lower uterine cavity, lower the ring forceps that is holding the anterior lip of the cervix. Move the left hand to the woman's abdomen and push the entire uterus superiorly (upward). This is to straighten out the angle between the vagina and the uterus, so that the instrument can easily move upward toward the uterine fundus. The ring forceps is removed as it is not required any more during the procedure.	 

S.No	Steps for insertion of IUCD using placental forceps
12.	Gently move placental forceps upward towards the fundus following the curve of the uterine cavity. The provider should take care not to apply excessive force. If the uterus is not pushed upward, the angle between the cervix and the uterus may not allow the instrument to advance smoothly. The provider should always keep the instrument closed so that the IUCD is not dropped accidentally in the mid-portion of the uterine cavity. 
13.	Confirm that the end of placental forceps has reached the fundus and tilt the forceps slightly inwards. When it reaches the uterine fundus, the provider will feel resistance and will also feel the thrust of the instrument at the fundus of the uterus with her left hand which is placed on the abdomen.
14.	Open placental forceps and release the IUCD at the fundus. Sweep placental forceps to side wall of the uterus. Stabilize uterus (using base of hand against lower part of body of uterus). Slowly remove placental forceps from uterine cavity, keeping it slightly open. Take particular care not to dislodge the IUCD as placental forceps are removed.  Stabilize the uterus until the placental forceps are completely o ut of the uterus. To help prevent the IUCD being drawn downward in the uterus, the instrument is swept to the right to ensure that the instrument is away from the IUCD.  Then the instrument is slowly withdrawn, keeping it slightly open at all times. If the instrument closes and catches the strings of the IUCD, it can accidentally pull the IUCD down from its fundal position, increasing the risk of expulsion. 

S.No	Steps for insertion of IUCD using placental forceps
	Counter traction is applied to stabilize the uterus while the instrument is being withdrawn and until it is completely out of the uterus. 
15.	Examine the cervix to ensure there is no bleeding. If IUCD is seen protruding from cervix, remove and reinsert.  It is important to check that the IUCD is not visible at the cervical os. If it is visible, or if the strings appear to be very long, then the IUCD has not been adequately placed at the fundus and the chance of spontaneous expulsion is higher. If it appears that the IUCD is not placed high enough, the provider can use the same forceps to remove the IUCD and repeat steps of insertion using aseptic procedures.
16.	Remove all instruments used and place them in 0.5% chlorine solution for 10 minutes for decontamination.
17.	Allow the woman to rest for few minutes. Support the initiation of routine postpartum care, including immediate breastfeeding. The woman should rest on the table for few minutes following the insertion procedure. The provider should reassure her that the insertion was done smoothly and that she now has an effective, safe and reliable long term spacing method of contraception.
18.	Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out and disposing of them. Perform hand hygiene. All infection prevention steps should be followed as per standard infection prevention procedures and facility protocol for waste management.
19.	Provide the woman with post insertion instructions.  • Provide IUCD card showing type of IUCD and date of insertion. • Inform her about the IUCD side effects and normal postpartum symptoms. • Tell the woman when to return for IUCD follow-up/PNC/ newborn checkup. • Emphasize that she should come back any time she has a concern or experiences warning signs.

S.No	Steps for insertion of IUCD using placental forceps
	• Inform her about the warning signs regarding IUCD. • Explain how to check for expulsion and what to do in case of expulsion. • Assure the woman that the IUCD will not affect breastfeeding and breast milk. • Ensure that the woman understands the post-insertion instructions. • Give written post-insertion instructions. These instructions should be reinforced again by the staff of the postpartum unit and repeated to the woman, and if possible with her family.
20.	Record information regarding the PPIUCD insertion in the woman's chart or record and in the Immediate PPIUCD register kept at the facility.

Postpartum Insertion of the IUCD within 48 Hours of Delivery

There are few notable differences between immediate postplacental insertion and immediate postpartum insertion of the IUCD. Refer to Annexure I for checklist for immediate postpartum insertion of the IUCD.

- The provider should ensure that the woman's understanding about the immediate PPIUCD is adequate.
- Make sure that there is adequate hygiene and her bladder is empty.
- Once the woman is on the procedure table the provider should do an abdominal examination to check the level of the uterus and to be certain there is good uterine tone.
- Perform appropriate hand hygiene and use a new pair of sterile or high level disinfected gloves.
- Insert the IUCD using the placental forceps or the ring forceps. Using the ring forceps may require some modification in the technique to bring the uterus a little down and may require slightly more pressure close to the cervix to allow the ring forceps with the IUCD to reach the fundus.
- The provider must ensure that the IUCD is placed at the uterine fundus and should visually examine the cervix following insertion. In some cases the strings may be visible within the cervical canal due to the rapid involution of the uterus. If the strings seem inappropriately long, the provider should consider whether the IUCD has actually rested at the uterine fundus. If there is doubt, it is better to remove the IUCD and reinsert it.

Intracesarean Insertion of the IUCD

Women who present to the hospital for scheduled cesarean section, or who require a cesarean section prior to the onset of labor, can be counseled about the insertion of the PPIUCD. Because they are not in active labor, they may be able to clearly consider the decision to use an IUCD.

The insertion of the IUCD during a cesarean is straightforward. However some factors should be considered. Refer to Annexure J for checklist for intracesarean insertion of the IUCD.

- Insertion can be done either manually or using a ring forceps since the provider can easily see and reach the uterine fundus. The provider should hold the IUCD between the middle and index fingers of the

hand and pass it through the uterine incision. Once it is placed at the fundus, the hand should be slowly withdrawn, noting whether the IUCD remains properly placed.

- The strings can be pointed towards the cervix but should NOT be pushed through the cervical canal. This is to prevent uterine infection by contamination of the uterine cavity with vaginal flora, and to prevent displacement of the IUCD from the fundus by drawing the strings downward toward the cervical canal.
- Care should be taken during closure of the uterine incision that the strings of the IUCD do not get included into the suture.

Tips for Reducing Spontaneous Expulsion

✓ **Right technique**

- Elevate the uterus.
- Place IUCD at the fundus.
- Sweep instrument to the side of the uterine cavity.
- Keep placental forceps closed while going in and open while coming out of the uterine cavity.

✓ **Right instrument**

- Use an instrument that is long enough to reach the fundus.

✓ **Right time**

- Postplacental and intracesarean insertions have lowest expulsion rates.

Post-Insertion Care for Immediate PPIUCD

Immediate post-insertion care at the health facility:

- The client should be advised to report any increase in more than expected vaginal bleeding or uterine cramping.
- Vaginal hemorrhage related to uterine atony should be managed as per standard procedure with uterine massage and uterotonics as necessary (Note, the immediate PPIUCD does not increase the risk of uterine atony.)
- If severe uterine cramping occurs and persists after immediate PPIUCD insertion, a speculum or bimanual exam should be performed to check for partial or complete expulsion.
- If the woman complains of fever, a full clinical evaluation needs to be done and in the presence of endometritis, an accepted antibiotic regimen should be used for treatment. See below for management of infection in association with the immediate PPIUCD.

Post-insertion Instructions to the woman:

- There may be vaginal bleeding or spotting or cramping for initial few days/weeks after insertion. These symptoms are normally experienced by the woman in the postpartum period. Take ibuprofen, paracetamol or other pain reliever as needed.

- Spontaneous expulsion can happen in some cases, and is most likely to occur during the first three months postpartum. Be observant whether the IUCD comes out. If it does, come to the health facility immediately for reinsertion or another contraceptive.
- At six weeks postpartum, the IUCD strings can be felt by some women. It is not necessary for her to check the strings. She may come to the health facility if she has any concern about the strings.
- Remember IUCD does not protect against STIs and HIV. Resume intercourse at any time she feels ready
- Return for removal of the IUCD at any time she wants a pregnancy and she will have almost immediate return of fertility.

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

- Heavy vaginal bleeding
- Severe lower abdominal discomfort
- Fever and not feeling well
- Unusual vaginal discharge
- Suspected expulsion: can either feel IUCD in the vagina or has seen it expelled from the vagina.
- Any other problems or questions she has related to IUCD.

Give a card to the client with the following information in writing:

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

CHAPTER 7
MANAGEMENT OF POTENTIAL PROBLEMS

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

A. Problems at the time of Insertion:

1. Client Discomfort or pain

Possible Signs/Symptoms

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

Management

- Reassure the client that a moderate amount of discomfort is associated with insertion and continue communicating with the client during the procedure.
- Perform the procedure as gently and as quickly as possible.

2. Displacement of the IUCD

Possible Signs/Symptoms

- IUCD can be visualized in the cervix or upper vagina after placement.
- The woman has discomfort or pain.
- Length of the string visible in the vagina is not consistent with fundal positioning in an immediate postpartum uterus.

Management

- Using an HLD or sterile forceps, remove the IUCD and reinsert the same IUCD if not contaminated, with all aseptic precautions. If the IUCD has been contaminated, discard it and use a new IUCD.

3. Cervical Laceration

Possible Signs/Symptoms

Excessive vaginal bleeding

Management

If laceration is seen, repair as needed depending on size of laceration and amount of bleeding.

4. Uterine Perforation

There were no reported cases of uterine perforation while placing the PPIUCD in any of the studies reviewed. However, if it occurs, the basic steps for managing a uterine perforation are the same as that of regular IUCD insertion.

Signs and symptoms

- Sudden loss of resistance to the inserting instrument during insertion
- Unexplained pain
- Uterine depth greater than expected.

Management

- If suspected during insertion, stop the procedure immediately and gently remove the instruments and IUCD.
- Keep the client at rest, start an IV drip and observe the vital signs and abdominal tenderness, guarding or rigidity.
- If there is severe abdominal pain, any change in the vital signs or peritoneal signs appear refer for emergency surgical intervention.
- Prophylactic antibiotics can be given.

Problems Encountered After Immediate PPIUCD Insertion

1. Changes in Menstrual Bleeding Patterns

Possible Signs/Symptoms

Increase in amount and duration of menstrual bleeding more than what is usually expected in the postpartum period or intermenstrual bleeding.

Management

- Determine severity of symptoms: how much more bleeding than usual; how long have symptoms lasted; when did the symptoms start; are they accompanied by other symptoms (e.g., pain, fever); how well is the woman tolerating them?
- If symptoms are mild and consistent with postpartum uterine involution, reassure.
- If bleeding is persistently heavy and prolonged or associated with clinical or laboratory signs consistent with severe anaemia, offer iron replacement therapy and consider removal with the patient's consent.
- If client desires treatment, offer a short course of nonsteroidal anti-inflammatory drugs (NSAIDs) during bleeding for a period of three to five days.
- If client finds bleeding unacceptable, remove IUCD and counsel her regarding alternative methods of family planning

- Where appropriate, rule out other gynaecologic pathology and pregnancy and refer to a qualified practitioner if indicated.

2. Cramping or Pain

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

Possible Signs/Symptoms

Increased cramping or pain which may or may not be associated with menstruation

Management

- Determine severity of symptoms: how severe is pain; how long has pain lasted, when did pain start; is pain accompanied by other symptoms (e.g., bleeding, fever); how well is the woman tolerating the pain.
- Perform an appropriate assessment to rule out pregnancy and infection
- If symptoms and physical findings are mild and consistent with postpartum uterine involution, reassure.

a. Recommend a short course of NSAIDs immediately before and during menstruation to help reduce menstrual pain and cramping which is bothersome to the client. If cramping or pain is severe, remove the IUCD.

3. Infection

The risk of upper genital tract infection among IUCD users is less than 1%. This risk is highest within the first 20 days after IUCD insertion, and is related to either insertion technique (due to lack of proper infection prevention practices) or pre-existing infection rather than to the IUCD itself.

Possible Signs/Symptoms

- Lower abdominal pain
- Fever
- Painful intercourse
- Bleeding after intercourse or between periods once resumption of normal monthly periods has occurred postpartum
- New onset of pain associated with periods
- Abnormal vaginal discharge
- Nausea and vomiting

Management

- Perform an appropriate assessment to include vital signs, abdominal and pelvic examination and appropriate laboratory studies (pregnancy test, CBC, cultures) to rule out other problems: endometritis; appendicitis; partial IUCD expulsion; uterine perforation; pregnancy/ectopic

pregnancy; or urinary tract infection. (See the section below for management of pregnancy with the IUCD in place).

- Rule out PID and endometritis if suspected, begin treatment immediately with an appropriate antibiotic regimen as per national guidelines/local protocols for RTI/STI. Remove the IUCD if symptoms persist more than 72 hours.
- If the woman does not want to keep the IUCD during treatment, remove the IUCD two to three days after antibiotic treatment has begun.
- Where STI is suspected/ history of high risk behaviour, counsel the woman regarding condom use for protection against future STIs and recommend treatment for the partner.

4. IUCD String Problems

Possible Signs/Symptoms

- Partner can feel strings
- Longer strings, shorter strings
- Missing strings

Management

b. Reassure the woman and her partner that the strings are very flexible and not harmful.

c. If it is very bothersome to the woman's partner, the strings can be cut short if they are long.

d. If the strings are too short and bother the partner, a new IUCD may be inserted.

Management for Missing Strings Refer the Protocol for missing strings in Annexure L.

5. Partial or Complete IUCD Expulsion

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

Possible Signs/Symptoms

- New onset of irregular bleeding and/or cramping
- Expelled IUCD seen (complete expulsion)
- IUCD felt/seen in the vaginal canal (partial expulsion)
- Missed menstrual period (see below for pregnancy with an IUCD in place)
- Missing or longer strings

Management

- Conduct an appropriate assessment including pelvic examination to rule out other possible causes of symptoms such as infection and pregnancy.
- When other possible causes of symptoms are ruled out, manage based on findings:

- If complete expulsion of the IUCD is confirmed (e.g., seen by the woman, confirmed by X-ray or ultrasound): insert IUCD if desired after assessing the client for excluding pregnancy and infection or counsel for another family planning method.
- If partial IUCD expulsion is confirmed (e.g., felt/seen by the woman or clinician): remove the IUCD and provide another IUCD if desired and appropriate (not pregnant or infected) or counsel for another family planning method.
- If the IUCD appears to be embedded in the cervical canal and cannot be easily removed by the standard technique, refer the woman for IUCD removal to a specialist.

6. Pregnancy with an IUCD in Place

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

Possible Signs/Symptoms

- Missed menstrual period
- Other signs/symptoms of pregnancy
- Missing strings
- Strings which are shorter or longer than expected

Management

- Confirm pregnancy and trimester. If the woman is in her second or third trimester of pregnancy, manage according to national guidelines/local protocols and refer to a specialist, if needed.
- Rule out ectopic pregnancy if she complaints of sharp/stabbing pain which is unilateral; abnormal vaginal bleeding; light-headedness/dizziness; fainting. If ectopic pregnancy is suspected, immediately refer/transport the woman to a surgical facility.
- When ectopic pregnancy has been ruled out, and if the pregnancy is in the first trimester:
  - Counsel the woman on the benefits and risks of immediate removal of the IUCD: removing the IUCD slightly increases the risk of abortion; and leaving the IUCD in place can cause second trimester abortion, infection and preterm delivery.
  - If the woman requests removal, proceed with immediate removal if the strings are visible and the pregnancy is in the first trimester. If the strings are not visible, do an ultrasound to determine whether the IUCD is still in the uterus or has been expelled. If the IUCD is still in place, do not try to remove it.
  - If the woman declines removal, provide antenatal care as per national guidelines/local protocol and arrange close monitoring of the pregnancy by a qualified provider. Stress the importance of returning to the clinic immediately if she experiences signs of spontaneous abortion or infection (e.g., fever, low abdominal pain, and/or bleeding) or any other warning signs. Ensure that IUCD is removed at delivery.

CHAPTER 8
FOLLOW-UP CARE

Background

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

Key Objectives

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

Routine Follow-up Visit Postpartum

After immediate PPIUCD insertion, a woman should be advised to return to the clinic for routine postpartum care at 6th week as per guidelines, unless she has serious problems which require emergency services. Routine immediate PPIUCD followup care should be integrated with standard postpartum services.

The woman is also encouraged to return anytime if she is experiencing problems, if she wants the IUCD removed, or for any reason she feels that she needs to consult a health provider.

If the woman lives far from the health facility where the Immediate postpartum IUCD was inserted, she should be counseled and supported by ANM, ASHA to attend the nearby health facility for follow-up care.

In addition to the usual elements of the postpartum check-up, the following activities are to be performed:

- Ask the client about her satisfaction with the method.
- Conduct a pelvic examination to examine the visibility of the strings and to cut them if the woman finds them uncomfortable. Also to rule out conditions like STI or PID, pregnancy, expulsion of IUCD.
- Reinforce the messages on warning signs and spontaneous expulsion of IUCD during the first few months.
- If the immediate PPIUCD has been expelled, offer the client another contraceptive method or plan to insert another IUCD as for the interval procedure if she wishes.
- Encourage use of condoms for STI protection, as appropriate.

- If the PPIUCD is in place and the client has no problems, no other follow-up visits are required. Clients should be advised to return for removal as desired or at the end of the recommended period.
- If the client is not satisfied or has any of the following problems, IUCD may be removed in the similar way as for the interval IUCD:
    - Partial expulsion
    - Puerperal sepsis
    - Perforation of the uterine wall
    - Persistent uterine cramping of unknown origin

CHAPTER 9
QUALITY ASSURANCE FOR POSTPARTUM IUCD SERVICES

Quality of care refers to the way in which individuals and couples are treated by the health care system. The objective of this chapter is to provide clinicians and clinic managers the basic information and tools on **how to improve the quality of services.**

Improving the quality of IUCD services includes ensuring providers' performance as per standards, creating a supportive work environment, meeting clients' needs effectively and acknowledging the achievements of the providers and sustaining the progress made.

Provision of quality postpartum IUCD clinical services require adequate infrastructure, supplies and trained personnel.

It is important to ensure that all personnel of the obstetrics/maternity care team are oriented to immediate PPIUCD service provision and that counseling messages are uniform and consistent right from the antenatal care clinic to the labor room, postpartum ward and family planning clinic.

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

Service Delivery Criteria

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

- ***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 in or near the postpartum ward where immediate postpartum insertions can take place.
- ***Supplies:*** Uninterrupted supply of consumables and appropriate instruments should be ensured.
- ***Personnel:*** Training of service providers in the standard technique and protocol
- ***Coordination of care:*** a system of communication and sharing of information between the antenatal care service, the labor/delivery unit, the postpartum ward and the outpatient postpartum care unit.
- ***Infection prevention practices:*** Ensuring the availability of materials and clean running water for infection prevention.
- ***IEC/BCC:*** Availability of posters or panels and Flip charts on the family planning services offered and information related to clinic timing.
- ***Record maintenance:*** The clinic has a simple FP client record system. The records are reviewed and analyzed regularly. It is very important to maintain careful records of immediate PPIUCD services to monitor the acceptance and continuation rate of IUCD .

  Refer to Annexure M for supplies and equipment for postpartum IUCD clinical services.

- ***Management systems:*** Adequate integration of all of the above activities so that services are provided in a manner that ensure good counseling, appropriate infection prevention practices and adequate follow-up.

Refer to Annexure O for a sample format for Insertion and follow-up registers and Annexure P for reporting format.

Performance Standards for Postpartum IUCD Services

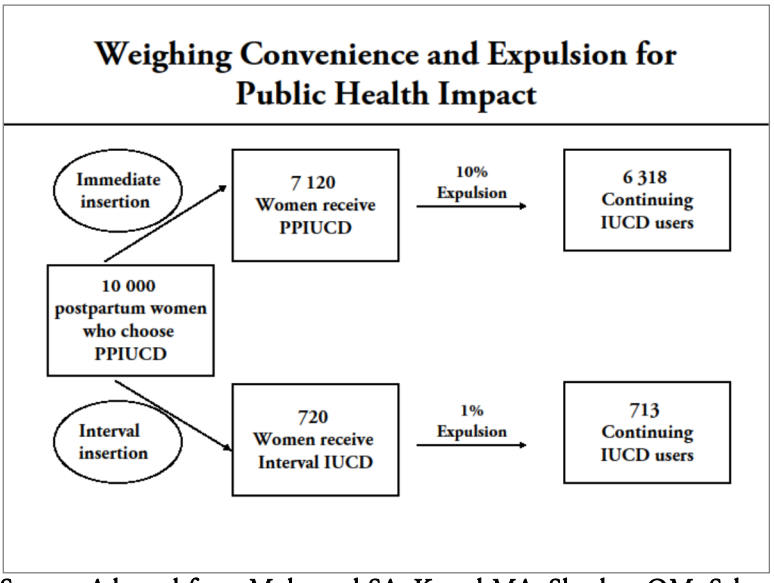
These performance standards are meant to serve as a guide to the establishment and maintenance of high quality clinical services. Refer to Annexure N for the performance standards for provision of immediate PPIUCD services

Written routine protocols and efficient record keeping are mandatory to ensure quality in services

Public Health Significance of PPIUCD

- Very few women come to the health facility for postpartum care. Postpartum care rates, counseling and provision of family planning services during postpartum care are low.
- Assuming that women will return later often can leave women with no option at all.
- While the expulsion rate may be as high as 8-10%, this implies that the retention rate is still 90-92%. (With good technique expulsion rate is reduced to <3%). Thus, despite the potentially higher expulsion rates for immediate PPIUCDs, the public health benefit of the service is high
- In situations of limited access to care and infrequent postpartum care, this level of programmatic achievement can be considered a success.

Figure 6.3 Public Health Approach PPIUCD



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

Annexures

Annexure A

CLIENT MESSAGES ABOUT BASIC INFORMATION OF IUCD

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

What it is	The IUCD is a small plastic device that is inserted into the uterus.
When is it inserted	It is inserted either immediately after the placenta comes out, during a cesarean section or in the first two days after delivery, while the client is still in the healthcare facility. This makes it very convenient for her, because by the time she leaves the hospital, she will have her family planning method active and effective.
Who can use it	Most postpartum women can safely use the IUCD, including those who are young, breastfeeding, or do hard work. It is especially good for women who think they do not want any more children, but want to delay sterilization until they are certain. Some women should not use the IUCD, including women who have an abnormal shaped uterus or have a high personal risk of sexually transmitted infection. Sometimes women develop an infection during the time of birth. They should wait until after the infection has been treated to have the IUCD inserted.
Effectiveness	The IUCD is more than 99% effective in preventing pregnancy, making it one of the most effective, reversible contraceptive methods currently available.
Mechanism of action	The IUCD prevents pregnancy by preventing the sperm from fertilizing the egg.
Breastfeeding	Using an IUCD immediately postpartum will not affect breastfeeding adversely and will not change the amount or quality of breastmilk.
Course of protection	The IUCD begins to work immediately and the Copper T 380A is effective for up to 10 years.

Side effects	Copper-bearing IUCDs (e.g., the Copper T) have fewer side effects than hormonal methods (e.g., the pill), but sometimes cause an increase in the amount, duration, and painfulness of menstrual periods. These symptoms are usually not noticed by postpartum women, especially those who are breastfeeding, because they lessen or go away spontaneously in the first few months after insertion.
Health benefits and possible risks	The IUCD is very safe at preventing pregnancy. When it is inserted immediately postpartum, about 5–10 women out of 100 will find that the IUCD has fallen out during the first three months. If this happens, she should return to the health facility and have another IUCD inserted to continue protection against pregnancy.
Protection from HIV and other	The IUCD offers no protection against HIV or other STIs. Only barrier methods (e.g., the condom) help protect against exposure to HIV and other STIs.
STIs	If the woman thinks that she has a "very high personal risk" for certain STIs she should not use the IUCD.
Cost and Convenience	Getting an PPIUCD is inexpensive and very convenient. The IUCD will be placed before the woman leaves the healthcare facility after delivery. In most cases, only one follow-up visit after 6 weeks postpartum to the clinic is required.
Additional Action and Removal	Once the IUCD is inserted, no additional actions are needed by the woman. She must come to the health facility to have it removed whenever she wants to get pregnant, otherwise, at the end of the recommended period. She will be able to get pregnant soon after IUCD is removed. The woman can get the IUCD removed any time she desires for a pregnancy or to change to another method. If she wants to continue to use the IUCD for a longer time, she can use it for 10 years and then have it replaced with another one.

Annexure B

POSTPARTUM IUCD COUNSELING CHECKLIST

(TO BE USED BY THE COUNSELOR/PROVIDER FOR SELF ASSESMENT OF PERFORMANCE FOR QUALITY COUNSELING SERVICES)

COUNSELING ON IMMEDIATE PPIUCD				
STEP/TASK	**ASSESSMENT**			**COMMENTS**
GREET – Establish a good rapport and initiate counseling on PPFP				
1. Establish a supportive, trusting relationship. Show respect for the client and help her feel at ease.				
2. Allow the client to explain her needs and concerns and listen to her.				
3. Involve client's family members-husband or important family member during the counseling session with her consent.				
Ask – Determine reproductive goals and use of other contraception				
4. Ask about any previous experiences with family planning regarding any problems and reasons for discontinuing; her knowledge about the return of fertility and the benefits of spacing pregnancies.				
5. Assess partner's/family's attitude about family planning.				
6. Ask about her reproductive goals.				
7. Ask about her need for protection against STIs. Explain and support condom use, as a method of dual protection.				
8. Ask whether she is interested in a particular family planning method.				
TELL – Provide the client with information about the postpartum family planning methods				
9. Provide general information about benefits of spacing births. Advise that to ensure her health and the health of her baby (and family) she should wait at least two years after this birth before trying to get pregnant again. Advise about the return of fertility postpartum and the risk of pregnancy. Advise how LAM and breastfeeding are different. Provide information about the health, social and economic benefits of spacing births.				

COUNSELING ON IMMEDIATE PPIUCD				
STEP/TASK	**ASSESSMENT**			**COMMENTS**
10. Provide information about birth spacing methods. Based on client's prior knowledge and interest, briefly explain the benefits, limitations and use of the following methods: LAM, Condoms, POPs, DMPA, PPIUCD, NSV, and Postpartum Tubectomy. Show the methods (using poster or wall chart) and allow the client to touch or feel the items, including IUCD, using a contraceptive tray and models. Correct any misconceptions about family planning methods.				
HELP – Assist the client to arrive at a choice or give her additional information that she might need to make a decision				
11. Help the client to choose a method by giving her any additional information that she may need and answer her questions.				
12. Support the client's choice and tell her what the next steps will be for providing her with her choice.				
EVALUATE AND EXPLAIN – Determine if she can safely use the method, and provide key information about how to use the method (focus on PPIUCD)				
13. Evaluate the client's health and determine if she can safely use the method by asking about her medical and reproductive history. Refer to Chapter 5: Medical Eligibility Criteria and Client Assessment in the reference manual for details.				
14. Discuss key information about the PPIUCD with the client. Effectiveness: prevents almost 100% of pregnancies. How does the IUCD prevent pregnancy: causes a chemical change that damages the sperm before it meets the egg. How long does the IUCD prevent pregnancy: can be used as long as the woman likes, even upto 10 years. The IUCD can be removed at any time by a trained provider if the woman wants it and fertility will return immediately.				

COUNSELING ON IMMEDIATE PPIUCD				
STEP/TASK	**ASSESSMENT**			**COMMENTS**
15. Discuss the following advantages of the PPIUCD. Immediate and simple placement immediately after delivery. No further action required by the client. Immediate return of fertility on removal. Does not affect breastfeeding. Long acting and reversible: can be used to prevent pregnancy for a short time or as long as ten years.				
16. Discuss the following limitations of the PPIUCD. Heavier and more painful menses especially first few cycles. May not be noticed by the client after PPIUCD insertion. Does not protect against STIs, including HIV/AIDS. Higher risk of expulsion when inserted postpartum.				
17. Discuss the following warning signs and explains that she should return to the health facility as soon as possible if she has any of the following: Foul smelling vaginal discharge different from the usual lochia Lower abdominal pain, especially if accompanied by not feeling well, fever or chills, especially during the first 20 days after insertion Has a doubt that she might be pregnant Has a doubt that the IUCD may have fallen out				
18. Check that the woman understands the key information by asking questions or asking her to repeat key information.				
RETURN – Plan for next steps and for when she will arrive to hospital for delivery				
19. Plan for next steps. If client cannot arrive at a conclusion on this visit, ask her to plan for a discussion with her family and come for a follow-up discussion on her next visit. Note key points in the client's record card about her postpartum contraceptive choice or which method interests her. Provide information to her about when to come back to the facility.				

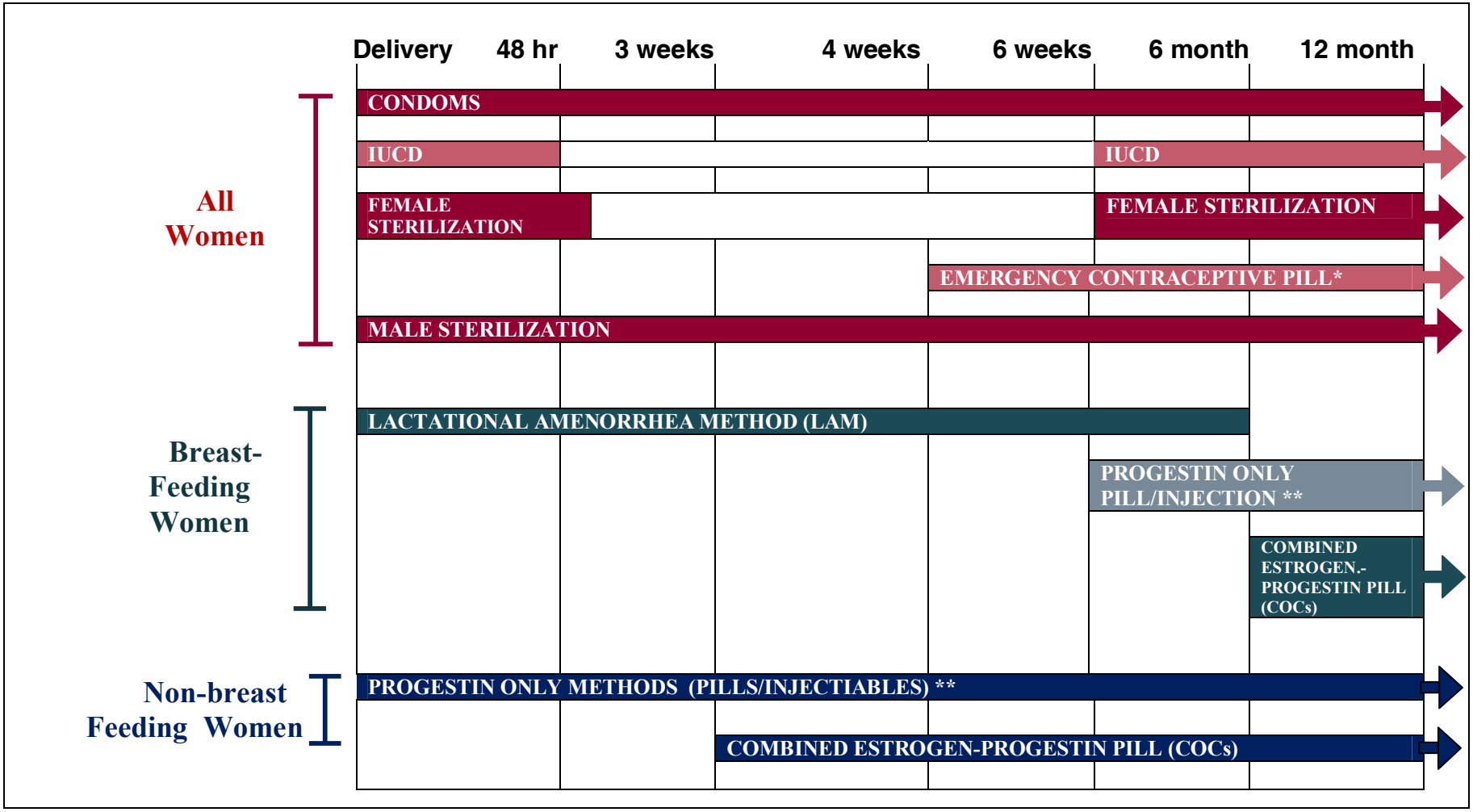
Annexure C

JOB AID FOR POSTPARTUM FAMILY PLANNING COUNSELING AND TIME FOR INITIATION OF CONTRACEPTIVES

ANC COUNSELING GUIDE: IMMEDIATE POST PARTUM FAMILY PLANNING

METHODS	BENEFITS	LIMITATIONS	CLIENT ASSESSMENT/CONSIDERATIONS
Postpartum IUCD	Used right after delivery; long term protection 99% effective. Immediate return of fertility upon removal.	Heavier, painful menses (first few cycles). Does not protect against STIs/ HIV.	Not appropriate for women who have: Chorioamnionitis; ROM >18 hrs; PPH
Progestin Only Pills	Woman can start 6 weeks postpartum, even if breastfeeding. About 99% effective. Immediate return of fertility after stopping pills.	Must be taken daily. Bleeding changes may be experienced. Does not protect against STIs/ HIV.	Not appropriate for women who: have cirrhosis or active liver disease, blood clot in legs or lungs, history of breast cancer or take medications for TB or seizures.
Condom	Can prevent pregnancy, some STIs and HIV. Can be used once couple resumes intercourse.	Must have reliable access to resupply. About 85% effective.	Must be used correctly with EVERY act of sex. Can provide supply before discharge.
Postpartum Ligation	Permanent method of FP. Simple procedure >99% (not 100%) effective. Serious complications are rare.	Does not protect against STIs/HIV. Requires surgical procedure.	For women who do not want more children. Hospital must be set up to offer the surgery. Can be done in first 7 days postpartum.
LAM	Good for mother and newborn. Start immediately after birth. 98% effective if all 3 criteria met.	Does not protect against STIs/ HIV. Short-term method—reliable for 6 months. Use another method if any criteria not met.	Effective if ALL 3 criteria present: exclusive breastfeeding day & night; menses not returned; baby less than six months old.
Male Sterilization	Permanent method for men. Simple procedure 99% effective. Serious complications are rare. No weakness or difficulty during intercourse.	Does not protect against STIs/HIV Requires use of condoms or another contraceptive for three months post-procedure to be effective.	Appropriate for those couples who have decided to limit family; Are aware of the permanent nature of the method. Men who do not have infection of the genitalia.
Emergency Contraception 1. Emergency Contraceptive Pills (ECPs) 2. IUCD	Safe, easy to use and available at chemist shop or at health center. Can be used by all women. 85% effective if ECP used within 72 hours; can be used upto 120 hours (5 days) after an unprotected intercourse. Earlier the better. IUCD for Emergency Contraception can be continued as a regular method if appropriate.	Not a regular FP method, intended for emergency use only. A regular FP method use required Not effective once implantation of fertilized ovum has begun. Effectiveness dependent on the time of use after the unprotected intercourse.	Not effective in pregnant women. Should not be used as an abortifacient. IUCD not appropriate for women who have: Cervical cancer or trophoblastic disease; Abnormality in the structure of the uterus (fibroids, septum); risk of STIs.

SAFE TIMES FOR POSTPARTUM INITIATION OF VARIOUS METHODS OF FAMILY PLANNING



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

** This is available in private sector.

Annexure D

STEPS IN PROCESSING INSTRUMENTS AND OTHER ITEMS USED IN PPIUCD SERVICES[1]

INSTRUMENTS/ITEM	DECONTAMINATION	CLEANING	HLD	STERILIZATION
	Is the first step in handling dirty instruments; Reduces risk of HBV and HIV transmission	Removes all visible blood, body fluids, and dirt.	Recommended method of final-processing; destroys all viruses, bacteria, parasites, fungi, and some endospores.	Alternative method of final-processing; destroys all microorganisms including endospores.
Examination table top and other large surface areas	Wipe off with 0.5% chlorine solution.	Wash with soap and water if organic material remains after decontamination.	Not necessary.	Not necessary.
Instruments used for IUCD insertion or removal (e.g., speculum, ring forceps, Kelly placental forceps, bowl)	Soak in 0.5% chlorine solution for 10 minutes in an open position before cleaning. Rinse or wash immediately.	Using a brush, wash with detergent and water. Rinse with clean water. If they will be sterilized, air or towel dry and package.	• Steam or boil for 20 minutes. • Chemically high-level disinfect by soaking for 20 minutes. Rinse well with boiled water and air dry before use or storage.	Autoclave at 121°C (250°F) and 106 kPa (15 lbs/in^2) for 20 minutes (30 minutes if wrapped).
Storage containers for instruments	Soak in 0.5% chlorine solution for 10 minutes before cleaning. Rinse or wash immediately.	Wash with detergent and water. Rinse with clean water, air or towel dry.	Boil container and lid for 20 minutes. If container is too large: • Fill container with 0.5% chlorine solution and soak for 20 minutes. • Rinse with water that has been boiled for 20 minutes and air dry before use.	Autoclave at 121°C (250°F) and 106 kPa (15 lbs/in^2) for 20 minutes (30 minutes if wrapped).

[1]Adapted from: Perkins 1983

Annexure E

ADDITIONAL INFORMATION ON CHEMICALS USED IN INFECTION PREVENTION PROCESSES

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

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

Making Dilute Chlorine Solutions for Decontamination and HLD

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

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

Table E.1 Preparing Dilute Chlorine Solution from Dry Powder[2]

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

[A]Use boiled water when preparing a 0.1% chlorine solution for HLD because tap water contains microscopic organic matter that inactivates chlorine.
[B]For dry powders, read x grams per liter (example: Calcium hypochlorite—7.1 grams mixed with 1 liter water).
[C]Chloramine releases chlorine at a slower rate than does hypochlorite. Before using the solution, be sure the tablet is completely dissolved.

[2]Adapted from: WHO 1989

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

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

$$Grams/Liter = \frac{\%\ Dilute}{\%\ Concentrate} \times 1000$$

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

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

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

STEP 2: Add 14.2 grams (14 g) to one liter of water. This is equal to approximately 3 level teaspoons of powder.

Choosing Appropriate Chemicals for HLD

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

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

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

Storing Chemicals and Processing Chemical Containers

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

Preparing and Using Chemical Disinfectants

Information on preparing solutions and using for high-level disinfection and simple disinfection is provided in Table E.3.

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

CHEMICALS FOR STERILIZATION AND/OR HIGH-LEVEL DISINFECTION										
Disinfectant (common solution or brand)	**Effective Concentration**	**How to Dilute**	**Skin Irritant**	**Eye Irritant**	**Respiratory Irritant**	**Corrosive**	**Leaves Residue**	**Time Needed for HLD**	**Time Needed for Sterilization**	**Activated Shelf Life**[A]
Chlorine	0.1%	Dilution procedures vary[B]	Yes (with prolonged contact)	Yes	Yes	Yes[C]	Yes	20 minutes	Do not use	Change every 24 hours, sooner if cloudy.
Glutaraldehyde (Cidex7)	Varies (2–4%)	Add activator	Yes	Yes (vapors)	Yes	No	Yes	20 minutes at 25°C[D]	10 hours for Cidex	Change every 14–28 days, sooner if cloudy. (See manufacturer's instructions)
CHEMICALS FOR DISINFECTION (**Note:** alcohols and iodophors are **not** high-level disinfectants.)										
Alcohol (ethyl or isopropyl)	60–90%	Use full strength	Yes (can dry skin)	Yes	No	No	No	Do not use	Do not use	If container (bottle) kept closed, use until empty.
Lodophors (10% povidone-iodine [PVI])	Approximately 2.5%	1 part 10% PVI to 3 parts water	No	Yes	No	Yes	Yes	Do not use	Do not use	If container (bottle) kept closed, use until empty.

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

[B]See Table E.1 and Textbox E.1 for instructions on preparing chlorine solutions.

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

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

[3]*Adapted from*: Rutala 1996

Annexure F

MEDICAL ELIGIBILITY CRITERIA (MEC) FOR IUCD INSERTION

CATEGORY	WITH CLINICAL JUDGEMENT	WITH LIMITED CLINICAL JUDGEMENT
1	Use method in any circumstances	Yes (Use the Method)
2	Generally use the method	
3	Use of method not usually recommended unless other more appropriate methods are not available or not acceptable	No (Do not use the method)
4	Method not to be used	

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

Characteristics and conditions listed below are in WHO Eligibility Criteria Category one. Women with characteristics and conditions in WHO category 2 also can use this method. With proper counseling, women of any age or number of children can use IUCD. (Age less than 20 and having no children are characteristics in WHO Eligibility Criteria Category 2).

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

Annexure G

JOB-AID FOR IMMEDIATE PPIUCD PRE-INSERTION SCREENING OF CLIENT

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

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

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

Annexure H

CHECKLIST FOR CLINICAL SKILLS POSTPLACENTAL INSERTION OF THE IUCD (COPPER T 380A) USING FORCEPS

(TO BE USED BY THE COUNSELOR/PROVIDER FOR SELF ASSESSMENT OF PERFORMANCE FOR QUALITY COUNSELING SERVICES)

CHECKLIST FOR POSTPLACENTAL INSERTION OF THE IUCD (USING FORCEPS)				
STEP/TASK	**CASES**			**COMMENTS**
Pre-Insertion Screening and Medical Assessment (done prior to conducting vaginal delivery)				
1. Reviews woman's record to ensure that she is an appropriate client for IUCD.				
2. Ensures that she has been appropriately counseled for immediate PPIUCD insertion.				
3. Using the job-aid for immediate PPIUCD Pre-Insertion Screening of client, confirms that that there are no delivery-related conditions which prevent insertion of IUCD now: • Rupture of membranes for greater than 18 hours • Chorioamnionitis • Unresolved postpartum hemorrhage				
4. If any of these conditions exist, informs the woman, explains that this is not a safe time for insertion of the IUCD, plans re-evaluation for an IUCD at 6 weeks postpartum. Counsels her and offers her another method for PPFP.				
5. Confirm that correct sterile instruments, supplies and light source are available in the labor room for immediate postplacental insertion.				
6. Confirms that IUCDs are available in the labor room.				
7. Talks to the woman with kindness and respect.				
8. Confirms with the woman whether she still wants an IUCD.				
9. Explains that you will insert the IUCD following delivery of baby and placenta. Answers any questions she might have.				
Pre-Insertion Tasks				
10. If insertion is performed by the same provider that assisted the delivery, put on new pair of sterile or HLD gloves. If insertion is performed by a different provider who has not assisted the delivery then performs hand hygiene and puts on HLD or sterile gloves.				
11. Ensures that active management of third stage of labor has been performed.				

CHECKLIST FOR POSTPLACENTAL INSERTION OF THE IUCD (USING FORCEPS)				
STEP/TASK	**CASES**			**COMMENTS**
12. Arranges IUCD insertion instruments and supplies on sterile tray or draped area. Keeps IUCD in sterile package to the side of sterile draped area.				
13. Inspects perineum, labia and vaginal walls for lacerations. If lacerations are not bleeding heavily, insert the IUCD and repairs the lacerations if needed.				
Insertion of the IUCD				
14. Gently visualizes cervix by depressing the posterior wall of the vagina.				
15. Cleans cervix and vagina with antiseptic solution 2 times using 2 swabs and waits for 2 minutes.				
16. Gently grasps the anterior lip of the cervix with the ring forceps (speculum may be removed at this time if necessary, leaves forceps at the side gently).				
17. Opens sterile package of IUCD from bottom by pulling back plastic cover approximately 1/3 upwards.				
18. Holds IUCD package, stabilize IUCD in package and removes plunger rod, inserter tube and card from the package.				
19. Grasps IUCD with Kelly placental forceps in the sterile package using no-touch technique.				
20. Gently lifts anterior lip of cervix using ring forceps and applies gentle traction to steady the cervix.				
21. Inserts placental forceps holding IUCD into lower uterine cavity upto the point of feeling slight resistance against back wall of the uterus. Avoids touching walls of the vagina. Gently removes ring forceps from the cervix and leaves it on the sterile towel.				
22. Moves hand to the lower part of abdomen (base of hand on lower part of uterus and fingers towards fundus) and gently pushes uterus upward in the abdomen to reduce the angle and curvature between the uterus and vagina.				
23. Gently moves the placental forceps holding the IUCD upward towards the uterine fundus. Lowers right hand (hand holding the placental forceps) down, to enable forceps to easily pass vaginal-uterine angle and follow the curve of the uterine cavity. Keeps placental forceps closed while moving up so IUCD does not become displaced. Takes care not to perforate the uterus.				
24. Continues gently advancing the forceps until uterine fundus is reached. Confirms that the end of the forceps has reached the fundus.				
25. Opens the forceps, tilts it slightly towards mid line, and releases IUCD at the fundus.				

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

Annexure I

SKILLS CHECKLIST FOR IMMEDIATE POSTPARTUM INSERTION OF THE IUCD

(COPPER T 380A)

(TO BE USED BY THE COUNSELOR/PROVIDER FOR SELF ASSESSMENT OF PERFORMANCE FOR QUALITY COUNSELING SERVICES)

CHECKLIST FOR IMMEDIATE POSTPARTUM INSERTION OF THE IUCD				
STEP/TASK	**CASES**			**COMMENTS**
Counseling, Screening and Medical Assessment				
1. Reviews the client's record to ensure that the IUCD is an appropriate method for her.				
2. Ensures that she has been appropriately counseled for Immediate PPIUCD insertion.				
3. If she was not counseled and assessed for immediate postpartum IUCD during ANC, provides her with counseling now (refer to Annexure B immediate postpartum IUCD counseling checklist).				
4. Using the Pre-Insertion Screening Job Aid, confirms that there are no delivery-related conditions which prevent insertion of IUCD now: • Rupture of membranes for greater than 18 hours • Chorioamnionitis • Puerperal sepsis • Continued excessive postpartum bleeding • Extensive genital trauma where the repair would be disrupted by postpartum placement of an IUCD				
5. If the client is eligible for PPIUCD, ensures that she has recently emptied her bladder and washed her external genitalia.				
6. Helps her onto the procedure table.				
7. Determines level of uterus and that there is good uterine tone.				
8. Confirms availability of sterile or HLD instruments, supplies and light source.				
9. Confirms that IUCDs are available in the postpartum ward's procedure room or labor room (if the PPIUCD insertion will be done in the labor room).				
Pre-Insertion Tasks				
10. Performs hand hygiene and put HLD or sterile surgical gloves on both hands.				

CHECKLIST FOR IMMEDIATE POSTPARTUM INSERTION OF THE IUCD				
STEP/TASK	**CASES**			**COMMENTS**
11. Arranges IUCD insertion instruments and supplies on sterile or HLD tray or draped area. Keep IUCD in sterile package to the side of sterile/HLD draped area.				
12. Inspects the external genitalia.				
Insertion of the IUCD within 48 hours of delivery (refer to steps 14 to 31 of Skills Checklist for Postplacental Insertion of the IUCD using forceps)				
Post-Insertion Tasks (refer to steps 32 to 35 of Skills Checklist for Postplacental Insertion of the IUCD using forceps)				
13. Tells the client that IUCD has been successfully placed. Reassure her and answers any questions she may have. Tells the post-insertion instructions to the client: • Reviews IUCD side effects and normal postpartum symptoms. • Tells the client when to return for IUCD/PNC/ newborn checkup. • Emphasizes that she should come back any time she has a concern or experiences warning signs. • Informs about the warning signs for IUCD • Explains how to check for expulsion and what to do in case of expulsion. • Assures the woman that the IUCD will not affect breastfeeding and breast milk. • Ensures that the woman understands the post insertion instructions. • Gives written post-insertion instructions, if possible. • Provides card showing type of IUCD and date of insertion. • Tells her that detailed instructions will be provided prior to discharge.				
14. Records information in the client's chart or record.				
15. Records information in the procedure room register.				

Annexure J

CHECKLIST FOR CLINICAL SKILLS INTRACESAREAN INSERTION OF THE IUCD

(COPPER T 380A)

(TO BE USED BY THE COUNSELOR/PROVIDER FOR SELF ASSESSMENT OF PERFORMANCE FOR QUALITY COUNSELING SERVICES)

CHECKLIST FOR INTRACESAREAN INSERTION OF THE IUCD					
STEP/TASK	**CASES**				**COMMENTS**
Pre-surgical Screening and Medical Assessment					
1. Reviews woman's record to ensure that she is an appropriate client for IUCD.					
2. Ensures that she has been appropriately counseled for Immediate PPIUCD insertion.					
Using the Job-aid for immediate PPIUCD pre-insertion screening of client 3. Pre-Insertion Screening Job Aid, confirms that there are no delivery-related conditions which prevent insertion of the IUCD now: • Rupture of membranes for greater than 18 hours • Chorioamnionitis • Unresolved postpartum hemorrhage					
4. Confirms with the woman whether she still wants IUCD.					
5. Explains the procedure and answer any question she may have.					
6. Confirms that IUCDs are available in the operating theatre (OT).					
Insertion of the IUCD					
NOTE: IUCD is inserted manually through uterine incision, this takes place after delivery of the placenta and evaluation for any postpartum bleeding, but prior to repair of uterine incision.					
7. Inspects uterine cavity for malformations which would limit use of IUCD.					
8. Ensures that the nurse has opened IUCD on the sterile field.					
9. Stabilizes uterus by grasping it at fundus.					
10. Holds IUCD at end of fingers, between middle and index finger (alternatively, use ring forceps to hold the IUCD. Be certain to hold IUCD by the edge and not entangle strings in the forceps).					
11. Inserts IUCD through uterine incision at the fundus of the uterus.					
12. Releases IUCD at fundus of uterus.					

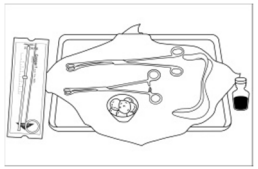
CHECKLIST FOR INTRACESAREAN INSERTION OF THE IUCD				
STEP/TASK	**CASES**			**COMMENTS**
13. Slowly removes the hand/forceps from the uterus. Take particular care not to dislodge IUCD as hand is removed.				
14. Guides IUCD strings towards to the lower uterine segment near internal os, but does not move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

Annexure K

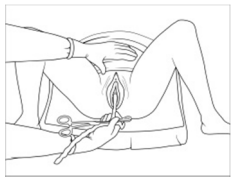
JOB AID FOR POSTPLACENTAL IUCD INSERTION TECHNIQUE

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

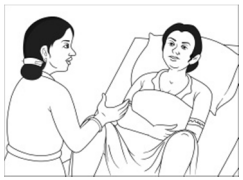
1. Be sure the woman has been consented.



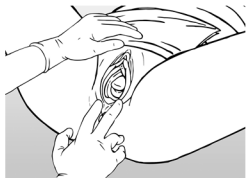
2. Be sure your supplies/equipment are ready.



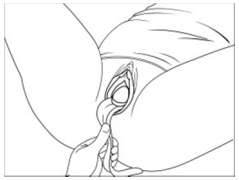
3. Complete Active Management 3rd Stage.



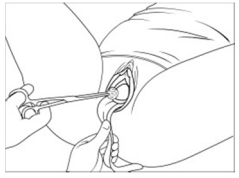
4. Ask the woman if she is still willing for IUD insertion.



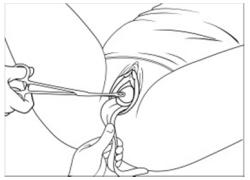
5. Inspect the perineum for lacerations.



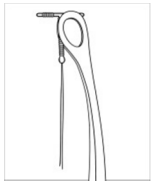
6. Visualize cervix using retractor.



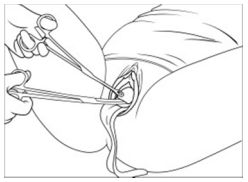
7. Clean cervix and vagina TWICE.



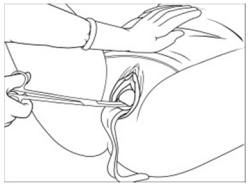
8. Grasp anterior lip of cervix with forceps.



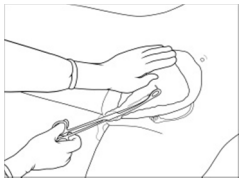
9. Hold the IUCD with forceps in a sterile packet.



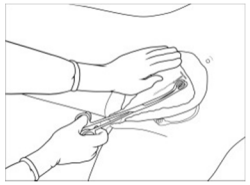
10. Insert forceps with IUCD through cervix to lower uterine cavity. Avoid touching vagina.



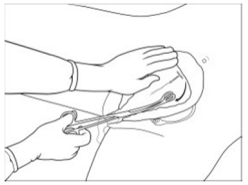
11. Move hand to abdomen; place it on top of sterile towel over the fundus of uterus.



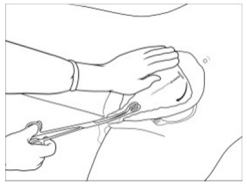
12. Move IUCD + forceps upward until it can be felt at fundus. Follow contour of uterine cavity.



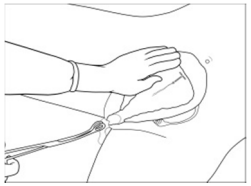
13. Open forceps and release IUD at fundus



14. Sweep forceps to side wall of uterus



15. Slowly remove forceps—keep slightly open



16. Stabilize uterus until forceps are out.

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

Annexure L

PROTOCOL FOR MISSING STRINGS

Case #_____

Date #_____

Protocol for Management of Missing PPIUCD Strings

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

Tick action taken

1 ☐ 2 ☐

3 ☐ 4 ☐

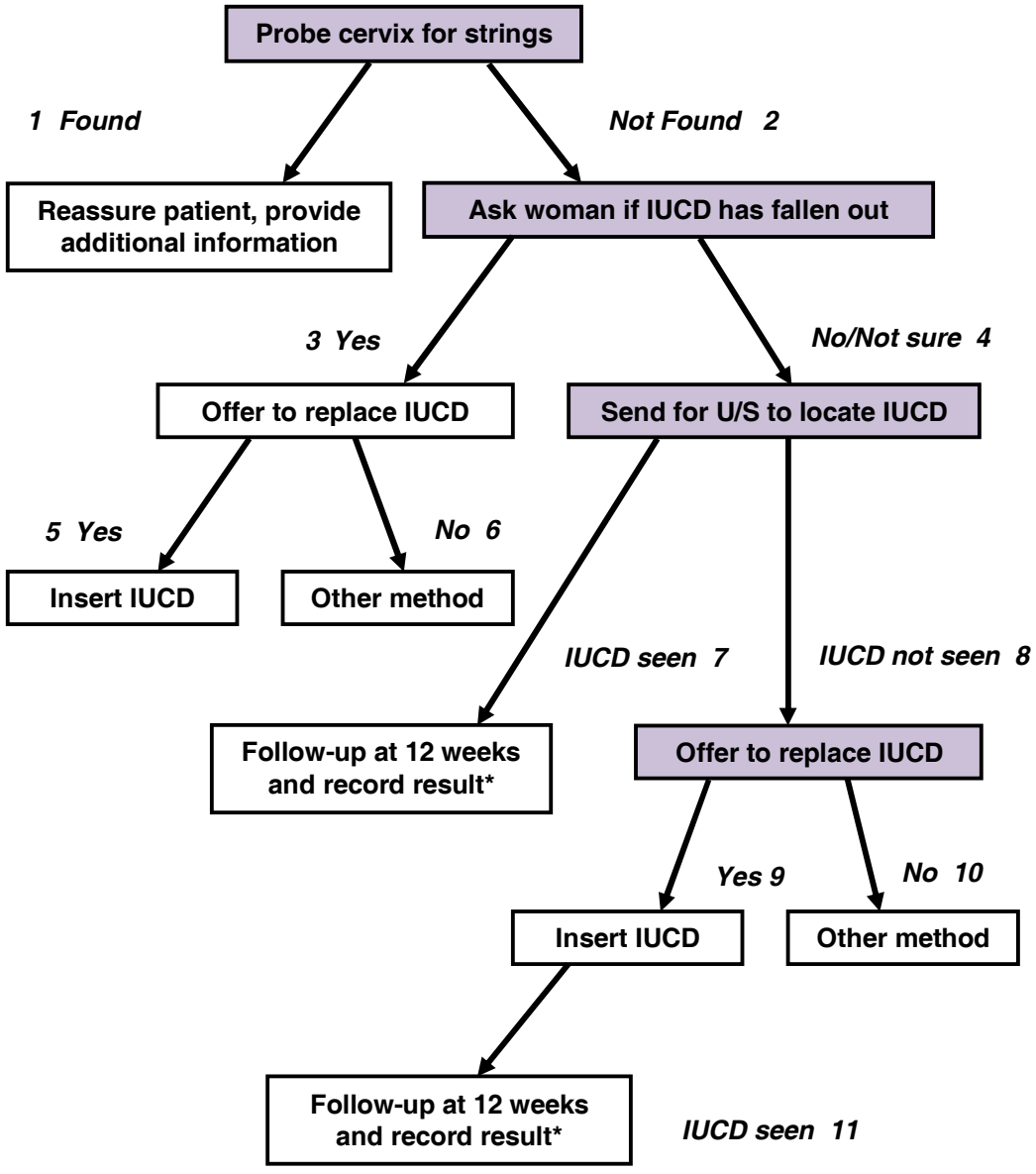
5 ☐ 6 ☐

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 12
2. remove IUCD with probe and replace 13

Annexure M

SUPPLIES AND EQUIPMENT FOR POSTPARTUM IUCD CLINICAL SERVICES

Items Required for PPFP and PPIUCD Counseling

- Samples of contraceptive methods, uterine and penile models
- Job aid for postpartum FP counseling and time for initiation of contraceptives
- Job aid for immediate PPIUCD pre-insertion screening of client
- Stamp for recording PPFP choice on ANC card
- ANC card with her choice of PPIUCD noted on it for the attention of the staff assisting in delivery
- IEC material: PPIUCD Poster for Antenatal and Postnatal Clinic; PPIUCD Leaflets, Flipbook for providers

Instruments and Supplies Needed for PPIUCD Insertion[4]

Insertion Technique	Instruments and Supplies	
Postplacental and Postpartum Insertion within 48 hours of delivery	1.	Flat surface for placing the instruments
	2.	Light source
	3.	HLD or sterile vaginal retractor (Sims or other vaginal retractor)
	4.	HLD or sterile ring forceps or sponge-holding forceps
	5.	HLD or sterile long placental forceps (Kelly placental forceps)
	6.	Bowl for cotton swabs
	7.	Cotton swabs
	8.	Povidone iodine or chlorhexidine
	9.	HLD or sterile gloves (if the same provider, who did the delivery, is inserting the IUCD, the same gloves may be worn)
	10.	Copper T 380 A, in a sterile package
Intracesarean Insertion	11.	Copper T 380 A, which has been opened onto the sterile field

- PPIUCD Insertion Register
- PPIUCD discharge instructions card to give to the woman

[4]Other standard supplies for delivery are not mentioned here

Instruments and Supplies Needed at PNC Follow-Up/Clinic

- PPIUCD follow-up register
- Supplies for performing speculum exam as needed
- Sims or Cusco or Graves speculum
- Long forceps
- Scissors
- Medications for management of common complaints
- Ibuprofen 400mg tablets
- Iron tablets
- IEC material: PPIUCD Poster, PPIUCD Leaflets, Flipbook for providers

Annexure N

PERFORMANCE STANDARDS FOR PPIUCD SERVICES

Name of Facility_____ **Date of Assessment**_____

State_____ **Name of Supervisor/Assessor**_____

Task /Item	Date	Date	Remarks
Initial Client Assessment and Counseling During Antenatal Care; Return Visits 1. The provider uses recommended counseling techniques. 2. Provider/counselor provides information on all benefits of pregnancy spacing and explores woman's knowledge about family planning methods. 3. The provider/counselor targets information-giving to the woman's interest and needs if the woman has a method/or several methods in mind. 4. The provider does a brief screening assessment and determines that the IUCD is an appropriate method for this woman. 5. Provider gives method-specific information about the IUCD. 6. Provider makes a notation which alerts other care providers that the woman has chosen postpartum insertion of the IUCD. 7. The provider conducts return visits appropriately. 8. The provider identifies woman with problems and manages complications, as necessary. **IUCD Counseling and Client Assessment During Labor or Immediate Postpartum Period** 9. The provider re-confirms with laboring woman that she has chosen the IUCD for postpartum FP. 10. The provider re-confirms with postpartum woman that she has chosen the IUCD for postpartum FP. 11. The provider counsels and screens a client not identified for the postpartum IUCD during ANC. 12. The provider ensures the IUCD is an appropriate postpartum contraceptive method for a laboring/recently postpartum woman. 13. The provider demonstrates good client-provider interaction and ensures client's rights.			

IUCD Service Provision 14. The provider completes all pre-insertion tasks for postplacental or intracesarean IUCD insertion. 15. The provider correctly inserts IUCD within 10 minutes after placental expulsion after a vaginal delivery (instrument insertion). 16. The provider correctly inserts IUCD during cesarean section. 17. The provider completes all pre-insertion tasks for postpartum IUCD insertion. 18. The provider performs a pelvic examination before immediate postpartum insertion of the IUCD. 19. The provider correctly inserts IUCD during the immediate postpartum period. 20. Post procedure infection prevention tasks and instrument processing are correctly carried out. 21. The provider provides post insertion instructions to the client. **Management and Record Keeping** 22. The provider records relevant information about the services provided in t patient's chart. 23. The provider records relevant information about the services provided in the register. 24. The facility has adequate supplies and materials for postpartum family planning. 25. The provider(s) have the required qualifications. 26. There is an organized facility-wide system in place to ensure that every postpartum woman is counseled and offered postpartum family planning.			

Annexure O (i)

POSTPARTUM IUCD INSERTION REGISTER FORMAT

S. No	Indoor Reg No	Name	Age	Postal Address	Phone No	No. of Living Children	Date of PPIUCD insertion	Counseled during *(Tick appropriate column)*			Name of Provider who inserted PPIUCD	Type of PPIUCD insertion *(Tick appropriate column)*			Instrument used for insertion *(Tick appropriate column)*			Due date for FU	Remarks
								Antenatal Care	Early Labor	Postpartum Period		Post placental (within 10 min)	Immediate PP (within 48 hrs.)	Intra Caesarean	Manual	Long Placental Forceps (Kelly)	Sponge/ Ring Forceps		

Annexure O (ii)

POSTPARTUM IUCD FOLLOW-UP REGISTER FORMAT

S. No	Indoor Reg No	Name	Age	Phone No	Date of insertion	Type of PPIUCD insertion *(Tick appropriate column)*			Name of provider who inserted PPIUCD	Due date of FU	Actual date of FU	Type of FU *(Tick appropriate column)*		Time of FU *(Tick appropriate column)*		Finding of FU *(Tick appropriate column)*					Action taken for complica-tions	Reason for removal	Remarks
						Postpartum (within 10 min.)	Immediate PP (within 48 hrs.)	Intracesarean				Clinic Visit	Telephonic	Up to 6 weeks	After 6 weeks	Expulsion	Infection	Missing Strings	Other Complaints (Specify)	No complaint			

Annexure P

MONTHLY PPFP/PPIUCD SERVICES REPORT

Name of the Facility _____

Type of Facility- ☐ Medical college ☐ District Hospital ☐ FRU ☐ CHC ☐ 24x7 PHC
☐ Pvt Hospital ☐ Pvt Clinic

District _____ State_____

Reporting Period – *From*_____(*dd/mm/yyyy*) *to*_____(*dd/mm/yyyy*)

Item	Number
1) No. of women attending the ANC clinic	
2) No of clients counseled for PPFP at ANC clinic	
3) No. of deliveries conducted in the facility	
a) Normal Deliveries	
b) Caesarean	
c) Assisted	
TOTAL	
4) No. of women counseled for PPFP during early labor (EL) and postpartum(PP) period	
5) No. of deliveries with use of utero-tonic drug for AMTSL	
a) Oxytocin	
b) Misoprostol	
c) Other *(Specify)*	
TOTAL	
6) No. of postpartum female sterilization performed	
7) No. of PPIUCD Insertion	
a) Postplacental (within 10 min)	
b) Postpartum (within 48 hrs)	
c) Intracesarean	
TOTAL	
8) No. of PPIUCD clients followed up	
a) At Clinic	
b) By Telephone	
TOTAL	
9) No of clients coming for follow-up	
a) Upto 6 weeks	
b) After 6 weeks	

10) No. of clients reporting	
a) Expulsion	
b) Infection	
c) Missing Strings	
d) Other Complaints *(Specify)*	
e) No complaint	
11) No. of PPIUCD removed*(please specify the reasons for each removal in the space below)*	

Signature of the Head of Department

Seal and Date

Resources

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