FEDERAL MINISTRY OF HEALTH

MANUAL

FOR TRAINING

DOCTORS AND NURSES/MIDWIVES

ON

POSTPARTUM LONG-ACTING REVERSIBLE
CONTRACEPTIVE (PP LARC) METHODS

PARTICIPANTS’ REFERENCE BOOK

2017
## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACRONYMS</td>
<td>5</td>
</tr>
<tr>
<td>INTRODUCTION TO THE TRAINING PROGRAM</td>
<td>5</td>
</tr>
<tr>
<td>MODULE ONE: OVERVIEW OF FAMILY PLANNING IN NIGERIA</td>
<td></td>
</tr>
<tr>
<td>MODULE ONE: SESSION 1 - OVERVIEW OF FAMILY PLANNING IN NIGERIA</td>
<td></td>
</tr>
<tr>
<td>MODULE TWO: OVERVIEW OF POSTPARTUM INTRAUTERINE DEVICE (PPIUD) AND POSTPARTUM IMPLANTS (PP IMPLANTS)</td>
<td>24</td>
</tr>
<tr>
<td>MODULE TWO: SESSION 1 OVERVIEW OF POSTPARTUM INTRAUTERINE DEVICE (PPIUD)</td>
<td>26</td>
</tr>
<tr>
<td>MODULE TWO: SESSION 2 - OVERVIEW OF POSTPARTUM IMPLANTS</td>
<td>33</td>
</tr>
<tr>
<td>MODULE THREE - ANATOMY AND PHYSIOLOGY OF THE FEMALE HUMAN REPRODUCTIVE SYSTEM</td>
<td>39</td>
</tr>
<tr>
<td>MODULE THREE: SESSION 1 - ANATOMY AND PHYSIOLOGY OF THE FEMALE REPRODUCTIVE SYSTEM</td>
<td>42</td>
</tr>
<tr>
<td>MODULE THREE: SESSION 2 - CHANGES IN THE UTERUS, CERVIX AND VAGINA DURING THE POSTPARTUM PERIOD</td>
<td>48</td>
</tr>
<tr>
<td>MODULE THREE: SESSION 3 - OVULATION, MENSTRUATION AND FERTILIZATION/CONCEPTION</td>
<td>54</td>
</tr>
<tr>
<td>MODULE FOUR – Counseling for PPIUD and Implants</td>
<td></td>
</tr>
<tr>
<td>MODULE FOUR: SESSION 1</td>
<td></td>
</tr>
<tr>
<td>INTRODUCTION TO COUNSELING</td>
<td></td>
</tr>
<tr>
<td>MODULE FOUR: SESSION 2</td>
<td></td>
</tr>
<tr>
<td>THE BALANCED COUNSELING STRATEGY PLUS (BCS+)</td>
<td>62</td>
</tr>
<tr>
<td>MODULE FIVE</td>
<td>87</td>
</tr>
<tr>
<td>CLIENT ASSESSMENT</td>
<td>88</td>
</tr>
<tr>
<td>MODULE FIVE: SESSION 1</td>
<td>91</td>
</tr>
<tr>
<td>CLIENT ASSESSMENT FOR PPIUD</td>
<td>91</td>
</tr>
<tr>
<td>MODULE FIVE: SESSION 2</td>
<td>97</td>
</tr>
<tr>
<td>CLIENT ASSESSMENT FOR POSTPARTUM IMPLANTS</td>
<td>97</td>
</tr>
<tr>
<td>MODULE FIVE: SESSION 3</td>
<td>103</td>
</tr>
</tbody>
</table>
MEDICAL ELIGIBILITY CRITERIA (MEC) ................................................................. 104

MODULE SIX .................................................................................................................. 106

POSTPARTUM IUD AND POSTPARTUM IMPLANTS INSERTION AND REMOVAL TECHNIQUES 108

MODULE SIX: SESSION 1 - POSTPARTUM IUD INSERTION TECHNIQUES ..................... 113

MODULE SIX: SESSION 2 .................................................................................................. 134

POSTPARTUM IMPLANTS INSERTION: JADELLE INSERTION TECHNIQUES .................... 134

MODULE SIX: SESSION 3 .................................................................................................. 144

IMPLANON® (CLASSIC) AND IMPLANON NXT™ INSERTION TECHNIQUES .................... 144

MODULE SIX: SESSION 4 .................................................................................................. 163

IUD REMOVAL TECHNIQUES .......................................................................................... 163

MODULE SIX: SESSION 5 .................................................................................................. 168

IMPLANT REMOVAL TECHNIQUES ............................................................................... 168

MODULE SEVEN ............................................................................................................... 184

INFECTION PREVENTION ............................................................................................... 184

MODULE SEVEN: SESSION 1 ........................................................................................... 188

INTRODUCTION AND DEFINITION OF TERMS ............................................................... 188

MODULE SEVEN: SESSION 2 ........................................................................................... 198

ASEPTIC TECHNIQUE ....................................................................................................... 198

MODULE SEVEN: SESSION 3 ........................................................................................... 213

STEPS FOR INSTRUMENTS PROCESSING AND STORAGE ............................................... 213

MODULE SEVEN: SESSION 4 ........................................................................................... 222

USE AND DISPOSAL OF NEEDLES AND SHARPS .......................................................... 222

MODULE SEVEN: SESSION 5 ........................................................................................... 231

HOUSEKEEPING AND WASTE DISPOSAL ..................................................................... 231

MODULE EIGHT ................................................................................................................ 236

FOLLOW UP AND MANAGEMENT OF SIDE EFFECTS AND COMPLICATIONS OF PPIUD AND PP IMPLANTS ................................................................................................. 236

MODULE EIGHT: SESSION 1 ............................................................................................. 239

ROUTINE FOLLOW-UP FOR PPIUD ............................................................................... 239

MODULE EIGHT: SESSION 2 ............................................................................................. 242
MANAGEMENT OF SIDE EFFECTS AND COMPLICATIONS OF PPIUD ........................................... 242
MODULE EIGHT: SESSION 3 ........................................................................................................ 250
PROBLEM MANAGEMENT DURING USE OF IMPLANTS ...................................................... 250
MODULE NINE .............................................................................................................................. 255
RECORD KEEPING, HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS) ............... 255
AND CONTRACEPTIVE LOGISTICS MANAGEMENT SYSTEM (CLMS) ......................... 255
MODULE NINE - SESSION 1: ....................................................................................................... 257
RECORD KEEPING AND HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS) ........ 257
MODULE NINE - SESSION 2: ....................................................................................................... 262
CONTRACEPTIVE LOGISTICS MANAGEMENT SYSTEM (CLMS) ........................................ 262
MODULE TEN ............................................................................................................................... 267
COMPETENCY-BASED CHECKLIST AND LEARNING GUIDES ....................................... 267
MODULE ELEVEN: ...................................................................................................................... 294
CLINICAL PRACTICUM .............................................................................................................. 302
APPENDIX .................................................................................................................................. 302
BIBLIOGRAPHY ......................................................................................................................... 302
<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>BCS</td>
<td>Balanced Counseling Strategy</td>
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<tr>
<td>BCS+</td>
<td>The Balanced Counseling Strategy Plus</td>
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<tr>
<td>CBO</td>
<td>Community Based Organization</td>
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<tr>
<td>CPR</td>
<td>Contraceptive prevalence rates</td>
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<tr>
<td>CSO</td>
<td>Community Serving Organization</td>
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<tr>
<td>FMOH</td>
<td>Federal Ministry of Health</td>
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<tr>
<td>GON</td>
<td>Government of Nigeria</td>
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<tr>
<td>HCT</td>
<td>HIV Counseling and Testing</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IEC</td>
<td>Information Education and Communication</td>
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<tr>
<td>IUD</td>
<td>Intra-uterine Device</td>
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<tr>
<td>IP</td>
<td>Infection Prevention</td>
</tr>
<tr>
<td>LGA</td>
<td>Local Government Area</td>
</tr>
<tr>
<td>MCHIP</td>
<td>Maternal and Child Health Integrated Programmes</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MEC</td>
<td>Medical Eligibility Criteria</td>
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<tr>
<td>MIS</td>
<td>Management Information System</td>
</tr>
<tr>
<td>NACA</td>
<td>National Agency for the Control of AIDS</td>
</tr>
<tr>
<td>NDHS</td>
<td>Nigeria Demographic and Health Survey</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
</tr>
<tr>
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</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>NPC</td>
<td>National Population Commission</td>
</tr>
<tr>
<td>PPIUD</td>
<td>Postpartum Intrauterine Device</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>PNC</td>
<td>Postnatal Check</td>
</tr>
<tr>
<td>PP Implants</td>
<td>Postpartum Implants</td>
</tr>
<tr>
<td>RTI</td>
<td>Reproductive Tract Infections</td>
</tr>
<tr>
<td>SDP</td>
<td>Service Delivery Point</td>
</tr>
<tr>
<td>SOP</td>
<td>Standard Operating Procedure</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>SOPs</td>
<td>Standard Operating Procedures/Standards of Practice</td>
</tr>
<tr>
<td>USAID</td>
<td>United State Agency for International Development</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
INTRODUCTION TO THE TRAINING PROGRAM

The World Health Organization (WHO) defines Postpartum Family Planning as *The prevention of unintended pregnancies and closely spaced pregnancies through the first 12 months following childbirth*. Several contraceptive methods, including the IUD and Implants, are appropriate for use soon after a woman delivers a baby. Postpartum contraception offers several benefits for women e.g. convenience, meeting women's needs, particularly healthy mothers and babies, and providing access to services amongst others. The Postpartum LARC Methods (IUDs and Implants) Training Manual is designed to equip Doctors and Nurses/Midwives with the necessary skills to perform PPIUD and PP Implants insertions.

**COURSE GOAL:**

To equip Doctors and Nurses/Midwives with the required skills to provide safe and effective Postpartum LARCs services.

**TRAINING OBJECTIVES:**

By the end of the training, the participants should be able to;

- Describe key points about PPIUD Postpartum Implants and how they work
- Describe the uniqueness of counseling for PPIUD and PP Implants and basic steps to follow when confirming informed choice
- Counsel for PPIUD and PP Implants
- Perform PPIUD insertion using appropriate technique for each timing
- Perform PP Implants insertion using appropriate technique
- Explain post insertion instructions
- Describe appropriate Infection Prevention procedures before, during and after PPIUD and PP Implants insertion
- Discuss actions to be taken in the event of problems/complications
- Discuss procedure for follow-up

**COURSE DESIGN:**

This is a competency-based training course. It will focus on the skills, facts and attitudes needed to perform PPIUD and PP Implants insertions. The training will progress from classroom to practical demonstration of skills on models and clients. Participants are expected to perform 5 insertions to be certified. Successful completion will be based on acquisition of knowledge, attitudes and skills.

**DURATION OF TRAINING - 6 days**
TRAINING/LEARNING METHODS

- Illustrated lectures
- Discussion
- Group work
- Demonstration/return demonstration
- Model practice
- Role play
- Supervised clinical practice

TRAINING MATERIALS

- Flip chart stand/paper
- Markers
- Masking tape
- IUD samples
- Mama U model
- ZOE pelvic model
- Arm models
- Cu T 380A
- Implants – Jadelle, Implanon® (classic) and Implanon NXT™
- Kelly’s forceps
- Sterile gloves
- Disinfectant e.g. JIK
- Plastic buckets
- Video tapes
- Participants reference book
- LCD Projector
- Laptop

EVALUATION

- Pre and post tests
- Competency based checklist
- Feedback

COURSE

- End of course questionnaire

TRAINERS
• Trainers' Evaluation questionnaire
MODULE FRAMEWORK AND PRESENTATIONS
MODULE ONE

OVERVIEW OF FAMILY PLANNING IN NIGERIA

Time: 1 hour

LEARNING OBJECTIVES

By the end of the session, participants should be able to:

• Describe Nigeria's rapid population growth and the age structure of the population.
• Discuss the trends in Nigeria's fertility rates and how they impact development.
• Compare Nigeria's fertility rates with those of other countries.
• Discuss the use of modern contraception in Nigeria.
• Discuss the trends in Nigeria's Contraceptive Prevalence Rate (CPR).
• Classify the different types of modern contraceptive methods.
• Discuss the barriers to the use of modern contraception in Nigeria.

SESSION OVERVIEW

• Nigeria's Rapid Population Growth and Age Structure of Nigeria's population.
• Trends in Nigeria's Fertility Rates and how they impact development.
• Comparing Nigeria's Fertility Rate with those of other countries.
• Use of modern contraception in Nigeria.
• Trends in Nigeria's Contraceptive Prevalence Rate (CPR).
• Classification of modern contraceptive methods.
• Barriers to the use of modern contraception in Nigeria.

METHODS

• Lecture
• Discussion
• Brainstorming

MATERIALS

• Flip chart Stand/paper
• Markers
• LCD Projector/ Laptop

SUMMARY

EVALUATION
In the past four decades, Nigeria has made very bold efforts to achieve rapid economic development. However, amongst other factors, rapid population growth has affected the quality of life and made achievement of socio-economic development goals difficult.

**Nigeria's Population Growth**

In 1963, both Nigeria and Britain had the same population size of 56 million. However in 2011, Nigeria's population stood at 167 million while Britain was 62 million. Between 1963 and 2011 (48 years), Nigeria tripled its population, and with sustained fertility of 5.7 and the growth rate of 3%, population will double in less than 24 years. The current population estimate for Nigeria is 186,053,386 (The World Fact Book, 2016).

![Figure 1.1: Population of Nigeria – Rapid Growth](source.png)

Nigeria has a very youthful population which is not good for the country's economic development. Having fewer children will certainly help the economy. The darker bars at the bottom of the figure below represent Nigerian children ages zero through 14. The boys are on the left and the girls on the right. These are all children that the adults, in the middle, have to feed and educate. So, these are “dependents” and the adults are the working-age population. Our older citizens are also dependent, assuming they are not working, so they too need working-age people to support them. Therefore, the ratio of people who are in the working-age to people who are too young or old to work (dependents) is low, about 1:4. That is, every working class person is feeding at least four dependents, and little is left to grow its economy, such as investing in economic activities, business, and more education.
This implies that the more dependents a population has, the harder it is for it to grow its economy because all the money is spent on just trying to help these dependents to survive (feeding them, giving them the basics they need to survive). However, when there are fewer dependents then the working-age population can spend more money on other things like investments that make the economy grow.

**High Fertility Rates**

Nigeria has very high fertility rate compared with other nations. Only a few nations, such as Chad, have higher fertility rates. Cultural, social, and religious attitudes and beliefs are some of the drivers of the high fertility rate.

Figure 1.3: Fertility Rates in Nigeria by Zones

Source: NDHS 2013

Figure 1.4: Comparison of Nigeria's Fertility Rate with Other Countries

Source: NDHS 2013
Use of Modern Contraceptives

One main reason for the country’s high fertility rate is the low use of modern contraceptives; only 10% of our married women of childbearing age use modern contraception right now. In comparison, some of the other countries have up to 77% of married women using modern contraception. Can the country not afford to pay for modern contraception? The Nigerian Government made a commitment during the London Family Planning Summit of 2012 to increase the CPR from the current figure of 15% (NDHS 2013) to 36% by the year 2018 through a comprehensive five-year costed scale-up plan.
In Thailand, from the 1960s to the 1990s, fertility levels fell from a little bit higher than where Nigeria is today down to 2.3 births per woman. And during those same years, the GDP per capita was rising very fast. This is not a coincidence. Thailand's drop in fertility helped to free up resources, which, when properly invested, contributed to rapid economic growth.

In economic terms, fertility decline and thus slower population growth creates:

- The potential to increase the rate of economic growth
- A path out of poverty for many families

At the family level, when parents have fewer children, they can focus on the quality of each child's education, nutrition, or other aspects of life. Each child can have more educational and other opportunities, as there are fewer dependent children per working adult. If there are fewer dependents per working adult, then more money can be saved and invested in things like modern agriculture.

**Education**

In the education sector, if Nigeria continues on its current path of high fertility, the number of students that will enter primary schools will increase - more than double by 2040. How shall the nation take care of these students? If the country takes the path of low fertility, the number of students entering primary school won't rise as quickly, making the number of students more manageable. And if the nation has fewer students under the Low Fertility Scenario, there will be less pressure to build new schools.

**Health**

Fertility affects health mainly because certain types of births are exceptionally risky. High risk births are defined as births that are too closely spaced, too young or too old, or when the mother
has too many children. All of these could cause death or injury to the mother and child. In Nigeria, more than 6 in 10 births fall in at least one of the high risk categories. In Nigeria, this means that more than half the children born have an elevated risk of dying before their 5th birthday. This risk could be significantly diminished by using child spacing to avoid births that are too closely spaced or that fall into other high-risk categories. Lower fertility also puts less strain on the nation's healthcare system and health workers, including Doctors, Nurses/Midwives and CHEWs. At present, the country does not have adequate health workers, especially midwives. The number of midwives required would increase faster under the High Fertility Scenario. But under the Low Fertility Scenario, the number of midwives required would increase more slowly. The same is true for hospitals. Nigeria may need more hospitals to care for even its current population, but under rapid population growth, it will need even more hospitals, not just for child birth but for other medical necessities as well. By the current estimates, even to just maintain current standards of care, the number of hospitals required in Nigeria would more than double between now and 2040 if the nation continues at high fertility. But if it is able to lower fertility, then the number of hospitals required will not increase as much, and the challenge will be easier to manage. By 2040, Nigeria could save 47 billion naira in health expenditures under the Low Fertility Scenario.

In summary, lower fertility in Nigeria just in the next 10 years could help us avert 1.5 million child deaths. It could help us save 31,000 women’s lives, reduce health complications for mothers and children, and reduce stress on the national budgets and medical staff.

**Agriculture**

Nigeria strives for a productive agricultural sector and wants to conserve natural resources for sustainable development. In the agricultural sector, as in other sectors, lower fertility yields benefits for Nigeria. Nigeria has become a rice-eating country. Under the High Fertility Scenario, more people are eating rice - 1.8 billion metric tons by 2040. Where is this rice going to come from? This is a question for national food security (whether the country can feed the number of people it has). Nigeria is already importing some rice. If the country pursues a Low Fertility Scenario, the rice needed could be reduced by 400 million metric tons per year by 2040. This would also mean less money needed to pay for rice imports.

**Economy**

The national development policy is to become a modern and prosperous country over the next 30 years. The economy can benefit in many ways from slower population growth. If it is assumed that Nigeria's real GDP grows at 6 percent each year, then under the High Fertility Scenario, each Nigerian's average GDP will not grow very fast. Annual GDP per capita will only grow to 748,000 Naira per person by 2040. But if there are fewer people, the nation can invest more in them, and spread the wealth among fewer people, GDP per person would grow faster.

If Nigeria has lower fertility, it will also need fewer jobs because there will be fewer teenagers that are growing up and looking for jobs. In the High Fertility Scenario, the number of additional jobs that Nigeria needs each year will grow so fast that it is probably impossible to keep up. These new job seekers will have nothing to look forward to, no hope. And under the Lower Fertility Scenario it
is still an incredible challenge to try to generate enough jobs for these teenagers who are growing up and entering the workforce, but at least it's a lot more manageable. There will be fewer new job seekers and better security.
CLASSIFICATION OF MODERN FAMILY PLANNING METHODS
## A. HORMONAL CONTRACEPTIVES

<table>
<thead>
<tr>
<th>Oral Pills</th>
<th>Vaginal Pills</th>
<th>Emergency Contraceptive Pills</th>
<th>Injectables</th>
<th>Implants</th>
<th>Vaginal Rings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined pills</td>
<td>Combined pills (intermittent or continuous)</td>
<td>Postinor 2</td>
<td>Combined injectables, e.g. Norigynon Progestin-only injectables, e.g. Depot Medroxy-progesterone acetate (DMPA), Sayana press, Norethisterone enanthate (NET-EN)</td>
<td>Biodegradable implants Non-biodegradable implants, e.g. Jadelle, Zarin and Implanon®</td>
<td>Progesterone vaginal ring</td>
</tr>
</tbody>
</table>

## B. NON HORMONAL CONTRACEPTIVES

***INTRA-UTERINE CONTRACEPTIVE DEVICES (IUD)***

| Copper T 380A | Mirena |

## C. BARRIER METHODS

| Male Condom | Female Condom e.g. Femshield | Diaphragms | Cervical caps | Chemical barriers, e.g. foaming tablets, foams, jellies, etc. |

## D. VOLUNTARY SURGICAL CONTRACEPTION
The wide choice of family planning methods now available allows health programmes to offer an appropriate method to each individual. Most modern contraceptive methods are virtually without risk and in addition, offer substantial benefits besides preventing pregnancies. The methods most often used to avoid closely spaced pregnancies or pregnancies at a young age are oral contraceptives, barrier methods and spermicides, emergency contraceptive pills (ECPs) and natural family planning methods. Intra-uterine devices (IUDs), injectables and implants are longer acting methods, and may be preferred by older women or those who already have all the children they want. Since voluntary surgical contraception is generally permanent, it is inappropriate for couples who want more children.

**Barriers to the Use of Contraceptive Methods in Nigeria**

Family Planning clients are often restricted by the choice of methods offered to them, or are deterred from using contraception due to the side effects related to use of available methods. Other barriers include lack of access, lack of knowledge and awareness and provider bias. Some methods are provider-dependent and are not under the control of the client. In addition, myths and misconception, inappropriate criteria, gender and socio-cultural norms and inappropriate clinic hours also constitute major barriers to the use of contraceptives.
SUMMARY

The National Population Policy recognized the adverse effect of rapidly growing population on the quality of life, development and security, hence, the Federal Government, in partnership with donor agencies, have intensified effort to ensure that Nigerian couples have access to free contraceptive commodities.

Nigeria seeks better jobs, food security, better health and education for its people. The nation wants wealthier people (higher per capita income) and a better quality of life. And to do that, the Nigerian people need to advocate for support for family planning at the state, local, and community levels, and expand access to family planning commodities Meeting the contraceptive needs of women generally is an important component of comprehensive maternal and child health services. To assist women who want to prevent or delay pregnancies, programmes should offer family planning information and services.

Careful counseling can help women to choose methods that are safe, effective and convenient - methods that best meet their short and long term family planning needs. Well-designed family planning programmes provide services that women require both before and after their babies are born. When women's reproductive health needs are met, they have greater chance of not dying from childbirth and healthier families.

EVALUATION

- Mention how Nigeria's high fertility rate has impacted on its development?
- Discuss the trends in Nigeria's Contraceptive Prevalence Rate (CPR)?
- Mention the different types of modern contraceptive methods?
- What are the barriers to the use of modern contraception in Nigeria?
MODULE TWO: OVERVIEW OF POSTPARTUM INTRAUTERINE DEVICE (PPIUD) AND POSTPARTUM IMPLANTS (PP IMPLANTS)

This module covers key points about Postpartum Intrauterine Device and Postpartum Implants and how they work, the benefits of postpartum contraception services, including PPIUD and Postpartum Implants, clients' rights and quality of care, and the key components of service delivery, including the importance of the client- provider interaction.

Session 1: Overview of Postpartum IUD
Session 2: Overview of Postpartum Implants
# Module Two

## Overview of Postpartum Intrauterine Device (PPIUD) and Postpartum Implants (PP Implants)

### Module Plan

<table>
<thead>
<tr>
<th>Session</th>
<th>Duration</th>
<th>Objectives</th>
<th>Method</th>
<th>Resources</th>
</tr>
</thead>
</table>
| Session 1: Overview of Postpartum IUD | 30 minutes | • Explain key points about PPIUD and how it works  
• Explain the benefits of Postpartum contraception including P Postpartum IUD | • Lecture  
• Discussion  
• Brainstorming | • Flip chart stand/paper  
• Markers  
• LCD Projector  
• Laptop  
• Cu T380A |
| Session 2: Overview of Postpartum Implants | 30 minutes | • Explain key points about Postpartum Implants and how they work  
• Explain the benefits of Postpartum contraception including Postpartum Implants | • Lecture  
• Discussion  
• Brainstorming | • Flip chart stand/paper  
• Markers  
• LCD Projector  
• Laptop  
• Jadelle  
• Implanon® (classic)  
• Implanon NXT™ |
MODULE TWO: SESSION 1 OVERVIEW OF POSTPARTUM INTRAUTERINE DEVICE (PPIUD)

Time: 30 mins

LEARNING OBJECTIVES:

By the end of the session, participants should be able to:

- Explain key points about PPIUD and how it works.
- Explain the benefits of post-partum contraception including PPIUD.

SESSION OVERVIEW

- Key points about PPIUD.
- Benefits of postpartum contraception.

METHODS

- Lecture
- Discussion
- Brainstorming

MATERIALS

- Flip chart stand/paper
- Markers
- LCD Projector
- Laptop
- Masking tape
- Cu T 380A

SUMMARY

EVALUATION
Key points about PPIUD

Intrauterine devices (IUDs) are small flexible devices made of metal and/or plastic that can prevent pregnancy when inserted into a woman's uterus through her vagina.

- The types of IUDs available in Nigeria include:
  - Copper T 380A IUD (CuT 380A)
  - Levonogestrel Intrauterine System (e.g. Mirena),

Figure 2.1.1: CuT 380A

- A T-shaped intrauterine device (IUD), measuring 32 mm horizontally and 36 mm vertically, with a 3 mm diameter bulb at the tip of the vertical stem.
- A thread is tied through the tip, resulting in two white threads, each at least 10.5 cm in length, to aid in detection and removal of the device.
- The T-frame is made of materials which aid in detecting the device under x-ray.
Cu T 380A also contains copper: approximately 176 mg of wire coiled along the vertical stem and a 68.7 mg collar on each side of the horizontal arm.

The total exposed copper surface area is $380 \pm 23 \text{ mm}^2$. One unit weighs less than 1g.

Each Cu T 380A is packaged together with an insertion tube and solid white rod in a sterilized pouch.

A moveable flange on the insertion tube aids in gauging the depth of insertion through the cervical canal and into the uterine cavity.

Figure 2.1.3: Levonorgestrel Intra-uterine System (Mirena)
How CuT 380A IUD works: It prevents pregnancy by inhibiting fertilization, transport of the egg, and the migration of sperm into the upper female genital tract.

Advantages of CuT 380 A-bearing IUDs:

- IUDs are highly effective and safe for majority of women
- They are reversible
- They are independent of intercourse
- They are private
- No day-to-day action is required
- IUDs are easily available
- They have no effect on lactation
- There is no drug interaction
- They are long-acting (Cu-T-380A is effective for as long as 10 years)

PPIUD timing: This training course will focus primarily on pre-discharge and post placental insertion.

- Postpartum: a general term for IUD insertion that takes place after delivery and before the woman leaves the hospital.
- Pre-discharge: insertion after the post placental period, but within 48 hours of delivery and before the woman leaves the hospital.
- Post placental: insertion immediately after expulsion of the placenta. It is recommended that the insertion takes place within 10 mins after expulsion of the placenta following a vaginal delivery, or at the time of caesarean section.
- Trans-Caesarean: insertion that takes place following a Caesarean delivery, before the uterus is closed.
- Post-Caesarean: pre-discharge insertion following caesarean delivery.
• Post-abortion: IUD insertion following abortion. Following a second trimester abortion a postpartum insertion technique is used. After a first trimester abortion the IUD is inserted using an interval technique. This is due to the differences in anatomy and physiology between the first and second trimester.

• Interval: Insertion that takes place anytime more than six weeks after delivery.

**Duration of use:** The Copper T380A, which will be used in this training course, is effective for 10 years. If a different IUD is used, the provider must refer to its package insert for information on the duration of its effectiveness.

**Effectiveness:** IUDs are highly effective methods of contraception. Expulsion rates for PPIUDs are slightly higher than interval insertion (Interval – 3%, Post placental - 9.5%, Pre discharge – 37%). To prevent expulsion, the provider must place the IUD high in the fundus.

**Differences between postpartum and interval IUDs:**

The difference between PPIUD and interval IUD are insertion technique and timing of insertion.

**Management of services:**

PPIUD services must be carefully structured and well organized to be effective (e.g., antenatal counseling is necessary for post placental and trans-caesarean insertion). The number of service providers involved, the unpredictable nature of the obstetric setting, and the importance of the timing of the IUD insertion contribute to the complexity of structuring of PPIUD program. In order to maximize counseling and referral opportunities before the woman arrives at the hospital for delivery, or before she is discharged, and to increase the likelihood that the woman will return for follow-up care, it is important to involve staff from various hospital departments, such as antenatal care, obstetrics, maternity, postnatal care, family planning, and well-baby services. Module 10 of this curriculum provides more information about management of services.

**Benefits of Postpartum Contraception**

Several contraceptive methods, including the IUD, are appropriate for use soon after a woman delivers a baby. Postpartum contraception offers several benefits for women:

1. Convenience: The woman or her partner leaves the hospital with a method of contraception that does not require her returning for a special visit at a later date.
2. Meeting women's needs: A six-country research study found that many pregnant and postpartum women are interested in learning about and using postpartum contraception, but that services are often unavailable (Landry et al., 1992).
3. Healthy mothers and babies: Postpartum family planning generally helps mothers maintain good health for themselves and their babies by reducing the total number of births, the percentage of high-risk births, and the number of unplanned pregnancies. Numerous studies have shown that children born two years or more after the preceding birth are more likely to survive.

4. Access to services: Many women visit health care facilities during the antenatal period, delivery, and after the birth of baby. Each client-provider contact associated with childbirth during antenatal visits, for delivery, and after the birth of the baby is an opportunity for clients and their partners to ask questions, and for providers to offer information and counseling and to supply the contraceptive method the client desires.

The postpartum IUD has an additional benefit that women may find attractive. After a woman has interval insertion, she is likely to experience cramping for the first few months as well as bleeding or spotting between menstrual periods. In the case of the postpartum IUD, these side effects are usually masked by normal postpartum recovery.

In addition to the benefits described above, postpartum contraception can be cost effective. A study conducted at a large hospital (FH, 1994) found that the costs of offering postpartum contraceptive services were significantly less than the cost of providing other reproductive health services on an outpatient basis. In addition, providing postpartum contraceptive services helps to relieve overcrowded outpatient facilities, thus allowing more women to be served.

**SUMMARY:**

The session described the key points about PPIUD and how it works. It also explained the benefits of postpartum contraception including PPIUD.

**EVALUATION:**

- Described how PPIUD works?
- List 3 benefits of postpartum contraception?
MODULE TWO: SESSION 2 - OVERVIEW OF POSTPARTUM IMPLANTS

Time: 30 mins

LEARNING OBJECTIVES

By the end of this session, participants should be able to:

• Explain key points about postpartum Implants and how they work.
• Explain the benefits of Postpartum contraception including Postpartum Implants.

SESSION OVERVIEW

• Key points about postpartum Implants.
• Benefits of postpartum contraception.

METHODS

• Lecture
• Discussion
• Brainstorming

MATERIALS

• Flip chart Stand/paper
• Markers
• LCD Projector
• Laptop
• Masking tape
• Jadelle, Implanon® classic, Implanon NXT™

SUMMARY/ EVALUATION
Key points about Postpartum Implants

Types, characteristics, effectiveness and mechanism of action of Implants:

- Contraceptive implants are progestin-only contraceptives inserted under the skin of a woman’s upper arm by a minor surgical procedure.
- A blood level of the progestin is reached within a few hours after placement and is maintained at an effective level for at least 3-5 years.

Types of Contraceptive Implants:

- Jadelle – two silicon rods; each containing 75mg levonorgestrel. It is an improved version of Norplant. Its effectiveness is for 5 years.
- Implanon® – one rod containing 68mg of etonogestrel. It is effective for 3 years.
- Implanon NXT™ – a newer version of Implanon® which can be seen on X-ray, making it possible to check the location of the implant. Implanon NXT™ also has a preloaded sterile applicator which is for single use and disposable.

Jadelle:

Jadelle is an implant system that provides effective, long-acting, reversible contraception for women. Two thin, flexible rods made of silicone tubing and filled with levonorgestrel, a synthetic progestin, are inserted just under the skin of a woman's upper, inner arm through a minor surgical procedure. Protection from pregnancy is provided within 24 hours, when insertion is performed during the first week of a woman's menstrual cycle. The woman rapidly returns to her normal fertility when the implants are removed. Since Jadelle does not contain estrogen, the most common side effects are changes in menstrual bleeding patterns. Most other common side effects are similar to those experienced by women who use other hormonal contraceptives.

Composition:

The outer part of the Jadelle rod is silicone rubber tubing, similar to the material used in catheters and heart valves since the 1950s. It also is the same kind of material used in Norplant capsules, another contraceptive implant system. The rods release levonorgestrel, a synthetic progestin that has been used in combined oral contraceptives and in progestin-only pills for more than 30 years. What is "new" about the rods is their delivery system, which can provide contraceptive protection for up to five years.
Implanon® and Implanon NXT™:

Implanon® is a reversible, non-biodegradable, long-acting hormonal, sub-dermal contraceptive that contains etonorgestrel. It is a single-rod system with a disposable applicator. A newer version of Implanon® is also available, it is called Nexplanon® or Implanon NXT™™ and it is radio-opaque-this means it can be seen on X-ray, which is useful for checking the location of the implant. Implanon® and Nexplanon are the only contraceptive implants with Food and Drug Administration (FDA) approval available in the U.S. Implanon NXT™ also has a preloaded, sterile applicator which is for single use and disposable. Inserters familiar with the applicator for Implanon® need to familiarize themselves with the one for Implanon NXT™™.

Composition:

Implanon® releases 3-keto-desogestrel, which is the active metabolite of the well-known progestogen, desogestrel, developed by Organon. The molecule 3-keto-desogestrel has
been given the international non-proprietary name of etonorgestrel (ENG), as shown in the figure below. Each Implanon NXT™ contains 68 mg of etonorgestrel. Desogestrel has been used in combined oral contraceptives for many years and therefore the pharmacological effects of desogestrel, and consequently those of etonorgestrel, have been established. However, both Implanon® and Implanon NXT™ continuously releases etonorgestrel and the first-pass effect is avoided, therefore the clinical pharmacology is not completely covered by former experiences with desogestrel-containing combined oral contraceptives (COCs).

**Figure 2.2.2: Implanon® classic and Implanon NXT™**
After the insertion of the Implanon®, etonogestrel is rapidly absorbed into the circulation. Ovulation-inhibition concentrations are reached within 1 day. Maximum serum concentrations are reached within 1 to 13 days. The release rate of the implant decreases with time.

**Mechanisms of Action of Implants:**

- Inhibition of ovulation
- Thickening of cervical mucus, making it impermeable to sperm
- Thinning of the endometrium

**Effectiveness:**

Jadelle is one of the most effective reversible contraceptives available. The cumulative pregnancy rate in clinical trials was 0.3 for three years and 1.1 percent for five years. Jadelle has a lower failure rate than the pill and most IUDs. Its efficacy is comparable to that of surgical sterilization.

The effectiveness of Implanon® is less than one pregnancy per 100 women (1 per 1,000 women) for over three years of use. The high degree of protection against pregnancy is obtained among other reasons because, in contrast to OCs, the contraceptive action of Implanon® is not dependent on the regular intake of tablets. The contraceptive effect of Implanon® is related to the plasma levels of etonogestrel, which are inversely related to the body weight, and decrease with time after insertion. The clinical experience with Implanon® in heavier women in the third year of use is limited. Therefore, it cannot be excluded that the contraceptive effects in these women during the third year of use may be lower than for women of normal weight. Clinicians may therefore consider earlier replacement of the implant in heavier women.

**Postpartum Insertion:**

- Can be inserted in the delivery room or at any other time postpartum before hospital discharge.
- The technique for implant insertion does not differ from that for interval insertion.

**Contraindications:**

- There are no contraindications or risks specific to the postpartum period apart from theoretical issues related to breastfeeding.
- Observational studies suggest they have no effect on successful initiation and continuation of breastfeeding.
- Active venous thromboembolic disorder.
- Presence or history of severe hepatic disease.
• Presence or history of hepatic tumor.
• Breast cancer.

**Benefits of Postpartum Implants insertion:**

• Women are not known to be pregnant before the insertion.
• Many of them are well motivated to avoid short-interval pregnancy.
• The woman and clinician are in the same place at the same time, thereby eliminating potential access barriers.
• No need for additional visit for insertion.
• It is cost effective.

**SUMMARY:**

The session described the key points about postpartum implants and how they work. It also explained the benefits of postpartum contraception.

**EVALUATION:**

• List the various types of contraceptive implants?
• Describe their mechanisms of action?
• List 4 benefits of postpartum implant insertion?
MODULE THREE - ANATOMY AND PHYSIOLOGY OF THE FEMALE HUMAN REPRODUCTIVE SYSTEM

Session 1: Anatomy and Physiology of the Female Reproductive System

Session 2: Changes in the uterus, cervix and vagina during the postpartum period

Session 3: Ovulation, Menstruation and Fertilization/Conception
## MODULE THREE

### ANATOMY AND PHYSIOLOGY OF THE FEMALE HUMAN REPRODUCTIVE SYSTEM

#### MODULE PLAN

<table>
<thead>
<tr>
<th>SESSION</th>
<th>DURATION</th>
<th>OBJECTIVES</th>
<th>METHOD</th>
<th>RESOURCES</th>
</tr>
</thead>
</table>
| Session 1: Anatomy and Physiology of the Female Reproductive System | 40 mins | • Identify on a diagram the names of the external and internal organs of the female reproductive system  
• Mention the functions of each of the female reproductive organs | • Lecture  
• Discussion  
• Brainstorming | • Flip chart stand/paper  
• Markers  
• LCD Projector/Laptop |
| Session 2: Changes in the uterus, cervix and vagina during the postpartum period | 40 mins | • Describe changes that occur in the uterus, cervix and vagina during the Postpartum and non-pregnant anatomy and physiology.  
• Enumerate key differences between postpartum and non-pregnant anatomy and physiology  
• Explain why the immediate postpartum period is the most appropriate time for PPIUD insertion, as opposed to the period between 48 hours and six weeks post-partum. | • Lecture  
• Discussion  
• Brainstorming | • Flip charts Stand/paper  
• Markers  
• LCD Projector/Laptop |
| Session 3: Ovulation, Menstruation and Fertilization/Conception | 45 mins | • Explain the meaning of ovulation  
• Understand how ovulation occurs  
• Explain what menstruation is  
• Discuss the type of health education necessary during menstruation | • Lecture  
• Discussion  
• Brainstorming | • Flip chart stand/paper  
• Markers  
• LCD Projector/Laptop |
- Describe the process of fertilization and conception
MODULE THREE: SESSION 1 - ANATOMY AND PHYSIOLOGY OF THE FEMALE REPRODUCTIVE SYSTEM

Time: 40 minutes

LEARNING OBJECTIVES:

By the end of this session, the participants should be able to:

- Identify on a diagram the names of the external and internal organs of the female reproductive system.
- Mention the functions of each of the female reproductive organs.

SESSION OVERVIEW

- Introduction.
- External Female Reproductive Organs.
- Internal Female Reproductive Organs.

METHODS

- Lecture
- Discussion
- Brainstorming

MATERIALS

- Flip chart Stand/paper
- Markers
- LCD Projector/ Laptop
- Masking tape

SUMMARY

EVALUATION
A. Introduction
The female reproductive system is the part of a woman responsible for producing a baby.
The system consists of two parts:
- The external female reproductive organs
- The internal female reproductive organs

B. The External Female Reproductive Organs

Mons pubis
- This is spread over the pubic bone and becomes covered with hair at puberty.
- It protects the external organs.

Labia majora
- These are two thick outer lips immediately below the fatty pad.
- They protect the vagina.

Labia minora
- These are two thin soft inner lips, pinkish in colour and very sensitive.
- They cover and protect the opening of the urethra and the opening to the vagina.

Clitoris
- The clitoris lies between the upper part of the labia minora and majora, just above the opening of the vagina.
- It is the most sensitive part of a woman and responds to sexual stimulation.
- This is the part that is erroneously cut and removed during female circumcision (genital mutilation/genital cutting).
- It is the centre of female sexual excitement.
Figure 3.1.1: The Female External Reproductive Organs
C. Internal Female Reproductive Organs

Figure 3.1.2: The Female Internal Reproductive Organs (Internal Genitalia)

Vagina
- It is the opening to the cervix and other reproductive organs.
- It serves as an outlet for menstruation.
- It holds the penis during intercourse.
- It serves as a passage for the baby.
- It also serves as a route for drug administration.
**Bartholin's gland**
- These are two small glands situated under the big lips of the vagina.
- They release drops of lubricant into the small lips when a woman is sexually stimulated and this prevents friction and discomfort during sexual intercourse.

**Hymen**
- This is a thin membrane that covers the vagina when a girl is a virgin but is torn during first exposure to sexual intercourse. The hymen may also be torn during vigorous exercise or use of tampons.
- It protects the vagina from infection before puberty.

**Urethra**
- This is the opening situated between the vagina and the clitoris.
- It serves as a passage for urine.

**Cervix**
- The cervix is the mouth of the womb that protrudes into the vagina. In a non-pregnant woman, it feels like the tip of the nose when touched.
- It dilates during labour to allow the baby to be delivered.
- It is the passage for menstruation.
- It produce a secretion which helps the sperm to move.
- It is the passage through which the IUD is placed into the womb.

**Uterus**
- The uterus is a bigger sac that lies in the pelvic cavity behind the bladder and in front of the rectum.
- It accommodates and protects the fertilized egg that gets implanted there until it is fully developed into a baby and delivered.
- During labour, it helps to push the baby out.
- It is the place where an IUD, a family planning method, is placed.

**Fallopian tubes**
- They are two in number and are located on each side of the womb near the top (fundus) of the egg bag. Each has a finger-like structure (fimbria) at both ends to assist in drawing the ripe egg into the Fallopian tube.
- It serves as a meeting place for the male's seed and the female egg.
- It serves as a place for the egg to be fertilized by the sperm.
- It serves as the passage for the fertilized egg to move to the womb.

**Ovaries**
- They are two small egg-shaped bags on each side of the fallopian tube.
- They produce ripe eggs once a month.
- They produce the female sex hormone that make a woman look like a female and keep the reproductive system in good order.
**Ovum**
- This is the female sex cell. It is about the size of a pinhead.
- A ripe egg released each month into the fallopian tube for fertilization by the male's seed. If not fertilized, it dissolves and is absorbed into the uterus and comes out with the menstrual blood.

**SUMMARY**

This session describes the anatomy of the external and internal genital organs in the female and their functions.

**EVALUATION**

- List the organs that constitute the female external genitalia and their functions?
- List the organs that constitute the female internal genitalia and their functions?
MODULE THREE: SESSION 2 - CHANGES IN THE UTERUS, CERVIX AND VAGINA DURING THE POSTPARTUM PERIOD

Time: 40 mins

LEARNING OBJECTIVES:

By the end of this session, the participants should be able to:

- Describe changes that occur in the uterus, cervix and vagina during the Postpartum and non-pregnant anatomy and physiology.
- Enumerate key differences between postpartum and non-pregnant anatomy and physiology.
- Explain why the immediate postpartum period is the most appropriate time for PPIUD insertion, as opposed to the period between 48 hours and six weeks post-partum.

SESSION OVERVIEW

- Changes in the uterus, cervix and vagina during the postpartum period.
- Key differences between Postpartum and non-pregnant anatomy and physiology.
- Post placental and pre discharge periods: appropriate times for IUD insertion.

METHODS

- Brainstorming
- Lecture
- Discussion

MATERIALS

- Flip chart stand/paper
- Markers
- LCD Projector
- Laptop
- Masking tape

SUMMARY

EVALUATION
Changes in the Uterus, Cervix, and Vagina during the Postpartum Period:

The puerperium is the period of adjustment after pregnancy and delivery when the anatomic and physiologic changes of pregnancy are reversed and the body returns to the normal non pregnant state. The early puerperium extends until the first week postpartum. Remote puerperium, which includes the period of time required for involution of the genital organs, has traditionally extended through the sixth week postpartum. Majority of non-lactating women resume menstrual cycles at this time or soon thereafter.

The immediate puerperium includes the first 24 hours postpartum. This time period and beyond (up to 48 hours postpartum) is appropriate for inserting a PPIUD.

During the immediate puerperium, two characteristics of the uterine muscle are emphasized:

- **Retractility** - a Permanent and Passive Phenomenon, which produces a definite shortening of the uterine fiber.
- **Contractility** - an intermittent and active phenomenon, which produces a temporary shortening of the same fiber.

The Uterus

Just after delivery of the placenta, the fundus of the uterus is just below the umbilicus. The uterus itself weighs about 1 kg and its size is roughly that of a 20-week pregnancy, measuring between 25 and 30cm from cervix to fundus.

During the first 12 hours postpartum, uterine contractions are regular, strong, and coordinated. The intensity, frequency, and regularity of contraction decrease after the first postpartum day as involution changes proceed.

The immediate postpartum uterus is a smooth cavity with apposition of the anterior and posterior walls, each having a thickness of 4 to 5 cm. As the uterus involutes, its walls come together gradually. This action holds a newly inserted IUD securely in place; it does not push the IUD out.

In the first day, the very thinned-out inferior segment is folded (accordioned), which permits great mobility of the corpus, still thick (5 cm thick) and heavy, and causes it to tilt forward. This mobility of the corpus is aided by the shortening of the suspensory ligaments of the uterus.

After two days postpartum, the uterus starts to get smaller. By the sixth day, the uterus is halfway between the umbilicus and the superior edge of the pubis. At the end of the first postpartum week, the uterus will normally have decreased to the size of a 12-week gestation, weighing about 500g. The observed changes in the uterus are primarily changes in uterine length, since the transverse diameter remains relatively constant during the puerperium.
At the end of week two, the uterus weighs about 300 g and soon it weighs 100g or less. Within two weeks, it cannot be felt above the symphysis any longer. The uterus returns to its normal, non-pregnant dimensions within four weeks. The total number of muscle cells in the uterus does not diminish; what diminishes considerably is the size of each cell.

During the first 12 days, the uterus is palpable in an abdominal position (Figure 4.4). After the twelfth day, involution has positioned the uterus in the pelvis. This gradual regression of the uterus is achieved by the continuous contraction and retraction of the organ. The uterus maintains a globulous shape, flattened front to back until the eight day, when it becomes pear-shaped as the cervix and isthmic regions are reformed. When there is infection, the process of involution is delayed.

**The Cervix**

Immediately after the third stage, the cervix and lower uterine segment are collapsed and limp. The cervix slowly contracts. As the cervix narrows, it thickens, and a canal is reformed.

By the end of the first week, the cervix has narrowed so much that it becomes difficult to insert a finger, being a little more than 1 cm dilated. The internal Os closes by the twelfth day; the external Os narrows more slowly. When involution is completed the external Os does not return to its pre-delivery appearance completely.

**The Vagina**

Early in the first six weeks postpartum, the vagina forms a spacious, smooth-walled passage that gradually diminishes in size but rarely returns to pre-pregnant dimensions. After vaginal delivery, the over distended and smooth-walled vagina gradually returns to its antepartum condition by about the third week. Anatomical folds reappear by the third week.

The voluntary muscles of the pelvic floor and the pelvic support gradually regain their tone during the puerperium.

**Key Points for IUD Insertion**

- In the immediate postpartum period, the lower uterine segment is contracted. This anatomic change may cause a provider to mistakenly believe that he or she has already reached the fundus when inserting an IUD, and that the IUD is being properly placed at the fundus when it is not. This is important because inserting the IUD in this incorrect position may result in an expulsion. Such an expulsion may cause client dissatisfaction and reduce the likelihood of continued use of an IUD.

You will need to exert slight pressure to move the IUD past the contracted lower uterine segment. To do this, place your other hand (the one not holding the IUD) on the client's abdomen where the
uterine fundus can be palpated. The IUD should be directed towards the hand at the fundus (the hand not holding the IUD). This technique will be covered in more detail in Module six which addresses insertion techniques.

### Key Differences between Postpartum and Non pregnant Anatomy and Physiology

<table>
<thead>
<tr>
<th>Anatomical Structure</th>
<th>Non pregnant</th>
<th>Pregnant</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UTERUS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weighs approximately 100 g or less</td>
<td>Can weigh from as much as 1 kg immediately postpartum and gradually less and less</td>
<td></td>
</tr>
<tr>
<td>Is situated in the pelvis</td>
<td>Immediately after birth, the uterus is just below the umbilicus; it gradually moves lower until it is back in the nonpregnant position</td>
<td></td>
</tr>
<tr>
<td>Usually contracts only during menses</td>
<td>During first 12 hours, uterine contractions are regular, strong, and coordinated; intensity, frequency and regularity of contractions decrease after the first postpartum day</td>
<td></td>
</tr>
<tr>
<td>Walls are together creating a “potential” space</td>
<td>Walls are first distended and separated; but they come together during involution</td>
<td></td>
</tr>
<tr>
<td><strong>CERVIX</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is a narrow canal between the uterine cavity and vagina</td>
<td>Immediately after the third stage, the cervix and lower uterine segment are collapsed and limp, the cervical os slowly contracts; by the end of the first week, it is a little more than 1 cm dilated</td>
<td></td>
</tr>
</tbody>
</table>
VAGINA

| Is a narrow passage with anatomical folds (rugae) | In the first six weeks postpartum, the vagina forms a spacious smooth-walled passage |

**Post-placental and Pre-discharge Periods: Appropriate Times for IUD Insertion**

Module 2: Overview of PPIUD presented definitions regarding the timing of PPIUD insertion.

Pre-discharge insertion is done within 48 hours of delivery and before the woman leaves the hospital. Post-placental insertion is done within 10 mins after expulsion of the placenta following vaginal delivery, or at the time of caesarean delivery. Post-placental insertion is preferred because it has a much lower expulsion rate.

![Timing of Insertion Expulsion Rate Table]

- **Interval** (more than 4 weeks after delivery) - Low (3% for skilled inserters)
- **Immediate Postpartum** (within 10 minutes) - Slightly higher (*up to 9.5%)
- **Early Postpartum** (between 10 minutes and 48 hours) - Moderately higher (*up to 37%)

*Data on expulsion rates for late postpartum insertions (48 hours to 4 weeks) are limited. Late postpartum insertions are not recommended due to an increased risk of perforation.*

*Source: Chi IC, Wilkens L, Rogers S. Expulsions in immediate postpartum insertions of Lippes Loop D and copper T IUDs and their counterpart delta devices, 1985; 32(2): 119-34.*
These time periods are recommended because:

- The cervix is dilated so it is important to ensure high fundal placement of the IUD manually or with forceps.
- IUD side effects such as cramping are often less noticeable to the client because they are masked by normal postpartum physiological changes, such as cramping and postpartum lochia.
- Puerperal insertion (from 1-6 weeks after delivery) is not recommended because the uterus is soft, the risk of perforation is increased, and the position of the fundus is not easy to determine.

Summary:

The session described the Anatomy and physiology of the female reproductive organs, the changes that occur in the uterus, cervix and vagina during the post-partum period.

It explained why the immediate post-partum period is most appropriate for PPIUD insertion.

Evaluation:

- Describe the changes in the female reproductive organs in the post-partum period?
- Why is the first 48 hours important for post-partum IUD insertion?
MODULE THREE: SESSION 3 - OVULATION, MENSTRUATION AND FERTILIZATION/CONCEPTION

Time: 45 Mins

LEARNING OBJECTIVES:

By the end of this session, the participants should be able to:

- Explain the meaning of ovulation.
- Understand how ovulation occurs.
- Explain what menstruation is.
- Discuss the type of health education necessary during menstruation.
- Describe the process of fertilization and conception.

SESSION OVERVIEW

- Introduction.
- Ovulation.
- Definition of menstruation.
- Fertilization/Conception.
- Definition of fertilization.
- Process of fertilization.
- Implantation.

METHODS

- Brainstorming
- Lecture
- Discussion

MATERIALS

- Flip chart stand/paper
- Markers
- LCD Projector
- Laptop
- Masking tape

SUMMARY

EVALUATION
A. Introduction

This session addresses the topics of ovulation, menstruation and fertilization/conception.

B. Ovulation

- Ovulation is the release of a mature egg from the ovaries into the Fallopian tubes.
- It usually happens once every month after a girl reaches puberty.
- This period is known as the fertile period, when a woman can become pregnant if she has sexual intercourse.
- Ovulation usually occurs 14 days before a woman sees her next menses. Therefore, in women with a 28 days cycle, ovulation occurs in the middle of the menstrual cycle.

C. Definition of Menstruation

- Menstruation is the process whereby the lining of the womb that has prepared itself to welcome a fertilized egg peels off or sheds off because fertilization has not occurred.
- This results in the flow of blood through the vagina.
- The flow of blood is referred to as menstruation or “period”.

When menstruation begins:

- Menstruation normally starts when a girl reaches between 10 and 14 years of age.
- Menstruation occurs every 21 to 35 days and lasts 3 to 7 days.

D. Menstrual Process and Cycle

28 day menstrual cycle

The events in a 28 days menstrual cycle are as follows:

Day 1 – 5

- Menstrual bleeding occurs. This normally lasts for 3 to 7 days. The first day of menstrual period is referred to as “day 1” of the menstrual cycle.

Day 5 – 7

- Each month after the last bleeding, the body begins to produce secretions (hormones) which help the eggs in the egg-bag to begin to grow.

Day 7 – 11

- The lining of the womb starts to build up to receive the female's egg in case it is united with the male seed (sperm).

Day 11 – 14

- A ripe egg is released from the ovary. This is known as ovulation.
Day 14 – 21
- The released ripe egg moves to the egg-carrying tube (Fallopian tube). The body makes sure that the lining of the womb is nourished and filled with blood to ensure that the fertilized egg survives.

Day 21 – 28
- If the male seed (sperm) fails to reach and unite with the female egg, the prepared lining of the womb will start peeling or shedding off.
- At the end of the cycle, this shedding comes in the form of blood called “period” menstruation. When this happens, a new cycle starts.

Figure 3.3.1: The Menstrual Cycle
E. Process of Fertilization

Step 1:
- Every 14\textsuperscript{th} day (of a 28 days cycle) in the month, when ovulation occurs, a ripe egg leaves one of the ovaries where thousands of eggs are stored.
- The ripe egg moves into the fallopian tube to wait for the sperm.

Step 2:
- Likewise, the sperm that is produced by the testes gets released in millions into the vas deferens.
- During intercourse, the man ejaculates and deposits his seeds into the vagina.

Step 3:
- The sperm which is very active and fast, swims through the mouth of the cervix into the womb.
- If intercourse occurs during or near the time of ovulation when a ripe egg is ready and live sperm meets a ripe egg in one of the tubes, fertilization occurs.
- This can happen within 1 hour to 1 hour 30 mins after ejaculation.
- The male's seed or female egg may also arrive in the Fallopian tube to await each other. The sperm has an average life span of 2 to 3 days (48 – 72 hours) to fertilize the female egg within the woman's body.
- Likewise, the ovum can only survive for 40 hours after ovulation.
- Therefore, fertilization can only occur if a woman has sexual intercourse during the period of ovulation (peri-ovulatory period, i.e., two to three days before ovulation or one to two days after ovulation).
- If fertilization fails to happen, the egg is absorbed into the body.
Step 4:
- Fertilization then occurs. A single sperm is usually responsible for fertilizing the female egg.
- If fertilization fails to happen, the egg is absorbed into the body.

F. Implantation
- Implantation occurs when the fertilized egg attaches itself to the uterine lining.
- The attached fertilized egg now develops inside the womb for the next 40 weeks until it is delivered as a baby.

Figure 3.3.3: The Process of Implantation
SUMMARY

This session described the menstrual process/cycle. It also described how fertilization occurs and what happens when there is no fertilization.

EVALUATION:

• What is ovulation?
• Describe how it occurs.
• What is menstruation?
• What is fertilization?
• Explain how pregnancy occurs?
MODULE FOUR
COUNSELING FOR PPIUDs AND IMPLANTS

Session 1: Introduction to Counseling.
MODULE FOUR

Session 1: Introduction to Counseling

Time: 1 hour

LEARNING OBJECTIVES

By the end of this session, participants should be able to:

- Define Counseling.
- State the objectives of counseling in Family Planning.
- Discuss the qualities of a successful counselor.
- Mention the types of counseling required for IUD and Implant services.
- Discuss the concerns and perceptions of potential users of IUDs and Implants.
- Explain the term “Informed Choice”.
- Discuss the “Rights of the Client”.

SESSION OVERVIEW

- Definition of Counseling.
- Objectives of counseling in Family Planning.
- Qualities of a successful counselor.
- Types of counseling required for IUD and Implant services.
- Concerns and perceptions of potential users of IUDs and Implants.
- “Informed Choice”.
- “Rights of the Client”.

METHODS

- Illustrated lecture
- Discussion
- Demonstration and Return Demonstration
- Role Play

MATERIALS

- Flip chart and flip chart stand
- Markers
- LCD Projector
- Laptop
INTRODUCTION

What is Counseling?

Counseling refers to providing the client with information and support to allow her to make a decision regarding her immediate reproductive health needs, for example, by describing to the woman (and sometimes her partner as well) the contraceptive options available to her, the benefits and risks of the methods, and what side effects to expect.

Good counseling also encourages the client to ask questions about the method she selects, to return to the clinic if she has problems, and to feel free to switch methods if she is unhappy with the one initially chosen. Counseling plays an important role in increasing the satisfaction of users of long-acting family planning methods such as IUD and implants.

What are the objectives of Counseling?

The counselor’s objectives should be to:

- Provide complete, accurate information in terms the client can understand.
- Identify and discuss any concerns or fears a client may have.
- Help the client choose the best family planning method for her.
- Inform the client adequately about effectiveness, side effects, benefits, and risks on available methods.

It is also part of the counselor’s job to ensure, particularly with clinic based methods such as Cu T 380A, Jadelle and Implanon NXT™ (sub-dermal implant), that the woman can stop using a method for medical or personal reasons and that she has access to removal.

What are the qualities of a successful counselor?

A good counselor identifies with the perceptions of the client and takes the extra few minutes required to put the client at ease and allow her beliefs and feelings about contraceptive methods to emerge. Producing such an atmosphere will be cost-effective in the long run. For example, when counseling is done effectively, women will be more satisfied with their choices and less likely to discontinue use after a short period of time or because of unexpected bleeding disturbances.

A Good Counselor has:

- A sensitivity that earns the trust of the client.
- A good understanding of all available family planning methods, not only IUDs and sub-dermal implants.
• An understanding of the cultural and psychological factors that affect a woman's or a couple's decision to use IUD or sub-dermal implants or other family planning methods.

• A non-judgmental approach, treating the client with respect and kindness.

• A way of encouraging clients to ask questions.

• An ability to listen.

• The ability to recognize when he or she cannot sufficiently help a client and to refer the client to other professionals.

• An appreciation of non-verbal communication (body language).

Sound knowledge and good communication skills are essential if the counselor is to discuss IUDs or sub-dermal implants (and other methods) appropriately and to reduce the number of women who discontinue the method because of ignorance or unnecessary anxiety. The counselor must recognize the potential importance of views of other members of the family and should help the client deal with them.

The counselor should present relevant information clearly and concisely. Overly technical information and academic language and jargon should be avoided. Questions, particularly about the negative aspects of the method, should be answered honestly.

**What types of counseling are required?**

Cu T 380A and sub-dermal implant users will need three stages of counseling. The information should preferably come from more than one source, and service providers need to work as team in counseling.

*Pre Insertion Counseling*

Given prior to a decision to use IUD and sub-dermal Implants

• Discuss the woman's (or couple's) fertility intentions

• Then provide information on all available contraceptive methods

• Present an overview of Cu T 380A and sub-dermal implants:
  
  o Facts
  
  o Reversibility
  
  o Advantages and disadvantages including side-effects (particularly those related to menstrual irregularities)
  
  o The timing of insertion
  
  o The contraceptive to use until insertion and
  
  o The freedom of the client to discontinue the method whenever desired
Post-Insertion Counseling

Though usually given immediately after the insertion of the IUD or implant, some elements of post-insertion counseling should be given earlier and reinforced at this time (e.g. post-insertion care). Information on a follow-up schedule and indications for a quick return to the clinic must be provided.

Follow-up Counseling

Information given during post-insertion counseling should be reinforced at each visit. Counselors need to listen attentively and be prepared to answer questions on the problems the patient has encountered. Answering questions helps a client to cope with any problem or side effects. Again, counselors should reassure clients that removal is available on demand.

Counseling for Postpartum Family Planning

<table>
<thead>
<tr>
<th>Timing of Counseling</th>
<th>Constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>The best time to counsel for postpartum family planning is during the antenatal period.</td>
<td>The pregnant woman and her partner are often more concerned about other issues during the antenatal period (e.g., her own health and the health of the baby before, during, and after delivery).</td>
</tr>
<tr>
<td>If counseling was not provided during the antenatal period, maternity staff can provide it before the woman is discharged.</td>
<td>Family planning counseling is never recommended during delivery or when the client is under extreme stress (e.g., if the health of the newborn baby is in question or the client is sedated). The client may be too distracted by the needs of her new baby, or her own physical condition, to think about family planning. Maternity staff may be too busy to provide adequate counseling before the woman is discharged.</td>
</tr>
</tbody>
</table>
If the client is considering PPIUD, implants, or sterilization for the first time, the period after delivery and before discharge may not be enough time for her and her partner to adequately consider the choice. However, an interval IUD insertion would be an acceptable alternative in this situation.

<table>
<thead>
<tr>
<th>Linkages with Other Service Sectors.</th>
<th>Constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective counseling and provision of postpartum family planning services require good communication between antenatal, labour, delivery, and family planning services.</td>
<td>Within the same institution, these different service sectors are usually in separate places, with separate staff, and separate record-keeping systems. Communication between these sectors is often poor. Women often receive antenatal care and family planning services through community health centers, which may have weak links to hospital-based, maternity services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staffing Issues</th>
<th>Constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both counseling and service provision for postpartum family planning are usually provided by maternity staff.</td>
<td>The staff are often not trained in family planning. They may not be aware of methods available for postpartum use. They are rarely trained in counseling.</td>
</tr>
</tbody>
</table>
## Family Planning Methods Appropriate for Postpartum Use

<table>
<thead>
<tr>
<th>For women who are not breast feeding</th>
<th>Breastfeeding women: up to 6 weeks postpartum</th>
<th>Breastfeeding women: after 6 weeks postpartum</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Tubal Ligation</td>
<td>• LAM (lactational amenorrhoea method)</td>
<td>• LAM (lactational amenorrhoea method)</td>
</tr>
<tr>
<td>• Vasectomy for partner</td>
<td>• Tubal ligation</td>
<td>• Tubal ligation</td>
</tr>
<tr>
<td>• PPUI D</td>
<td>• Vasectomy</td>
<td>• Vasectomy</td>
</tr>
<tr>
<td>• Oral contraceptives</td>
<td>• PPIUD (up to 48hrs post delivery)</td>
<td>• IUD</td>
</tr>
<tr>
<td>• COCP as from 3wks</td>
<td>• Progestin-only pill</td>
<td>• Oral contraceptives</td>
</tr>
<tr>
<td>• progestin-only pills</td>
<td>• Implants</td>
<td>• OCP after 6 months</td>
</tr>
<tr>
<td>• Progestin-only injectables</td>
<td>• Condoms</td>
<td>• Progestin-only pills</td>
</tr>
<tr>
<td>• Implants</td>
<td>• Spermicides</td>
<td>• Progestin-only injectables</td>
</tr>
<tr>
<td>• Condoms</td>
<td></td>
<td>• Implants</td>
</tr>
<tr>
<td>• Spermicides</td>
<td></td>
<td>• Condoms</td>
</tr>
<tr>
<td>• Diaphragm with spermicide</td>
<td></td>
<td>• Spermicides</td>
</tr>
<tr>
<td>(after 6 weeks)</td>
<td></td>
<td>• Diaphragm with spermicide</td>
</tr>
</tbody>
</table>


### Service Provider’s Responsibilities in Counseling:

The clinician who inserts the PPIUD or Postpartum Implant is responsible for making sure that the client has received high quality family planning counseling. Even though the provider may not personally conduct all of the counseling, he/she is responsible for all client care, including adequate counseling.
Two key provider responsibilities are:

1. Prior to inserting the PPIUD or Implant: Confirm that the client has made an informed, voluntary decision before she lies down on the examining table. Key questions to ask the client:
   - Why did you choose this method?
   - What do you know about how it works?
   - What other methods did you consider?
   - What is your partner's preference?
   - What do you know about the side effects?
   - Do you have any questions for me?

2. Before and during insertion:
   Put the client at ease by:
   - Smiling at her.
   - Finding out her name and then using it when talking to her.
   - Talking to her before she lies down on the examining table (see above).
   - Periodically asking her if she is comfortable during the procedure.

Concerns and Perceptions of Potential Users of IUDs and Implants

- The device or capsule can travel in the body.
- Belief that insertion/removal is a major surgical procedure.
- Returning to the clinic (distance and time) for insertion and removal at proper time.
- Inconvenience (time and cost) of follow-up visits.
- With foreign object in womb or the arm, soul cannot leave body after death.
- Family/friends will notice and women will have the stigma of using family planning.
- Religious reasons.
- Never knowing when spotting will occur.
- For Implants, sites can become unattractive.
- No way to hide use of method from husband.
- Rumours that women are being used as guinea pigs.
- Chance of losing fertility, sex drive etc.
- Fear that the device or capsules will cause weakness and/or ill health to self and/or husband.
- Traditional dislike for surgical procedures
- For sub-dermal implants, amenorrhoea causes a permanent build-up of blood in uterus that must be “drained” periodically, or illness will result.
What does “Informed Choice” mean?

When a person freely makes a thought-out decision based on accurate, useful information, this is an informed choice. One important purpose of family planning counseling is to help the client make informed choices about reproductive health and family planning.

“Informed” means that:

Clients have the clear, accurate, and specific information they need to make their own reproductive choices including a choice among family planning methods. Good quality family planning programs can explain each family planning method as needed, without information overload and can help clients use each method effectively and safely.

Clients understand their own needs because they have thought about their own situations. Through person-to-person discussions and counseling, and through mass media messages, good quality family planning programmes help clients match family planning methods with their needs.

“Choice” means that: 'Clients have a range of family planning methods to choose from. Good quality family planning services offer different methods to suit people's differing needs – not just 1 or 2 methods. If service providers cannot provide a method or service, they refer clients somewhere else for that method.

Clients make their own decisions. Family planning providers help clients think through their decisions, but they do not pressure clients to make a certain choice or to use a certain method.

RIGHTS OF THE CLIENT

The health provider must endeavour to respect the rights of the client seeking family planning and reproductive health services by providing them with relevant information concerning their reproductive health. Such rights include:

1. **Information**

   Clients have a right to timely, accurate, and appropriate information related to their family planning/reproductive health and HIV needs such as reasons for referral to another health facility, and the type of reproductive health or HIV services the client is expected to receive at the referred health facility.

2. **Access to Services**

   The right of the client includes sharing the likely financial implication of referral as applicable, clients concern, possible constraints such as proximity, discrimination/stigmatization, sexual orientation and possible general bias including religion.
3. **Informed Choice**
Guidance to client's informed choice based upon access to and full understanding of all necessary information for the client's perspective. This should result in a voluntary and informed decision by the client.

4. **Safe Services**
Client deserves assurances for safe services and skilled health providers at the receiving health care facility.

5. **Privacy and Confidentiality**
   
   Client must be assured that privacy and confidentiality will be maintained at the facility.

6. **Dignity, comfort and expression of opinion**
   
   The client must be treated with respect and her opinion must be considered. The client also has the right to continuity of services and supplies, follow-up and referral.

**SUMMARY**

Counseling provides clients with information that would help her make informed choice. A good counselor is sensitive to the clients' needs and is ready to address user concerns regarding future reproductive goals, choice of contraceptive method and adverse effect of the chosen method.

**EVALUATION**

- What is counseling?
- Why is counseling important?
- What types of counseling are mandatory when providing IUD and implant services?
MODULE FOUR

Session 2: The Balanced Counseling Strategy Plus (BCS+)

Time: 1 hour

LEARNING OBJECTIVES:

By the end of this session, participants should be able to:

- Define the Balanced Counseling Strategy Plus.
- State the objectives of the Balanced Counseling Strategy Plus.
- Discuss the tools and job aids necessary for offering Balanced Counseling Strategy Plus.
- Discuss the steps in the Balanced Counseling Strategy Plus.
- Effectively counsel family planning clients using the steps, tools and job-aids in the Balanced Counseling Strategy Plus.

SESSION OVERVIEW

- Tools and job aids necessary for offering Balanced Counseling Strategy Plus.
- Demonstration of counseling family planning clients using the steps, tools and job aids in the Balanced Counseling Strategy Plus.

METHODS

- Illustrated lecture
- Discussion
- Demonstration and Return Demonstration
- Role Play

MATERIALS

- Flip chart and flip chart stand
- Markers
- LCD Projector
- Laptop
- Tools and Job Aids of BCS+
SUMMARY

EVALUATION
What is Balanced Counseling Strategy (BCS)?

The Balanced Counseling Strategy (BCS) is a practical, interactive, and client-friendly strategy for improving counseling within family planning consultations. This strategy, tested and refined in several countries, comprises a series of steps to determine the contraceptive method that best suits the client according to her/his preferences and needs. This strategy improves the quality of the provider's counseling and allows the client to take ownership of the decision.

The BCS uses three key job aids for counseling clients about family planning:

- An algorithm to guide the provider through the Counseling process,
- A set of Counseling cards for contraceptive methods, and
- Corresponding brochures for each method

The BCS Algorithm

This summarizes the 19 steps recommended to implement the BCS during a family planning consultation. The steps are organized under four stages of the consultation:

- Pre choice needs assessment
- Method choice
- Post-choice actions and
- STI/HIV prevention, risk assessment, and counseling and testing

During each stage of the consultation, the provider is given step-by-step guidance on how to use the BCS+ job aids. Depending on the client's response to the issues discussed, the algorithm outlines which action to take.

The Counseling Cards

These are the cards that a provider uses during a counseling session. There are 19 counseling cards.

- The first card contains 6 questions that the service provider asks to rule out whether a client is pregnant.
- There are 14 method-specific cards that contain information about each family planning method. Each method card has an illustration of the contraceptive method on the front side of the card. The back of the card contains a list of 5 to 7 key features of the method and describes the method's effectiveness. These cards are used to first exclude those methods that are inappropriate for the client's reproductive intentions and then to narrow down the choice to reach a final decision.
• Four counseling cards provide information on STI/HIV transmission and prevention, risk assessment, dual protection, and HIV C&T that are used during the fourth stage of the consultation.

**Method Brochures**

These brochures on each of the 14 contraceptive methods are designed to help the client better understand the method chosen. The provider gives the client the brochure of the selected method and a brochure with information on condoms to take home. Providers should encourage low-literate clients to take the brochure home so that their partner or other trusted friend can review the brochure with them again.

**What is Balanced Counseling Strategy Plus (BCS+)?**

The Balanced Counseling Strategy Plus (BCS+) integrates counseling on STI/HIV transmission and prevention along with family planning by helping the provider to conduct an STI/HIV risk assessment, discuss dual protection, and discuss and offer the client opportunities for HIV C&T.

The BCS+ is divided into four counseling stages. Each stage contains a sequence of steps to follow. The BCS+ assumes that the motive of a client's visit is for family planning but serves to also offer the client STI/HIV services in the clinic or through referral. The BCS+ process can be summarized as a decision-making algorithm.

The summary of the four counseling stages are:

**Pre-Choice Stage**

During this stage, the provider creates the conditions that help a client select a family planning method. The provider:

- Cordially greets the client
- Emphasizes to the client that, during the consultation, other reproductive health issues such as STIs, including HIV, will be addressed depending on her/his individual circumstance
- Rules out pregnancy using the counseling card with the checklist of questions
- If the client is not pregnant, displays all the method cards and asks the four questions described in the algorithm
- Sets aside the cards of the methods that are not appropriate for the client as the client responds to each question (setting aside these cards helps to avoid giving information on methods that are not relevant to the client’s needs).

• If pregnancy cannot be ruled out, the provider skips to steps 12 to 19 to discuss STI/HIV transmission and prevention, risk assessment, dual protection and HIV C&T.
• Then the client is given a back-up method, such as condoms, and asked to return when she has her menstruation.

**Method Choice Stage**

During this stage, the provider offers more extensive information about the methods that have not been set aside, including their effectiveness. This helps the client select a method suited to her/his reproductive needs. Following the steps in the BCS+ algorithm, the provider continues to narrow down the number of counseling method cards until a method is chosen.

**Post-Choice Stage**

During this stage, the provider uses the method brochure to give the client complete information about the method that has been chosen. If the client has conditions where the method is not advised or is not satisfied with the method, the provider returns to the Method Choice Stage to help the client select another method. The provider also encourages the client to involve their partner(s) in decisions about contraception, either through discussion or visit to the clinic.

**STI/HIV Prevention, Risk Assessment, and Counseling and Testing Stage**

During this stage, the provider uses the four counseling cards to discuss STI/HIV transmission and prevention, conduct a risk assessment, define dual protection, and discuss and offer the client opportunities for HIV C&T. If the client is willing to be tested, the provider encourages the client to disclose their STI/HIV status to their partner(s), and lets the client know both the benefits and risks of disclosure. The provider gives follow-up instructions, the method brochure and condom brochure, emphasizing dual protection.
Figure 4.2.1: Balanced Counseling Model with specific tasks for providers

Algorithm for Using the Balanced Counseling Strategy

**Pre-Choice**
1. Establish and maintain a warm, cardinal relationship. Listen for the client's contraceptive needs.
2. Rule out pregnancy using the counseling card with 6 questions.
   - If client answers: Then:
     - "Yes" to any of the questions and she is not close to or symptomatic of pregnancy:
       1. Pregnancy is unlikely.
       2. Continue to Step 3.
     - "No" to all of the questions:
       1. Pregnancy cannot be ruled out.
       2. Give client a pregnancy test if available.
       3. Ask client to return when she has her menstrual bleeding.
       4. Provide her with a back-up method, such as condoms, to use until then.
       5. End the session.
3. Display all of the counseling cards. If the client wants a particular method, go to Step 7.
4. Ask all of the following questions. Set aside counseling cards based on the client's responses.
   - a) Do you wish to have children in the future?
     - If "Yes," set aside vasectomy and tubal ligation cards. Explain why.
     - If "No," keep all cards and continue.
   b) Are you breastfeeding an infant less than 6 months old?
     - If "Yes," set aside the combined oral contraceptives (the Pill) and combined injectable.
     - If "No," or she has begun her monthly bleeding again, set aside the LAM card. Explain why.
   c) Does your partner support you in family planning?
     - If "Yes," continue with the next question.
   d) Are there any methods that you do not want to use or have not tolerated in the past?
     - If "Yes," set aside the cards the client does not want.
     - If "No," keep the rest of the cards.

**Method Choice**
5. Give information on the methods that have not been set aside. Indicate their effectiveness.
   - a) Arrange the remaining cards in order of effectiveness (number on back of each card).
   - b) In order of effectiveness (lowest number to highest), read the 5 to 7 features of each method not set aside.
6. Ask the client to choose the method that is most convenient for her/him.
7. Using the brochure, determine if the client has any condition for which the method is not advised.
   - a) Together with the client review section under "Method not advised if you" in the brochure of the method chosen.
   - b) If the method is not advisable for the client, ask the client to select another method from the cards that remain. Repeat the process from Step 5 (Step 4 if client already had the method in mind).

**Post-Choice**
8. Inform the client about the method chosen using the brochure of the method as a counseling tool.
9. Determine the client's comprehension and reinforce key information.
10. Make sure the client has made a definite decision. Give her/him the method chosen and/or a referral and back-up method, depending on the method selected.
11. Complete the counseling session. Invite the client to return anytime. Thank her/him for the visit. End the session.

Source: Leon et al., 2003b.
Steps of the Balanced Counseling Strategy Plus

Pre-Choice Stage

During this stage, the provider creates the necessary conditions to help the client select a method.

Step 1. Establish and maintain a warm, cordial relationship. Listen to the client’s contraceptive needs.

- Establish a formal but friendly manner.
- Call the client by her/his name.
- Demonstrate interest in what the client tells you.
- Establish eye contact with the client.
- Listen to and answer her/his questions.
- Show support and understanding without judgment.
- Ask questions to encourage participation in the discussion.
- Ask whether the client would like a family planning method. If so rule out pregnancy as described in Step 2.

Step 2. Rule out pregnancy using the pregnancy checklist card with 6 questions.

Pregnancy is a contraindication to the use of most family planning methods, except barrier methods such as condoms. It is important to rule out the possibility of the client being pregnant, which can be done by asking the 6 questions on the pregnancy checklist card.

*Checklist to be reasonably sure a woman is not pregnant:*

- Did you have a baby less than six months ago? If so are you fully or nearly fully breastfeeding? Have you had no monthly menstrual bleeding since giving birth?
- Have you abstained from unprotected sex since your last menstrual bleeding or delivery?
- Have you given birth during the last four weeks?
- Did your last menstrual bleeding start within the past 7 days (or 12 days if you plan to use an intrauterine device (IUD))?
- Have you had a miscarriage or abortion in the last 7 days?
- Have you been using a reliable contraceptive method consistently and correctly?
Rule out pregnancy using the table below:

<table>
<thead>
<tr>
<th>If the client answers:</th>
<th>Then:</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Yes” to any of the questions and is free of symptoms and signs of pregnancy</td>
<td>1) Pregnancy is unlikely</td>
</tr>
<tr>
<td></td>
<td>2) Continue to <strong>Step 3</strong></td>
</tr>
<tr>
<td>“No” to all of the questions</td>
<td>1. Pregnancy cannot be ruled out</td>
</tr>
<tr>
<td></td>
<td>2. Give the client a pregnancy test, if available, or refer her to</td>
</tr>
<tr>
<td></td>
<td>the antenatal clinic.</td>
</tr>
<tr>
<td></td>
<td>3. Ask her to return when she has her next menstrual bleeding.</td>
</tr>
<tr>
<td></td>
<td>4. Provide her with a back-up method, such as condom to use</td>
</tr>
<tr>
<td></td>
<td>until then.</td>
</tr>
<tr>
<td></td>
<td>5. Go to <strong>Steps 12 to 19</strong></td>
</tr>
</tbody>
</table>

**Step 3. Display all of the method cards. Determine whether the client wants a particular method.**

1. Display all the BCS method cards on a desk or table, grouped by method type (temporary, fertility awareness, permanent).
2. Each card has information about a different family planning method.
3. Ask whether the client has a particular method in mind.

<table>
<thead>
<tr>
<th>If the client:</th>
<th>Do this:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Says “No”</td>
<td>Continue to <strong>Step 4</strong>.</td>
</tr>
<tr>
<td>Says “Yes”</td>
<td>1) Ask what the client knows about the method.</td>
</tr>
<tr>
<td></td>
<td>2) If the information is correct, go to <strong>Step 7</strong>.</td>
</tr>
</tbody>
</table>
• Gives incomplete information about the method s/he has chosen  

-Or-  
• Does not know other alternatives that might be more convenient

1) Correct any is information.
2) If necessary, go to Step 4 to help the client choose a method.

Step 4. Ask all of the following questions. Set aside cards based on the client's responses.

1. Using the display of method cards, begin the process by saying something like, “Now we are going to discuss your contraceptive needs. We will narrow down the number of methods that might be best for you. Then I will discuss the features of each method with you. This will help us to find the right method for your needs.”

2. Ask the 4 questions below. Based on the client's responses, set aside the cards of methods that do not suit her/his needs.

<table>
<thead>
<tr>
<th>If:</th>
<th>Do this:</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Yes”</td>
<td>1) Set aside the vasectomy and tubal ligation cards. Explain that sterilization is permanent and not suitable for someone who thinks s/he might want to have another child.</td>
</tr>
<tr>
<td>“No”</td>
<td>Keep all cards and continue.</td>
</tr>
</tbody>
</table>

b) Are you breastfeeding an infant less than 6 months old?

<table>
<thead>
<tr>
<th>If:</th>
<th>Do this:</th>
</tr>
</thead>
</table>

c) Does your partner support you in family planning?

<table>
<thead>
<tr>
<th>If:</th>
<th>Do this:</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Yes”</td>
<td>Continue with the next question.</td>
</tr>
</tbody>
</table>
| “No”         | 1) Set aside the following cards: Standard Day Method and Two Day Method  
               2) Explain that these require partner cooperation.  
               3) Invite the client to bring her/his partner to a Counseling session to discuss family planning with a provider.  
               4) Point out that male and female condoms also require partner cooperation but they are important for protecting against STIs, including  
               5) Continue with the next question. |

d) Are there any methods that you do not want to use or have not tolerated in the past?

<table>
<thead>
<tr>
<th>If:</th>
<th>Do this:</th>
</tr>
</thead>
</table>
| “Yes”        | 1) Ask which methods s/he used and her/his experience with each.  
               2) Set aside the cards of the methods the client does not want. |
| “No”         | Keep the rest of the cards.                  |
The client has eliminated a method because of rumours or false information.

1) Provide the correct information.
2) Do not set aside the card of that method.

3. If certain methods, such as the IUD, implants, tubal ligation, or vasectomy, are never offered at your health care facility, still talk to the client about these methods.

**Method Choice Stage**

**Step 5: Give information on the methods that have not been set aside and indicate their effectiveness.**

1. Arrange the remaining method cards that have been set aside on your desk or table according to their level or effectiveness.

2. Display them with the lowest numbers first and the highest numbers last. *(The number is on the bottom left-hand side of the back of the card. This number indicates the effectiveness of the method).*

3. Explain the effectiveness of the methods. Effectiveness is measured in number of pregnancies among 100 women in the first year of use. The lower number means fewer women get pregnant using the method.

4. Begin with the card with the lowest number. Read the 5 to 7 key features of each method on the cards displayed. You may also ask the client to read these attributes her/himself.

5. Explain that the condom (male and female) is the only method that provides dual protection against pregnancy and STIs, including HIV. Emphasize the following:
   
   a) Male and female condoms significantly reduce the risk of infection with STIs, including HIV, when used correctly and consistently with every act of sex.
   
   b) When used consistently and correctly, condom use prevents 80 percent to 95 percent of HIV transmission that would have occurred without condoms.
c) Condoms reduce the risk of becoming infected with many STIs. When used consistently and correctly, they:

- Protect best against the spread of STIs by discharge, such as HIV, Gonorrhea, and Chlamydia.
- Also protect against spread of STIs from skin-to-skin contact, such as herpes and human papilloma virus.

**Step 6. Ask the client to choose the method that is most convenient for her/him.**

1. Ask the client whether s/he has questions or comments about each method discussed. Respond to any questions. Resolve any doubts before proceeding.

2. Ask the client to choose a method that is most convenient for her/him.

3. If the client asks that you choose the method, explain that s/he is the only person who knows her/his needs. You may give recommendations about a method, but allow the client to make the final choice.

4. Once the client selects a method, do not take the remaining cards off the table. You may need to return to them if the method chosen is not advised or the client changes her/his mind.

5. If the client does not like any of the methods discussed or cannot make up her/his mind, give the client a back-up method, such as condoms, to use until s/he decides on a method of choice. Condoms can provide dual protection against pregnancy and STIs until the client has another or additional method. Go to Step 12.

**Step 7. Using the method-specific brochure, determine whether the client has any conditions for which the method is not advised.**

1. Select the BCS+ method-specific brochure corresponding to the method chosen by the client.

2. Together with the client, review the section entitled, “Method not advised if you...” in the method brochure. This lists conditions when the method is not advised.

---

**For example.** For IUD:

Method NOT advised if you:
3. Using simple, clear language; ask probing questions to make sure that the client does not have any conditions for which the method is not advised.

4. Based on the client's response, decide whether to provide the method or return to a previous step.

<table>
<thead>
<tr>
<th>If the client:</th>
<th>Do this:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has no conditions</td>
<td>Go to Step 8</td>
</tr>
</tbody>
</table>
| Has any condition | 1) Explain the need to choose another method.  
2) Return to Step 5 |
| Has any condition and reached this step from Step 3 (already had the method in mind) | 1) Explain the need to choose another method.  
2) Return to Step 4. |

Post-Choice Stage

Step 8. Discuss the method chosen with the client using the method brochure as a Counseling tool.

2. Use the method brochure as a counseling tool to review all the information about the method chosen by the client. Begin by saying something like, “Mrs./Mr. (name), this brochure is for you to take home. Before you go, I would like to review the information with you.”

3. Using clear, simple language, review the information about the method presented in the brochure:
4. Give the client the brochure. Encourage her/him to review the brochure again at home and when s/he needs to remember anything about the method.

5. If the client selects a method not available on site, then:
   a) Still give client the brochure of the method chosen.
   b) Refer the client to a facility or commercial outlet where s/he can obtain the method.
   c) Provide client with an alternative, suitable method until s/he can obtain the choice.

6. If the client selects a method that is temporarily unavailable (out of stock), then:
   a) Give the client a brochure of the method chosen.
   b) Refer the client to a facility or commercial outlet where s/he can obtain the method.
   c) Provide client with a back-up method until s/he can obtain the method of choice.
   d) Ask the client to return when the method is in stock at your health care facility.

**Step 9. Determine the client's comprehension and reinforce key information.**

1. Make sure the client fully understands all aspects of the method s/he has chosen. Comprehension is key to healthy, effective use of the method.
2. Validate comprehension by asking the client to answer the following questions in her/his own words. (S/he may refer to the brochure.)

   o How do you use the method you have chosen?
   o What side effects might you experience with the method?
   o Can the method protect you against getting an STI, including HIV?
   o What are the signs indicating when you should return to the health care facility?
3. Assure the client that is s/he cannot remember all the details. Make sure the client can find the information in the brochure. (Note: If the client cannot read or has very low literacy skills, ask the client to identify a person at home who can read the information on the method chosen.

4. Ask whether the client has any questions. Reinforce the basic information on the method chosen.

**Step 10. Make sure the client has made a definite decision:** Give her/him the method chosen and/or a referral and back-up method, depending on the method selected.

1. Ask the client whether her/his choice is a definite one. Make sure s/he is happy with the choice of method.

<table>
<thead>
<tr>
<th>If the client is:</th>
<th>Do this:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happy with the method chosen</td>
<td>1) Give her/him the method and brochure</td>
</tr>
<tr>
<td></td>
<td>2) If IUD, implant, tubal ligation, or vasectomy is chosen and not available on site, give a referral for the procedure.</td>
</tr>
<tr>
<td></td>
<td>3) If the client cannot immediately use the chosen method, provide a back-up method (e.g., condoms). Give the BCS+ brochure on condoms.</td>
</tr>
<tr>
<td></td>
<td>4) Suggest that s/he may also abstain from sex until s/he obtains the method of choice.</td>
</tr>
<tr>
<td>Not happy with the method chosen and wishes to consider other options.</td>
<td>1) Assure the client that it is fine to change her/his mind. The client has a right to informed choice.</td>
</tr>
<tr>
<td></td>
<td>2) Return to <strong>Step 5.</strong></td>
</tr>
</tbody>
</table>

2. Do not let the client leave empty-handed. If a method is not available, make sure that the client has a back-up method (e.g., condoms), a referral, and the BCS+ brochure on condoms.
3. Give the client her/his brochure.

**Step 11. Encourage the client to involve partner(s) in decisions about/practice of contraception through discussion or a visit to the clinic.**

1. Encourage the client to discuss her/his contraceptive method with their partner.

2. Mention that this can help them in the following manner:

   - Partner can remind you of the time to take your method, if taking a method a method regularly, and follow-up dates.
   - You can negotiate condom use to prevent STI, including HIV.
   - You can discuss your plans to have children, whether you are HIV positive or negative.
   - You can let him know that the prevention of mother-to-child transmission (PMTCT) of HIV during pregnancy can reduce transmission to babies.
   - S/he can support you if you need wellness and HIV services (antiretroviral therapy [ART]).

**STI/HIV Prevention, Risk Assessment, and Counseling and Testing Stage.**

Use the four Counseling cards to discuss STI/HIV transmission and prevention, risk assessment, dual protection, and HIV C&T. During the discussion, emphasize that prevention, early detection, and prompt management of STIs, including HIV, are beneficial to the client, her/his partner and family, and the community at large.


**SUMMARY**
The Balanced Counseling Strategy Plus (BCS+) is a practical, interactive, and client friendly tool for improving counseling within family planning consultations. The strategy improves the quality of the provider’s counseling and allows the client to take ownership of the decision. The BCS has proved to be an effective tool that assists family planning providers to improve the quality of their care. The approach is practical, low cost, and easy to adapt to local contexts.

EVALUATION

- Mention the job aids of the BCS+?
- List the four Counseling stages of the BCS+?
- Why is it important to give the BCS+ Method Brochure to the client to take home?
CLIENT ASSESSMENT
This module covers the various aspects of client assessment- taking the client medical history, performing a physical examination, and comparing the findings to the PPIUD and PP Implant criteria. It enumerates the contraindications to PPIUD and PP implant insertion

Session 1: Client Assessment for PPIUD Insertion

Session 2: Client assessment for PP Implants insertion

Session 3: The WHO Medical Eligibility Criteria (MEC)
## MODULE FIVE
### CLIENT ASSESSMENT

### MODULE PLAN

<table>
<thead>
<tr>
<th>SESSION</th>
<th>DURATION</th>
<th>OBJECTIVES</th>
<th>METHOD</th>
<th>MATERIALS</th>
</tr>
</thead>
</table>
| Session 1: Client Assessment For postpartum IUD Insertion | 30 minutes | • State what should be included in a medical history and physical exam, and which lab procedures are appropriate for a PPIUD client assessment  
• perform an STI risk assessment and respond appropriately  
• list contraindications for PPIUD | • Lecture  
• Discussion  
• Case studies  
• Handout  
• Demonstration and return demonstration | • Flip chart  
Stand/paper  
• Markers  
• Masking tape  
• MEC wheel |
| Session 2: Client Assessment for postpartum Implant insertion | 30 minutes | • State what should be included in a medical history and physical exam, and which lab procedures are appropriate for a PP Implant client assessment  
perform an STI risk assessment and respond appropriately  
• list contraindications for PP Implant | • Lecture  
• Discussion  
• Case studies  
• Handout  
• Demonstration and return demonstration | • Flip chart  
Stand/paper  
• Markers  
• Masking tape  
• MEC wheel  
• Client assessment checklist |
<table>
<thead>
<tr>
<th>Session 3: The WHO Medical Eligibility Criteria (MEC)</th>
<th>35 minutes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Define WHO Medical Eligibility Criteria (MEC)</td>
<td>• Lecture</td>
<td></td>
</tr>
<tr>
<td>• Explain how to select contraceptive method using WHO MEC</td>
<td>• Discussion</td>
<td></td>
</tr>
<tr>
<td>• Discuss the practical approach to the use of the WHO 2015 MEC wheel</td>
<td>• Case studies</td>
<td></td>
</tr>
<tr>
<td>• Discuss the WHO Postpartum Family Planning Compendium and its recommendations on PPIUD and Implants</td>
<td>• Demonstration and return demonstration</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Flip chart stand/papers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Markers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Masking tape</td>
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<td></td>
<td></td>
<td>• MEC wheel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• WHO Postpartum Family Planning Compendium (electronic resource material)</td>
</tr>
</tbody>
</table>
MODULE FIVE: SESSION 1

CLIENT ASSESSMENT FOR PPIUD

TIME: 1 hour

LEARNING OBJECTIVES

By the end of this session, participants should be able to:

• State what should be included in a medical history and physical examination, and which laboratory procedures are appropriate for a PPIUD client assessment.
• Perform an STI risk assessment and respond appropriately.
• List contraindications to PPIUD.

SESSION OVERVIEW

• What to be included in medical history and physical examination, and laboratory procedure appropriate for PPIUD client assessment.
• STI risk assessment.
• Contraindications to PPIUD.

METHODS

• Lecture
• Discussion
• Case studies
• Demonstration and Return Demonstration

MATERIALS

• Flip chart stand/paper
• Markers
• Masking tape
• MEC wheel
• Client assessment checklist

SUMMARY

EVALUATION
Overview of Client Assessment for PPIUD

One component of quality care in a clinical setting is a thorough client assessment. In the family planning setting, the client assessment, combined with effective client counseling, allows for an appropriate match to be made between the client's contraceptive selection(s) and the clinical evaluation.

A client assessment that is well done will address client safety and satisfaction, and will consider the client's general health. A provider skilled in client assessment will involve the client in the process in a way that furthers the woman's understanding of why the assessment is needed, of her own health status, and of some of the potential problems that can result with inappropriate provision of the PPIUD.

Few women are clinically inappropriate PPIUD candidates. A thorough client assessment will enable the provider to identify those women and help them select a clinically suitable contraceptive method that the client will be satisfied with.

Component of Client Assessment

The components of a client assessment are:

- Taking and assessing the client's medical history
  This includes general medical, obstetric and menstrual history (obstetric history includes current pregnancy/delivery), an assessment of STI risk, and evaluation of her access to follow-up care.
- Performing a physical examination.

After these steps are completed and if the client is an appropriate candidate, the provider may insert the PPIUD and provide post insertion instructions to the client.

Client History

The first step in taking a client's history is to confirm that she wants an IUD inserted postpartum. While this may seem obvious, it is a critical information that is sometimes overlooked. Confirming the client's choice not only saves the clinician and the client time, but more importantly, it ensures the client has made an informed choice and offers her another opportunity to change her mind if she wishes to do so.

The clinician who inserts the PPIUD may not need to conduct an entire history-taking session if it has already been done. This clinician is responsible for reviewing the history and confirming the information with the client. Confirming the history with the client helps her to understand the importance of a clinical evaluation.
The clinician should make sure that the following information has been documented and is available in the client record.

The three essential components of a client history for a PPIUD candidate are:

1. General medical, obstetric, and menstrual history.
2. STI risk assessment.
3. Evaluation of access to follow-up care.

1. General, Medical, Obstetric and menstrual history
Obstetric history includes the current pregnancy and delivery. Providers should follow standard content for the clinical history from the health care facility.

2. STI risk assessment
When dispensing a contraceptive method, such as an IUD, which offers no protection against STIs (including HIV infection), providers have a particular responsibility to ensure that clients are educated about their risk of acquiring an STI and how to protect themselves and their partners from sexual transmission of infections.

When an IUD is introduced into a uterus that is already infected with pathogens (this includes organisms transmitted sexually or otherwise), the IUD may promote a clinically significant infection.

Ideally an STI risk assessment should be conducted, and any infection should be treated during antenatal care. After delivery, the provider should confirm that the client's STI risk is the same as when it was assessed ante-natally. If no risk assessment was done ante-natally, the provider should work with the client to assess her STI risk.

Client who may be at increased risk now or in the future are poor candidates for IUDs, but good candidates for barrier methods.

Because of the sensitive nature of sexuality and sexually transmitted infections in many cultures, providers may hesitate to ask question about STI risk. Likewise, clients may hesitate to respond honestly. The provider should ask questions and reply to the client's responses in a respectful and culturally sensitive manner.

A basic guide for STI risk assessment is on the next page. It should be noted that the first symptoms listed require further investigation for pregnant women, since they may also be side effects of pregnancy or symptoms of problems that are not related to STIs. (Questions about other symptoms are appropriate for a non-pregnant woman, but are not listed here).
Basic Questions for STI Risk Assessment

An STI risk assessment should at least include questions for the client concerning the following issues:

• Do you currently have any of the following symptoms?
  o Vaginal discharge with unusual color or odour?
  o Genital sores?
  o Bleeding after intercourse?

• Do you have a partner with any of the following symptoms?
  o Urethral discharge?
  o Genital sores?
  o Pain when urinating?

• Have you recently had an STI or pelvic inflammatory disease (PID), or have you had previous syndromic treatment for a reproductive tract infection (RTI)?

• Have you had a new sexual partner in the last three months?

• Have you had more than one sexual partner in the last three months?

• Does your partner have other sex partners?

• Do you think you might have an STI or other RTI?

Next Steps: If the client answers yes to any of the above, an examination and further evaluation for STIs should be conducted before a PPIUD is inserted. Upon examination, if there is any indication of a possible RTI, delay insertion until:

• Further evaluation is done.
• Treatment, if required, is completed.
• The infection (and risk of re-infection) is resolved.

3. Access to IUD follow-up care

If a client wants a PPIUD and does not have access to a health center for IUD follow-up care, this should be taken into consideration when determining whether or not, from a clinical perspective, the client is an appropriate IUD candidate.

Questions to discuss with the client include:

• Where will you go to have the strings shortened when they pass through the cervix into the vagina?
• Where will you go if you want to have the IUD removed?
• Where will you go for medical treatment if you have (or think you may have) any problem associated with the IUD?

It is the provider's responsibility to make sure the woman understands that, with an IUD, there will be times when she will need to access health care services.

Whether or not a woman without easy access to IUD follow-up care services is an appropriate PPIUD candidate requires consideration on a case-by-case basis. The decision should be made together by the provider and the woman.

Physical Examination

The provider must perform a post-delivery physical examination before the PPIUD is inserted to ensure that insertion is appropriate, given the client's current condition.

The following are physical examination points to highlight for the PPIUD client:

Pre-discharge Insertion

• Perform a physical examination to assess the woman's overall postpartum condition.
• Evaluate the involution of the uterus and check the cervix for tears.

Post placental insertion

• Determine that the entire placenta has been expelled. Massage the uterus until it becomes firm and bleeding subsides.
• If the client has delivered vaginally after a previous caesarean section, palpate the previous incision to identify any defect that might be present.
• Examine the cervix for injury using a retractor or speculum.

Laboratory findings

• If laboratory tests have been done during the woman's pregnancy and/or delivery, review the results to ensure they are within normal limits.
• The only laboratory test recommended specifically for PPIUD insertion is hemoglobin or hematocrit.

Contraindications to PPIUD Insertion:

Few conditions present an unacceptable health risk and are thus considered contraindications for the insertion of a PPIUD. Following is a summary of conditions that require particular consideration in the case of PPIUDs; this information is in accordance with the National FP/RH policy guidelines and standards of practice March 2010.
Because of the unacceptable health risk represented by these conditions in relation to PPIUD, postpartum IUD insertion is not appropriate for a client who has:

- Had an STI (or probable STI) within the past three months.
- Fever or any other signs of abdominal or pelvic infection, (especially following prolonged rupture of membranes), or any pelvic infection within the past three months.
- Intra-partum or postpartum hemorrhage that continues after completely emptying the uterus, or unexplained vaginal bleeding not resolved by this delivery.
- Bleeding disorders, such as disseminated intravascular coagulation (DIC).
- Anatomical uterine abnormality that makes proper fundal placement of the IUD impossible.
- Known pelvic tuberculosis.

In the following conditions, the theoretical or proven risk usually outweighs the advantages of using a PPIUD (WHO 2015 MEC Wheel Category 3). Particular consideration must be made of the circumstances, and the provider must weigh the advantages and disadvantages of inserting a postpartum IUD for clients who have the following characteristics:

- At high risk for STIs (i.e., have multiple sexual partners or have a partner who has multiple sexual partners).
- AIDS or are HIV positive. These clients are at increased risk of opportunistic infections of the reproductive tract and of increased blood loss with copper IUDs.
- Severe anemia (hemoglobin less than 9, hematocrit less than 29). Women with an IUD may have increased menstrual blood loss; however, women with severe anemia should avoid pregnancy and may get pregnant while waiting for the hemoglobin level to rise.
- Prolonged rupture of membranes (greater than 24 hours), without signs of infection at the time of postpartum insertion.
- Cervical cancer awaiting treatment; The IUD will probably need to be removed for treatment.
- Do not have access to a health center for follow-up care.

**SUMMARY**

The module discussed proper Client Assessment prior to postpartum IUD insertion.

**EVALUATION**

- List 2 laboratory procedures to be performed before PPIUD insertion?
- List 4 contraindications to PPIUD insertion?
MODULE FIVE: SESSION 2

CLIENT ASSESSMENT FOR POSTPARTUM IMPLANTS

TIME: 1 hour

LEARNING OBJECTIVES

By the end of the session, participants should be able to;

• State what should be included in a medical history and physical examination, and which laboratory procedures are appropriate for a PP implant client assessment.
• Perform an STI risk assessment and respond appropriately.
• List contraindications for PP implant insertion.

SESSION OVERVIEW:
• Medical history and physical examination, and laboratory procedures appropriate for postpartum implant client assessment.
• STI risk assessment.
• Contraindications to PP Implant insertion.

METHODS:
• Lecture
• Discussion
• Case studies
• Demonstration and Return Demonstration

MATERIALS
• Flip chart stand/paper
• markers
• Masking tape
• LCD Projector
• Laptop
• Handout

SUMMARY

EVALUATION

CONTENT

Overview of Client Assessment for PP implant

One component of quality care in a clinical setting is a thorough client assessment. In the family planning setting, the client assessment, combined with effective client counseling, allows for an appropriate match to be made between the client's contraceptive selection(s) and the clinical evaluation.

A client assessment that is well done will address client safety and satisfaction, and will consider the client's general health. A provider skilled in client assessment will involve the client in the
process in a way that furthers the woman’s understanding of why the assessment is needed, of her own health status, and of some of the potential problems that can result with inappropriate provision of the PP implant.

Few women are clinically inappropriate PP implant candidates. A thorough client assessment will enable the provider to identify those women and help them select a clinically suitable contraceptive method that the client will be satisfied with.

**Component of Client Assessment**

The components of a client assessment are:

- Taking and assessing the client's medical history
  - This includes general, medical, obstetric and menstrual history (obstetric history includes current pregnancy/delivery), an assessment of STI risk, and evaluation of her assessment to follow-up care.
- Performing a physical examination.

After these steps are completed and if the client is an appropriate candidate, the provider may insert the PP implant and provide post insertion instructions to the client.

**Client History**

The first step in taking a client's history is to confirm that she wants an implant inserted postpartum. While this may seem obvious, it is a critical information that is sometimes overlooked. Confirming the client's choice not only saves the clinician and the client time, but more importantly, it ensures the client makes an informed choice and offers her another opportunity to change her mind if she wishes to do so.

The clinician who inserts the PP implant may not need to conduct an entire history-taking session if it has already been done. This clinician is responsible for reviewing the history and confirming the information with the client. Confirming the history with the client helps her to understand the importance of a clinical evaluation.

The clinician should make sure that the following information has been documented and is available in the client record.

The three essential components of a client history for a PP implant candidate are:

1. General medical, obstetric, and menstrual history.
2. STI risk assessment.
3. Evaluation of access to follow-up care.
1. **General, Medical, Obstetric and menstrual history**
Obstetric history includes the current pregnancy and delivery. Providers should follow standard content for the clinical history from the health care facility.

2. **STI risk assessment**
When dispensing a contraceptive method, such as an implant, which offers no protection against STIs (including HIV infection), providers have a particular responsibility to ensure that clients are educated about their risk of acquiring an STI and how to protect themselves and their partners from sexual transmission of infections.

Ideally an STI risk assessment should be conducted during antenatal care. After delivery, the provider should confirm that the client's STI risk is the same as when it was assessed ante-natally. If no risk assessment was done ante-natally, the provider should work with the client to assess her STI risk now.

Clients who may be at increased risk now or in the future are poor candidates for implants; but good candidates for barrier methods.
Because of the sensitive nature of sexuality and sexually transmitted infections in many cultures, providers may hesitate to ask questions about STI risk. Likewise, clients may hesitate to respond honestly. The provider should ask questions and reply to the client's responses in a respectful and culturally sensitive manner.

A basic guide for STI risk assessment is on the next page. It should be noted that the first symptoms listed require further investigation for pregnant women, since they may also be side effects of pregnancy or symptoms of problems that are not related to STIs. (Questions about other symptoms are appropriate for a non-pregnant woman, but are not listed here).

**Basic Questions for STI Risk Assessment**
An STI risk assessment should at least include questions for the client concerning the following issues:

- Do you currently have any of the following symptoms?
  - Vaginal discharge with unusual color or odour?
  - Genital sores?
  - Bleeding after intercourse?
- Do you have a partner with any of the following symptoms?
  - Urethral discharge?
o Genital sores?
o Pain when urinating?

- Have you recently had an STI or pelvic inflammatory disease (PID), or have you had previous syndromic treatment for a reproductive tract infection (RTI)?
- Have you had a new sexual partner in the last three months?
- Have you had more than one sexual partner in the last three months?
- Does your partner have other sex partners?
- Do you think you might have an STI or other RTI?

Next Steps: If the client answers yes to any of the above, an examination and further evaluation for STIs should be conducted.

3. Access to Implant follow-up care
If a client wants a PP implant and does not have access to a health center for implant follow-up care, this should be taken into consideration when determining whether or not, from a clinical perspective, the client is an appropriate implant candidate.

Questions to discuss with the client include:
- Where will you go if you want to have the implant removed?
- Where will you go for medical treatment if you have (or think you may have) any problem associated with the implant?

It is the provider’s responsibility to make sure the woman understands that, with an implant, there will be times when she will need to access health care services.

Whether or not a woman without easy access to implant follow-up care services is an appropriate PP implant candidate requires consideration on a case-by-case basis. The decision should be made together by the provider and the woman.

Physical Examination
The provider must perform a post-delivery physical examination before the PP implant is inserted to ensure that insertion is appropriate, given the client's current condition.

The following are physical examination points to highlight for the PP implant client:

Pre-discharge Insertion
- Perform a physical examination including the breast to assess the woman's overall postpartum condition including lactation.

Laboratory findings
• If laboratory tests have been done during the woman's pregnancy and/or delivery, review the results to ensure they are within normal limits.

Contraindications to PP implant Insertion:

Few conditions present an unacceptable health risk and are thus considered contraindications for the insertion of a PP implant. The following is a summary of conditions that require particular consideration in the case of PP implants:

- Past or current history of breast cancer.
- Hormonal contraceptives are contraindicated.
- Do not have access to a health center for follow-up care.

SUMMARY

The module discussed proper Client Assessment prior to postpartum implant insertion.

EVALUATION

• List 2 laboratory procedures to be performed before PP implant insertion?
• List 4 contraindications to PP Implants insertion?
MODULE FIVE: SESSION 3

THE WORLD HEALTH ORGANIZATION MEDICAL ELIGIBILITY CRITERIA (MEC)

Time: 35 minutes

LEARNING OBJECTIVES

By the end of the session, the Participants should be able to:

- Define WHO Medical Eligibility Criteria (MEC).
- Explain how to select contraceptive method using WHO MEC.
- Discuss the practical approach to the use of the WHO MEC wheel.
- Discuss the WHO Postpartum Family Planning Compendium and its recommendations on PPIUD and Implants.

SESSION OVERVIEW

- Definition of WHO Medical Eligibility Criteria.
- How to select contraceptive method using WHO MEC.
- Contraceptive methods that can be used in the postpartum according to WHO MEC.

METHODS

- Lecture
- Discussion
- Case studies
- Demonstration and Return Demonstration

MATERIALS

- Flip chart stand/paper
- markers
- Masking tape
- WHO MEC Wheel 2015
- WHO Postpartum Family Planning Compendium 2016
- Handout
MODULE FIVE: SESSION 3

The World Health Organization Medical Eligibility Criteria (MEC)

The WHO Medical Eligibility Criteria is a document that reviews the medical eligibility criteria for use of contraception, offering guidance on the safety of use of different methods for women and men with specific characteristics or known medical conditions. The recommendations are based on systematic reviews of available clinical and epidemiological research.

How to select contraceptive method using WHO Medical Eligibility Criteria (MEC)

Medical eligibility criteria for each contraceptive method, with the exception of female and male surgical sterilization, were classified using four categories:

1. A condition for which there is no restriction for the use of the contraceptive method. No restriction to use. Use method under any circumstance.
2. A condition where the advantages of using the method generally outweighs the theoretical or proven risks. Benefits generally outweigh the risks. Generally use the method
3. A condition where the theoretical or proven risks usually outweigh the advantages of using the method. Risks generally outweigh the benefits. Use of the method not usually recommended except where other methods are unavailable/unacceptable
4. A condition which represents an unacceptable health risk if the contraceptive method is used. Unacceptable health risks. Method not to be used.

Practical approach to the WHO MEC WHEEL

Application of the MEC during client counseling and assessment can be with the aid of the MEC wheel. The wheel contains the medical eligibility criteria for starting use of contraceptive methods, based on Medical Eligibility Criteria for Contraceptive Use, 5th edition (2015), one of WHO’s evidence-based guidelines. It guides family planning providers in recommending safe and effective contraception methods for women with medical conditions or medically-relevant characteristics, including postpartum period (refer to WHO Medical Eligibility Criteria Wheel for Contraceptive Use, 2015 for practical application).
The WHO Postpartum Family Planning Compendium

The WHO Postpartum Family Planning Compendium was developed with the aim of creating a user-friendly platform for WHO guidance regarding postpartum family planning for use by family planning service providers, programme managers and policy makers. It was introduced in January 2016. The resource is available on http://srhr.org/postpartumfp.
WHO recommendation on PPIUD and Implants based on the Compendium

Cu T380A

- If less than 48 hours postpartum, IUD can be inserted.
- If four weeks or more postpartum and has not resumed menstruation, IUD can be inserted after ruling out pregnancy. No additional contraceptive method is needed.
• If four weeks or more postpartum and her menstrual cycles have returned, IUD can be inserted as advised for other women having menstrual cycles.
• If more than 48 hours but less than 4 weeks postpartum, IUD is not recommended.

**Progestogen-only Implants**

*Breast feeding or non-breastfeeding:*

• If less than 21 days postpartum, Implants can be inserted. No additional contraceptive protection is needed.
• If 21 days or more postpartum and she has not resumed menstruation, Implants can be inserted if pregnancy is ruled out. She should abstain from sex or use contraceptive protection for the next two days.
• If her menstrual cycles have returned, Implants can be inserted as advised for other women having menstrual cycles.

**Summary**

This session discussed the WHO Medical Eligibility Criteria and the use of the WHO MEC wheel. It also discussed the WHO (2016) Postpartum Family Planning Compendium and recommendations on when to insert Cu IUD or progestogens-only Implants in the postpartum period.

**Evaluation**

• Define WHO Medical Eligibility Criteria?
• List the four categories using the WHO MEC?
• What are the recommendations of the WHO Postpartum Family Planning Compendium on PPIUD and Implants?
MODULE SIX

POSTPARTUM IUD AND POSTPARTUM IMPLANTS INSERTION AND REMOVAL TECHNIQUES

This module covers the various types of PPIUD and PP Implants insertion and removal techniques and when they are used.

It also explains how the techniques differ because of the various timings. The advantages and disadvantages of the different techniques as well as the differences and similarities of post-partum and interval IUD are discussed.

Session 1: PPIUD insertion techniques

Session 2: PP Implants Insertion techniques
- Jadelle
- Implanon®

Session 3: IUD removal technique

Session 4: Implant removal technique
## MODULE SIX

**PPIUD AND PP IMPLANTS INSERTION AND REMOVAL TECHNIQUES**

### MODULE PLAN

<table>
<thead>
<tr>
<th>SESSION</th>
<th>DURATION</th>
<th>OBJECTIVES</th>
<th>METHOD</th>
<th>MATERIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1: PP IUD insertion</td>
<td>2 hours</td>
<td>• Identify the 2 types of insertion techniques</td>
<td>Lecture</td>
<td>Flip chart</td>
</tr>
<tr>
<td>techniques</td>
<td></td>
<td>• Identify the techniques that is appropriate to each particular timing</td>
<td>Discussion</td>
<td>Stand/paper</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Explain the advantage of different techniques</td>
<td>Handout</td>
<td>Markers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Describe the points of post insertion instruction</td>
<td>Demonstration</td>
<td>Masking tape</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Describe key differences and similarities for postpartum and interval</td>
<td>Demonstration and</td>
<td>Pelvic model (Zoe and Mama U)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>insertion</td>
<td>return demonstration</td>
<td>Insertion Kit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Checklist</td>
<td>Sample IUDs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Placebos</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Insertion demonstration videos</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Learning guides and checklist</td>
</tr>
<tr>
<td>Session 2: Jadelle Implants</td>
<td>1 hour</td>
<td>• Identify the equipment and materials for Jadelle Implant insertion</td>
<td>Lecture</td>
<td>Flip chart</td>
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<tr>
<td>Insertion techniques</td>
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<td>procedures.</td>
<td>Discussion</td>
<td>Stand/paper</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Demonstrate the correct insertion technique with regard to asepsis,</td>
<td>Handout</td>
<td>Markers</td>
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<td>Demonstration</td>
<td>Masking tape</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>return demonstration</td>
<td>Arm model</td>
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<td></td>
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<td>Insertion Kit</td>
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<td>Sample Jadelle</td>
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<td>Placebos</td>
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<td>Anaesthesia, location of incision, and careful correct placement of the implants.</td>
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<td>Demonstrate the unique insertion techniques of Jadelle implant.</td>
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<td>Demonstrate the correct application of dressing after insertion.</td>
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<td>Explain the instructions to be given to clients after insertion.</td>
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<td>Schedule follow-up appointments with the clients after the procedure.</td>
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**Session 2: IMPLANON® Insertion techniques**

**1 hour**

- Identify the equipment and materials for Implanon® and Implanon NXT™ Implants' insertion procedures.
- Demonstrate the correct insertion technique with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the implants.

- Lecture
- Discussion
- Handout
- Demonstration and return demonstration
- Checklist

- Insertion demonstration videos
- Learning guides and checklist

- Flip chart
  - Stand/paper
  - Markers
  - Masking tape
  - Arm model
  - Insertion Kit
  - Sample Implanon® and Implanon NXT™
  - Placebos
  - Insertion demonstration videos
  - Learning guides and checklist
- Demonstrate the unique insertion techniques of Implanon® (classic) and Implanon® NXT™ implants.
- Demonstrate the correct application of dressing after insertion.
- Explain the instructions to be given to clients after insertion.
- Schedule follow-up appointments with the clients after the procedure.

| Session 3: IUD removal technique | 1 hour |  | • Identify the indications for removal of IUDs.  
• Identify the equipment and materials for IUD removal procedures  
• Demonstrate the correct removal techniques with regards to asepsis, and removal procedure.  
• List what to do when difficulties arise during removal.  
• List appropriate steps for  | • Lecture  
• Discussion  
• Handout  
• Demonstration and return demonstration  | • Flip chart  
• Stand/paper  
• Markers  
• LCD Projector  
• Pelvic model (Zoe)  
• CuT 380A  
• Learning Guide for CuT 380A IUD Removal Techniques |
| Session 4: Implant removal technique | 1 hour | • Identify the equipment and materials for implant removal procedures  
• Demonstrate the correct removal techniques with regards to asepsis, anaesthetic, length and location of incision, and removal procedure.  
• List what to do when difficulties arise during removal.  
• List appropriate steps for reinsertion.  
• Demonstrate post-removal counseling techniques.  
• Identify indication for removal. | • Lecture  
• Discussion  
• Handout  
• Demonstration and return demonstration | • Flip chart  
• Stand/paper  
• Markers  
• LCD Projector  
• Laptop  
• Arm model  
• Learning Guide for Implant Removal Techniques |
MODULE SIX: SESSION 1
POSTPARTUM IUD INSERTION TECHNIQUES

TIME: 2 hours

LEARNING OBJECTIVES

By the end of this session, participants should be able to:

- Identify the 2 types of insertion technique.
- Identify the technique appropriate to each particular timing.
- Explain the advantages of different techniques.
- Describe the key steps of each technique.
- Describe key points of post insertion instructions.
- Describe key differences and similarities for post-partum and interval insertion.

SESSION OVERVIEW:

- Types of insertion technique.
- Appropriate technique for various timings.
- Advantages of different techniques.
- Key points of post insertion instructions.
- Differences and similarities: Interval and post-partum insertion.

METHODS:

- Lecture
- Discussion
- Demonstration and return demonstration
- Checklist

MATERIALS:

- Flip chart stand and paper
- Checklist
- Markers
- Masking tape
- Pelvic model (Zoe and Mama U)
- Insertion Kit
- Sample IUDs
- Placebos
- Insertion demonstration videos
- Learning guides and checklist
TYPES OF PPIUD INSERTION TECHNIQUES:

There are 2 types of insertion techniques: Forceps and Manual Insertion.

**FORCEPS INSERTION:**
This method of insertion is performed after expulsion of the placenta and within 48 hours of delivery. It entails the placement of the IUD in the uterine fundus with a Kelly's forceps. It is simple to perform and more comfortable for the client.

Fig 6.1.1: Diagram of a Kelly's forceps holding copper T IUD
Steps in Forceps insertion with Kelly’s forceps (Adapted from Postpartum IUCD Reference Manual, November 2010. USAID and MCHIP).

1. Check the woman’s record to ensure that she is appropriate client for PPIUD. Rule out conditions which prevent insertion which prevent insertion of IUD, e.g., prolonged rupture of membranes > 18 hours, chorioamnionitis and unresolved postpartum haemorrhage.

2. Confirm that sterile instruments, supplies and light source are available.

3. Perform hand hygiene and put on sterile gloves.

4. Arrange instruments and supplies on sterile tray or draped area (fig. 6.1.2).

5. In lithotomy position, inspect perineum, labia and vaginal walls for lacerations. If lacerations are not bleeding heavily, insert the IUD and repair if needed.

6. Gently visualize cervix by inserting a Sims speculum in the vagina and depressing the posterior wall of the vagina.

7. Gently clean cervix with antiseptic solution two times with the ring (sponge holding) forceps (fig.6.1.3).
8. Gently grasp anterior lip of the cervix with the ring forceps up to the first lock.

9. Grasp IUD with long placental (Kelly’s) forceps (fig. 6.1.4).

Figure 6.1.4: Grasping the IUD inside the package

It should be held just on the edge of the placental forceps so that it can easily be released from the instrument when opened (fig.6.1.5 and fig. 6.1.6).
10. Apply gentle traction on the anterior lip of the cervix using the ring forceps and insert IUD into lower uterine cavity. Avoid touching the walls of vagina (fig. 6.1.7 and fig. 6.1.8).
Figure 6.1.7: Position of the IUD as it is held to enter the vagina

Note: The vaginal speculum is not shown in the illustration.

Figure 6.1.8: The vaginal speculum is removed and the forceps holding the IUD are pushed into the vagina

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 uterus upward. This is to straighten out the angle between the vagina and the uterus, so that the instrument can easily move upwards towards the uterine fundus (fig.6.1.9). The ring forceps is the removed.
12. Gently move the placental forceps upward towards the fundus following the curve of the uterine cavity (fig.6.1.10).

13. Confirm that the end of the forceps has reached the fundus and tilt the forceps slightly inwards. The provider will feel resistance and will also feel the thrust of the instrument at the
fundus with his/her left hand placed on the abdomen when it reaches the uterine fundus (fig.6.1.11).

**Figure 6.1.11: Placement of hands on abdomen to confirm that forceps holding the IUD have reached the uterine fundus**

![Image of hands on abdomen](image1)

Note: The forceps holding the cervix are not shown.

**Figure 6.1.12: The forceps holding the IUD are turned 45° to the right**

![Image of forceps turned 45°](image2)

Note: The forceps holding the cervix are not shown, to allow for a clear view of the rotation of the forceps holding the IUD

14. Open placental forceps and release the IUD at the fundus. Sweep the placental forceps to the right side wall of the uterus. Slowly remove the forceps from uterine cavity, keep it slightly open. Take particular care not to dislodge the IUD as placental forceps are removed. Apply counter pressure as the instrument is being withdrawn and until it is completely out of the uterus.

15. Examine the cervix to ensure that there is no bleeding. Ensure that the IUD is not visible at the cervical Os, or the strings appear to be very long. If that happens, the IUD is not placed high enough.
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.

18. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning the inside out and disposing of them. Perform hand hygiene. Follow all infection prevention procedures.

19. Provide the woman with post insertion instructions.

20. Record information regarding the PPIUD insertion in her chart or record and in the Immediate PPIUD register.
MANUAL INSERTION

The manual method of insertion is appropriate when performed within 10 mins of expulsion of the placenta. Manual insertion requires no special instruments but may be less comfortable for the client than insertion with ring forceps. The insertion is achieved using the gloved hand to place the IUD high in the fundus.

Steps in Manual insertion:

Figure 6.1.12: The IUD held appropriately between the index finger and the middle finger
Figure 6.1.13: The position of the hand to enter the vagina

Figure 6.1.14: The hand holding the IUD enters the vagina
Insertion Techniques for Various Timings

Timing terms: This curriculum uses the following terminology to designate the timing for IUD insertion:

- **Post-partum**: a general term for IUD insertion that takes place after delivery and before the woman leaves the hospital.
- **Pre-discharge**: insertion after the post-placental period, but within 48 hours of delivery and before the woman leaves the hospital.
- **Post-placental**: insertion immediately after expulsion of the placenta. It is recommended that the insertion take place within 10 mins after expulsion of the placenta following a vaginal delivery, or at the time of caesarean section. (Global PPIUD reference manual October 2013).
- **Trans-Caesarean**: insertion that takes place following a caesarean delivery, before the uterus is closed.
- **Post-Caesarean**: pre-discharge insertion following caesarean delivery.
• **Post-Abortion**: IUD insertion following abortion. Following a second trimester abortion a postpartum insertion technique is used. After a first trimester abortion the IUD is inserted using an interval technique. This is due to the differences in anatomy and physiology between the first and second trimester.

• **Interval**: anytime more than four to six weeks after delivery.

**Fig.6.1.16: Location of the IUD within the Uterus following insertion**

![Image of IUD location](image)

### Appropriate Insertion Technique for Specific Timing

<table>
<thead>
<tr>
<th></th>
<th>Pre-discharge</th>
<th>Post placental</th>
<th>Trans - Caesarean</th>
<th>Post Caesarean</th>
<th>2nd Trimester Abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forceps</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

1st trimester insertion is the same as an interval IUD insertion (not taught in this course).

**Other notes regarding insertion techniques:**

• A Kelly's placental forceps is recommended for instruments insertion (pre-discharge or post-placental). This forceps is longer than a ring, or sponge forceps, and also slightly curved, both of which make it more effective in placing the IUD at the uterine fundus.

• Post placental insertion can be done manually or with forceps. Each method has distinct advantages:
• Post placental manual insertion: lower chance of perforation than with instruments insertion; no need for special instrument, no need for manipulation of the client after the delivery; done on the delivery table.

• Post placental forceps insertion: less uncomfortable for the client than manual insertion, especially if she has not received anesthesia for delivery; lower risk of contamination; less risk of pulling out the IUD while taking out the hand; is easier to perform than manual insertion; easy to teach.

• Use of a Graves speculum is recommended for pre-discharge insertion. An important advantage of the Graves is that the junction of the two blades can be extended vertically and the blades can also be opened wide, which makes it easy to see the cervix and provides enough room to pass the necessary instruments through when the speculum is let go. With other specula, such as the Cusco, only the upper blade can be opened. The Sims speculum requires another person to hold the speculum in place.

Regardless of the type or timing of the PPIUD insertion, a "non-touch" technique of insertion must be used in order to reduce the likelihood of the uterus being contaminated by the introduction of additional microorganisms during the insertion. "Non-Touch" technique means that the sterile IUD is handled only with sterile gloves/instruments. The walls of the vagina are not touched as the IUD is passed through.

Note: Manual examination of the uterus is not recommended before PPIUD insertion except when obstetrical situations require it (e.g., retained placenta or membranes).

Special or additional anesthesia, beyond that which is prescribed for delivery, is not required. The administration of oxytocin (Pitocin), often used following delivery, is not required for PPIUD insertion. Strong oxytocic drugs may cause lower uterine contraction, making post-placental IUD insertion difficult.

Sterile gloves and instruments must be used for PPIUD insertion.

Good insertion technique includes not only technical skill and safety, but also attention to the client's needs. Women will be concerned about the procedure and about the amount of pain they might feel. The clinician should avoid causing more pain and work to minimize the client's tension and maximize her comfort.

Procedure for Pre-discharge Insertion:

Pre-discharge insertion occurs any time after the post-placental period, but within 48 hours after delivery while the cervix is still wide open and the woman is still in the hospital. A long forceps such as the Kelly's placenta forceps is the preferred instruments (Fig 6.1.1.) However, if the Kelly's
placenta forceps is not available, insertion using a ring forceps or another long forceps is appropriate.

**Procedure for Post-placental insertion: Manual Insertion and Instrumental Insertion:**

Post-placental insertion is done immediately after expulsion of the placenta. It may be done manually or using a Kelly's placental or rings forceps. It has been recommended that the insertion take place within 10 mins after expulsion of the placenta following a vaginal delivery, or at the time of caesarean section. (Global PPIUD reference manual, October 2013).

Note: Manual examinations of the uterus are not recommended before PPIUD insertion except when obstetrical situations require it (e.g., retained placenta or membranes).

**Procedure for Trans-Caesarean Insertion**

The method is appropriate for use at the time of caesarean section, after delivery of the placenta and bleeding from the uterine incision has been controlled. The procedure is:

- Massage the uterus until bleeding subsides.
- Place the IUD at the top (fundus) of the uterine cavity manually or with a Kelly's placental or ring forceps.
- Before closing the uterine incision, place the strings in the lower uterine segment.

**Procedure for Post-Caesarean Insertion**

Post-Caesarean IUD insertion is a pre-discharge insertion following a Caesarean section.

**Important:** The clinician must exercise caution to avoid inserting the forceps and IUD through the caesarean incision.

**IUD Insertion Following First Trimester Abortion:**

Ovulation frequently occurs within two weeks after an abortion. Therefore, post abortion contraceptive counseling and provision of services are essential. An IUD can be inserted immediately after an uncomplicated first trimester abortion.

The risk of complications (perforation, bleeding, and infection) following post abortion insertion is no greater than that following interval IUD insertion, as long as the cervix or uterine cavity is not infected and the uterus has been completely evacuated.

The technique for IUD insertion following a first trimester abortion is the same as interval insertion, using the inserter supplied with the IUD. The interval IUD insertion technique is not part of this training.
IUD Insertion Following Second Trimester Abortion:

The technique for IUD insertion following a second trimester abortion is the same as pre-discharge insertion, because the cervix is partially dilated a ring forceps maybe used.

If a stillbirth or a third trimester abortion has occurred, the Kelly's placental forceps may be preferred.

Differences and Similarities: Interval and Postpartum Insertion

<table>
<thead>
<tr>
<th>Interval</th>
<th>Postpartum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Difference:</strong></td>
<td></td>
</tr>
<tr>
<td>Cervical Os closed</td>
<td>Cervical Os dilated</td>
</tr>
<tr>
<td>Uterus must be sounded before insertion to know depth of fundus for IUD placement</td>
<td>Fundal placement confirmed by manual palpation of the fundus through the abdomen</td>
</tr>
<tr>
<td>Strings cut 3-4 cm from cervix at time of insertion</td>
<td>Strings remain in uterus</td>
</tr>
<tr>
<td>Inserter is used</td>
<td>IUD inserted with special inserter</td>
</tr>
</tbody>
</table>

**Similarities**

- Fundal placement required for effectiveness
- Care must be taken to avoid perforating the uterus at the time of insertion
- With some IUDs the supplied sterile Inserter is used

Same

Same
Post-insertion instructions:

It is important to give the PPIUD client clear instructions to help her use the method safely, effectively, and with satisfaction. Instructions should be given orally as well as in writing (see Appendix D). Providers should use simple language when speaking to and writing for the client and give instructions in a language the client can easily understand.

- Tell the client what kind of IUD she has received.
- Explain how long the IUD will prevent pregnancy.
- Assure the client that the IUD has no effect on breast milk and that she can breastfeed her baby.
- Tell the client that she may have sexual intercourse as soon as it is comfortable for her.
- Discuss the possibility that the IUD may be expelled, especially during the first few weeks after insertion.
- Tell the client that she may have cramping or pain, or find the IUD if it is expelled. Explain that the client can have another IUD inserted if she chooses. Explain that within a few weeks, the IUD strings will probably come from the womb into the vagina.
- Tell her that a health care worker will shorten the strings during a follow-up visit. She may return before her six-week check-up if the strings are a problem.
- Explain how to check for the IUD strings. Tell the woman that she should wait to begin checking for the strings until after six weeks postpartum.
  1. Wash her hands using soap. This helps to reduce the chance of infection.
  2. Sit in a squatting position, or stand with one foot up on a step or ledge.
  3. Gently insert her finger into her vagina and feel for the cervix, which feels firm, like the tip of the nose.
  4. Feel for the strings, but do not pull the strings. That could move the IUD or cause it to come out.
- Tell the client that she should check the strings at least once a month, after her period, but should not check for the strings until after six weeks postpartum. Emphasize that the client should return to the clinic if the strings seem to have become shorter or longer once they have been shortened by the health care provider, or if they seem to be missing and she can no longer feel them.
- Tell the client that once menstruation returns, some women with IUDs have more cramping and heavier bleeding during their periods, longer periods, or spotting or bleeding between periods. These side effects usually go away after a few months of IUD use:
- Tell the client that the IUD will not protect her or her partner against HIV infection and other STIs.
- Describe the warning signs for potential complications: late period or other signs of pregnancy; bleeding or spotting between periods or after intercourse; severe pain in her
belly; pain during intercourse; usual discharge from the vagina beyond six weeks postpartum; missing, shorter, or longer strings; feeling the IUD when checking the strings.

- Tell the client where to seek help if a problem occurs. Encourage her to go to a health facility at any time if she is concerned about any aspect of IUD use.
- Assure the client that she can have the IUD removed if she changes her mind about the method. Discourage her from removing the IUD herself.
- Tell the client when she needs to return for routine follow-up and removal. The first follow-up visit for PPIUD clients is usually done at the six-week postpartum checkup. Thereafter, an annual pelvic exam is recommended.
- Give the woman written instructions. If she has difficulty reading, ask her to identify someone in her family or neighborhood who can read the instruction to her.
- Ask the client to repeat the instructions in her own words.

Expulsion rates:

<table>
<thead>
<tr>
<th>Time Of IUD Insertion</th>
<th>Definition</th>
<th>Expulsion Rate</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postplacental</td>
<td>Within 10 minutes after delivery of placenta</td>
<td>9.5–12.5%</td>
<td>Ideal; low expulsion rates</td>
</tr>
<tr>
<td>Immediate Postpartum</td>
<td>After 10 minutes to 48 hours post delivery</td>
<td>25–37%</td>
<td>Still safe</td>
</tr>
<tr>
<td>Late Postpartum</td>
<td>After 48 hours to 4 weeks post delivery</td>
<td>NOT RECOMMENDED</td>
<td>Increased risk of perforation and expulsion</td>
</tr>
<tr>
<td>Interval-Extended</td>
<td>After 4 weeks post delivery</td>
<td>3–13%</td>
<td>Safe</td>
</tr>
</tbody>
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Risk of Expulsion and Timing of Insertion Postpartum
Instruments for PPIUD Insertion

In order to perform effective, safe insertions you will need to have certain instruments and supplies prepared before the procedure.

For Pre-discharge Insertion:

- IUD
- Graves speculum
- Sterile gloves
- Ring forceps
- Kelly's forceps (preferred; if not available you will need a second ring forceps)
- Gauze
- Antiseptic solutions
- Bucket and 0.5% chlorine solution for decontamination of instruments

For Post-placental Manual Insertion:

- IUD
- Retractor or Sims speculum
- Sterile gloves
- Ring forceps
- Gauze
- Antiseptic solutions
- Bucket and 0.5% chlorine solution for decontamination of instruments

For Post-placental Instruments Insertion:

- IUD
- Retractor or Sims speculum
- Sterile gloves
- Two ring forceps or one ring and one Kelly's placental forceps
- Gauze
- Antiseptic solutions
- Bucket and 0.5% chlorine solution for decontamination of instruments

For trans-Caesarean Insertion:

- IUD
- Sterile gloves
- Ring forceps
- Gauze
- Bucket and 0.5% chlorine solution for decontamination of instruments
SUMMARY

The session described the types of PPIUD insertion technique, timing, key steps of each technique, key points in post insertion instructions, advantages and disadvantages of each technique.

EVALUATION

• Describe the types of insertion technique
• Describe the appropriate timing for each technique
• List 3 Advantages of each technique
• Describe key differences and similarities for post-partum and interval insertion
MODULE SIX: SESSION 2

POSTPARTUM IMPLANTS INSERTION: JADELLE INSERTION TECHNIQUES

Time: 1 hour

LEARNING OBJECTIVES

By the end of this session, participants should be able to:

• Identify the equipment and materials for Jadelle Implant insertion procedures.
• Demonstrate the correct insertion technique with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the implants.
• Demonstrate the unique insertion techniques of Jadelle implant.
• Demonstrate the correct application of dressing after insertion.
• Explain the instructions to be given to clients after insertion.
• Schedule follow-up appointments with the clients after the procedure.

SESSION OVERVIEW:

• Equipment and materials for Jadelle implant insertion procedures.
• Demonstration of the correct insertion technique for Jadelle implant with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the implant.
• Demonstration of the correct application of dressing after insertion.
• Instructions to be given to clients after insertion.
• Scheduling follow-up appointments with the clients after the procedure.

METHODS:

• Lecture
• Discussion
• Hand out
• Demonstration and return demonstration
• Checklist

MATERIALS:

• Flip chart
• Checklist
• Markers
• Masking tape
• Jadelle
• Arm model

SUMMARY

EVALUATION
CONTENT

Introduction

- Insertion techniques involve correct sub-dermal placement of the implants.
- The insertion procedure for Implanon® being slightly different from those of Jadelle is described separately.

Equipment and materials for Implant insertion procedures

- One set of implant capsules
- Trocar and cannula as supplied
- Sterilized surgical drapes
- Sterile gloves preferably devoid of talcum powder
- Antiseptic solution like Savlon, Hibitane or Betadine
- Local anesthetic agent like Xylocaine without Adrenaline 1%
- Syringe and needle
- Sterile gauze/ cotton wool
- Plaster
- Artery forceps (2)
- Scalpel and blade (size 12) (optional)
- Examination couch with arm rest
- Disinfectant solution, e.g. Jik, Bethadine
- Plastic bowl

Correct insertion technique with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the implants.

Client Preparation

The following steps should be noted in Client preparation

- Give clear information about probable changes in bleeding pattern during the menstrual cycle and other possible side effects;
- Describe the insertion and removal procedures and what the client should expect during and afterwards;
- Ensure client's cooperation and relaxation;
- Review client assessment data to determine if the client is an appropriate candidate for implants or if she has any problems that should be monitored more frequently while the implants are in place;
- Do a general examination;
- Do a pelvic examination if needed or requested by client
Note: Pelvic examinations are not necessary for safe implant initiation and use, but may be indicated for other reasons and are part of the preventive medicine practices and health promotion);

Correct insertion technique with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the implant:

**Steps for inserting contraceptive implant**
- Instruct the client to lie on the couch with arm stretched out comfortably.
- Support arm with arm rest.
- Use proper infection prevention procedure.
- Wash hands with soap and running water.
- Ask the patient to lie down on the examination table with her non-dominant arm extended on a sterile cloth on the other table, at right angles to her body. The implants will be inserted sub-dermally in the shape of a narrow V, opening towards the armpit.
- Clean the area of insertion with antiseptic solution: iodine (if available) and finally with spirit.
- Apply sterile drapes exposing the insertion area only (under the skin of the upper arm).

**Figure 6.2.1: Sub-dermal placement of Jadelle implants**

- Clean the client’s upper arm with an antiseptic solution, and cover the arm with either two sterile clothes or a dry sterile fenestrated drape. The optimal insertion area is in the medial aspect of the upper arm about 6 – 8 cm above the fold of the elbow.
- Open the Jadelle pouch by pulling apart the films of the pouch and let the two implants drop on a sterile cloth. Do not touch the inside of the package or its contents with bare hands. There should be two implants.

**Note:** Always use sterile gloves or forceps when handling the rods. If an implant is contaminated, e.g., falls on the floor. Leave it for later disposal. Open a new package and continue with the procedure.

- First determine the absence of known allergies to the anaesthetic agent or related drugs. Fill the syringe with 2 – 4 mL of local anaesthetic.
- Anaesthetize the insertion area by inserting the needle just under the skin about 4 to 5.5 cm in the direction where you are planning to introduce the trocar.
• Insert the trocar directly through the skin without making an incision with a scalpel.

**Figure 6.2.2: Anaesthetizing the insertion area**

• The trocar has two marks. The mark close to the handle indicates how far the trocar should be introduced under the skin before loading the implant. The mark closest to the tip indicates how much of the trocar should be left under the skin following the insertion of the first implant. When inserting the trocar, avoid touching the part of the trocar that will go under the skin.

**Figure 6.2.3: Marks on the Trocar**

• Once the tip of the trocar is beneath the skin, it should be directed along the skin horizontally by pointing slightly upwards toward the raising the skin (tenting) to keep the implant in the sub-dermal plane. Throughout the insertion procedure, the trocar should be oriented with the bevel up.

**Note:** It is important to keep the trocar sub-dermal by tenting the skin with the trocar, as failure to do so may result in deep placement of the implants causing a more difficult removal. Do not force the trocar, and if you feel any resistance, try another direction.
Figure 6.2.4: Introducing the trocar just beneath the skin

- Advance the trocar beneath the skin about 5.5 cm from the incision to the mark closest to the handle of the trocar.

Figure 6.2.5: Advancing to the mark while tenting

- Remove the plunger when the trocar is advanced to the correct mark (Figure 6.2.6).
- Load the first implant into the trocar either with tweezers or fingers.
- Push the implant gently with the plunger to the tip of the trocar until resistance is felt.
- Never force the plunger.
Hold the plunger steady and pull the trocar back along it until it touches the handle of the plunger. Do not completely remove the trocar until both implants have been placed. The trocar is withdrawn only to the mark closest to its tip.

Note: It is important to keep the plunger steady and not to push the implant into the tissue

- When you can see the mark near the tip of the trocar in the incision, the implant has been released and will remain in place beneath the skin. You can check by palpation.
- Insert the second implant next to the first one to form a V-shape. Advancing again to the mark.
Figure 6.2.8: Inserting the second implant. Advancing again to the mark forming a narrow “V”

- Fix the position of the first implant with the left forefinger and advance the trocar along the side of the finger. This will ensure a suitable distance between implants.
- Remove the plunger and load the second implant.

Figure 6.2.9: Loading the second implant

- Hold the plunger steady while pulling the trocar back (figure 6.2.10).

Figure 6.2.10: Holding the plunger while pulling the trocar back

- To prevent expulsion, leave a distance of about 5 mm between the puncture sites and the ends of the implants. Their correct position can be checked by cautious palpation of the insertion area.
- After the insertion, apply small gauze slightly soaked in iodine solution before covering with plaster/elastoplast.
Observe the client for at least 15 to 20 mins for bleeding from the incision or adverse effects before sending her home.

**Instructions to the service provider following the insertion of the implants**

- Before removing gloves, place instruments into a container filled with 0.5% chlorine solution for decontamination.
- The surgical drape (if used) must be washed before re-use. Place in a dry covered container and remove to the designated washing area.
- While still wearing gloves, place all contaminated objects (gauze, cotton and other waste items) in a properly marked, leak-proof container with a tight-fitting lid or in a plastic bag.
- Immerse both gloved hands briefly in chlorine solution and then carefully remove gloves by turning inside out and place in the waste container.
- Wash hands thoroughly with soap and running water.
- All waste materials should be disposed of by burning or burying as per the facility’s protocol.

**Client Care after the procedure**

- Place a note in the client's record indicating the location of the capsules and specifying any unusual events that may have occurred during insertion. (A simple drawing showing the approximate location of the capsules in the client's arm is helpful).
- Observe the client for bleeding from the incision or adverse effects before sending her home. Give the woman a written post insertion care instructions (if available) as appropriate.

**Client's instructions for wound care at home**

- There may be bruising, swelling or tenderness at the insertion site for a few days. This is normal.
• Keep the area around the insertion site dry and clean for at least 48 hours. The incision could become infected if the area gets wet while bathing.
• Leave the gauze pressure and plaster in place for 48 hours and the band-aid or surgical tape in place until the incision heals (i.e. normally 3 to 5 days).
• Routine work can be done immediately. Avoid bumping the area, carrying heavy loads or applying unusual pressure to the site.
• After healing, the area can be touched and washed with normal pressure.
• If signs of infection occur, such as fever with inflammation (redness plus heat) at the site, or if there is persistent arm pain for several days, return to the clinic.

**Schedule follow-up appointments with the clients after the procedure**

Instructions on “Follow-up Visits” are as follows:

**First visit (3 – 5 days after insertion)**

- Ask the client about her health generally.
- Inspect the wound at the insertion site.
- Ask about any complaints.

**At 6 weeks routine postnatal clinic visit**

- **Third Month after insertion**
  - Ask about variations in her menstrual cycle, including inter-menstrual bleeding or spotting and excessive blood loss.

**Schedule of subsequent follow-ups (if all is well):**

- Ask about variations in her menstrual cycle, including inter-menstrual bleeding or spotting and excessive blood loss.
- Yearly visits until the client wishes to have the device removed or the life span of the device expires – at 5 years.
- Repeat the activities of first visit at each subsequent visit.
- Encourage a pap smear every two years.
SUMMARY

• Insertion techniques involve paying attention to asepsis, anaesthesia, as well as the length and location of the puncture site.
• Careful sub-dermal placement ensures easy removal thereafter.

EVALUATION

• Mention the steps of the correct procedure for Jadelle insertion technique?
• List the post-insertion instructions given to the client?
• State the correct procedure for follow-up visits?
• State the warning signs a client must report after implant insertion?
MODULE SIX: SESSION 2

IMPLANON® (CLASSIC) AND IMPLANON NXT™ INSERTION TECHNIQUES

Time: 1 hour

LEARNING OBJECTIVES

By the end of this session, participants should be able to:

• Identify the equipment and materials for Implanon® and Implanon NXT™ Implants' insertion procedures.
• Demonstrate the correct insertion technique with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the implants.
• Demonstrate the unique insertion techniques of Implanon® (classic) and Implanon NXT™ implants.
• Demonstrate the correct application of dressing after insertion.
• Explain the instructions to be given to clients after insertion.
• Schedule follow-up appointments with the clients after the procedure.

SESSION OVERVIEW:

• Equipment and materials for Implanon® and Implanon NXT™ implants insertion procedures.
• Timing of insertion with regard to menstruation, postpartum, post abortion and lactation periods.
• Demonstration of the correct insertion technique for Implanon® implants with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the implants.
• Demonstration of the correct application of dressing after insertion.
• Instructions to be given to clients after insertion.
• Scheduling follow-up appointments with the clients after the procedure.

METHODS:

• Lecture
• Discussion
• Hand out
• Demonstration and return demonstration
• Checklist

MATERIALS:

• Flip chart
• Checklist
• Markers
• Masking tape
• Sample Implanon®
• LCD Projector
• Learning Guide for Implanon®
• Arm model

SUMMARY

EVALUATION
Introduction

Only a physician who is familiar with the procedure of Implanon® (classic) and Implanon NXT™ insertion should undertake the procedure and it must be done under aseptic conditions. Both the insertion of Implanon® and Implanon NXT™ implants are performed with the specially designed applicator.

**Figure 6.2.12: Components of an Implanon® Applicator**

Note: The procedure used for insertion of Implanon® is opposite to giving an injection. When inserting Implanon®, the obturator must remain fixed while the cannula (needle) is retracted from the arm. For normal injections the plunger is pushed and the body of the syringe remains fixed.
Materials required for Implanon® and Implanon NXT™ insertion as shown in Figure 6.3.3

- One set of implant capsules
- Examining table for the patient to rest her arm on
- Sterile cloth (1)
- Marker pen (2)
- Antiseptic solution (3)
- Sterile gloves (4)
- Local anaesthetic spray, or injection of 1 mL Lidocaine [Xylocaine] (5)
- Preloaded, sterile Implanon® applicator containing a single rod (6)
- Sterile gauze and compress (7)
Client Preparation

- Give clear information about probable changes in bleeding pattern during the menstrual cycle and other possible side effects;
- Describe the insertion and removal procedures and what the client should expect during and afterwards;
- Ensure client's cooperation and relaxation;
- Review client assessment data to determine if the client is an appropriate candidate for Implanon® implants or if she has any problems that should be monitored more frequently while the implants are in place;
  - Do a general examination;
  - Do a pelvic examination if needed or requested by client
    Note: pelvic examinations are not necessary for safe implant initiation and use, but may be indicated for other reasons and are part of the preventive medicine practices and health promotion);
  - Instruct the client to lie on the couch with arm stretched out comfortably;
  - Support arm with arm rest;
  - Use proper infection prevention procedure;
  - Wash hands with soap and running water;
  - Ask the patient to lie down on the examination table with her non-dominant arm extended on a sterile cloth on the other table, at right angles to her body;
  - Clean the area of insertion with antiseptic solution: iodine (if available) and finally with spirit;
  - Apply sterile drapes exposing the insertion area only (under the skin of the upper arm).

Correct insertion technique with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the Implanon® (classic) and Implanon NXT™ Implants

- Allow the subject to lie on her back with her non-dominant arm (the arm which the woman does not use for writing) turned outwards and bent at the elbow. If preferred, a sitting position can be taken.
- Arrange the materials and instruments so that they are accessible.
- To minimize the risk of neural or vascular damage, Implanon® should be inserted at the inner side of the upper arm (non-dominant arm) about 6-8 cm above the elbow crease in the groove between the biceps and the triceps (sulcus bicipitalis medialis).
Note: When Implanon® is inserted too deeply (intramuscularly or in the fascia) this may cause neural or vascular damage. Too deep insertions have been associated with paraesthesia (due to neural damage) and migration of the implant (due to intramuscular or fascial insertion), and in rare cases with intravascular insertion. Moreover, when the implant is inserted too deeply, it may not be palpable and the localization and/or removal can be difficult later on.
Mark the insertion site.

Prepare the insertion site with a cotton swab soaked with antiseptic.

Anaesthetize with an anaesthetic spray or with 2mL of Lidocaine without adrenaline (Xylocaine 1%) applied just under the skin along the “insertion canal”.

Carefully remove the sterile disposable applicator carrying the Implanon® from its blister.

While keeping the shield on the needle, visually verify the presence of the implant, seen as a white body inside the needle tip. If the implant is not seen, tap the top of the needle shield against a firm surface to bring the implant into the needle tip, following visual confirmation, the implant should be lowered back into the needle by doing the opposite. The needle shield can now be removed.

Note: The implant can fall out the needle prior to insertion. Therefore, always hold the applicator in the upward position (i.e., with the needle pointed upwards) until the time of insertion. This is to prevent the implant from dropping out.

Keep the needle and the implant sterile. If contamination occurs, a new package with a new sterile applicator must be used.

- Always hold the applicator in the upward position (i.e. with the needle pointed upward) until the time of insertion. This prevents the implant from dropping out.
- Stretch the skin around the insertion site with thumb and index finger (Figure 6.3.4 above).
- Insert first only the tip of the needle, slightly angled (200).
• Release the skin.
• Lower the applicator to a horizontal position (Figure 6.3.7)
• Lift the skin with the tip of the needle, but keep the needle in the sub-dermal connective tissue.
• Gently insert, while lifting the skin, the needle to its full length without using force to ensure superficial insertion (Figure 6.3.8).
• Keep the applicator parallel to the surface of the skin
• Break the seal of the applicator (Figure 6.3.9).
• Turn the obturator 90° (Figure 6.3.10).
• Fix the obturator with one hand against the arm and with the other hand slowly retract the cannula (needle) out of the arm (Figure 6.3.11).
Figure 6.2.19: Lifting the skin with the needle during insertion

Figure 6.2.20: Breaking the seal of the applicator
Figure 6.2.21: Turning the obturator 90°

Figure 6.2.22: Retracting the cannula (needle) out of the skin

**Note:** Never push against the obturator.

- Check the needle for the absence of the implant. Do not confuse the protruding end of the obturator with the implant (same colour). (Figure 23)

**Note:** This procedure is opposite to giving an injection, where the plunger is pushed and the syringe is fixed. By keeping the obturator in its place and simultaneously pulling the cannula, the implant will remain in the upper arm.

- Always verify the presence of the implant by palpation and have the woman palpate it herself.
• Apply sterile gauze with a pressure bandage to prevent bruising.

Figure 6.2.23: Checking the needle for the absence of the implant

Note: In case the implant cannot be palpated or when the presence of the implant is doubtful, other methods must be applied to confirm its presence. Suitable methods to locate the implant are, first of all, ultrasound (USS) and secondly, magnetic resonance imaging (MRI). In case these imaging methods fail, it is advised to verify the presence of the implant by measuring the etonogestrel level in a blood sample of the subject. In this case Organon will also provide the appropriate procedure.

Until the presence of Implanon® has been confirmed, a contraceptive barrier method must be used.

• Apply sterile gauze with a pressure bandage to prevent bruising.

The Trainer provides the participants with clear instructions regarding Waste Disposal and Decontamination as follows:

• Properly discard the Implanon® Inserter.
• Before removing gloves, place any used instrument into a container filled with 0.5% chlorine solution for decontamination.
• The surgical drape (if used) must be washed before reuse. Place in a dry covered container and remove to the designated washing area.
• While still wearing gloves, place all contaminated objects (gauze, cotton and other waste items) in a properly marked, leak-proof container with a tight-fitting lid or in a plastic bag.
• Immerse both gloved hand briefly in chlorine solution and then carefully remove gloves by turning inside out and place in the waste container.
• Wash hands thoroughly with soap and running water.
• Fill out the User Card and hand it over to the subject to facilitate removal of the implant later on (Fill also the client's record which is kept in the facility).
Note: The applicator is for single use only and must be adequately disposed of in accordance with local regulations governing the handling of biohazardous waste. Demonstrate the correct insertion technique with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the Implanon NXT™.

- Implanon® is a sub-dermal, long-acting hormonal contraceptive, effective for up to 3 years.
- It is a progestin-only implant preloaded in a disposable applicator.
- Implanon NXT™ is radiopaque and comparable to Implanon®.
- It has a preloaded, sterile applicator which is for single use and disposable. Inserters familiar with the applicator for Implanon® need to familiarize themselves with the one for Implanon NXT™.

Preparation for insertion of Implanon NXT™

- Insertion of IMPLANON NXT™ should be performed under aseptic conditions.
- Insertion of the implant should only be performed with the preloaded applicator.
- It is recommended that the health care provider performs the procedure in a sitting position.
- Confirm no allergies to antiseptic and anesthetic.
- Allow the woman to lie on her back with her non-dominant arm turned outwards and bent at the elbow.
- To minimize the risk of neural or vascular damage, the implant should be inserted sub-dermally at the inner side of the non-dominant (arm less commonly used) upper arm about 8-10 cm above the medial epicondyle of the humerus in order to avoid the large blood vessels and nerves that lie deeper in the subcutaneous tissue in the sulcus between the triceps and biceps muscles.

Figure 6.2.24: Correct Placement of Implanon NXT™ Sub-dermally
• Make 2 marks: one at insertion site and a second one a few centimeters above the insertion site to be used as direction guide during insertion.
• Clean the insertion site with an antiseptic.
• Anesthetize the insertion area (for example, with anesthetic spray or by injecting 2 mL of 1% lignocaine just under the skin along the planned insertion tunnel).
• Remove the sterile disposable applicator carrying the implant from its blister.

Figure 6.2.25: Removing the sterile disposable applicator carrying the implant from its blister

• Keep the needle and the implant sterile (if contamination occurs, a new package with a new sterile applicator must be used).
• Implanon NXT™ should be inserted  If the implant is inserted too deeply, neural or vascular damage may occur. Too deep or incorrect insertions have been associated with paresthesia (due to neural damage) and migration of the implant (due to intramuscular or fascial insertion), and in rare cases with intravascular insertion. Moreover, when the implant is inserted too deeply, it may not be palpable and the localization and/or removal can be difficult.
• Hold the applicator just above the needle at the textured surface area and remove the transparent protection cap from the needle which contains the implant.
• If the cap does not come off easily the applicator should not be used and must be replaced.
• You may see the white colored implant by looking into the tip of the needle.
• Do not touch the purple slider until you have fully inserted the needle subcutaneously, as it will retract the needle and release the implant from the applicator.
- Stretch the skin around the insertion site with thumb and index finger.
- Puncture the skin with the tip of the needle angled about 30°.

**Figure 6.2.26: Puncture the skin with the tip of the needle angled about 30°**

- During the entire insertion procedure you should be able to see the insertion site and the movement of the needle.
- Lower the applicator to a horizontal position.
- While lifting the skin with the tip of the needle, slide the needle to its full length.
• You may feel slight resistance but do not exert excessive force.
• If the needle is not inserted to its full length, the implant will not be inserted properly.
• While keeping the applicator in the same position and the needle inserted to its full length, unlock the purple slider by pushing it slightly down.

    Figure 6.2.28: Unlocking the purple slider by pushing it slightly down

• Move the slider fully back until it stops, leaving the implant now in its final position and locking the needle inside the body of the applicator.
• Now the implant is in its final position.
• Inserting the needle to its full length is crucial; failure to do so will result in a partly visible implant protruding from the skin.
• If partial protrusion occurs, discard the implant and reinsert a new sterile implant using a new applicator.
• Remove the applicator.

Post-Insertion Steps

• Apply a small adhesive bandage over the insertion site.
• Apply sterile gauze with a pressure bandage to minimize bruising. The woman may remove the pressure bandage after 24 hours and the small bandage after 3-5 days.
• Complete the User Card and give it to the woman to keep and complete the adhesive labels and affix to the woman's medical record.
• The applicator is for single use only and must be disposed of by the inserting physician in accordance with local regulations for biohazardous waste.

Confirmation immediately after insertion

• Always verify the presence of the implant by palpation.
• If the implant is not palpable, confirm its presence in the arm with imaging techniques as soon as possible.
• The woman must use a backup method of contraception until the presence of the implant has been confirmed.

Figure 6.2.29: Confirmation of the implant immediately after insertion
Waste Disposal and Decontamination:
The following are instructions regarding *Waste Disposal and Decontamination*:

- Properly discard the Implanon NXT™ Applicator.
- Before removing gloves, place any used instrument into a container filled with 0.5% chlorine solution for decontamination.
- The surgical drape (if used) must be washed before re-use. Place in a dry covered container and remove to the designated washing area.
- While still wearing gloves, place all contaminated objects (gauze, cotton and other waste items) in a properly marked, leak-proof container with a tight-fitting lid or in a plastic bag.
- Immerse both gloved hand briefly in chlorine solution and then carefully remove gloves by turning inside out and place in the waste container.
- Wash hands thoroughly with soap and running water.
- Fill out the User Card and hand it over to the subject to facilitate removal of the implant later on (Fill also the client's record which is kept in the facility).

**If you cannot feel the Implant or in doubt of its presence:**
- Check the applicator. The needle should be fully retracted and only the purple tip of the obturator should be visible. In any other case, the insertion must be considered to not have been complete.
- Use other methods to confirm the presence of the implant presence in the arm. Suitable methods are: two-dimensional X-ray, ultrasound scanning (USS) with a high-frequency linear array transducer (10 MHz or greater), computerized tomography (CT scan), or magnetic resonance imaging (MRI). Prior to the application of X-ray, USS, CT, or MRI for the localization of the implant, it is recommended, to consult the local supplier of Implanon NXT™ for instructions.
- In case these imaging methods fail, it is advised to verify the presence of the implant in the arm by measuring the etonogestrel level in a blood sample of the subject. In this case the local supplier will provide the appropriate procedure.

**Instructions to be given the clients after insertion**

*Client Care*

- Place a note in the client's record indicating the location of the capsules and specifying any unusual events that may have occurred during insertion. (A simple drawing showing the approximate location of the capsules in the client's arm is helpful).
- Observe the client for at least 15 to 20 mins for bleeding from the incision or adverse effects before sending her home. She should be given written post insertion care instructions (if available) as appropriate.
Client's instructions for wound care at home

- There may be bruising, swelling or tenderness at the insertion site for a few days. This is normal.
- Keep the area around the insertion site dry and clean for at least 48 hours (use cellophane protection during baths). The site could become infected if the area gets wet while bathing.
- Leave the gauze pressure and plaster in place for 48 hours and the band-aid or surgical tape in place until the incision heals (i.e. normally 3 to 5 days).
- Routine work can be done immediately. Avoid bumping the area, carrying heavy loads or applying unusual pressure to the site.
- After healing, the area can be touched and washed with normal pressure.
- If signs of infection occur, such as fever with inflammation (redness plus heat) at the site, or if there is persistent arm pain for several days, return to the clinic.

Back-up method:

There is no need for a back-up method if the implant is inserted less than 21 days postpartum. However, if it is greater than 21 days and the menses has not resumed, there is a need for a back-up method.

Schedule follow-up appointments with the clients after the procedure

First visit (3 – 5 days after insertion)
- Ask the client about her health generally.
- Inspect the wound at the insertion site.
- Ask about any complaints.

At routine 6 weeks postnatal clinic visit

Third Month after insertion
- Ask about variations in her menstrual cycle, including inter-menstrual bleeding or spotting and excessive blood loss.

Schedule of subsequent follow-ups (if all is well):
- Ask about variations in her menstrual cycle, including inter-menstrual bleeding or spotting and excessive blood loss.
- Yearly visits until the client wishes to have the device removed or the life span of the device expires at 3 years for Implanon® derivatives and at 5 years for Jadelle.
- Repeat the activities of first visit at each subsequent visit;
- Encourage a pap smear every two years
Summary

- As in the Jadelle Insertion techniques, attention must be paid to asepsis, anaesthesia, as well as the length and location of the puncture site.
- Careful sub-dermal placement ensures easy removal thereafter.
- Implanon® and Implanon NXT™ have single use pre-loaded applicators unlike Jadelle implants.

EVALUATION

- Mention the steps of the correct procedure for Implanon® insertion?
- List the post-insertion instructions given to the client?
- State the correct procedure for follow-up visits following Implanon® insertion?
- State the warning signs a client must report after Implanon® insertion?
MODULE SIX: SESSION 3

IUD REMOVAL TECHNIQUES

Time: 1 hour

Learning Objectives:

By the end of this session, participants should be able to:

- Identify the indications for removal of IUDs.
- Identify the equipment and materials for IUD removal procedures.
- Demonstrate the correct removal techniques with regards to asepsis, and removal procedure.
- List what to do when difficulties arise during removal.
- List appropriate steps for reinsertion, if needed.
- Demonstrate post-removal counseling techniques.

Session Overview:

- Indications for removal of IUDs.
- Equipment and materials for IUD removal procedures.
- Demonstration of the correct removal techniques with regards to asepsis, and removal procedure.
- What to do when difficulties arise during removal.
- Appropriate steps for reinsertion, if needed.
- Demonstration of post-removal counseling techniques.

METHODS

- Lecture
- Discussion
- Demonstration and Return Demonstration

MATERIALS

- Training Arm
- Video Films or Removal Techniques and VCR
- Removal Kit
- LCD Projector/Laptop
- Implant Capsules
- Plaster and Dressing
- Antiseptic Solution
- Sterile Gloves
SUMMARY

EVALUATION
Copper-releasing IUDs such as Cu T 380A can be removed / replaced after 12 years. Unless an IUD is being removed for a medical reason or at the client's request, a new IUD can be inserted immediately after removing the old, if the client so desires. IUD removal is usually a routine, uncomplicated and painless procedure provided the provider is gentle and careful. For routine removals, especially if the client wants a replacement, it may be easier to remove the IUD during the menses.

To avoid breaking the strings, the provider should apply gently, steady traction and remove the IUD slowly. As with IUD insertion, to minimize the risk of infection with IUD removal, the same infection prevention practices must be followed.

Reasons for removal
- Client desires pregnancy
- Menopause, no need for contraception
- Client desires another method of contraception
- Life of IUD has expired
- Accidental pregnancy
- Client is not able/willing to tolerate side effects
- Dyspareunia (painful intercourse)
- Partial expulsion of the device
- Cervical perforation
- Uterine perforation

When to remove IUDs
Remove IUDs whenever a client insists on having it removed or when there are indications for removal. The best time to remove is during menses, because the cervix is slightly dilated, soft and removal is less uncomfortable.

Equipment and materials
The instruments and equipment for removal are the same as for insertion. In addition, an alligator forceps should be available. All instruments should be high-level disinfected (or sterilized).

Procedure for removal
- Prepare equipment and materials as for insertion, but include alligator forceps and retrieval hook.
- Explain the removal procedure to the client to ensure her cooperation and relaxation.
- Ensure that the client has emptied her bladder.
- Place the client in the dorsal position with the legs flexed at the hip and knees.
- With sterile-gloved hand, part the labia and gently pass a Cusco's speculum.
- Visualize the cervix.
- Clean the cervix and fornices with antiseptic solution
• Tell the client that you are going to remove the IUD.
• Ask her to take slow, deep breaths and relax. Inform her that there may be some cramping, which is normal.
• Grasp the IUD strings near the external Os with artery forceps and apply gentle and steady traction to remove device.

**Note:** The device can usually be removed without difficulty and excessive force should not be applied.

• To avoid breaking the strings, apply steady, but gentle, traction and remove the IUD slowly.
• If the strings break off, but the IUD is still visible, grasp the device with the forceps and remove it.
• Check that no part has broken off the device.
• Show device to the client.
• Clean the cervix with an antiseptic solution.
• Apply a perineal pad.

**Post-removal instructions**

• Explain to the client that slight vaginal spotting may continue for a few days.
• If client wishes to use another method of contraception, counsel and/or initiate accordingly.

**Difficulty in the removal of IUDs**

**Trained family planning doctors should do the removal of IUDs.** If traction, as described above, does not result in the removal of the device, or strings are not visible or strings are too short, proceed as follows:

• Probe the cervical canal with narrow artery forceps and attempt removal (if this fails, device is probably embedded in the endometrium).
• Explore the uterine cavity with alligator forceps, Sharman's curette, or retriever hook.
• If this fails, dilate the cervix with small dilators and attempt removal again (cervical block may be necessary, or give appropriate analgesics).
• X-ray or scan with ultrasound to exclude partial or complete extrusion through the uterine wall. If this is found, explore the uterine cavity under general anesthesia and be prepared to remove a completely extruded IUD by laparoscopy or laparotomy.
SUMMARY

IUD removal is usually a routine, uncomplicated and painless procedure provided the provider is gentle and careful. For routine removals, especially if the client wants are placement, it may be easier to remove the IUD during the menses.

To avoid breaking the strings, the provider should apply gently, steady traction and remove the IUD slowly. As with IUD insertion, to minimize the risk of infection with IUD removal, the same infection prevention practices must be followed.

EVALUATION

- List the essential steps in standard removal technique?
- List 5 key points for successful removal?
- Enumerate indications for removal?
MODULE SIX: SESSION 4

IMPLANT REMOVAL TECHNIQUE

Time: 1 hour

LEARNING OBJECTIVES

By the end of this session, the participants should be able to:

- Identify the equipment and materials for implant removal procedures.
- Demonstrate the correct removal techniques with regards to asepsis, anaesthetic, length and location of incision, and removal procedure.
- List what to do when difficulties arise during removal.
- List appropriate steps for reinsertion.
- Demonstrate post-removal counseling techniques.
- Identify indication for removal.

SESSION OVERVIEW

- Equipment and materials for implant removal procedures.
- Demonstration of the correct removal techniques with regards to asepsis, anaesthetic, length and location of incision, and removal procedure.
- What to do when difficulties arise during removal.
- Appropriate steps for reinsertion.
- Demonstration of post-removal counseling techniques.
- Identification of indications for removal.

METHODS

- Lecture
- Discussion
- Demonstration and Return Demonstration

MATERIALS

- Training Arm
- Video Films or Removal Techniques and VCR
- Removal Kit
- LCD Projector/Laptop
- Implant Capsules
- Plaster and Dressing
- Antiseptic Solution
- Sterile Gloves
SUMMARY

EVALUATION

CONTENT

Unlike insertion, removal of implants does not have to be timed to the menses and can be done at any time. Correct insertion – with the capsules placed sub-dermally – makes the removal procedure much easier.

While all types of clinicians (physicians, nurses and midwives) can be trained to insert and remove the capsules, a clinician skilled in removal should be consulted if difficulty in removing the capsules is anticipated. Clinicians need to work gently, carefully and patiently when removing capsules. As with insertion, using the recommended practices for the prevention of infection is essential for minimizing the risk of disease transmission and infections following removal of the implants.

Removal requires more patience and skill than insertion. Moreover, with atypically placed capsules (i.e., those inserted too deep and/or in an irregular pattern), removal using any technique takes longer and is associated with more blood loss than insertion (WHO, 1990).

Pre-removal Counseling

• Before removing the capsules, talk with the client about her reason for removal and answer any questions.
• Ask the client about her present reproductive goals (e.g. does she want to continue spacing or limiting births
• Briefly describe the removal process and what she should expect both during the removal and afterwards.

General procedure for removal

Note: An easy removal depends on correct insertion. Routinely, removals take slightly longer than insertion - usually from 10 to 20 minutes If the capsules were placed properly they will be easier to remove; if they were placed too deep, removal could be difficult.

• Locate the capsules first with ungloved fingers. Most clinicians choose to mark the position of each capsule with a ballpoint or marking pen.
• Swab the clients arm with an antiseptic before the local anaesthetic is injected. The anaesthetic should be injected under the ends of the capsules nearest the incision site; anaesthetic applied over the capsules makes them difficult to feel (palpate).

Note: Generally, only one small incision will be needed through which the two capsules (Jadelle) will be removed. The incision should be no longer than 4 mm. Where the incision is placed will depend on the position of the implants (i.e. correctly or atypically placed). The first capsule to be removed should be one that is easiest to reach (i.e. closest to the surface or nearest the incision).
STEP-BY-STEP INSTRUCTIONS FOR REMOVAL

- Before starting the procedure, check to be certain the client is not allergic to local anaesthetics.
- Ask the client to wash her entire arm with soap and water, and rinse, being sure to remove all traces of soap. (Residual soap decreases the effectiveness of some antiseptics). This step is particularly important when the client's hygiene is poor.
- Cover the procedure table (and arm support or side table, if used) with a clean, dry cloth.
- Check that all instruments and other items are in excellent condition (e.g. the scalpel must be sharp and the forceps should have a very tight grasp) and have been sterilized (or high-level disinfected).

The following items are needed for each removal (Figure 6.5.1):

- Examination table/couch for the woman to lie on.
- Arm support or side table.
- Soap for washing the arm.
- Sterile (or clean), dry surgical drape.
- Three bowls (one for the antiseptic solution, one for cotton balls soaked in boiled or sterile water to remove the talc from gloves and one containing 0.5% chlorine solution for decontaminating removed capsules).
- Pairs of sterile (or high-level disinfected) surgical gloves.
- Antiseptic solution.
- Local anaesthetic - 1:5 concentration without epinephrine (adrenaline).
- Syringe (2 or 5 ml) and 2.5 to 4cm (1 – 1 ½ inches) long needle (22 gauge).
- Scalpel with #11 blade.
- Curved and straight forceps (mosquito and Crile).
- Implanon® / Jadelle holding forceps.
- Ordinary and straight forceps (mosquito and Crile).
- Ordinary band-aid or sterile gauze with surgical tape or plaster.
- Sterile gauze and compresses.
- Epinephrine (Adrenaline) readily available for emergency use in anaphylactic shock.
• Confirm the position of each capsule by making a mark at both ends of the capsules (tip) using a ballpoint or marking pen.
• Prepare an instrument tray and open the sterile instrument pack without touching the instruments and other items.
• Wash hands thoroughly with soap and water and dry them with a clean cloth.
• Put sterile or gloves on both hands. (A separate pair of gloves must be worn for each client to avoid cross-contamination).

**Note:** Do not use powder with gloves. The tiny granules (talc) may fall into the removal site and cause scarring (fibrous reaction). If gloves are powdered, wipe off the fingers with sterile gauze soaked with sterile or boiled water.

• Ask the client to lie on the table so that the arm with the capsules rests on the table or arm support. Her arm should be well supported and should be comfortable when extended straight or kept slightly bent, as the clinician prefers.
• Locate the two capsules Jadelle, or one capsule of Implanon® by palpation.
• To gauge where to make the incision, palpate the end of the capsule(s) with bare (ungloved) fingers (If it is difficult to find the capsules, refer to the client's file where the original capsule placement should have been recorded and a diagram may be available).

**TIP:** To make locating the capsules easier, moisten fingertips with a small amount of soapy water or antiseptic solution such as Betadine or Povidone. Doing this decreases friction between the clinician's fingertips and the client's skin and allows the capsules to be more easily felt.
• Arrange supplies and instruments so that they are easily accessible.
• Prepare the removal site with an antiseptic solution. Use a sterile or high-level disinfected sponge forceps to hold a cotton or gauze swab soaked with antiseptic solution. (If preparation is done with a gloved hand, care must be taken not to contaminate the glove by touching any unprepared skin). Begin wiping at the incision site and move outward in a circular motion for 8 to 13 cm (3 to 5 inches) and allow to air dry before proceeding. Wipe off excess antiseptic only if necessary to see pen marks.
• If a sterile surgical drape with a hole in it is available, it should be used to cover the arm. The hole should be large enough to expose the area where the capsules are located.
• Again, locate the two capsule(s) by palpating.
• After determining the absence of known allergies to the anaesthetic agent or related drugs, fill a syringe with about 3 ml of a local anaesthetic (1% Lignocaine without adrenaline).

Insert the needle just under the skin where the incision will be made. Next pull back on the plunger to be sure the needle is not in a blood vessel (aspirate). Inject a small amount of anaesthetic to raise a small wheal (raised area).

**Figure 6.4.4: Injecting local anaesthetic under the narrow V-end of the implants**

• Gently advance the needle under the first capsule, about one third of its length (1 cm). Slowly withdraw the needle while injecting anaesthetic (about 0.5 ml) to raise the end of the capsule.

*Remember:* Correctly injecting the local anesthetic under the tips of the capsules is critical to an easy and rapid removal. Without removing the needle, slide the tip over and insert it under the next capsule (if Jadelle or Implanon® implants).
Note: Never put anaesthetic over the capsules because the tissue swelling makes it difficult to palpate the capsules. If necessary, additional small amounts of anaesthetic can be added as the removal process continues.

- Before starting, gently touch the incision site with the hypodermic needle or scalpel to be sure the anaesthetic is working.

Note: To prevent local anaesthetic toxicity the total dose should not exceed 10ml (10 grams/litre) of a 1% local anaesthetic without adrenaline.

Figure 6.4.5: Making an incision

- Choose a point for the incision that is equidistant from the ends of all the capsules and which is close to and about 5 mm below the distal (toward the elbow) ends of the capsules.
- If appropriate, the removal incision may be made at the point of the previous insertion incision. Before selecting this site, however, make sure that neither of the capsule ends are under the old incision. (This avoids the possibility of cutting though the capsules).
- At the site chosen, make a small transverse incision of about 4 mm or less with a scalpel. Do not make a large incision.

Note: If another set of capsules is to be inserted, usually the same incision can be used for both removal and insertion of a new set (see Second Insertion in this module).

- Begin by selecting the capsule closest to the surface or nearest the incision.
- Push the tip of the capsule gently toward the incision with the gloved fingers of one hand until it can be seen at the incision. When the tip is visible in the incision, insert the curved forceps (mosquito or Crile) with the jaws curving up and grasp the end of the capsule.
Note: If the capsules cannot be easily moved into the incision, this may be due to scarring (fibrous tissue formation) around the tips of the capsules.

- Insert the curved forceps through the incision with the jaws pointed up toward the skin and advance until they are below the ends (tips) of the capsules nearest the elbow.
- Then open and close the forceps jaws (blunt dissection) to break up the scar tissue surrounding the tip of the capsule. Repeat until the tips of the two capsules are free (easily moveable).
- Next, push the tip of the first capsule as close to the incision as possible. While pressing on (stabilizing) the capsule with the first (forefinger) and middle fingers of one hand.
- Re-insert the curved forceps under the end of the capsule (jaws pointing up toward the skin).
- Grasp the capsule near the tip (5 to 10mm) and gently pull it into the incision.
• Clean off and open the fibrous tissue sheath surrounding the capsule by rubbing vigorously with sterile gauze to expose the tip of the capsule.

• Alternatively, if rubbing the fibrous tissue sheath will not open it, the scalpel can be used. To avoid cutting the capsule, use the backside (non-sharp edge) of the scalpel.
• Grasp the freed tip of the capsule with a second pair of forceps. Release the first forceps and slowly and gently remove the capsule with the second forceps.
Figure 6.4.9: Grasping the end of implant with the Crile forceps

- Since tissue usually does not adhere to silicone rubber, the capsule should slide out easily. If for some reason the capsule does not come out easily, remove any remaining fibrous tissue from the capsule by gently rubbing with sterile gauze or scarping with the scalpel blade.

**Note:** As capsules are removed, place them in a small bowl containing 0.5% chlorine solution for decontamination prior to disposal. In addition, by looking at the capsules in the bowl, the clinician can tell whether or not the capsules are broken – undamaged capsules will float; broken capsules will sink gradually to the bottom.
- If additional anaesthetic is required, inject it only under the capsule so as not to obscure them.
Repeat using the same technique to remove the remaining capsule.
It is important to show the client all capsules to reassure her.

Figure 6.4.11: Be sure that both implants (2 rods for Jadelle and 1 rod for Implanon®) are removed
Removing Hard-to-Retrieve Capsules

- Occasionally, one or more of the capsules may be difficult to remove. For example, if even after bluntly breaking up the scar tissue, the tip of a capsule cannot be pushed close to the incision site or the capsule has been inserted too deeply (i.e. into the subcutaneous or fatty tissue).
- Feel both tips of the capsule with the forefinger and middle finger. Keeping the middle finger on the tip of the capsule nearest the client’s shoulder and the forefinger on the tip nearest elbow, push the capsule as close to the incision as possible.
- Insert the forceps (curved mosquito or Crile) into the incision until the jaws are well beneath the capsule. At the same time keep pressure on the capsule with your fingers to stabilize it.
- Firmly grasp the capsule from below with the jaws of the curved forceps.
- Although 1 to 2 cm of the forceps is now inside the incision, do not try to pull the capsule out. Instead, while continuing to push the capsule toward the incision, flip the handle of the forceps 180° toward the client’s shoulder and grasp the handle with the opposite hand.

Note: If the capsule does not become visible after flipping, twist the forceps 180° around its main axis. With gentle pulling, the tip of the capsule should then become visible in the incision on the opposite side of the forceps.

- Clean off and open the fibrous tissue sheath surrounding the capsule by rubbing with sterile gauze to expose the tip of the capsule. Alternatively, if rubbing with gauze does not open the fibrous tissue sheath, the scalpel can be used.
- After opening the fibrous sheath, use the second forceps to grasp the part of the capsule that becomes visible. Release the first forceps and gently remove the capsule.

Note: Any remaining “difficult-to-remove” capsule can be removed using the same technique. If necessary, inject additional small amounts of local anaesthetic under any remaining capsules.

Tips for Difficult Implant Removal

When Capsules are not palpable

There are two ways to locate capsules that have been inserted too deep to feel with the fingers: x-ray and ultrasound. By using a radio-opaque object to mark the original incision site, the capsules, which are also radio-opaque, usually can be detected by x-ray (set at 50-55 kilovolts and 4-5 milliamperes, exposure time 0.03 seconds). Their depth usually cannot be determined by a single x-ray. Thus, further examination may be required to establish their exact location. With ultrasound, the image caused by the capsules also can be detected (i.e. a shadow and echo-free area will be present under each capsule). Special adjustments (positioning of the ultrasound probe) may be necessary to focus the ultrasound image.
Capsules that are broken

Removal of the capsules is more difficult if they are broken during attempts to get them out. Once the capsule is damaged, it may break again with each attempt to grasp it with the forceps. Rarely, removal of a broken capsule may require an additional incision at the proximal end of the capsule (end nearest the shoulder) so that the remaining piece can be removed more easily.

PROCEDURE FOR SECOND INSERTIONS

- If the client wants to continue using implants, a new set of capsules can be inserted at the time the current set is removed. When levonorgestrel levels following first insertion were compared with those following insertion of a second set of implants, no significant difference was observed after placement in the same site or in the opposite arm.
- The capsules may be placed through the same incision in the same general direction as the previous set.
- Alternatively, the capsules can be inserted in the opposite direction. Be sure the tips of the capsules do not lie so close to the elbow fold as to interfere with movement.
- A new incision should be necessary only if there is too much soft tissue trauma (bruising) in the area of the original insertion or if there is not enough room between the incision and the elbow fold.
- In the unlikely event that the removal site is unsuitable, or at the client's request, the new set can be inserted in the other arm.

PROCEDURE TO FOLLOW AFTER REMOVAL OF THE CAPSULES

Covering the Incision:

- If the client does not want another set of implants, clean the area around the incision site with a small amount of antiseptic solution applied to a cotton or gauze swab.
- Use the forceps to hold the edges of the incision together briefly (10 to 15 seconds). This will help reduce bleeding from the incision. Then apply gauze soaked in slight iodine solution to the incision area.
- With the edges of the incision together, close with a band-aid, or surgical tape with sterile cotton. Sutures are not necessary and may increase scarring. Check for any bleeding.

Waste Disposal and Decontamination:

- Before removing gloves, gently place instruments into a container filled with a 0.5% chlorine solution for decontamination. Soak all items for 10 mins, then rinse immediately with clean water to avoid discoloration or corrosion of metal items.
- While still wearing gloves, place all contaminated objects (capsules, gauze, cotton and other waste items) in a properly marked, leak-proof container with a tight-fitting lid or in a plastic bag.
- Immerse both gloved hands briefly in chlorine solution and then carefully removed gloves by turning inside out and place in the waste container.
- Wash hands thoroughly with soap and water.
• All waste materials should be disposed of by burning or burying.

Client Care:
• Place a note in the client's record indicating the date of removal and specifying any unusual events that may have occurred during removal.
• Observe the client for at least 15 to 20 mins for bleeding from the incision or adverse effects before sending her home.

Client Instructions for Wound Care at Home:
• There may be bruising swelling or tenderness at the insertion site for a few days. Clients should be reassured that this is normal.
• Keep the area around the removal site dry and clean for at least 48 hours. (The incision could become infected if the area gets wet while bathing).
• If used, leave the gauze pressure and plaster in place for 48 hours and the band-aid or surgical tape in place until the incision heals (i.e. normally 3 to 5 days).
• Routine work can be done immediately. Avoid bumping the area, carrying heavy loads or applying unusual pressure to the site.
• After healing, the area can be touched and washed with normal pressure.
• If signs of infection occur, such as fever, inflammation (redness plus heat) at the site or persistent arm pain for several days, return to the clinic.
• The client should be told when to come back for a follow-up visit, if needed. Discuss what to do if she experiences any problems. Answer any questions.
• The fibrous sheaths in the arm (tracks where the capsules were located) may be felt for some time. This sensation will disappear within a few months.

KEY POINTS FOR SUCCESSFUL REMOVAL
• An easy removal depends on correct insertion. If the capsules were placed properly, they will be easier to remove. If they were placed too deep, problems can occur.
• Routine removals should take only slightly longer than insertions - usually from 10 to 20 minutes.
• Palpate the area to identify the location of each capsule and mark the position of each capsule with a pen.
• Use recommended infection prevention practices to avoid infections.
• Inject small amounts (usually not more than 3 ml total) of the local anaesthetic under the capsule ends nearest the original incision site. If the anaesthetic is applied over the capsules, it will obscure them and make removal more difficult.
• If the capsules are positioned correctly, only one small incision (up to 4 mm long) should be necessary for removal of all the capsules.
• Remove first the capsule that is nearest the point of the incision or closest to the surface of the skin.
• Add incremental amounts of anaesthetic only under the capsule tips.
• Control bleeding by applying pressure.
• Do not take extraordinary measures to remove the last one or two capsules if they are difficult to reach. If removal takes more than 30 mins, ask the client to return when the incision site is fully healed (in about 4 to 6 weeks) and try again, or refer to a more experienced clinician.
• Finally, and most importantly, the clinician should work gently, carefully and patiently to avoid injuring the client's arm.

REASONS FOR REMOVING IMPLANTS
The indication for removal may be personal or medical. Providers may perceive implants as 3-5 years method; however clients need constant reassuring that the implant may be removed at any time and for any reason. One of the advantages of Implant is that when the implanted capsules are removed, the woman's fertility returns to normal almost immediately. If the woman wishes to have the implant removed, it is important that access to removal is readily available. Experience shows that in some instances, where the providers have been trained to do insertion only, they may be hesitant about doing removal thus preventing easy access to removal for the client.

Indications for Removal
• Medical Reasons
  • Excessive bleeding
  • Pregnancy
  • Jaundice
  • Seizure
  • Migraine
  • Severe headache
  • Blurred vision
  • Weight problems

Personal Reasons
• Planned pregnancy
• Client dissatisfaction (her reason to stop)
• At the end of 3-5 years depending on the type being used.
SUMMARY
Correct removal techniques involve paying proper attention to asepsis, adequate anaesthesia and appropriate location of the incision. The provider needs to work gently, carefully and patiently. Removal procedures take longer time than insertions. The removal procedure can be interrupted if difficulties are encountered and the client asked to return after 4-6 weeks for completion of the removal of remaining capsule(s). Clients should always be given instructions for wound care at home on discharge.

EVALUATION
• List the essential steps in standard removal technique?
• List 5 key points for successful removal?
• Enumerate indications for removal?
MODULE SEVEN
INFECTION PREVENTION
The module covers the information necessary for participants to perform, or supervise, the infection prevention (IP) practices used in providing reproductive health/family planning services. These are practices that help reduce the risk of transmitting infection in health care facilities.

Session 1: Introduction, and Definition of Terms
Session 2: Aseptic Techniques
Session 3: Steps for Processing Instruments and storage
Session 4: Use and Disposal of Needles and other Sharps
Session 5: Housekeeping and Waste Disposal
## Module Seven

### Infection Prevention

#### Module Plan

<table>
<thead>
<tr>
<th>Session</th>
<th>Duration</th>
<th>Objectives</th>
<th>Method</th>
<th>Materials</th>
</tr>
</thead>
</table>
| Session 1: Introduction and Definition of Terms | 35 mins | • Discuss importance of Infection Prevention  
• Explain disease transmission cycle  
• Identify roles of family planning service provider in Infection Prevention  
• Identify potential consequences of Infection Practices  
• Define infection prevention terms  
• Explain standard precautions | • Lecture  
• Discussion  
• Handout  
• Group exercise | • Flip chart stand/paper  
• Coloured  
• Markers  
• LCD Projector/Laptop |
| Session 2: Aseptic techniques | 30 mins | • Define aseptic techniques  
• Describe ways to properly prepare a client for PPIUD/PP implant procedures  
• Determine proper use of gloves  
• Demonstrate appropriate attire for Reproductive Health/Family Planning service provision  
• Explain the importance of establishing and maintaining sterile field | • Lecture  
• Discussion  
• Demonstration and return demonstration | • Flip chart stand/paper  
• Coloured  
• Markers  
• LCD Projector/Laptop  
• TV and Video tapes  
• Samples of locally available antiseptics |
| Session 3: Steps of Processing Instruments and Storage | 30 mins | - Explain steps of processing instruments and other items  
- Demonstrate appropriate order for conducting the steps.  
- Explain the importance of carrying out the steps in the correct order  
- Identify how to appropriately organize an area of the facility for processing instruments and other items | - Lecture  
- Discussion  
- Handout  
- Group exercise | - Flip chart stand/paper  
- Coloured  
- Markers  
- LCD Projector/Laptop |
| Session 4: Use and Disposal of Needles and other Sharps | 30 mins | - List ways that health workers can get injured by sharps  
- Describe actions that surgical team can take to prevent or minimize injuries by needles/sharps  
- Describe the proper procedures for usage and disposal of needles and other sharps  
- Describe the proper procedures for giving injections and use of multi-dose vials | - Lecture  
- Discussion  
- Handout  
- Group exercise | - Flip chart stand/paper  
- Coloured  
- Markers  
- LCD Projector/Laptop |
| Session 5: House – Keeping and | 30 mins | - Explain housekeeping in a health facility | - Lecture  
- Discussion | - Flip chart stand/paper  
- Coloured |
| Waste Disposal | • List 5 general housekeeping guidelines  
• Describe how to prepare disinfectant cleaning solution  
• Describe appropriate waste disposal steps  
• State the importance of correct disposal of waste | • Demonstration and return Demonstration  
• Handout  
• Case studies | • Markers  
• LCD Projector/Laptop |
MODULE SEVEN: SESSION 1
INTRODUCTION AND DEFINITION OF TERMS
Time: 35 mins

LEARNING OBJECTIVES

By the end of this session, participants should be able to:

• Discuss importance of infection prevention (IP).
• Explain disease transmission cycle.
• Identify roles of family planning provider in infection prevention.
• Identify potential consequences of poor infection prevention practices.
• Define infection prevention terms.
• Explain standard precautions.

SESSION OVERVIEW

• Importance of infection prevention.
• The disease transmission cycle.
• Roles of family planning service provider in Infection Prevention.
• Potential consequences of poor Infection Prevention practices during clinical services.
• Definition of infection prevention terms.
• Standard precautions.

METHODS

• Discussion
• Demonstration and return demonstration
• Hand out
• Group exercise
• Case studies.

MATERIALS

• Flip chart stand/paper
• Coloured markers
• Masking tape
• LCD Projector/ Laptop
• TV and Video tapes
SUMMARY

EVALUATION
Introduction

Importance of Infection Prevention

Proper infection prevention practices must be followed in order to minimize the risk of infection and serious diseases to the client, the service provider, and all facility staff members.

People with infections, both clients and staff member, may not have any sign or symptoms of the infections they carry. This is particularly notable for HIV and hepatitis viruses. This is also the case for other infections as well. Therefore, it is important for all staff to practice proper infection prevention with all clients at all times.

As a service provider, you are responsible for client and staff safety. This includes ensuring that appropriate infection prevention practices are followed at your facilities. In almost all settings, there is room for improving infection prevention practices, and service providers play an important role in this ongoing improvement process.

The six components of the disease-transmission cycle:

1. Infectious agent
An infectious agent is the microorganism that can cause infection or disease. The infectious agent includes bacteria, viruses, fungi and parasites.

2. Reservoir
The place where the infectious agent survives, grows, and/or multiplies. People, animals, plants, soil, air, water, other solutions, instruments and other items used in clinical procedures can serve as reservoirs for potentially infectious microorganisms.

3. Portal of exit from reservoir
This refers to the route by which the infectious agent leaves the reservoir. The infectious agent can leave the reservoir through the bloodstream, broken skin (e.g. puncture, cut, surgical site, or rash), mucous membranes (e.g. eyes, nose, mouth), the respiratory tract (e.g. lungs), the genitourinary tract, the gastrointestinal tract or the placenta by means of blood, excretions, secretions or droplets that come from these places.

4. Mode of transmission
This is the way in which the infectious agent moves from the reservoir to a susceptible host.
Transmission can occur by four modes:

- **Contact**: The infectious agent can be transmitted directly from the reservoir to a susceptible host through touch (e.g. staphylococcus), sexual intercourse (e.g. gonorrhea, HIV), on droplets (e.g. influenza, tuberculosis).

- **Vehicle**: The infectious agent can be transmitted indirectly from the reservoir to a susceptible host by material that maintains the life of the infectious agent. Such vehicles include food (e.g. salmonella), blood (e.g. hepatitis B, HIV), water (e.g. cholera, shigella) or instruments and other items (e.g. hepatitis B, HIV, Pseudomonas).

- **Airborne**: The infectious agent can be carried by air currents (e.g. measles, tuberculosis).

- **Vector**: The infectious agent can be transmitted to susceptible host through insects and other invertebrate animals (e.g. mosquitoes can transmit malaria and yellow fever; fleas can transmit plague).

### 5. Portal of entry

This is the route by which the infectious agent moves into the susceptible host. The infectious agent can enter the susceptible host through the bloodstream, broken skin (e.g., puncture, cut, surgical site, rash), mucous membrane (e.g. eyes, nose, mouth), the respiratory tracts (e.g., lungs) the genitourinary tract (e.g. vaginal, penis), the gastro-intestinal tract (e.g. mouth, anus), or the placenta.

### 6. Susceptible host

A susceptible host is a person who can become infected by the infectious agent. For the purpose of this training, susceptible hosts include clients, service providers, ancillary staff and members of the community.

**Note**: The "mode of transmission" is the easiest point at which to break the disease transmission cycle. In a healthcare facility, this can be accomplished by following appropriate infection prevention practices, such as hand washing, practicing aseptic technique, correctly processing of instruments and other items for reuse, and correct disposal of medical waste.
Potential Consequences of Poor Infection Prevention Practices during Service provision

There are several serious consequences of using ineffective infection prevention practices during service provision.

- Infection, such as HIV, hepatitis and others infections commonly found in clinic settings (e.g. staphylococcus and streptococcus) may be transmitted to clients, providers or clinic staff.
- Many infections are caused by the provider (iatrogenic) and are the consequence of inappropriate infection prevention practices. These infections can occur in the reproductive tract as endometritis or PID, and can be life-threatening.
- A client who acquires a postpartum infection as a result of using family planning methods may never want to use the method again.
Supply Requirements for Infection Prevention

Supplies needed for optimum infection prevention practices include:

- Water
- Hand washing soap
- Antiseptics
- Supplies and equipment for sterilization or high-level disinfections (HLD) of instruments
- Sterile gloves
- Utility gloves
- Bleach (Hypochlorite solution)
- Bucket (plastic preferred)
- Container for measuring bleach
- Detergent for instruments and facilities
- Brush for cleaning instruments.

The family planning service provider's role in Infection Prevention

Service providers play an important role in improving the infection prevention practices in the facilities where they work. The service provider's role in effective infection prevention efforts begins with a basic understanding of infection transmission and proper infection prevention practices. Along with good Infection Prevention practices, the provider has a responsibility to supervise IP practices of other staff and to facilitate improved IP practices in the facilities. The provider needs to:

- Establish procedures to address situations in which clients and staff are exposed to risk of infection.
- Provide staff with orientations and training before new infection prevention procedures are begun.
- Provide adequate equipment, supplies, and facilities for implementing new or improved infection prevention practices.
- Conduct periodic reviews to make sure the implementation of infection prevention practices is going well, and to bring to light any staff concerns.

In addition the service provider should ensure that staff receives training in infection prevention. All staff (including nurses, physicians, cleaners and housekeepers) will need to be oriented to the importance of infection prevention. Topics such as the following should be addressed:
• The process of disease transmission and potential routes of infection in the hospital or clinic environment
• The key role each staff member plays in infection prevention
• Practices for minimizing disease transmission (including hand washing; use of gloves, gowns, and other protective barriers; decontamination of gloves and instruments; proper and prompt housekeeping and appropriate waste disposal as per protocols).

Definition of Infection Prevention Terms

Microorganisms are the causative agents of infections. They include bacteria, viruses, fungi and parasites. For Infection prevention purposes bacteria can be further divided into three categories: vegetative (staphylococcus), mycobacteria (tuberculosis) and endospores (tetanus) which are the most difficult to kill.

The terms asepsis, antisepsis, decontamination, cleaning, disinfection and sterilization may confusing. For the purpose of this manual, the following definitions will be used;

• **Asepsis** and aseptic technique are general terms used to describe the combination of efforts made to prevent entry of microorganisms into any area of the body where they are likely to cause infection. The goal of asepsis is to reduce microorganisms on both animate surfaces (skin and tissue) and inanimate objects (surgical instruments and other items).

• **Antisepsis** is the prevention of infection by killing or inhibiting the growth of microorganisms on skin and other body tissues using a chemical agent (antiseptic) e.g. hibitane, Savlon and Purit.

• **Decontamination** is the process that makes objects safer to be handled by staff before cleaning (i.e. reduces, but does not eliminate the number of microorganisms on instruments and other items)". Objects to be decontaminated include large surfaces (e.g. pelvic examination or operating tables) and surgical instruments, gloves and other items contaminated with blood or body fluids.

• **Cleaning** is the process that physically removes all visible blood, body fluids or any other foreign material such as dust or dirt from skin or inanimate objects.

• **Disinfection** is the process that eliminates most, but not all, disease-causing microorganisms from inanimate objects.

• **High-level disinfection (HLD)** by boiling, steaming or the use of chemicals eliminates microorganisms except some bacterial endospores from inanimate objects.

• **Sterilization** is the process that eliminates all microorganisms (bacteria, viruses, fungi and parasites) including bacteria endospores from inanimate objects.
Standard Precautions

Definition

**Standard precautions** are a set of clinical practice recommendations designed to help minimize the risk of exposure to infectious materials, such as blood and other body fluids, by both client and staff. They help break the disease-transmission cycle at the mode of transmission step. It was formally known as universal precautions.

Figure 7.1.2: Standard precautions
Figure 7.1.3: Components of standard precautions
SUMMARY
The session described the importance of infection prevention in the provision of Reproductive Health/ Family Planning services. The service provider’s role is to understand, introduce and supervise infection prevention in health facilities, so that the risks posed to clients by poor practices will be eliminated.

EVALUATION
- Discuss the importance of Infection Prevention?
- Define Asepsis, Antisepsis, Decontamination, High Level Disinfectant and Sterilization?
- Identify the family planning service provider’ roles in Infection Prevention?
- List activities involved in Standard Precautions?
MODULE SEVEN: SESSION 2

ASEPTIC TECHNIQUE

TIME: 40 mins

LEARNING OBJECTIVES

By the end of this session, participants should be able to:

• Define aseptic technique.
• Explain the importance of hand washing in Infection Prevention.
• Determine proper use of gloves.
• Demonstrate appropriate attire for Reproductive Health/Family Planning service provision.
• Explain the importance of establishing and maintaining a sterile field.
• Describe ways to properly prepare a client for PPIUD and PP Implant procedures.

SESSION OVERVIEW

• Definition of aseptic techniques.
• Importance of hand washing in Infection Prevention.
• Proper use of gloves.
• Appropriate attire for procedure.
• Importance of establishing and maintaining a sterile field.
• Ways to properly prepare a client for PPIUD and PP Implant procedures.

METHODS

• Discussion
• Demonstration and return demonstration
• Case studies

MATERIALS

• Flip chart stand/paper
• Coloured markers
• Masking tape
• TV and Video tapes
• LCD Projector/Laptop
• Samples of locally available antiseptics and disinfectants
Aseptic Technique

Definition

Aseptic technique is defined as practices that help reduce the risk of post procedure infections in clients by reducing the likelihood that, during clinical procedures, microorganisms will enter areas of the body where they can cause disease.

Placing a physical, mechanical or chemical "barrier" between microorganisms and an individual, whether a client or health worker, is an effective means of preventing the spread of disease (i.e., the barrier serves to break the disease transmission cycle).

The following aseptic techniques refer to practices that create protective barriers for infection prevention:

- Hand washing;
- Wearing gloves (both hands) either for surgery or when handling contaminated waste materials or soiled instruments;
- Wearing appropriate attire (e.g., protective goggles, face mask or apron) when contact with blood or body fluids is possible;
- Using antiseptic solutions to prepare the skin prior to clinical procedure;
- Using safe work practices such as not recapping or bending needles, safely handling surgical instruments, and properly disposing off waste materials;
- Maintaining a safer environment in the procedure area.

Importance of Hand washing in Infection Prevention:

Hand washing

Hand washing is one of the most effective ways to reduce the risk of infection.

Methods of hand washing:

- Hand washing with plain soap and under running water (i.e. routine hand washing).
- Hand washing with an antiseptic and running water.
- Alcohol hand scrub.

Appropriate Time for Hand washing

Hands should be washed:

- Before examining each client.
- After examining each client.
• After touching any instrument or object that might be contaminated with blood or other Body fluids, or after touching mucous membranes (e.g., eyes, nose, mouth).
• Before putting on gloves for clinical procedures.
• After removing gloves (hands can become contaminated if gloves contain invisible holes or tears).

To clean hands when running water is not available, use either:
• A bucket with a tap that can be turned off to lather hands and turned on again for rinsing.
• A bucket and pitcher, with one person pouring the water over the other’s hands and allowing it to drain into the bucket.
• An alcohol hand rub, which does not require water.

Importance of Hand Washing
• To remove normal microorganism from outer layer of the skin.
• To remove transient microorganism that service providers pick up during service provision.
• To reduce the risk of infection transmission from service provider to client and vice versa.

Steps for Hand Washing with plain soap and running water (routine hand washing):

1. Wet hands with running water.
2. Rub hands together with soap and lather well. Make sure to rub all parts.
3. Vigorously weave fingers and thumbs together and slide them back and forth for 10-15 seconds or longer if hands are visibly soiled. Remember to wash around nails. Proceed as follows (Fig. 7.2.1);
   • Palm to palm
   • Between fingers
   • Back of hands
   • Base of thumbs
   • Back of fingers
   • Finger nails
   • Wrists
4. Rinse hands under a stream of clear running water until all soap lather is gone.
5. Dry hands with a clean towel or allow hands to air dry.
**Surgical Hand Scrub**

1. Remove all jewelries
2. Wet hands and forearms thoroughly
3. Clean finger nails with a brush
4. Hold your hands up above the level of your elbows
5. Apply antiseptic
6. Using a circular motion, begin at the fingertips of one hand, lather and wash between fingers, continuing from fingertips first, holding your hands above the level of your elbow
7. Using sterile towel, wipe your arms dry from finger tips to elbow
8. Use one side of the towel to dry the first hand and the other side to dry the second hand
9. Keep your hands above the level of your elbows and do not touch anything

Figure 7.2.2 : Steps of surgical hand scrub
Note:
Recent studies have shown that there is no added advantage in the reduction of microorganisms on the hands when using a brush compared to scrubbing with antiseptic alone. Surgical hand scrub may be performed using a soft brush, a sponge or antiseptic alone. Avoid using a hard brush, which is not necessary and may irritate the skin.

Steps for Alcohol Hand Rub:

- Apply 3-5 ml of alcohol or an alcohol hand rub solution.
- Rub hands together until they are dry.

Because using alcohol alone tends to dry the skin, it is better to use an alcohol hand rub solution.

How to prepare an alcohol hand rub solution:

- Add 2ml of glycine, propylene glycol, or sorbitol and 100ml of 60-90% of alcohol.

Note: An alcohol hand rub does not remove soil or organic material such as blood. Therefore, an alcohol hand rub should not be used when hands are visibly soiled.
USE OF GLOVES

Hand Gloving:

To prevent the spread of infections, sterile or high-level disinfected surgical gloves should be worn during all procedures in which there will be contact with the blood stream or tissues under the skin (e.g. surgical procedures, insertion of implants, pelvic examinations).

Proper Use of Gloves

When to wear gloves:

- When performing a procedure, such as inserting or removing IUD in the clinic.
- When disposing contaminated waste items (e.g. cotton wool, gauze or dressings).
- A separate pair of gloves must be used for each client to avoid cross-contamination.
- Remove used gloves before touching anything.
- Processing gloves for reuse is not recommended, since gloves are difficult to properly process.
- Studies have shown that invisible holes or tears are likely to occur when gloves are processed.

<table>
<thead>
<tr>
<th>Glove requirement</th>
<th>Preferred gloves (surgical, examination, Utility)</th>
<th>Acceptable gloves (if preferred glove is not available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drawing blood</td>
<td>Examination</td>
<td>Surgical</td>
</tr>
<tr>
<td>Performing pelvic exam</td>
<td>Examination</td>
<td>Surgical</td>
</tr>
<tr>
<td>Handling medical or hazardous chemical waste</td>
<td>Utility</td>
<td>Examination/surgical</td>
</tr>
<tr>
<td>Performing a vasectomy</td>
<td>Surgical</td>
<td>No alternative</td>
</tr>
<tr>
<td>Handling or cleaning used instruments and other items</td>
<td>Utility</td>
<td>Examination/surgical</td>
</tr>
<tr>
<td>Removing and inserting implants</td>
<td>Surgical</td>
<td>No alternative</td>
</tr>
<tr>
<td>Procedure</td>
<td>Type</td>
<td>Alternative</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Inserting/removing IUD</td>
<td>Surgical</td>
<td>No alternative</td>
</tr>
<tr>
<td>Performing a mini-laparotomy for tubal ligation</td>
<td>Surgical</td>
<td>No alternative</td>
</tr>
<tr>
<td>Cleaning spilled blood or other body fluids</td>
<td>Utility</td>
<td>Exam/Surgical</td>
</tr>
<tr>
<td>Performing manual vacuum aspiration</td>
<td>Surgical</td>
<td>No alternative</td>
</tr>
</tbody>
</table>

**Steps for wearing sterile gloves:**

Prepare a large, clean, dry area for opening the package of gloves (if the gloves have been processed and are not wrapped in a package, lay them on a sterile or high-level disinfected surface). Either (1) open the outer glove package and then perform a surgical hand scrub, or (2) perform a surgical hand scrub and then ask someone to open the package for you. Dry your hands completely.

**Figure 7.2.3 Steps for wearing sterile gloves**

Open the inner glove wrapper, exposing the cuffed gloves with the palms up.

Pick up the glove by the cuff, touching only the inside portion of the cuff (the side that will be touching your skin when the glove is on).
While holding the cuff, slip your other hand into the glove. (Pointing the fingers of the glove toward the floor will keep the fingers open). Be careful not to touch anything, and hold the gloves above waist level. (Note: if the first glove is not fitted correctly, wait to make any adjustment until the second glove is on. Then use the sterile fingers of one glove to adjust the sterile portion of the other glove)

Pick up the second glove by sliding the fingers of the gloved hand under the cuff of the second glove. Be careful not to contaminate the gloved hand with the ungloved hand as the second glove is being put on

Put the second glove on the ungloved hand by maintaining a steady pull through the cuff. Adjust the position of the gloved fingers until the gloves fit comfortably.

1. Pick up one glove with thumb and forefinger.

2. Pull glove on hand.

3. Slip partially gloved hand under cuff of second glove.

4. Pull second glove over other hand and pull glove up to gloved wrist.

5. Slip fingers of completely gloved hand under cuff of first hand, pull glove to gloved wrist.

Steps for removing surgical gloves

Rinse gloved hands in a basin of decontaminated solution to remove blood or other body fluids

Grasp one of the gloves near the cuff and pull it part of the way off. Turn the glove partially on your hand before removing the second glove to protect you from touching the outside surface of either glove with your bare hands

Leaving the first glove over your fingers, grasp the second glove near the cuff and pull it part of the way off. The glove will run inside out. It is important to keep the second glove partially on your hand to protect you from touching the outside surface of the first glove with your bare hand

Pull off the two gloves at the same time, being careful to touch only the inside surfaces of the gloves with your bare hands
If the gloves are disposable or are not intact, dispose of them properly (as stated under information on managing medical waste at the end of this chapter. Wash your hands immediately after removing the gloves, since the gloves may contain invisible holes or tears, leaving you at risk of exposure to contaminated blood and other body fluids.

**Appropriate Attire for Procedure**

Surgical attire, surgical gloves, caps, masks, and gowns help to reduce the risk of post procedure infections in clients by reducing the likelihood that clients will be exposed to potentially infectious microorganisms. In addition, this attire as well as protective eyewear, waterproof and sturdy footwear-protects the service providers from exposure to clients' potentially infectious blood and other body fluids.

Appropriate attire, including cap and mask should be worn when sterile packs are opened and during most surgical procedures. Some minor surgical procedures (e.g vasectomy, insertion/removal of Implants) can be performed safely without wearing a cap, mask or sterile gown.

**Preparation of Client for PPIUD and PP Implant procedures**

- Clean vagina with antiseptic such as chlorhexidine with cetrimide, e.g. savlon.
- Clean cervix with Iodophor, e.g. Betadine.
- Prepare the skin using antiseptic, e.g., Iodophor (Betadine), 4% Chlorhexidine (e.g. Hibitane), 1-3 % Iodine, followed by 60-90% alcohol).
- Wipe off excess antiseptic with sterile dry gauze.
SUMMARY

Observing aseptic techniques when conducting medical procedures remains one of the major strategies for preventing infection. The understanding of the various procedures of proper hand washing, gloving and removal of used gloves and the wearing of proper attires is imperative for the maintenance of a sterile field.

EVALUATION

- Define aseptic technique?
- State the importance of hand washing and describe the seven steps of hand washing?
- Describe the activities for preparing a client for PPIUD/Implant procedure?
MODULE SEVEN: SESSION 3

STEPS FOR INSTRUMENTS PROCESSING AND STORAGE

TIME: 30 Mins

LEARNING OBJECTIVES

By the end of this session, participants should be able to:

- Explain steps for processing instruments and other items.
- Demonstrate appropriate order for conducting the steps.
- Discuss how to appropriately store processed equipment instruments.

SESSION OVERVIEW

- Steps for processing instruments and other items.
- Appropriate order for conducting the steps.
- Storage of processed instruments.

METHODS

- Lecture
- Discussions
- Demonstration and return demonstration
- Hand out
- Case studies

MATERIALS

- Flip chart stand and paper
- Colored markers
- Masking Tape
- LCD Projector/Laptop

SUMMARY

EVALUATION
STEPS FOR PROCESSING INSTRUMENTS AND STORAGE

To prevent transmission of infections via instruments, steps for instruments processing, which include decontamination, cleaning and sterilization or high level disinfection must be followed properly.

**Step 1: Decontamination**

Decontamination kills many disease-causing microorganisms such as hepatitis virus and HIV, making instruments and other items safer for handling during cleaning. Decontamination is performed by soaking used instruments and other items in 0.5% chlorine solution for 10 minutes.

**MAKING CHLORINE SOLUTION FROM LIQUID**

Use the following formula to prepare chlorine solution from liquid form;

\[
\frac{\% \text{ Chlorine in solution}}{\% \text{ Chlorine solution desired}} - 1 = \text{Number parts water needed per part chlorine}
\]

Example: to make 0.5% chlorine solution from bleach with 3.5% active chlorine;

\[
\frac{3.5}{0.5} - 1 = 7 - 1 = 6
\]

Thus, add 6 parts water to 1 part liquid bleach.

Note: Instruments should not be exposed to chlorine for prolonged periods. A 10 minute time period is sufficient for decontamination.

Large surfaces such as examination and operating tables, laboratory bench tops and other equipment that may have come in contact with blood or body fluids also should be decontaminated. Wiping them down with a suitable disinfectant (e.g. 0.5 % chlorine or 1-2 % phenol) is a practical, inexpensive way to decontaminate these items.

**Step 2: Cleaning**

Cleaning instruments with detergent and water removes blood and particles and improves the quality of subsequent high level disinfection or sterilization. A brush should be used for cleaning most instruments. Service providers and other staff members must wear utility gloves while cleaning instruments.
Step 3: Sterilization or High-Level Disinfection (HLD)

To be effective, both sterilization and high-level disinfection (HLD) MUST be preceded by decontamination, careful cleaning and thorough rinsing. When sterilization of instruments is not possible, HLD is the only acceptable alternative.

A). Sterilization

- Sterilization using steam, dry heat or chemical solutions destroys all microorganisms (bacteria, viruses, fungi and parasites) including bacterial endospores from instruments and other items.
- Sterilization is the method recommended for items that come in contact with blood stream or tissues beneath the skin (such as reusable needles, syringes and other instruments).
- Jointed instruments such as ring forceps should be opened or unlocked for sterilization.
- Sterilization must be done using steam (autoclaving), dry heat (oven) or chemical solutions.
- Sterilized items should be used immediately or stored in a sterile covered container.

i) Steam Sterilization

- Instruments may be sterilized either unwrapped or wrapped.
- If items are to be wrapped before steam sterilization, use two layers of paper wrap or two layers of cotton fabric (do not use canvas).
- The wrapped items or wrapped packs should be arranged to allow free circulation of steam.
- Steam items at 121°C (250°F) and 106 kPa Pressure (15ibs/in2). Steam 30 mins for wrapped, 20 mins for unwrapped items.

Note: Do not begin timing until the steam sterilizer reaches the desired temperature and pressure.

- ‘Allow unwrapped items or wrapped packs to dry before removing them from the steam sterilizer. Allow items to cool before storage or use.
ii) **Dry Heat Sterilization**

- Items can be wrapped in a foil or double layered cotton fabric before dry-heat sterilization.
- Sterilize items at 170°C (340°F) for 60 mins or 160°C (320°F) for 120 mins.

**Note:** Do not begin timing until oven reaches the desired temperature.
• Dry heat can dull sharp instruments and needles. These items should not be sterilized at temperatures higher than 160°C.
• Items should be allowed to cool before they are removed from the oven.

**Figure 7.3.2: Dry heat sterilizers**

**iii) Chemical Sterilization**
- Cover all items with correct dilution of 2% glutaraldehyde solution (Cidex). Do not use sporicidin for sterilization.
- Jointed instruments such as ring forceps should be opened or unlocked.
- Soak items for 10 hours for Cidex.
- Nothing should be added to or removed from the chemical solution once timing has begun. After soaking items, rinse them with sterile water.
- Air-dry before use or storage.

**B. High-Level Disinfection (HLD)**

If sterilization is not available, high level disinfection is the only acceptable alternative for preparing instruments and other reusable items for use in PPIUD insertion.

High-Level disinfection (HLD) is effective in eliminating all microorganisms except some bacterial endospores.

There are two methods of HLD: boiling and chemical HLD:
i) Boiling

High-Level Disinfection by Boiling using a steamer

Figure 7.3.3: HLD by steaming – Two-Tiered Steamer

Disinfection of cannulae used during manual vacuum aspiration (MVA) is to steam them in a steamer containing one to three tiers of cannulae. MVA cannulae may be high-level disinfected or sterilized by other methods. However, high-level disinfection of gloves by other methods is less appropriate and not recommended.

Steps of HLD by Steaming
These steps should be followed for steaming MVA cannulae and other materials as shown in the diagram below:

1. Decontaminate and clean all instruments and other items to be high-level disinfected.
2. Because water must touch all surfaces for HLD to be achieved completely, submerge all instruments and other items in the water in the pot or boiler. Open all hinged instruments and other items and disassemble those with sliding or multiple parts. Place all bowls and containers upright, not upside-down and fill with water.
3. Cover the pot or close the lid on the boiler and bring the water to a gentle rolling boil.
4. When the water comes to a rolling boil, start timing for 20 minutes. Use a timer or make sure to record the time that boiling begins. From this point on, do not add or remove any additional water, instruments or other items.
5. Lower the heat to keep the water at a gentle and continuous boiling; too vigorous a boil will cause the water to evaporate and may damage the instruments and other items if they bounce around the container and hit the sidewalls and other instruments or items. The lower the heat also saves fuel/electricity.
6. After 20 minutes, remove the instruments and other items using dry, high-level disinfected pickups (lifters, cheatle forceps). Place the instruments and other items on a high level disinfected tray or in a high level disinfected container away from insects and dust and in a low-traffic area. Allow to air-dry before use or storage.

i) Chemical HLD

High-Level Disinfection using Chemicals

Chemicals that can be used include Glutaraldehyde solution, 0.5% chlorine solution and 8% formaldehyde solution.

Steps for HLD Using Chemicals

219
1. Decontaminate, clean and thoroughly dry all instruments and other items to be high level disinfected. Water from wet instruments and other items dilutes the chemical solution, thereby reducing its effectiveness.

2. When using a glutaraldehyde solution: Prepare the solution by following the manufacturer’s instructions or use a solution that was previously prepared as long as it is clear (not cloudy) and hasn’t expired. Ideally an indicator strip should be used each time the solution is to be used to determine if the solution is still effective. After preparing the solution, put it in a clean container with a lid. Mark the container with the date the solution was prepared and the date it expires.
   a. When using chlorine solution: Fresh solution should be made each day (or sooner, if the solution becomes cloudy). Put the solution in a clean container with a lid.

Note: Chlorine is not for use on laparoscopic equipment.

3. Open all hinged instruments and other items and disassemble those with sliding or multiple parts; the solution must contact all surfaces in order for HLD to be achieved. Completely submerge all instruments and other items in the solution; all parts of the instruments and other items should be under the surface of the solution. Place any bowls and containers upright, not upside-down and fill with the solution.

4. Cover the containers and allow the instruments and other items to soak for 20 minutes. Do not add or remove any instruments or any other items to or from the solution once timing has begun.

5. Remove the instruments and other items from the solution using dry, high level disinfected pickups (lifters, cheatle forceps).

6. Rinse thoroughly with boiled water to remove the residue that chemical sterilants leave on instruments and other items; the residue is toxic to skin and tissues.

7. Storage: Place the instruments and other items on a high level; disinfected tray or in a high level disinfected container and allow to air-dry before use or storage.

8. Use instruments and other items immediately or keep in a covered, dry, high level disinfected container and used within one week.

**Step 4: Storage of Processed Equipment and instruments**

- Proper storage of HLD or sterilized items is as important as the HLD or sterilization process itself.
- Items should be stored dry.
- If possible, store processed items in an enclosed cabinet.
- Do not store pick up forceps in a bottle filled with antiseptic solution (microorganisms will multiply in a standing solution even if an antiseptic has been added).
- HLD or sterilize pick-up forceps each day and store them dry in a high level disinfected or sterile bottle.
• Wrapped items must be considered contaminated when:
  - The package is torn or damaged
  - The wrapping is wet
  - The expiration date is exceeded
• Wrapped Items can be used for up to one week. Wrapped items sealed in plastic can be used for up to one month.
• Unwrapped items must be used immediately or stored in a covered sterile container (for up to one week).

SUMMARY

Instruments must be decontaminated, cleaned and sterilized, or high-level disinfected by steaming, boiling, or use of chemicals. HLD is recommended only when sterilization is not available or not recommended. Sterilized or high-level disinfected instruments should be properly stored.

EVALUATION:

• Describe the steps for instrument processing?
• Explain strategies for storing processed instruments?
• When do you consider sterilized wrapped items contaminated?
MODULE SEVEN: SESSION 4

USE AND DISPOSAL OF NEEDLES AND SHARPS

TIME: 30 Mins

LEARNING OBJECTIVES

By the end of this session, participants should be able to:

- List ways that health workers can become injured by sharps.
- Describe the actions that health workers can take to prevent or minimize injuries by needles/sharps.
- Describe the proper procedures for safe use and disposal of needles and other sharps.
- Describe the proper procedures for giving injections and use of multi-dose vials.

SESSION OVERVIEW

- How injuries commonly occur.
- Injury prevention strategies.
- Special consideration for health care providers living with HIV.
- Post exposure care for the injured health care staff.
- Procedure for giving injections and use of multi dose vials.

METHODS

- Lecture
- Discussions
- Demonstration and return demonstration
- Hand out
- Case studies

MATERIALS

- Flip charts stand and paper
- Coloured markers
- Masking Tape
- Transparencies
- LCD Projector/ Laptops
- Power point projectors
CONTENT

All staff (doctors, nurses, and those who are responsible for disposal of thrash) that come in contact with sharps are at risk of infections.

How injuries commonly occur

- Recapping the hypodermic needles after use (this is one of the major causes of sharp objects injuries).
- Manipulation of used sharps before disposal (such as bending, breaking or cutting of hypodermic needles, which can cause the blood inside to splash or cause staff to accidentally injure themselves).
- Accidentally sticking another staff member when there is a sudden motion involving persons carrying unprotected sharps.
- Leaving sharp items in areas where they are expected such as on surgical drapes or bed line.
- Accidentally sticking or cutting of oneself during surgical procedures in which there is limited visibility of the hands many sharp instruments are used or sharp instruments/suture needles are used in confined spaces (such as obstetric/gynecological and orthopedic procedures).
- Handling or disposing of waste that contains used hypodermic needles or other sharps.
- Unexpected client motion at the time of injections (Always warn clients when you are about to give them injections).
- During placement of needles or sharps into disposal container that are full or do not allow for easy insertion of the items.
- When the surgeon or assistant uses his finger as a guide or when tissue is hand held during suturing, during manual retraction of tissues/organs or when tying suture material with the needle still attached.
- When needle holders with the needle are left exposed.
- Other devices that cause stick injuries and perforation of gloves include the use of suture needle without a needle holder, wire sutures, trocars, stylets, sharp pointed scissors, sharp pointed retractors, skin hooks, penetrating towel clips and tenaculi.
- Scalpel injuries occur most frequently when instruments are handed from the suer to an assistant (Transferring between personnel’s).

To prevent injuries due to sharps:

- Handle hypodermic needles, syringes and other sharps minimally after use and use extreme care whenever sharps are handles.
- Avoid recapping needles and do not bend, break or cute them before disposal.
- Dispose of hypodermic needles, scalpel blades and other sharps in puncture-resistant containers immediately (or as soon as practicable) after use.
• Incinerate/burn or bury the container when three quarters full.
• Always wear utility gloves when disposing off sharp containers.
• Always wear utility gloves when washing sharps.
• Use the “hands-free-technique” described below to pass instruments during clinical procedures.
• Let clients know when you are going to give injection to avoid clients startling and causing an injury.
• Manipulate or reposition scalpels using forceps to grasp the blade.
• Consider using staples in place of suture and suture needles, if it would be an appropriate option.
• Use curved needles with a needle holder as a safer option to straight, hand help needles
• Blunt instruments can be an alternative for preventing injuries such as rounded point scissors, non-penetrating towel clips, blunt retractors, and synthetic sutures instead of wire sutures.
• When transferring sharps between personnel’s, avoid hand to hand transfer.

The hands-free technique for passing sharps:

• Health care workers can accidentally stick each other if or when passing sharps during a procedure, or when there is a sudden motion involving persons carrying unprotected sharps (such as on surgical drapes).
• Unprotected sharps should not be passed directly from one person to another.
• In the operating theatre or procedure room, pass sharp instruments and other items in such a way that the surgeon and assistant are never touching the instrument or other items at the same time (known as the hands-free technique).

Disposal of needles and other sharps

Improper disposal of contaminated sharp objects can cause infections in the health care facility and the community. Make hypodermic needles or other sharps unusable by incinerating them. If an industrial incinerator that will destroy hypodermic needles and other sharps is not available, reduce the risk of infections by decontaminating sharps before disposal and bury them in a pit to make it difficult for others to scavenge them.

Sharps-disposal container: a puncture resistant container for disposal of used needles and other sharp objects. A sharps-disposal container may be made out of a heavy cardboard box, an empty plastic jug or a metal container.
Figure 7.4: Sharp containers

Standard Sharps Containers

Improvised Sharps containers
Procedure for Giving Injections and Use of Multi-dose Vials

To reduce the risk of transmitting infections between clients

- Always use a new or correctly reprocessed hypodermic needle and syringe every time an injection is given.
- Never change the needle without also changing the syringe between clients. Reusing the same syringe to give injections to multiple clients even if the needle is changed is not a safe practice.

Before giving an injection:

- If there is visible dirt, wash the injection site with soap and water.
- Wipe the client’s skin at the injection site with an antiseptic solution to minimize the number of microorganisms and reduce the risk of infections. Using a fresh swab, wipe in a circular motion from the centre upwards.
- If alcohol is used allow the alcohol to dry in order to provide maximum effectiveness in reducing microorganisms.

Unexpected client motion at the time of injection can lead to accidents. Therefore always warn clients when you are about to give an injection. To avoid needle stick accidents follow the instructions for proper disposal and decontamination of used needles and syringes.

To avoid transmitting infections when giving IV fluids

- Unhook the needle or catheter from the IV line and dispose it off in a sharps-disposal.
- Throw away the IV line and any remaining fluid. Microorganisms can survive and grow in IV fluids; if the line and bag/bottle of fluid are reused, infection can be transmitted to other clients.
- Never use the same IV line and fluid bag/bottle with multiple clients.

Use of Multi dose vial

Before filling a syringe from a multi-dose vial:

- Check the vial to be sure there are no leaks or cracks.
- Check the solution to be sure if it is not cloudy and that there is no particle in the vial.
- Note: Most solutions that come in vials are clear. One exception is the injectable contraceptive Depo-Provera, which is milky.
- Wipe the top of the vial with a fresh cotton swab soaked with 60-70% alcohol; allow to dry.
To reduce the risk of transmitting infections between clients:

- Always use a new or correctly processed hypodermic needle and syringe every time medication is withdrawn from a multi-dose vial. Reusing the same syringe to give injections to multiple clients even if the needle is changed is not a safe practice.
- Never leave one needle inserted in the vial cap for multiple uses. This provides a direct route for microorganisms to enter the vial and contaminate the fluid between each use.
- Wash hands with soap and water.

**Post Exposure care:**

*When the health worker is injured, the following steps should be under taken:*

- Where there is bleeding, allow the site to bleed briefly. (There is no scientific evidence that cleaning the wound with an antiseptic or squeezing the wound decreases the risk of transmitting blood borne organisms).
- If a mucus membrane has been injured or has come in contact with blood or bodily fluid, flush with a large amount of water.
- If the eyes have been splashed, irrigate with clean water, saline or sterile irrigating solution.
- In the absence of water an antiseptic solution can be used to flush the area but remember that antiseptic solutions have not been proven to be any more effective than soap and water.
- Assess the injured health workers risk for infection following exposure, depth of wound, type of instruments involved, amount and type of bodily fluid.
- If feasible determine the HIV status of the source patient with appropriate counseling and disclosure of serological status. This is particularly important step in settings where resources are limited and recommended prophylactic drugs may not be readily available. Determining that the source patient is negative will eliminate the need for drug therapy its attendant side effects, costs and emotional stress of not knowing the risk following exposure or whether the drug therapy will work. Based on the assessment findings determine the need for prophylaxis.
- Post exposure care includes voluntary counseling, HIV testing, treatment and follow up care.
- If the health care worker will receive antiretroviral drugs, counsel the workers about the possible side effects associated with prophylactic drugs (ZDV and 3TC). Although these drugs are usually well tolerated some of the more common side effects include:
  - Upset stomach (nausea, vomiting and diarrhea), tiredness or headache with ZDV.
  - Upset stomach (rarely pancreatitis with 3TC).
- Jaundice and kidney stones in people taking ZDV; this can be reduced by drinking 48 ounces of fluids during 24 hours period.

- Counsel the injured health worker about behaviors to prevent transmission of HIV such as not providing blood, organ or semen donations, abstaining from sexual intercourse. If abstinence will be difficult or not possible for the health worker counsel him/her to use latex condoms consistently and correctly to reduce the risk of sexual transmission of HIV. Encourage the injured health worker to include their partners in counseling. In settings where breast-milk substitutes are affordable accessible and can be safely used, Women may be advised to avoid breastfeeding during the PEP period to prevent exposing their infants to HIV in the breast-milk.

- Post exposure care should include the following where feasible:
  - Baseline VCT and periodically up to 6 months after exposure e.g. at 6 weeks HIV antibody testing of the health worker as soon as possible after, 12 weeks and 6 months.
  - When antiretroviral drugs are being taken for PEP, assessment of toxicity with complete blood count, kidney and liver function tests before starting treatment and at 2 weeks after starting treatments.
  - Instruct the health care staff under treatment to report any sudden or severe flu like illness that occurs during the follow up period especially if it involves fever, rash, muscle aches, tiredness, malaise or swollen glands. These symptoms may suggest HIV infection, drug reaction or other medical conditions. Instruct the person to contact their provider if any questions or problems occur during the follow up period.
  - Counsel the injured worker regarding her/his emotional response, fears, and/or concerns regarding the reaction of their partner or spouse.

**Note:** Use of prophylactic therapy depends on the availability of the drugs. In many industrialized countries all occupational injuries where the source patient is known to be HIV-infected or at high risk for HIV infection are considered for antiretroviral drugs. In some middle income countries the recommendations apply only to serious accidents. Currently in many resources constrained countries, antiretroviral drugs may not be available or only one drug may available for post exposure care.
SUMMARY

- The session described the proper procedure for safe use and disposal of needles and other sharps.
- It also described essential elements of Post Exposure Care.

EVALUATION

- List four ways that health workers can become injured by sharps?
- Describe the strategies for the prevention of injuries during surgery?
- Describe appropriate procedures for the disposal of needles and sharps?
MODULE SEVEN: SESSION 5

HOUSEKEEPING AND WASTE DISPOSAL

TIME: 30 mins

LEARNING OBJECTIVES

By the end of this session, participants should be able to:

- Explain housekeeping in a health facility.
- List 5 general housekeeping guidelines.
- Describe how to prepare disinfectant cleaning solution.
- Describe appropriate waste disposal.
- State the importance of correct waste disposal.

SESSION OVERVIEW

- Importance of Housekeeping and waste disposal.
- Role of housekeeping in infection prevention.
- List 5 general housekeeping guidelines.
- Preparation of disinfectant cleaning solution.

METHODS

- Lecture
- Discussion
- Demonstration and return demonstration
- Handout
- Case studies

MATERIALS

- Flip charts stand paper
- Markers
- Masking tape
- LCD Projector/ Laptop

SUMMARY

EVALUATION
Definition:

Housekeeping refers to the general cleaning and maintenance of cleanliness in a health care facility. In addition to cleanliness, the purpose of housekeeping is to reduce the number of microorganisms in the facility (thus reducing clients' and staff members' risk of infections) and provide an appealing work and service-delivery space.

Importance of Housekeeping and Waste Disposal

The purpose of proper waste disposal of clinic wastes is to:

- Prevent spread of infection to clinic personnel who handle the waste and to the local community.
- Protect those who handle wastes from accidental injury.
- Provide an aesthetically pleasing atmosphere.

Creating open piles of waste should be avoided because they:

- Pose infection risks and fire hazards
- Produce foul odors
- Attract insects
- Are unsightly

If waste is not disposed of properly, contaminated waste is a potential source of infection for both staff and the local community

- Always keep waste containers in convenient places for users.
- Always dispose of contaminated waste properly never simply throw it outside or leave it in an open pit.
- Always wear utility gloves when handling and transporting waste and wash both the gloves and your hands afterwards.

Waste containers

- Use washable, leak-proof containers.
- If a container is reusable, disinfect it with a 0.5% chlorine solution after each use.
- Use waste bags.
Liquid waste

- If possible, pour waste down a utility drain or into a flushable toilet or latrine and know where the drain empties.
- If you cannot pour waste down a drain, latrine, or toilet, bury it in a pit.
- Always be careful when disposing of liquid waste. Do not allow the liquid to splash while you are pouring it.

Role of Housekeeping in Infection Prevention

The cleanliness of a health care facility is vital to the health and safety of its clients, staff, and visitors, as well as to the community at large; it is the foundation for preventing the transmission of infections in the facility. The facility’s cleanliness is often the first thing that a client or visitor notices, and it is a sign of the staffs concern for the clients, other staff, and visitors. In addition, an appealing environment contributes to staff members' satisfaction in working at the facility (making them likely to be more productive) and is more pleasant for clients (which promotes use of the services). In places where clients and visitors may be unaccustomed to the standards of hygiene required in a health care facility, health care workers need to pay special attention to housekeeping.

General guidelines for housekeeping:

- Cleaning schedules should be created, pasted where all staffs responsible for housekeeping can see them and closely followed.
- Always wear gloves (preferably heavy utility gloves) and shoes when cleaning client care.
- Cleaning should be done in a way that minimizes the scattering of dust and dirt that may contain microorganisms. Use a damp or wet mop to clean walls, floors and surfaces; avoid dry dusting or sweeping which increase the spread of dust and micrograms.
- Scrubbing is the most effective way to remove dirt and micro-organisms. Scrubbing should be a part of every cleaning procedure.
- Wash surfaces, such as walls from top to bottom so that debris falls to the floor, where it can be cleaned up last. Similarly clean highest fixtures first and work down for example, clean ceiling lamps first, then shelves, then selves then tables and then the floor.
- Change cleaning solutions where they appear dirty. The disinfectant’s ability to kill potentially infectious microorganisms is reduced when the solution contains a lot of soil.

Remember: Supplies and equipment used for cleaning need to be cleaned to prevent the spread of infections. Housekeeping equipment, such as mops, buckets and cloths should be decontaminated, cleaned in detergent and water, rinsed in clean water and allowed to dry before being reused. Contaminated cleaning equipment spreads, rather than reduces, microorganism in the environment.
Waste Disposal

Contaminated wastes may carry high loads of microorganisms which are potentially infectious to anyone who contact or handle them, and to the community at large, if not disposed of properly. Contaminated wastes include blood, pus, urine, stool, and other body fluids as well as items that come in contact with them such as gauze or used dressings. Wastes from procedure rooms, delivery rooms, operating rooms, and laboratories should be considered contaminated. In addition, contaminated waste may include items that can inflict injury (e.g., used needles and blades) and spread blood-borne diseases such as hepatitis B and HIV infection.

Proper handling of waste items minimizes the spread of infection to clinic personnel and to the local community. Where available, all contaminated wastes should be transported to disposal sites in covered containers. Persons handling wastes should wear utility gloves. Dispose of all sharp items in puncture resistant containers. Carefully pour liquid waste down a utility drain or flushable toilet or latrine. Wash hands, gloves and containers after disposal of infectious waste.

It is best to burn or bury contaminated waste rather than use community waste collection because of the likelihood of the waste being deposited into a community dump site. This would increase the risk of exposure to other people. Burning or burying on site may be more difficult, but it is best for the community.

SUMMARY

The session described the housekeeping and waste disposal methods required for control of spread of infection.

EVALUATION

- State the importance of housekeeping and waste disposal?
- List 3 ways to dispose waste?
- List four general housekeeping guidelines?
MODULE EIGHT
FOLLOW UP AND MANAGEMENT OF SIDE EFFECTS AND COMPLICATIONS OF PPIUD AND PP IMPLANTS

This module covers routine follow-up care, assessment and management of side effects and complications and prevention of complications. If you have experience with interval IUDs, it will be helpful in studying PPIUD follow-up.

Session 1: Routine Follow-up for PPIUD
Session 2: Management of side effects and complications of PPIUD
Session 3: Management of side effects and complications of PP Implants
# MODULE EIGHT

FOLLOW-UP AND MANAGEMENT OF SIDE EFFECTS AND COMPLICATIONS OF PPIUD/IMPLANT

## MODULE PLAN

<table>
<thead>
<tr>
<th>Session</th>
<th>Duration</th>
<th>Objectives</th>
<th>Method</th>
<th>Materials</th>
</tr>
</thead>
</table>
| **Session 1:** Routine follow-up | 20 mins | • List key components of the first routine PPIUD follow-up visit and subsequent visits | • Lecture  
• Discussion  
• Handout | • Flip chart stand/paper  
• Masking tape  
• Markers  
• LCD Projector/Laptop |
| **Session 2:** Management of side effects and complications of PPIUD | 1 hour | • Define side effects and complications and distinguish between them  
• List potential PPIUD side effects and complications  
• State how to prevent insertion-related side effects  
• Describe clinical management of the most common side effects and complications  
• Demonstrate appropriate client-provider interaction | • Lecture  
• Discussion  
• Handout | • Flip chart stand/paper  
• Masking tape  
• Markers  
• LCD Projector/Laptop |
| **Session 3:** | 1 hour | • List the common side effects, the occasional side effects and the warning signs requiring | • Brainstorming  
• Discussion | • Flip chart stand/paper  
• Masking tape |
### Management of side effects and complications of PP Implants

- **prompt medical attention** in implant users
  - Indicate what actions should be taken medically for each side effect
  - Demonstrate through case studies and role plays ways of handling client concerns about side effects of implant
  - Demonstrate counseling clients on side effects of implants in the language the client understands

- **Illustrated lecture**
- **Small group discussion**

- **Markers**
- **LCD Projector/Laptop**
MODULE EIGHT: SESSION 1

ROUTINE FOLLOW-UP FOR PPIUD

TIME: 20 mins

LEARNING OBJECTIVE

By the end of this session, the participants should be able to:

- List key components of the first routine PPIUD follow-up visit and subsequent visits.

SESSION OVERVIEW

- Key component of first routine PPIUD follow-up visit.
- Annual follow-up visit.

METHODS

- Lecture
- Discussion
- Handout

MATERIALS

- Flip chart stand/paper
- Masking tape
- Coloured markers
- LCD Projector/Laptop

SUMMARY

EVALUATION
The First Routine PPIUD Follow-Up Visit

The first PPIUD follow-up visit is done at the same time as the routine 4-6 week postpartum checkup. The following should be attended to, in addition to the usual elements of the postpartum checkup:

- Perform a physical exam, including a speculum examination to inspect the cervix.
- Confirm the presence of the strings.
- If necessary, shorten string length to 3 to 4cm from the cervical Os.
- If no strings are present and the client has not noticed an expulsion, follow the protocol for missing strings (see "Missing Strings," National Family Planning/Reproductive Health Service Protocols Chapter 9, page 178).
- Advise the client to return for routine annual exams, or anytime she is concerned about IUD-related problem.
- If the PPIUD has been expelled, offer the client another contraceptive method or insert another IUD, if the woman wishes.

Ways in which the Postpartum IUD differs from the Interval IUD

- Expulsion rates are higher with postpartum insertions (9.5% if placed within 10 mins of placental delivery and up to 37% if placed more than 10 % after the delivery of the placental up to 48 hours postpartum).
- Expulsion rates may be higher until service providers become more experienced with insertion.
- Strings descend from the uterus over time and then need to be cut to the proper length.
- Initial PPIUD follow-up care is in addition to the routine postpartum follow-up visit, although all care may be given at the same visit.

Information to be reviewed with the client during the Follow-Up Visit

The following information should have been provided to the client verbally and in writing at the time of insertion (see Module 5). The information should be reviewed during the first follow-up visit.

- Type of IUD the client is using
- How to check the strings
- When and where to return for check-ups
- When the IUD expires
- Side effects that can be expected
- Warning signs of complications (see National Family Planning/Reproductive Health Service Protocols Chapter 9 page 172)
- Instruction in the event of expulsion or complication
- Where to seek help if an expulsion or complication occurs
- The fact that the IUD does not provide protection against STIs including HIV
Annual Follow-Up Visits

Clients who continue IUD use should return once a year. If they experience any potential IUD-related problems, they should return for an examination. At such visits, be sure to:

- Ask the client if she has any questions, complaints, or side effect or complications and respond appropriately.
- Conduct a speculum and bimanual examination.
- Confirm the presence of the strings.
- Look for signs of any reproductive tract infection, and treat or refer if present.
- Review the client for the warning signs that require immediate medical attention (see National FP/RH Service Protocols Chapter 9 page 172).
- Make an appointment for the next visit (annual or otherwise, as needed).
- Remind the client when the IUD needs to be removed.

SUMMARY

The session described the key components of the first routine PPIUD follow up visit and subsequent visits.

EVALUATION:

- List the components of the first routine PPIUD follow up visit?
MODULE EIGHT: SESSION 2

MANAGEMENT OF SIDE EFFECTS AND COMPLICATIONS OF PPIUD

Time: 1 hour

LEARNING OBJECTIVES

By the end of this session, the participants should be able to:

- Define side effects and complications and distinguish between them.
- List potential PPIUD side effects and complications.
- Identify warning signs of potential complications.
- State how to prevent insertion-related complications.
- Describe clinical management of the most common side effects and complications.
- Demonstrate appropriate client provider interaction.

SESSION OVERVIEW

- Definition of side effects and complications.
- Potential PPIUD side effects and complications.
- Warning signs of potential complications.
- Prevention of insertion-related complications.
- Management of common PPIUD side effects and complications.
- Client Provider Interactions.

METHODS

- Lecture
- Discussion
- Case study

MATERIALS

- Flip chart stand/Paper
- Masking tape
- Coloured markers
- LCD Projector/Laptop

SUMMARY

EVALUATION
Side Effects and Complications

Definitions
Note: The following are technical definitions that to be explained to clients.

Side effects: A consequence of a procedure, contraceptive method, or medication other than that intended. A side effect does not require exceptional intervention, but it may require attention and management. For example, spotting with an IUD in place is an example of a side effect.

Complications: An unexpected condition that requires intervention or management beyond what was planned or what is normally provided. For example, pelvic inflammatory disease (PID) is an example of a PPIUD complication.

Potential Side Effects of PPIUDs
Cramping, spotting or bleeding between menstrual periods, heavier menstrual periods, and partner complaints about strings.

Clients are less likely to discontinue the use of PPIUDs if they expect and understand the potential side effects and know how to manage them.

Potential PPIUD-Related Complications
- Insertion-related complications include vasovagal reaction, uterine perforation, and cervical perforation.
- Post-insertion complications include bleeding, PID, expulsion, pregnancy, and missing strings.

The warning signs for IUD complications are represented by the acronym "PAINS",
P Period late (pregnancy), abnormal spotting or bleeding
A Abdominal pain, pain with intercourse
I Infection exposure (any STI), abnormal discharge
N Not feeling well, fever, chills
S String missing, shorter of longer, or feeling the IUD when checking for strings.
Prevention of PPIUD-Related Complications

Many PPIUD insertion-related complications can be prevented by:

- Careful screening of clients
- Following proper infection prevention techniques
- Following appropriate insertion technique

Management of Side Effects and Complications

Note: Any time the IUD is removed for medical reasons or client request, the client should be counseled about other contraceptive methods and provided with one if she wishes.

Variations in Management of Complications

Health care providers everywhere have different approaches to managing clinical conditions. The suggestions included in this module for managing PPIUD side effects and complications have been used extensively and observed to result in safe, client-oriented care.

Cramping and Abdominal Pain

Mild cramping is common immediately following insertion, but this may be masked by normal postpartum uterine involution. Pain at the time of insertion that is persistent and increasing with abdominal tenderness may indicate uterine perforation. The IUD must be removed. Surgical removal may be necessary if perforation has occurred.

Cramping and pain that occurs months or years after insertion may indicate pregnancy or infection, and both must be ruled out along with other potential pathology in the evaluation process.

The IUD should be removed whenever a woman is experiencing severe cramping.

Bleeding or Menstrual Changes

While some spotting is expected during the first few months following IUD insertion, any abnormal bleeding may indicate pregnancy or infection, and both must be ruled out in the evaluation process. All other potential pathology (such as dysfunctional uterine bleeding, uterine fibroids, cervical or uterine cancer, and cervical or uterine polyps) should also be kept in mind as possible causes of irregular bleeding. The possibility of anemia should also be considered, with treatment provided as needed.
Spotting between Periods

If menses begin immediately at postpartum, spotting may be noticed for the first three months following insertion. The spotting usually corrects itself if it is not as the result of underlying pathology.

Partner Irritated by String

This complaint usually arises because the string is too short causing its sharp point to irritate the partner. Consider removing and replacing the PPIUD, leaving a longer string. If the string is cut even shorter, the woman will have no way to check for the string to ensure the PPIUD is in place.

Strings Too Long

First rule out partial expulsion, and if ruled out, cut the string to 3-4 cm in length.

Missing Strings

At the first routine follow-up visit after postpartum insertion, IUD strings may not be visible. This may indicate either an unrecognized expulsion or that the IUD is in place but the strings have not spontaneously descended. In one study, 25% of the strings had not descended at one month, 13% had not descended at six months, and 4% had not descended at two years (Forest, 1971). Sometimes it is possible to find the strings with gentle probing of the endocervical canal. If they are not located, the presence of the IUD can usually be determined using a uterine sound. Sterile, non-touch technique must be used to minimize the risk of contamination of the uterus during instrumentation. One must evaluate the client to rule out an existing pregnancy before sounding the uterus. After six weeks postpartum, if the client is not menstruating and is not breast feeding, a urine or blood pregnancy test and an examination are performed to exclude pregnancy. A physical examination alone in very early pregnancy is not sufficient to exclude pregnancy. If urine or blood pregnancy test is not available, an alternative method of contraception is offered to the client. A subsequent examination is performed after several weeks, by which time pregnancy can be diagnosed by physical examination. If there is no pregnancy, the following steps may be followed:

- If no string is visible, examine the cervical canal for the string.
- If no string is found in the cervical canal, prepare the cervix as for IUD insertion and explore the uterus with an appropriate, sterile (or high-level disinfected) instruments.
- If the string is found and brought through the cervical Os without moving the IUD, follow-up the client routinely. If there is any possibility the IUD has been dislodged, remove it and replace it with another IUD.
- If the string or IUD is not found with the aid of instruments, obtain x-ray or ultrasound. Another contraceptive method should be offered for use in the interim. If no IUD is
identified, rule out pregnancy. If there is no pregnancy and the client wishes it, reinsert another IUD.

- If the IUD is identified in the uterus, it may be left in position or removed. If left in the uterus, the woman will have no way to check for the string to ensure for herself that the IUD is in place. If the IUD is found by ultrasound scan to be outside of the uterus, perforation has occurred. The IUD will need to be removed surgically.

**Partial Expulsion**

If the IUD is present in the cervical canal, remove the IUD. Another IUD may be immediately inserted if no pathology is present, there is no chance that pregnancy has occurred, and the client requests another.

**Complete Expulsion**

- Insert another IUD if the client wishes and is not pregnant.
- Counsel on other methods, if client doesn’t want to continue with IUD.

**Perforation**

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

If perforation is recognized or suspected at the time of inserting a PPIUD:

1. Stop the insertion immediately. If the IUD already has been placed, remove it, if possible, by pulling on the strings.
2. Keep the client at rest, and observe for signs of intra-abdominal bleeding such as falling blood pressure, rising pulse, severe abdominal pain, tenderness, guarding, or rigidity.
3. Check the vital signs every 15 mins during the first 90 mins following the perforation. Have the client sit up from a resting position. Observe her for signs of fainting or a rapid change in pulse (more than 30 beat per minute).
4. If there is a change in vital signs, or if the client exhibits spontaneous pain or peritoneal signs, hospitalization is needed.
5. If there are no peritoneal signs or symptoms, the client may be sent home after two hours of observation. Another IUD may be inserted after four weeks if the client desires it.

**Pelvic Inflammatory Disease**

If PID occurs with IUD in-situ, treat the PID and leave the IUD in place, unless if the client wants it removed. If the client wants it removed, start her on antibiotics before removing it.
Pregnancy with the IUD in place

Pregnancy with an IUD in place is rare. There is a 50% risk of spontaneous abortion when an intrauterine pregnancy occurs with an IUD in place.

It is generally recommended that an IUD should be removed as soon as possible when pregnancy is diagnosed. There might be a risk of spontaneous abortion related to the removal of the IUD in early pregnancy. If the string is not visible, the IUD was either expelled before pregnancy or the strings have been drawn into the uterus with the growing pregnancy. Removal of the IUD without a visible string depends on service provider skill and availability of ultrasound. The risk of spontaneous abortion increases with the use of instruments inside the uterus.

Women must be advised of the risks of spontaneous abortion when they are diagnosed with a pregnancy with an IUD in place.

There is a theoretical increased risk of infection and septic abortion during pregnancy when an IUD is left in uterus. This risk is based on experience with the Dalkon Shield, an IUD which is no longer available, and may or may not apply to the Copper T 380A. A woman with an IUD remaining in place throughout her pregnancy must be monitored closely for any signs of infection.

Client-Provider Interaction during Follow-up

Client-provider interaction has been discussed during this training course. Important points that are relevant for follow-up care are as follows:

- Service providers need to realize that, depending on circumstances, a client may not have received enough information about side effects and complications up to the point when she sees the service provider.
- Empathy is important, especially when a client is experiencing side effects or complications.
- As with any health problem, it is important to identify the severity of the symptoms the client is experiencing. The questions below are examples of what might be asked of a client who complains of problems that may be related to her IUD. The questions will vary, depending on the client's complaint.

Examples

- How does the cramping compare to what you felt during your menstrual periods before the IUD was inserted?
- How many pads do you use per day (or hour)? Are they soaked through?
- How often do you have to change the cloth or pads?
- Where is the pain? (This may help assess if the problem is related to the IUD).
- Do you have to take painkillers? What are you taking and how often?
• What kind of work do you do? Can you still work? Still do cooking?

It is useful to use terminology that lets the client know exactly when to come back for medical attention (e.g., "If you're soaking the cloth eight times a day, you should come back"). Give her specific instructions so she can figure out when bleeding (or any other symptom) is excessive.

Summary:

The session described the common side effects and complications that may occur with PPIUD insertion. It also discussed the management of these side effects and complications.

Evaluation: Case Studies

After reviewing the management of side effects and complications, you may use the following case studies, or case histories of your own, to lead participants in a discussion of clinical situations. The discussion should at least include the previous management suggestions and the differential diagnoses listed for each case below.

1. A client comes for her first follow-up visit five weeks after delivery. She reports that the IUD strings are missing.

Differential diagnosis:

• Strings not yet descended (normal)
• Complete expulsion
• Strings in cervical canal

2. Three months postpartum, a client returns for her first follow-up visit (she didn't return for a six-week postpartum visit). She is complaining about lower abdominal pain with intercourse.

Differential diagnosis:

• Infection (possibly PID)
• Pregnancy
• Positional pain with intercourse (normal)
• Delivery-associated trauma

3. Saying that "the strings seem to have gotten shorter," a client is in today for her first annual follow-up visit.

Differential diagnosis:

• Pregnancy
• Strings coiled in cervical canal
4. The client returns at three months postpartum and complains of heavy bleeding for seven days for the last two months, with spotting between these periods.

*Differential diagnosis:*

- New bleeding pattern, within normal limits for CuT 380A user
- Infection
- Pregnancy
- Dysfunctional uterine bleeding
- Uterine fibroids
- Cervical or uterine cancer
- Cervical or uterine polyps
- Anaemia, secondary to heavy bleeding
MODULE EIGHT: SESSION 3
PROBLEM MANAGEMENT DURING USE OF IMPLANTS

Time: 1 hour

LEARNING OBJECTIVES:

By the end of this session, participants should be able to:

• List the common side effects, the occasional side effects and the warning signs requiring prompt medical attention in implant users.
• Indicate what action should be taken medically for each side effect.
• Demonstrate through case studies and role plays ways of handling client concerns about side effects of implant.
• Demonstrate counseling clients on side effects of implants in the language the client understands.

SESSION OVERVIEW:

• Common side effects, the occasional side effects and the warning signs requiring prompt medical attention in implant users.
• What action should be taken medically for each side effect.
• Demonstration through case studies and role plays of ways of handling client concerns about side effects of implant.
• Demonstrate counseling clients on side effects of implants in clear everyday language.

METHODS:

• Brainstorming
• Discussion
• Illustrated Lecture
• Small group discussion

MATERIALS:

• Flip chart Stand/Paper
• Coloured markers
• LCD Projector/Laptop

SUMMARY

EVALUATION
Most side effects and other health problems associated with the use of implants are not life threatening. Changes in menstrual bleeding patterns are by far the most common adverse effect. In addition to menstrual bleeding changes, women using Jadelle implants occasionally develop enlarged ovarian follicles. Fortunately, they rarely cause symptoms and usually are discovered only incidentally at pelvic examinations. In addition, they generally shrink and disappear spontaneously and rarely require treatment.

Ectopic pregnancies also have occurred, although clinical studies have shown no increase in the rate of ectopic pregnancies per year among implants users compared with women not using any contraceptive method. Finally, several other conditions that may or may not be associated with the use of implants have been reported. They include headache, breast tenderness and/or discharge, weight gain, increased body or facial hair (hirsutism) and vaginal infection (vaginitis).

In this session, additional information and guidelines for assessing and managing the most important of these side effects and other health problems are provided. These include:

- Pain after insertion or removal
- Infection at the insertion site
- Irregular or heavy bleeding

**Management of problems associated with contraceptive implants**

**Pain after insertion or removal**
If no signs of infection
- Advise her to avoid pressing on the implants for a few days and never press on the implants if tender.
- Give Aspirin or another non-steroidal anti-inflammatory drug.

**Infection at the insertion site**
- If there is redness, heat, pain or pus, do not remove the implants.
- Clean the infected area with soap and water or antiseptic. Given an oral antibiotic, e.g. Amoxicillin 500gm tds for 7 days and ask the client to return in one week. Then if no improvement, remove the implants or refer for removal.
- If there is an abscess clean the infected area with antiseptic, make an incision, and drain the pus.
- Treat the wound and given oral antibiotic for seven days.

Ask client to return in 7 days if she still has symptoms (heat, pain, drainage, redness). If infection is still present, remove the implants or refer for removal. Help to choose another method.

**Irregular or heavy vaginal bleeding**
Take history and examine. Ask the client:
- the duration and quantity of bleeding
• if it coincides in timing with implants insertion
• the presence of abdominal pain or fainting spells if no underlying condition is suspected (implant is still in place and bleeding started after implant initiation)
• Reassure the client that bleeding changes are common in women who are using implants, they are not harmful and usually become less or stops altogether after the first year of use

If the client finds the bleeding unacceptable and no estrogen contraindication, offer:
• One cycle of low-dose combined oral contraceptive pill containing the progestin levonorgestrel. The same progestin present in the implants is best for controlling bleeding
• Ibuprofen or other non-steroidal anti-inflammatory drugs, but not aspirin.

If bleeding is very heavy (twice as much as usual):
• Check for anaemia. If present, treat or refer.
• advise on food containing iron.

If bleeding is unacceptable to the client, help her choose another method and remove implant.

Note: Uterine evacuation is not necessary and is contraindicated if bleeding is due to gynecological issues. Treat or refer for care as appropriate.

Unexplained abnormal vaginal bleeding that suggests underlying medical condition unrelated to method use:
• The client can continue using implant while her condition is being evaluated
• If no cause of bleeding can be found, consider stopping implants to make diagnosis easier
• Provide another method until the condition is evaluated and treated (other than hormonal method or IUD)
• Treat any underlying medical problems or refer for care.
• If bleeding is caused by STI or PID, she can continue using implants during treatment
• If caused by cervical or endometrial cancer, she can continue using implants while awaiting treatment
• Check blood pressure

Check that the implant is still in place and complete

If underlying condition is suspected, perform abdominal and pelvic examinations to exclude pregnancy or related complications, e.g. abortion or ectopic pregnancy (pregnancy is highly unlikely if it was ruled out prior to insertion of the implant and implant is still in place).

Investigations
• Pregnancy test or a pelvic ultrasound if indicated
• Refer as indicated

Physical examination
• Check mucous membrane for colour and pallor
• Check weight
• If ectopic pregnancy or another serious condition is suspected, refer for immediate diagnosis and care
• Implants can remain in place
• If pain is due to ovarian cyst, Implants can remain in place.
• Re-assure the client that these cysts usually disappear on their own without surgery
• To be sure there is no problem, see the client again in about three weeks if possible

**Headaches**

If these headaches are ordinary:
• Suggest painkillers such as ibuprofen or paracetamol, reassure
• If migrainous headaches with aura (blurred vision, temporary loss of vision, seeing flashing lights or zigzag line) started or became worse after she began using the method, remove implants.
• Help client to choose non-hormonal contraceptive method
• Refer for care as needed

**Amenorrhea**

If there is no pregnancy and amenorrhea is less than six weeks:
• Re-assure the client that menstruation may resume within 4–6 weeks or onset of last menses
• Give follow-up appointment for 2–4 weeks

If the client is pregnant:
• Remove the implant
• Refer immediately for antenatal care

**Severe pain in lower abdomen**

• Take history and Examine
• Rule out ovarian cyst, complicated ovarian cyst, ovarian tumour, pelvic inflammatory disease, appendicitis, ectopic pregnancy or ruptured tumour
• Be particularly alert for additional signs or symptoms of ectopic pregnancy, which is rare, but serious:
  • abnormal vaginal bleeding or no monthly bleeding, particularly if this has changed from her
  • previous bleeding pattern
  • light-headedness or dizziness
  • fainting
Warning Signs/Special Concerns – *(Client must return to the Clinic as soon as possible)*

The client should report to the nearest family planning clinic if she notices any of the following:

- Severe lower abdominal pain
- Heavy vaginal bleeding
- Arm pain
- Pus or bleeding at the insertion site (this may indicate infection)
- Expulsion of an implant (this rarely occurs with proper placement)
- Episodes of migraine, repeated bad headaches, or blurred vision
- Delayed menstrual cycles after along interval of regular cycles
- Suspicion of pregnancy
- Jaundice

**SUMMARY**

Most of the health problems associated with implants' use are mild. Good counseling about these side effects enables the client to tolerate them while improving continuation rates. Changes in menstrual bleeding patterns are by far the most common adverse effect. Management of the side effects ranges from simple reassurance, medical treatment, to referral for further care. User concerns must be patiently listened to and addressed accordingly.

**EVALUATION**

- List the common side effects of implant use?
- What is the warning signs requiring prompt medical attention?
- What are the known medical treatments for vaginal bleeding in implant users?
- Describe five examples of user concerns?
MODULE NINE

RECORD KEEPING, HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS)
AND CONTRACEPTIVE LOGISTICS MANAGEMENT SYSTEM (CLMS)

SESSION 1: Record Keeping and Health Management Information System

SESSION 2: Contraceptive Logistics Management System
## Module Plan

<table>
<thead>
<tr>
<th>Session</th>
<th>Duration</th>
<th>Objectives</th>
<th>Method</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1: Record Keeping and Health Management Information System (HMIS)</td>
<td>45 mins</td>
<td>• Describe the HMIS&lt;br&gt;• Mention the importance of HMIS&lt;br&gt;• State the reasons for accurate record keeping and its implication for data quality&lt;br&gt;• List the advantages of Record Keeping&lt;br&gt;• Explain the disadvantages of NOT keeping records&lt;br&gt;• Explain the content of the various national record keeping forms</td>
<td>• Lecture&lt;br&gt;• Group work&lt;br&gt;• Brainstorming&lt;br&gt;• Discussion</td>
<td>• Flip chart stand/paper&lt;br&gt;• Markers&lt;br&gt;• LCD Projector/Laptop&lt;br&gt;• Various HMIS tools</td>
</tr>
<tr>
<td>Session 2: Contraceptive Logistics Management System (CLMS)</td>
<td>30 mins</td>
<td>• Explain logistics management&lt;br&gt;• Describe National Contraceptive Logistics Management system (CLMS)&lt;br&gt;• Demonstrate use of CLMS tools</td>
<td>• Handout&lt;br&gt;• Brainstorming&lt;br&gt;• Discussion&lt;br&gt;• Lecture</td>
<td>• Flip Chart Stand/Paper&lt;br&gt;• LCD Projector&lt;br&gt;• Laptop&lt;br&gt;•</td>
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MODULE NINE: SESSION 1

RECORD KEEPING AND HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS)

Time: 50 Minutes

LEARNING OBJECTIVES:

By the end of this session, participants should be able to:

- Describe the HMIS.
- Mention the importance of HMIS.
- State the reasons for accurate record keeping and its implication for data quality.
- List the advantages of Record Keeping.
- Explain the disadvantages of NOT keeping records.
- Explain the content of the various national record keeping forms.

SESSION OVERVIEW

- Description of the HMIS.
- The importance of HMIS.
- Reasons for accurate record keeping and its implication for data quality.
- Advantages of Record Keeping.
- Disadvantages of NOT keeping records.
- Content of the various national record keeping forms.

METHODS

- Lecture
- Group work
- Brainstorming
- Discussion

MATERIALS

- Flip chart stand/paper
- Markers
- LCD Projector/Laptop
- Various HMIS tools

SUMMARY

EVALUATION
Health Management Information System (HMIS) is an organized way of recording, collating, and interpreting information for planning and decision-making. Facility managers and supervisors will need to be equipped to monitor the quality of services. Monitoring activities would include assessing adherence to service protocols, checking for contraceptive stock outs, and reviewing service statistics, such as the number of FP clients referred to other services. This module discusses the importance of Record Keeping in FP Programme, information needed to measure Programme Success and inform programme or service delivery improvement.

Importance of HMIS

The effective management of any programme depends on availability of information for optional decision-making. In this regard, the setting up of MIS will provide the programme management with necessary information for decision. The quality of management decision making will be determined by the quality of MIS; it is essential for effective programme management. Other uses of HMIS are:

- It provides feedback on the performance of the critical functions of the programme
- Such feedback allows managers to take corrective actions when problems arise
- It provides stakeholders with regular assessments of programme performance
- It is useful for measurement of programme output, i.e. products or services delivered to programme participants or other such activities viewed as part of programme's contribution to society. Examples are number of clients served, the nature and volume of advocacy or promotional effects, numbers and types of IEC materials produced and distributed
- It is used in the assessment of programme impact
- It provides answer to specific management and research questions
- It is an important monitoring tool
- It is critical for resource allocation and evaluation.

Advantages of Record Keeping

Helps us to:

- Know the total number of client
- Know the number of new clients and old clients to determine the rate of new acceptor and revisits for each method
- Know the number of female clients attending the family planning clinics at the various locations in the community for comparison
- Use data for assessment, planning, implementation, and evaluation e.g.
  - give an account of commodities and determine future need
  - determine future needs regarding staffing and facilities
- know the progress of family planning in the community and society
- use data for future planning
- use data for research purpose
• use data for referral purposes

**Disadvantages of Not Keeping Record**

Provider would not:
  • Know the total number of clients served
  • Be able to determine the rate of acceptors for each method/procedure
  • Be able to compare number of clients with other family planning facilities in the community
  • Be able to assess or plan for future improvements and evaluate up-to-date progress
  • Be able to supply evidence of past work
  • Be able to conduct good research due to e.g. lack of statistics
  • Give good impression of clinic activities
  • Be able to help planners to determine the general needs of the clinic
  • Be able to make planning and evaluation easy
  • Be able to obtain other adequate information in case a problem of a legal nature arises

**HMIS TOOLS**

HMIS tools are used for keeping track of various services provided by the programme and activities performed.

**Types of National Family Planning HMIS Tools**

• Family Planning Register (Facility Register)

• Daily Consumption Record (DCR)

• Requisition, Issue and Report Form (RIRF)

• Community Based Distributor (CBD voucher)

**Client Record form/Instruction (Form A)**

• This form is used to record client's history.

**Tally Sheets/Daily Activity Summary Forms (Form B1.1 & B1.2)**

• This is used to record services provided to client at the facility level. Information in this sheet is summed up at the end of every day and this summation should be transferred into the monthly summary sheets.
Monthly Summary Form (Form C1.1 & C1.2)
- This form is to be used for compilation of data in the Tally/Daily Activity Summary Form, i.e. Forms B1.1 & B 1.2. It should be completed monthly by the responsible health worker in the facility.

Facility Based Referral Form (Form D)
- It is used by clinical service providers or outreach workers who provide clinical services to refer a client to a referral centre where further services can be obtained. This form is designed in a way that enable service providers keep track of how many referrals they have made and how many of these referrals have gone to the points of referral and follow-up. It enables providers keep track of clients for follow up purposes.

Quarterly Summary Form (Form E)
- This form is used for compilation of data in the Monthly Summary Form (C1.1 & C1.2). It should be completed monthly or at the end of the quarter by the responsible health worker in the facility.

Annual Summary Form (Form F)
- This is used for compilation of the annual facility data. It should be a summary of all quarterly reports for the year in question.

Outreach Activity Form (Form G)
- This is used for obtaining a record of reproductive health outreach activities undertaken by individual health worker (peer educator, community health extension worker etc) during the month in question.

Monthly Outreach Summary Form (Form H.1)
- This is used for summarizing all reproductive health outreach activities undertaken by individual health worker (peer educator, community health extension worker etc.) during the month in question. This form is filled by the supervising officer, and submitted to the project coordinator, who would use the information generated for programme planning and report writing.

Quarterly/Annual Outreach Summary Form (Form H.2)
- This form summarizes all outreach reproductive health activities carried out by health workers during the quarter and year under reference.

Outreach Referral Forms (Form J)
- To be used by clinical service providers or outreach workers to refer a client to a referral centre, where further services can be obtained.

Appointment Card (Form K)
- This card is used by the service provider to enter appointments for the client.
A copy of each of the forms discussed above will be available for practice during the training.

**SUMMARY**

- Record Keeping in FP Programme helps to generate information needed to measure programme success and inform programme or service delivery improvement.
- Effective management of FP programme depends on availability of information for optimal decision-making.
- The setting up of MIS will provide the programme management with necessary information for decision.
- The quality of management decision-making will be determined by the quality of MIS.

**EVALUATION**

- State the importance of record keeping in FP programme?
- List the advantages of record keeping?
- Describe the content of the national record keeping forms?
MODULE NINE - SESSION 2:
CONTRACEPTIVE LOGISTICS MANAGEMENT SYSTEM (CLMS)

Time: 35 Mins

LEARNING OBJECTIVES

By the end of the Session, participant should be able to:

• Explain logistics management.
• Describe National Contraceptive Logistics Management System (CLMS).
• Demonstrate use of CLMS tools.

SESSION OVERVIEW

• Introduction.
• Logistics management.
• The National Contraceptive Logistics Management System (CLMS).
• Demonstration of use of CLMS tools.

METHODS

• Lecture
• Group work
• Brain storming
• Discussion

MATERIALS

• Flip Chart Stand/Paper
• Markers
• LCD Projector/ Laptop

SUMMARY

EVALUATION


**Introduction**

A logistics management system is an organized system that uses data and information gathered from various communities and service delivery sites to provide a steady supply of commodities and consumables that are required to maintain uninterrupted services in those communities. The Contraceptive Logistics Management System (CLMS) provides commodities for effective contraceptive services at all service delivery points, ensuring that all Nigerians are able to receive the contraceptives they need through their service delivery point or community based agents (CBA). This requires that the system guarantees the supply of:

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<td>In the <strong>RIGHT QUANTITIES</strong></td>
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<td>In the <strong>RIGHT CONDITION</strong></td>
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**Objectives of CLMS:**

- Enhanced distribution of a complete range of family planning methods through the different levels of the supply chain management system (Federal Central Contraceptive Warehouse, state stores, Local Government Store (LGA) and Service Delivery Point (SDP)).
- Sustained availability of contraceptives with adequate stock levels to meet demand at all times.
- Expand access to a complete range of contraceptive methods with greater choice for clients.
- Improved ordering and stock management, ensuring that requests corresponds to actual need.
- Increased capacity at all levels of the system to manage contraceptive supply.
- Adequate flow of essential information on the movement of contraceptives and funds collected through the system, improve contraceptive quality throughout the supply chain through procurement standards and proper storage.
- Reduced waste and increased efficiency throughout the supply chain.
Contraceptive Commodities Selection
Selection depends on factors such as the pattern of: clients' preferences, the capacity of service providers to offer wide range of FP methods and the quality of care.

Contraceptive Security

This is guaranteed by a program's ability to:

- Accurately estimate requirements
- Control financial resources
- Technically procure products
- Distribute products to the customer for the medium to long-term
- Guarantee maximizing quality through good storage practices
- Guarantee maximizing quality through Inventory control
- Ensure maximizing quality through supervision of supplies

Flow of contraceptives through the public sector supply system:
The CLMS focuses on forecasting and procuring the right contraceptive quantities, storing and distributing them through all levels of the health system and delivering them to clients, as displayed on the chart below:
Contraceptive Commodities Forecasting and Procurement

Once the commodities to be procured are determined, the next step is to ascertain the quantities required for procurement. The process of determining those quantities to procure is what is called forecasting. Forecasting is usually done at National level and covers a period of more than one year. The following data sources are used to forecast:

1. Logistics data: This is applied to determine the availability of consumption and stock position.
2. Demographic data: this takes into account the population being served and the extent of unmet need for FP in the area.
3. Service statistics: This is very important in forecasting because it helps inform the project managers whether there is a need to recruit more staff to achieve the goals of the forecast or to reduce expected consumption due to limited staff in the field.
4. Targets: Every service delivery point should have annual targets in volume of services to be rendered, which will derive from LGA and State targets. Once the forecast has been discussed and approved, then a procurement plan is developed.
Contraceptive Commodities Distribution and Storage
The commodities distribution process begins when the commodities are sent from the manufacturers or suppliers and ends when the commodity consumption information is sent to the Central Medical store. An effective distribution system is the pillar of contraceptive commodity logistics management system. Such a system should not only maintain a constant supply of the commodities but also keep the commodities in good conditions throughout the distribution process, minimize losses due to spoilage and expiry, maintain accurate records, reduce theft and fraud and provide information for forecasting future commodity needs.

Contraceptive commodity consumption
The CLMS delivers the correct commodities to the service delivery points. However, efforts in selection, procurement and distribution would be wasted if the commodities are not used rationally. Rational use of the commodities requires that FP clients receive FP methods that are appropriate to their needs and choices, in adequate doses that meet their individual requirements, for the adequate period of time, at the lowest cost to them and their community.

Management Support
The contraceptive commodity logistics management cycle is driven by factors that must be in place for the system to operate smoothly. These factors include competent human resources, sufficient finances to fund the activities and purchase the commodities, a functional logistics management information system that provides vital information for planning, and managerial support in form of supervision and evaluation.

Summary
Prompt and regular remittance of data compiled from good records kept on contraceptive services rendered at service points to the CBD helps the CLMS to place orders for adequate quantities of contraceptive commodities from manufacturers, which are then distributed to the service sites to ensure uninterrupted availability of services to clients.

EVALUATION
- Explain CLMS?
- Mention 4 objectives of the CLMS?
- Describe the flow of contraceptive through the public sector supply system?
MODULE TEN
COMPETENCY-BASED CHECKLIST AND LEARNING GUIDES

Time: 1 hour

LEARNING OBJECTIVES

By the end of the session, participants should be able to:
- Discuss progress in skill area.
- Explain the use of learning guides and checklist.
- Discuss the advantages and disadvantages of competency-based skill assessment instruments.
- Demonstrate the use of competency based assessment instrument.
- Discuss the care of anatomic models.

SESSION OVERVIEW
- Progress in skill area.
- Description of learning guides and checklist.
- Advantages and disadvantages of competency-based skill assessment instruments.
- Demonstration of the use of competency based assessment instruments.
- Care of anatomic models.

METHODS
- Illustrated Lecture
- Discussion
- Group work
- Demonstration & Return Demonstration

MATERIALS
- LCD Projector
- Laptop
- Flip Chart Stand/Paper
- Marker
- Varieties of clinical skills Learning Guides and Checklists
- Anatomic models
- Learning Guide for PPIUD Insertion Techniques
- Learning Guide for PPIUD Counseling Skills
- Learning Guide for Implant (Jadelle) Insertion Techniques
- Learning Guide for Implant (Implanon® classic) Insertion Techniques
- Learning Guide for Implant (Implanon NXT™) Insertion Techniques
- Learning Guide for Implant Removal Skills (All Implants)
SUMMARY

EVALUATION
Introduction
In the past, deciding whether a participant was competent (qualified) to perform a skill or activity during and, most important, after clinical training was often extremely difficult. This was due, in part, to the fact that competency was tied to the completion of a specified number of supervised procedures or activities. Unfortunately, unless participant performance is objectively measured relative to a predetermined standard, it is difficult to determine competency.
Competency-based skill assessments (learning guides and checklists), which measure clinical skills or other observable behaviours relative to a predetermined standard, have made this task much easier. While learning guides are used to facilitate learning the steps or tasks (and sequence, if necessary) in performing a particular skill or activity, checklist are used to evaluate performance of the skill or activity objectively.

Progress in Skill area
Progress in the skill area is measured with reference to various levels or stages of performance. The three levels of performance in acquiring a new skill are:

Skill Acquisition:
This represents the initial phase in learning a new clinical skill or activity. One or more practice sessions are needed for learning how to perform the required steps and the sequence (if necessary) in which they should be performed. Assistance and coaching are necessary to achieve correct performance of the skill or activity.

Skill Competency:
This represents an intermediate phase in learning a new clinical skill or activity. The participant can perform the required steps in the proper sequence (if necessary) but may not progress from step to step efficiently.

Skill proficiency:
This represents the final phase in learning a new clinical skill or activity. The participant efficiently and precisely performs the steps in the proper sequence (if necessary).

Advantages of competency-based skill assessment instruments
The single greatest advantage of a competency-based assessment is that it can be used to facilitate learning a wide variety of skills or activities and measure participant behaviour in a realistic job-related situation.

Competency-based assessment instruments such as learning guides:
- Focus on a skill that the participant typically would be expected to perform on the job, and
- Break down the skill or activity into the essential steps required to complete the procedure.
Using competency-based clinical training:
- Ensures that training is based on a standardized procedure
- Standardizes training materials and audiovisual aids
- Forms the basis of classroom or clinical demonstrations as well as participant practice sessions.

Limitations of competency-based skill assessment instruments:
- It will take time and energy first to develop the instruments/tools and then to apply them to each participant.
- An assessment can be applied only by a clinical trainer who is proficient in the clinical procedure or activity being learned.
- An adequate number of skilled clinical trainers must be available to conduct the training because competency-based clinical training usually requires a one-on-one relationship.

Using the Learning Guides
A learning guide contains the individual steps or tasks in sequence (if necessary) required for performing a skill or activity in a standardized way. Learning guides are designed to help the participant learn the correct steps and sequence in which they should be performed (skill acquisition), and measure progressive learning in small steps as the participant gains confidence and skill (skill competency). Learning guides can be used as a self or peer assessment tool.

Examples of how learning guides can be used at different stages of the course are given below.
- Initially, participants can use the learning guides to follow the steps as the clinical trainer role-plays counseling a client or demonstrates a clinical procedure using anatomic models.
- Subsequently, during the classroom sessions in which participants are paired, one “service provider” participant performs the procedure while the other participant uses the learning guide to prompt the “service provider” on each step.
- During these sessions, the clinical trainer(s) can circulate from group to group to monitor how learning is progressing and check to see that the participants are following the steps outlined in the learning guide.
- After participants become confident in performing the skill or activity (e.g. inserting an IUD in the pelvic model), they can use the learning guide to rate each other's performance. This exercise can serve as a point of discussion during a clinical conference before participants provide services to clients.
- Before the first clinic session, participants again are paired. Here, one “service provider” participant performs the procedure while the other observes and uses the learning guide to remind the “service provider” of any missed steps. During this session, the clinical trainer circulates, coaching the participants as necessary as they perform the procedure.

Note: The participant is not expected to perform all the steps or tasks correctly the first time s/he practices them.

Instead the learning guides are intended to:
- Assist the participant in learning the correct steps and sequence in which they should be
performed (skill acquisition).

- Measure progressive learning in small steps as the participant gains confidence and skill (skill competency).

Prior to using the Learning Guide for any clinical skills, the entire process of the activity will be reviewed with the participants by the trainer. The participants also observe the activity performed in the clinic with a client. Thus, by the time the group breaks up into pairs to begin practicing and rating each other’s performance, each participant should be familiar with the processes for the clinical skill. Used consistently, the learning guides enable each participant to chart her/his progress and to identify areas for improvement. For example, before the participant attempts the skill or activity (e.g. IUD insertion) for the first time, the trainer should briefly review the steps involved and discuss the expected outcome. In addition, immediately after the skill or activity has been completed the trainer should meet with the participant. The purpose of this meeting is to provide positive feedback regarding learning progress and to define the areas (knowledge, attitude or practice) where improvement is needed in subsequent practice sessions. Because the learning guides are used to assist in developing skills, it is important that the rating (scoring) be done carefully and as objectively as possible.

**Using Checklists**

The checklist generally is derived from a learning guide. Unlike the learning guides which are quite detailed, competency-based checklists should contain only sufficient detail to permit the clinical trainer to evaluate and record the overall performance of the skill or activity. If a checklist is too detailed, it can distract the clinical trainer from the primary purpose, which is to observe the overall performance of the participant objectively. Using;

**Checklists in competency-based clinical training:**

- Ensures that participants have mastered the clinical skills and activities, first with models and then with clients.
- Ensures that all participants will have their skills measured according to the same standard.
- Forms the basis for follow up observations and evaluations.

**Sample Learning Guides**

The samples being introduced in this Module are:

- Learning Guide for PPIUD Insertion and Removal Techniques
- Learning Guide for PPIUD Counseling Skills
- Learning Guide for Implant (Jadelle) Insertion Techniques
- Learning Guide for Implant (Implanon®) Insertion Techniques
- Learning Guide for Implant (Implanon NXT™) Insertion Techniques
- Learning Guide for Implant Removal Skills (All Implants)
Summary
Providing participants with good counseling and clinical skills is one of the central purposes of most family planning training courses. Each participant is expected to acquire the knowledge, attitudinal concepts and skills defined in the training course objectives. This is accomplished through the use of knowledge and skill assessments.
Being able to measure learning progress satisfactorily and evaluate performance objectively are extremely important elements in the process of improving the quality of clinical training. The use of well-designed, competency-based knowledge and skill assessment instruments can make mastering these skills easier.
Learning guides enable participants to chart their progress in learning new skills and by breaking the skill or activity down into its essential elements, to pinpoint areas for improvement. Finally, evaluating whether participants have acquired new skills can be accomplished using competency-based (performance) checklists. These checklists can be used to measure a wide variety of participant skills and behaviours in realistic job-related situations.

EVALUATION
• What are the terms associated with learning?
• What is a competency-based training?
• State three advantages of using the learning guide during training?
ANNEX A

PPIUD CLINICAL SKILLS CHECKLIST

A. Pre-discharge IUD Insertion Using Kelly placental forceps
B. Post-placental manual IUD Insertion
C. Post-placental IUD Insertion using Kelly Placental Forceps
PRE-DISCHARGE IUD INSERTION USING KELLY PLACENTAL FORCEPS

Place a tick (✓) in the case cell, if step/task is performed satisfactorily, a cross (×) if it is not performed satisfactorily, or N/O if not observed.

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

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<th>TASK</th>
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<td><strong>PRE-INSERTION TASK</strong></td>
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<td>1 Determines that client has been counseled</td>
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<td>2 Confirms that the woman's choice is the IUD</td>
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<td>3 Asks if she has any questions and is responsive to client's needs</td>
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<td>4 Describes exam and insertion procedure and what to expect</td>
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<td>A Medical and Reproductive Health History: Reviews client record or interviews client to verify that the pertinent information is recorded and to determine if woman is appropriate for postpartum IUD insertion</td>
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<td>B Obstetrical events related to present delivery: Reviews client record to verify that the pertinent information is recorded and to determine if woman is appropriate for postpartum IUD insertion</td>
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<td>C Physical Examination</td>
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<td>1 Wears HLD or sterile gloves as required throughout clinical procedure</td>
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<td>2 Palpates uterus to evaluate the contraction and size</td>
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<td>3 Provides adequate light</td>
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<td>4 Inspects external genitals, vaginal, and cervix, and using a retractor if necessary, checks for appropriate suture of injuries of any</td>
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<td>6</td>
<td>Tells client what is going to be done and encourages her to express any discomfort</td>
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<td>7</td>
<td>Places a sterile drape over the woman's abdomen</td>
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<td>8</td>
<td>Cleans the external genital area</td>
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<td>9</td>
<td>Gently inserts a Graves speculum</td>
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<td>10</td>
<td>Prepares cervix and vaginal with liberal application of antiseptic solution</td>
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<td>11</td>
<td>Gently grasps the anterior lip of the cervix with a sterile ring forceps</td>
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<tr>
<td>12</td>
<td>Grasps IUD with sterile Kelly placental forceps</td>
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<td>13</td>
<td>Grasps ring forceps on the cervix and holds the cervix in view while introducing the Kelly placental forceps using a &quot;non-touch&quot; technique</td>
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<td>14</td>
<td>Continuing with a &quot;non-touch&quot; technique, gently inserts the Kelly forceps with the IUD through the cervix and into the uterine cavity</td>
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<td>15</td>
<td>Gently releases the hand that is holding the cervix with the ring forceps and moves it to the abdomen</td>
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<td>16</td>
<td>With free hand, stabilizes the IUD in an upward motion towards the umbilicus</td>
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<td>17</td>
<td>Moves the Kelly's forceps with the IUD in an upward motion towards the umbilicus</td>
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<td>18</td>
<td>If the woman has delivered vaginally after a previous C-section, takes care to avoid placing the IUD through any defect in the previous incision</td>
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<td>19</td>
<td>By feeling the fundus at the tip of the Kelly forceps, verifies the correct position of IUD at the funds</td>
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<td>20</td>
<td>Releases the IUD from the Kelly forceps</td>
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<td>21</td>
<td>Slowly removes the Kelly forceps from the uterine cavity</td>
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<td>22</td>
<td>Examines cervix; if strings can be seen, removes and reinserts the IUD</td>
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<td>23</td>
<td>Removes the ring forceps from the anterior lip of the cervix and</td>
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removes the Graves speculum

**POST-INSERTION TASKS**

24 Places used instruments in 0.5% chlorine solution for 10 mins for decontamination

25 Appropriately disposes of waste materials (used gauze, cotton, single-use gloves)

26 Removes reusable gloves and places them in 0.5% chlorine solution

27 Washes hands with soap and water and dries with clean, dry cloth

28 Completes IUD card for client and all necessary information in client record

**POST-INSERTION COUNSELING** (to be done prior to discharge)

29 Teaches client how and when to check for strings

31 Reminds client of the warning signs of complications

32 Reviews information that the IUD does not provide protection against STIs

33 Discusses what to do if client experiences any side effects, complications, or other problems related to her IUD

34 Provides follow-up visit instructions and appointments

35 Remind client of 10-years effective life of Copper T380A IUD

36 Assures client she can return at any time to receive advice, medical attention, and, if desired, to have IUD removed.

37 Has client repeat the instructions

**Unsatisfactory**: Does not perform the step or task according to written procedure or guidelines or requires assistance from trainer. **Not observed**: Step or Task not performed by participant during evaluation by trainer.

Name of Participant: ________________________  Dates of Training: __________
POST PLACENTAL MANUAL IUD INSERTION

Place a tick (√) in the case cell, if step/task is performed satisfactorily, a cross (X) if it is not performed satisfactorily, or N/O if not observed.

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

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<td>2. Confirms that the woman's choice is the IUD</td>
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<td>A. Medical and Reproductive Health History: Reviews client record or</td>
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<td>Interviews client to verify that the pertinent information is</td>
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<td>recorded and to determine if woman is appropriate for</td>
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<td>B. Obstetrical events related to present delivery: Reviews client</td>
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<td>record to verify that the pertinent information is recorded</td>
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<td>and to determine if woman is appropriate for postpartum IUD</td>
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<td>C. Physical Examination</td>
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<td>2. Inspects placenta to make certain there are no missing</td>
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<td>Inspects external genitals, checks for tears</td>
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<td>6</td>
<td>Visualizes cervix and vagina, using retractor if necessary; checks for cervical or vaginal tears</td>
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<td>7</td>
<td>If the woman has delivered vaginally after a previous Caesarean section, manually palpates the previous incision to identify any defects that might be present</td>
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<td><strong>INSERTION PROCEDURE</strong></td>
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<td>Tells client what is going to be done and encourages her to express any discomfort</td>
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<td>9</td>
<td>Place a sterile drape over the woman's abdomen</td>
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<td>10</td>
<td>Cleans the external genital area, preps cervix and vaginal with liberal application of antiseptic solution</td>
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<td>11</td>
<td>Gently grasps the anterior lip of the cervix with a sterile ring forceps</td>
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<td>12</td>
<td>Holding the IUD by gripping the vertical rod between the index and middle fingers, inserts it through the cervix and into the uterine cavity</td>
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<tr>
<td>13</td>
<td>Gently releases the hand that is holding the cervix with the ring forceps and moves it to the abdomen</td>
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<td>14</td>
<td>With free hand, stabilizes the uterine fundus by grasping uterus through abdominal wall</td>
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<td>15</td>
<td>Moves the hand holding the IUD in an upward motion towards the umbilicus reinserts the IUD. -13.</td>
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<td>16</td>
<td>By palpation with the tip of the fingers holding the IUD, verifies the correct position of the IUD at the fundus</td>
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<td>17</td>
<td>Releases the IUD from the fingers</td>
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<td>18</td>
<td>Slowly removes the hand from the uterine</td>
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<td>Examine cervix; if strings can be seen, removes and reinserts the IUD</td>
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<tr>
<td>20</td>
<td>Removes the ring forceps from the anterior lip of the cervix</td>
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**POST-INSERTION TASKS**

<table>
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<tr>
<th></th>
<th>Places used instruments in 0.5% chlorine solution for 10 mins for decontamination</th>
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<tr>
<td>21</td>
<td>Appropriately disposes of waste materials (used gauze, cotton, single-use gloves)</td>
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<td>22</td>
<td>Removes reusable gloves and places them in 0.5% chlorine solution</td>
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<tr>
<td>23</td>
<td>Washes hands with soap and water and dries with clean, dry cloth</td>
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<td>24</td>
<td>Completes IUD card for client and all necessary information in client record</td>
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**POST-INSERTION COUNSELING**

(to be done prior to discharge)

<table>
<thead>
<tr>
<th></th>
<th>Teaches client how and when to check for strings</th>
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<tr>
<td>26</td>
<td>Reminds client of the warning signs of complications</td>
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<td>27</td>
<td>Reviews information that the IUD does not provide protection against STIs</td>
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<td>28</td>
<td>Discusses what to do if client experiences any side effects, complications, or other problems related to her IUD</td>
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<tr>
<td>29</td>
<td>Provides follow-up visit instructions and appointments</td>
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<tr>
<td>30</td>
<td>Reminds client of 10-year effective life of Copper T380A IUD</td>
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<tr>
<td>31</td>
<td>Assures client she can return at any time to receive advice, medical attention, and, if desired, to have IUD removed</td>
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<tr>
<td>32</td>
<td>Has client repeat the instructions</td>
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</table>
### C. POST PLACENTAL FORCEPS IUD INSERTION

Place a tick (✓) in the case cell, if step/task is performed satisfactorily, a cross (X) if it is not performed satisfactorily, or N/O if not observed.

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**Not observed:** Step or Task not performed by participant during evaluation by trainer.

Name of Participant: ________________________  Dates of Training: ______________

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<tr>
<th>TASK</th>
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#### PRE DISCHARGE IUD INSERTION USING KELLY PLACENTAL FORCEPS

#### PRE INSERTION TASK

1. Determines whether client has been counseled during antenatal period
2. Confirms that the woman's choice is the IUD
3. Asks if she has any questions and is responsive to client's needs
4. Describes insertion procedure and what to expect

#### CLIENT ASSESSMENT TASK

A. Reproductive Health History: Reviews client record or interviews client to verify that the pertinent information is recorded and to determine if woman is appropriate for postpartum IUD insertion
B. Obstetrical events related to present delivery: Reviews client record to verify that the pertinent information is recorded and to determine if woman is appropriate for postpartum IUD insertion
C. Physical Examination
1. Wear HLD or sterile gloves as required throughout clinical
1. **procedure**

2. <br>Inspects placenta to make certain there are no missing cotyledons and that membranes have been totally recovered the anterior lip of the cervix

3. <br>Palpates uterus to stimulate corpus to contract and to confirm the size. Removes the second ring forceps from

4. <br>Provides adequate light seen, removes and reinserts the IUD

5. <br>Inspects external genitals, checks for tears

6. <br>Visualizes cervix and vagina, using retractor if necessary; checks for cervical or vaginal tears

7. <br>If the woman has delivered vaginally after a previous C-section, manually palpates the previous incision to identify any defects that might be present

**INSERTION PROCEDURE**

8. <br>Tells client what is going to be done and encourages her to express any discomfort

9. <br>Place a sterile drape over the woman's abdomen

10. <br>Cleans the external genital area, preps cervix and vaginal with liberal application of antiseptic solution

11. <br>Grasps IUD with sterile of HLD forceps (ring or Kelly placental)

12. <br>Gently grasps the anterior lip of the cervix with a second sterile ring forceps

13. <br>Using a "no touch' technique, gently inserts the forceps holding or HLD through the cervix and into the uterine cavity 10. By feeling the fundus at the tip of the

14. <br>Gently releases the hand that is holding the cervix with the ring forceps and moves it to the abdomen

15. <br>With free hand, stabilizes uterine fundus by grasping uterus
through abdominal wall

16 Moves the forceps with the IUD in an upward motion towards the umbilicus

17 By feeling the fundus at the tip of the forceps, verifies the correct position of IUD at the fundus

18 Releases the IUD from the forceps

19 Slowly removes the forceps from the uterine cavity

20 Examines cervix; if strings can be seen, removes and reinserts the IUD

21 Removes the second ring forceps from the anterior lip of the cervix

**POST-INSERTION TASKS**

22 Places used instruments in 0.5% chlorine solution for 10 mins for decontamination

23 Appropriately disposes of waste materials (used gauze, cotton, single-use gloves)

24 Removes reusable gloves and places them in 0.5% chlorine solution

25 Washes hands with soap and water and dries with clean, dry cloth

26 Completes IUD card for client and all necessary information in client record

**POST-INSERTION COUNSELING**

(to be done prior to discharge)

27 Teaches client how and when to check for strings client repeat the instructions

28 Reminds client of the warning signs of complications

29 Reviews information that the IUD does not provide protection against STIs desired, to have IUD removed
30 Discusses what to do if client experiences any side effects, complications, or other problems related to her IUD

31 Provides follow-up visit instructions and appointments

32 Reminds client of 10-year effective life of Copper T380A IUD

33 Assures client she can return at any time to receive advice, medical attention and if desired to have IUD removed

34 Has client repeat the instructions

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**CLINICAL SKILLS CHECKLIST FOR IMPLANTS INSERTION TECHNIQUES**

**Learning Guide for Implant (Jadelle) Insertion Techniques**

Rate the performance of each step or task observed using the following rating scale:

- **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
- **Competently performed:** Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently
- **Proficiently performed:** Step or task efficiently and precisely performed in the proper sequence (if necessary)

<table>
<thead>
<tr>
<th>Task/Activity</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>PRE-INSERTION COUNSELING</strong></td>
<td>1   2   3   4   5</td>
</tr>
<tr>
<td>1 Greets woman respectfully and with kindness</td>
<td></td>
</tr>
<tr>
<td>2 Asks woman about her reproductive goals</td>
<td></td>
</tr>
<tr>
<td>3 If Jadelle Counseling has not been done, arranges for counseling prior to performing the procedure</td>
<td></td>
</tr>
<tr>
<td>4 Determines that the woman’s contraceptive choice is Jadelle</td>
<td></td>
</tr>
<tr>
<td>5 Reviews Client Screening Checklist to determine if the woman is an appropriate candidate for Jadelle</td>
<td></td>
</tr>
<tr>
<td>6 Performs (or refers for) further evaluation, if indicated</td>
<td></td>
</tr>
<tr>
<td>7 Assesses woman’s knowledge about Jadelle ’s major side effects</td>
<td></td>
</tr>
<tr>
<td>8 Responds to client ’s needs and concerns about Jadelle</td>
<td></td>
</tr>
<tr>
<td>9 Describes insertion process and what to expect</td>
<td></td>
</tr>
<tr>
<td><strong>INSERTION OF JADELLE</strong></td>
<td></td>
</tr>
<tr>
<td>10 Ensures that client has thoroughly washed her arm with soap and water</td>
<td></td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td>11</td>
<td>Selects and positions woman’s arm correctly</td>
</tr>
<tr>
<td>12</td>
<td>Determines the correct area on arm for insertion</td>
</tr>
<tr>
<td>13</td>
<td>Determines that required sterile or high level disinfected (HLD) instruments and the 2 Jadelle capsules are present</td>
</tr>
<tr>
<td></td>
<td><strong>PRE INSERTION TASKS</strong></td>
</tr>
<tr>
<td>14</td>
<td>Washes hands with soap and water</td>
</tr>
<tr>
<td>15</td>
<td>Puts on sterile gloves</td>
</tr>
<tr>
<td>16</td>
<td>Correctly prepares insertion site with antiseptic solution</td>
</tr>
<tr>
<td>17</td>
<td>Places sterile or drape over arm</td>
</tr>
<tr>
<td>18</td>
<td>Injects local anaesthesia just under skin; raises a small wheal</td>
</tr>
<tr>
<td>19</td>
<td>Advances needle to its hub and inject about 1 ml of local anaesthetic in each of 2 subdermal tracks (check for anaesthetic effect)</td>
</tr>
<tr>
<td></td>
<td><strong>INSERTING JADELLE CAPSULES</strong></td>
</tr>
<tr>
<td>20</td>
<td>Inserts trocar directly subdermally at an angle of 45°</td>
</tr>
<tr>
<td>21</td>
<td>While tenting the skin, advances trocar and plunger to mark (1) near hub of trocar</td>
</tr>
<tr>
<td>22</td>
<td>Removes plunger and load the first capsule into trocar (with gloved hand or forceps)</td>
</tr>
<tr>
<td>23</td>
<td>Reinserts plunger and advance it until resistance is felt.</td>
</tr>
<tr>
<td>24</td>
<td>Holds plunger firmly in place with one hand and slides trocar out of incision until it reaches plunger handle</td>
</tr>
<tr>
<td>25</td>
<td>Withdraws trocar and plunger together until mark (2) near trocar tip just clears the insertion wound (does not remove trocar from skin)</td>
</tr>
<tr>
<td>26</td>
<td>With finger holding previously-placed capsule, guides insertion of trocar and plunger to mark (1)</td>
</tr>
<tr>
<td>27</td>
<td>Withdraws trocar only after insertion of second capsule</td>
</tr>
<tr>
<td>28</td>
<td>Palpates capsule to check that the two capsules have been inserted in a fan distribution (20° apart)</td>
</tr>
<tr>
<td>29</td>
<td>Palpates puncture site to check that two capsules are well clear of puncture site</td>
</tr>
<tr>
<td></td>
<td><strong>POST- INSERTION TASKS</strong></td>
</tr>
<tr>
<td>30</td>
<td>Close the puncture wound with gauze, band aid or plaster after applying slight iodine solution to the gauze dressing</td>
</tr>
<tr>
<td>31</td>
<td>Applies pressure dressing snugly</td>
</tr>
<tr>
<td>32</td>
<td>Properly disposes of waste materials</td>
</tr>
<tr>
<td>33</td>
<td>Removes reusable gloves correctly and immerse them in chlorine solution</td>
</tr>
<tr>
<td>34</td>
<td>Washes hands with soap and water</td>
</tr>
<tr>
<td></td>
<td><strong>POST-INSERTION COUNSELING</strong></td>
</tr>
<tr>
<td>35</td>
<td>Draws the location of capsules in clients record and notes anything unusual</td>
</tr>
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<td></td>
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</tr>
<tr>
<td>36</td>
<td>Instructs the client regarding wound care and return visit</td>
</tr>
<tr>
<td>37</td>
<td>Assures the client that she can have capsules removed at any time if she desired</td>
</tr>
</tbody>
</table>
LEARNING GUIDE FOR IMPLANT (IMPLANON®) INSERTION TECHNIQUES

Rate the performance of each step or task observed using the following rating scale:

**Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

**Competently performed**: Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently

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<td>1</td>
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</tr>
<tr>
<td>1. Greet the client respectfully and with kindness</td>
<td></td>
</tr>
<tr>
<td>2. Ask the client about her reproductive goals</td>
<td></td>
</tr>
<tr>
<td>3. If Implanon® Counseling not done, arranges for counseling prior to performing procedure</td>
<td></td>
</tr>
<tr>
<td>4. Determines that the client’s contraceptive choice is Implanon®</td>
<td></td>
</tr>
<tr>
<td>5. Reviews the Client Screening Checklist to determine if she is an appropriate candidate for Implanon®</td>
<td></td>
</tr>
<tr>
<td>6. Performs (or refers for) further evaluation, if indicated</td>
<td></td>
</tr>
<tr>
<td>7. Assesses the client’s knowledge about Implanon® major side effects</td>
<td></td>
</tr>
<tr>
<td>8. Responds to the client’s needs and concerns about Implanon®</td>
<td></td>
</tr>
<tr>
<td>9. Describes the insertion procedure and what to expect</td>
<td></td>
</tr>
<tr>
<td><strong>GETTING READY</strong></td>
<td></td>
</tr>
<tr>
<td>10. Checks to be sure client has thoroughly washed her arm with soap and water</td>
<td></td>
</tr>
<tr>
<td>11. Selects and positions woman’s arm correctly</td>
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</tr>
<tr>
<td>12. Marks correct area on arm for insertion</td>
<td></td>
</tr>
<tr>
<td>13. Determines that required sterile or high level disinfected (HLD) instruments and Implanon® applicator</td>
<td></td>
</tr>
<tr>
<td><strong>PRE-INSERTION TASKS</strong></td>
<td></td>
</tr>
<tr>
<td>14. Washes hands with soap and water</td>
<td></td>
</tr>
<tr>
<td>15. Puts on sterile or gloves</td>
<td></td>
</tr>
<tr>
<td>16. Correctly cleans the removal site with antiseptic solution</td>
<td></td>
</tr>
<tr>
<td>17. Places sterile drape over arm</td>
<td></td>
</tr>
<tr>
<td>18. Injects local anaesthesia just under skin; raises a small wheal</td>
<td></td>
</tr>
<tr>
<td>19. Advances needle to its hub injects about 2 ml of local anaesthetic along insertion or removal</td>
<td></td>
</tr>
<tr>
<td><strong>INSERTING IMPLANON® CAPSULES</strong></td>
<td></td>
</tr>
<tr>
<td>20. Stretches skin at insertion site with thumb and index finger and inserts tip of needle angled at 20°</td>
<td></td>
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<tr>
<td></td>
<td>Description</td>
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<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>21.</td>
<td>Advances needle to its full length while lifting the skin</td>
</tr>
<tr>
<td>22.</td>
<td>Breaks the seal of applicator and turns the obturator to 90°</td>
</tr>
<tr>
<td>23.</td>
<td>Fixes the obturator with one hand against the arm and retracts the cannula out of arm</td>
</tr>
<tr>
<td>24.</td>
<td>Checks the needle for absence of the Implant</td>
</tr>
<tr>
<td>25.</td>
<td>Palpates to verify presence of implant</td>
</tr>
<tr>
<td>26.</td>
<td>Applies sterile gauze with a pressure bandage</td>
</tr>
<tr>
<td>27.</td>
<td>Fills out user card and hands it to client</td>
</tr>
<tr>
<td>28.</td>
<td>Draws position of implant in client record</td>
</tr>
<tr>
<td>29.</td>
<td>Drops applicator in sharps disposal container</td>
</tr>
<tr>
<td>30.</td>
<td>Instructs client regarding wound care and return visit</td>
</tr>
<tr>
<td>31.</td>
<td>Assures client that she can have the capsule removed at any time if she desires</td>
</tr>
<tr>
<td>32.</td>
<td>Observes client for at least 5 mins before sending home</td>
</tr>
</tbody>
</table>
LEARNING GUIDE FOR IMPLANT (IMPLANON NXT™) INSERTION TECHNIQUES

Rate the performance of each step or task observed using the following rating scale:

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</tr>
<tr>
<td>Task/Activity</td>
<td>Case Count</td>
</tr>
<tr>
<td>1. Greets the client respectfully and with kindness</td>
<td></td>
</tr>
<tr>
<td>2. Asks the client about her reproductive goals</td>
<td></td>
</tr>
<tr>
<td>3. If Implanon NXT™ Counseling not done, arranges for counseling prior to performing procedure</td>
<td></td>
</tr>
<tr>
<td>4. Determines that the client’s contraceptive choice is Implanon NXT™</td>
<td></td>
</tr>
<tr>
<td>5. Reviews the Client Screening Checklist to determine if she is an appropriate candidate for Implanon NXT™</td>
<td></td>
</tr>
<tr>
<td>6. Performs (or refers for) further EVALUATION, if indicated</td>
<td></td>
</tr>
<tr>
<td>7. Assesses the client’s knowledge about Implanon NXT™ major side effects</td>
<td></td>
</tr>
<tr>
<td>8. Responds to the client’s needs and concerns about Implanon NXT™</td>
<td></td>
</tr>
<tr>
<td>9. Describes the insertion procedure and what to expect</td>
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<tr>
<td><strong>GETTING READY</strong></td>
<td></td>
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<td>10. Checks to be sure client has thoroughly washed her arm with soap and water</td>
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<tr>
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</tr>
<tr>
<td>12. Marks correct area on arm for insertion</td>
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</tbody>
</table>
Determines that required sterile or high level disinfected (HLD) instruments and Implanon NXT™ applicator

### PRE-INSERTION TASKS

<table>
<thead>
<tr>
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<th>2</th>
<th>3</th>
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<th>5</th>
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</thead>
<tbody>
<tr>
<td>Washes hands with soap and water</td>
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<td></td>
<td></td>
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<tr>
<td>Puts on sterile or gloves</td>
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<tr>
<td>Correctly cleans the removal site with antiseptic solution</td>
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<tr>
<td>Places sterile drape over arm</td>
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<td>Injects local anaesthesia just under skin; raises a small wheal</td>
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<td>Advances needle to its hub injects about 2 ml of local anaesthetic along insertion or removal</td>
<td></td>
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### INSERTING IMPLANON NXT™ CAPSULES

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Remove the sterile preloaded disposable applicator for IMPLANON NXT™ carrying the implant from its blister.</td>
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<td></td>
</tr>
<tr>
<td>Hold the applicator just above the needle at the textured surface area and remove the transparent protection cap from the needle which contains the implant</td>
<td></td>
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</tr>
<tr>
<td>If the cap does not come off easily, the applicator should not be used. You may see the white-colored implant by looking into the tip of the needle</td>
<td></td>
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</tr>
<tr>
<td>With free hand, stretch the skin around the insertion site with thumb and index finger. Puncture the skin with the tip of the needle angled about 30°</td>
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</tr>
<tr>
<td>Lower the applicator to a horizontal position. While lifting the skin with the tip of the needle, slides the needle to its full length. You may feel slight resistance but do not exert excessive force.</td>
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</tr>
<tr>
<td>While keeping the applicator in the same position and the needle inserted to its full length, unlock the purple slider by pushing it slightly down. Move the slider fully back until it stops, leaving the implant now in its final subdermal position and locking the needle inside the body of the applicator.</td>
<td></td>
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<tr>
<td>Verify the presence of the implant in the woman’s arm immediately after insertion by palpation. By palpating both</td>
<td></td>
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</tr>
</tbody>
</table>
ends of the implant, you should be able to confirm the presence of the 4 cm rod

27  Apply a small adhesive bandage over the insertion site.

28  Request that the woman palpate the implant.

29  Palpate to verify presence of implant

**POST-INSERTION TASKS**

30  Applies sterile gauze with a pressure bandage

31  Fills out user card and hands it to client

32  Draws position of implant in client record

33  Drops applicator in sharps disposal container

**POST-INSERTION COUNSELING**

34  Instructs client regarding wound care and return visit

35  Assures client that she can have the capsule removed at any time if she desires

36  Observes client for at least 5 mins before sending home
LEARNING GUIDE FOR IMPLANT REMOVAL TECHNIQUES (ALL IMPLANTS)
Rate the performance of each step or task observed using the following rating scale:
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</tr>
<tr>
<td>1</td>
<td>Greet woman respectfully and with kindness</td>
</tr>
<tr>
<td>2</td>
<td>Ask client her reasons for removal and answer any Questions</td>
</tr>
<tr>
<td>3</td>
<td>Review client’s present reproductive goals</td>
</tr>
<tr>
<td>4</td>
<td>Describe the removal procedure and what to expect</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>REMOVAL OF IMPLANT CAPSULES</th>
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<tr>
<th>GETTING READY</th>
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<tr>
<td>6</td>
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<tr>
<td>9</td>
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<tr>
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<table>
<thead>
<tr>
<th>REMOVAL OF IMPLANT CAPSULES (STANDARD METHOD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tasks/Activity</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
</tbody>
</table>
1. Grasp end of capsule with small forceps

2. If necessary, open fibrous sheath with scalpel and remove capsules

3. Inject more anaesthetic if required

### DIFFICULT REMOVALS

<table>
<thead>
<tr>
<th>Tasks/Activity</th>
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</tr>
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<tbody>
<tr>
<td>1. If capsules are not close to incision, grasp distant capsule with tips of curved forceps and properly rotate (flips and/or twists) forceps to expose capsules</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Clean fibrous sheaths from implant with scalpel blade, gauze or forceps tip</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. Grasp exposed capsule with second forceps and removes it</td>
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### REMOVING CAPSULES (POP-OUT METHOD)

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</tr>
</thead>
<tbody>
<tr>
<td>1. Push on proximal end of capsules (nearest the shoulder) to cause distal tip (nearest the elbow) to protrude (push up skin)</td>
<td></td>
<td></td>
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<tr>
<td>2. Open fibrous sheaths over tip with scalpel if needed through the incision.</td>
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<tr>
<td>3. Gently squeeze tip into the incision and “pops out” capsule</td>
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<tr>
<td>4. After removal of all the capsules, count again to be sure six complete capsules have been removed and show them to the client</td>
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### REMOVING CAPSULES ("U" TECHNIQUE METHOD)

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</thead>
<tbody>
<tr>
<td>1. Make a vertical 4 mm incision about 5 mm from the disposal end of the rods between the two implant (or one in case of Implanon®) capsules</td>
<td></td>
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<tr>
<td>2. Insert the implant holding forceps through the incision</td>
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<tr>
<td>3. Stabilize the closest rod with index finger</td>
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<tr>
<td>4. Grasp the rod and pulls towards incision</td>
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</tr>
<tr>
<td>5. Clean off fibrous sheath with gauze or scalpel</td>
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</tr>
<tr>
<td>6. Remove the rod with Crile/Mosquito forceps</td>
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### POST-REMOVALS TASKS
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<tbody>
<tr>
<td>3 1 Bring the edges of incision together and place a gauze slightly soaked with iodide on top of it</td>
<td></td>
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<tr>
<td>3 2 Close it with a butterfly bandage, band aid or surgical tape</td>
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<tr>
<td>3 3 Place all instruments in chlorine solution for decontamination</td>
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<td>3 4 Properly dispose of wastes materials</td>
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<tr>
<td>3 5 Wash hands with soap and water</td>
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</table>

**POST-REMOVALS COUNSELING**

<table>
<thead>
<tr>
<th>Tasks/Activity</th>
<th>1</th>
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</thead>
<tbody>
<tr>
<td>3 6 Instruct the client regarding wound care and return visit</td>
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<td>3 7 Discuss what to do if any problems</td>
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<td>3 8 Counsel the client regarding new contraceptive method, if desired</td>
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<tr>
<td>3 9 Assist the client in obtaining new contraceptive method or provide temporary (barrier) method until method of choice can be started</td>
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<tr>
<td>4 0 Observe client for at least five mins before sending home</td>
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</table>
# MODULE ELEVEN: SUPERVISED CLINICAL PRACTICE

## MODULE PLAN

<table>
<thead>
<tr>
<th>SESSION</th>
<th>DURATION</th>
<th>OBJECTIVES</th>
<th>METHODS</th>
<th>RESOURCES</th>
</tr>
</thead>
</table>
| Clinical Practicum    | 6 hours  | • Explain the rationale for the use of models during IUD and implant training  
• Discuss the “Client's Rights” during clinical training  
• List the guidelines for clinical observation and practice and decorum in the clinical area  
• Mention “Infection Prevention Reminders”  
• Discuss the guidelines for the daily Post-practice sessions  
• List the guidelines for completing the “Clinical Procedures Record Sheet” | • Illustrated lecture  
• Discussion  
• Brainstorming | • Flip Chart Stand/Paper  
• Markers  
• LCD projector  
• Laptop |
MODULE ELEVEN:
SUPERVISED CLINICAL PRACTICE

Time: 6 hours

LEARNING OBJECTIVES

By the end of this session, participants should be able to:

• Explain the rationale for the use of models during IUD and implant training
• Discuss the “Client's Rights” during clinical training
• List the guidelines for clinical observation and practice and decorum in the clinical area
• Mention “Infection Prevention Reminders”
• Discuss the guidelines for the daily Post-practice sessions
• List the guidelines for completing the “Clinical Procedures Record Sheet”

SESSION OVERVIEW:

• Rationale for the use of models during IUD and Implant training
• “Client's Rights” during clinical training
• Guidelines for clinical observation and practice, and decorum in the clinical area
• “Infection Prevention Reminders”
• Guidelines for the daily Post-practice sessions
• Guidelines for completing the “Clinical Procedures Record Sheet”

METHODS

• Illustrated lecture
• Discussion
• Brainstorming

MATERIALS

• Flip Chart and Stand
• Markers
• LCD Projector/ Laptop
• Pelvic training models (Zoe, Mama U)
• Arm Models

SUMMARY

EVALUATION
This module includes guidance on the clinical practice for this training programme. Most of the participants' time will be spent on clinical practice. Since this is a competency-based course, the participants will practice IUD and implant insertion and removal skills on models first, observe these same procedures on clients and then perform them under supervision on clients.

Practice on Pelvic and Arm Models

A major component of humanistic training is the use of anatomic models, which simulates the human body, and other learning aids such as slide sets and videotapes. The effective use of models:

- Facilitates learning,
- Shortens training time, and
- Helps participants to correct mistakes in technique that could hurt the client.

Before a participant attempts a clinical procedure with a client, two learning activities should occur:

- The clinical trainer should demonstrate the required skills and client interactions several times using an anatomic model and appropriate audiovisual aids (e.g. slide sets or videotapes).
- While being supervised, the participant should practice the required skills and client interactions using the model and actual instruments in a simulated setting which is as similar as possible to the real situation.

The participants will practice using the Learning Guides for Clinical Skills in IUD and Implant Insertion and Removal Techniques on models; the trainer(s) will evaluate each participant's performance using the Observation Checklist. Once the participant passes the assessment on the model, she/he will be allowed to practice on clients. The final skills evaluation will be done while the participant is performing IUD and Implant Insertion and Removal Techniques on clients. The participants must be supervised by the trainers at all times during the clinical practice. The number of procedures each participant must perform on models or clients before achieving competency will vary according to the participant's skill and experience. Only when skill competency and some degree of skill proficiency have been demonstrated with models, however, should participants have their first contacts with clients.

Client's Rights during clinical training

Client safety and client satisfaction are the goals of this training in long-acting contraceptive services. Therefore, the client's rights of privacy and confidentiality are a part of clinical training. The client's permission must be obtained before any participant observer assists with or performs any services. The client should understand that she has the right to refuse care from a participant (provider-in-training) without loss or postponement of services. If the client should refuse
participant assisted or performed services, the trainer or other staff members should perform the procedure. Clients who consent to participate in training should be informed in advance that they will receive care from a trainee under the direct supervision of a qualified trainer. The client should be informed about the role of each individual inside the service area, e.g., supervisors, trainers, participants, service providers. When conducting counseling, performing a physical examination or giving services, an environment that protects the client's bodily privacy and confidentiality of speech must be created and maintained. Communication between the participant and the trainer during feedback encounters or coaching must be discreet. Corrective feedback should be limited to situations that could harm or cause discomfort to the client. The client's right to confidentiality must be protected. This may be challenging to maintain strictly during training situations when specific cases are used in learning exercises. However, such discussion should take place in private areas out of hearing of other staff and clients; no reference should be made to any client by her name. Hallways, corridors, waiting areas, and other public areas are not appropriate places for discussions of clients.

Guidelines for clinical observation and practice
The most important concerns during clinical observation/practice are ensuring the client's comfort and providing a safe, effective procedure. Therefore:

- The operating clinician (whether a trainer or a participant) should give a running commentary to the other participants throughout the procedure.
- If a participant performing a procedure wants the trainer to take over the procedure, he or she should make a straightforward request such as "I need help" or "Please, show me again how to do this".
- If a participant notices a complication that is unobserved by the operator, he or she has a responsibility to report the situation immediately to the trainer. This should be done in a way that does not alarm the client.
- If a complication arises during any procedure, the trainer is responsible for managing the situation and will complete the procedure.
- If the trainer wants to take the procedure from a participant, he or she will say something like "Let me help you with this step" or "Perhaps, I can show you an easier or better way to do this" or "The client is uncomfortable, so I'll finish. You can watch and do the next case.
- The participants who are observing the procedure should not interfere with the work of the participant conducting the procedure.
- The participants who are observing should hold all questions and comments until after the procedure is completed and until they are not in the presence of the client.
- The participant performing the procedure should answer the client's questions. If the client becomes impatient, angry, anxious, or restless during the procedure and if the participant is unable to reassure her, the trainer should take over the procedure.
- If complications arise during the procedure, the trainer must be in charge. The trainer may choose to permit a participant to manage the complication, as a learning experience, but only under supervision.
• If a participant notices a problem or a break in sterile technique that was unobserved by the trainer, that participant is responsible for reporting the situation to the trainer immediately in a way that does not alarm the client.

Client-Provider Interaction Highlights

• When performing an IUD or implant insertion and removal procedures, it is important to remember the principles of effective client-provider interaction. Clients will be awake and will be concerned about the procedure and the amount of pain they may feel. By using gentle techniques, providers can avoid giving women more pain.
• The provider can do several things to minimize the client’s tension and maximize her comfort, which will contribute to the safe and efficient performance of the procedure.
• Some clients like to be informed of each step of the procedure, while others prefer to be distracted. Soothing music or discussion of a topic of interest to the client might help. Some providers have placed a picture on the ceiling for the client to focus on. Ask the client what will help her to relax.
• Inform the client that she might feel some discomfort. Request that she tells you if she feels any discomfort or pain.
• Before, during, and after the procedure, be aware of the client's need for privacy and her concerns about modesty.

Infection Prevention Highlights during IUD and Implant Insertion and Removal procedures

Before the procedure:
• Insertion and removal of IUD or implants can be performed in an examination room or a special room. Wash hands thoroughly between clients, before putting gloves on.

During the procedure:
• Use instruments, gloves, and drapes that have been sterilized or high-level disinfected.
• Maintain asepsis.

After the procedure:
• While still wearing gloves, dispose of contaminated wastes (gauze, cotton, and other waste items) in a covered, leak-proof container of plastic bag.
• Ensure that instruments and reusable items are decontaminated in a 0.5% chlorine solution for 10 mins immediately after use, while they are still in the procedure room.
• Ensure that the examination table, instrument stands, and other surfaces contaminated during the procedure are decontaminated by wiping with a cloth soaked in a 0.5% chlorine solution. If organic material remains after decontamination, wash with detergent and water.
• Decontamination and cleaning of the examination tables and couches between clients is important.
• Wash hands after removing gloves.
Clinical Observation
All participants will have the opportunity to observe procedures performed by the trainer and by other participants during the training programme. In addition to insertion and removal techniques, you will also observe, whenever possible, pre-procedure activities (such as client assessment) and post-procedure activities (such as giving instructions to the client). The goal is for you to have a comprehensive understanding of all the service-delivery steps.
During observation of cases, participants should follow along with the IUD or implant Clinical Skills Learning Guides as they observe. In addition to watching for the steps of insertion and or removal, also observe how the provider interacts with the client and what the provider does in terms of infection prevention practices.

Supervised Clinical Practice
Once the participants' skills have been evaluated as satisfactory on the models, they may insert IUDs or implant under the trainer's supervision. The participants should not perform an insertion on a client until the trainer has evaluated their skills on the model using the appropriate Implant Clinical Skills Learning Guide.

The following tips may help a participant with clinical practice:

- Depending on his/her prior clinical experience, a participant may begin by observing an IUD or implant insertion, assisting the trainer in performing an insertion, or performing an insertion with the trainer's guidance
- The participant must exercise patience. The participant should realise that s/he is learning a new technique, and it will take repetitive performance on the model and on clients before s/he feels comfortable with the technique
- The participant should start with model practice and continue model practice during the early portion of his/her training to help fine-tune the skills and help him/her correct problems he/she is having in clinical practice
- During clinical training, the trainer is present to provide the participant with support and guidance. He/she should ask questions and seek help if needed, being careful not to cause the client any extra concern
- After each practice session, all participants will have time to review and discuss the cases with the trainers and other observers. The trainer will provide the participants with coaching as needed during this post-practice session
- When you and the trainer determine that a participant is ready, the trainer will evaluate his/her performance using the appropriate IUD or implant Clinical Skills Checklists

Guidelines for conducting Post-practice Sessions
- At the post-practice meeting the trainers will provide an opportunity for self-assessment in relation to the focus for the day.
- The participants may use the Learning Guide to assess their own performance.
• The trainers will use the post-practice meeting to give feedback to the entire group, and to jointly develop problem-solving approaches for skills difficulties.

During the post-practice meeting, the following questions will be used to review the day's experience:
• What went well?
• What new learning needs did you have?
• What new skill(s) did you learn?
• What did not go well?
• What do you think would have helped to make the procedures go better?
• How could problems, which arose, have been avoided?
• What was done to solve the problem?
• How did the team members work together? How could they have worked more effectively?
• Are there steps that you want to review before the next clinical practice session?

The feedback should highlight the positive aspects and address the mistakes.

**Guidelines for completing Participant's Clinical Service Procedures Record Sheet**

The participants' Clinical Service Record Sheet is to assist each participant to keep a track of all the procedures observed or performed during the training programme. These record sheets are not expected to replace the clinic Client Record Form that must be completed for each client by the participant.

**SUMMARY**

This module provides the information and guidelines as to how the model and clinical practice sessions of this training programme will be conducted so that IUDs and implants will be correctly placed and/or removed safely. The ultimate goal is to provide high quality IUD and implant services both during and after the training programme. The client's right to confidentiality must be protected. The priority concerns during clinical observation and practice are the client's comfort and safety and performing an effective procedure.

**EVALUATION**

• Why are models used during IUD and Implant training programmes?
• Mention the rights of the client during clinical training programme?
• Why must decorum be maintained in the clinical area during training?
• Mention four “infection prevention reminders” during clinical practice?
SAMPLE WRITTEN POST INSERTION INSTRUCTIONS FOR CLIENTS

Note: information in parenthesis will change depending upon the type of IUD used

Client’s name: ________________________________________________________________

Date of IUD insertion: _______________________________________________________

Here is some information about your IUD

• The name of the IUD is the Copper T380A
• The Copper T380A protects against pregnancy for 10 years. If you choose to, you can have the IUD taken out anytime. A health care worker should take it out. Do not take it out yourself. You should have the IUD removed after 10 years.
• Now that you have an IUD, you can still breastfeed your baby
• When their periods return, some women have more cramping, heavier bleeding during their periods, longer periods or spotting or bleeding between periods
• The side effects usually go away a few months of your IUD

Please follow these instructions for safe use of the IUD

• The IUD will not protect you or your partner against HIV infection and other sexually transmitted diseases (STIs). Asides from abstinences, latex condoms offer the best protection against HIV infection and other STIs. Return to the clinic or an STI clinic if you think there is any chance you may have been exposed to HIV infection or another STI
• The IUD sometimes comes out. This is most likely to happen in the first weeks after insertions. If you think that the IUD has come out, return to the clinic or see a local health care provider. Use another contraceptive method in the meantime
• You will need to have a checkup four to six weeks after you had your baby. Go to (name the place) for this checkup.
• You should have a checkup once a year.
• Be sure to check for the strings of your IUD at least once a month, right after your period. The first time to check the strings is six weeks after delivery
Pre and Post test questions

Instructions: Select the single best answer to each question.
State True or False OR Circle/Tick your answer.

A. Anatomy and Physiology of the female reproductive system, and ovulation, menstruation, fertilization/conception

1. The ultimate stoppage of menstrual cycle is called
   a. Puberty
   b. Menarche
   c. Menopause
   d. Old age

2. The fertilized egg is called ______________
   a. Ovum
   b. Blastocyst
   c. Diploid cell
   d. Zygote

B. Postpartum IUD Overview

3. Postpartum contraception helps couples practice healthy spacing of pregnancies. _____

4. The most appropriate timing for postpartum IUD insertion is between 48 hours and four weeks postpartum. _____

5. In many developing countries, postpartum women have:
   a. BETTER access to family planning services than women who are not postpartum
   b. Worse access to family planning services than women who are not postpartum
   c. No interest in family planning services

6. For health reasons, how long should women wait after delivering a baby before trying to become pregnant again?
   a. For at least 1 year
   b. For at least 2 years
   c. Until regular monthly periods have started again

C. Postpartum Anatomy and Physiology (1 mark/question)

7. The immediate postpartum uterus is a smooth cavity with narrow apposition of the anterior and posterior walls, each of which is 4–5 cm thick. _____
8. Because of normal postpartum changes:
a. The woman is less likely to notice initial slight bleeding and cramping caused by the iud.
b. The strings should be trimmed immediately after insertion of the IUD.
c. The woman should check for the IUD strings at least once a day (to ensure that it has not been expelled).

D. Counseling and Informed Choice (1 mark /question) 3 marks

9. The best time to counsel a client for postpartum family planning is immediately following delivery.

10. Counseling about the use and benefits of a PPIUD can be provided:
a. Only during routine antenatal care visits, if the husband has agreed to it.
b. During active labor, so that the IUD can be placed immediately after delivery of the placenta.
C. During the latent phase labor, if the woman is comfortable.

E. Infection Prevention (1 mark /question)

11. Decontamination and cleaning of the table top are necessary at the end of each day, not in between clients.

12. Which of the following IP practices is acceptable?
a. Surgical (metal) instruments that have been decontaminated and thoroughly cleaned can be safely used for insertion of the IUD postpartum.
b. It is not necessary to use an antiseptic when inserting an IUD immediately after delivery because the provider is still wearing sterile gloves.
c. To minimize the risk of staff contracting hepatitis b or hiv/aids during the cleaning process, instruments used in iud insertion should be soaked first for 10 minutes in 0.5% chorine solution.

13. If an IUD is still inside an undamaged, sealed package but appears tarnished or discolored, the provider should:
a. Insert the iud if the package is not beyond the expiration date.
b. Send the IUD back to the manufacturer.
c. Discard the IUD because it is unsterile.

F. Client Assessment ( 1 mark /question)

14. Prolonged rupture of membranes or prolonged labor could increase the risk of infection; the provision of an IUD postpartum might need to be postponed.

15. Which of the following is a condition for which PPIUD insertion is considered Category 4 (meaning the method should not be used), according to the World Health Organization’s Medical Eligibility Criteria (WHO MEC)?
a. AIDS
G. Postpartum IUD Insertion Techniques (1 mark/question)

16. There is the same probability of IUD expulsion after a ringed forceps postplacental insertion as after a ringed forceps immediate postpartum insertion. _____

17. If a woman has had a normal vaginal delivery and an immediate/postplacental IUD insertion is planned:
a. The IUD should be inserted 30 minutes after active management of the third stage of labor is performed
b. Active management of the third stage of labor should be performed as usual, immediately before the iud is inserted
c. Active management of the third stage labor should be avoided, if possible, if the woman is having a PPIUD

H. Post-partum IUD Follow-Up (1 mark/question)

18. Which one of the following is TRUE about IUD strings?
a. The strings should be passed through the cervix into the vagina during intracesarean placement.
b. The strings should not be visible at the cervix after immediate/postplacental insertion of the iud.
c. The woman should check for the strings each month to make sure the IUD has not fallen out.

19. If the IUD strings are not visible at the first routine follow-up visit after a postpartum insertion, expulsion has definitely occurred. _____

I. Prevention and Management of Side Effects and Complications (1 mark/question)

20. The risk of expulsion after postpartum IUD insertion is minimal. _____

21. Sometimes during the first postpartum IUD post insertion visit, the strings may have not yet descended. _____

J. Implant (4 marks/each)

22. The following are correct regarding counseling on all implants use.
   a. Insertion is painless _____
   b. Dislocation of the rod is very unlikely_____
   c. Removal is after 5 years _____
   d. Can be done in the consulting room _____

23. Removal of implants:
a. Local infiltration is necessary ______
b. Can be done only during menstruation. ______
c. Counseling is not mandatory. ______
d. Can be done with a new razor blade where scalpel is in short supply. ______

K. CLMS (1 mark/question)

24. Which of the following is good storage practice
   a. Store medical supplies away from insecticides, chemicals, old files, office supplies, and other materials
   b. Clean and disinfect store room only when products are issued or received.
   c. Store commodities beside the window, directly on the ground and under direct sunlight
   d. Store supplies in a manner accessible for first-in first-out (FIFO)

25. Which of the following is NOT a contraceptives logistics management system (CLMS) tool
   a. Daily consumption record (DCR)
   b. Request, Issue and Receipt Form (RIRF)
   c. Inventory control card (ICC)/ Tally card
   d. Family Planning (FP) register
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