Expanding Contraceptive Choice:

Integrating Intrauterine Devices (IUDs) into NGO Family Planning Programs in India

Headquartered in Washington, D.C. The Centre for Development and Population Activities (CEDPA) is an international nonprofit organization that seeks to empower women at all levels of society to be full partners in development. Founded in 1975, CEDPA supports programs and training in leadership, capacity building, advocacy, governance and civil society, youth participation and reproductive health.

Family Health International (FHI) is dedicated to improving lives, knowledge, and understanding worldwide through a highly diversified program of research, education and services in family health and HIV/AIDS prevention and care.

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The Government of India, as part of its continual efforts to improve the quality of family planning services has replaced the CuT-200B with CuT-380A in its National program.

CuT-380A has a distinct advantage over CuT-200B as it is effective for 10 years and thus can be offered as an alternative for sterilization to women who have completed their family size. It also offers the advantage of immediate reversibility without the risks associated with sterilization.

I hope that this handbook will assist in orienting the staff of NGOs to CuT-380A and would enable them to promote it in the National Family Welfare Programme.

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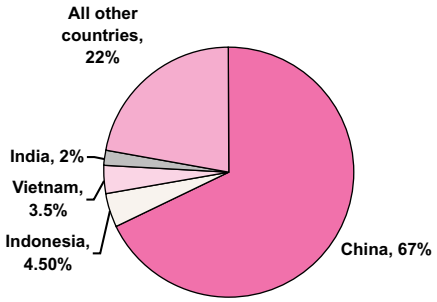
Overview

The Intrauterine Device (IUD), also known as the intrauterine contraceptive device or IUCD, is the world's most widely used reversible family planning method. It is the second most commonly used form of contraception, ranking second only to female sterilization. Approximately 100 million women worldwide use the IUD for fertility control.



In India, IUDs have been part of the Indian National Family Planning Programme since the sixties. However, only two percent of women, aged 15-45 years, use the method (National Family Health Survey (NFHS) II 1998-99). Many myths and misconceptions about the method are prevalent in the country which need to be addressed. The discontinuation rate is also high. The reasons for discontinuation are reported to be poor counseling of clients and poor skills of the providers in inserting the device, all of which are indicators of poor quality of care.

In India, several Non-Governmental Organizations (NGOs) are providing condoms and oral contraceptive pills in their family planning programs. However, very few NGOs, even those with clinical facilities, have added IUDs to their program. There is a general hesitation among NGO program managers to add this method because of its low use, programmatic and technical constraints, and misconceptions and myths associated with this method.

This Handbook contains updated information on the IUD which will enable NGOs to provide quality services which includes counseling, and addressing the IUD myths and misconceptions among both providers and clients and improving skills of the providers for IUD insertion and removal. This Handbook is meant for NGOs that:

- are interested in providing a balanced method mix to clients;
- are interested in exploring opportunities to integrate the IUD into their existing family planning services;
- have little previous experience in offering the IUD as part of their family planning programs.

IUD is the world's most widely used reversible Family Planning method

What are Intrauterine Devices (IUDs)?

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

There are different types of IUDs:

Copper-bearing IUDs are the most common. They are made of plastic with copper sleeves or copper wire on their arms and stem. This group includes:

- Copper-T such as CuT-200B, and the CuT-380A are one of the most widely distributed copper IUDs in the world.
- Multi Load such as MLCu-375

Other types of IUDs include **inert IUDs** such as Lippes Loop and **hormone-releasing IUDs** such as LNG-20.

In the Indian Family Planning Program, CuT-380A has replaced CuT-200B. This handbook will focus on the new CuT-380A.

CuT-380A

CuT-200B

How effective are IUDs?

The CuT-380A IUD is very effective because it does not rely on client's ability to use it consistently and correctly. The risk of pregnancy is 0.6 - 0.8 pregnancies per 100 women in first year of use (that is 6-8 per 1,000 women will become pregnant).

Recent research[1] provides strong evidence that CuT-380A remains very effective for up to 12 years. However, the 10-year duration of use is still the standard of care in most countries, including India.

[1] *World Health Organization. Long-term reversible contraception: Twelve years of experience with the TCu380A and TCu220C. Contraception 1997 Dec; 56:341-352*

How do they work?

All the mechanisms of action of copper-bearing IUDs are still not completely understood. However, researchers believe that the main mechanisms of action are:

- The IUD prevents sperm from fertilizing eggs.
- The IUD creates a foreign body reaction in the uterus, which
  - Makes it hard for sperm to move through the woman's reproductive tract,
  - Damages sperm and eggs before they meet.

For whom IUDs are most appropriate?

- Women who need an effective reversible method of contraception to space their children.
- Women who need effective coverage for several years, or indefinitely, having completed their desired family size, but who prefer not to be sterilized.
- Mothers who are breastfeeding.
- Women who have difficulty in obtaining regular contraceptive supplies.
- Women whose domestic arrangements lack privacy for storing or using other methods of contraception.
- Women who are forgetful about using daily contraception or who are erratic users, or who dislike using methods related to the time of sexual intercourse.

In addition, IUDs can be safely used by women who are postpartum, postabortion, and women who have a chronic condition, including hypertension, cardiovascular disease, diabetes, liver or gall bladder disease.

For whom IUDs are not suitable?

IUDs should not be inserted in women who have:

- Known or suspected pregnancy.
- Cervical, endometrial, or ovarian cancer.
- Unexplained vaginal bleeding (before evaluation).
- Malignant trophoblastic disease or known pelvic tuberculosis.
- Uterine distortion that impedes correct IUD placement.
- Untreated infection following childbirth or following incomplete abortion.
- Current PID, purulent cervicitis or high individual risk of exposure to gonorrhea or chlamydia.

Please refer to Annexure 1: Medical Eligibility Checklist for Copper Bearing IUDs and Annexure 2: FHI's Quick Reference Chart for the WHO Medical Eligibility Criteria

Many Women Can Use the Copper-Bearing IUDs[2]

In general, women CAN use IUDs safely and effectively. IUDs can be used in any circumstances by women who:

- Smoke cigarettes,
- Have just had an abortion or miscarriage (if no evidence of infection or risk of infection),
- Take antibiotics or anticonvulsants,
- Are overweight or thin,
- Are breastfeeding.

Also, women with following conditions CAN use IUDs:

- Benign breast disease,
- Breast cancer,
- Headaches,
- High blood pressure,
- Unexplained vaginal menstrual bleeding (after evaluation),
- Blood clotting problems,
- Varicose veins,
- Heart disease (disease involving heart valves may require treatment with antibiotics before IUD insertion),
- History of stroke,
- Diabetes,
- Liver or disease of gallbladder,
- Malaria,
- Schistosomiasis (without anemia),
- Thyroid disease,
- Eplilepsy,
- Nonpelvic tuberculosis,
- Past ectopic pregnancy,
- Past pelvic surgery
- HIV+ women *(discussed in detail under the section "Is the IUD safe for HIV+ women)*

[2] *The Essentials of Contraceptive Technology: A Handbook for Clinical Staff, March 2003*

What are the advantages of IUDs?

The various advantages of copper IUDs are:

- Long-lasting reversible method. Recent research provides strong evidence that CuT-380A remains very effective for up to 12 years. However, the 10-year duration of use is still the standard of care in most countries, including India.
- A single decision leads to effective long-term prevention of pregnancy.
- Very effective.
- Little to remember (no daily upkeep).
- No interference with sex.
- No hormonal side effects with copper-bearing or inert IUDs.
- Immediately reversible. When women have their IUDs removed, they can become pregnant as quickly as women who have not used IUDs.
- Copper-bearing and inert IUDs have no effect on amount or quality of breast milk.
- Can be used through menopause (one year or so after last menstrual period).
- No interactions with any medicines.

What are the disadvantages and limitations of the IUDs?

Although current IUDs are very safe and effective, there are some limitations of this method which are:

- Does not protect against sexually transmitted infections (STIs) including HIV/AIDS. Not a good method for women with current STIs such as gonnorhea or chlyamidia, or for a women at high individual risk of STIs, such as someone with multiple sex partners (or partners with multiple sex partners) who do not use condoms consistently and correctly.
- Women with an STI at the time of IUD insertion have a slightly increased risk of developing Pelvic Inflammatory Disease (PID). PID can lead to infertility.
- It has to be inserted and removed by a trained health care provider, after proper screening.

IUDs do not protect against STIs/HIV

- May come out of the uterus (expulsion), possibly without the woman's knowing (more common when IUD is inserted soon after childbirth or in women who have never had children, but this is rare).
- Does not protect against ectopic pregnancy as well as it does against normal pregnancy.
- The woman has to check the position of the IUD strings from time to time. To do this, she must put her fingers into her vagina. Some women may not feel comfortable doing this.

Some of the common side effects (*not* signs of sickness) of IUDs are listed below. Effective counseling and reassurance, however, can help lessen concerns and anxieties during the initial post insertion period. But, if a woman does find the side effects unacceptable, or requests to have an IUD removed for any reason, she should have that request honored.

- Menstrual changes (common in the **first 3 months** but likely to lessen after 3 months):
  - Longer and heavier menstrual periods,
  - Bleeding or spotting between periods,
  - More cramps or pain during periods.

A client needs to seek medical attention, if she experiences the following complications:

- Severe cramps and pain beyond the first 3 to 5 days after insertion, which may be due to perforation of the uterus, or infection. This condition is related to the insertion procedure and is very rare if appropriate insertion technique is used.
- Heavy menstrual bleeding or bleeding between periods, possibly contributing to anemia.

HIV+ Women may generally use IUDs

Are the IUDs safe for HIV+ women?

Yes. An HIV+ woman who wants to avoid pregnancy has the same need for safe and effective contraception as any other woman, and IUDs can be one of the methods an HIV+ woman chooses to use.

In 2004, the World Health Organization updated its "Medical Eligibility Criteria for Contraceptive Use" based on the latest clinical and epidemiological research. This update states that women who are HIV+ or who are at high risk of HIV may generally use IUDs, though follow-up may be required (Category 2). Women who have an IUD inserted when they are HIV+ and later develop AIDS, may continue to use the IUD (it does not

need to be removed). Women who have AIDS and are not on ARVs, should not consider initiating IUD use, unless no other method is available or acceptable (requires follow-up). However, women who have AIDS and are doing clinically well on ARVs may have an IUD inserted.

The IUDs may be an appropriate choice for HIV+ women, provided they have continuing access to medical services and follow-up.

No greater risk of IUD-related complications in HIV+ users. IUD does *not* increase the risk of IUD-related complications in even the most severely immuno-compromised HIV+ users.

No evidence of increased risk of HIV transmission by HIV+ users. No evidence exists that IUD use increases an HIV+ woman's risk of transmitting her virus to an uninfected sexual partner. But to guard against transmission, sexually active HIV+ clients should use condoms, regardless of what other contraceptive methods they are using.

No greater risk of HIV acquisition by HIV-negative users. Studies conducted amongst HIV-negative suggest that IUD users are not at increased risk of HIV acquisition. However, since the IUD does not offer protection against STIs and HIV, an HIV-negative woman choosing an IUD should be counseled about dual method i.e using a condom in addition to an IUD to prevent STIs and HIV.

Key points for clients:

- HIV+ clients need to be informed of the range of contraceptive options and understand the risks and benefits of each.
- A client's HIV status should not prevent her from choosing an IUD.
- As long as she has no other contraindications to IUD use, an HIV+ woman should be counselled that she will not be at increased health risk if she uses the IUD and has access to medical follow-up as needed.

Key points for providers:

- Providers should present a range of contraceptive options to clients so they can make informed choices after assessing the risks and benefits of each method.
- Inserting an IUD in an HIV+ woman will not endanger her health but medical follow-up may be required.

Key points for policy-makers:

- The World Health Organization has indicated that the IUD is a safe option for many HIV+ women.

IUDs and infertility

IUDs do not increase the risk of infertility. The presence of STIs at the time of IUD insertion is the main risk factor for PID and possible subsequent infertility. The IUD itself contributes very little to this risk. Even in settings with high STI prevalence, the risk of PID attributable to the IUD insertion is less than 0.5 percent. Any risk of PID after IUD insertion decreases over time. Twenty days after an IUD has been inserted, the IUD user is no more likely to develop PID than a non-user.

Can IUDs be provided to Nulliparous women?

IUDs can safely be provided to nulliparous women. Use of an IUD does not increase risk of tubal infertility among nulliparous women. Regardless of whether a woman has had a child, the IUD is among the safest methods of contraception, especially if a woman is free of STIs at the time of insertion.

IUDs can safely be provided to nulliparous women

The Government of India Guidelines for IUD Insertion for Medical Officers (2003) states that "IUDs are appropriate for any women in the reproductive age group, who has borne a child and wants to space or prevent pregnancy. If requested by a nulliparous woman, she should be referred to a specialist".

What are some of the common myths associated with IUDs?

Myth: IUDs are not reversible

Fact: IUDs are a safe, effective and reversible long-term contraception option.

Myth: IUDs increase the risk of sexually transmitted infections (STIs)

Fact: Sexually transmitted infections (STIs) are a risk associated with sexual activity, regardless of contraceptive choice. IUD use does not increase the risk of contracting a STI. If, however, a woman has a cervical STI at the time of IUD insertion, there is a slightly higher risk of upper genital tract infection, including PID. Patients should talk to their healthcare providers to learn more about the ways they can reduce their risk of contracting STIs.

Myth: IUDs cause Pelvic Inflammatory Disease (PID)

Fact: Current research suggests that after the first month of use, IUDs do not increase the risk of pelvic inflammatory disease (PID). The first month carries an increased risk of PID due to the possibility of introducing bacteria into the upper genital tract during insertion.

Myth: IUDs cause infertility, which is mainly caused by PID

Fact: The modern IUD itself does not lead to PID or infertility unless there was infection present at a time of insertion. Providers can largely reduce a woman's risk of developing PID by screening clients for current STIs or high individual risk of STIs and carefully following infection prevention procedures during insertion.

Myth: IUDs increase the risk of ectopic pregnancy

Fact: Like all contraceptive methods, including tubal ligation, the use of IUDs substantially *reduces* the risk of ectopic pregnancy compared to sexually active women using no method of contraception. However, in the rare cases when a woman becomes pregnant with an IUD in place, there is a somewhat greater chance that her pregnancy will be ectopic because IUDs are better at preventing uterine pregnancies than they are at preventing ectopic pregnancies.

Myth: IUDs cause discomfort for both the woman and her partner

Fact: The IUD is small, soft, and flexible and should not be felt at all once correctly inserted. And, because the IUD is placed in the uterus, it should not interfere with intercourse. Only the soft nylon threads hang high up in the vagina, and sometimes the partner feels them during intercourse. This should cause no harm or discomfort to him. If it does, the woman should visit the provider to discuss this. One solution is to shorten the strings. However, in such cases women should be counseled that it would be difficult to check for strings to make sure IUD is in place.

Myth: IUDs work by aborting the foetus

Fact: Research shows that the IUD acts as a contraceptive before implantation takes place. It prevents fertilization by affecting sperm movement and viability, so they cannot reach the fallopian tube and unite with the egg.

Myth: IUD can leave the uterus and travel to distant parts of the body

Fact: IUD lies in the uterine cavity and it cannot travel or reach distant parts of the body. However, sometimes it is displaced from the uterus and comes out of the uterine cavity through the vagina (expulsion). Also, during IUD insertion, there is a small risk of perforation of the uterus, especially if the provider is not skilled enough. If perforation occurs, the IUD can enter the abdominal cavity, next to the uterus, but will not travel to other parts of the body.

Service Delivery

- Why should my NGO expand the basket of contraceptives?
- What are some of the service delivery issues?
- What are the program requirements?
- What should my organization do to introduce the IUD in our FP program?
- What is the cost of IUD to provider, client and program?

Why should my NGO expand the basket of contraceptives?

Contraceptive technology is an evolving, dynamic and ever-changing subject. To offer-high quality services and care, policy-makers, administrators and providers of contraceptive services need to remain abreast of current information and practices.

Introduction of new contraceptives is an important way of increasing contraceptive utilization and addressing a large unmet need. The introduction of new technologies is also a means for improving quality of care by making available a wider choice of contraceptive options to potential users.

An NGO that is interested in considering expansion of the method mix is also signaling an awareness of the need for expanded informed choice and service-related improvement. If couples have a wide range of methods to choose from, they are better able to choose a method to suit their needs, leading to increased use, lower discontinuation rates, and better client satisfaction.

What are some of the Service Delivery Issues?

Adding or introducing a new contraceptive method can improve quality of care by expanding choice. However, careful attention must be given to quality of care during the introduction process. Listed below, from "***Selected Practice Recommendations for Contraceptive Use, WHO 2004***" are some issues to consider when planning the introduction of IUDs into programs:

Informed Choice: Clients should be given adequate information in order to make an informed, voluntary choice of a contraceptive method. Information given to clients to help them make this choice should at least include: understanding of the relative effectiveness of the method; correct use of the method; how it works; common side-effects; health risks and benefits of the method; signs and symptoms that would necessitate a return to the clinic; information on return to fertility after discontinuing method use; and information on STI protection.

***Trained Providers*:** Appropriately trained personnel in adequately equipped facilities must be available in order for the IUD to be offered, and appropriate infection prevention procedures must be followed. **In India,**

Adding a contraceptive method improves quality of care

medical doctors, Lady Health Visitors (LHVs) and Auxillary Nurse Midwives (ANMs) trained in IUD insertion and removal provide these services.

Supplies: Adequate and appropriate equipment and supplies need to be maintained and held in stock.

Screening: Service providers should be provided with guidelines (or client cards or other screening tools) to enable them to appropriately screen clients for whom the IUDs would carry unacceptable health risks.

Counseling: Service providers must be trained in providing family planning counselling to help clients make informed and voluntary decisions about their fertility. Counselling is a key element in quality of care and is also an important part of both initiation and follow-up visits.

What are the program requirements?

NGOs that want to offer the IUD successfully must support providers by offering adequate training and supervision, establishing a supportive environment for offering the method and ensuring that the providers have the materials and supplies they need to offer the IUD. The long-term goal is for the organization to incorporate the IUD into all of its materials and policies.

If a program decides to offer the IUD they should be able to:

- Provide training and technical assistance to create proper provider capacity to counsel couples; screen women who opt for the IUD; and insert and remove IUDs;
- Monitor and supervise providers to ensure they are providing good-quality IUD services;
- Integrate the IUD into family planning registers and service statistics;
- Conduct Behaviour Change Communication (BCC) activities to dispel common misconceptions related to IUDs and inform the community of the availability of IUD services;
- Maintain a sufficient supply of IUDs and IE&C materials to provide quality IUD services;
- Provide or establish an effective referral system for other family planning methods and reproductive health services not offered at that location; and
- Adapt organizational norms and policies to support IUD provision.

What should my organization do to introduce the IUD into our FP program?

Setting up IUD services: Once you are clear about your primary objectives for incorporating the IUD into your services, you will be able to design appropriate service delivery strategies. Some programs introduce the IUD to improve choice, others to reduce unmet need among hard to reach groups.

The first step is to **decide how the IUD will be provided**. Consider who currently provides family planning in your organization, who has time and interest to offer the IUD, and who has the ability to provide quality counseling to both men and women on the IUD.

Other decisions to be made include what IUD services will involve and what will be the charge, if any, for the service.

At this point you will need to consider how your organization will cover the **costs** of IUD introduction. These may include the costs of training providers, purchase of IUDs, and money to do local social marketing.

Organizations must put in place **guidelines and policies** which support the efforts of providers to offer the IUD. An important step is to include the IUD in the management information system.

Preparing providers to offer the method: Most of the problems that are still associated with IUDs, including perforations, expulsions, and infections, result from improper or careless screening and insertion techniques. Providers should receive high quality training, which includes practice with insertions. It is essential that training also includes procedures for IUD removal. Insertion and removal training could include initial practice with plastic pelvic models (Zoe models) followed by supervised clinical practice.

IUDs can be inserted by medical doctors, Lady Health Visitors (LHVs) and ANMs trained in IUD insertion and removal. It is important to note that client satisfaction with an IUD is much influenced by service delivery factors such as counseling, insertion procedures and follow-up.

Setting up of proper facilities: IUD contraceptives should be inserted primarily at a sub-centre, primary health centre, community health centre or hospital However, with proper planning and monitoring, they can be

provided at alternative locations, such as outreach service sites, like RCH Camps and NGO Clinics. **IUDs should never be provided at a client's home.**

Ensuring reliable supplies: Maintaining a consistently adequate supply of contraceptives is extremely important. Ordering supplies requires knowledge of local contraceptive usage rates, frequency of ordering and receiving supplies, anticipated delays and available storage space.

Programs can ensure a reliable supply of IUDs by:

- Ensuring that one, or at the most two, types of IUD should be available in clinics. This will benefit training efforts as well as service delivery. It is recommended that CuT-380A, with its proven safety and efficacy and long lifespan, should be the IUD of choice.
- Calculating Supplies - Only one IUD is required for each new user, but in planning for expulsions and replacements, the program managers should order three IUDs for every two acceptors.
- Calculating Reserve Stocks - Reserve stocks are the supplies on hand to ensure adequate services in the event that usage is higher than expected or previous orders do not arrive when anticipated. Each clinic should have an estimated maximum and minimum amount of contraceptive supplies.
- Storing Supplies - IUD storage needs are similar to storage needs of other contraceptives. At every step in the journey from the manufacturer to the client, contraceptives have to be stored. Stock should be kept away from excessive heat, humidity, direct sunlight, water, insects and animals. The room or area where they are stored should be well ventilated. It should either have windows to provide cross ventilation, or a fan to provide good air circulation.
- The IUDs should be used on first-to-expire, first-to-be-used basis.
- Training providers in logistics i.e. ordering and management of supplies.

Please refer to Annexure 3 for Equipment and Supplies required for IUD insertion and removal

Establishing appropriate eligibility criteria: The World Health Organization (WHO), in collaboration with various international bodies, have developed the Medical Eligibility Criteria for use of various contraceptive methods.

IUDs should never be provided at a client's home

Please refer to Annexure 1: Medical Eligibility Checklist for Copper Bearing IUDs and Annexure 2: FHI's Quick Reference Chart for the WHO Medical Eligibility Criteria

Establishing appropriate screening and counseling: The combined goals of screening and counseling are to provide high quality care that enables the client to make a well-informed choice of a contraceptive method that is safe for her to use. Client screening procedures are necessary to identify the most appropriate methods for the client and ensure safe use of the method. Also, research has shown that, in general, appropriate counseling leads to improved client satisfaction and continued use of any contraceptive method.

- **Screening of clients** Screening involves STI risk assessment by medical and sexual history, and pelvic examination, including speculum examination, to determine the position of the uterus, the presence of infection, or any abnormality that might interfere with proper insertion and placement of IUD. Laboratory STI screening contributes to the safe use of the IUD, but is not essential for women not at high individual risk of STIs. Lack of access to laboratory screening should not restrict provision of IUDs in women not at high individual risk for STIs.
- **Counselling** All women who contemplate using an IUD should be counseled to ensure that their choice is informed and free, and that they understand relevant information related to its use. When a client is advised on possible use of an IUD, her parity, and sexual behaviour (including risk of pelvic infection) must be taken into account. Childbearing goals and the acceptability and appropriateness of other methods of contraception must also be considered.

If the client chooses an IUD, the following specific issues must be covered in detail during the counseling session:

- Characteristics of IUDs,what are its advantages and limitations.
- Effectiveness and how the IUDs work.
- Common side effects and complications.
- Signs of possible complications that require an immediate return to the clinic.

- Client's risk for STIs and limitation of IUD in protecting from STIs and HIV.
- Insertion and removal procedures explained in a simple manner.
- Post-insertion instructions and instructions for follow-up visits.
- Common myths and misconceptions associated with the method.

Preventing infection by properly handling used IUD equipment: With proper training of staff and diligent application of recommended infection prevention practices, health workers can reduce the risk to clients of post-IUD infections. Providers must also follow basic infection prevention measures, which include washing hands, wearing sterile or High Level Disinfected (HLD) gloves, and carefully disinfecting the vagina and cervix. Use only sterile IUDs and sterile or high-level disinfected equipment. Properly decontaminate instruments after the insertion procedure, and safely dispose off any contaminated waste materials.

Getting the word out: An important part of introducing/adding a new method in your program is letting people know that it is available. Organizations have used posters, flyers, street theater, radio and television spots to raise awareness of the method. Ideally, the IUD would be integrated into ongoing BCC campaigns and materials. Influential individuals, such as reproductive health experts and religious and community leaders, can also help to get the word out. Increasing awareness of the IUD and regular IUD services is a critical piece of IUD provision and needs to be equally paired with investing resources on training providers and equipping the clinic.

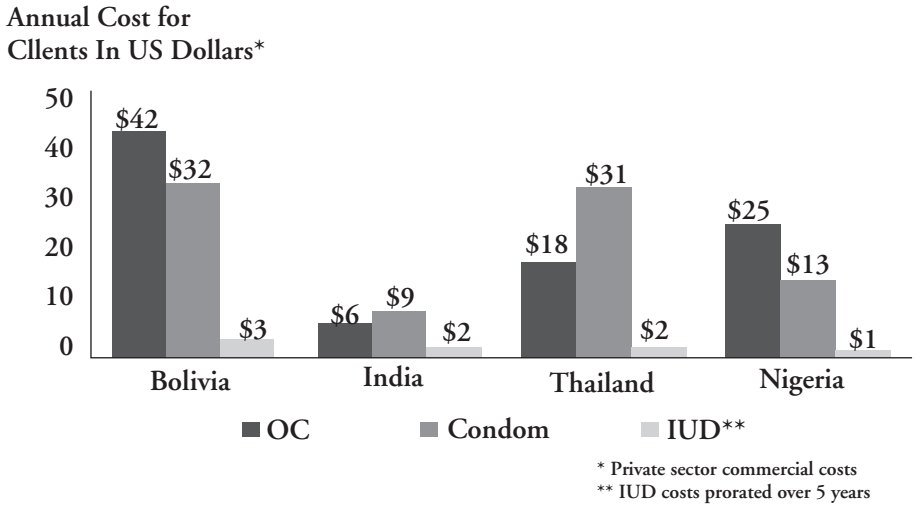
IUDs have extremely low commodity costs and require few clinic visits

What is the cost of the IUD to the provider, client and program?

IUDs are the most cost-efficient form of reversible contraceptive, considering all program costs (including materials and staff time for initial and follow-up visits) as well as the length of time each method will protect a woman from pregnancy. For clients, IUDs can have a higher "start-up" cost than other contraceptive methods; however, the method entails substantially lower costs over time.

The annual cost of an IUD to the client and the program can be much less than that of other contraceptive methods. This is because IUDs are long-acting, have an extremely low commodity cost and require few clinic visits. In some countries, the cost difference is even more dramatic. The figure below shows the prorated annual cost of IUDs as compared to condoms and oral contraceptives in the commercial sector in Bolivia, India, Thailand, and Nigeria.

Comparison of Method Costs



* Private sector commercial costs
** IUD costs prorated over 5 years

Source : Population Crises Committee 1991

Client Information

- Important Things for the Client to Remember
- Frequently Asked Questions

Important Things for the Client to Remember[3]

- **Little to do once the IUD is in place.**
  - You may have cramps for the first few days, vaginal discharge or spotting for a few weeks, and somewhat heavier menstrual periods for initial 2-3 months. Do not worry, these problems will subside and get normal by 2-3 months.
  - Check the IUD strings to be sure the IUD remains in place. Always wash hands first. Insert your index finger high up in your vagina until you feel a somewhat firm structure like the tip of your nose. It is the month of your uterus (cervix). With your index finger, feel the IUD strings in the vagina around the mouth of uterus (cervix) but do not pull the strings. Check once a week for the first month and then after every menstrual period. Check the pads for an expelled IUD in the initial few periods If you think the IUD might be out of place, or you do not feel the strings come to the clinic immdiately.

- **IUDs do not prevent sexually transmitted infections (STIs) including HIV/AIDS.** If you think you might get an STI, use condoms regularly in addition to IUD.

- **Please come back:**
  - In 3 to 6 weeks after insertion for a routine checkup.
  - If you have very heavy bleeding or bad pain in the belly (especially pain with fever).
  - If you suspect having a sexually transmitted infection (STI).
  - If you suspect to be pregnant (miss a period).
  - If the IUD might be out of place (can not feel strings).
  - Any time you want help, advice, or another method.
  - Any time you want the IUD removed, for any reason.

  Meet your provider as soon as possible.

- **You can keep your CuT-380A IUD for 10 years or remove it any time.** The CuT-380A IUD becomes less effective after 10 years. A trained family planning provider can take out your IUD. You can get a new IUD put in at the same time if you want or you can switch to another contraceptive method of your choice.

[3] *The Essentials of Contraceptive Technology: A Handbook for Clinical Staff, March 2003*

Frequently Asked Questions (FAQ)

1. **Can the IUD travel from the woman's uterus to other parts of her body, such as her heart or her brain?**
   IUD lies in the uterine cavity and it cannot travel or reach distant parts of the body. However, it can be displaced (4-7% of cases) from the uterus and comes out of the uterine cavity through the vagina (expulsion). During IUD insertion, there is a small risk of perforation of the uterus, especially if the provider is not skilled enough. If perforation occurs, the IUD can enter the abdominal cavity, next to the uterus, but will not travel to other parts of the body.

2. **Will the IUD prevent a woman from having babies after it is removed?**
   In general, no. A woman can become pregnant after her IUD is removed. The return to fertility is immediate after removal of the IUD. It is important to remember that there are other factors that affect woman's ability to become pregnant (such as age, for example) and these factors should always be taken into account.

3. **When can a woman get an IUD inserted after she has had a baby?**
   The IUD can be inserted immediately or within 48 hours of delivery or through the abdominal incision right after a cesarean section by a doctor, incase of a institutional delivery. If more than 48 hrs. Since childbirth, delay IUD insertion until at least 4 weeks after childbirth.

4. **Can a woman get an IUD inserted just after abortion or miscarriage?**
   Yes. An IUD can be inserted immediately after a complete abortion or miscarriage unless the woman has a pelvic infection. Insertion following miscarriage after 16 weeks gestation requires special training.

5. **Must an IUD be inserted only during a woman's menstrual period?**
   No. An IUD can be inserted at any time during her menstrual cycle if it is reasonably certain that the woman is not pregnant.

6. **Should antibiotics be given before IUD insertion to prevent infection?**
   There is no evidence that giving antibiotics prior to the time of IUD insertion reduce risk of infection. When IUD insertion is done correctly with well-screened clients, there is little risk of infection, with or without antibiotics.

7. Can a woman be too young or too old to use an IUD?

No. There is no minimum or maximum age, so long as the woman has no other contraindications to IUD insertion and is properly counseled about the advantages and disadvantages of the IUD.

8. Can a woman get her IUD on the same day that she has her initial counseling?

Yes. If it is reasonably certain that she is not pregnant and has no sexually transmitted infections, there is no medical reason for a separate visit. It may be inconvenient for a woman to come back again. Also, she may become pregnant before she returns to have her IUD inserted.

9. Can a woman with diabetes use an IUD?

Yes. IUDs are safe for women with diabetes.

10. Should a woman have a "rest period" after using her IUD for several years or after the IUD reaches its recommended time for removal?

No. This is not necessary, and it may be harmful. There is less risk of pelvic infection in replacing an IUD at the same time the old one is being removed than there is in two separate procedures. Also, a woman could become pregnant before her new IUD is inserted.

11. Will the IUD cause discomfort to a woman's partner during sex?

Generally, no.

If the strings are cut 3 cms. from the cervix at the time of insertion, it is less likely that they will hurt the partner. However, if the man can still feel the strings and it bothers him, cutting the strings shooter should solve the problem. In this case woman should be told beforehand, however, that this will mean she will not be able to feel the strings to check her IUD, and removing her IUD may be more difficult. A man may feel discomfort during sex if the IUD has started to come out through the cervix. If a woman suspects this, she should see a health care provider immediately.

Provider Information

- When can a woman have a copper-bearing IUD inserted?
- How to insert and remove IUD?
- What instructions to give to the client after IUD insertion?
- How to follow-up and manage any problems?

When can a woman have a copper-bearing IUD inserted?[4]

A woman having menstrual cycles

- She can have the copper-bearing IUD inserted at any time during the menstrual cycle, at her convenience, if it is reasonably certain that she is not pregnant. No additional contraceptive protection is needed.

Postpartum women, including those who have had caesarean section (whether breastfeeding or not)

- If she is 4 or more weeks postpartum and amenorrhoeic, she can have a copper-bearing IUD inserted, if it is reasonably certain that she is not pregnant. No additional contraceptive protection is needed.
- If she is 4 or more weeks postpartum and her menstrual cycles have returned, she can have a copper-bearing IUD inserted as advised for other women having menstrual cycles.

Women who have had a recent abortion

- If she had a first-trimester abortion, she can have a copper-bearing IUD inserted immediately postabortion if there are no signs of infection present.
- If she had a second-trimester abortion, she can generally have a copper-bearing IUD inserted immediately postabortion if there are no signs of infection present.

Women who are not menstruating and are not postpartum

- She can have a copper-bearing IUD inserted at any time, *if it can be determined that she is not pregnant*. No additional contraceptive protection is needed.

Switching from another method

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

[4] *Adapted from Selected Practice Recommendations for Contraceptive Use, World Health Organization (WHO) 2004*

How to insert and remove IUD?

A woman who chooses the IUD benefits from good counseling. A provider who listens to a woman's concerns, answers her questions, and gives clear, practical information about side effects, especially probable bleeding changes and possible pain after insertion, will help the woman use the IUD with success and satisfaction.

Inserting Copper-T

1. Make sure that the IUD is in a **sterile package.** It is important that providers inspect the package to make sure it has not been damaged or opened and has not expired. Copper IUDs may oxidize while in the package, causing the surface to appear less shiny or discolored. This is not a problem as long as the sterile package is intact. Tarnished or discolored IUDs are as safe and effective as the shiny ones. The expiration date printed on the IUD package indicates the date when the sterile packaging expires, not the date when the IUD's effectiveness expires. IUDs should not be inserted after the expiration date has passed.

2. **Follow the manufacturer's instructions** for IUD insertion carefully. Insertion procedures vary for different types of IUDs. Providers must be sure to follow specific instructions for each type of device. Copper IUD is inserted by withdrawal technique and not by pushing it in the uterine cavity with a plunger.

3. For the procedure for the IUD clinical services please refer to **Annexure** 4 for the correct and sequential steps for IUD insertion using infection prevention techniques. These instructions are to guide all service providers who perform IUD insertions. These instructions can also be used as a job-aid to assist providers perform each step in a correct sequence during provision of IUD services to initial few clients until they become skilled and proficient in the procedure. This job-aid can also help the provider self-assess her/his skills for IUD insertion.

4. The woman should be **asked to tell the provider if she feels discomfort or pain** at any time during the procedure. After the insertion, the provider asks the client how she feels and, if she feels dizzy when sitting, suggests that she lie quietly for 5 or 10 minutes. Any cramping probably will not last long.

Good counseling leads to a satisfied IUD client

According to GOI Guidelines for IUD insertion for Medical Officers (2003), copper IUD should not be inserted into a uterus, which is less than 6 centimetres and more than 9 centimetres in length. If there is difficulty in introducing the sound in the cervical canal or it causes pain, stop the procedure. Refer to a specialist.

Removing the IUD

Possible reasons for removal:

- The client requests removal. Providers must not refuse or delay when the client asks to have her IUD removed, whatever her reason, whether it is personal or medical.
- Any side effects that make the client want her IUD removed, including pain.
- A medical reason for removal:
  - Pregnancy (If it is not possible to remove, counsel about an increased risk of septic miscarriage),
  - Acute pelvic inflammatory disease (endometritis or salpingitis): only if woman wants to discontinue IUD use. If she wants to continue with IUD, infection can be treated with IUD in place,
  - Perforation of the uterus,
  - IUD has come out of place (partial expulsion).
- When the effective lifespan of an IUD has passed.
- When the woman reaches menopause (at least one year after her last period).

A client who requests that an IUD be removed should have that request honoured

To remove the IUD:

- Removing an IUD is usually simple. It can be done any time throughout the menstrual cycle. Removal may be somewhat easier during menstruation. For IUD removal refer to **Annexure 5** for correct and sequential steps.
- If IUD strings are inside the uterus refer the client to a specialist.

What Instructions to give to the Client after IUD insertion?

A woman who gets an IUD inserted should be given the following instructions:

1. **Make sure she knows about her IUD**:
   - Exactly what kind of IUD she has and what it looks like.
   - When to have her IUD removed or replaced. (For the CuT-380A IUD, a maximum of 10 years after insertion and for CuT-200B, it is 3 years after insertion.) Provide the client with a written record of month and year of IUD insertion and month and year when it should be removed.
   - Refer to **Annexure 6** for client card

2. **She can expect some common side-effects**:
   - Some cramping pain for the first day or two after insertion. She can take aspirin, paracetamol, or ibuprofen.
   - Some vaginal discharge for a few weeks after insertion. This is normal.
   - Heavier menstrual periods. Possible bleeding between menstrual periods, especially during the first few months (2-3 months) after IUD insertion.

3. **When and how she should check the IUD**. Sometimes IUDs come out. This can happen especially in the first month or so after insertion or during a menstrual period. An IUD can come out without the woman feeling it.

4. **When should the client** check that her IUD is in place:
   - During the first month after insertion **once a week**.
   - Then once every month after a menstrual period.
   - If she notices any possible symptoms of serious problems.

   To check her IUD, a woman should:
   - Wash her hands.
   - Sit in a squatting position.

- Insert 1 or 2 fingers into her vagina as far as she can until she feels the strings. She should return to the health care provider if she thinks the IUD might be out of place. She should not pull on the strings. She might pull the IUD out of place.
- Wash her hands again.

5. **When should she see a health provider:** If she has the possible symptoms of serious problems that require medical attention. She should be explained that serious complications of IUD use are rare. Still, she should see a doctor or nurse if she has any of these following symptoms. The IUD may or may not cause these problems.

    - **Severe bleeding or abdominal cramping during the first three to five days after insertion** This could indicate that the uterus or cervix may have been perforated when the IUD was inserted, or it could indicate an infection.
    - **Irregular bleeding and/or pain in every cycle** This can indicate IUD dislocation or perforation.
    - **Fever and chills, or an unusual vaginal discharge** These can indicate an infection. This is a concern especially during the first month after the IUD is inserted since this is when PID, although rare, is most likely to develop.

Additional signs of possible complications include:

- **Pain during intercourse** This could indicate an infection, perforation or partial expulsion.
- **A missed menstrual period, other signs of pregnancy or an expelled IUD** This could indicate uterine or ectopic pregnancy.
- **IUD strings that appear shorter or longer or are missing** This can be a sign that the IUD may have been partially or completely expelled or has perforated the uterus. However, providers should advise the client that the IUD strings are sometimes difficult to locate until after the first menses because they may be lying in the cervical canal above the opening of the cervix. This may happen only if IUD is inserted with in 48 hours after delivery and immediately after abortions.

Other specific reasons to return to the clinic

- Her partner feels the IUD strings during intercourse and this bothers him. At the clinic she can have the strings cut shorter.
- She or her partner is not pleased with the IUD.

- She wants another family planning method.
- Copper-bearing IUD has reached the end of its effectiveness.
- She wants the IUD removed for any reason at any time for example she may want to have a baby.
- She has any questions or concerns.

How to follow-up and manage any problems?

Follow-up

Plan with the woman for a return visit **after her next menstrual period or in 3 to 6 weeks** for checkup and pelvic examination. During the checkup and exam make sure that her IUD is still in place and that no infection has developed. The visit can be planned at any time that is convenient for her when she is not menstruating.

If she has no problems at the time of her checkup or during the following months, she needs only to return to the clinic yearly for routine checkups. This can be combined with a general/yearly health exam.

A client who requests that an IUD be removed should have that request honored as soon as possible. It is not advisable to discourage the client from having the IUD removed if she does not want to continue using it.

Conduct a pelvic exam if you suspect:

- Sexually transmitted infection or pelvic inflammatory disease; or
- The IUD is out of place (for example woman says that she can't feel the strings)

Discuss the following with the client:

1. Ask if the client has any questions or anything to discuss.
2. Ask the client about her experience with the IUD, whether she is satisfied, and whether she has any problems. Give her any information or help that she needs and invite her to return again any time she has questions or concerns. If she has problems that cannot be resolved, help her choose another method.

3. Remind her of the reasons for returning.
4. Remind her how long her IUD will keep working and when it should be removed.

Managing Any Problems

If the client reports any of the common side effects of IUDs:

1. Do not dismiss the woman's concerns or take them lightly.
2. If the woman is worried but wants to continue the method, reassure her that such side effects are not usually signs of danger.
3. If she does not want to continue with the method, remove the IUD or refer for removal even if her problems with the IUD would not harm her health. If she wants a new method, help her choose one.

For this problem:	Try these suggestions:
Prolonged or heavy bleeding (Prolonged bleeding = more than 8 days. Heavy bleeding = twice as long or twice as much as usual for her.)	• Reassure her that heavier and longer bleeding are common in the first 3 to 6 months of use and will probably lessen over time. • Rule out gynecological problems if clinically warranted. If a gynecologic problem is found, treat or refer to a specialist. She can continue using her IUD while her condition is being evaluated. • To avoid anemia, give her iron supplements and/or name foods containing iron and advise the woman to eat more of them if possible. • If the client wishes or if bleeding continues to be heavy or prolonged and especially if she shows signs of anemia remove the IUD and help her choose another method.
Unexplained abnormal vaginal bleeding that suggests pregnancy or an underlying medical condition	• She can continue using her IUD while her condition is being evaluated. • Evaluate and treat any underlying medical problem, or refer to a specialist.

Lower abdominal pain that suggests pelvic inflammatory disease (PID)	• **Diagnose**. Take history and do abdominal and pelvic exams. If pelvic exam is not possible, do an external genital exam. If one or more of the following is found, **refer to a specialist at once**: • Missed a menstrual period, her period is late, or she is pregnant, • Pain or tenderness when pressure is put on the abdomen during exam, • Vaginal bleeding, • A pelvic mass. • Oral temperature of 38.3 C (101F) or higher, • Abnormal cervical or vaginal discharge, • Pain when moving the cervix during pelvic exam, • Tenderness in the area of fallopian tube or ovary, • Recent sex partner with urethral discharge or treated for gonorrhea. **Note**: Diagnosis can be difficult. PID signs and symptoms may be mild or absent. Also, the common signs and symptoms or PID often also occur with other abdominal conditions, such as ectopic pregnancy or appendicitis. • **Treat or immediately refer for treatment.** • **The IUD can stay in place** if the woman wants to keep it. If she wants it removed, take it out. Start antibiotic treatment before taking out the IUD. ANMs to refer the client to a lady doctor for treatment. • **Follow up**. If the woman does not improve in 2 or 3 days after starting treatment, or if she develops a tubal abscess, she should be sent to hospital. The IUD may be removed. If she improves, schedule another follow-up for just after she has finished taking all her medicine.
Active sexually transmitted infection (STI) or acute purulent cervicitis (a pus like discharge from the openings of cervix)	• **Treat sex partner(s).** Urge the client to have her sex partner come for STI treatment. • Diagnose and treat the STIs, or refer for treatment. • If the woman wants to continue using IUD there is no need to remove it. Treat the infection with the IUD in place. • Counsel and recommend Condom use.

Pregnancy	• If the IUD strings are visible and pregnancy is in the first trimester (less than 13 weeks): - Explain that it is best to remove the IUD to avoid risk of severe infection, miscarriage, and premature birth. Explain that the IUD removal itself will have a slightly increased risk of miscarriage. - If she consents, remove the IUD or refer for removal. Explain that she should see a nurse or doctor if she has excessive bleeding, cramping, pain, abnormal vaginal discharge, or fever. • If the strings cannot be found and/or the pregnancy is beyond the first trimester: - Explain that she is at increased risk of spontaneous septic abortion. Her pregnancy should be followed closely by a health provider. She should see a health provider if she has excessive bleeding, cramping pain, abnormal vaginal discharge, or fever. **Note on Ectopic Pregnancy:** Pregnancies among users of IUDs are few. When pregnancy occurs, however, 1 in every 30 is ectopic. IUDs, especially, CuT-380A, offer significant protection against ectopic pregnancy, but they still sometimes occur. Ectopic pregnancy is life-threatening and requires immediate treatment. If ectopic pregnancy is suspected, refer to a specialist.
Partner complains about IUD strings	• Explain to woman (and partner, if possible) that what her partner feels is normal. Recommend that they try again. • Describe other options to the client: • Strings can be cut shorter. • The IUD can be removed.

References:

1. The Essentials of Contraceptive Technology: A Handbook for Clinical Staff, March 2003
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12. Reproductive Health Resource Document for Uttar Pradesh, India: SIFPSA 1996
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Annexure :

- Annexure 1: FHI's Medical Eligibility Checklist for Copper Bearing IUDs
- Annexure 2 : FHI's Quick Reference Chart for the WHO Medical Eligibility Criteria
- Annexure 3 : Equipment and Supplies Needed for IUD insertion
- Annexure 4 : Steps for IUD Insertion
- Annexure 5 : Steps for IUD Removal
- Annexure 6 : Client Card

Annexure 1:
FHI's Medical Eligibility Checklist for Copper Bearing IUDs

Checklist for Screening Clients Who Want to Initiate the Use of Copper IUD

You must be reasonably sure the client is not pregnant. If she is not menstruating at the time of her visit, and pregnancy tests are not available, refer to *"How to be Reasonably Sure a Client is Not Pregnant"* on next page.

Please ask the client all of these questions, note 'yes' responses, and follow the instructions.

NO		YES
	1. Have you given birth within the last 4 weeks?	
	2. Do you have bleeding between menstrual periods that is unusual for you, or bleeding after intercourse (sex)?	
	3. Have you been told that you have any type of cancer in your genital organs, trophoblastic disease, or pelvic tuberculosis?	
	4. Within the last 3 months, have you had more than one sexual partner or been told you have an STI?	
	5. Within the last 3 months, has your partner been told that he has an STI or has he had any symptoms, for example, penile discharge?	
	6. Do you think your partner has had another sexual partner within the last 3 months?	
	7. Are you HIV-positive and have you developed AIDS?	

If the client answers NO to all these questions, proceed with pelvic exam on next page.

If the client answered YES to *question 1 only*, she might be a good candidate for IUD, but the insertion should be delayed until 4 weeks after delivery. Ask her to come back at that time.

If the client answered YES to *questions 2 or 3 only*, an IUD cannot be inserted without further evaluation. (See explanations for questions 2 and 3 on the back.)

If the client answered YES to *questions 4, 5, or 6* she is not a good candidate for IUD. If she answered YES to the second part of *question 7* and is not currently taking ARV drugs, she is not a good candidate for IUD (HIV-positive women without AIDS can still be good candidates for IUD).

Pelvic Exam

Once you have completed the pelvic exam, please answer all of these questions, note the 'yes' responses, and follow the instructions.

NO		YES
	8. Is there any type of ulcer on the vulva, vagina, or cervix?	
	9. Does the client feel pain in her lower abdomen when you move the cervix?	
	10. Is there adnexal tenderness?	
	11. Is there purulent cervical discharge?	
	12. Does the cervix bleed easily when touched?	
	13. Is there an anatomical abnormality of the uterine cavity that will not allow appropriate IUD insertion?	
	14. Were you unable to determine the size and/or position of the uterus?	

If the answer to all the above questions is NO, you may now insert the IUD.

If the answer to any of these questions is YES, the IUD cannot be inserted without further evaluation. (See explanations on the back for each individual question.)

How to be Reasonably Sure a Client is Not Pregnant

If the client answers YES to any question, proceed to the first box directly below the YES column.

NO		YES
	15. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, *and* have you had no menstrual period since then?	
	16. Have you abstained from sexual intercourse since your last menstrual period?	
	17. Have you had a baby in the last 4 weeks?	
	18. Did your last menstrual period start within the past 7 days (or within the last 12 days if you are planning to use an IUD)?	
	19. Have you had a miscarriage or abortion in the last 7 days?	
	20. Have you been using a reliable contraceptive method consistently and correctly?	

Client answered NO to *all* of the questions.

Pregnancy cannot be ruled out.

Client should await menses or use pregnancy test.

Client answered YES to *at least one* question.

Client is free of signs or symptoms of pregnancy.

Provide client with desired method.

Family Health International, May 2005
P.O. Box 13950, Research Triangle Park, NC 27709 USA ? Fax: (919) 544-7261 ? *http://www.fhi.org*

Explanation of IUD Checklist and Pelvic Exam Questions

This checklist is an easy-to-use screening tool for health care providers who are responsible for inserting intrauterine devices (IUDs). It is based on the guidelines provided in the 2004 World Health Organization (WHO) document *Improving Access to Quality Care in Family Planning: Medical Eligibility Criteria for Contraceptive Use.* A person not doing insertion may administer the checklist on ruling out pregnancy and the first seven questions of the IUD checklist. **Women who are ruled out because they answered "yes" to some of the IUD checklist questions may still be good candidates for an IUD after the suspected condition is excluded through appropriate evaluation.** The language and style of the checklist can be adapted to meet local cultural and linguistic needs, as long as the intent of the questions is not changed. Because even small changes in wording can cause significant changes in meaning, FHI recommends that any translations be reviewed by someone with expertise and knowledge of the medical basis for the checklist.

1 **Have you given birth within the last 4 weeks?**

IUDs can be inserted by a trained professional within the first 48 hours after giving birth. However, there is an increased risk of perforating the uterus when IUDs are inserted after 48 hours and up to 4 weeks postpartum. Women who answered "yes" to this question only should wait until 4 weeks after delivery to have an IUD inserted. Since there is no risk of pregnancy during the first 4 weeks postpartum in breastfeeding or nonbreastfeeding women, there is no need to provide her with contraceptives to use in the meantime, unless you believe the woman may not return to the clinic at the specified time.

2 **Do you have bleeding between menstrual periods that is unusual for you, or bleeding after intercourse (sex)?**

Unexplained vaginal bleeding may be a sign of an underlying pathological condition, such as genital malignancy (cancer), or it could be a sign of a pregnancy-related problem. All these possibilities must be ruled out before an IUD can be inserted. If necessary, women should be referred to a higher-level provider or specialist for evaluation and diagnosis. Counsel her about other contraceptive options available and provide condoms to use in the meantime.

3 **Have you been told that you have any type of cancer in your genital organs, trophoblastic disease, or pelvic tuberculosis?**

There is a concern about the increased risk of infection, perforation, and bleeding at insertion in women with genital cancer. Women with trophoblastic disease may require multiple uterine curettages, and an IUD is unwise in this situation. There is also an increased risk of perforation. Women with known pelvic tuberculosis may have a higher risk of secondary infection and bleeding if an IUD is inserted. If a woman has any one of these three conditions, she should not have an IUD inserted. Counsel her about other contraceptive options available and provide condoms to use in the meantime.

4 **Within the last 3 months, have you had more than one sexual partner or been told you have an STI?**

(Note: There are two parts in this question. Answering "yes" to either part or both parts of the question restricts IUD insertion.) This question is intended to identify women at high individual risk of STIs. There is a possibility that these women currently have an STI and, unless it can be reliably ruled out, are not good candidates for IUD insertion. IUD insertion may increase risk of pelvic inflammatory disease (PID) in these women. They should be counseled about other contraceptive options and provided with condoms for STI protection. However, if other contraceptive methods are not available or acceptable and there are no signs of STI, an IUD still can be inserted. Careful follow-up is required in such cases.

5 **Within the last 3 months, has your partner been told that he has an STI or do you know if he has any symptoms, for example, penile discharge?**

(Note: There are two parts to this question. Answering "yes" to either part or both parts of the question restricts IUD insertion.)

This question is intended to identify women at high individual risk of STIs. Women whose partners have an STI may have an infection as well. IUD insertion may increase risk of PID in these women. They should be counseled about other contraceptive options and provided with condoms for STI protection. However, if other contraceptive methods are not available or acceptable, an IUD still can be inserted. Careful follow-up is required in such cases.

6 **Do you think your partner has had more than one sexual partner within the last 3 months?**

(Note: Where polygamy is common, the provider should ask about sexual partners outside of the union.)

This question is intended to identify women at high individual risk of STIs. Women whose partners have more than one sexual partner may have an STI. Unless an STI can be reliably ruled out, these women are not good candidates for the IUD, as they may be at higher risk of PID following IUD insertion. They should be counseled about other contraceptive options and provided with condoms for STI protection. However, if other contraceptive methods are not available or acceptable, an IUD still can be inserted. Careful follow-up is required in such cases.

7 **Are you HIV-positive *and* have you developed AIDS?**

This is a two-part question - both parts need to be asked together and the answer "yes" must apply to both parts. There is concern that HIV-positive women who have developed AIDS may be at increased risk of STIs and PID because of a suppressed immune system. IUD use may further increase this risk. **However, HIV-positive women without AIDS can be appropriate candidates for IUD insertion. Also, women with AIDS who are doing clinically well on antiretroviral therapy can be appropriate candidates for the IUD.**

8 **Is there any type of ulcer on the vulva, vagina, or cervix?**

Genital ulcers or lesions may indicate a current STI. While ulcerative STI is not a contraindication for IUD insertion, it indicates that the woman is at high individual risk of STIs in general, in which case IUDs are not generally recommended. Diagnosis should be established and treatment provided as needed. An IUD still can be inserted if Co-infection with gonorrhea and chlamydia are ruled out.

9 **Does the client feel pain in her lower abdomen when you move the cervix?**

Cervical motion tenderness is a sign of PID. Women with current PID should not use an IUD. Treatment should be provided as appropriate. If necessary, referral should be made to a higher-level provider or specialist. Counsel the client about condom use. If, through appropriate additional evaluation beyond the checklist, PID may be excluded, then the woman can receive the IUD.

10 **Is there adnexa tenderness?**

Adnexa tenderness or/and adnexa mass may be a symptom of a malignancy or PID. Women with genital cancer or PID should not use an IUD. Diagnosis and treatment should be provided as appropriate. If necessary, referral should be made to a higher-level provider or specialist.

11 **Is there a purulent cervical discharge?**

Purulent cervical discharge is a sign of cervicitis and possibly PID. Women with current PID should not use an IUD. Treatment should be provided as appropriate. If necessary, referral should be made to a higher-level provider or specialist. Counsel the client about condom use.

12 **Does the cervix bleed easily when touched?**

If the cervix bleeds easily at contact, it may indicate that the client has an STI or cervical cancer. Women with current STI or cervical cancer should not have an IUD inserted. Treatment should be provided as appropriate. If necessary, referral should be made to a higher-level provider or specialist. If, through appropriate additional evaluation beyond the checklist, these conditions may be excluded, then the woman can receive the IUD.

13 **Is there an anatomical abnormality of the uterine cavity that will not allow appropriate IUD insertion?**

If there is an anatomical abnormality that distorts the uterine cavity, proper IUD placement may not be possible. Cervical stenosis also may preclude an IUD insertion.

14 **Were you unable to determine the size and/or position of the uterus?**

Determining size and position of the uterus is essential prior to IUD insertion to ensure high fundal placement of the IUD and to minimize the risk of perforation.

Annexure 2: FHI's Quick Reference Chart for the WHO Medical Eligibility Criteria

FHI's QUICK REFERENCE CHART

for the WHO Medical Eligibility Criteria for Contraceptive Use

to initiate or continue the use of

Combined Oral Contraceptive (COC), Noristerat (NET-EN), Depo-Provera (DMPA), Copper Intrauterine Device (Cu-IUD)

		COC	NET-EN/ DMPA	Cu-IUD
Age	Menarche to 39 years	2	1	1
	40 years or more	2	1	1
	Menarche to 17 years	1	2	1
	18 years to 45 years	1	2	1
	More than 45 years	1	2	1
	Less than 20 years	1	1	2
	20 years or more	1	1	2
Nulliparous		2	2	1
Breastfeeding	Less than 6 weeks postpartum	4	3	*
	6 weeks to 6 months postpartum	3	2	2
	6 months postpartum or more	2	2	2
Smoking	Age < 35 years	1	2	2
	Age ? 35 years, < 15 cigarettes/day	3	2	2
	Age ? 35 years, ? 15 cigarettes/day	4	2	2
Hypertension	History of hypertension where blood pressure	3	1	2
	CANNOT be evaluated	3	2	2
	Controlled and CAN be evaluated	3	2	2
	Systolic 140 - 159 or Diastolic 90 - 99	3	2	2
	Systolic ? 160 or Diastolic ? 100	4	3	2
Headaches	Non-migrainous (mild or severe)	I C	1	2
	Migraine without aura (age < 35 years)	I C	I C	2
	Migraine without aura (age ? 35 years)	I C	I C	2
	Migraines with aura	4	I C	2
History of deep venous thrombosis		4	3	2
Superficial thrombophlebitis		3	2	2
Complicated valvular heart disease		4	2	3
Ischemic heart disease/stroke		4	3	2
Diabetes	Non-vascular disease	3	2	2
	Vascular disease or diabetes of > 20 years	4	3	2
Malaria		2	2	2
Non-pelvic tuberculosis		2	2	2
Thyroid disease		2	2	2
Iron deficiency anemia		2	2	3

		COC	NET-EN/ DMPA	Cu-IUD
Known hyperlipidemias		3	2	2
Cancers	Cervical	2	2	I C
	Endometrial	1	1	I C
	Ovarian	1	1	I C
Breast Disease	Undiagnosed mass	3	3	2
	Family history of cancer	1	1	2
	Current cancer	4	4	2
Uterine fibroids		1	1	2
Endometriosis		1	1	2
Trophoblast disease		1	1	4
Vaginal bleeding patterns	Irregular without heavy bleeding	1	2	2
	Heavy or prolonged, regular and irregular	1	1	2
	Unexplained bleeding	2	3	I C
Cirrhosis	Mild	3	3	2
	Severe	4	4	2
Current symptomatic gall bladder disease		3	3	2
Cholestasis	Related to the pregnancy	2	2	2
	Related to oral contraceptives	3	3	2
Hepatitis	Active	4	4	2
	Client is a carrier	1	1	2
Liver tumors		4	4	2
STIs/PID	Current purulent cervicitis, chlamydia, gonorrhea	1	1	I C
	Vaginitis	1	1	2
	Pelvic inflamatory disease (PID)	1	1	I C
	Other STIs (excluding HIV/hepatitis)	1	1	2
	Increased risk of STIs	1	1	2
	Increased individual risk of STIs	1	1	I C
HIV	High risk of HIV or HIV-infected	1	1	2
AIDS	No antiretroviral therapy (ARV), or not doing well on ARV therapy	1	1	I C
	Clinically well on ARV therapy	2	2	2
Use of:	Griseofulvin	2	2	2
	Rifampicin	3	2	2
	Other antibiotics	1	1	2

Category 1 — There are *no* restrictions for use.

Category 2 — Generally use; *some follow-up may be needed.*

Category 3 — Usually *not* recommended; clinical judgment and continuing access to clinical services are required for use.

Category 4 — The method *should not be used* .

I/C (Initiation/Continuation): A woman may fall into either one category or another, depending on whether she is *initiating* or *continuing* to use a method. For example, a client with current PID who wants to initiate IUD use would be considered as Category 4, and should not have an IUD inserted. However, if she develops PID while using the IUD, she would be considered as Category 2. This means she could generally continue using the IUD and be treated for PID with the IUD in place. Where I/C is not marked, a woman with that condition falls in the category indicated - whether or not she is initiating or continuing use of the method.

*Postpartum IUD use by breastfeeding and non-breastfeeding women is Category 2 up to 48 hours postpartum, Category 3 from 48 hours to four weeks, and Category 1 four weeks and after.

Source: Adapted from *Improving Access to Quality Care in Family Planning: Medical Eligibility Criteria for Contraceptive Use* . Geneva: World Health Organization. Third edition, 2004.

Available: http://www.who.int/reproductive-health/publications/MEC_3/index.htm.

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Annexure 3: Equipment and Supplies Needed for IUD Provision[5]

Clinics will need to have the following supplies for IUD services:

- Copper T insertion kit which contains the following:
  1. Sim's/Cusco's speculum (large, medium, small)
  2. Anterior vaginal wall retractor
  3. Allis forceps/volsellum (small toothed)
  4. Sponge holding forceps
  5. Uterine Sound
  6. Scissors
  7. Toothed Forceps
  8. Gloves
  9. Sterilized cotton swabs
  10. Bowl for antiseptic solution
  11. Kidney tray for keeping used instruments
- Cheatles Forceps
- Antiseptic solution (any one of the following):
  1. If Povidone Iodine solution is available, it is preferable to use it.
  2. Chorhexidine 1% or Cetrimide 2% (Ensure that the above are freshly prepared)
- Proper light source/torch
- IUD in a pre-sterilised packet. Ensure that the packet is not open or damaged and that the date of expiry is not over.

IP Equipment :

[5] *Guidelines for IUD Insertion for Health Workers (Female), Department of Family Welfare, Ministry of Health and Family Welfare, Government of India*

Annexure 4:
Steps for IUD Insertion

1. Ask client to empty her bladder.
2. Tell client what is going to be done. Encourage her to ask questions.
3. Ask client to lie down on the examination table, palpate her abdomen and check for supra pubic tenderness / pain in lower abdomen. Cover the client adequately.
4. Provide adequate light to see the cervix
5. Wash hands with soap and water and air dry.
6. Put on HLD gloves in both hands
7 Arrange instruments and supplies in the HLD tray.
8. Inspect external genitalia and urethral opening. Gently perform per speculum examination and check cervix and vagina for dirty discharge, abnormality. Gently remove speculum and put aside in an HLD kidney tray or container.
9. Perform bimanual pelvic examination to note the size and direction of the uterus and for any abnormality or pain.
10. Insert speculum gently in the vagina and apply antiseptic to cervix 1-2 times and discard cotton swabs in a covered waste container.
11 Gently grasp cervix with volsellum or tenaculum.
12. Gently insert the sound in the uterus without touching side walls of vagina using 'No Touch Technique' only once through the cervix. Detect depth of uterine cavity by withdrawing the uterine sound from the cervix and noting the level of secretions on it. Also note the direction of the uterus. Remove sound and place it in the kidney tray or in 0.5% chlorine solution for decontamination. If there is difficulty in inserting the sound in the cervix, stop the procedure and refer the client to a specialist.
13. Briefly dip gloved hands in 0.5% chlorine solution.
14. Load the IUD in its sterile package. Remove loaded IUD and insert without touching any unsterile or HLD surface. Be careful not to push white rod towards IUD or it will come out.
15. Insert the IUD in the uterus using the withdrawal technique.

16. Hold blue gauge in horizontal position. Gently pass loaded inserter tube through the cervix while gently steadying the Volsellum/Tenaculum until blue gauge touches the cervix or until resistance is felt.
17. Hold Volsellum/Tenaculum and white rod stationary in one hand.
18. Release arms of the IUD using withdrawal technique (pull inserter tube towards you until it touches thumb grip of white rod).
19. Remove plunger gently and push in (up) on the inserter tube until slight resistance is felt to ensure high fundel placement.
20. Partially withdraw the inserter tube and cut strings 3-4 cms. length from the cervix. Remove inserter tube and discard in waste container.
21. Gently remove the Volsellum/Tenaculum and place in 0.5% chlorine solution for decontamination.
22. Examine cervix and if there is bleeding at the puncture sites, place cotton (or gauge) swab over bleeding and apply gentle pressure for 30-60 seconds.
23. Gently remove speculum and place in 0.5% chlorine solution for decontamination.
24. Place used instruments in 0.5% Chlorine solution for 10 minutes.
25. Dispose of waste material in covered container.
26. If re-using gloves, immerse both hands in 0.5% chlorine solution and remove gloves by turning them inside out and place them in 0.5% chlorine solution for 10 minutes.
27. Wash hands with soap and water and air dry.
28. Complete client record.
29. Tell client that IUD has been inserted. Remind the client of 10 years effective life of CuT-380A and 3 years for CuT-200B.
30. Assure client she can return any time to seek advice or if she wants it removed.
31. Answer any queries.
32. Teach client how to check for strings.
33. Discuss what to do if the client has any side effects or problems.
34. If the client feels dizzy, let has lie on the table for 10-15 minutes.
35. Give her a return date after her next menstrual period.

Annexure 5:
Steps for IUD Removal

1. Ask client to empty her bladder.
2. Tell client what is going to be done. Encourage her to ask questions.
3. Ask client to lie down on the examination table, palpate her abdomen and check for supra pubic tenderness / pain in lower abdomen. Cover the client adequately.
4. Provide adequate light to see the cervix
5. Wash hands with soap and water and air dry.
6. Put on HLD gloves
7. Arrange instruments and supplies in the HLD tray.
8. Insert vaginal speculum
9. Grasp both strings with a long artery or Bozeman's forceps near the cervix and gently pull on the strings to remove the IUD.
10. Show the IUD to the client and dispose of in a covered waste container.
11. Immerse gloves in 0.5% chlorine solution.
12. Gently remove speculum and put it in 0.5% chlorine solution.
13. Help client choose another method of contraception. A new IUD can be inserted immediately after removal of previous IUD if the client wants to continue the method.

Annexure 6: Client Card

Front Side

Client Card

Name _____ Age _____

Reg. No. _____

Address _____

_____

Date of IUD Insertion _____

Date of return for IUD Removal _____

Next visit on _____ , _____

_____ , _____

Back Side

Reasons to return to the clinic

- Late or missed period (possible pregnancy)
- Abnormal spotting or bleeding
- Abdominal pain, pain during intercourse
- Abnormal vaginal discharge (excessive, foul smelling, discoloured)
- Not feeling well, fever, chills
- String missing, shorter or longer


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