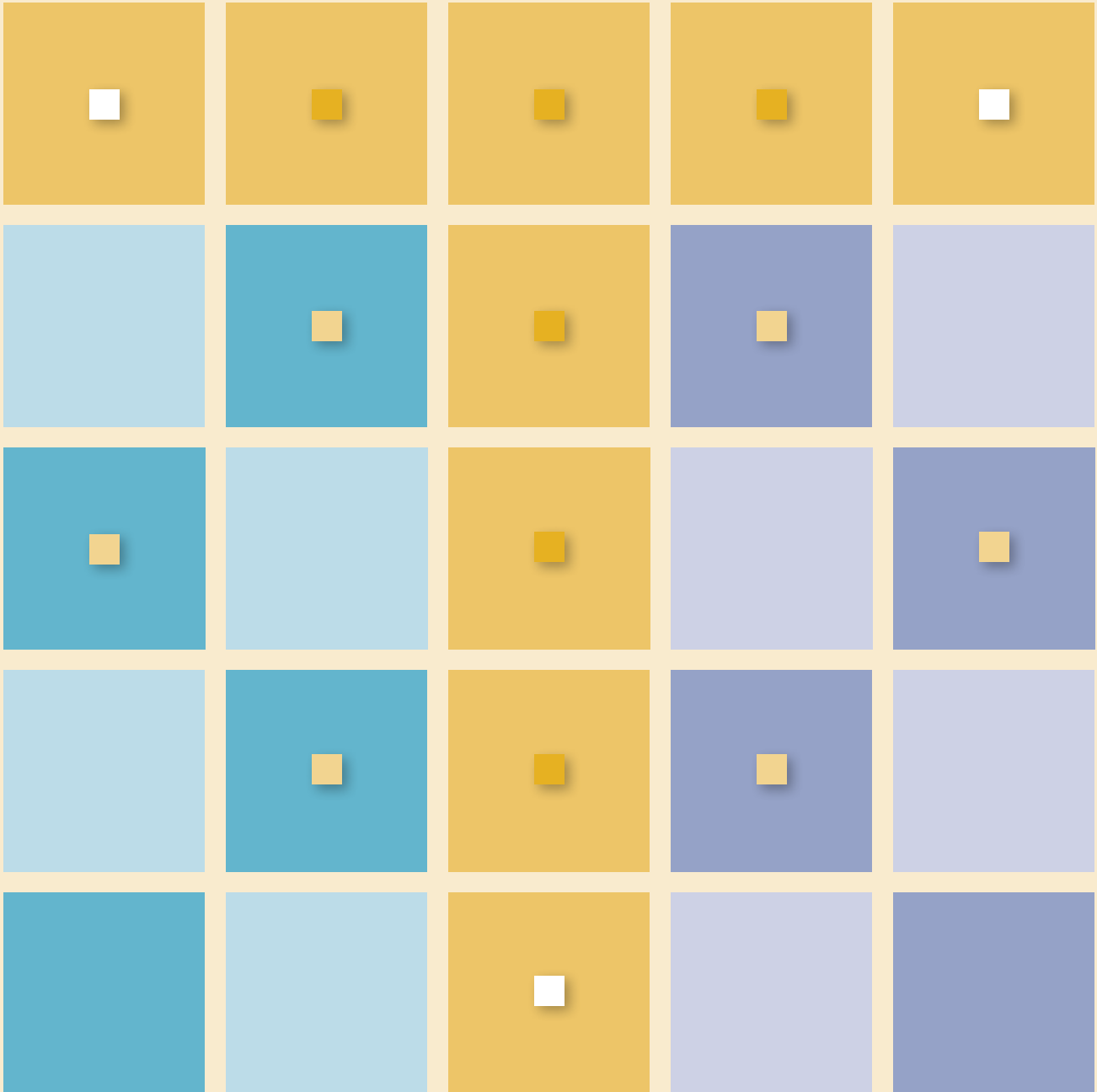


Training and Reference Guide for a Screening Checklist to Initiate Use of the Copper IUD



Second edition

This second edition of the *Training and Reference Guide for a Screening Checklist to Initiate Use of the Copper IUD* is consistent with the 2008 revisions to the World Health Organization's *Medical Eligibility Criteria for Contraceptive Use*. Family Health International (FHI) developed this guide, along with other similar guides, to provide training and reference materials in support of the FHI checklists. Each of these guides has been published under FHI's Contraceptive and Reproductive Health Technologies Research and Utilization (CRTU) program, which is supported by the U.S. Agency for International Development (USAID) under the terms of Cooperative Agreement No. GPO-A-00-05-00022-00. The contents of this series of publications do not necessarily reflect the views of USAID.

FHI is a public health and development organization working to improve the lives of the world's most vulnerable people. FHI conducts research and implements programs that advance public health and build local capacity to address development problems. FHI has been a global leader in family planning and reproductive health since 1971 and in the worldwide response to HIV/AIDS since 1986. Our research and programs also address malaria, tuberculosis, and other infectious and chronic diseases.

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This training and reference guide was developed for family planning service providers interested in using the *Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD*, commonly referred to as the “IUD Checklist.” Designed to serve as both a training and reference tool, the guide is composed of two parts: a training module and a collection of essential, up-to-date reference materials on the copper intrauterine device (IUD). This guide is part of a series to train on other checklists, namely the *Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives*, the *Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN)*, the *Checklist for Screening Clients Who Want to Initiate Contraceptive Implants*, and the checklist entitled *How to Be Reasonably Sure a Client Is Not Pregnant*.

The IUD Checklist was developed to assist service providers in screening clients who have already been counseled about contraceptive options and who have made an informed decision to use the copper IUD. This simple job aid is based on the technical guidance provided by the World Health Organization (WHO) in its *Medical Eligibility Criteria for Contraceptive Use* (2004, updated 2008). The checklist supports the application of these guidelines—known as the WHO MEC—into service delivery practice.

Research findings have established that the IUD is safe and effective for use by most women, including those who have not yet given birth and those living with or at risk of HIV infection. For some women, IUD insertion is not recommended because of the presence of certain medical conditions, such as pelvic inflammatory disease (PID) or cervical cancer. The IUD Checklist provides a series of questions to screen for medical conditions known to preclude safe IUD insertion and use, allowing the provider to determine if a woman is medically eligible to receive this method.

The IUD Checklist also provides a series of questions to rule out pregnancy. This is a required practice, because IUD insertion in a pregnant woman may result in a septic miscarriage. Pregnancy can be reliably determined with a pregnancy test, but in many areas of the world these tests often are either unavailable or unaffordable. In such cases, clients who are not menstruating at the time of their visit (occasionally referred to in this guide as “nonmenstruating women,” for the sake of simplicity) are often denied contraception by providers who rely on the presence of menses as an indicator that a woman is not pregnant. Usually, these women are required to wait for their menses to return before they can initiate a contraceptive method, thus putting them at risk of an unwanted pregnancy. The pregnancy-related questions on the IUD Checklist are taken from the checklist entitled *How to Be Reasonably Sure a Client Is Not Pregnant*. This checklist, referred to as the “Pregnancy Checklist,” has been shown to be 99 percent effective in ruling out pregnancy.

Purpose of the Training and Reference Guide

This publication is intended to provide program managers, administrators, trainers, and service providers with

- a training module on how to use the IUD Checklist;
- an overview of the IUD Checklist and guidance for adapting it for local use;
- information on the most current research regarding the validity, effectiveness and use of the IUD Checklist;
- current, essential, evidence-based information on the IUD.

Intended Users of This Guide

This guide can be used by

- trainers, facilitators, program managers, and administrators responsible for training service providers to use the IUD Checklist;
- service providers who need to apply the IUD Checklist in their practices and are responsible for learning how to use it;
- policy-makers and program managers interested in introducing the IUD Checklist for use in their community.



Note: This guide focuses exclusively on how to use the IUD Checklist. In order to provide quality services, providers who offer or plan to offer the Copper IUD to their clients may also need training or information on additional topics, such as IUD insertion techniques, details on various contraceptive methods, and family planning counseling techniques.

For more comprehensive, evidence-based information on the IUD, please visit www.iudtoolkit.org.

Intended Participants of the Training

Training on the IUD Checklist would benefit both clinical and non-clinical service providers who either counsel clients about IUDs or provide this contraceptive method. Some examples of appropriate participants would be

- family planning providers;
- providers appropriately trained in conducting pelvic exams, such as physicians, midwives, clinical officers, nurses, or auxiliary nurses;
- non-clinical health workers, such as counselors or assistants, who can be trained to use the first two sets of screening questions. A clinical service provider would then complete the checklist based on the results of the pelvic exam.

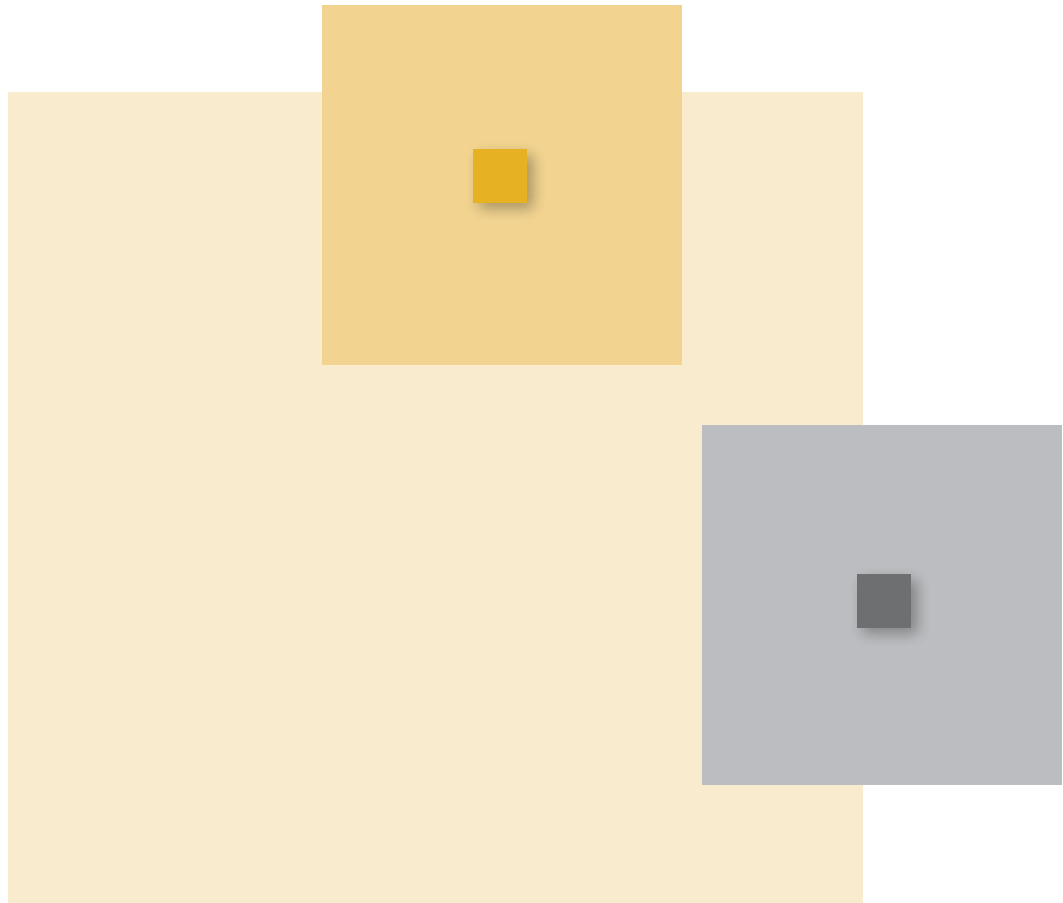
How to Use This Guide

Using the guide as a training tool

This guide provides a curriculum for training service providers to use the IUD Checklist. Training on the IUD Checklist can be completed in approximately six hours. Facilitators are free to adapt the training in order to serve the needs of their particular audience and may add or delete activities or use the information provided to create their own training. Additional tools that may assist the facilitator in preparing or adapting the training have been assembled in the section entitled Collateral Materials. They are described on page 9. Training schedules for different types of audiences are also available and may be found in the section entitled Supplementary Training Schedules, page 73.

Using the guide as a reference tool

This guide also provides reference information that supplements the training. This information includes recommendations on adapting the checklist to the local context, basic evidence-based information on the IUD, and an annotated bibliography.



Learning Objectives

By the end of the training, participants will have learned or become familiar with

- the rationale, purpose, and design of the IUD Checklist;
- the medical eligibility criteria to screen clients for IUD initiation;
- proper use of the checklist.

Number of participants

No more than 30 people are recommended per training.

Time

A minimum of six hours is required to complete all sessions. This includes the Optional Session, but does not include breaks.

Structure of the Module

Session	Time	Topic	Training Method
1	30 minutes	Welcome and Introductions Exercise A: Peel the Cabbage	Large group activity; group discussion
2	20 minutes	Rationale and Purpose of the IUD Checklist	Facilitator presentation
	10 minutes	Exercise B: Demonstrating the Benefits of Using the Pregnancy Checklist	Small group activity
	40 minutes	Exercise C: Review of the WHO Medical Eligibility Criteria	Large group activity
3	40 minutes	Design of and Instructions for Using the IUD Checklist	Facilitator presentation
	170 minutes	Exercise D: Practice Using the IUD Checklist	Small group activity
4	15 minutes	Wrap-Up	Group discussion
Optional Session	25 minutes	Summary of Research Findings	Facilitator presentation

Each training session has four components:

- **Objective**—a short description of the purpose and learning objective(s) for the session
- **Time**—anticipated length of the session
- **Training Steps**—basic steps that guide the trainer through the activities
- **Facilitator’s Resource**—detailed information to convey to participants, as indicated in the training steps

Training Materials

Facilitators will need the following materials:

- flip-chart paper
- tape
- markers
- colored pencils for all participants (red and green are recommended)
- training handouts:
 - the *Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD*
 - two versions of the Quick Reference Chart (one with the categories colored in and one with no color)
 - Scenario Exercises for Participants
 - Answer Guide to Scenarios

* The training handouts can be found on pages 37-54. They are also available as separate, printable PDF files in the section entitled Collateral Materials (see page 9).

Preparation for Facilitators

In order to understand the purpose, content, and approach of the training, we recommend that facilitators master the information contained in this guide. Facilitators should also be very familiar with the training handouts used in conjunction with the participant exercises, with the source documents for the technical guidance, and with the presentations. (All handouts, source documents, and presentations are accessible from the Collateral Materials section.) Some sessions require advance preparation, such as photocopying, preparing flip charts, or preparing components for exercises. Facilitators should know their audience and adapt the training accordingly.

Due to the technical nature of the subject matter, it is highly likely that questions will arise that are beyond the scope of the information provided in the training portion of this guide. The information provided in the reference guide or in the collateral materials may help facilitators to address some of these questions. As this guide does not aim to comprehensively answer all questions around IUD provision, additional training may be required. In those limited cases where the facilitator does not have a clinical background, it is recommended that someone with a clinical background be present to answer technical questions.

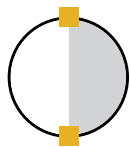
Key information for the facilitator is noted throughout the training module with the following symbol.



Collateral Materials

Following is the list of the collateral materials accompanying this training and reference guide, which have been assembled to help facilitators prepare their training sessions. These materials, which [may be accessed by clicking this link](#), will also be useful when adapting the content for different audiences or participant groups. The source documents for the technical guidance and the training handouts, in PDF format, are printable. There are also *Powerpoint* presentations with speaker notes, as well as agendas and certificates in *Microsoft Word*, which are editable.

1. Participant agenda for a combined training on all five checklists
2. *PowerPoint* presentations for orienting different audiences to the checklists
 - *PowerPoint* presentation A (for facilitators):
How to Use Screening Checklists to Initiate Use of Contraceptives
 - *PowerPoint* presentation B (for policy-makers and program managers):
Screening Checklists to Initiate Use of Contraceptives—Tools for Service Providers
3. Handouts for participants:
 - Scenario Exercises for Participants
 - Answer Guide to Scenarios
 - Quick Reference Charts
 - Five Screening Checklists
 - Certificate of Attendance (sample)
4. Electronic versions of all five training and reference guides
5. Basic, essential, evidence-based information on combined oral contraceptives (COCs), depot-medroxyprogesterone acetate (DMPA), intrauterine devices (IUDs), and implants:
 - *Medical Eligibility Criteria for Contraceptive Use*, WHO 2004
 - Revisions to the *Medical Eligibility Criteria for Contraceptive Use*, WHO 2008
 - *Selected Practice Recommendations for Contraceptive Use*, WHO 2004
 - Revisions to the *Selected Practice Recommendations for Contraceptive Use*, WHO 2008
 - *PowerPoint* presentation C: Overview of COCs
 - *PowerPoint* presentation D: Overview of Injectables—DMPA and NET-EN
 - *PowerPoint* presentation E: Overview of the IUD
 - *PowerPoint* presentation F: Overview of Implants
 - *PowerPoint* presentation G: Hormonal Contraceptives—Considerations for Women with HIV and AIDS



**30
minutes**

- Objectives:**
- To present the learning objectives of the training
 - To facilitate introductions among participants and facilitator(s)
 - To develop a common understanding of training expectations and group norms
 - To “break the ice” and help participants become engaged in the training

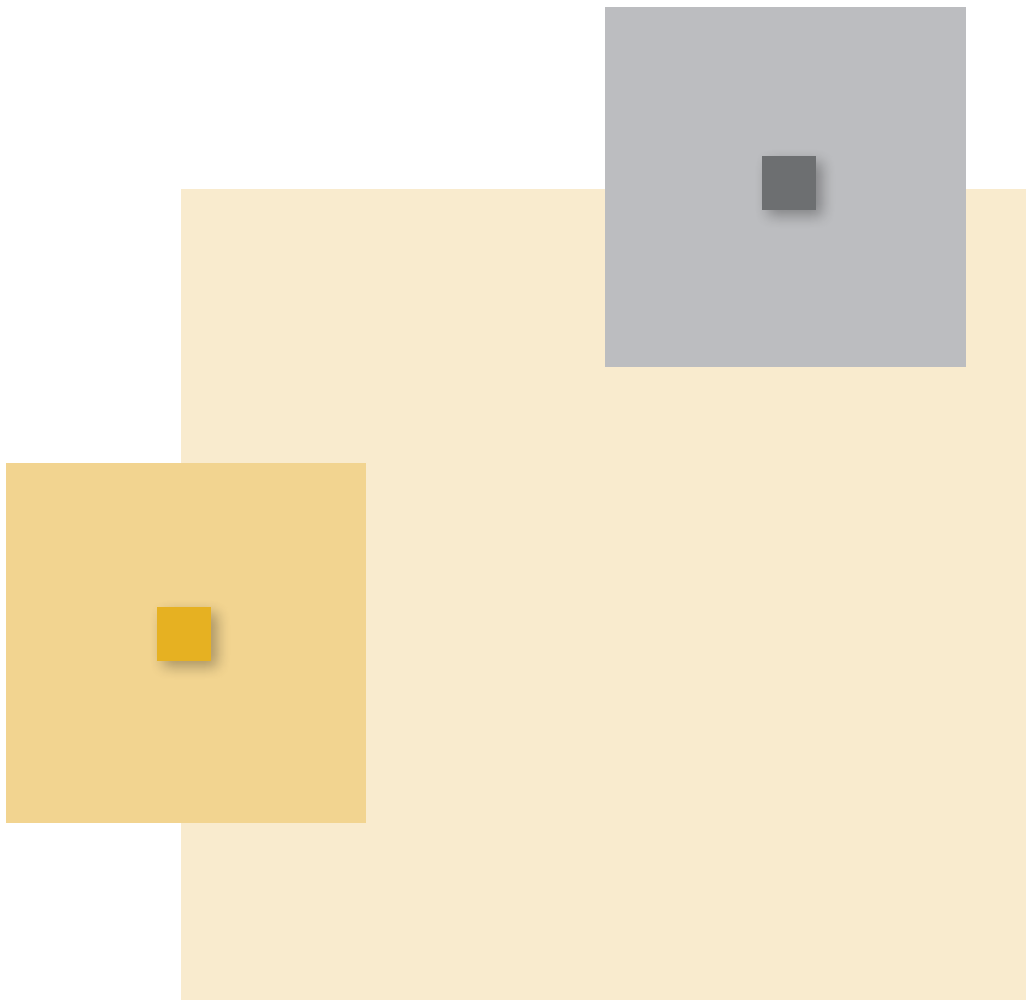
Training Steps:

1. Welcome the participants and introduce yourself and any other facilitators. Provide an opportunity for participants to introduce themselves, as well. You may choose to have participants do this by stating their name and area of expertise or by using the icebreaker activity in the shaded box below. The icebreaker activity will also help you to understand your audience better.
2. Ask participants to state what they expect to learn from the workshop. Write their expectations on flip-chart paper and save them for later. These expectations will be valuable at the end of the workshop as an evaluation tool.
3. Ask participants to suggest guidelines, or norms, to be followed by the group during the training session. Group norms could include: switching off mobile phones, respecting others’ right to speak, etc.
4. Launch the training by discussing the title of the IUD Checklist and the learning objectives of the training. Highlight any relevant expectations that were previously expressed by participants.
5. Conduct Exercise A (page 12) to engage participants in an introductory discussion of their current practices for screening women who wish to have an IUD inserted.

Icebreaker Activity

Each participant talks to the person next to them for five minutes to find out: a) their name, b) the name of their organization and the nature of their work, and c) why they are attending the training today. Participants should then present this information back to the group.

6. Explain that the *Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD*, which we will often refer to as the “IUD Checklist”, was developed to help providers correctly determine that a woman has no conditions that would prevent her from safely receiving an IUD.
7. Explain that participants will review the IUD Checklist and will practice using it later in the training. In so doing, they will discover the answers to the following questions:
 - Why was the IUD Checklist developed?
 - How should service providers use the IUD Checklist?
 - What is the basis for the IUD Checklist?
 - How does the IUD Checklist work?



Exercise A: Peel the Cabbage

Preparation

Prior to the training, write the following three questions at least four times, each on a different piece of paper. You should have at least 12 pieces of paper. Mix the pages up and then layer and crumple them so that they resemble a cabbage. Include additional questions on additional pieces of paper, as appropriate. Also write each of these three questions on a different flip-chart page, and tape up each page for all to see.

Name one practice that you follow to determine if a woman can safely receive an IUD.

Name one approach to ruling out pregnancy prior to IUD insertion.

Name one health condition that prevents women from having an IUD inserted.

Objective: Participants will discuss their current practices for screening women who wish to start using an IUD

1. Toss “the cabbage” to one of the participants. The person holding the cabbage must peel off the top layer and answer the question. After answering the question, the participant “tosses the cabbage” to another participant to answer the next question. If this question has already been asked, the participant must come up with a different response. Continue tossing the cabbage until all the questions are answered. **Possible answers are given below.**

Name one practice that you follow to determine if a woman can safely receive an IUD.

Take the client’s medical history, ask questions about the presence of certain symptoms, require laboratory tests, use the IUD Checklist, etc.

Name one approach to ruling out pregnancy prior to IUD insertion.

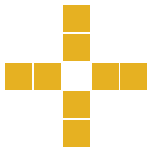
Administer a pregnancy test, check for the presence of menses, perform a pelvic exam, use the Pregnancy Checklist, etc.

Name one health condition that prevents women from having an IUD inserted.

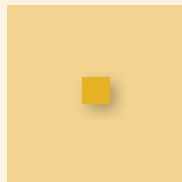
Current pelvic inflammatory disease (PID), cervical cancer, sexually transmitted infections (STIs), etc.

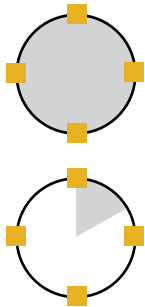
2. If appropriate for your audience, you may chose to make the exercise fun by having the group give some form of mild “penalty” to participants who cannot answer their questions. This might include such things as raising one hand, bending their heads to one side, or standing on one foot, until the cabbage is completely peeled. Let the participants be creative!

3. Conclude the exercise by telling participants they will have the opportunity to see whether their answers were correct or not at the end of Exercises B and C in Session Two.

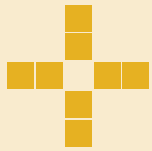


Participants may already have extensive knowledge and practical experience in family planning. Make an effort to incorporate participants’ questions, knowledge, and experiences into your training session, as appropriate.





70
minutes



If there are national guidelines or protocols for the provision of family planning, it is important to link the checklists to these documents to promote utilization of the checklist.

Objective: To learn why and how the checklist was developed

Training Steps:

1. Hold up a copy of the IUD Checklist to show participants, **but do not distribute it until later in the session, at the end of Exercise C.** Check to see if the participants are familiar with the checklist, by asking the following questions:
 - How many of you already use the IUD Checklist to decide if a woman can safely have an IUD inserted?
 - For those who use the checklist, do you find it useful in your work? How?
2. Explain what the IUD Checklist is and why it was developed. If appropriate for your audience, and if needed, you may also choose to discuss the research on the IUD and Pregnancy Checklists (see Optional Session, page 34).
3. Engage participants in a discussion of how service providers should use the IUD Checklist. Ask participants the following question to emphasize the use of this job aid to improve efficiency in their daily work:
 - In your daily work, how easy is it to use your national guidelines/protocols to determine if a woman can safely have an IUD inserted?
4. Discuss the basis for the three sets of questions on the IUD Checklist.
 - First, explain the concept of the Pregnancy Checklist questions, what they are, and why they were developed.
 - Then, perform Exercise B (page 15) to help participants understand the usefulness of the Pregnancy Checklist questions for ruling out pregnancy among women who are not menstruating at the time of their visit.
 - Next, introduce the WHO MEC and explain its purpose.
 - Finally, perform Exercise C (page 17) to help participants understand how the four MEC categories work in relation to the use of IUDs.

Exercise B: Demonstrating the Benefits of Using the Pregnancy Checklist

Preparation

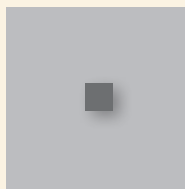
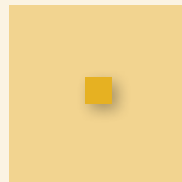
In advance of the training, write each of the following statements on a separate piece of paper. The statements represent six circumstances that prevent a woman from becoming pregnant and one that does not.

- **Client 1:** "I've not had sexual intercourse since my last menstrual period."
- **Client 2:** "I always use condoms during intercourse, but I want to start using something else."
- **Client 3:** "I just started my menses six days ago."
- **Client 4:** "I have a 3-week-old baby."
- **Client 5:** "Five days ago, I had a miscarriage."
- **Client 6:** "I am fully breastfeeding my 5-month-old baby. Since having my baby, I have not had my menstrual period."
- **Client 7:** "It has been two weeks since I had my last menstrual period."

Objective: Participants will gain a better understanding of the benefits of using the Pregnancy Checklist by visually comparing the number of women who would potentially receive contraception at the time of their visit when providers do and do not use the checklist. This exercise is based on studies of the Pregnancy Checklist done in Kenya, Guatemala, Mali, Senegal, and Egypt.

1. Ask seven participants to come to the front of the room. They will represent seven female clients seeking an IUD who are not menstruating at the time of their visit.
2. Tell the rest of the participants they will act as providers. They will need to rule out pregnancy before providing contraception to these women and are to rely on their current practices to make their determinations. Ask them to explain how they would respond to these clients. Participants might say these clients should be
 - sent home with condoms and asked to return when menstruating, or to return four weeks later for an exam if still not menstruating (whichever comes first);
 - given pregnancy tests;
 - given pelvic or abdominal exams;
 - asked more questions.

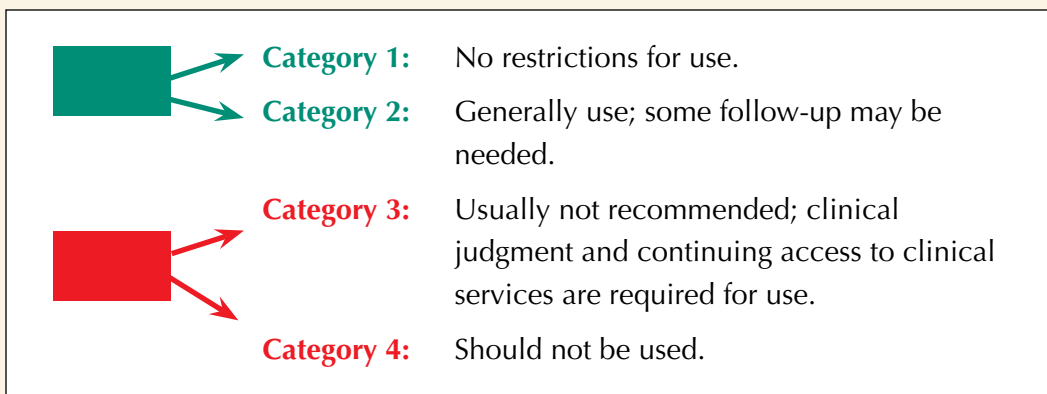
3. Now distribute your prepared statements, one to each volunteer “client.” Have the first client read the first statement out loud. Then ask the group acting as providers whether pregnancy can be ruled out for this particular client. Require participants to explain their answers.
4. Repeat the exercise for all seven clients. Correct any mistakes as you go along.
5. Conclude the exercise by stating that clients 1-6 represent the six questions on the Pregnancy Checklist that allow pregnancy to be ruled out. Emphasize that if these questions were not asked, these clients would not be able to receive an IUD right away. Point out that the Pregnancy Checklist prompts providers to inquire about all six of these conditions when facing a client. Explain that, for client 7, pregnancy has not been ruled out. Since it has been two weeks since her last menstrual period, there is a possibility she is pregnant. However, the Pregnancy Checklist cannot determine that this woman is, in fact, pregnant.



Exercise C: Review of the WHO Medical Eligibility Criteria

Preparation

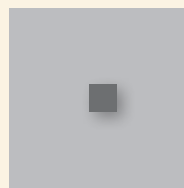
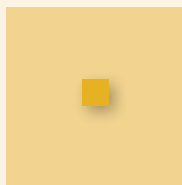
- Prior to the training, make photocopies of both Quick Reference Charts (pages 49-50) and the IUD Checklist (pages 51-54) to distribute to each participant.
- You will also need green and red pens or markers for each participant.
- In addition, you may want to prepare a flip-chart page containing the information in the box below.



Objective: Participants will review the Quick Reference Chart to become familiar with relevant conditions that have been studied and determined to be safe, or not safe, for IUD insertion and use

1. Give each participant a blank copy of the Quick Reference Chart, along with a green and a red pencil or marker.
2. Present the information in the box above, illustrating that the four MEC categories may be simplified into two categories: GREEN (representing categories 1 and 2) indicates that the method may be used and RED (representing categories 3 and 4) indicates that the woman is not medically eligible to use the method.
3. Ask participants to use the green and red pencils or markers to color in the rectangles to the right of the conditions listed on the chart. Choose a maximum of four conditions, such as pregnancy, STIs/PID, HIV, and AIDS. Have participants use GREEN if they think the condition falls under category 1 or 2 and RED if they believe the condition falls under category 3 or 4. They should choose the color based on their knowledge, assumptions, or best guess. At your discretion, participants can work individually, in pairs, or as a group. Allow 10 minutes to complete this task. (If no colored pencils or markers are available, have participants write a “G” for green or an “R” for red in the rectangles.)

4. Now, distribute copies of the color version of the Quick Reference Chart and ask the participants to compare their own answers to it. Allow about 10 minutes for them to assess whether their answers were correct or incorrect. **Note that the color version of the chart has four colors, one for each category. To make this activity simpler, only two colors are being used instead of four. Explain to participants that light red/pink is RED and light green is GREEN.**
5. Ask volunteers to share which color or category they assigned to each condition. Correct any misinformation as you go along. Be sure to cover “Significant Issues Affecting Medical Eligibility” for IUD insertion, as outlined on pages 22 and 23.
6. Distribute a copy of the IUD Checklist. Ask participants to compare questions 7-21 of the IUD Checklist with the conditions colored in red on the Quick Reference Chart. Participants will quickly see that the checklist questions only ask about category 3 and 4 conditions (red categories). Explain that these questions were written to identify women who should not have an IUD inserted or who will require additional evaluation by a higher level provider before inserting an IUD. Category 1 and 2 conditions (green categories) are not addressed on the checklist, because research shows that women with these conditions can have an IUD inserted safely.



Facilitator's Resource:

Why Was the IUD Checklist Developed?

- The IUD Checklist was developed to help family planning providers screen women for certain medical conditions in order to determine quickly and with confidence whether a client may safely have an IUD inserted as her contraceptive method of choice.
- Screening is necessary because some medical conditions preclude safe IUD insertion. **Most** women who want to initiate use of an IUD can safely and effectively do so. **Some** women need further evaluation and/or treatment before having an IUD inserted. For example, a woman who recently had gonorrhea should not have an IUD inserted unless it is determined through further evaluation that she is not currently infected. A **few** women, such as those who have current pelvic inflammatory disease (PID) or cervical cancer, should not have an IUD inserted under any circumstances.
- Screening prior to IUD insertion should also include ruling out pregnancy, because IUD insertion in a pregnant woman could result in a septic miscarriage.
- The IUD Checklist would benefit both clinical and non-clinical service providers who either counsel clients about IUDs or provide this contraceptive method, such as
 - family planning providers;
 - providers appropriately trained to conduct pelvic exams, such as physicians, midwives, clinical officers, nurses, or auxiliary nurses;
 - non-clinical health workers, such as counselors or assistants, who can be trained to use the first two sets of screening questions. A clinical service provider would then complete the checklist based on the results of the pelvic exam.

How Should Service Providers Use the IUD Checklist?

- As a screening/decision-making tool
 - The IUD Checklist can be used as a screening tool to help a provider determine whether a woman (1) is a good candidate for IUD use, (2) will need further evaluation, or (3) should choose another family planning method. The checklist screens for **known** conditions only. It is **not** a diagnostic tool, such as a blood test, which can determine whether a woman has a particular disease or condition.
 - The checklist is not a counseling tool and should only be used after counseling has been completed and the woman has made an informed decision to have an IUD inserted. In order to make an informed decision,

each woman should be counseled about her contraceptive options by a provider who is properly trained in counseling techniques and in providing information on various contraceptive methods.

- As a job aid for using resources more efficiently
 - The IUD Checklist can save time for both providers and clients by giving providers simple questions to rule out pregnancy, thus eliminating the need for most nonmenstruating clients to make another appointment.
 - Evidence-based practice guidelines can be lengthy and complicated. Use of the IUD Checklist provides a way to apply these same guidelines in a simple, efficient, and timely manner.

What Is the Basis for the IUD Checklist?

- The IUD Checklist is composed of three sets of questions to determine if the client is medically eligible to use an IUD:
 - Questions 1-6 allow providers to be reasonably sure that the client is not pregnant.
 - The next two sets of questions (questions 7-14 and 15-21) allow the provider to identify women who may have medical contraindications for IUD insertion other than pregnancy.
- All three sets of questions on the IUD checklist are based on WHO's *Medical Eligibility Criteria for Contraceptive Use* (2004, updated 2008), which is commonly known as the WHO MEC. The WHO MEC is a set of recommendations to support the development of national guidelines for the safe provision of contraceptives. It is updated by a WHO expert working-group every five years (or as needed), in order to reflect the latest clinical and epidemiological data. The Quick Reference Chart on page 50 is a condensed version of the information contained in the WHO MEC.

First we will discuss the questions designed to rule out pregnancy, and then we will discuss the questions related to other medical eligibility issues.

■ **Pregnancy-Related Questions (Questions 1-6)**

- The first set of questions on the IUD Checklist (questions 1-6) is taken from another checklist entitled *How to Be Reasonably Sure a Client Is Not Pregnant* (Pregnancy Checklist). Ruling out pregnancy prior to IUD insertion is essential, because IUD insertion in a pregnant woman could result in a septic miscarriage. Also, the pregnancy-related questions help to address a medical barrier that women often encounter when seeking an IUD at a time when they are not menstruating. In countries where resources are limited and pregnancy tests are often unavailable or unaffordable, many providers worry that these women may be pregnant (unless they are within four weeks

postpartum). Many of these clients are sent home without contraception to await menses. Those who are unable to return—generally because of time or financial constraints—risk unintended pregnancy.

- The questions from the Pregnancy Checklist help providers to be reasonably sure a woman is not pregnant or to decide that another approach is required to rule out pregnancy. Each question describes a situation that effectively **prevents** a woman from getting pregnant. **The checklist is not a diagnostic tool for determining if a woman is pregnant.** (Note: In the event that pregnancy is not ruled out by questions 1-6, this still does not *necessarily* mean the woman is pregnant. It only means that another approach will be needed to make a definitive determination.)

■ **Other Medical Eligibility Questions (Questions 7-21)**

- The WHO MEC considers various individual characteristics (e.g., age, breastfeeding status) or health conditions (e.g., diabetes, hypertension) that may or may not affect eligibility for the use of each contraceptive method and classifies them into one of the following four categories.

Category	Recommendation
1	No restriction for use of method
2	Advantage of using method outweighs theoretical or proven risk: method generally can be used, but follow-up may be required
3	Theoretical or proven risk outweighs the advantages of using method: method not recommended except if other more appropriate methods are not available/acceptable
4	Method should not be used

- The IUD checklist poses questions related to categories 3 and 4 only. These two categories cover conditions for which the method is not recommended or should not be used. Category 1 and 2 conditions are not addressed on the checklist, because research shows that women with these conditions can have an IUD inserted safely.
- The IUD checklist incorporates two screening approaches: medical/personal history and pelvic examination. This is why questions 7-14 solicit answers from the client, whereas questions 15-21 are answered by the provider, based on his/her findings from the pelvic exam.

■ Significant Issues Affecting Medical Eligibility

The following is a brief summary of some significant issues affecting medical eligibility for IUD insertion. These issues should be discussed during Step 5 of Exercise C and may also be reemphasized during discussion of the scenarios. The following information was taken from the research which informed the development of the WHO MEC. Additional information may be found in the reference section of this guide (pages 59-68) and in the guidance provided on the IUD Checklist itself.

- **Use of the IUD by nulliparous women**

In the past, concerns had been raised about whether IUD use was associated with infertility. These concerns led to the recommendation that nulliparous women should not receive an IUD. Subsequently, nine well designed studies, conducted between 1985 and 2002, examined this issue specifically. These studies, which were reviewed by the WHO expert working-group, suggested there is no increased risk of infertility. The recommendation has since been changed to allow nulliparous women to receive an IUD.

- **Use of the IUD by women with pelvic inflammatory disease (PID)**

Current PID is a contraindication for IUD insertion. If a woman presents with PID, she should be treated with antibiotics and may have an IUD inserted when she is cured. A woman who is already using an IUD and who subsequently develops PID does not need to have her IUD removed, but can be treated for PID with the IUD in place if she chooses to continue using her IUD. Research has shown that there is no difference in clinical outcomes of PID when treated with the IUD left in place or taken out.

- **PID and Sexually Transmitted Infections (STIs)**

There is a potentially small increase in the risk of PID if an IUD is inserted in a woman with current gonorrhea or chlamydial infection. However, it is important to understand that women with gonorrhea or chlamydia may develop PID, with or without an IUD. It has been shown that IUD insertion in women with current infection may increase this risk slightly, by 0.15 to 0.30 percent. Therefore, the recommendation is to treat any current cervical infection and to provide condoms until the infection has cleared. If the woman still wishes to use an IUD once the infection has cleared, the device may be inserted. Careful follow-up should be provided in these cases.

Identifying women who are at risk for an STI and determining appropriate next steps may be difficult. Women should be considered at high individual risk of infection if they have certain factors, such as multiple partners, a partner with multiple partners, or if their partners have symptoms of an

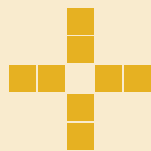
STI or were recently diagnosed with an STI. (**Note:** In countries where polygamous marriage is practiced, this risk is impacted by the sexual behaviors of each of the partners in the marriage. In other words, whenever the husband or any of the wives has more than one partner, the risk of contracting an STI increases.) Women at high individual risk generally should not have an IUD inserted. When contraceptive methods other than the IUD are not available or acceptable to a woman, she should be counseled about risk, checked for STI symptoms, and have the IUD inserted if there are no symptoms. (If possible, testing for current gonorrhea or chlamydial infection can be done, but is not mandatory.) Women should also be counseled to return in approximately four weeks after insertion to check for signs of infection, or be told to return immediately if she experiences symptoms of pelvic infection, such as low abdominal pain, vaginal discharge or fever.

- **Use of the IUD by women with HIV infection and AIDS**

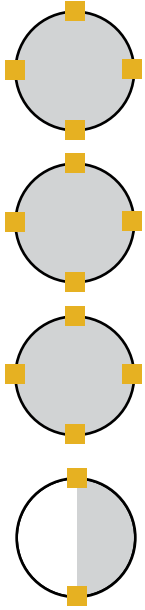
Human immunodeficiency virus (HIV) is a virus that attacks the immune system, making it difficult for the body to fight infection and disease. HIV is the virus that eventually causes acquired immunodeficiency syndrome (AIDS), which increases a person's risk of developing certain cancers and infections. AIDS is the last and most severe stage of the HIV infection.

IUDs can generally be initiated and used by HIV-infected women or by women at high risk of becoming infected with HIV. Women with AIDS should not have an IUD inserted unless they are clinically well on antiretroviral (ARV) therapy. However, women who develop AIDS while using an IUD can continue using the device even if they are not receiving ARV therapy.

IUD use has not been found to increase the risk of acquiring or transmitting HIV. There is some evidence showing no increased risk of complications, such as PID, for HIV-positive women compared to non-infected women. The risk of complications does increase in a woman with AIDS who is not on ARV therapy, and therefore the difference in status between HIV and AIDS should be considered.



Questions may be likely about these and other medical eligibility criteria. Details provided in the WHO MEC, on the IUD Checklist, and in the reference section of this guide may assist in providing answers to these questions.



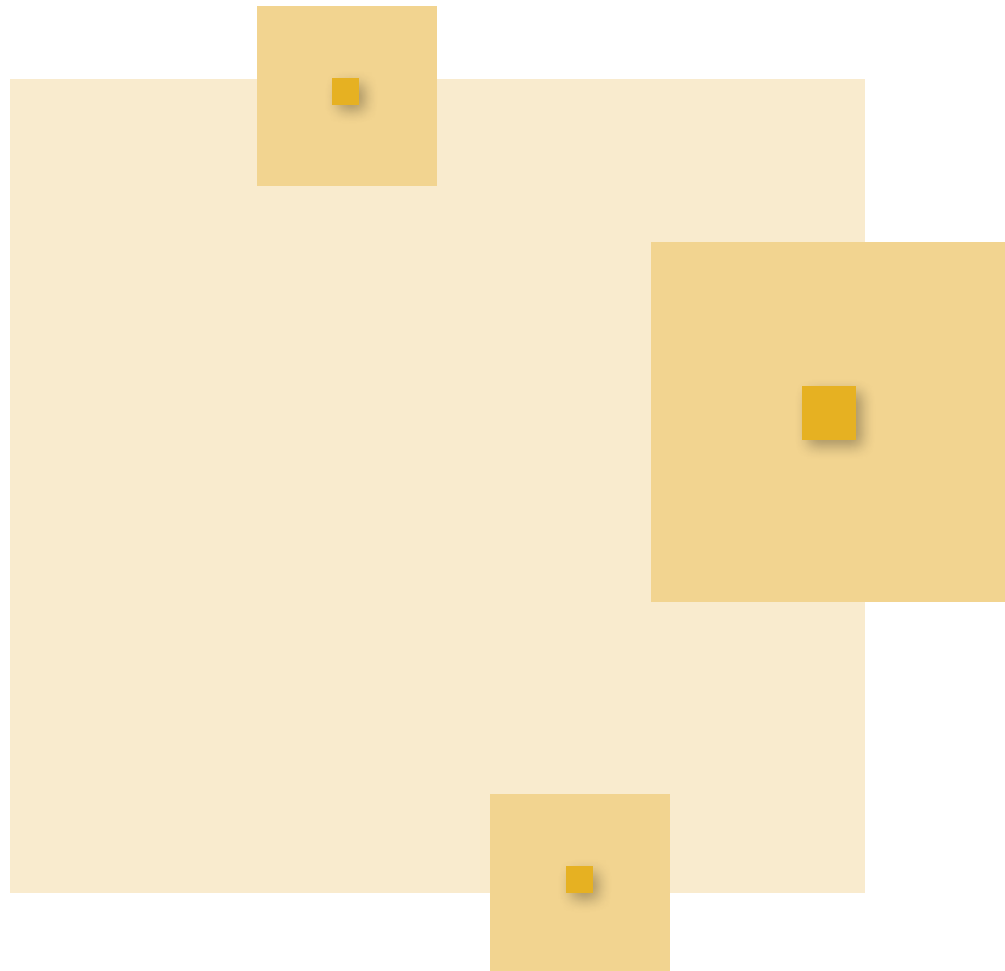
3 hours and 30 minutes

Objectives: To understand the design of the IUD Checklist

To practice using the IUD Checklist in different scenarios to ensure that participants are comfortable using it

Training Steps:

1. Discuss the checklist’s design and explain how to use the checklist.
2. Ask participants if they have any questions, and clarify anything they did not understand.
3. Conduct Exercise D (page 25) to allow everyone in the group to practice administering the checklist.



Exercise D: Practice Using the IUD Checklist

Preparation

Prior to the training:

- Photocopy the Scenario Exercises for Participants (pages 37-38).
- Make sure you are familiar with the information provided in the Answer Guide to Scenarios (pages 39-48).
- Make photocopies, if desired, of the Answer Guide to distribute at the end of the session.
- Prepare a flip-chart page containing the following questions:
 - Is this client a good candidate for receiving an IUD during today's visit?
 - Why or why not?
 - What course of action would you take next? (For example: counsel, refer, provide an IUD, send the client home with condoms to await menses, administer a pregnancy test, etc.)
 - Did you experience any problems applying the checklist to your scenarios?

Objective: To help participants become comfortable using the IUD Checklist

1. Introduce the scenario exercises and explain that participants will be grouped in pairs. Each pair will receive two scenarios. Within each pair, one participant will play the role of the client and the other will play the provider administering the checklist. Participants will then switch roles for the second scenario and repeat the process. This way, everyone will have a chance to practice using the checklist and to experience both roles.
2. Explain that after they role-play their scenarios, each pair should discuss and be able to answer the questions on the flip chart.
3. Divide the participants into pairs and distribute two scenarios to each pair. Participants will have 10 minutes to role-play each scenario and 10 minutes to answer the questions on the flip chart (40 minutes total). Give the following instructions, according to the role the participants will play:

For participants acting as providers

- Make sure you have read and understood the checklist questions and explanations before administering the checklist to the client.
- Ask the client the checklist questions and follow instructions to determine if the client can receive an IUD.
- Trust the client's response.

- Base your decisions on the IUD Checklist questions only, and not on any assumptions about the client. Making assumptions could lead you to the wrong conclusion and cause you to deny your client access to contraception unnecessarily.
- You may answer questions or define terms, if necessary. However, do not make substantive changes to the checklist questions. For example, do not separate one question into two questions or combine two questions into one.

For participants acting as clients

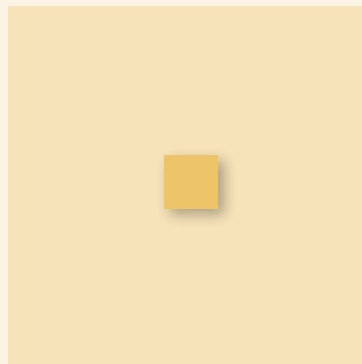
- Read the scenario carefully and answer the checklist questions based on the situations outlined in the scenario.
- If a situation is not specifically described in the scenario, you should answer “NO.” For example, if the scenario does not specify that the woman’s last menstrual period started within the past seven days, you, as a client, should answer “NO” to that question.

4. Reconvene the group and discuss each scenario with the whole group. Depending on the number of participant pairs, this part of the exercise may take between one and a half to two hours. For each scenario, ask a participant pair to share their answers to the questions on the flip chart. If they do not answer questions 1 or 2 correctly, or if additional possibilities exist in answer to question 3, solicit responses from the other participants, or provide it from the answer guide.
5. For each checklist question, discuss any concerns participants have about its phrasing or clarity. Help the group find ways to explain or rephrase the question without changing its meaning. **Be familiar with the information in the section of this guide entitled Adapting the Checklist to the Local Context, page 57.**
6. When discussing a scenario in which pregnancy cannot be ruled out, emphasize that the client should be told she is not **necessarily** pregnant, but that, in light of her responses, another approach will be needed to rule out pregnancy (either a pregnancy test, a pelvic exam, or awaiting her next menses). If she has to wait to rule out pregnancy, always provide her with an interim form of protection against pregnancy, such as condoms.
7. After all the scenarios have been discussed, the Answer Guide to Scenarios (pages 39-48) may be distributed to the participants for their future reference.

8. A course of action has been outlined for each scenario. However, if any adaptations are made to the scenarios and/or checklist, it should be recognized that the course of action may change somewhat, as well.
9. The scenarios have been designed to work with any provider training group. To further adapt the training to meet the needs of a specific audience, scenarios may be modified by the facilitator or by another qualified person. Additional scenarios may also be created.

Optional approaches for conducting scenarios

- Ask one or more of the participant pairs to role-play in front of the larger group. Have the whole group discuss each scenario before going on to the next one.
- Instead of role-playing in pairs, ask participants to work individually, each one developing a response to his/her scenario(s). Then have some participants present their responses to the larger group.
- Ask participants to work individually and then find two or three people who had the same scenario. They should discuss their responses and see how they differ. These small groups could then share with the larger group.



Facilitator's Resource:

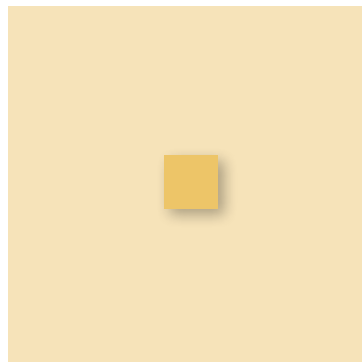
How Does the IUD Checklist Work?

- The IUD Checklist is designed to use the provider's time as efficiently as possible. **Notice that instructions for the first two sets of questions on the checklist state: "As soon as the client answers YES to any question, stop, and follow the instructions after question 6 (or after question 14)."** This means that if the client answers "YES" to any question, the provider is finished with that set of questions. Therefore, depending on the client's responses, the questioning may proceed question by question, OR the provider may discover the woman is not a good candidate early in the questioning.
- The IUD Checklist consists of 21 questions, as well as instructions for providers based on a woman's responses. The first set of questions is meant to identify women who are not pregnant (questions 1-6, related to pregnancy). The second and third sets of questions are meant to determine if the woman has no conditions that could preclude safe insertion of an IUD (questions 7-21, related to medical eligibility). Each of the checklist questions is explained in more detail on the reverse side of the checklist. Providers should refer to these explanations to understand the intent of the questions.
- **Pregnancy-Related Questions**
 - **"Yes" response**—If a woman answers "YES" to any **one** question and is free from signs and symptoms of pregnancy, providers can be 99 percent sure she is not pregnant. As instructed on the checklist, continue with the screening. However, if the client answered "YES" to question 1, read the guidance provided and follow the instructions to delay insertion until four weeks after delivery of her baby.
 - **"No" response**—If a woman answers "NO" to **all** questions, she has not been protected from pregnancy. To rule out pregnancy in these women, the provider will need to do a pregnancy test, conduct a pelvic exam, or have the woman return when she is menstruating. If the client is sent home to await her menses, always provide her with condoms to use in the meantime.
- **Medical Eligibility Questions Based on History**
 - **"Yes" response**—If a woman answers "YES" to any **one** of these questions, she is not medically eligible for an IUD; *however*, some of these women may become medically eligible after further evaluation. See the instruction box at the bottom of this set of questions and follow the guidance provided there.
 - **"No" response**—If a woman answers "NO" to **all** questions, proceed with the pelvic exam with the assistance of the third set of questions.

■ Medical Eligibility Based on Pelvic Exam

Only those providers trained to conduct a pelvic exam will continue with this set of questions. Unlike the previous two sets of questions, in which the client gives the answer, this set of questions is designed for the **provider** to answer, based on his/her observations during the pelvic exam.

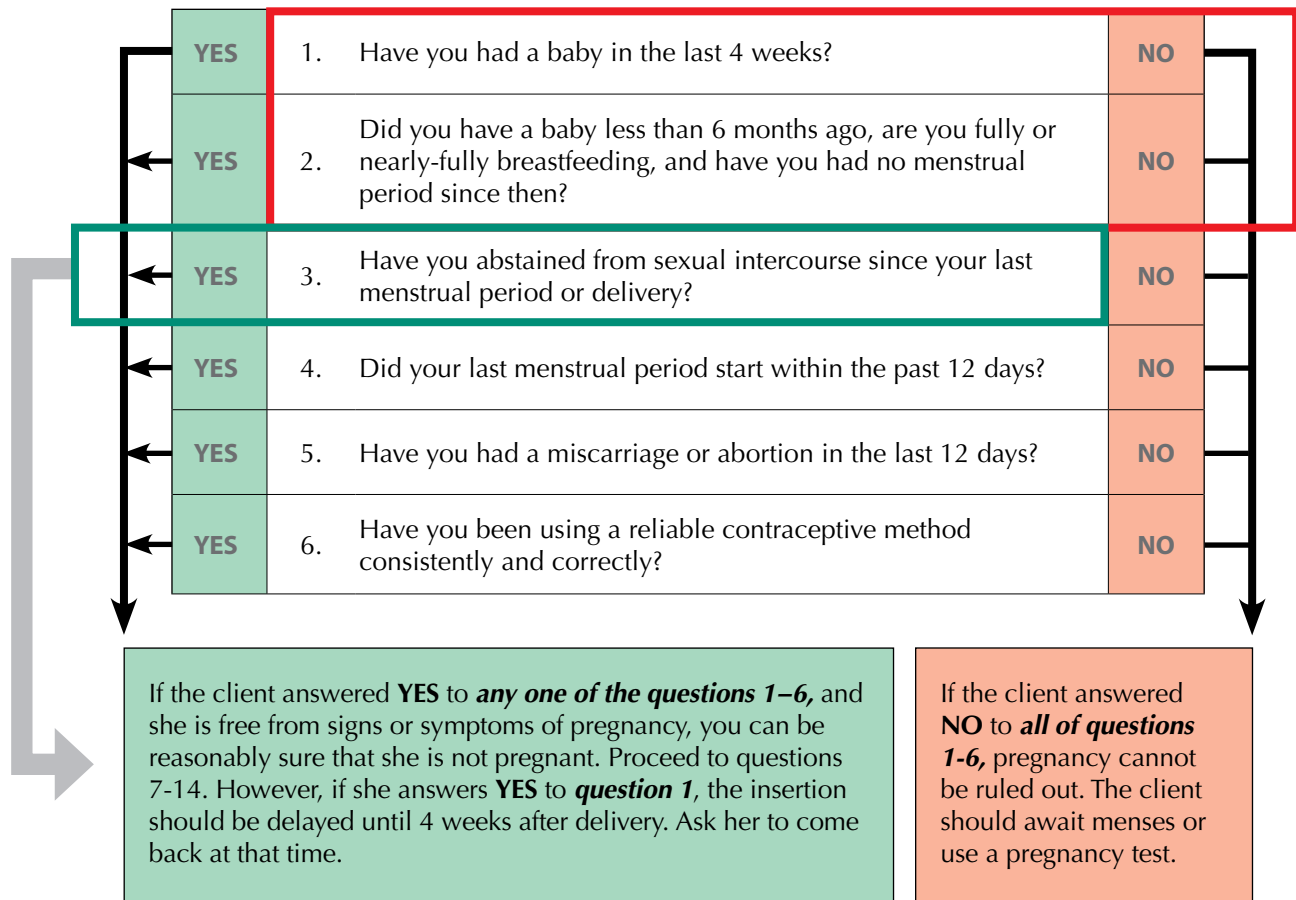
- **“Yes” response**—If the provider determines the answer is “YES” to any **one** of these questions, the client cannot receive an IUD immediately, but must wait until her medical condition is evaluated. Follow the guidance provided with the relevant checklist question to determine next steps.
 - **“No” response**—If the provider determines the answers are “NO” to **all** the questions, the client is medically eligible to receive an IUD. The provider may insert the IUD.
- Generally, the conditions asked about on the checklist are serious enough that a woman would know if she has them, because she would have had to seek medical attention for them. This is why several of the questions begin with “Have you ever been told ...,” “Do you have...,” and “Have you ever had...” If a woman has not been told she has a condition, providers should assume she does not have it.
- Providers should make an effort to build trusting relationships with clients before administering the IUD Checklist. For example, the provider might wish to convey to the client the necessity of answering as accurately and as honestly as possible, in order to avoid possible complications from IUD use. The majority of women will answer honestly to the best of their ability.



Example

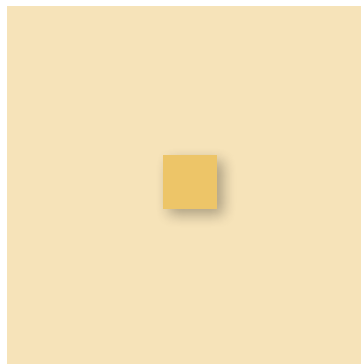
Suppose that a woman answers “NO” to questions 1 and 2, but then answers “YES” to question 3, as she has not had sexual intercourse since her last menstrual period. At this point, the provider should stop asking questions, because a “YES” response to any of the questions indicates a circumstance under which it is highly unlikely that a woman could be pregnant.

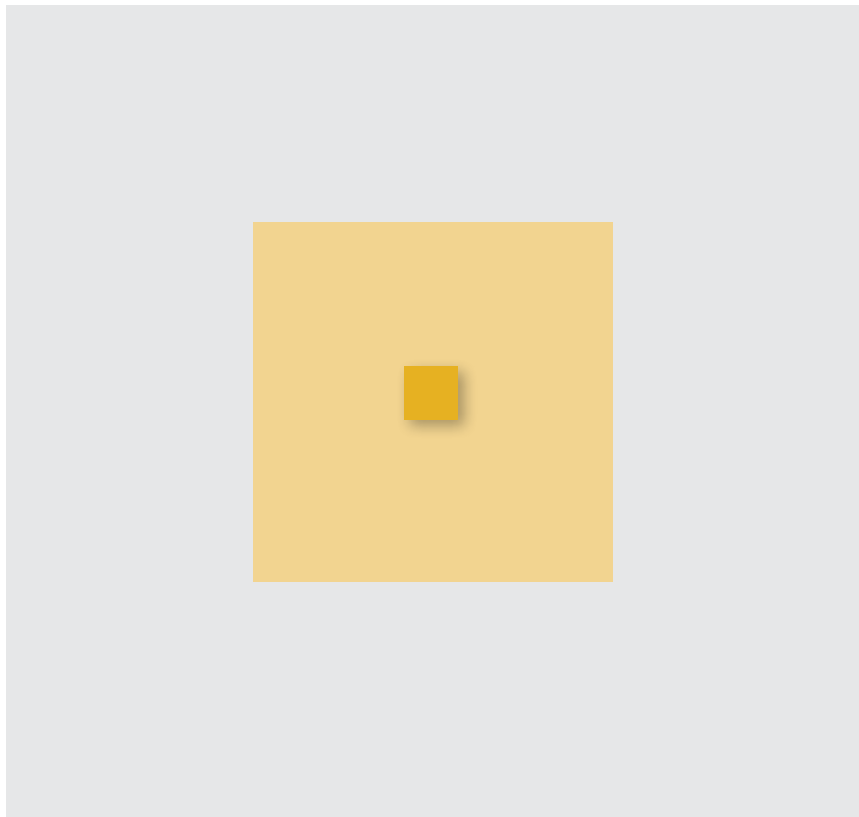
First, be reasonably sure that the client is not pregnant. If she is not menstruating at the time of her visit, ask the client questions 1-6. As soon as the client answers YES to any question, stop, and follow the instructions after question 6.



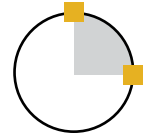
Optional information: Participants may inquire about the design elements of the checklist, such as arrows and colors. An explanation is provided below for your use in addressing these questions. It is important to note that while these design elements provide visual cues, they are **secondary** to the written instructions on the checklist, which participants **must** follow.

- The arrows next to the “YES” responses and the straight lines next to the “NO” responses offer cues as to how to proceed through the questions. The arrows indicate the provider should end the questioning and jump directly to the instruction box below that set of questions. The straight lines indicate the provider must proceed to the next question.
- Generally, if the client’s response falls in the GREEN boxes, she is a good candidate, and if her response falls in the RED box, she is probably not a good candidate. However, for the eligibility questions, ALL of the client’s answers must fall in the green boxes for the woman to be a good candidate, whereas for the pregnancy questions ONE answer in the green boxes is sufficient for her to be a good candidate.





- Objectives:**
- To summarize what was accomplished during the training session
 - To address any remaining issues
 - To thank participants for their attention and participation



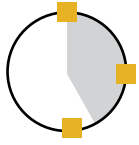
15 minutes

Training Steps:

1. Briefly summarize the objectives and accomplishments of the training.
2. Show participants the flip-chart page containing the expectations they expressed at the beginning of the training. Ask participants if these expectations have been met.
3. Engage participants in a wrap-up discussion, by asking the following questions:
 - How easy or difficult was it to use the IUD Checklist?
 - How easy or difficult was it to explain questions to the client?
 - What problems did you encounter while using the checklist?
 - Do you foresee any barriers to using the checklist in your work? How could these barriers be overcome?
 - What would help you to use the checklist in your work?
 - Do you have any suggestions for improving the checklist or for getting more providers to use it?
 - What did you find helpful about the training?
 - Could the training be improved in any way? If so, how?

This is a good way to end the training, because it allows you to address any issues or concerns that participants may have. Also, FHI requests that you compile these responses and forward them to our staff at publications@fhi.org for future improvements to this guide.

4. Thank the participants for their time and energy. Tell them whom they should contact for more information or materials.
5. Distribute certificates of attendance to each participant.



25 minutes

Objective: To understand the research surrounding the need for and the effectiveness of the IUD and Pregnancy Checklists

Training Steps:

1. Summarize the research on the acceptability of the IUD Checklist.
2. Summarize the research on the rationale for the Pregnancy Checklist.
3. Summarize the research validating the Pregnancy Checklist.

Facilitator's Resource:

Research on the Acceptability of the IUD Checklist

- A field test to examine the acceptability of the IUD Checklist among providers was conducted in four countries (Bangladesh, the Dominican Republic, Kenya, and Senegal). A total of 16 focus groups, involving 135 active family planning providers, were held to solicit providers' points of view.
- Results:
 - Providers found the checklist easy to use and thought it would enhance identification of eligible IUD users.
 - Nevertheless, many providers relied on outdated knowledge of IUD eligibility, rather than follow the checklist recommendations. Providers correctly determined eligibility for new categories of IUD use only 69 percent of the time.
- Conclusions:
 - The IUD Checklist is a useful job aid for providers, but training on the WHO medical eligibility criteria should precede its introduction to ensure that the checklist is used correctly.

Research on the Rationale for the Pregnancy Checklist

- The Pregnancy Checklist was developed to reduce barriers to contraception for women who are not menstruating at the time of their visit. Research on menstruation requirements has been done in several countries.
 - Kenya—an estimated one-third of all new clients were sent home without a contraceptive method because of a menstruation requirement (Stanback et al. 1999).
 - Ghana—76 percent of health care providers said they would send a client home if she was not menstruating at the time of her visit (Twum-Baah and Stanback 1995).

- Cameroon—only one-third of nonmenstruating clients received hormonal contraceptive methods, because providers were unsure of clients' pregnancy status (Nkwi et al. 1995).
- Jamaica—92 percent of clients were required to be menstruating or to have a negative pregnancy test at the time contraceptives were provided (McFarlane et al. 1996).
- Additional research evaluated whether using the Pregnancy Checklist reduced the number of women denied contraceptives because they were not menstruating at the time of their visits.
 - In Guatemala, 16 percent of nonmenstruating women were denied their contraceptive choice when no checklist was used. After providers began using the checklist, only 2 percent of women were denied (Stanback et al. 2005).
 - In Senegal, the situation was similar. Fewer women were denied their contraceptive method of choice after providers were introduced to the checklist—11 percent were denied without the checklist versus 6 percent when the checklist was available (Stanback et al. 2005).

Research on the Validity of the Pregnancy Checklist

- The Pregnancy Checklist has been extensively tested to ensure that it is valid and that women identified by the checklist as not pregnant truly are not pregnant. Research has been done in Kenya, Guatemala, Mali, Senegal, and Egypt. Those studies posed several questions to determine the checklist's validity.

Does the checklist accurately predict that a woman is not pregnant?

Yes—Researchers compared the checklist results with a pregnancy test and found that more than 99 percent of the time the checklist was correct in ruling out pregnancy. In the very rare cases where the checklist ruled out pregnancy but the client was actually pregnant, the reasons for this were contraceptive failure or inaccurate answers given by the client.

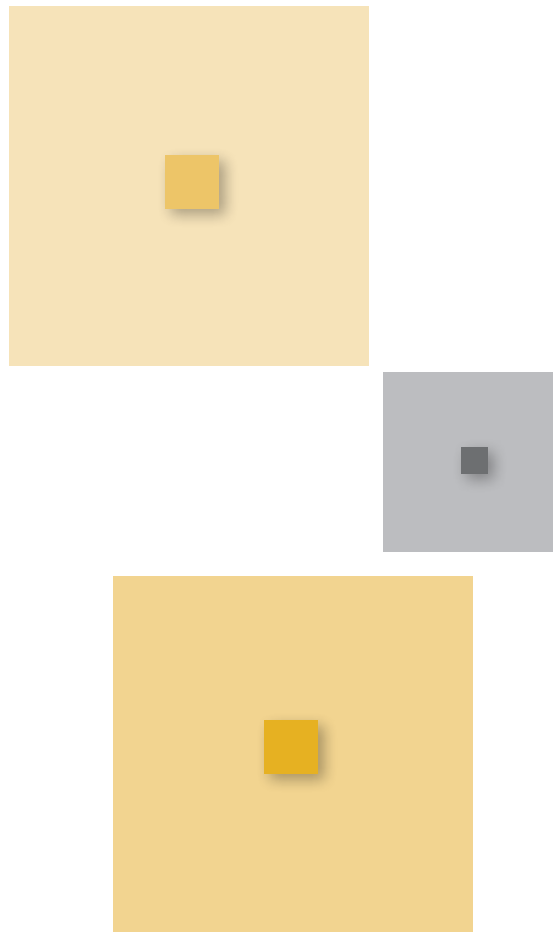
Can the checklist predict that a woman is pregnant?

No—Most women who are identified as possibly pregnant are, in fact, not pregnant. Researchers gave pregnancy tests to women who answered “No” to all questions and found that fewer than 15 percent were actually pregnant. If pregnancy is not ruled out by the checklist, the woman should be referred for additional evaluation or a pregnancy test, or should await menses.



Emphasize that the checklist was developed to RULE OUT pregnancy and to minimize barriers women face in seeking contraception. The checklist CANNOT be used to diagnose pregnancy.

- **Optional information:** The end of the Pregnancy Checklist states that “If the client answered **YES** to **at least one of the questions** and she is free of signs or symptoms of pregnancy, provide client with desired method.” Research shows that the six questions are much more reliable in determining whether a woman is not pregnant than are signs and symptoms. If a provider is trained to do so, signs and symptoms should be assessed in addition to, but not instead of, administering the checklist. If a provider is not trained to assess signs and symptoms of pregnancy, the provider should feel confident that pregnancy has been ruled out, based on the answers to the questions alone. (Symptoms may include nausea, mood changes, and missed menstrual period(s), and signs may be uterine softness and breast tenderness.)



- 1 IUD Scenario**

You are a 23-year-old woman who gave birth to your first child six weeks ago and you have abstained from sexual intercourse since the delivery. You and your husband are mutually monogamous.
- 2 IUD Scenario**

You are a 30-year-old woman who is married, monogamous, and has three children. You know that you are HIV positive, but have had no symptoms and feel healthy. You have been using a reliable contraceptive method consistently and correctly.
- 3 IUD Scenario**

You are a 32-year-old woman who wants no more children. You and your husband are mutually monogamous. You report recently having had unexplained bleeding after intercourse with your husband. Your last menstrual period started four days ago.
- 4 IUD Scenario**

You are a 31-year-old monogamous, married woman. You gave birth to your fifth child four months ago, have been exclusively breastfeeding the child, and have not yet started your menses.
- 5 IUD Scenario**

You are a 30-year-old woman with five children. You had a miscarriage four days ago. You are married and faithful to your husband. However, your husband often travels for work, and you think he is with other women when he is away from home.
- 6 IUD Scenario**

You are a 26-year-old woman who gave birth to your first child three weeks ago. You and your husband want to wait at least two or three years before having another baby.
- 7 IUD Scenario**

You are a 28-year-old divorced woman who has two children. You have one primary sexual partner, and a second casual partner. You had your last menstrual period six days ago.
- 8 IUD Scenario**

You are a 33-year-old married woman with three children. You do not want to risk getting pregnant again, since you were recently diagnosed with endometrial cancer. You have abstained from sexual intercourse since your last menstrual period.
- 9 IUD Scenario**

You are a 25-year-old woman with one child who is five months old. You are fully breastfeeding and have not had a menstrual period. You are living with your

boyfriend, and you both want to wait three to four years to have another child. You have no other partners and think your boyfriend is also faithful. However, you worry about his health, since you have noticed that he recently had a penile discharge.

10 IUD Scenario

You are a 26-year-old woman who has been diagnosed with AIDS and you do not want to have any children and pass on your disease. You are not taking antiretroviral treatments. You have been using contraceptive pills consistently and correctly, but you are afraid you may forget to take a pill, and you want to switch to another method that is easier to use.

11 IUD Scenario

You are a 34-year-old married woman with four children. Neither you nor your husband has ever had an STI. You admit that you recently had sex with someone other than your husband and you did not use a condom. But it only happened a couple of times.

12 IUD Scenario

You are a 21-year-old married woman with no children. You and your husband do not want any children right now, but you are nervous because you are not using contraception. You are menstruating at the time of your visit.

13 IUD Scenario

You are a 27-year-old divorced woman with two children. Two months ago you were treated for gonorrhea. Your menstrual period started seven days ago.

14 IUD Scenario

You are a 35-year-old woman in a monogamous marriage with two children. During the pelvic examination, the provider notes that you have cervical motion tenderness. Your menstrual period started seven days ago.

15 IUD Scenario

You are a 29-year-old woman in a monogamous relationship with your boyfriend and you feel that you have enough children already. You started your menstrual period 12 days ago. The provider will note during the pelvic examination that you have an ulceration on your outer genitals.

16 IUD Scenario

You have been using condoms consistently and correctly for the past six months. During the pelvic exam, the provider was not able to determine the position of the uterus.

IUD Scenario 1

You are a 23-year-old woman who gave birth to your first child six weeks ago and you have abstained from sexual intercourse since the delivery. You and your husband are mutually monogamous.

1. *Is this client a good candidate for receiving an IUD during today's visit?*

Yes.

2. *Why or why not?*

This client is eligible because she would answer "YES" to question 3, making it likely she is not pregnant.

3. *What course of action would you take next?*

You may insert the IUD. Be sure to remind the client to come back to the clinic approximately one month after her IUD insertion for a follow-up visit. At that time, you should check for signs of infection and make sure that she has adapted well to the method.

IUD Scenario 2

You are a 30-year-old woman who is married, monogamous, and has three children. You know that you are HIV positive, but have had no symptoms and feel healthy. You have been using a reliable contraceptive method consistently and correctly.

1. *Is this client a good candidate for receiving an IUD during today's visit?*

Yes.

2. *Why or why not?*

HIV infection is not a contraindication for IUD insertion or continuing use. As the explanation for question 14 indicates, a woman with HIV infection who has not developed AIDS may be an appropriate candidate for IUD insertion. You can also be reasonably sure she is not pregnant, since she would answer "YES" to question 6.

3. *What course of action would you take next?*

You may insert the IUD. Be sure to remind the client to come back to the clinic approximately one month after her IUD insertion for a follow-up visit. At that time, you should check for signs of infection and make sure that she has adapted well to the method.

Note to the facilitator: You may choose to ask a follow-up question, such as "What would you do if this client returns in a few years having developed AIDS?" The answer is that the client can continue IUD use regardless of AIDS status, and therefore no action would need to be taken.

IUD Scenario 3

You are a 32-year-old woman who wants no more children. You and your husband are mutually monogamous. You report recently having had unexplained bleeding after intercourse with your husband. Your last menstrual period started four days ago.

1. *Is this client a good candidate for receiving an IUD during today's visit?*

No.

2. *Why or why not?*

The explanation for question 7 indicates that unexplained vaginal bleeding could be the sign of an underlying condition, such as cancer or an infection.

3. *What course of action would you take next?*

An IUD should not be inserted until the client's condition has been further evaluated. Underlying conditions that preclude IUD insertion should be ruled out. If you do not have the capacity to rule out cancer or an infection, the client should be referred to a higher-level provider or specialist for evaluation and diagnosis. In either case, the woman should be counseled about other suitable contraceptive methods, and be provided with a method (such as condoms), until such time as a determination of her eligibility for the IUD is made.

IUD Scenario 4

You are a 31-year-old monogamous, married woman. You gave birth to your fifth child four months ago, have been exclusively breastfeeding the child, and have not yet started your menses.

1. *Is this client a good candidate for receiving an IUD during today's visit?*

Yes.

2. *Why or why not?*

This client is eligible because she would answer "YES" to question 2, making it likely she is not pregnant.

3. *What course of action would you take next?*

You may insert the IUD. Be sure to remind the client to come back to the clinic approximately one month after her IUD insertion for a follow-up visit. At that time, you should check for signs of infection and make sure that she has adapted well to the method.

IUD Scenario 5

You are a 30-year-old woman with five children. You had a miscarriage four days ago. You are married and faithful to your husband. However, your husband often travels for work, and you think he is with other women when he is away from home.

1. Is this client a good candidate for receiving an IUD during today's visit?

No.

2. Why or why not?

The explanation for question 10 indicates that a woman whose partner has more than one sexual partner is at high individual risk of sexually transmitted infections (STIs). Unless an STI can be reliably ruled out, these women are not good candidates for an IUD, as they may be at higher risk of pelvic inflammatory disease (PID) following IUD insertion.

3. What course of action would you take next?

You should counsel the client about other contraceptive options. If, after counseling, she still wishes to have an IUD inserted and laboratory tests are available, you can test her to determine if she has a gonorrheal or chlamydial infection. If she has either of these infections, you can treat her and, after treatment is completed, you may provide her with an IUD. You should counsel the client to use condoms during the period of testing and treatment to be sure she does not become reinfected by her husband. She also should be counseled to refer her husband for treatment.

If there is no other acceptable contraceptive method available for the client, and you cannot test for STIs, you may insert the IUD and follow her closely to be sure she does not develop PID.

IUD Scenario 6

You are a 26-year-old woman who gave birth to your first child three weeks ago. You and your husband want to wait at least two or three years before having another baby.

1. Is this client a good candidate for receiving an IUD during today's visit?

No.

2. Why or why not?

Although the client answered "YES" to question 1, making it highly likely she is not pregnant, women who are between 48 hours and 4 weeks postpartum have

higher risk of uterine perforation during IUD insertion. The IUD is also more likely to be expelled if it is inserted during this time.

3. *What course of action would you take next?*

You should request that the client come back for IUD insertion once she is four weeks postpartum. Explain to her that there is no need for contraception during the waiting time, since there is no risk of pregnancy during the first four weeks postpartum.

IUD Scenario 7

You are a 28-year-old divorced woman who has two children. You have one primary sexual partner, and a second casual partner. You had your last menstrual period six days ago.

1. *Is this client a good candidate for receiving an IUD during today's visit?*

No.

2. *Why or why not?*

Question 10 identifies this client as possibly being at high individual risk of STI, since she has more than one sexual partner. There is a possibility that this woman currently has an STI and, unless it can be reliably ruled out, she is not a good candidate for IUD insertion. IUD insertion increases risk of PID in women with current sexually transmitted infections.

3. *What course of action would you suggest next for this client?*

You should counsel the client about other contraceptive options. If, after counseling, she still wishes to have an IUD inserted and laboratory tests are available, you can test her to determine if she has a gonorrheal or chlamydial infection. If she has either of these infections, you can treat her and, after treatment is completed, you may provide her with an IUD. You should counsel the client to use condoms during the time of testing and treatment to be sure she does not become reinfected, and you should counsel her to refer her partner for treatment.

If there is no other acceptable contraceptive method available for the client and you cannot test for STIs, you may insert the IUD and follow her closely to be sure she does not develop PID.

IUD Scenario 8

You are a 33-year-old married woman with three children. You do not want to risk getting pregnant again, since you were recently diagnosed with endometrial cancer. You have abstained from sexual intercourse since your last menstrual period.

1. Is this client a good candidate for receiving an IUD during today's visit?

No.

2. Why or why not?

The explanation for question 8 indicates that women who have any type of cancer in their genital organs have an increased risk of infection, perforation and bleeding at IUD insertion and therefore are not good candidates.

3. What course of action would you take next?

This client should be counseled about other contraceptive methods that may be appropriate for her. Until she decides on another method, she should be provided with condoms to use.

Note: Endometrial cancer requires surgery that will leave the woman sterile, but in the meantime she should be provided with the contraceptive method of her choice, other than an IUD.

IUD Scenario 9

You are a 25-year-old woman with one child who is five months old. You are fully breastfeeding and have not had a menstrual period. You are living with your boyfriend, and you both want to wait three to four years to have another child. You have no other partners and think your boyfriend is also faithful. However, you worry about his health, since you have noticed that he recently had a penile discharge.

1. Is this client a good candidate for receiving an IUD during today's visit?

No.

2. Why or why not?

The explanation for question 13 points out that recent penile discharge in a sexual partner may be a sign that he has a sexually transmitted infection. Having a partner with an STI puts a woman at high individual risk of STI herself. Unless an STI can be reliably ruled out, this client is not a good candidate for the IUD, since women with STIs are at higher risk of PID following IUD insertion.

3. *What course of action would you take next?*

You should counsel the client about other contraceptive options. If, after counseling, she still wishes to have an IUD inserted and laboratory tests are available, you can test her to determine if she has a gonorrheal or chlamydial infection. If she has either of these infections, you can treat her and, after treatment is completed, you may provide the client with an IUD. You should counsel the client to use condoms during the time of testing and treatment to be sure she does not become reinfected, and you should counsel her to refer her partner for treatment.

If there is no other acceptable contraceptive method available for the client, and you cannot test for STIs, you may insert the IUD and follow her closely to be sure she does not develop PID.

IUD Scenario 10

You are a 26-year-old woman who has been diagnosed with AIDS and you do not want to have any children and pass on your disease. You are not taking antiretroviral treatments. You have been using contraceptive pills consistently and correctly, but you are afraid you may forget to take a pill and you want to switch to another method that is easier to use.

1. *Is this client a good candidate for receiving an IUD during today's visit?*

No.

2. *Why or why not?*

The explanation provided for question 14 states that if a woman answers “YES” to this question, she should be asked if she is taking ARVs. A woman who has AIDS is not an appropriate candidate for an IUD unless she is doing clinically well on ARVs. There is concern that HIV-positive clients who have developed AIDS and are not taking ARVs may be at increased risk of STIs and PID, because of a suppressed immune system. An IUD may further increase that risk.

3. *What course of action would you take next?*

You should counsel this client about other contraceptive methods that may be appropriate for her. Because she wants a method that doesn't require a daily routine, counsel her about implants, injectables, and sterilization. Until she decides on another method, she should be provided with condoms to use. She should also receive counseling regarding ARV treatment, if possible.

IUD Scenario 11

You are a 34-year-old married woman with four children. Neither you nor your husband has ever had an STI. You admit that you recently had sex with someone other than your husband and you did not use a condom. But it only happened a couple of times.

1. Is this client a good candidate for receiving an IUD during today's visit?

No.

2. Why or why not?

According to the explanation provided for question 10, a woman who has more than one sexual partner is at high individual risk of sexually transmitted infections. This woman is at high individual risk since she reports unprotected sex with a casual partner. Unless an STI can be reliably ruled out, this client is not a good candidate for the IUD, as she is at higher risk of PID following IUD insertion.

3. What course of action would you take next?

You should counsel the client about other contraceptive options. If, after counseling, she still wishes to have an IUD inserted and laboratory tests are available, you can test her to determine if she has a gonorrheal or chlamydial infection. If she has either of these infections, you can treat her and, after treatment is completed, you may provide the client with an IUD. You should counsel the client to use condoms during the time of testing and treatment to be sure she does not become reinfected, and you should counsel her to refer her partners for treatment.

If there is no other acceptable contraceptive method available for the client, and you cannot test for STIs, you may insert the IUD and follow her closely to be sure she does not develop PID.

IUD Scenario 12

You are a 21-year-old married woman with no children. You and your husband do not want any children right now, but you are nervous because you are not using contraception. You are menstruating at the time of your visit.

1. Is this client a good candidate for receiving an IUD during today's visit?

Yes.

2. Why or why not?

Neither young age nor absence of children is a contraindication for IUD use. Since the client is menstruating at the time of the visit, you can be reasonably sure that she is not pregnant.

3. What course of action would you take next?

Insert the IUD. Be sure to remind the client to come back to the clinic approximately one month after her IUD insertion for a follow-up visit. At that time, you should check for signs of infection and make sure that she has adapted well to the method.

IUD Scenario 13

You are a 27-year-old divorced woman with two children. Two months ago you were treated for gonorrhea. Your menstrual period started seven days ago.

1. Is this client a good candidate for receiving an IUD during today's visit?

No.

2. Why or why not?

The explanation provided for question 12 states that having an STI in the past three months requires further evaluation before proceeding, because there is a possibility the client may have a current infection. A client with chlamydia and/or gonorrhea infection is at higher risk of PID if an IUD is inserted.

3. What course of action would you take next?

You should counsel the client about other contraceptive options. If, after counseling, she still wishes to have an IUD inserted and laboratory tests are available, you can test her to rule out gonorrheal infection. If she has been reinfected, retreat and, after treatment is completed, you may provide the client with an IUD. You should counsel the client to use condoms during the time of testing and treatment to be sure she does not become reinfected, and you should counsel her to refer her partner for treatment.

If there is no other acceptable contraceptive method available for the client, and you cannot test for STIs, you may insert the IUD and follow her closely to be sure she does not develop PID.

IUD Scenario 14

You are a 35-year-old woman in a monogamous marriage with two children. During the pelvic examination, the provider notes that you have cervical motion tenderness. Your menstrual period started seven days ago.

1. Is this client a good candidate for receiving an IUD during today's visit?

No.

2. Why or why not?

The explanation provided for question 16 states that pain in a client's lower abdomen when the cervix is moved is a sign of cervical infection (cervicitis)

and possible PID. Women with current cervicitis or PID should not have an IUD inserted.

3. What course of action would you take next?

The client should be treated for PID. If you are not sure how, or don't have the means to treat it, you should refer the client to a higher-level provider or specialist. She should also be counseled about other contraceptive options that can be provided immediately. If she still wants an IUD, the insertion can be done after she is cured from PID. Until she is cured, the client should be advised to use condoms.

IUD Scenario 15

You are a 29-year-old woman in a monogamous relationship with your boyfriend and you feel that you have enough children already. You started your menstrual period 12 days ago. The provider will note during the pelvic examination that you have an ulceration on your outer genitals.

1. Is this client a good candidate for receiving an IUD during today's visit?

No.

2. Why or why not?

The explanation for question 15 states that a genital ulcer may indicate a sexually transmitted infection, such as syphilis or chancroid. While ulcerative STIs are not contraindications for IUD insertion, they do indicate that a woman is at high individual risk for STIs in general, and there is a possibility of coinfection with other STIs, such as gonorrhea or chlamydia. Since gonorrhea and chlamydia are often asymptomatic among women, any woman at high individual risk is generally not considered an appropriate IUD candidate.

For general purposes, pregnancy is ruled out if the client started her last menstrual period within the past seven days. When considering eligibility for the copper IUD however, the time frame is extended to 12 days, due to the additional contraceptive effectiveness of the IUD. If the copper IUD is inserted before day 12 of the menstrual cycle, the possibility of pregnancy is very low.

3. What course of action would you take next?

The client should be treated for ulcerative STIs (according to your clinic guidelines, using either laboratory tests or the syndromic approach). If you can rule out gonorrhea and chlamydia through laboratory tests, the client can receive an IUD. The client should be advised to use condoms during the period of diagnosis and treatment. Counsel her about other contraceptive options and counsel her to refer her partner for treatment.

IUD Scenario 16

You have been using condoms consistently and correctly for the past six months. During the pelvic exam, the provider was not able to determine the position of the uterus.

1. Is this client a good candidate for receiving an IUD during today's visit?

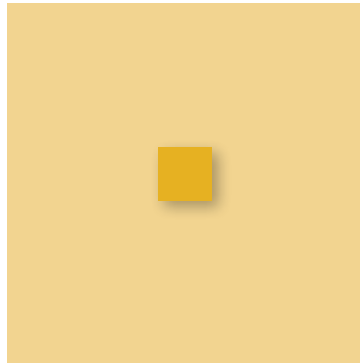
No.

2. Why or why not?

As stated in the explanation for question 21, the inability to determine the position of the uterus may increase the risk of uterine perforation.

3. What course of action would you take next?

If you cannot determine the position of the client's uterus, you should not insert the IUD. Counsel her about other contraceptive options or, depending on your experience with IUD insertions, refer her to a more experienced provider. The client should be provided with condoms to use in the meantime.



Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use – to initiate or continue use of combined oral contraceptives (COCs), depot-medroxyprogesterone acetate (DMPA), progestin-only implants, copper intrauterine device (Cu-IUD)

CONDITION	COC	DMPA	Implants	Cu-IUD
Pregnancy	NA	NA	NA	
Breastfeeding				
Less than 6 weeks postpartum				
6 weeks to < 6 months postpartum				NC
6 months postpartum or more				
Postpartum				
Less than 21 days, non-breastfeeding				NC
< 48 hours including immediate post-placental				
≥ 48 hours to less than 4 weeks	NC	NC	NC	
Puerperal sepsis				
Postabortion				
Immediate post-septic				
Smoking				
Age ≥ 35 years, < 15 cigarettes/day				
Age ≥ 35 years, ≥ 15 cigarettes/day				
Multiple risk factors for cardiovascular disease				
Hypertension				
History of (where BP cannot be evaluated)				
BP is controlled and can be evaluated				
Elevated BP (systolic 140 - 159 or diastolic 90 - 99)				
Elevated BP (systolic ≥ 160 or diastolic ≥ 100)				
Vascular disease				
History of DVT/PE				
Deep venous thrombosis (DVT) and pulmonary embolism (PE)				
Acute DVT/PE				
DVT/PE, established on anticoagulant therapy				
Major surgery with prolonged immobilization				
Known thrombotic mutations				
Ischemic heart disease (current or history of) or stroke (history of)				
Known hyperlipidemias				
Complicated valvular heart disease				
Systemic lupus erythematosus				
Positive or unknown antiphospholipid antibodies				
Severe thrombocytopenia				
Immunosuppressive treatment				
Headaches				
Non-migrainous (mild or severe)				
Migraine without aura (age < 35 years)				
Migraine without aura (age ≥ 35 years)				
Migraines with aura (at any age)				
Irregular without heavy bleeding				
Heavy or prolonged, regular and irregular				
Unexplained bleeding (prior to evaluation)				

- 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.

CONDITION	COC	DMPA	Implants	Cu-IUD
Gestational trophoblastic disease				
Regressing or undetectable β-hCG levels				
Persistently elevated β-hCG levels or malignant disease				
Cancers				
Cervical (awaiting treatment)				
Endometrial				
Ovarian				
Breast disease				
Undiagnosed mass	*	*	*	*
Current cancer				
Past w/ no evidence of current disease for 5 yrs				
Uterine distortion due to fibroids or anatomical abnormalities				
STIs/PID				
Current purulent cervicitis, chlamydia, gonorrhea				
Vaginitis				
Current pelvic inflammatory disease (PID)				
Other STIs (excluding HIV/hepatitis)				
Increased risk of STIs				
Very high individual risk of exposure to STIs				
Pelvic tuberculosis				
Diabetes				
Non-vascular disease				
Vascular disease or diabetes for > 20 years				
Symptomatic gall bladder disease (current or medically treated)				
Cholestasis (history of)				
Related to pregnancy				
Related to oral contraceptives				
Hepatitis				
Acute or flare				
Chronic or client is a carrier				
Cirrhosis				
Mild				
Severe				
Liver tumors (hepatocellular adenoma and malignant hepatoma)				
HIV				
High risk of HIV or HIV-infected				
AIDS				
No antiretroviral therapy (ARV)				
Clinically well on ARV therapy				
Not clinically well on ARV therapy				
see drug interactions				
see drug interactions				
Drug interactions, including use of:				
Nucleoside reverse transcriptase inhibitors				
Non-nucleoside reverse transcriptase inhibitors				
Ritonavir, ritonavir-boosted protease inhibitors				
Rifampicin or rifabutin				
Anticonvulsant therapy**				

Unlike previous versions of the MEC Quick Reference Chart, this version includes a complete list of all conditions classified as Category 3 and 4 by WHO. 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, the category is the same for initiation and continuation.

NA (not applicable): Women who are pregnant do not require contraception.

NC (not classified): The condition is not part of the WHO classification for this method.

* Evaluation of an undiagnosed mass should be pursued as soon as possible.

** Anticonvulsants include: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine, and lamotrigine. Lamotrigine is a category 1 for implants.



Source: Adapted from Medical Eligibility Criteria for Contraceptive Use, Geneva: World Health Organization, updated 2008. Available: http://www.who.int/reproductive-health/family_planning/guidelines.htm

Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use – to initiate or continue use of combined oral contraceptives (COCs), depot-medroxyprogesterone acetate (DMPA), progestin-only implants, copper intrauterine device (Cu-IUD)

CONDITION	COC	DMPA	Implants	Cu-IUD
Pregnancy	NA	NA	NA	NA
Breastfeeding				
Less than 6 weeks postpartum				
6 weeks to < 6 months postpartum				NC
6 months postpartum or more				
Postpartum				
Less than 21 days, non-breastfeeding				NC
< 48 hours including immediate post-placental				
≥ 48 hours to less than 4 weeks	NC	NC	NC	
Puerperal sepsis				
Postabortion				
Immediate post-septic				
Smoking				
Age ≥ 35 years, < 15 cigarettes/day				
Age ≥ 35 years, ≥ 15 cigarettes/day				
Multiple risk factors for cardiovascular disease				
Hypertension				
History of (where BP cannot be evaluated)				
BP is controlled and can be evaluated				
Elevated BP (systolic 140 - 159 or diastolic 90 - 99)				
Elevated BP (systolic ≥ 160 or diastolic ≥ 100)				
Vascular disease				
Deep venous thrombosis (DVT) and pulmonary embolism (PE)				
History of DVT/PE				
Acute DVT/PE				
DVT/PE, established on anticoagulant therapy				
Major surgery with prolonged immobilization				
Known thrombogenic mutations				
Ischemic heart disease (current or history of) or stroke (history of)				
Known hyperlipidemias				
Complicated valvular heart disease				
Systemic lupus erythematosus				
Positive or unknown antiphospholipid antibodies				
Severe thrombocytopenia		I C		I C
Immunosuppressive treatment				I C
Headaches				
Non-migrainous (mild or severe)	I C			
Migraine without aura (age < 35 years)	I C			
Migraine without aura (age ≥ 35 years)	I C			
Migraines with aura (at any age)	I C			I C
Vaginal bleeding patterns				
Irregular without heavy bleeding				
Heavy or prolonged, regular and irregular				
Unexplained bleeding (prior to evaluation)				I C

- **Category 1** There are no restrictions for use.
- **Category 2** Generally use; some follow-up may be needed.
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CONDITION	COC	DMPA	Implants	Cu-IUD
Gestational trophoblastic disease				
Regressing or undetectable β-hCG levels				
Persistently elevated β-hCG levels or malignant disease				
Cancers				
Cervical (awaiting treatment)				I C
Endometrial				I C
Ovarian				I C
Breast disease				
Undiagnosed mass	*	*	*	*
Current cancer				
Past w/ no evidence of current disease for 5 yrs				
Uterine distortion due to fibroids or anatomical abnormalities				
STIs/PID				
Current purulent cervicitis, chlamydia, gonorrhea				I C
Vaginitis				
Current pelvic inflammatory disease (PID)				I C
Other STIs (excluding HIV/hepatitis)				
Increased risk of STIs				I C
Very high individual risk of exposure to STIs				I C
Pelvic tuberculosis				
Diabetes				
Non-vascular disease				
Vascular disease or diabetes for > 20 years				
Symptomatic gall bladder disease (current or medically treated)				
Cholelithiasis (history of)				
Related to pregnancy				
Related to oral contraceptives				
Hepatitis				
Acute or flare	I C			
Chronic or client is a carrier				
Cirrhosis				
Mild				
Severe				
Liver tumors (hepatocellular adenoma and malignant hepatoma)				
HIV				
High risk of HIV or HIV-infected				
No antiretroviral therapy (ARV)				I C
Clinically well on ARV therapy				
Not clinically well on ARV therapy				I C
Drug interactions, including use of:				
Nucleoside reverse transcriptase inhibitors				
Non-nucleoside reverse transcriptase inhibitors				
Ritonavir, ritonavir-boosted protease inhibitors				
Rifampicin or rifabutin				
Anticonvulsant therapy**				

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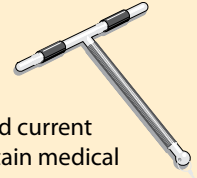
** Anticonvulsants include: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine, and lamotrigine. Lamotrigine is a category 1 for implants.



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

Research findings over the past 25 years have established that intrauterine devices (IUDs) are safe and effective for use by most women, including those who have not given birth, who want to space births, and those living with or at risk of HIV infection. For some women, IUDs are not recommended because of the presence of certain medical conditions, such as genital cancer and current cervical infection. For these reasons, women who desire to use an IUD must be screened for certain medical conditions to determine if they are appropriate candidates for the IUD.



Family Health International (FHI), with support from the U.S. Agency for International Development (USAID), has developed a simple checklist (see center spread) to help health care providers screen clients who were counseled about contraceptive options and made an informed decision to use an IUD. This checklist is a revised version of the *Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD* produced by FHI in 2007. Changes reflected in this version are based on the recently revised recommendations of the *Medical Eligibility Criteria for Contraceptive Use* (WHO, updated 2008) as advised by research over the past several years. It consists of a list of 21 questions designed to identify medical conditions and high-risk behaviors that would prevent safe IUD use or require further evaluation. Clients who are ruled out because of their response to some of the medical eligibility questions may still be good candidates for an IUD if the suspected condition can be excluded through appropriate evaluation.

A health care provider should complete the checklist before inserting an IUD. In some settings the responsibility for completing the checklist may be shared — by a counselor who completes questions 1–14, and an appropriately trained health care provider who determines the answers to the remaining questions during the pelvic exam. Providers trained to perform insertions may include nurses, nurse-midwives, nurse-practitioners, midwives, physicians, and, depending on educational and professional standards in each country, physician's assistants and associates.

This checklist is part of a series of provider checklists for reproductive health services. The other checklists include the *Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives*, the *Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN)*, the *Checklist for Screening Clients Who Want to Initiate Contraceptive Implants*, and the *Checklist on How to be Reasonably Sure a Client is Not Pregnant*. For more information about the provider checklists, please visit www.fhi.org.

Determining Current Pregnancy

Questions 1–6 are intended to help a provider determine, with reasonable certainty, whether a client is not pregnant. If a client answers “yes” to any of these questions and there are no signs or symptoms of pregnancy, it is highly likely that she is not pregnant. An IUD should never be inserted in a woman who is pregnant, as it may result in a septic miscarriage. However, if a client answers “yes” to question 1, IUD insertion should be delayed until four weeks postpartum. There is an increased risk of perforating the uterus when IUDs are inserted after 48 hours and up to four weeks postpartum. However, IUDs can be inserted by a trained professional within the first 48 hours after the client has given birth.

Assessing Medical Eligibility for the IUD

7. 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 infection. All these possibilities must be ruled out before an IUD can be inserted. If necessary, refer the client to a higher-level provider or specialist for evaluation and diagnosis. Counsel the client about other contraceptive options available, and provide condoms to use in the meantime.

8. 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 clients with genital cancer. Clients with trophoblastic disease may require multiple uterine curettages, and an IUD is unwise in this situation. There is also an increased risk of perforation. Clients 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.

9. Have you ever been told that you have a rheumatic disease, such as lupus?

This question is intended to identify women who have been diagnosed with systemic lupus disease with severe thrombocytopenia. Women with severe thrombocytopenia have an increased risk of bleeding and should not initiate use of an IUD.

Note: Questions 10–13 are intended to identify clients at high individual risk of sexually transmitted infections (STIs), because there is a possibility that they may currently have chlamydia and/or gonorrhea infection. Unless these STIs can be

Continued on page 54

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

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

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

If the client answered **YES** to **any one of questions 1–6** and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. Proceed to questions 7–14. However, if she answers **YES** to **question 1**, the insertion should be delayed until 4 weeks after delivery. Ask her to come back at that time.

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

To determine if the client is medically eligible to use an IUD, ask questions 7–14. As soon as the client answers **YES** to **any question**, stop, and follow the instructions after question 14.

NO	7. Do you have bleeding between menstrual periods that is unusual for you, or bleeding after intercourse (sex)?	YES
NO	8. Have you been told that you have any type of cancer in your genital organs, trophoblastic disease, or pelvic tuberculosis?	YES
NO	9. Have you ever been told that you have a rheumatic disease such as lupus?	YES
NO	10. Within the last 3 months, have you had more than one sexual partner?	YES
NO	11. Within the last 3 months, do you think your partner has had another sexual partner?	YES
NO	12. Within the last 3 months, have you been told you have an STI?	YES
NO	13. Within the last 3 months, has your partner been told that he has an STI, or do you know if he has had any symptoms – for example, penile discharge?	YES
NO	14. Are you HIV-positive, and have you developed AIDS?	YES

If the client answered **NO** to *all* of questions 7–14, proceed with the **PELVIC EXAM**.

During the pelvic exam, the provider should determine the answers to questions 15–21.

If the client answered **YES** to *any* of questions 7–9, an IUD cannot be inserted. Further evaluation of the condition is required.

If the client answered **YES** to *any* of questions 10–13, she is not a good candidate for an IUD unless chlamydia and/or gonorrhea infection can be reliably ruled out.

If she answered **YES** to the *second part of question 14* and is not currently taking ARV drugs, IUD insertion is not usually recommended. If she is doing clinically well on ARVs, the IUD may generally be inserted. HIV-positive women without AIDS also generally can initiate IUD use.

NO	15. Is there any type of ulcer on the vulva, vagina, or cervix?	YES
NO	16. Does the client feel pain in her lower abdomen when you move the cervix?	YES
NO	17. Is there adnexa tenderness?	YES
NO	18. Is there purulent cervical discharge?	YES
NO	19. Does the cervix bleed easily when touched?	YES
NO	20. Is there an anatomical abnormality of the uterine cavity that will not allow appropriate IUD insertion?	YES
NO	21. Were you unable to determine the size and/or position of the uterus?	YES

If the answer to *all* of questions 15–21 is **NO**, you may insert the IUD.

If the answer to *any* of questions 15–21 is **YES**, the IUD cannot be inserted without further evaluation. See explanations for more instructions.



reliably ruled out, clients at high risk are not good candidates for IUD insertion. IUD insertion may increase risk of pelvic inflammatory disease (PID) in these clients. 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.

10. Within the last 3 months, have you had more than one sexual partner?

Clients who have multiple sexual partners are at high risk of contracting STIs. Unless chlamydia and/or gonorrhea infection can be reliably ruled out, these clients are not good candidates for IUD insertion. (See note regarding questions 10–13).

11. Within the last 3 months, do you think your partner has had another sexual partner?

Clients whose partners have more than one sexual partner are at high risk of contracting STIs. Unless chlamydia and/or gonorrhea infection can be reliably ruled out, these clients are not good candidates for IUD insertion. In situations where polygamy is common, the provider should ask about sexual partners outside of the union. (See note regarding questions 10–13).

12. Within the last 3 months, have you been told you have an STI?

There is a possibility that these clients currently have chlamydia and/or gonorrhea infection. Unless these STIs can be reliably ruled out, these clients are not good candidates for IUD insertion. (See note regarding questions 10–13).

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

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

Clients whose partners have STIs may have these infections as well. Unless chlamydia and/or gonorrhea infection can be reliably ruled out, these clients are not good candidates for IUD insertion. (See note regarding questions 10–13).

14. Are you HIV-positive, and have you developed AIDS?

If the woman is HIV-positive but has not developed AIDS, the IUD may generally be used. However, if the woman has developed AIDS, ask whether she is taking ARVs and make sure she is doing clinically well. If she is doing clinically well, she may be a candidate for the IUD. If she is not, an IUD usually is not recommended unless other more appropriate methods are not available or not acceptable. There is concern that HIV-positive clients who have developed AIDS and are not taking ARVs may be at increased risk of STIs and PID because of a suppressed immune system. IUD use may further increase that risk.

Pelvic Examination

15. Is there any type of ulcer on the vulva, vagina, or cervix?

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

16. Does the client feel pain in her lower abdomen when you move the cervix?

Cervical motion tenderness is a sign of PID. Clients 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 and other contraceptives.

17. Is there adnexa tenderness?

Adnexa tenderness and/or adnexa mass is a sign of a malignancy or PID. Clients 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.

18. Is there purulent cervical discharge?

Purulent cervical discharge is a sign of cervicitis and possibly PID. Clients with current cervicitis or 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.

19. Does the cervix bleed easily when touched?

If the cervix bleeds easily at contact, it may indicate that the client has cervicitis or cervical cancer. Clients with current cervicitis 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.

20. 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.

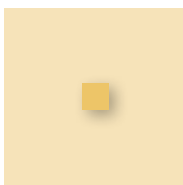
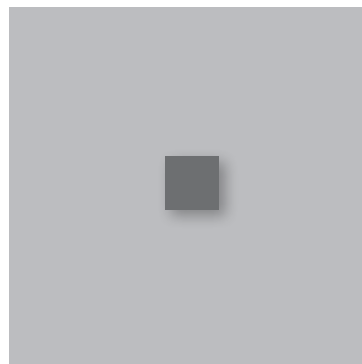
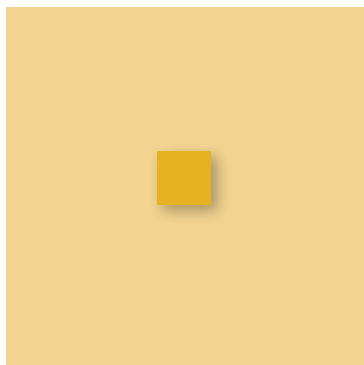
21. Were you unable to determine the size and/or position of the uterus?

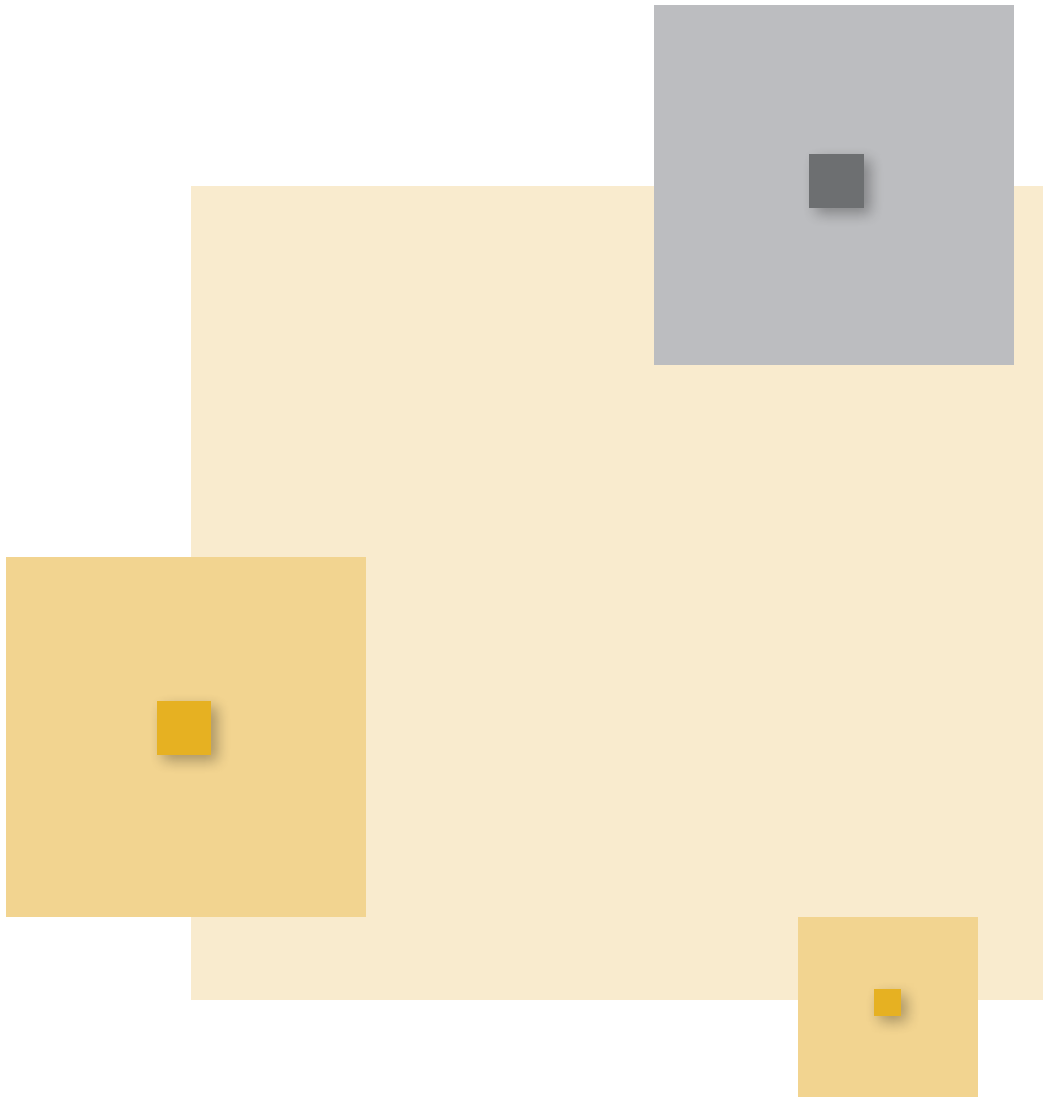
Determining size and position of the uterus is essential before IUD insertion to ensure high fundal placement of the IUD and to minimize the risk of perforation.

The purpose of this reference guide is to provide essential information that supplements the training module. The reference guide provides

- recommendations on adapting the checklist to the local context;
- basic evidence-based information on the copper IUD;
- an annotated bibliography.

The facilitator should anticipate—and be prepared to answer—questions that are likely to arise and that are beyond the scope of the IUD Checklist. The checklist is intended solely to help providers decide if clients may or may not safely initiate use of the copper IUD. However, participants may well inquire about such issues as IUD side effects or IUD use by specific client populations, such as women who are at risk of HIV or who are living with AIDS, etc. This guide does not attempt to provide comprehensive information about the copper IUD, and trainers should consult other resources, as needed. It is recommended to have a clinician with experience in IUD insertion cofacilitate the training, if possible.





The IUD Checklist can be adapted to meet the specific needs of a local area or program, or to align with national guidelines that may apply. However, before the adapted version is finalized and put into use, we strongly recommend that any changes be reviewed by an expert who understands the medical basis for the checklist. Likewise, the corresponding training module should be adjusted to reflect any changes. The intent of each question is explained on the reverse side of the checklist to help with these adaptations. The following are examples of situations in which adaptation may be needed.

- **Adapting the checklist to the local language and style**

Whenever necessary, the checklist should be translated and the style adapted to meet the cultural and linguistic needs of the intended users of the checklist and their clients. In addition to English, the checklist has been produced in French, Spanish, Kiswahili and several other languages. These checklists are available on FHI's web site, www.fhi.org.

- **Adapting for local culture**

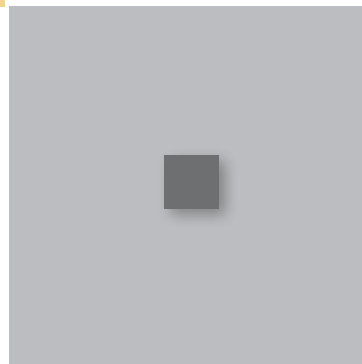
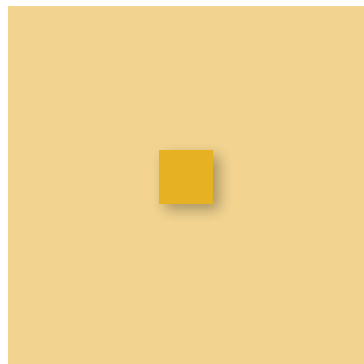
Some of the questions on the checklist deal with personal issues and may need to be asked in a sensitive manner. For example, question 5 asks about miscarriage and abortion. To help ensure that the client feels safe and comfortable answering honestly, it may be useful to ask instead, "Have you lost a pregnancy in the last 12 days?"

- **Adapting the checklist for comprehension**

Adaptations may also be made if the questions are too technical to be understood. Be careful, however, not to inadvertently change the intent of the question, because even small changes in wording can cause significant changes in meaning. For audiences with low literacy levels, it may be helpful to develop materials that convey key messages through illustrations with simple captions. Illustrations also should be appropriate for the local target audience.

The purpose of the IUD Checklist is to allow more women to receive this contraceptive method safely. Poor adaptations of the checklist questions could prevent eligible women from receiving an IUD. The following are examples of **poorly adapted** checklist questions.

Original Question	Poorly Adapted Question	Reason
Changes to the approach/structure of the question		
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?	Are you fully or nearly fully breastfeeding and have you had no menstrual period since you gave birth?	The structure of the question is changed in this example. The original question identifies women who are experiencing lactational amenorrhea, which is defined by the three criteria in the question, and can be used to effectively prevent unintended pregnancy. Removing “Did you have a baby less than 6 months ago?” removes one of the criteria, so this question can no longer be used to identify women with lactational amenorrhea.



FACT SHEET: Intrauterine Device—TCu-380A

An intrauterine device (IUD) is a small device inserted into a woman's uterine cavity to prevent pregnancy. The IUD containing copper (TCu-380A) is the most commonly used and is effective for up to 12 years.

Primary mechanisms of action

Prevents fertilization by

- impairing viability of sperm
- interfering with sperm movement

Characteristics of IUDs

- Highly effective
- No constant supplies needed
- Easy to use
- Does not interfere with intercourse
- Rapid return to fertility
- Have beneficial non-contraceptive effects (protection from endometrial cancer and ectopic pregnancy)
- Provider needed to initiate and discontinue use
- May cause minor pain or discomfort during insertion and removal procedures
- Has common side effects
- Complications are rare (i.e., pelvic inflammatory disease and uterine perforation)
- Small risk of expulsion (woman needs to check for IUD strings after menses)
- No protection against sexually transmitted infections, including HIV

Possible side effects (*generally not signs of a health problem*)

- Pain or cramping during menses
- Prolonged and heavy menstrual bleeding
- Bleeding or spotting between monthly periods

Who can have an IUD inserted

- Women of any parity or reproductive age, including young and nulliparous women
- Women who have no health conditions that preclude the use of an IUD

Who should not have an IUD inserted (*for a complete list, see WHO eligibility criteria*)

Women who have the following conditions (contraindications):

- pregnancy



- septic infection following childbirth or abortion (if insertion is immediately postpartum or postabortion)
- unexplained vaginal bleeding (before evaluation)
- cervical, endometrial, or ovarian cancer
- current pelvic inflammatory disease
- current purulent cervicitis (gonorrhoea or chlamydia)
- malignant gestational trophoblastic disease
- known pelvic tuberculosis
- uterine fibroid or other anatomical abnormalities resulting in distortion of the uterine cavity, which is incompatible with IUD insertion

IUD use by women with HIV and AIDS

- An IUD can be provided to a woman with HIV if she has no symptoms of AIDS.
- An IUD generally should not be initiated in a woman with AIDS who is not taking antiretroviral drugs (ARVs).
- A woman who develops AIDS while using an IUD can continue to use the device.
- A woman with AIDS who is doing clinically well on ARV therapy can both initiate and continue IUD use, but follow-up may be required.
- Women with HIV who choose to use an IUD should be counselled about dual method use and consider using condoms in addition to the IUD.

Provide follow-up and counseling for

- Any client concerns or questions
- Common side effects
- Any signs of complications; counsel the woman to come back immediately if any of the following symptoms develop:
 - bleeding or severe abdominal cramping during the first three to five days after insertion (perforation)
 - irregular bleeding or pain in every cycle (possible dislocation, partial expulsion, or perforation)
 - fever and chills, unusual vaginal discharge, or low abdominal pain (possible infection)
 - missing strings (possible expulsion)
 - missing or delayed menstrual period (possible pregnancy)

Dispelling myths regarding IUDs

IUDs do not:

- Migrate from the woman's uterus to other parts of her body
- Prevent a woman from having children after it is removed
- Require a "rest" period (a new IUD can be inserted the same day the existing IUD is removed)

No More Waiting!

Using a Checklist to Rule Out Pregnancy Is an Effective Way to Increase Access to Contraceptives

Summary

Nonmenstruating women need not wait for the onset of their menses to initiate their contraceptive method of choice. Several research studies conducted in various countries show that a simple checklist developed to help providers rule out pregnancy among such clients is correct 99 percent of the time and is effective in reducing the proportion of clients denied contraceptive services. Using this checklist offers an effective and inexpensive alternative to laboratory tests and increases women's access to essential family planning services.

Family planning providers are required to determine whether a woman might already be pregnant before initiating use of her contraceptive method of choice. When pregnancy tests are unavailable or unaffordable, health providers often rely on the presence of menstruation as an indicator to rule out pregnancy. When women do not present with menses at the time of their visit, they are sent home—often without any contraception—to await the onset of menses. This is because providers fear that contraception can harm an unrecognized pregnancy. Data analyzed from family planning programs in Cameroon, Ghana, Jamaica, Kenya and Senegal have found that a significant proportion of new, nonmenstruating clients (25 percent to 50 percent) are denied their desired method as a result of their menstrual status.¹ Clients sent home because of such menstruation requirements risk unplanned pregnancies, if they are unable to return because of time or financial constraints.

How to Be Reasonably Sure a Client Is Not Pregnant

Ask the client questions 1-6. As soon as the client answers **YES** to **any question**, stop, and follow the instructions.

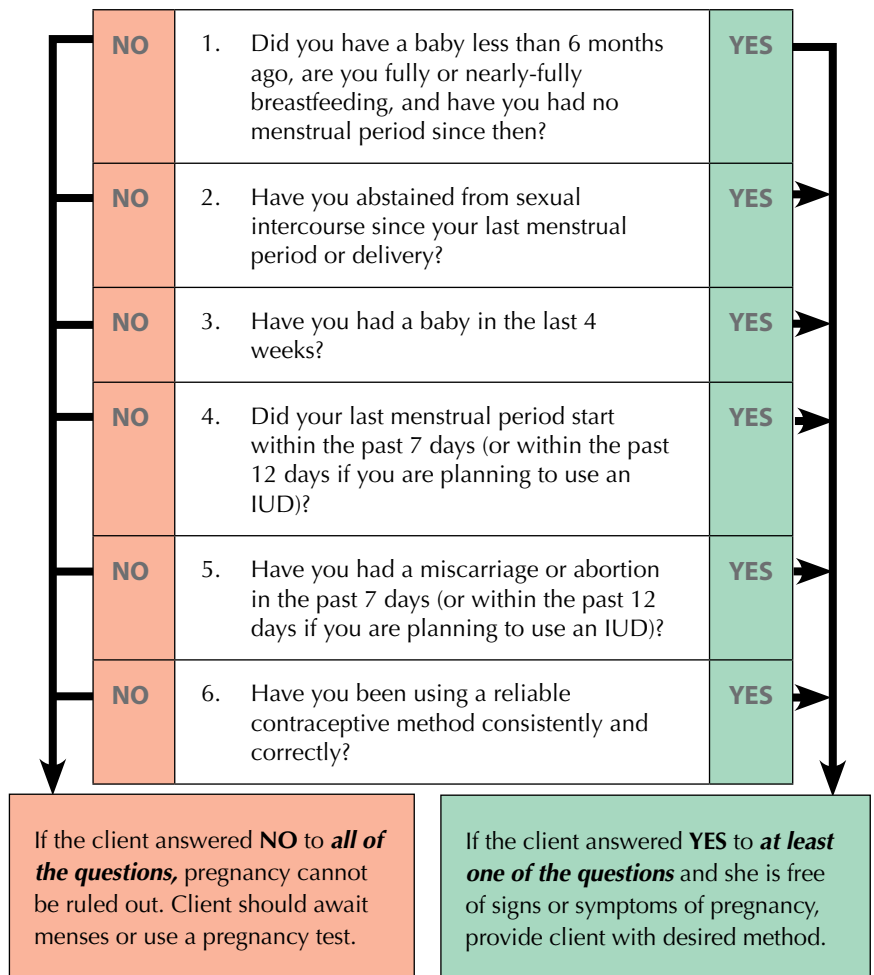


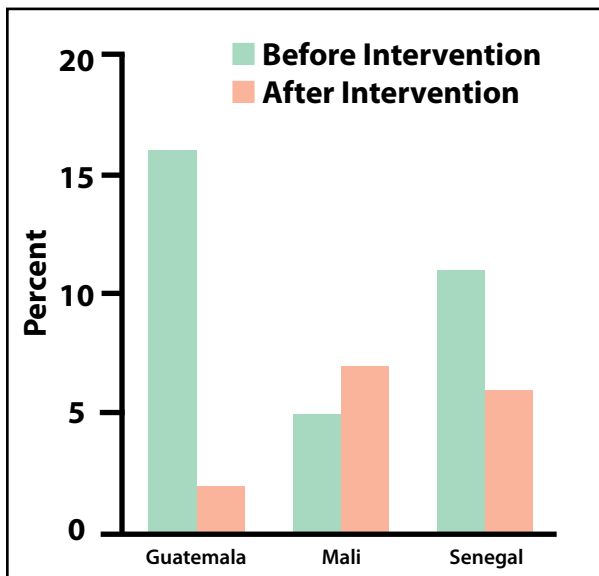
Figure 1

Family Health International (FHI) developed a simple checklist to rule out pregnancy among such clients with a reasonable degree of certainty. The checklist consists of six questions that providers ask clients while taking their medical history. If the client answers “yes” to any of these questions, and there are no signs or symptoms of pregnancy, then a provider can be reasonably sure that the woman is not pregnant. (See Figure 1.) The six questions are based on criteria established by the World Health Organization (WHO) that indicate conditions that effectively prevent a woman from getting pregnant.

Checklist Correctly Rules Out Pregnancy

A study to test the validity of the checklist against a standard pregnancy test was first conducted in Kenya² in 1999 and later repeated in Egypt in 2005. In both studies, the checklist correctly ruled out pregnancy 99 percent of the time. In addition, each of the six individual questions had a high predictive value in ruling out pregnancy. As a result, both studies concluded that in low-resource settings, where pregnancy tests are not available, nonmenstruating women should not leave a family planning clinic without an effective method, given that providers can be reasonably sure a woman is not pregnant as determined by a “yes” response to any of the six questions on the checklist.

Figure 2
Percentage of all new family planning clients denied their desired method as a result of their menstrual status, before and after the checklist intervention, in Guatemala, Mali, and Senegal, 2001-03



1. Stanback J, Thompson A, Hardee K, Janowitz B. Menstruation requirements: a significant barrier to contraceptive access in developing countries. *Stud Fam Plann* 1997;28(3):245-50.

2. Stanback J, Qureshi Z, Sekadde-Kigundu C, Gonzalez B, Nutley T. Checklist for ruling out pregnancy among family planning clients in primary care. *Lancet* 1999;354(9178):566.

3. Stanback J, Diabate F, Dieng T, Duarte de Morales T, Cummings S, Traoré M. Ruling out pregnancy among family planning clients: the impact of a checklist in three countries. *Stud Fam Plann* 2005;36(4):311-15.

Checklist Allows Significantly More Women Access to Contraceptives

An operations research study was conducted in Guatemala, Mali, and Senegal from 2001 to 2003 to determine the impact of the checklist on family planning services.³ The study results showed that where denial of services to nonmenstruating family planning clients was a problem, introduction of the pregnancy checklist significantly reduced denial rates and improved access to contraceptive services.

Among new family planning clients, denial of the desired method due to menstrual status decreased significantly—from 16 percent to 2 percent in Guatemala and from 11 percent to 6 percent in Senegal. Denial rates in Mali, which were low from the start, increased slightly. However, this increase was not statistically significant. (See Figure 2.)

Uses of the Pregnancy Checklist Beyond Family Planning

Although originally developed as a tool for family planning providers, the pregnancy checklist may prove useful to other health providers in low-resource settings who also need to rule out pregnancy. For example, providers who prescribe and pharmacists who dispense medications that should be avoided during pregnancy, including certain antibiotics or anti-seizure drugs, can adapt the pregnancy checklist for use in their settings.

IUDs: A Resurging Method

Programs and providers are now making IUDs more available. Reasons for this resurgence include:

- recognition of the IUD's many advantages;
- new research findings on safety—resulting in liberalized guidance from WHO;
- a new program strategy, focusing on developing a core of skilled providers motivated to offer IUDs.

Main positives

For Copper-T380A IUDs, positives include very high effectiveness, potentially 10+ years of use, low cost of commodity, convenience, suitability for a wide variety of women and very high client satisfaction generally.

Main negatives

Most women report no or negligible side effects. However, an important minority have significant pain, bleeding, spotting or expulsion. In addition, for women at risk of gonorrhea and chlamydia, IUD use increases the possibility of pelvic infection. Program requirements are extensive, including skilled providers, good counseling, supplies, equipment, and time and place to perform insertions.

New evidence on safety

A study in Kenya found that HIV+ and HIV- women adopting IUDs had similar rates of complications.¹ A study in Mexico found that IUDs were not associated with infertility.² Accumulated evidence from a number of studies indicates that the absolute increase in risk of pelvic inflammatory disease (PID) associated with the IUD is quite low, even where STIs are relatively common.

Broadened eligibility based on WHO guidance

In response to such new evidence, WHO, in late 2003, changed the medical eligibility classification for the IUD from category 3 to 2 (“generally use the method”) for HIV+ women and for those with successfully treated AIDS. Also, increased STI risk is now a category 2 unless a woman has a “very high individual likelihood of exposure” to gonorrhea or chlamydia.

Mechanism of action

Contrary to the common belief that the IUD works by preventing implantation, in fact the IUD works predominantly by inhibiting sperm from reaching the egg and by altering the egg, thus preventing fertilization.

Unjustified medical barriers

Common barriers include restrictions on eligibility related to age or parity (in fact, IUDs can be used by women of any age or parity), restricting insertion to the menstrual period, withholding insertion because of a vaginal discharge and mandating excessive follow-up visits (actually, one check-up, 3 to 6 weeks after insertion or after the next menstrual period, is recommended).

Current problems with IUD programming

In a number of countries the IUD is the leading method. However, in many others it is a minor method. Contributing factors to underutilization include: stigma and aftermath of the IUD issues of the 1970s and '80s; exaggeration of the legitimate concern about STIs and the relationship to PID; provider perspective (notably, that providing IUDs is a lot of work that requires skill and confidence, as well as moderately extensive equipment and supplies); and poor management of common side effects.

New program approach

As with any program effort, the focus should include guidelines, training, supplies and logistics, communication, supervision, organization of work, etc. In the past, programs have often tried, unsuccessfully, to advance IUD use by very broad-based approaches, such as training many providers across various skill levels. In principle, someone with minimal training can insert an IUD. In actual practice, however, such providers may lack confidence, experience and proficiency, or may lose these attributes rapidly without a large volume of IUD clients. An alternative approach is to focus on a smaller number of skilled providers and support expansion through those providers who perform well. Evidence collected on the national level in Bolivia (where IUDs are the number one method), as well as from smaller efforts in Bangladesh, India and Pakistan, supports this approach. In any case, a key step is to become acquainted with providers' views and gain insight into what might motivate them to provide IUDs.

Many programs have not taken the IUD seriously because of an incorrect view that STIs are too common in their client population to offer this method. Such concerns can be addressed by building on the new WHO guidance and the new research findings and by removing common medical barriers.

¹Morrison CS, et al. Is the intrauterine device appropriate contraception for HIV-1-infected women? *Br J Obstet Gynaecol* 2001;108(8):784-90.

²Hubacher D, et al. Use of copper intrauterine devices and the risk of tubal infertility among nulligravid women. *N Engl J Med* 2001;345(8):561-67.

Source: The preceding Global Health Technical Brief is reprinted from the MAQ website (Maximizing Access and Quality), a USAID initiative.

Intrauterine Devices: Safe, Effective, and Underused

Summary

Intrauterine devices (IUDs) are the most popular form of reversible contraception in the world. IUDs are extremely safe and effective, and they can be used by women as a long-term method. They are also among the most cost-efficient reversible methods of contraception. IUDs do not increase a woman's risk of pelvic inflammatory disease (PID), which can lead to infertility. Rather, pre-existing sexually transmitted infections (STIs) increase the risk of infection and subsequent infertility. Clinicians other than physicians can be trained to evaluate candidates and insert IUDs safely. Proper technique and timing is essential to minimize the risk of early expulsion and infection.

Overview

Intrauterine devices (IUDs) are among the most reliable and cost-effective contraceptives available. Though little-used in the United States, they are the most popular form of reversible contraception worldwide. Globally, 12 percent of all married women of reproductive age use an IUD. This is surpassed only by nonreversible surgical sterilization (19%). The most popular IUD in most countries is the 380A (copper T). The copper T is approved for 10 years of use and may be effective for upwards of 12 years. Another type of IUD is hormonal. The most common hormonal IUD is the levonorgestrel (LNg) intrauterine system. The effectiveness of both devices rivals that of surgical sterilization and may surpass that of implants.

Although the initial cost of an IUD is relatively high, with a seven- to 10-year service life, IUDs are among the most cost-effective forms of contraception. Additional costs incurred during use tend to be minimal.

IUDs require insertion in a clinical setting by trained personnel and require a follow-up visit after one month. Some protocols require three additional follow-up visits in the first year; however, a recent study in Mexico (Hubacher, et al., 1999) found no significant difference in rates of PID between clients who had two follow-up visits (at one month and 12 months), and clients who had four follow-up visits in the first year.

Women of any reproductive age, including those who have never had children (nulliparous), can use IUDs. However, nulliparous women and women under 20 years of age have a higher risk of expulsion. IUDs may be inserted at any time during

Key Points

IUDs are extremely safe, effective, and economical. They have a service life of five to 10 years and produce very few side effects. In general, the associated risk of PID is very low.

While the initial cost of an IUD is relatively high, due to the need for clinical visits and trained inserters, the cost of continuing use is minimal.

Proper insertion techniques are of paramount importance and reduce the risks of PID and expulsion of the device.

An IUD should not be used by a woman who has experienced an STI within the past three months. The presence of STIs during IUD insertion can lead to PID.

In populations with a high prevalence of STIs, prophylactic administration of antibiotics may reduce the incidence of PID.

the menstrual cycle, as long as the provider is reasonably sure the woman is not pregnant. Contraindications for IUD use are few and relate mainly to the presence of genitourinary infection. Women with genitourinary infection after childbirth or abortion, women with an ongoing STI or PID, and women who have had an STI or PID within the past three months should not have an IUD inserted. On the other hand, many of the contraindications for other family planning methods do not apply to IUDs. For example, women who smoke, breastfeed (after six weeks for LNg), or take antibiotics, can use an IUD.

In general, women report fewer side effects with IUDs than with oral, implantable, or injectable contraceptives. However, complaints of intermenstrual bleeding and cramping, especially during the first month of IUD use, are common and may lead to removal.

The copper T is associated with an increase in heavy and prolonged menstrual bleeding, dysmenorrhea, and intermenstrual spotting and cramping during the first few menstrual cycles after insertion. These effects are the primary reasons for discontinuation, but they generally decrease over time and are less common among older and parous users. In contrast, the primary reasons for discontinuation of the LNg intrauterine system are infrequent or absent menstruation.

IUDs do not increase the risk of ectopic pregnancy. However, up to half of the few pregnancies that do occur among IUD users are ectopic.

Continuation rates for the copper T and LNg intrauterine system are similar. A recent literature review by Fortney, et al. (1999), cites a number of articles on continuation rates. While study results varied, continuation rates were generally around 80 percent after the first year and between 38 percent and 50 percent after five years. In one nonclinical survey, the five-year continuation rate was as high as 68 percent.

Insertion

Trained clinicians other than physicians can insert IUDs safely. Proper technique is essential to reduce the risk of expulsion and infection. Insertion under hygienic conditions significantly reduces the risk of infection.

Between two percent and 10 percent of users spontaneously expel their IUD within the first year. Expulsion rates are highest in the first three months after insertion, and women younger than 20 years of age have the highest expulsion rates. A woman who has expelled an IUD has a 30 percent chance of subsequent expulsion.

Infertility Risk

Historically, the most important adverse effect associated with the IUD was PID, which can cause infertility. However, recent studies have found the causal relationship suspect. A study among 1,895 women (Hubacher, et al., 2001) found tubal infertility was not associated with prior IUD use, regardless of the duration. Furthermore, the study found that tubal infertility was not associated with the reason for IUD removal, or the presence or absence of gynecological problems related to IUD use. However, past exposure to chlamydia was strongly associated with infertility.

STIs And PID

PID in IUD users is related to poor insertion techniques and the presence of an STI at the time of insertion. PID is usually caused by a pathogen ascending from the vagina or cervix into the upper reproductive tract (uterus, fallopian tubes, ovaries), which can be facilitated by insertion of an IUD. The risk of PID is significantly increased in the first month after IUD insertion, but after the first three months of use, the risk in IUD users is comparable to that in nonusers.

Another recent study (Shelton, 2001) modeled the risk of PID based on the assumption that PID among IUD users results from insertion in the presence of cervical gonorrhea or chlamydia and occurs within the first few months after insertion. Fully symptomatic PID attributable to IUD use was uncommon, even in populations with a high prevalence of STI. The author estimated that the risk of clinical PID due to IUD use was 0.15 percent, or less than one in 600 women. With a high overall prevalence of gonorrhea or chlamydia of 30 percent, the PID risk increased to 0.3 percent.

Antibiotic Prophylaxis

Administering antibiotics prior to IUD insertion may reduce the likelihood of an unscheduled return visit to the clinic. While the reason is unclear, it has been suggested that antibiotics may reduce the risk of subclinical endometritis, which can cause pain or bleeding. However, antibiotics may not significantly reduce the likelihood of PID or premature IUD discontinuation.

A study evaluating antibiotic prophylaxis before IUD insertion (Grimes and Schulz, 1999) found that while the use of antibiotics significantly reduced the number of unscheduled return visits to the clinic, there was no statistically significant effect on rates of PID or premature IUD discontinuation. However, in populations with a high prevalence of STIs, antibiotic prophylaxis may offer a benefit. In settings where the prevalence of gonorrhea and chlamydia was high, prophylactic antibiotics prior to IUD insertion reduced the incidence of both PID and unscheduled return visits by one-third. Clinics operating in areas with high STI rates might want to consider these benefits.

Family Health International. *Network* 2000;20(1):1–20.

Fortney JA, Feldblum PJ, Raymond EG. Intrauterine devices—the optimal long-term contraceptive method? *J Reprod Med* 1999;44(3):269-74.

Grimes D, Schulz K. Prophylactic antibiotics for intrauterine device insertion: a meta-analysis of the randomized controlled trials. *Contraception* 1999;60(2):57-63.

Stewart GK. Intrauterine devices (IUDs). In Hatcher RA, Trussell J, Stewart F, et al., eds. *Contraceptive Technology, 17th ed.* New York: Ardent Media, Inc; 1998.

Hubacher D, Fortney J. Follow-up visits after IUD insertion—are more better? *J Reprod Med* 1999;44(9):801–6.

Hubacher D, Lara-Ricalde R, Taylor DJ, et al. Use of copper intrauterine devices and the risk of tubal infertility among nulligravid women. *N Engl J Med* 2001;345(8):561-67.

Morrison CS, Sekadde-Kigundu C, Miller WC, et al. Use of sexually transmitted disease risk assessment algorithms for selection of intrauterine device candidates. *Contraception* 1999;59(2):97-106.

Rivera R, Chen-Mok M, McMullen S. Analysis of client characteristics that may affect early discontinuation of the TCu-380A IUD. Unpublished paper. Family Health International, 1999.

© Family Health International, 2003. This work was supported by the U.S. Agency for International Development (USAID). The contents do not necessarily reflect USAID views and policy. For more information, contact FHI's Research to Practice initiative at rtop@fhi.org.

PB-02-03E

Choice Comes with Strings: IUCDs in an era of STIs/HIV

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True or False ?

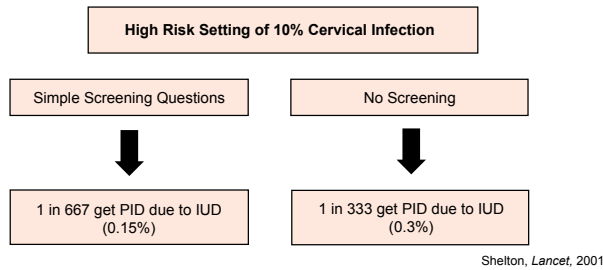
- | | |
|--|-------|
| 1. IUCDs cause pelvic inflammatory disease (PID), which can lead to infertility. | False |
| 2. IUCDs are not appropriate for young women, or women who have never given birth (nulliparous). | False |
| 3. IUCDs are contra-indicated for HIV-positive women. | False |

IUCDs: Good method with a bad reputation

IUCDs are one of the safest, most effective, and convenient contraceptive methods available, yet they regularly suffer a bad reputation. Of major concern is the erroneous assumption that IUCDs can lead to infertility, or that that they are not appropriate for young, nulliparous, or HIV+ women.

IUCDs in a high STI setting

Pelvic inflammatory disease (PID), which can lead to infertility, is caused by STIs such as chlamydia or gonorrhoea. Between 10 and 40 percent of women with chlamydia or gonorrhoea develop PID.¹ The IUCD itself contributes very little to PID.² Even in high STI settings, the additional risk of developing PID from IUCD insertion is extremely low.³



Risks are minimal and manageable

Dr. Jim Shelton, *USAID*, recently modeled the risks of inserting IUCDs in a clinic setting with an STI prevalence of 10 percent (considered high). He estimated that with simple screening criteria, the risk of developing PID that is directly attributable to IUCD insertion would be one in 667 women. Even without screening, the risk would be one in 333 women.²

Other reproductive health risks in perspective

Women in sub-Saharan Africa face many reproductive health risks due to unplanned, unwanted, or mistimed pregnancies. Access to effective contraceptives, including the IUCD, is essential.

Number of deliveries not attended by a skilled provider ⁴	1 in 2
Women who do not receive antenatal care during pregnancy ⁴	1 in 3
Lifetime risk of maternal mortality ⁴	1 in 16
Risk of death from unsafe abortion ⁵	1 in 147
Risk of PID attributable to IUD insertion (without screening) ³	1 in 333

1. Rees E. The treatment of pelvic inflammatory disease. *Am J Obstet Gynecol* 1980; 138: 1042-47; Stamm WE, Guinan ME, Johnson C, Starcher T, Holmes KK, McCormack WM. Effect of treatment regimens for *Neisseria gonorrhoeae* on simultaneous infection with *Chlamydia trachomatis*. *N Engl J Med* 1994; 310: 545-49; Platt R, Rice PA, McCormack WM. Risk of acquiring gonorrhoea and prevalence of abnormal adnexal findings among women recently exposed to gonorrhoea. *JAMA* 1983; 250: 3205-09.
2. Hubacher D, Lara-Ricalde R, Taylor D, et al. Use of copper intrauterine devices and the risk of tubal infertility among nulligravid women. *N Engl J Med* 2001; 345(8):561-67.
3. Shelton JD. Risk of clinical pelvic inflammatory disease attributable to an intrauterine device. *Lancet* 2001; 357(9254):443.

IUCD use among HIV+ women

Studies conducted in East Africa on IUCD use among HIV-positive women demonstrated:

- no increased cervical shedding of HIV
- no significant differences in complications, including pelvic inflammatory disease (PID) between HIV-positive and HIV-negative clients.⁶

WHO's Medical Eligibility Criteria for Contraceptive Use

The evidence on the safety of IUCDs for women at risk of STIs and HIV has led to the WHO changing its international guidelines on Medical Eligibility Criteria for Contraceptive Use.⁷

- Category 1: There is no restriction for the use of the contraceptive method.
- Category 2: The advantages of using the method generally outweigh the theoretical or proven risks. The method may generally be used, but careful follow-up may be required.
- Category 3: The theoretical or proven risk usually outweighs the advantages of using the method. Use of the method is not usually recommended unless other more appropriate methods are not available or acceptable; it requires clinical judgment and access to clinical services for follow-up.
- Category 4: The method should not be used.

STIs & HIV	2nd Ed. (2004)	3rd Ed. (2004)	
	Category	Initiation	Continuation
Current purulent cervicitis, chlamydia or gonorrhoea			
Vaginitis			
Increased risk of STIs			
High individual risk of STIs	New		
High risk of HIV			
HIV-infected			
AIDS No ARV or no clinical improvement on ARV			
AIDS No ARV or no clinical improvement on ARV	New		

What does this mean for programs?

- Need for revision of national service delivery policies and guidelines to reflect the new WHO changes
- Update pre- and in-service training materials (e.g., curricula, reference manuals)
- Inform, educate and communicate with providers and/or clients incorporating evidence-based key messages regarding the IUCD.

Key messages for training/IEC materials

IUCDs are:

- Extremely safe, even for HIV-positive women
- Effective (99.2% in first year)
- Low-cost for client and health system
- Appropriate for birth spacing
- Low-maintenance; one-month follow-up visit and yearly thereafter



Implementing Best Practices, Uganda, June 2004.

Funding for FHI's Research to Practice Initiative provided by USAID. The contents do not necessarily reflect USAID views and policy.

Shelton J, Angle M, Jacobstein R. Medical barriers to access to family planning. *Lancet* 1992;340:1334-1335.

While well-intentioned and based partly on medical rationale, some service delivery practices are unnecessary and can prevent access to family planning services for women and men who could safely use methods. There are six types of medical barriers: inappropriate or out-of-date contraindications; too-stringent eligibility criteria; unnecessary physical exams and laboratory tests; provider biases; limiting provision of contraception to physicians only; and government regulations that limit the types of contraceptives available. To reduce medical barriers, providers must work as a group to assess all service delivery practices, to determine whether they are essential to provision of contraception. The medical community should develop standard guidelines on contraceptive use. Family planning should be viewed as less medical: Women and men should be seen as clients, not patients, and increased emphasis should be placed on delivery of methods through community-based, over-the-counter, and social marketing outlets. Additional research should be conducted to assess contraceptive risks and benefits, to evaluate ways to reduce unnecessary restrictions, and to understand clients' perceptions of family planning methods and services.

Stanback J, Diabate F, Dieng T, Duarte de Morales T, Cummings S, Traoré M. Ruling out pregnancy among family planning clients: the impact of a checklist in three countries. *Stud Fam Plann* 2005;36(4):311-315.

Women in many countries are often denied vital family planning services if they are not menstruating when they present at clinics, for fear they might be pregnant. A simple checklist based on criteria approved by WHO has been developed to help providers rule out pregnancy among such clients, but its use is not yet widespread. Researchers in Guatemala, Mali, and Senegal conducted operations research to determine whether a simple, replicable introduction of this checklist improved access to contraceptive services by reducing the proportion of clients denied services. From 2001 to 2003, sociodemographic and service data were collected from 4,823 women from 16 clinics in the three countries. In each clinic, data were collected prior to introduction of the checklist and again three to six weeks after the intervention. Among new family planning clients, denial of the desired method due to menstrual status decreased significantly—from 16 percent to 2 percent in Guatemala and from 11 percent to 6 percent in Senegal. Multivariate analyses and bivariate analyses of changes within subgroups of nonmenstruating clients confirmed and reinforced these statistically significant findings. In Mali, denial rates were essentially unchanged, but they were low from the start. Where denial of

services to nonmenstruating family planning clients was a problem, introduction of the pregnancy checklist significantly reduced denial rates. This simple, inexpensive job aid improves women's access to essential family planning services.

Stanback J, Nakintu N, Qureshi Z, Nasution M. Does assessment of signs and symptoms add to the predictive value of an algorithm to rule out pregnancy? *J Fam Plann Reprod Health Care* 2006;32(1):27-29.

A WHO-endorsed "pregnancy checklist" has become a popular tool for ruling out pregnancy among family planning clients in developing countries. The checklist consists of six criteria excluding pregnancy, all conditional upon a seventh "master criterion" relating to signs or symptoms of pregnancy. Few data exist on the specificity of long-accepted signs and symptoms of pregnancy among family planning clients. A study based on a previous observational study in Kenya (n=1,852) found that signs and symptoms of pregnancy were rare (1.5 percent), as was pregnancy (1 percent). Signs and symptoms were more common (18.2 percent) among the 22 clients who tested positive for pregnancy than among the 1,830 clients (1.3 percent) who tested negative, but did not add significantly to their predictive value. Although the "signs and symptoms" criterion did not substantially improve the ability of the checklist to exclude pregnant clients, several reasons (including use of the checklist for IUD clients) render it unlikely that the checklist will be changed.

Stanback J, Nutley T, Gitonga J, Qureshi Z. Menstruation requirements as a barrier to contraceptive access in Kenya. *East Afr Med J* 1999;76(3):124-126.

A study was conducted in Kenya in 1996 to determine whether menstruation requirements pose a barrier to new clients seeking family planning services. Data were collected from eight public-sector health centers and one hospital in two provinces. Health providers tracked the menstrual status of women using a simple tally sheet. Forty-five percent of the women seeking services were not menstruating. Among the 345 nonmenstruating women, 51 percent were breastfeeding and amenorrheic, while 49 percent were between menstrual periods. Providers considered nonmenstruating women pregnant unless they were within six weeks postpartum. Women were told to go home and await the onset of menses or to have a pregnancy test at another facility. Researchers estimated that 78 percent of nonmenstruating women were sent home without their chosen method, and that up to one-third of all women were turned away. In most cases, pregnancy could have been ruled out with a simple checklist. Policy-makers should consider adopting national guidelines that remove the unnecessary menstruation requirement.

Stanback J, Qureshi Z, Sekadde-Kigonde C, Gonzalez B, Nutley T. Checklist for ruling out pregnancy among family-planning clients in primary care. *Lancet* 1999;354(9178):566.

Where pregnancy tests are unavailable, health providers, fearing possible harm to fetuses, often deny contraception to nonmenstruating clients. In Kenya, a trial (n=1,852) of a simple checklist to exclude pregnancy showed a negative predictive value of more than 99 percent. Use of this simple tool could improve access to services and reduce unwanted pregnancies and their sequelae.

Stanback J, Thompson A, Hardee K, Janowitz B. Menstruation requirements: a significant barrier to contraceptive access in developing countries. *Stud Fam Plann* 1997;28(3):245-250.

Some family planning clinics require women seeking hormonal contraception or IUDs to be menstruating before they can receive their chosen method. Studies in Ghana, Kenya, Cameroon, Senegal, and Jamaica have found that menstruation requirements negatively affect access to services for clients who could safely use contraceptives. As many as one-fourth to one-half of new clients seeking contraceptive services are sent home to await the onset of menses. These clients risk an unplanned pregnancy, and many are unable to return to the clinic because of time and money constraints. Because pregnancy is a contraindication to contraceptive use, health providers have used menstruation as a proxy for expensive pregnancy tests. Another rationale for menstruation requirements is timing—hormonal methods are usually initiated and IUDs typically inserted during menses. In addition, some providers believe pregnant women may use contraceptives to induce abortion. While many providers believe that women know about menstruation requirements, data from Kenya and Cameroon show that clients do not. Denial of contraceptive methods to nonmenstruating women is a serious obstacle to services that could be reduced by using a simple checklist to rule out pregnancy.

Wesson J, Gmach R, Gazi R, Ashraf A, Méndez JF, Olenja J, Nguer R, Janowitz B. Provider views on the acceptability of an IUD checklist screening tool. *Contraception* 2006;74(5):382-388.

A field test to examine the acceptability of the IUD Checklist among providers was conducted in four countries (Bangladesh, the Dominican Republic, Kenya, and Senegal). A total of 16 focus groups, involving 135 active family planning providers, were held to solicit providers' points of view. Providers found the checklist easy to use and thought it would facilitate identification of eligible IUD users. Nevertheless, many providers relied on prior knowledge of IUD eligibility, rather than the checklist recommendations. Providers only correctly determined eligibility for new categories

of IUD use 69 percent of the time. The IUD checklist is a useful job tool for providers, but training and effective dissemination of the World Health Organization medical eligibility criteria should precede its introduction to ensure that it is correctly used.

World Health Organization. *Medical Eligibility Criteria for Contraceptive Use*. Third edition. Geneva, Switzerland: Reproductive Health and Research, 2004, updated 2008.

The 2004 document was developed by a WHO expert working-group that convened 36 participants from 18 countries, including representatives of many agencies and organizations. The document is important for improving access to quality care in family planning, as it reviews the medical eligibility criteria used for selecting appropriate methods of contraception for a variety of clients. The document provides guidelines for eligibility based on the latest clinical and epidemiological data and is intended for use by policy-makers, family planning program managers and the scientific community. It aims to provide guidance to national family planning and reproductive health programs in preparing guidelines for the service delivery of contraceptive methods.

In April 2008, WHO convened a follow-on working group to revise the third edition in response to newly published evidence, as well as to provide recommendations for additional medical conditions. The working group was comprised of 43 participants from 23 countries and included international experts in family planning (clinicians, epidemiologists, policy-makers, programme managers), in evidence identification and synthesis, and in pharmacology, as well as users of the guideline.

World Health Organization. *Selected Practice Recommendations for Contraceptive Use*. Second edition. Geneva, Switzerland: Reproductive Health and Research, Family and Community Health, 2004, updated 2008.

Selected Practice Recommendations for Contraceptive Use is a companion guideline to *Medical Eligibility Criteria for Contraceptive Use*, published by WHO. This document provides guidance for using contraceptive methods safely and effectively once they are deemed to be medically appropriate. It is intended to be used by policy-makers, program managers, and the scientific community and aims to support national programs in preparing service delivery guidelines.

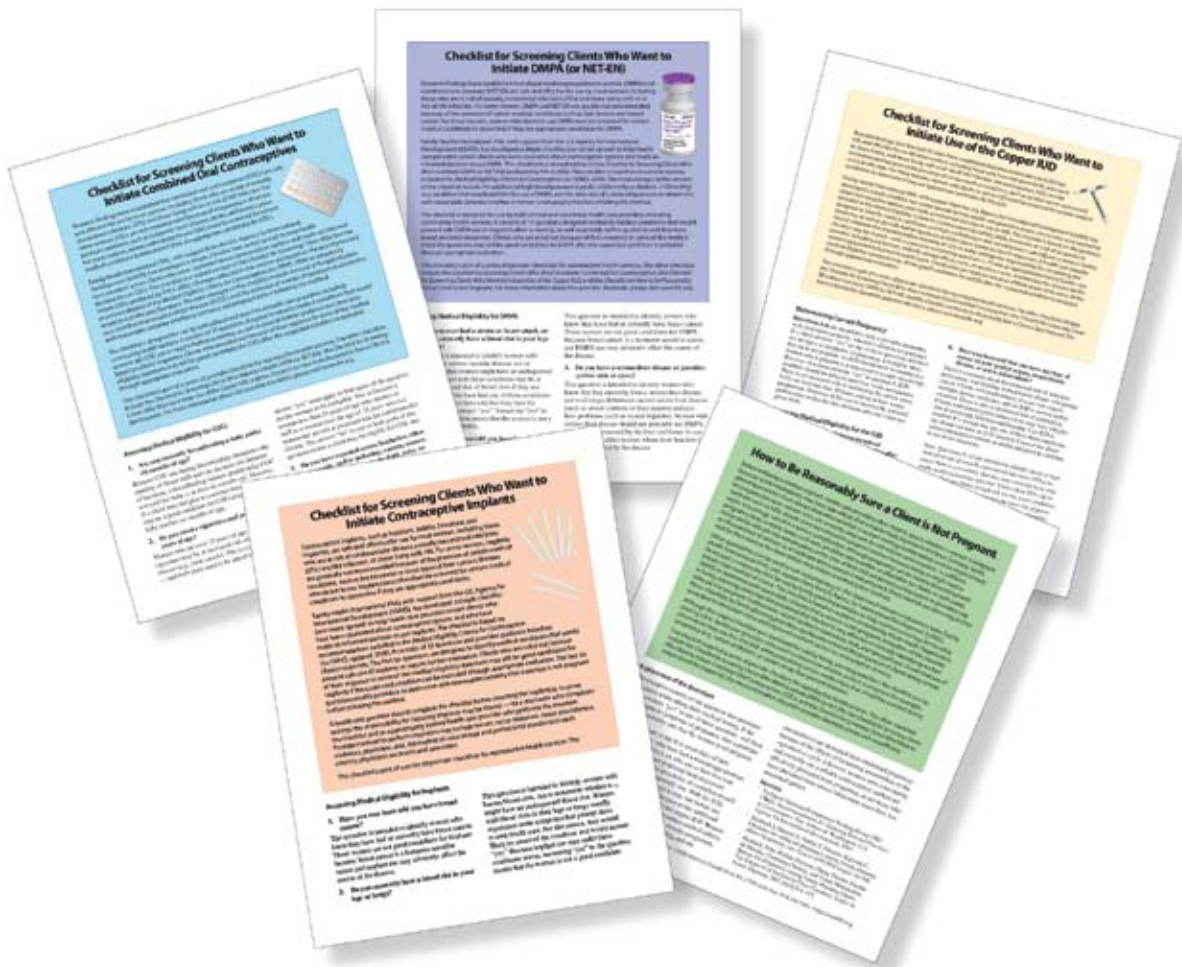
In April 2008, WHO convened an expert working-group to revise the second edition, in response to newly published evidence and requests for clarification of specific recommendations from users of the guideline. The working-group was comprised of 43 participants from 23 countries and included international experts in family planning (clinicians, epidemiologists, policy-makers, and programme managers), in evidence identification and synthesis, and in pharmacology, as well as guideline users.

Supplementary Training Schedules

A. Combined Training on All Five Provider Checklists

FHI has produced a series of five easy-to-use checklists. Four of the checklists are designed to assist clinical and non-clinical family planning service providers in screening women who want to initiate use of COCs, DMPA/NET-EN, the copper IUD, or implants. The fifth checklist helps providers rule out pregnancy among non-menstruating women seeking to initiate the contraceptive method of their choice. It is recommended that service providers be trained to use all five checklists, unless a particular checklist is not applicable to their scope of work.

A training and reference guide is available for each checklist. Familiarity with all five guides is necessary for conducting a combined training. The Suggested Schedule for a Combined Training and Overview of Sessions (provided on pages 74 and 75) follows the same structure used in the individual training guides. As always, facilitators who adapt the training should carefully consider the needs of their participants. The Notes section of the schedule will help determine what to include and how to adapt a session.

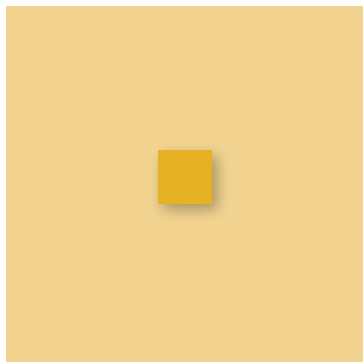


Suggested Schedule for a Combined Training and Overview of Sessions

Time: Approximately 9 hours

Session	Time	Topic	Notes
1	40 minutes	<p>Welcome and Introductions</p> <p>Exercise A: Peel the Cabbage</p>	<p>Adapt from any of the checklist trainings. Use the questions:</p> <ul style="list-style-type: none"> • What practice is currently used to determine if a woman is medically eligible to receive contraception? (Consider COCs, DMPA, IUDs, and implants.) • How is pregnancy ruled out? • Can you name some conditions that prevent women from using COCs, DMPA, IUDs or implants? (Create a separate list of conditions for each contraceptive method.)
2	20 minutes	<p>Rationale and Purpose of the Checklists</p>	<p>Adapt from the COC, DMPA, IUD, or Implant Checklist trainings.</p> <ul style="list-style-type: none"> • Show all five checklists, but do not distribute them to participants at this time. • Emphasize that all checklists were designed to help providers screen women for eligibility to use contraceptives safely and, therefore, to reduce barriers to contraception. The Pregnancy Checklist may have other purposes, as well. • Note that the checklists were designed for a variety of providers and can be used in a variety of settings. The IUD Checklist differs from the others in that it requires that one set of questions be administered by a provider trained to conduct a pelvic exam.
	80 minutes	<p>Exercise B: Review of the WHO Medical Eligibility Criteria</p> <p>Important Note: The order of the exercises varies somewhat from one guide to another. In the IUD Guide, the order of the MEC Review and Pregnancy Exercises (B and C) is reversed from that of the COC, DMPA and Implants Guides. There is no MEC Exercise in the Pregnancy Guide.</p>	<ul style="list-style-type: none"> • Follow steps 1-6 under Exercise B for COCs, DMPA, and implants, and under Exercise C for IUDs, with the following exceptions: <ul style="list-style-type: none"> Step 3: Choose a maximum of four conditions for each of the four contraceptive methods and allow a total of 30 minutes to complete the task. The following conditions are suggested for the exercise: <ul style="list-style-type: none"> <i>COCs, DMPA, and implants:</i> diabetes, high blood pressure, HIV/AIDS, and endometrial cancer <i>IUDs:</i> pregnancy, STIs/PID, HIV, and AIDS Step 4: Allow 30 minutes for participants to assess whether their answers were correct or incorrect. Step 6: Distribute a copy of the COC, DMPA, IUD, and Implant Checklists and complete the step. • Additional IUD discussion points should be brought up at this time (see Significant Issues Affecting Medical Eligibility, IUD Guide, Session 2, Facilitator's Resource).
	10 minutes	<p>Exercise C: Demonstrating the Benefits of Using the Pregnancy Checklist</p>	<p>Additional detail on the research related to the Pregnancy Checklist can be found in the Optional Session.</p>

Session	Time	Topic	Notes
3	30 minutes	Design of and Instructions for Using the Checklists	<p>All of the checklists have the same basic design and instructions for use. Therefore, the training presented in this guide can be easily adapted to apply to all of the checklists. Some notes:</p> <ul style="list-style-type: none"> • The Pregnancy Checklist contains one set of questions; the COC, DMPA, and Implant Checklists contain two sets; the IUD Checklist contains three sets. • The Pregnancy Checklist contains no questions related to medical eligibility. • When administering the COC, DMPA, IUD or Implant Checklists, there is no need for providers to also administer the Pregnancy Checklist (since the Pregnancy Checklist questions are included in each of the other checklists).
	3-6 hours	Exercise D: Practice Using All Five Checklists	<p>Provide participants the opportunity to use the COC, DMPA, IUD, and Implant Checklists. The time needed to complete the exercise will vary, depending on the number of scenarios selected. To save time, do not independently practice the Pregnancy Checklist, since it is incorporated in the other checklists. Review the optional approaches for conducting the scenarios as potential time-saving tools. The option chosen should be the most appropriate for the needs of the participants.</p>
4	20 minutes	Wrap-Up	Modify as needed from this or any of the trainings.



B. Training Para-Professionals on the IUD Checklist

The term “para-professional” applies here to service providers working in facilities where IUDs are provided, but who have no training in performing pelvic exams or IUD insertions. Such para-professionals may be trained to administer the first two sections of the IUD Checklist (questions 1-6 and 7-13) and to refer clients to appropriately trained health providers for IUD insertion. For this audience, the training content should be simplified, lecture sessions avoided, and the training practical in nature to ensure para-professionals’ understanding of the checklist and comfort in using it correctly. The outline below follows the same structure used in the individual training guides. As always, facilitators who adapt the training should carefully consider the needs of their participants. The Notes section will help determine what to include.

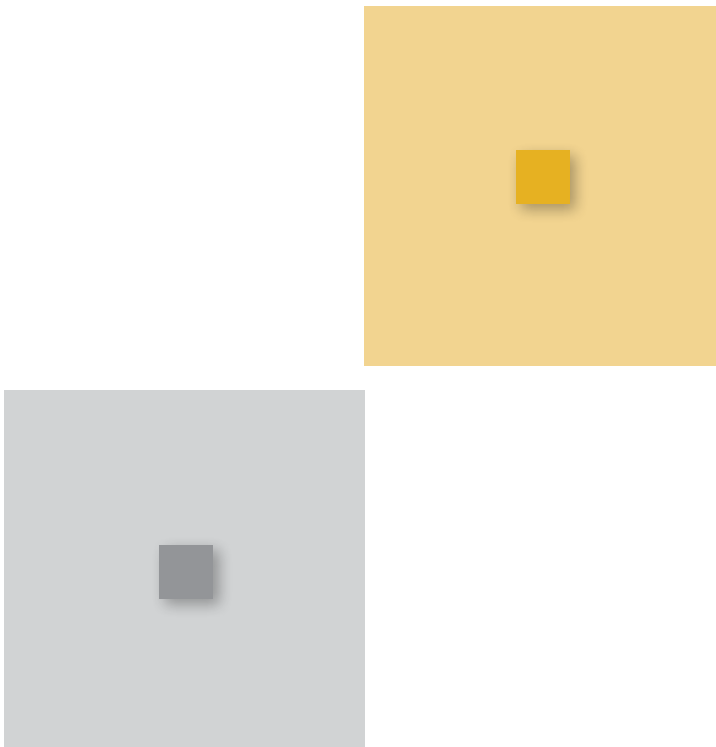
Suggested Schedule for Training Para-professionals and Overview of Sessions

Time: 2 hours

Session	Time	Topic	Notes
1	15 minutes	Welcome and Introductions Icebreaker Activity	Use Session 1 from this guide. Do not perform Exercise A: Peel the Cabbage.
2	20 minutes	Rationale and Purpose of the IUD Checklist Exercise B: Demonstrating the Benefits of Using the Pregnancy Checklist	Training Steps: <ul style="list-style-type: none"> Distribute copies of the IUD Checklist and the Quick Reference Chart to each participant. Briefly and in simple language explain what the IUD Checklist is and why it was developed. Clearly explain that the third set of questions is intended for skilled providers. Perform Exercise B: Demonstrating the Benefits of Using the Pregnancy Checklist to illustrate its effectiveness for ruling out the possibility of pregnancy in women who are not menstruating at the time they are seen by the para-professional. Use the Quick Reference Chart to illustrate that many women, even those with certain medical conditions, can safely have an IUD inserted. Allow five minutes for participants to familiarize themselves with the Quick Reference Chart. Do not perform Exercise C: Review of the WHO Medical Eligibility Criteria.
3	20 minutes	Design of and Instructions for Using the IUD Checklist	<ul style="list-style-type: none"> Briefly and simply explain the design of the IUD Checklist and go over instructions for using it. Discuss what is expected of participants once the first two sets of questions have been administered. For example, what are some ways of transitioning a client to the final screening portion (pelvic exam) if they have been deemed eligible thus far? What should the next step be if the client is not eligible? If pregnancy is not ruled out? After this, ask participants if they have any questions or need any items clarified.
	45 minutes	Exercise D: Practice Using the IUD Checklist	Review the optional approaches for conducting the scenarios as potential time-saving tools. The option chosen should be the most appropriate for the needs of the participants. Note: Omit scenarios 14, 15, or 16, since they are related to pelvic exams and are only relevant to providers who actually insert IUDs.
4	15 minutes	Wrap-Up	Modify as needed from this training.

C. Introducing Provider Checklists to Policy-makers and Program Managers

Policy-makers and program managers who are considering introducing the checklists in their service delivery settings will have different informational needs from those of providers. A slide presentation with speaker notes specifically tailored to this audience (*PowerPoint* presentation B) can be found in the collateral materials accompanying this guide. The presentation provides a broad overview of all five checklists, explains their rationale, and discusses general issues surrounding their use. Specific details on how to use the checklists have been excluded. Presenters may wish to address additional issues specific to local programs and are free to add slides and information, as necessary.



Sample Energizers

Energizers are highly recommended during training sessions, in particular during trainings involving lectures. In this training, an energizer is recommended between sessions two and three.

- **Coconut**

The facilitator shows the group how to spell out C-O-C-O-N-U-T by using full movements of the arms and the body. All participants then try this together.

- **The sun shines on...**

Participants sit or stand in a tight circle with one person in the middle. The person in the middle shouts “The sun shines on...” and names a color or articles of clothing that some in the group are wearing. For example, “The sun shines on all those wearing blue,” or “The sun shines on all those wearing socks,” or “The sun shines on all those with brown eyes.” All participants who have that attribute must change places with one another. The person in the middle tries to take one of their places as they move, so that there is another person left in the middle without a place. The new person in the middle shouts “The sun shines on...” and names a different color or type of clothing.

- **Body writing**

Ask participants to write their names in the air with a part of their bodies. They may choose to use an elbow, for example, or a leg. Continue in this way, until everyone has written his or her name with several body parts.

- **Football cheering**

The group pretends that they are attending a football game. The facilitator assigns specific cheers to various sections of the circle, such as *Pass*, *Kick*, *Dribble* or *Header*. When the facilitator points at a section, that section shouts its cheer. When the facilitator raises his/her hands in the air, everyone shouts “Goal!”

Source: Adapted from *International HIV/AIDS Alliance. 100 ways to energise groups: games to use in workshops, meetings and the community. Brighton, UK: International HIV/AIDS Alliance, 2002.*

Sample Certificate of Attendance

<p>_____</p> <p>Name of Sponsoring Organization</p> <p>_____</p> <p><i>certifies that</i></p> <p>Name of Participant</p> <p>_____</p> <p><i>has successfully completed training on the</i></p> <p>Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD</p> <p>_____</p> <p><i>(Date)</i></p> <p>_____</p> <p><i>(Place)</i></p> <p>_____</p> <p>Name of Person issuing certificate</p> <p>_____</p> <p>Title</p> <p>_____</p> <p>Sponsoring Organization</p> <p>_____</p> <p>Name of Person issuing certificate</p> <p>_____</p> <p>Title</p> <p>_____</p> <p>Sponsoring Organization</p> <p>_____</p>	
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