

Immediate Contraception Post Obstetric Event (ICPOE)

Educational material to accompany and support the discussion about the choice and use of long-acting reversible contraceptives following an obstetric event.



PAHO



CLP/WR
Latin American Center for Perinatology
Women and Reproductive Health

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Women and Reproductive Health



1.- The flipchart: what is it, what is it for and how is it used?

This educational material was designed to guide and support the conversation to promote contraception immediately after an obstetric event. This discussion usually takes place between technical health care providers, patients and the person that accompanies them.

That is why the material has two sides that are used simultaneously: one is for the technical staff and the other for the patient and the person accompanying her. As the technical workers are the ones who guide the conversation and read the material, they are the ones who will use it.

This is what should be considered when it is used:

- ✓ The material and contents are thought for a space fit for this conversation.
- ✓ The contents are arranged in an order that allows easy searching of the information according to the patient's situation, i.e., whether she is about to give birth to her child or whether she is undergoing miscarriage or abortion.

Hence, we recommend:

- ✓ Open the flipchart on the page where you want to start the conversation. The tabs lead you to the different topics and situations the patient may be experiencing.
e.g.: postpartum IUD.
- ✓ Hold the flipchart so that the patient can read the part meant for her and you can see the part for the health care provider.
- ✓ Search the tabs corresponding to the information you want to provide, taking care that the patient cannot see contents not intended for her.

e.g.: if the patient is having a delivery, it is important not to show the information meant for women receiving post-abortion care and vice versa.



2.- The discussion: how to start it and what to consider

- ✓ **Being** able to choose when to have a child, how many children and with whom.
- ✓ **Being** able to exercise sexuality freely and with pleasure, free from coercion or violence.
- ✓ **Being** able to have rights and to access methods that enable people to plan their life trajectory.

Among other things, all these empowerments are built based on the information and communication needed for decision-making.

It is therefore important for women to receive counselling and to be aware of the characteristics, risks and benefits of pregnancies and contraceptive methods.



When to have the conversation?

It is important to provide the space for conversation as far in advance of the obstetric event as possible and considering each patient's circumstances.

If it has not taken place previously, it should be scheduled as close to the event as possible and always before the patient is discharged from the hospital.

Remember that during antenatal visits there may be several opportunities to provide information, but in post-abortion care it is important to seize the moment the patient seeks care.



Debunking
myths

What should be considered?

1 The patient is pregnant. Regardless the course of her pregnancy, it is important to factor in the physical and affective vulnerabilities that occur during pregnancy, which get added to the patient's existing social and biographical vulnerabilities (socioeconomic, racial, territorial, related to gender, etc.).

2 The patient's linkage with the space and health care provider is neither equitable nor universal. Many women do not have a close, comfortable and secure relationship with health care facilities and HCPs. This bond depends on social and individual conceptions about health, medicine, professionals, etc.

3 It is important to promote dialogue and not just to provide information. Generate a space where you can relate and listen to each other. Find the time, languages and attitude that will enable an encounter with the patient:

- ✓ Frame the conversation and the issues you will discuss: *Now let's talk about the expected effects of the IUD.*
- ✓ Start by learning about her experience: *Do you know what contraceptives are? Which do you know?*
- ✓ Check if your message was understood, or if there are any doubts, if she wants it repeated. Encourage her to ask questions
- ✓ Speak clearly, precisely and plainly, using as little technical language as possible. Avoid infantilization
- ✓ Provide the care and advise she needs; do not be judgemental
- ✓ Ensure privacy and confidentiality as you see to her needs.



How to start the discussion

See some suggestions below:

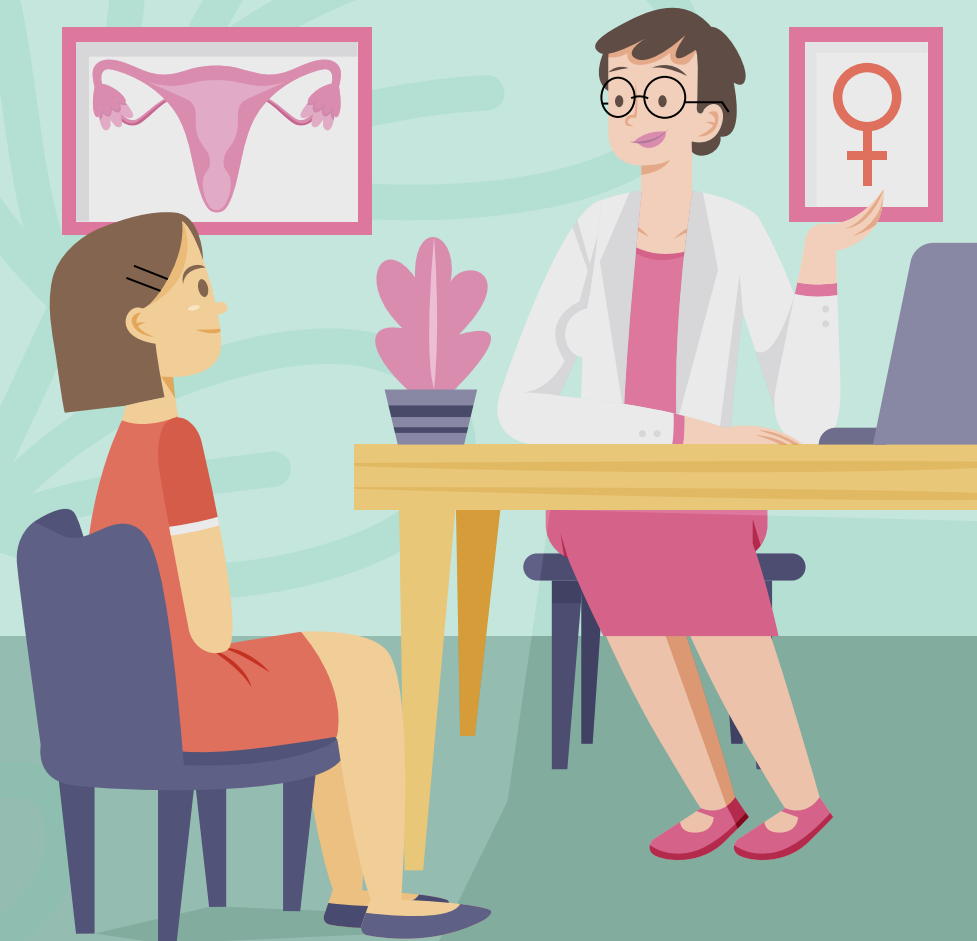
Do you already know how you are going to prevent getting pregnant in the near future?

If it is okay with you, we can discuss it.

It is important to talk about it so you may get more information about contraceptive methods and you can have sexual relations more freely.

Knowing some contraceptive methods also helps you decide whether to have more children or not and if yes, when you want to have them.

For your health, it is important to space your pregnancies?



3.- Women

Every woman has the right to contraception after a delivery, cesarean section or abortion. Adolescents demand more attention.

Health care providers can and should counsel adolescents in a non-judgmental and confidential manner.

Contraception enables a woman to:



Enjoy her sexuality freely.



Decide about motherhood: when to have children, how many to have and with whom.



Avoid risks by spacing pregnancies (premature births, anaemia and others).



3.-Women

In addition to the **social, economic and cultural vulnerabilities** that exacerbate when adolescents get pregnant, adolescent pregnancy poses a number of risks:

- 1 Maternal deaths (more than 70,000 mothers between 15 and 19 years of age die annually). Teenagers from 15 to 19 year of age are twice as likely to die as 20-year-old women.
- 2 Girls who get pregnant before the age of 15 are five times more likely to die during childbirth than 20-year-old women.
- 3 They are more prone to complications like pre-eclampsia and premature births and their children are more likely to die before they turn one year old.



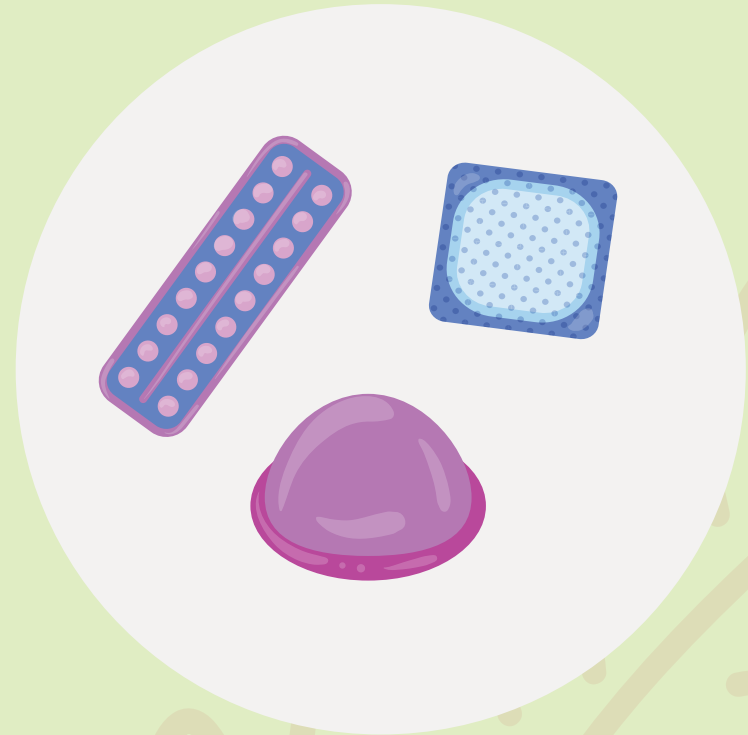
Some barriers make it difficult for adolescents to make decisions about their sexuality, including which contraceptive method to use:

- > They have difficulties accessing comprehensive sexuality education (CSE),
- > they are more familiar with short-acting contraceptive methods,
- > many teenagers of both sexes believe that some contraceptive methods have permanent effects if they have not yet had children,
- > they fear their families will discover they are having sexual relations, and
- > gender inequality in sex-affective relationships and the stigma and control that falls on adolescent girls.

To guarantee the rights of adolescent girls, it is essential that health care providers provide the information and advice in a non-judgmental manner, preserving confidentiality.

4.- Contraceptives:

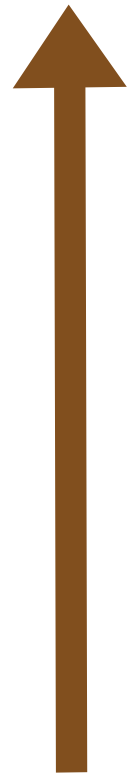
what are they and which are available?



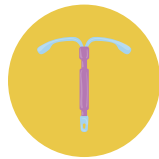
Contraceptives: What are they and which are available?

Contraception methods by effectiveness: **short and long action**

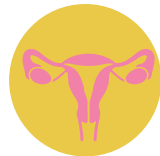
Most effective



Least effective



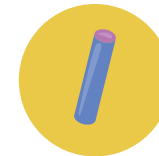
IUD



Female sterilization



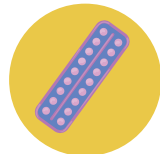
Male sterilization



Implant



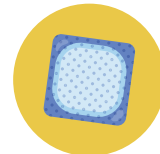
Injections



Pills



Vaginal ring



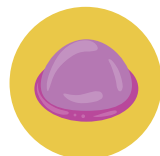
Patches



LAM
(Lactational
Amenorrhea
Method)



Male condoms



Diaphragm



Methods
based on fertility
knowledge



Female
condoms



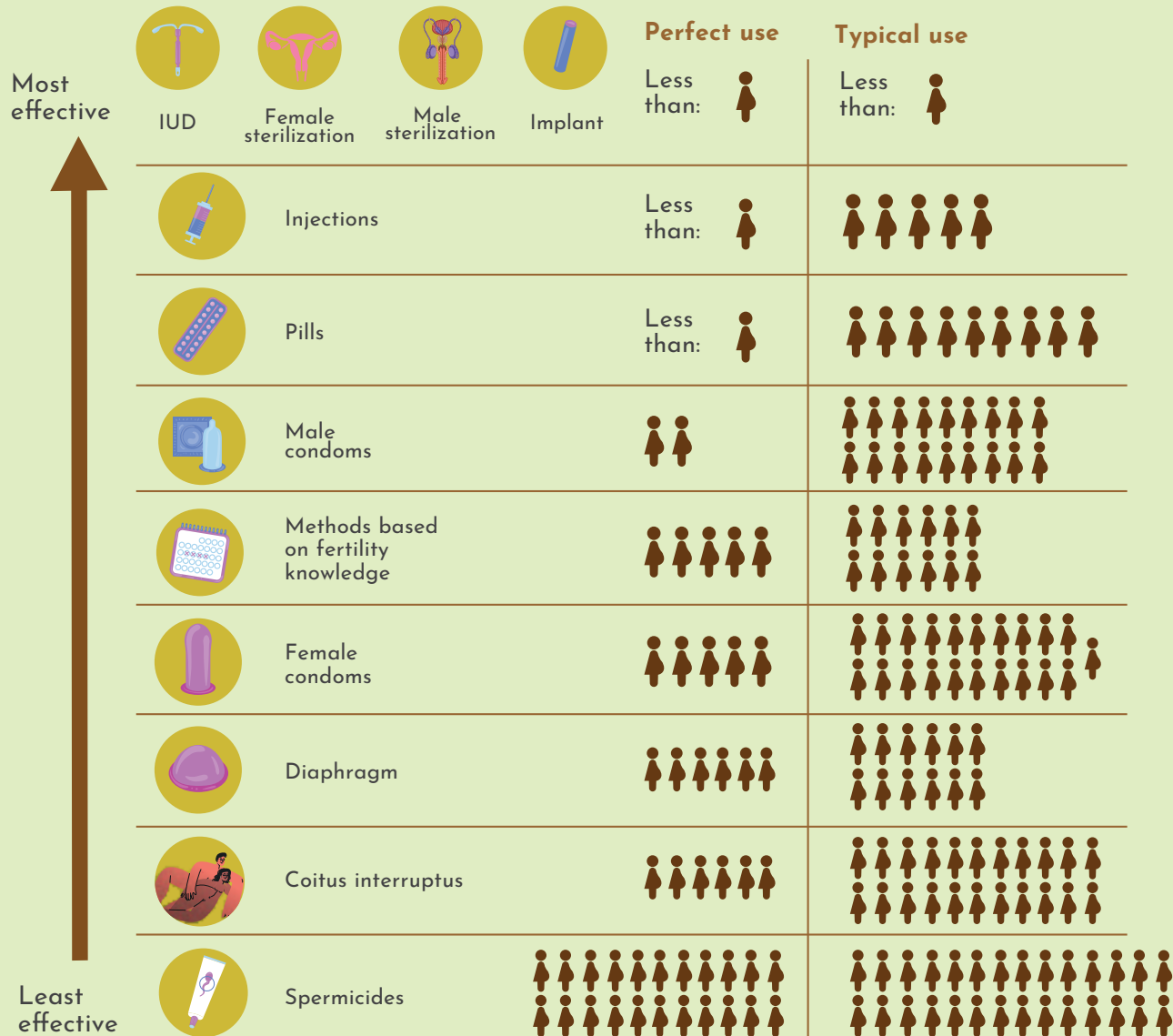
Spermicides



Withdrawal

Contraceptives: What are they, which are available and how effective are they?

(The number of pregnancies every 100 women the first year they use the method)



Contraceptive methods are used to prevent unintended pregnancies and to space pregnancies.

> Spacing pregnancies:

After an abortion, wait at least six months.

After delivery or cesarean section, wait at least two years

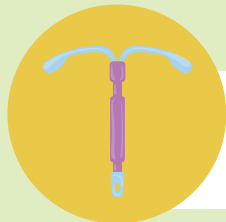
> To avoid risks including adverse maternal and perinatal outcomes, such as increased risk of premature rupture of membranes, anaemia and bleeding, preterm delivery and low birth weight.

5.- Long-acting
reversible
contraceptives
(LARCs).

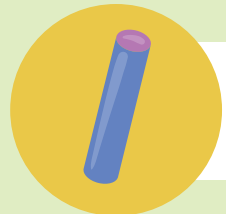


5.- Long-acting reversible contraceptives (LARCs)

Long-acting contraceptive (LARC) methods include:



IUDs



Implants

Pros:

- ✓ Long-lasting but not permanent.
- ✓ Effective and user friendly.
- ✓ User's error is almost impossible.
- ✓ Generally appropriate for women living with HIV and/or other chronic diseases.

⚠ These methods do not prevent the transmission of sexually transmitted diseases and should be combined with a barrier method when appropriate.



5.- Long-acting reversible contraceptives (LARCs)

Long-acting contraceptive methods (LARCs) include:



IUDs



Implants

Women who use contraception to space, delay, and limit their pregnancies reduce risks related to:

- 1 maternal death,
- 2 anemia,
- 3 stillbirths or low birth weight newborns,
- 4 preterm labor,
- 5 miscarriage and
- 6 complications such as haemorrhage, infection, severe preeclampsia and eclampsia.

The risk is higher if pregnancy occurs within:

- ✓ two years after a delivery or caesarean section,
- ✓ six months after an abortion.

Ventajas:

- ✓ Long-lasting but not permanent
- ✓ No permanent effects in childless women
- ✓ Effective and user friendly
- ✓ The user's error is almost impossible
- ✓ Generally appropriate for women living with HIV and/or other chronic diseases.

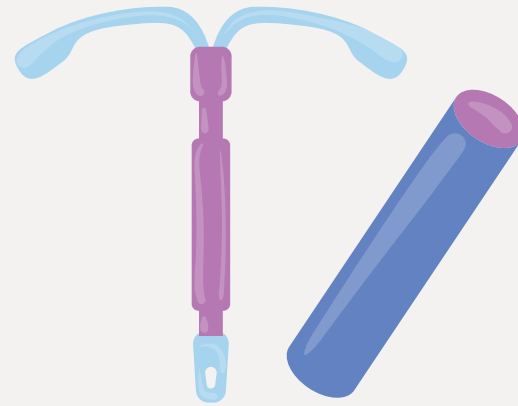


These methods do not prevent sexually transmitted diseases and should be combined with a barrier method when appropriate.

LARCs enhance protection in the case of some conditions.



6.-Types of long-acting reversible contraceptives.






6.1 Postpartum IUD




What is an IUD?

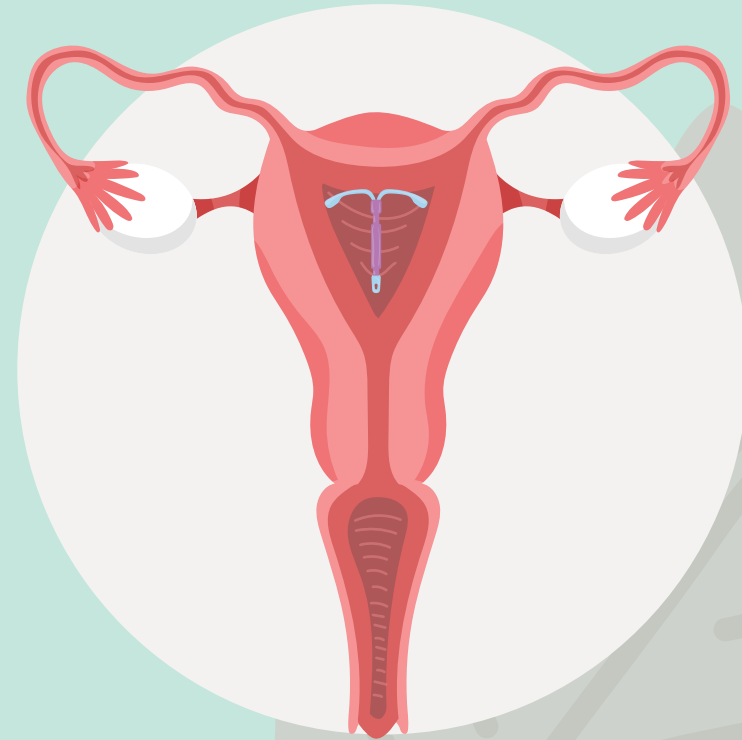
IUD / Intrauterine Device: is a device that is placed in the uterus.

How does it work?

-  It prevents sperm from reaching the Fallopian tubes and the egg.
-  99% effective.
-  Can be left in up to 12 years depending on the model.

When is it inserted?

-  During the caesarean section.
-  Immediate postpartum (within 10 minutes of placental delivery).
-  Early postpartum (up to 48 hours postpartum).






6.1 Postpartum IUD




What is an IUD?

IUD / Intrauterine Device: device inserted in the uterus.




How does it work?

-  It prevents fertilization.
-  Copper ions reduce the motility and performance of the sperm by altering the environment in the uterus and tubes, thus preventing the sperm reaching the Fallopian tubes and fertilizing the egg.
-  It is 99% effective and can be left in place for up to 12 years.

How does it work?

-  During the cesarean section.
-  In the immediate postpartum period (within 10 minutes after delivery of the placenta); this is the best option.
-  Early postpartum (up to 48 hours postpartum).

How is it inserted?

-  Post placenta or early postpartum: use long forceps (Kelly 33 cm).
-  During caesarean section: manually or with a ring forceps before closing the incision in the uterus.
-  Insertion is precluded if a puerperal infection such as chorioamnionitis and endometritis is suspected or if there was a prolonged rupture of the membranes.



Postpartum
IUD



Characteristics



After the IUD has been placed and there is not so much bleeding, you may resume sexual intercourse if she wishes.



It does not protect against sexually transmitted diseases.



It does not interfere with breastfeeding.



The IUD must be inserted and removed by a health care provider.



It is generally suitable for women with HIV.



The resulting contraception is reversible.



Side effects



First 4 to 6 weeks postpartum: cramping, intermittent vaginal bleeding and colics.



After 6 weeks of insertion, the patient will be able to feel the IUD strings. Do not pull or remove them.



Changes in the menstrual cycle.




Spontaneous expulsion of the IUD that was placed postpartum.




Risk of infection: very low.

Characteristics

- 1 Once the IUD is in place, sexual intercourse can be resumed.
- 2 It does not prevent the transmission of sexually transmitted diseases.
- 3 It does not interfere with breastfeeding.
- 4 If the patient feels discomfort: relieve pain with ibuprofen or acetaminophen (aspirin is not recommended because of its antiplatelet effect).
- 5 The IUD can be removed anytime by a health care provider.
- 6 Fertility will resume immediately following removal.


 An IUD can be inserted in a woman with HIV if she is free from any AIDS symptoms.


 The placement of an IUD is precluded in women with AIDS that are not taking their antiretroviral drugs.

 A woman who develops AIDS while using an IUD may continue to use it.


 A woman with AIDS who has good clinical outcomes with antiretroviral therapy can initiate and continue using an IUD but is likely to require closer follow-up.


Possible effects:


 First 4 to 6 weeks postpartum: **cramps, intermittent vaginal bleeding and colics.** Prescribe: Ibuprofen, acetaminophen or other pain relievers (not aspirin because of its anticoagulant effect).

 After 6 weeks of insertion, the presence of longer or shorter strings may reflect some complications: pregnancy or expulsion of the IUD. The strings should not be touched during vaginal hygiene, nor should they be removed or pulled. Tell the patient to seek care.

 **Changes in the menstrual cycle:** they usually disappear a couple of months after insertion.

 **Spontaneous expulsion** of the IUD inserted during the postpartum period: the first 3 months after childbirth it is important for the patient to check her sheets and underwear.

 **Lochia:** the woman should watch out for heavy bleeding or clots. If breastfeeding, amenorrhea may last up to 6 months. Consider: onset of symptoms / amount of bleeding / patient tolerance / concomitant symptoms.

 **Risk of infection:** very low; it is higher the first 20 days following insertion.



Follow-up visit

**Six 6 weeks after childbirth:
follow-up visit.**



It is important to check your sheets, sanitary pads and underwear during this period: watch for heavy bleeding or clots.

Follow-up

Record in writing the placement and follow-up of the device.

Controls

- 1 Speculum examination to **check** if the IUD **strings** descended into the vagina.
- 2 Clinical follow-up to **detect anaemia** in case of excessive or prolonged bleeding.
- 3 Perform abdominal and pelvic examination.

Protocol for the management of non-visible postpartum IUD strings






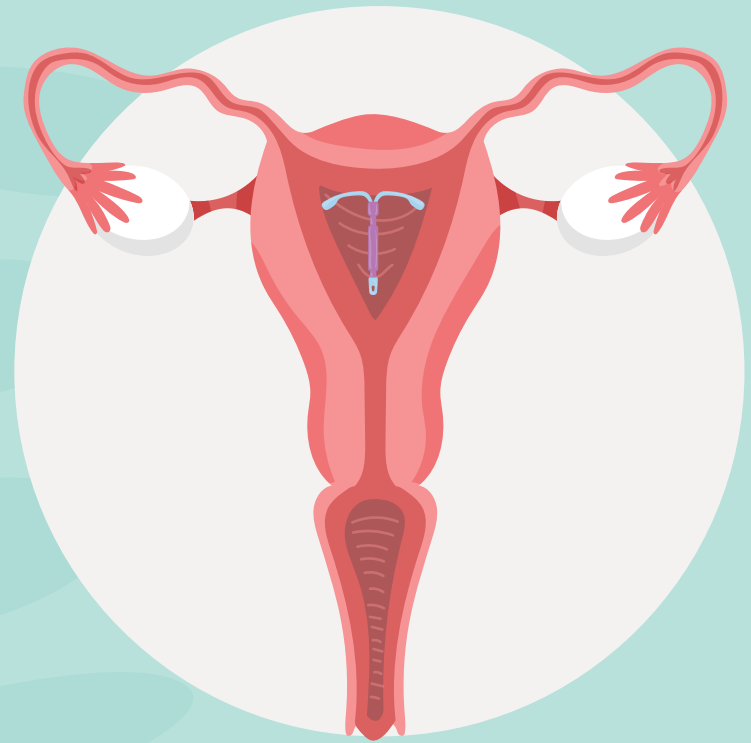
6.2 Post-abortion IUD

What is an IUD?

IUD / Intrauterine Device: device that is placed in the uterus.

How does it work?

-  It prevents the sperm reaching the Fallopian tubes and fertilizing the egg.
-  It is 99% effective.
-  It lasts up to 12 years.



6.2 Post-abortion IUD

What is an IUD?

IUD / Intrauterine Device: device that is placed in the uterus.

How does it work?

- ✓ Copper ions reduce the motility and performance of the sperm by altering the environment in the uterus and tubes, thus preventing the sperm reaching the Fallopian tubes and fertilizing the egg.
- ✓ It is 99% effective and can be left in place for up to 12 years depending on the model.

If the woman decides not to use a continuous contraception method,



Schedule a follow-up visit in two weeks.



Refer her to a contraceptive center.



Take note of her phone number and get her consent to send her a reminder to receive contraceptive care in two weeks.

When is it placed?

- After aspiration: immediately.
- After medical abortion: once expulsion is confirmed.

In what situations can it be placed?

As long as the woman chooses to do so, and she is free from infections, injuries or heavy bleeding.



When is it placed?

In the first and second trimesters following a first or second trimester abortion.

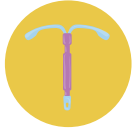
Post manual vacuum aspiration (MVA) or suction curettage: immediately.

Post medical abortion: after the expulsion has been confirmed.

In what situations can it be placed?

- 1 Always, provided there are no severe complications (infection, injury, severe bleeding) requiring treatment.
- 2 Always, provided patients receive care, counselling and follow-up to decide on the use of the contraceptive method.

Characteristics



Once the IUD is in place and bleeding has ceased, you may resume sexual intercourse whenever you wish.



Fertility will return immediately after removal of the IUD.



It does not interfere with breastfeeding.



The IUD can be removed by a health care provider anytime.



It does not prevent the transmission of sexually transmitted diseases.

Possible effects



Pain, cramps or colics during menstrual periods (copper/hormonal).



Prolonged and heavy menstrual bleeding (copper).



Bleeding or spotting between periods (copper/hormonal).



Benign ovarian (hormonal) cysts.

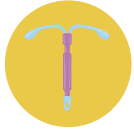


Headache and nausea (hormonal).



Mood swings (hormonal).

Características



Once the IUD is in place and bleeding is over, the woman may resume sexual intercourse whenever she wishes.



Fertility will return immediately after removal of the IUD.



It does not interfere with breastfeeding.



The IUD can be removed by a health care provider anytime.



It does not prevent the transmission of sexually transmitted diseases so it might need to be combined with a barrier method when deemed appropriate.

Side effects



Pain, colics or cramps during menstrual periods (IUD TCU 380 A/ LNG IUD)



Protracted and heavy menstrual bleeding (IUD TCU 380 A/ LNG IUD)



Bleeding or spotting between periods (IUD TCU 380 A/ IUD LNG)



Benign ovarian cysts (IUD LNG)



Headache and nausea (LNG IUD)



Mood swings (IUD LNG)

Advantages of
post abortion IUD





Follow-up visit

**Four to 6 weeks after
the procedure**



It is important to check your sheets, sanitary pads and underwear during this period: watch for heavy bleeding or clots.

Visita de seguimiento

A visit is recommended 4 to 6 weeks after the procedure to answer questions and detect any possible problems.

Record in writing the placement and monitoring of the device.

Controls

- 1 Speculum examination to check if the IUD strings have descended into the vagina.
- 2 Clinical course to detect anemia in case of excessive or prolonged bleeding.
- 3 Perform abdominal and pelvic examination.





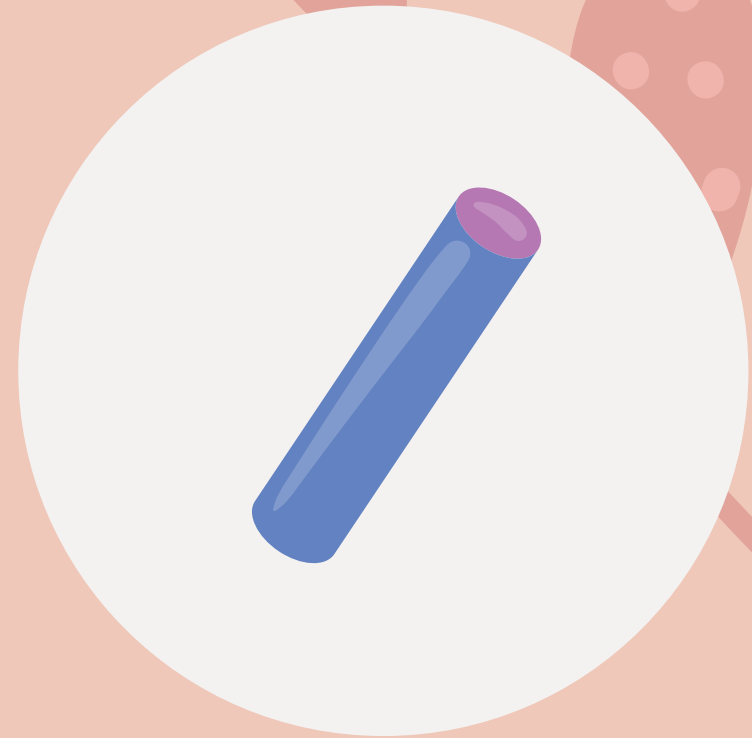
6.3 Implants

What are they?

They are progestin-only hormone-filled rods. The hormone passes into the blood constantly through the walls of the capsule.

What do they do?

-  They prevent ovulation.
-  They thicken cervical mucus, making it difficult for sperm to penetrate.



6.3 Implants

What are they?

They are progestin-only hormone-filled rods that are inserted under the skin of the upper arm.

The hormone passes into the bloodstream constantly through the capsule walls.

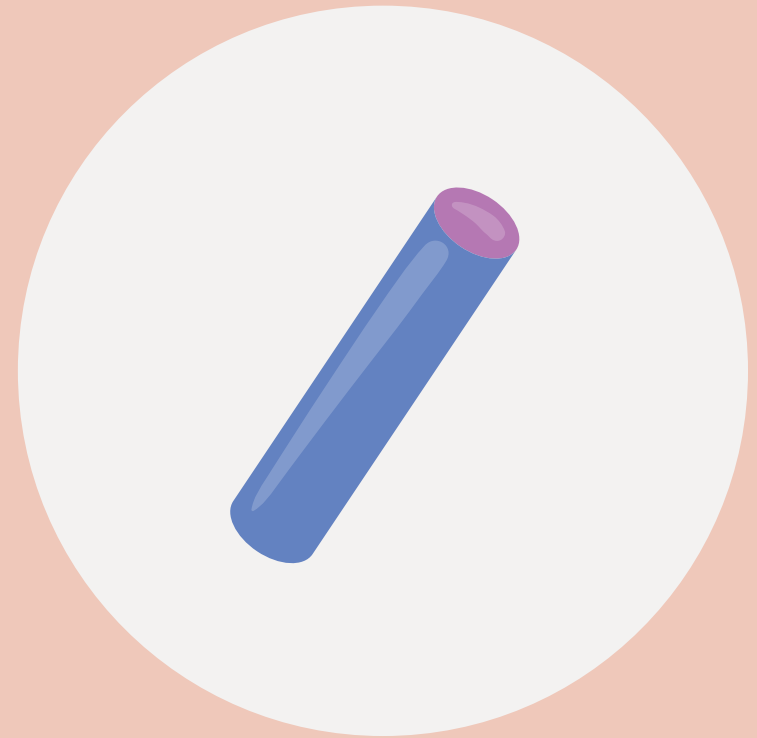
How do they work?



They prevent ovulation: release of eggs from the ovaries.



They thicken cervical mucus, making it difficult for sperm to penetrate.



How is the implant placed?

It is inserted under the skin.

video
procedure



When should it be placed?

- If the patient had an abortion, the implant can be placed whenever the patient wishes.
- It can be inserted during the immediate or late postpartum period.
- During the menstrual cycle: within 7 days of the cycle, the woman does not need to use a backup method.
- If the woman switches from one method to another she must use a back-up method for 7 days.

How is the implant placed?

It is inserted under the skin.

video
procedure



When should it be placed?

- If the patient had an abortion, the implant can be placed whenever the patient wishes.
- It can be inserted during the immediate or late postpartum period.
- During the menstrual cycle: within 7 days of the cycle, the woman does not need to use a backup method.
- If the woman switches from one method to another she must use a back-up method for 7 days.

Characteristics



Its efficacy is over 99%.



This contraceptive method must be inserted and removed by a trained health care provider.



You can get it removed at any time and you will regain fertility immediately.



It does not protect against sexually transmitted diseases.



In general, it is suitable for women with HIV or other chronic diseases.

Possible effects



Changes in menstrual bleeding.



The rod contour can be seen under the skin (especially when the skin is not stretched).



Bruising, hematomas, infection and bleeding may occur after surgery.



Mood swings, breast tenderness, appearance of ovarian follicles, acne.

Characteristics



Its efficacy is over 99%.



It must be inserted and removed by a trained healthcare provider.



It can be removed anytime and fertility is restored immediately.



It does not protect against genital tract infections or other sexually transmitted diseases.



It can be placed in women with HIV who are not taking antiretroviral drugs (ART), women with AIDS that are taking ART. In this case they are also advised to use condoms.

Side effects



Changes in menstrual bleeding patterns.



The rod contour may be visible under the skin (especially when the skin is not stretched).



Bruising, hematomas, infection and bleeding may occur after surgery.



Mood swings, breast tenderness, appearance of ovarian follicles, acne.






Post-implant care

- 1 Keep the incision area dry and clean for 48 hours.
- 2 Leave the compression bandage in place for 48 hours and cover it with an adhesive patch for 5-3 days.
- 3 Avoid lifting heavy objects the days following placement.



Follow-up visit

There is no need to see the doctor until the implant reaches the end of its life, unless you notice any of the symptoms below:

-  pus,
-  severe abdominal pain,
-  excessive vaginal bleeding,
-  prolonged absence of menstruation or
-  the rod has been expelled.

Post-implant care

- 1 Keep the incision area dry and clean for 48 hours.
- 2 Leave the compression bandage in place for 48 hours and cover it with an adhesive patch for 5-3 days.
- 3 Avoid lifting any heavy weights the days following placement.

Controls

If there are :

- ✓ Infection or pus at the insertion site.
- ✓ Prolonged or unusually heavy bleeding.
- ✓ Severe pain in the lower abdomen (signs of ectopic pregnancy).
- ✓ If after the implant is placed you have a pattern of regular cycles and suddenly you start with amenorrhea (signs of pregnancy).
- ✓ If the rod is expelled.

Follow-up visit

Unless indicated by the physician, it is not necessary to monitor the patient until the implant reaches the end of its life.

The patient should see the doctor if:

- She wishes to remove her implants or switch to another contraceptive method.
- She presents with signs or symptoms such as pus, severe abdominal pain, excessive vaginal bleeding, prolonged absence of menstruation or reports having expelled the rods.



Some medications may reduce the effectiveness of the implant.

7. Other highly effective contraceptives.



7.1 Progestin-only injection

What is it?

Injectables containing progestin, a hormone similar to progesterone, a hormone naturally produced in a woman's body.

How does it work?



It prevents ovulation.



It thickens cervical mucus, preventing the penetration of sperm.

How is it applied?

Intramuscular or subcutaneous. It is applied every 2 or 3 months.



7.1 Progestin-only injection



What is it?

Injectables containing progestin, a **hormone similar to progesterone**, a hormone naturally produced in a woman's body.

How does it work?

- 1 Gradually releases progestin into the blood.
- 2 Prevents ovulation: release of eggs from the ovaries.
- 3 Thickens cervical mucus, making it difficult for sperm to penetrate.

The duration of protection depends on the type of injectable.

- > Depot medroxyprogesterone acetate (DMPA) is more widely used, every 13 weeks or three months.
- > Norethisterone enanthate (NETE) is injected every 8 weeks or two months.

video of
conventional
intramuscular
injection



video of
subcutaneous
application
with uniject
system



Characteristics



Highly effective.



Easy to use.



Reversible.



Only the user knows that she is using it.



It does not interfere with breastfeeding.



It does not protect against sexually transmitted infections.



Women who have HIV and AIDS can generally use it.

Possible effects



Irregular bleeding or spotting between periods.



Prolonged or heavy bleeding.



Amenorrhea (absence of menstruation).



Weight gain.



Headaches and dizziness.

Characteristics




- ✓ Highly effective.
- ✓ Easy to use.
- ✓ Reversible. Delay to recover fertility: four months average.
- ✓ No interference with sexual relations.
- ✓ Only the user knows that she is using it.
- ✓ It has no effect on the quality or amount of breast milk.
- ✓ It offers health benefits unrelated to contraception: protection against endometrial cancer, fibroids, ectopic pregnancy and symptomatic pelvic inflammatory disease.
- ✓ It may reduce vaso-occlusive crises in women with sickle cell disease.
- ✓ Women with HIV and AIDS that are not taking antiretroviral drugs (ART) can use progestin-only injectables without restrictions.
- ✓ Women with AIDS or ART can generally use progestin-only injectables (both NETE and DMPA).
- ✓ These injections do not protect against sexually transmitted infections.

Side effects

- Irregular bleeding or spotting between periods.
- Prolonged or heavy bleeding (more common during the first months of use).
- Amenorrhea (common, especially after the first year of use).
- Weight gain (although it may not be a direct cause of the method).
- Headaches and dizziness (less common than with combined oral contraceptives).

When can you apply injectables?

Anytime, **if you are not pregnant.**

-  During the menstrual period.
-  When switching from another method.
-  Shortly after childbirth, caesarean section or abortion.

It is important to be accompanied both during counselling and at the time of the injection. You can ask your partner, friend, family member or any other person you trust to go with you.



When can it be applied?

- ✔ Postpartum and breastfeeding: anytime between the first 6 weeks and 6 months if menstrual bleeding has not resumed.
- ✔ If menstrual bleeding has already resumed, start within the first 7 days of bleeding.
- ✔ Immediate postpartum and less than 4 weeks not breastfeeding: it can be applied anytime, with no back-up method.
- ✔ Post abortion: immediately if initiated within 7 days. If initiated after 7 days, use a back-up method.
- ✔ Anytime, provided the woman is not pregnant.
- ✔ During the menstrual period: within 7 days after the start of the menstrual cycle, (no back-up method); more than 7 days with back-up method (e.g. condom for 7 days after injection).
- ✔ Switching from another method: If a woman switches from an IUD, she can start injectables immediately.

In which situations you cannot use injectables

- Multiple risk factors for cardiovascular disease.
- Blood pressure higher than 160/100 mmHg.
- Acute deep vein thrombosis (unless on anticoagulant therapy).
- History or current ischemic heart disease or stroke.
- Unexplained vaginal bleeding (prior to evaluation).
- History or current breast cancer.
- Diabetes with vascular complications.
- Severe cirrhosis; malignant or benign liver tumors, with the exception of focal nodular hyperplasia (a tumor consisting of scar tissue and normal liver cells).



- ✔ Importance of being accompanied.
- ✔ Pay attention to other circumstances of the patient: living conditions, if she has a partner or not, if she has suffered any episodes of violence.

8. Annexes.





Contraceptive methods

The efficacy of contraceptive methods is more important if the woman has any of the conditions below:

- Reproductive tract infections and disorders, including breast cancer. Also, if you have some sexually transmitted infections, such as gonorrhoea and chlamydia; vaginal infections, including bacterial vaginitis or sequelae of female genital mutilation.
- Cardiovascular disease (including high blood pressure), complicated valve disease; ischemic heart disease or infarction.
- Insulin-dependent diabetes (onset more than twenty years earlier) with compromise of the arteries, kidneys, eyes or nervous system.

- Sickle cell anaemia.
- Severe cirrhosis of the liver and cancerous liver tumours.
- Other infections such as schistosomiasis with liver fibrosis, tuberculosis, HIV/AIDS (although HIV/AIDS does not worsen with pregnancy, it can increase some health risks and affect the baby's health).





POSTPARTUM / POST-ABORTION IUD

Postpartum/post-abortion IUD care and follow up.

- IUD strings: If they are long, if they protrude through the vagina (especially postpartum) or if the patient complains, trim them so they will protrude 3 or 4 centimeters from the cervix.
- Persistent symptoms: perform pregnancy tests, blood tests and cultures to rule out problems such as endometriosis, appendicitis, partial expulsion of the IUD, uterine perforation, pregnancy, ectopic pregnancy or uterine tract infection.
- Symptoms of pelvic inflammatory disease: tenderness in the lower abdominal uterine area, tenderness or pain when the cervix is moved (cervical motion), yellow cervical discharge containing mucus and pus or cervical bleeding on touching the cervix, enlargement or hardening (induration) of one or both Fallopian tubes. Antibiotic therapy.
- If the patient does not want to continue with the IUD, remove it 2 or 3 days after the antibiotic therapy.

- Remove the IUD if symptoms do not improve within 72 hours or in case of sepsis.

If the device is expelled:

Check whether the expulsion was complete: it should be confirmed by X-ray or ultrasound. It is essential to see to the woman's need and will by replacing the device or providing her with an alternative contraceptive method.

If the device gets stuck in the vaginal canal, pull it out in the standard way or consult a specialist in the matter.

In case of total expulsion and pregnancy manage parental care.

In case of pregnancy:

Explain that although the IUD is one of the most effective forms of contraception, it can fail.

Approximately one third of pregnancies with IUD use are due to expulsion (partial or complete expulsion of the device). When pregnancy occurs, the IUD should be removed and an ectopic pregnancy ruled out.

FIGO's video. A practical guide to postpartum intrauterine device (PPIUD) insertion





IMPLANTS

How to treat the possible effects of an implant

1

In case of irregular and prolonged bleeding, the patient should be advised and reassured, explaining that this is part of the expected effects.

Heavy bleeding (twice the normal duration or twice the normal amount) is rare but can usually be treated with COCs.

2

A low-dose COC (30-35 ug ethinyl oestradiol) once daily for 20 days.

If COCs are not appropriate for personal or medical reasons try:
Ibuprofen (or other non-steroidal anti-inflammatory drug) up to 800 mg three times a day after meals for 5 days).

3

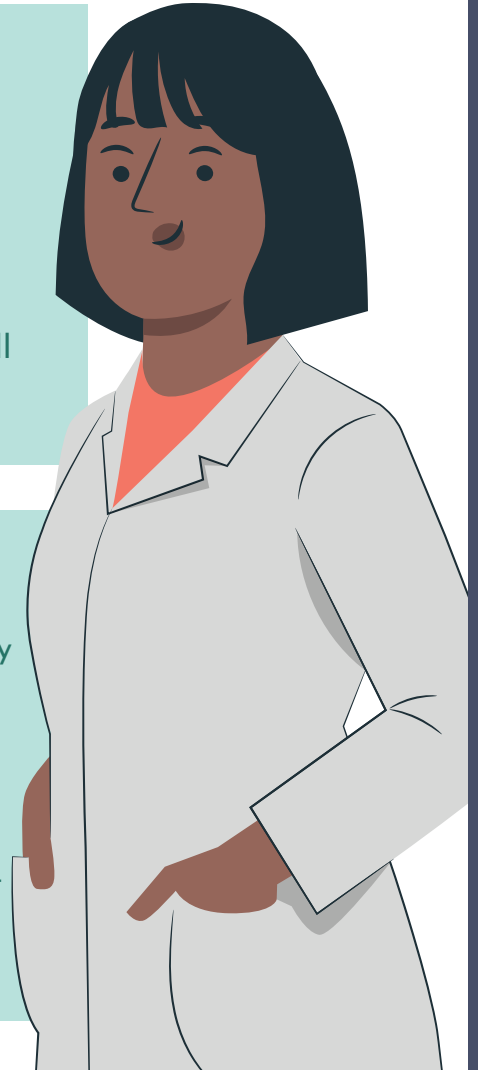
If bleeding has not diminished in 3-5 days or is much heavier (1-2 sanitary pads or cloths per hour), rule out other causes.

Administer 2 low-dose COC pills per day for the remainder of the cycle (at least 3-7 days) followed by 1 cycle (1 pill per day) of some COC.

4

If COCs or oestrogens do not correct the bleeding problem, the implants may have to be removed either for medical reasons (excessive bleeding) or to comply with the woman's wishes.

Do not perform a dilation and curettage procedure unless you suspect another medical condition.





Implant removal

- 1 Feel the location of each rod and mark it with a pen.
- 2 Insert a small amount of local anaesthetic (no more than 1 mL) under the end of the rod closest to the original incision site.
- 3 If the rods are placed correctly, a small incision (4 mm) will suffice. If 2 rods are removed, remove the rod closest to the incision first. Curb bleeding by applying pressure.
- 4 If after 30 minutes you have not been able to remove the rods, stop the procedure for the woman's comfort.

If a rod is left in the arm:

- ✓ Provide a back-up method of contraception.
- ✓ Instruct the woman to return in 4-6 weeks.
- ✓ Re-evaluate and try extracting it for a second time after 4-6 weeks.
- ✓ They are usually placed in a V-shape so that access can be gained through an incision at the base.

In case of broken rods:

- > Inject analgesic and use a curved mosquito forceps to hold the piece.
- > Ask the patient to come back in 4 to 6 weeks to check no pieces were left behind.

