



Government of Pakistan
Ministry of National Health Services,
Regulations & Coordination



Standardized Training Package on Family Planning

Trainer's Guide

Volume - I (Page 1 to 334)

&

Volume - II (Page 335 to 679)

Year - 2020



**World Health
Organization**





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Foreword

Family planning is a key issue that impacts the quality of lives of families, communities and society at large. Increased uptake of family planning services translate in to better health outcomes of mothers and children, improved status of women and economic development. Ministry of National Health Services, Regulations and Coordination is focusing on addressing the population growth rates through human-centered approach. The ability to meet people's needs is the most lasting and sustainable strategy which will ultimately lead to the completion of the fertility transition.

The Government of Pakistan's new narrative on population stipulates that, "Parents have the right to freely and responsibly decide the number and spacing of their children to fulfil the fundamental rights of their children and family by maintaining a balance (*tawazun*) between their family size and resources. The Government and society have the responsibility to facilitate parents to achieve this balance by providing universal access to family planning information and services."

Family planning has become an issue of national interest, a national priority. Investing more in contraceptive care, especially within the public health system, will help in meeting both family planning and maternal health goal and will support the 2018 Council of Common interests recommendations on family planning. Improving access to quality family planning services and accelerating efforts to ensure balanced population growth is critical to taking Pakistan forward and achieving the goals of development.

The Ministry is pleased to coordinate the consultative process of developing a comprehensive and updated document providing technical guidelines and quality of care standards along with the standardized in-service training package on family planning for facility and community based workers. The continuous support from WHO team has played a pivotal role in its successful completion. The Ministry would also like to thank all individuals and organizations, in-country and abroad for making valuable contributions. We urge all public and private institutions to make maximum use of it to guide family planning implementation.

A handwritten signature in blue ink, consisting of stylized letters and a horizontal line at the end.

(Aamir Ashraf Khawaja)

Secretary

Ministry of National Health Services
Regulations and Coordination
Government of Pakistan

Acknowledgments

The standardized in-service training package on family planning for facility and community-based workers has been developed with the objective of improving and maintaining quality of capacity building interventions by all partners. Family planning is among the priority health and population agenda in Pakistan. The National Task Force on Health and Population has also recommended to strengthen capacity building of healthcare providers on contraceptive service delivery.

This task was completed under the aegis of the Ministry of National Health Services, Regulations & Coordination (NHSR&C), Government of Pakistan, with the support of the World Health Organization and a broad range of stakeholders and partners. The Ministry is highly indebted to all for their relentless efforts.

The Ministry expresses deep appreciation to the technical experts who have led the task including Dr Noreen Zafar & Dr Rachid Beza (package for facility-based providers) and Dr Fauzia Aqeel Tariq (package for community-based providers). Gratitude is due for the galaxy of experts, both international and in-country, including members of the National RMNCAH&N Technical Working Group, who provided their valuable contributions during various phases of the process including the draft review, pilot training of trainers and final consensus building workshops. The detailed list of contributors is annexed. The process was started in early 2018 and completed by end of 2019, although the official approval from Ministry was delayed till late 2020 due to the COVID-19 situation.

Special thanks and gratitude is also extended to the Ministry team (Dr Nasser Mohiuddin, Dr Atiya Aabroo, Dr Ghazala Bashir, Dr Ambreen Nadeem), representatives from Departments of Health and Population Welfare from all the provinces, Azad Jammu & Kashmir and Gilgit-Baltistan, academic institutions, professional associations, civil society organizations, teams from WHO, UNFPA and UNICEF and the private sector, for their technical guidance and support. In particular, the great contributions from technical advisors based in WHO Eastern Mediterranean Region (Dr Karima Gholbzouri, Dr Nilmini Haemachandra), WHO Headquarters (Dr James Kiarie, Dr Rita Kabra, Dr Moazzam Ali), other global experts (Dr Mamdouh Wahba) and WHO country office Pakistan (Dr Lamia Mahmoud, Ms Ellen Thom, Dr Qudsia Uzma, Dr Yahya Gulzar, Dr Badar Munir, Dr Mazhar Khan, Dr Asfandyar Sherani) are deeply appreciated.



Dr Malik Muhammad Safi
Director General (Health)

TABLE OF CONTENTS

Volume - I (Page 1 to 334)

ABBREVIATIONS AND ACRONYMS	1
INTRODUCTION	1
MODULE 1 STATUS OF FAMILY PLANNING IN PAKISTAN	2
MODULE 2 OVERVIEW OF FAMILY PLANNING METHODS.....	4
MODULE 3 KEY FACTS ABOUT FAMILY PLANNING AND HUMAN RIGHTS BASED APPROACH	7
MODULE 4 COURSE DESIGN.....	16
MODULE TEMPLATE	18
MODULE 5 ADULT LEARNING AND EFFECTIVE TRAINING.....	21
MODULE 6 MEDICAL ELIGIBILITY CRITERIA(MEC).....	28
MODULE 7 HEALTHY TIMING & SPACING OF PREGNANCY	37
MODULE 8 FAMILY PLANNING COUNSELING	48
MODULE 9 INFECTION PREVENTION PRACTICES	77
MODULE 10 COMBINED ORAL CONTRACEPTIVES (COCS)	124
MODULE 11 PROGESTIN-ONLY PILLS (POPS)	154
MODULE 12 EMERGENCY CONTRACEPTION	175
MODULE 13 INJECTABLE CONTRACEPTION.....	200
MODULE 14 INTRAUTERINE DEVICES (IUCDS)	234
MODULE 15 CONTRACEPTIVE IMPLANTS	292

Volume - II (Page 335 to 679)

MODULE 16 LACTATIONAL AMENORRHEA METHOD (LAM).....	335
MODULE 17 CONTRACEPTIVE PATCH AND VAGINAL RING.....	348
MODULE 18 BARRIER METHODS	363
MODULE 19 NATURAL FAMILY PLANNING METHODS.....	394
MODULE 20 TUBAL LIGATION (FEMALE STERILIZATION).....	415
MODULE 21 VASECTOMY (MALE STERILIZATION)	451
MODULE 22 POST PARTUM FAMILY PLANNING	472
MODULE 23 POST ABORTION FAMILY PLANNING.....	484
MODULE 24 POST PARTUM INTRA UTERINE CONTRACEPTIVE DEVICE.....	507
MODULE 25 CONTRACEPTION FOR DIVERSE HIGH-RISK GROUPS.....	578
MODULE 26 FAMILY PLANNING IN CRISIS AND DISASTER SITUATIONS.....	615
MODULE 27 CONTRACEPTION AND SEXUALLY TRANSMITTED INFECTIONS.....	642
MODULE 28 EXCLUDING THE POSSIBILITY OF PREGNANCY	670
LIST OF CONTRIBUTORS	674

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immune deficiency syndrome
AMTSL	Active Management of third stage of labour
ANC	Antenatal care
ART	Antiretroviral therapy
ARVs	Antiretroviral (medications)
BCC	Behaviour Change Communication
BCG	Bacille Calmette–Guérin (vaccine)
BCS	Balanced counseling strategy
BF	Breastfeeding
BMD	Bone mineral density
BMI	Body mass index
BP	Blood pressure
C	Continuation
CCP	Combined contraceptive patch
CHG	Chlorhexidine gluconate
CHW	Community health worker
CIC	Combined injectable contraceptive
COC	Combined oral contraceptive
CPR	Contraceptive prevalence rate
Cu-IUCD	Copper-bearing intrauterine device
CVD	Cardiovascular disease
CYP	Couple-years protection
DMPA	Depot medroxyprogesterone acetate
DMPA-IM	Depot medroxyprogesterone acetate – intramuscular
DPT	Diphtheria-pertussis-tetanus
DVT	Deep vein thrombosis
EBF	Exclusive breast feeding
EC	Emergency contraception
ECP	Emergency contraceptive pill
EE	Ethinyl Estradiol
EPI	Expanded programme on immunization
ETG	Etonogestrel
EV	Estradiol valerate
FAB	Fertility awareness-based methods
FP	Family planning
FP/RH	Family planning/reproductive health
FSH	Follicle stimulating hormone

FTP	First time parents
GTN	Gestational trophoblastic neoplasia
HB	Haemoglobin
HbA1c	Glycosylated Hemoglobin
HBV	Hepatitis B virus
HIV	Human immunodeficiency virus
HLD	High-level disinfection
HMIS	Health management information system
HTSP	Health spacing and timing of pregnancy
IAWG	International agency working group
ICCM	Integrated community case management
IEC	Information exchange material
IM	Intramuscular
IMCI	Integrated management of childhood illnesses
IP	Infection prevention
IPC	infection prevention and control
IUCD	Intra uterine contraceptive device
LAM	Lactational amenorrhoea method
LARCs	Long acting reversible contraceptives
LH	Luteinizing hormone
LMP	Last menstrual period
LNG	Levonorgestrel
LNG IUCD	Levonorgestrel-releasing intrauterine device
MCHIP	Maternal and child health integrated program
MEC	Medical eligibility criteria
MIYCN	Mother, infant and young child nutrition
ML/LA	Minilaparotomy under local anesthesia
MNCH	Maternal, new born and child health
NA	Not Applicable
NET	Norethisterone enanthate
NFM	Natural family planning methods
NICE	National institute of clinical excellence
NSAID	Non-steroidal anti-inflammatory drug
OC	Oral contraceptive (pill)
PID	Pelvic inflammatory disease
PLWA	People living with AIDS

PM	Permanent methods
PMTCT	Prevention of mother-to-child transmission
PNC	Post-natal care
POC	Progestogen-only contraceptive
POI	Progestogen-only injectable
POP	Progestogen-only pill
PPFP	Postpartum family planning
PPIUD	Postpartum intrauterine contraceptive device
PPTO	Postpartum tubal occlusion
PREP	Pre –exposure prophylaxis
PROM	Prolonged rupture of membranes
RCT	Randomized controlled trial
RHRC	Regional human rights commission
ROM	Rupture of membranes
RTI	Regional training institute

SAE	Severe adverse event
SC	Subcutaneous
SDP	Service delivery point
SLE	Systemic lupus erythematosus
SPR	Selected practice recommendations
β-hCG	Beta-human chorionic gonadotropin
STI	Sexually transmitted infection
SVT	Superficial venous thrombosis
TO	Tubal occlusion
UNFPA	United nations population fund
USAID	United states agency for international development
VIA/VILI	Visual inspection with acetic acid / Visual inspection with Iodine
VS	Voluntary sterilization
VTE	Venous thromboembolism
WHO	World health organization

INTRODUCTION

According to the World Health Organization family planning is defined as, “The ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved by using contraceptive methods and treatment of involuntary infertility”.

Sustainable development Goals 3.7 and 5.6 support “universal access to sexual and reproductive health-care services, including for family planning” and “universal access to sexual and reproductive health and reproductive rights,” respectively. Family planning is an important multidimensional tool to help us achieve the SDGs by 2030.

Health care providers play a crucial role in delivering high-quality family planning services to people in need, with respect and dignity. Family planning services require availability of a range of FP modern methods, logistics system in place to ensure a sustainable supply of FP commodities, method-specific counselling for informed choice, and trained providers to provide appropriate counselling to clients and have the necessary technical skills to deliver FP service.

To strengthen the skills of FP health service providers and ensure a better quality of contraception care, WHO has developed a training resource package designed to be the key resource for FP trainers, supervisors, and program managers. It offers high-quality, user-friendly resources and materials for designing, conducting, and evaluating training for family planning (FP) service providers. All the FP training tools are evidence-based and reflect the updated World Health Organization (WHO) family planning guidance in the Medical Eligibility for Contraceptive Use (2015), Selected Practice Recommendations for Contraceptive Use (2016), and Family Planning: A Global Handbook for Providers (2018).

With this understanding, Ministry of Health with WHO technical support has developed this training package on family planning, aiming at adopting FP WHO updated recommendations into practice to ensure better FP services. This package is specifically designed for health care providers. It aims at acquiring skills in family planning counselling and helping women and couples to have informed choice for the right FP modern method. It is a comprehensive package that addresses all components of FP services and composed of facilitator guide and participant module.

The manuals are divided into four parts:

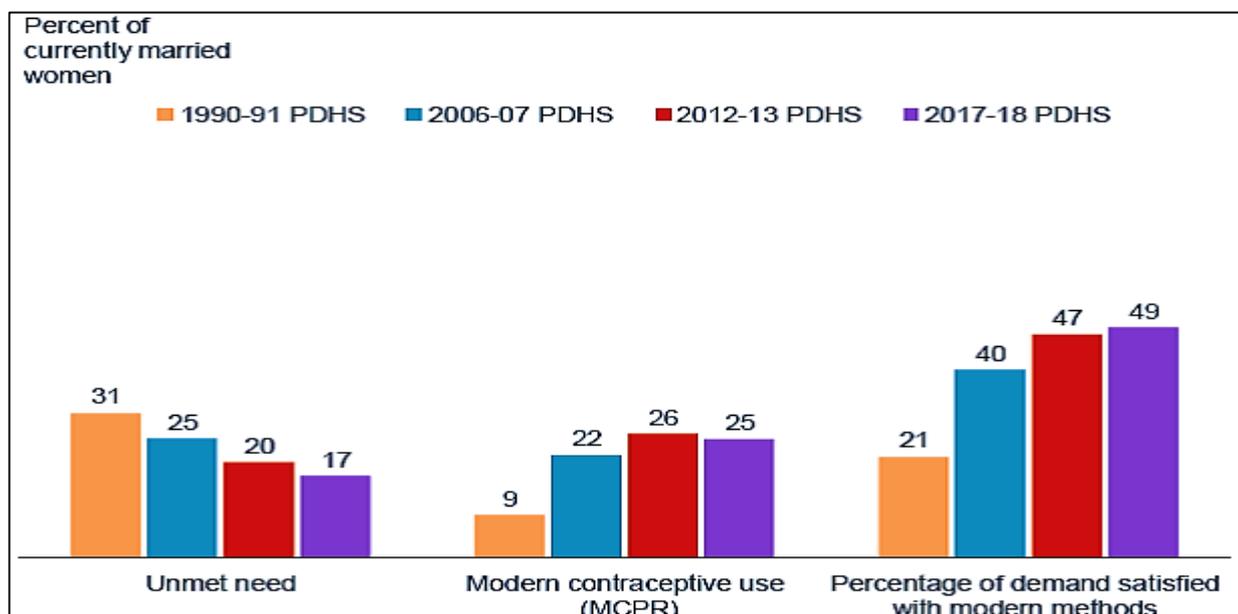
- First part is on how to conduct family planning training
- Second part is on cross cutting family planning training topics
- Third part is training modules on family planning modern methods
- Fourth part is about family planning in specific situations

STATUS OF FAMILY PLANNING IN PAKISTAN

Family planning is a conscious effort by a couple to limit or space the number of children they have, through the use of contraceptive methods. In Pakistan, overall, 34% of currently married women use a method of family planning, with 25% using a modern method and 9% using a traditional method.

Among currently married women, the most popular modern methods are the male condom and female sterilization (each used by 9%). The contraceptive prevalence rate (modern CPR) among married women varies with age, rising from 7% among women age 15-19, peaking at 48% for women age 40-44, and then slightly declining to 37% among women age 45-49.

Women in urban areas are more likely to use a contraceptive method than women in rural areas (43% and 29%, respectively). Use of contraceptive methods, both modern as well as traditional methods, increases with education. For instance, 22% of currently married women with no education used a modern method of contraception compared with 30% of women with secondary or higher level of education. Similarly, 7% of currently married women with no education used a traditional method compared with 14% with a higher level of education who used a traditional method.



The use of contraceptive methods has remained stagnant over the past 5 years (34% in the 2017-18 PDHS and 35% in the 2012-13 PDHS). An earlier rise in use of contraceptive methods was witnessed between 2006-07 PDHS and 2012-13 PDHS, mostly attributed to an increase in the use of traditional methods from 4% to 9% (NIPS and ICF International, 2013). The 2017-

18 PDHS revealed that about 14% of currently married women had husbands living elsewhere (data not shown), which could impact the use of contraception.

17% of currently married women have an unmet need for family planning services. 52% of currently married women have a demand for family planning. At present, 66% of the potential demand for family planning is being met. Thus, if all married women who said they want to space or limit their children were to use family planning methods, CPR would increase from 34% to 52%. The unmet need for family planning is higher in rural areas (19%) than in urban areas (15%). Women in the lowest wealth quintile have the highest unmet need (22%) for family planning, and unmet need decreases with wealth.

FURTHER READING

National Institute of Population Studies (NIPS) [Pakistan] and ICF. 2018. Pakistan Demographic and Health Survey 2017-18. Islamabad, Pakistan, and Rockville, Maryland, USA: NIPS and ICF.

http://www.nips.org.pk/abstract_files/PDHS%20-%201990-91.pdf

Pakistan Population. (2018-09-24). Retrieved 2018-12-29, from

<http://worldpopulationreview.com/countries/pakistan/> <http://www.worldometers.info/world-population/pakistan-population>

The 4 cornerstones can be found on the WHO Web site at:

http://www.who.int/reproductionhealth/publications/family_planning/

1. WHO Standard Practice Recommendations for Contraceptive Use
2. Family Planning: A Global Handbook for Providers- Essentials of Contraceptive Technology
3. World Health Organization (WHO) Medical Eligibility Criteria for Contraceptive Use
4. WHO Standard Practice Recommendations for Contraceptive Use- The Decision-Making Tool

OVERVIEW OF FAMILY PLANNING METHODS

Family planning is an individual's or the couple's capacity to anticipate and to have the desired number of children, at the time they want and at the optimal births spacing intervals established by themselves. This can be accomplished by using contraceptive methods and treatment of involuntary infertility

Family planning methods can be classified in various ways:

1. According to the timeline of evolution
 - a. Traditional and modern methods
 - b. Natural and artificial methods
2. Based on duration of action
 - a. Methods for spacing
 - b. Limiting the family size
3. Based on the mechanism of action
 - a. Hormonal and non-hormonal methods
 - b. Chemical and mechanical methods
 - c. Surgical and non-surgical methods

MODERN FAMILY PLANNING METHODS

HORMONAL CONTRACEPTIVES:

Hormonal contraceptives contain progestogen alone or in combination with estrogen to prevent a woman from ovulating. They are common, highly effective, and easy to use methods. There are several administrative routes (by mouth, intramuscular or dermal etc.) When a woman chooses a hormonal method, she must be counselled on correct use, what to do in case of a missed dose and possible side-effects, such as changes in menstrual bleeding patterns. These include, pills, injectables, skin patches, vaginal rings, intra uterine contraceptive devices and implants. Supportive counselling and continued reassurance during follow-up visits will help clients correctly use the method and manage common side-effects.

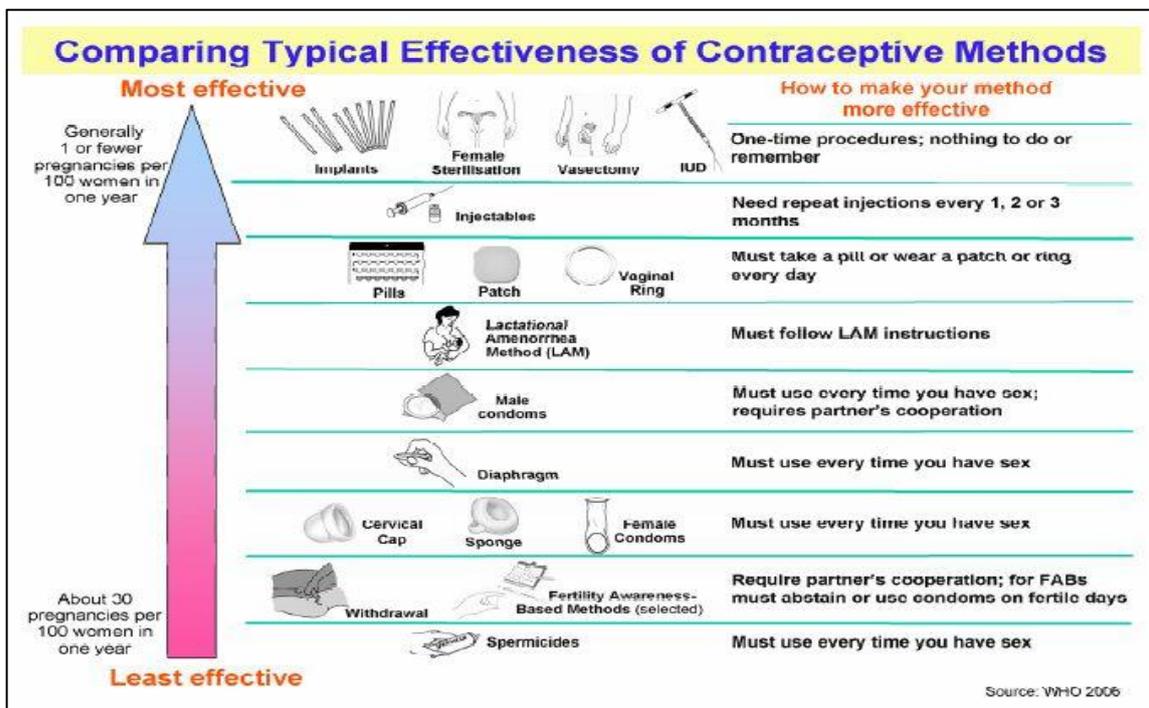
BARRIER METHODS

Barrier contraceptive methods prevent pregnancy by physically preventing sperm from entering the uterus. The most frequently used barrier methods are male and female condoms. Condoms are the only FP methods that protect against both pregnancy and STIs. Male

condoms may be used alone, or in addition to other methods either as backup or to prevent STIs. Other barrier methods include spermicides, cervical caps, female condoms, and diaphragms

INTRAUTERINE DEVICES (IUDS)

Intrauterine devices (IUDs) are small, flexible plastic devices that contain either copper or a progestogen. A specifically trained health-care provider inserts it into a woman’s uterus through her vagina and cervix, using proper infection- prevention procedures (including a “no-touch” insertion technique). IUDs are among the most effective methods in preventing



pregnancy.

EMERGENCY CONTRACEPTION (EC)

Emergency contraceptive pills are hormonal pills which are intended for use in the event of unprotected intercourse. Emergency contraceptive pills can prevent unwanted pregnancy if used within five days (120 hours) after unprotected sex. ECP should be taken as soon as possible after unprotected intercourse. They are most effective the sooner they are taken but can still be effective when taken up to five days after unprotected sex. A copper-bearing IUD can be inserted up to five days after unprotected intercourse as an emergency contraceptive. When the time of ovulation can be estimated, a copper-bearing IUD can be inserted beyond

five days after unprotected intercourse, as long as insertion does not occur more than five days after ovulation.

VOLUNTARY SURGICAL STERILIZATION:

Surgical methods (sterilization and vasectomy) provide long-term contraception for those who have completed their families and don't want to have any more children. Sterilization is a permanent form of birth control that either prevents a man from releasing sperm or prevents a woman from getting pregnant.

Male (vasectomy) and female (tubal ligation) sterilization are desirable methods of contraception for some clients who have decided to have no more children. Surgical contraception should only be performed in safe conditions with informed consent of the user, by trained personnel and with the necessary equipment. This method does not protect against STIs, including HIV.

FURTHER READING

1. World Health Organization/Department of Reproductive Health and Research (WHO/RHR); Johns Hopkins Bloomberg School of Public Health (JHSPH)/Centre for Communication Programs (CCP)
2. Family planning: a global handbook for providers. Baltimore (MD): CCP; 2007. Co-published by WHO. Available from: <https://www.fphandbook.org/>

KEY FACTS ABOUT FAMILY PLANNING AND HUMAN RIGHTS BASED APPROACH

FP allows people to attain their desired number of children and determine the spacing of pregnancies. The world's population has risen to an alarming level, which in turn leaves its nations bulging with population density. It is also a fact that while some countries are experiencing a population explosion, others show a negative growth. And those that are bursting at the seams ironically do not have the financial or natural resources to meet the demands of their growing populace. Hence, the concept of contraception as a method for population control is of paramount importance.

KEY FACTS

- An estimated 222 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception. `
- By preventing unintended pregnancy, family planning /contraception prevents deaths of mothers and children.
- Family planning / contraception helps to reduce the need for abortion as a FP method, especially prevents unsafe abortion.
- Contraceptive use prevented 218 million unintended pregnancies in developing countries in 2012, and, averting 55 million unplanned births, 138 million abortions (of which 40 million are unsafe), 25 million miscarriages and 118,000 maternal deaths. `
- Programmes should ensure that the contraceptive needs of such vulnerable groups as adolescent women, poor women and rural women are met and that inequities in information and access are reduced. `
- Family planning reinforces people's rights to determine the number and spacing of their children.
- Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through information, education and the use of contraceptive methods.
- Some family contraceptive methods help prevent the transmission of HIV and other sexually transmitted infections.

FAMILY PLANNING AND SDGS

SDGs 3.7 and 5.6 support “universal access to sexual and reproductive health-care services, including for family planning” and “universal access to sexual and reproductive health and

reproductive rights,” respectively. As shown below Family planning is an important multidimensional tool to help us achieve the SDG

ROLE OF FAMILY PLANNING IN ACHIEVING THE SDGS ACROSS FIVE THEMES

PEOPLE

1. Advances human rights
2. Helps reduce poverty
3. Contributes to improved nutrition outcomes
4. Saves lives
5. Prevents HIV/AIDS transmission and STIs
6. Supports women’s and girls’ education
7. Advances gender equality and empowerment

PLANET

1. Mitigates population growth’s effects on access to water and sanitation. Integrated population, health, and environment projects can expand access to clean and renewable energy.
2. Contributes to building resilient infrastructures.
3. Contributes to building safe, resilient, sustainable cities.
4. Helps reduce population effects on food and chemical waste.
5. Helps address the challenges of climate change.
6. Helps to protect declining marine resources.
7. Helps mitigate the effects of deforestation and unhealthy interaction among humans, domestic animals, and wildlife.

PROSPERITY

1. Contributes to economic growth.

PEACE

1. Promotes inclusive societies by addressing the needs of disadvantaged populations.
2. Contributes to peace and stability.

PARTNERSHIP

1. Family planning partnerships can support the achievement of the SDGs

UNMET-NEED FOR CONTRACEPTION

The reasons why more than 214 million women of reproductive age, in developing countries, that want to avoid pregnancy are not using a modern contraceptive include:

1. Limited choice of methods

2. Limited access to contraception, particularly among young people, poorer segments of populations, or unmarried people
3. Fear of side-effects
4. Cultural or religious opposition
5. Poor quality of available services
6. Users and providers' - bias
7. Gender-based barriers.

The unmet need for contraception in Pakistan is **17%** at present. This inequity is fuelled both by a growing population and a shortage of family planning services.

BENEFITS OF FAMILY PLANNING

Promotion of family planning and ensuring access to preferred contraceptive methods for women and couples is essential to securing the well-being and autonomy of women, while supporting the health and development of communities. Voluntary family planning helps women and men secure their rights to decide freely, for themselves, whether, when, and how many children they want to have, securing their basic human right.

Effective family planning services can:

I. PREVENT MATERNAL DEATHS

Effective family planning services have the potential of averting one third of the maternal deaths. The global community generally agrees that family planning prevents maternal deaths by:

- 1) Reducing the number of times, a woman is exposed to the risks of pregnancy
- 2) Helping women avoid unintended and closely spaced pregnancies
- 3) Helping women avoid underage births, or births after 35 years of age
- 4) Reproductive health care, including family planning services, can help women including adolescents to prevent unintended pregnancy, complications during pregnancy and delivery, and unsafe abortion.
- 5) In countries where less than 10 percent of women use contraception, the infant mortality rate is 100 deaths per 1,000 live births. Countries where over 30 per cent of women use contraception infant mortality rate is 52 per 1,000 births.
- 6) Condoms protect against STIs including HIV/AIDS.

II. REDUCE INFANT MORTALITY

Family planning improves the chances of survival of infants and children under five by reducing the risk of low birth weight, malnutrition and frequent illness or death. Family planning can prevent closely spaced and ill-timed pregnancies and births, which contribute to

some of the world's highest infant mortality rates. Infants of mothers who die as a result of giving birth also have a greater risk of death and poor health

III. IMPROVE ADOLESCENT HEALTH (LESS THAN 18 YEARS)

FP can save lives of teenage girls' by helping them to delay their first pregnancy. If pregnant, girls ages 10 to 14 are five times more susceptible to pregnancy-related illnesses or death than women ages 20 to 24. Marriage of girls before the age of 18 is considered normal in many countries, even though it is against international standards and many national laws.

Most adolescent girls who become pregnant have to leave school. This has long-term implications for them as individuals, their families and communities. Parents and the community should protect these girls by supporting healthy timing of pregnancies and by providing the girls with information and counselling. This support may help them to negotiate, if possible, delaying their first pregnancy until they are at least 18 years old.

Pregnant adolescents are more likely to have preterm or low birth-weight babies. Babies born to adolescents have higher rates of neonatal mortality. It is estimated that nearly 10 million adolescent girls marry each year, worldwide. These young brides are pressured to begin having children even though they are not fully physically developed and prepared for pregnancy. Many young girls marry older men, putting them at higher risk of contracting sexually transmitted infections (STIs), including HIV.

Even when the young girls are married at an early age, delaying the first pregnancy until 18 years of age is important and forms a part of the Health Timing and Spacing of Pregnancy (HTSP). This can help:

1. Help young girls attain their full growth potential.
2. Reduce the risk of injury and infection of reproductive organs, which are not yet fully developed.
3. Timing pregnancy to occur after age 18 improves adolescents' growth and development and reduces the risk of poor outcomes for their children like stunting, low birth weight, and preterm birth.

IV. HEALTHY TIMING & SPACING OF PREGNANCY (HTSP)

Family planning helps women time and space their pregnancies to ensure healthy nutritional outcomes: Spacing pregnancies at least 24 months apart (the equivalent of 3 years between births) is linked to reduction of a key measure of malnutrition and stunting among children under 5. Children born after a 2-year interval or less, compared with a 4-year interval, are 27% more likely to be stunted and 23% more likely to be underweight.

SPACE PREGNANCIES ADEQUATELY, THUS

1. Allow the mother enough time to replenish the nutrients lost during pregnancy and childbirth, reducing the risk of anemia and infections.
2. Allow her more time to take care of the youngest baby.
3. A healthy mother ensures that the risk of death among her children is reduced.

TIMING AND NUMBERS MATTER

The healthiest times for a pregnancy are between the ages of 18 and 34 and at least 24 months after a birth (which ensures about three years (33 months, exactly) between births), while avoiding underage births. Allow at least 6 months' gap before conception after abortion.

V. FAMILY PLANNING, WOMEN'S HEALTH AND EMPOWERMENT

1. Planning her family provides opportunities for continued learning and education, which contributes to empowerment.
2. Family planning helps a woman to plan her family, which may be the first decision she has taken about her own life. This decision gives her self-confidence and encourages her to make other decisions to improve her living conditions.
3. Repeated pregnancies and childbirth limit employment opportunities. Planning her family increases, a woman's chances for employment outside the home which in turn widens her access to additional resources for her family.
4. The ability to make decisions and the increased capacity to earn through employment will gradually empower a woman.

VI. PREVENT HIV/AIDS

Family planning reduces the risk of unintended pregnancies among women living with HIV, resulting in fewer infected babies and orphans. In addition, male and female condoms provide dual protection against unintended pregnancies and against STIs including HIV.

VII. EMPOWER PEOPLE AND ENHANCE EDUCATION

Family planning enables people to make informed choices about their sexual and reproductive health. Family planning represents an opportunity for women to pursue additional education and participate in public life, including paid employment in non-family organizations. Additionally, having smaller families allows parents to invest more in each child. Children with fewer siblings tend to stay in school longer than those with many siblings.

VIII. CONTROL POPULATION GROWTH

Family planning is key to slowing unsustainable population growth and the resulting negative impacts on the economy, environment, and national and regional development efforts

IX. NON-CONTRACEPTIVE BENEFITS

Some contraceptive methods provide many general health benefits such as the combined oral contraceptives:

1. They protect women from ovarian and uterine cancers and ovarian cysts
2. Protect women from benign diseases of the breast
3. Reduce the risk of ectopic pregnancy in women with a past history of the condition
4. Reduce pelvic inflammatory diseases

HUMAN RIGHTS BASED APPROACH TO FAMILY PLANNING

Recent WHO guidance, summarizing findings of a technical consensus meeting on contraceptive choice and human rights, advises programs on how to ensure human rights are respected and protected when services are scaled-up to reduce unmet need for family planning.³ This seminal document was reinforced and extended through a new conceptual framework for human rights-based family planning.^{4,5}

Taken together, the new documents about rights-based family planning are an important reminder of the need for voluntary, coercion-free contraceptive services. Those committed to the sexual and reproductive health field should have these values at their core.

THE RIGHT TO FP IS CLOSELY LINKED WITH OTHER HUMAN RIGHTS

I. Access to Contraception

- a. This will ensure reduction in the number of un-wanted pregnancies
- b. and will help ensure a woman's right to health and right to life.

II. Right to Privacy, Equality and Non-Discrimination

- a. These rights are sometimes denied in the context of family planning when, for example, someone is denied access to contraception because she or he is not married.

III. Right to Impart and Receive Information

- a. This right includes reproductive health and sex education for adolescents. Adolescents have a right to access FP services and information. Refusing FP information or contraception to adolescents based on age, marital status or parental or guardian consent may constitute a denial of adolescents' right to health and their right to non-discrimination.

IV. Right to Benefit from Scientific Progress

- a. This means that everyone has a right to benefit from developments in contraceptive technology, such as emergency contraception (EC).

V. Forced Contraception is Not Family-Planning

- a. Coercion to use contraception is a violation of international human rights law.

THE HUMAN RIGHTS PRINCIPLES GUIDING FP SERVICE PROVISION

Below is the list of fundamental guiding principles and all family planning providers must contribute to all of them.

Principle 1	Non-Discrimination: What you can do: Welcome all clients equally. Respect every client's needs and wishes. Set aside personal judgments and any negative opinions. Promise yourself to give every client the best care you can.
Principle 2	Availability of Contraceptive Information and Services: What you can do: Know the family planning methods available and how to provide them. Help make sure that supplies stay in stock. Do not rule out any method for a client, and do not hold back information
Principle 3	Accessible Information and Services: What you can do: Help make sure that everyone can use your facility, even if they have a physical disability. Participate in outreach, when possible. Do not ask clients, even young clients, to get someone else's permission to use family planning or a certain family planning method.
Principle 4	Acceptable Information and Services: What you can do: Be friendly and welcoming and help make your facility that way. Put yourself in the client's shoes. Think what is important to the clients—what they want and how they want it provided.
Principle 5	Quality: What you can do: Keep your knowledge and skills up to date. Use good communication skills. Check that contraceptives you provide are not out-of-date
Principle 6	Informed Decision-Making:

	What you can do: Explain family planning methods clearly, including how to use them, how effective they are, and what side effects they may have, if any. Help clients consider what is important to them in a family planning method
Principle 7	Privacy and Confidentiality: What you can do: Do not discuss your clients with others except with permission and as needed for their care. When talking with clients, find a place where others cannot hear. Do not tell others what your clients have said. Promptly put away clients' records.
Principle 8	Participation: What you can do: Ask clients what they think about family planning services. Act on what they say to improve care.
Principle 9	Accountability: What you can do: Hold yourself accountable for the care that you give clients and for their rights.

THE CHARTER OF HUMAN RIGHTS

Rights	Description
The Right to Life	No woman's life should be put at risk for reason of pregnancy.
The Right to Liberty and Security of the Person	No person should be subjected to female genital mutilation, forced pregnancy, sterilization, or abortion.
The Right to Equality and to be Free from all Forms of Discrimination	Equality and freedom from discrimination in one's sexual and reproductive life.
The Right to Privacy	All sexual and reproductive health-care services should be confidential and all women have the right to autonomous reproductive choices.
The Right to Freedom of Thought	Includes freedom from the restrictive interpretation of religious texts, beliefs, philosophies and customs as tools to curtail freedom of thought on sexual- and reproductive-health care and other issues.
The Right to Information and Education	Relating to sexual and reproductive health for all, including access to full information on the benefits, risks and effectiveness of all methods of fertility regulation, in order that all decisions taken are made on the basis of full, free and informed consent.
The Right to Choose Whether or Not to Marry	Recognizes that all persons have the right to protection against forced marriages.
The Right to Decide Whether or When to Have Children	Recognizes that all persons have the right to decide freely and responsibly. The number and spacing of their children and to have access to the information, education and means to enable them to exercise this right. It further recognizes that special protection should be accorded to women during a reasonable period before and after childbirth.

The Right to Health Care and Health Protection	Includes the right of clients to the highest possible quality of health care, and the right to be free from traditional practices which are harmful to health.
The Right to the Benefits of Scientific Progress	Includes the right of sexual and reproductive health-services and to new reproductive-health technologies that are safe, effective and acceptable.
The Right to Freedom of Assembly and Political Participation	Includes the right of all persons to seek to influence communities and governments to prioritize sexual and reproductive health and rights.
The Right to be Free from Torture and Ill-Treatment	Including the rights of all women, men and young people to protection against violence, sexual exploitation and abuse.

FURTHER READING

1. Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations; 2014
https://www.who.int/reproductivehealth/publications/family_planning/human-rights-contraception/en/
2. <https://www.unfpa.org/news/fifty-years-ago-it-became-official-family-planning-human-right>
3. Singh S, Darroch J, Ashford L, Vlassoff M. Adding it up: The costs and benefits of investing in family planning and maternal and new-born health. New York: Guttmacher Institute and United Nations Population Fund 2009.
<http://www.guttmacher.org/pubs/AddingItUp2009.pdf>.
4. ICPD. Programme of Action. Cairo, Egypt: International Conference on Population and Development 1994.
5. <https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception>
6. <http://who.int/mediacentre/factsheets/fs351/en/>
7. http://who.int/reproductivehealth/topics/family_planning/en/
8. <http://apps.who.int/iris/bitstream/10665/260156/1/9780999203705-eng.pdf?ua=1>
9. https://apps.who.int/iris/bitstream/handle/10665/112319/WHO_RHR_14.07_eng.pdf

COURSE DESIGN

This course is designed to provide facility-based health professionals, evidence based and up to date information, so as to enable them to offer equitable and high-quality family planning services.

COURSE GOALS

To strengthen the capability of participants in the areas of knowledge, attitude and skills in contraceptive technology needed to offer safe and high-quality family planning services.

TRAINING OBJECTIVES

1. Explain benefits of family planning methods.
2. Appropriately counsel client interested in using family planning.
3. Discuss indications, precautions and contraindications for each FP method.
4. Provide family planning methods appropriate to client's needs.
5. Use recommended infection prevention practices in the provision of FP services.
6. Provide FP services for groups with special needs like adolescents, PLWA and refugees.
7. Follow-up clients and manage side effects / complications for all family planning methods.

COURSE DESIGN

The manual is designed for an interactive working style, with active involvement of trainees in the learning process, offering the trainers a model to be followed during the training workshop.

COURSE DURATION

The suggested duration of the course is five days. It includes theoretical, practical and clinical sessions. A model of the course agenda is provided.

USING THIS MANUAL

This facilitator's guide is complemented by a learner's guide to facilitate training activities, to equip trainees with necessary knowledge, abilities and skills through their own experience and provide quality and client-focused family planning services.

ADVANCE PREPARATIONS FOR TRAINING

Planning for the training should start many weeks prior to the training date. All preparations must be completed ahead of time. It is helpful to use a checklist to ensure pre-allocation of tasks and their follow up.

CHECKLIST FOR MATERIALS, EQUIPMENT, AND SUPPLIES

MATERIALS	QUANTITY	PERSON RESPONSIBLE	STATUS
Family Planning Handbook 2018	One copy per participant and per trainer		
WHO Quality of Care Document	One copy per trainer		
Effectiveness of FP methods chart	One large print for display and one each for participants		
MEC charts	One large copy for display		
WHO MEC wheels	One copy per participant / trainer		
AUDIO-VISUAL EQUIPMENT			
Laptop and LCD projector	One of each		
USB	One for each participant		
COURSE MATERIALS			
Flipchart support stand	Two		
Flipchart paper	As needed		
Coloured markers for flipcharts	Two boxes of eight		
Masking tape	Two		
White and/or coloured paper for exercises and warm ups	As needed		
Folders, notepads, pens, markers, highlighters, name	One each per participant and per trainer		
Additional handouts	As needed (e.g. copies of the handouts, copies of presentation graphics for participants)		
MATERIALS FOR HANDS ON SESSIONS			
Instrument trays PPIUCD, implants and Injectables	One for every four/five participants		
Pelvic models for IUCD insertion	One for every four/five participants		
MAMA U for PPIUCD	One for every four/five participants		
Arm (for Implant insertion and removal)	One for every four/five participants (if used)		
Orange or other similar object (for injections)	One for every four/five participants		

Here is an Example Skeleton of the Format Followed in the Manual

MODULE TEMPLATE



Time of Session:

A brief summary of key points about the topic



Training Objectives

1. Describe the workshop goal, objectives, expected outcomes and agenda.
2. -----
3. -----
4. -----



Learning Outcomes

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

1. Understand the importance of the topic.
2. Know the advantages, disadvantages, indications, contraindications of each method.
3. Have detailed knowledge about side effects, complications, warning signs and their management.
4. Know the medical eligibility criteria
5. Discuss the key messages



Training/ Learning Methods

1. Small group activity, discussions and presentation
2. Large group discussions
3. Interactive presentations
4. Role-plays
5. Brainstorming
6. Games
7. Working in small groups or pairs



Advance Preparations

1. Activity preparation
2. PowerPoint presentation
3. Any other relevant material like models etc.
4. Handouts



Constitution of The Session

Description of the mini sessions:

1.	Brainstorming / activity	45 Mins
2.	Lecture/Discussion	30 Mins
3.	Group work/	20 Mins
4.	PowerPoint /group work	15 Mins
5.	Pass the parcel activity	10 Mins



Training Materials

Trainer's Material	Trainee's Material
Hand Outs: H1.1, H1.2, H1.3	Hand Outs: H1.1, H1.2, H1.3
Activity: A1.1a, A1.1b, A1.2, A1.3	Checklists: C1.1, C1.2, C1.3

Checklists: C1.1, C1.2, C1.3	Job aids: J1.1, J1.2
Job aids: J1.1, J1.2	
FAQs:	

The training sessions are color coded for convenience of the trainer. The title and Handouts are in green, Activity is in light blue and Job aids are in lemon.

SESSION 1
TITLE:
(Minutes)

Handout: (H1.1)

Activity: (A1.1)

Job Aid: (J1.1)

Checklist:

Important

ADULT LEARNING AND EFFECTIVE TRAINING

This manual is based on the adult learning principles. Adult learning is a dynamic, active & self-directed process, after being reoriented to learning. Effective teaching considers how students learn best. Immediate, descriptive feedback is essential if adult learners has to modify their behavior

CHARACTERISTICS OF AN EFFECTIVE TRAINING

Training programs that are deemed effective share a few common characteristics:

1. **Objective**: Trainers and participants both fully understand the purpose of the training and stay focused on what is to be achieved by the end of the course.
2. **Methodology**: An interesting mix of various training technique and are simple to follow yet are easy to apply, enable participants to meet objectives.
3. **Development**: Build on the existing skills and experience of participants and present new knowledge and skills in a context that is meaningful and relevant to their current scope of work.
4. **Involvement**: A training approach that ensures active participation of the audience.
5. **Practice**: Participants have the opportunity to practice new knowledge and skills on models first. Participants competent in model practice are then allowed clinical practice under supervision.
6. **Feedback**: Participants receive individual and, or collective constructive advice by trainers.
7. **Improvement**: Trainers use feedback from participants to improve upon the training process.
8. **Assessment**: Evaluations carried out to measure the extent to which trainers have been effective in helping participants meet their objectives.
9. **Post Training Follow Up**: Is important to check if the participants are using the skills correctly.

10. **Supportive Supervision:** Is important to fill in any existing gaps.

CONDUCTING LEARNING ACTIVITIES

1. Each session (or learning activity) must begin with clear **session objectives** which capture learners' interest and prepare them for learning.
2. The content of the session can be conveyed using an **illustrated lecture**, a brainstorming session, a demonstration, or a **small group activity**.
3. Participants involvement can be kept alive by encouraging **questions and answers** during the presentation / session.
4. Each session should close with a concise **summary** of key points.



KEY STEPS FOR PLANNING AN EFFECTIVE TRAINING

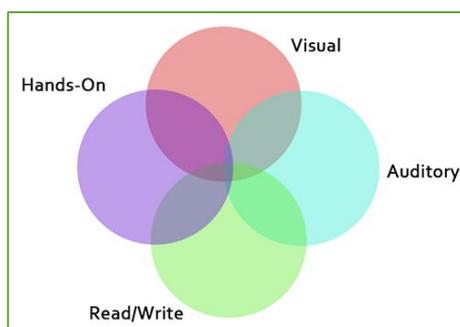
1. **Define objective of the training:** Why are you conducting the training?
2. **Develop and follow** selection criteria for selecting participants
3. **Define the needs of participants:** Who are the learners? What skills and experience do they already have? What are their learning needs?
4. **Define outcomes of the training:** What will the learners be able to do by the end of the course?
5. **Select an appropriate training approach:** Should training be conducted in groups, individually or through a combination of both approaches?
6. **Select trainers:** Who are the most appropriate people to provide training on this content, with this audience and using this approach?
7. **Select training site:** Where is the most appropriate place to conduct this training course?
8. **Determine the length of training:** How long should your training course be?
9. **Select and adapt training media and materials:** What mix of training media will best meet the needs of this group of learners?

10. **Prepare plan for transfer of training knowledge:** How will you help learners apply their new knowledge and skills when they leave the training?

11. **Prepare an evaluation plan:** How will you know if the training was effective?

HOW PEOPLE LEARN:

Everybody has different ways of learning and adults are no different. Visual learners tend to be the most common, and so one should keep this in mind but also remember there may be other learning styles present.



TRAINING TECHNIQUES

The training techniques used include a mix of adult learning techniques

Icebreakers and interactive activities	Set the climate for the next session or transition between sessions, energize participants and make them more alert, and provide a break between 'heavy' sessions.
Lectures	Activities conducted by the facilitator or a resource specialist to convey information, theories, or principles.
Large and small group discussions	Sharing of experiences and ideas, and joint problem solving among participants.
Action planning	Creation of plans by participants to apply new knowledge and skills.
Mini case studies	Use of health management information system (HMIS) data and district scenarios by the participants to suggest solutions to the health system problems.
Practicum	Participants have the opportunity to practice with facilitators at the field site.
Peer learning, support, and feedback	Participants provide immediate feedback to one another to strengthen skills and generate new ideas.

KEY CONCEPTS IN EFFECTIVE TEACHING

1. TIME KEEPING

A key focus of this course is the use of adult learning techniques. It is likely that the group will be diverse both in terms of professional disciplines and experience as well as life experience. Training experience and skills can also be expected to vary considerably.

Accordingly, facilitators should, wherever possible and within time constraints, seek inputs from participants at the start of each session regarding their experience on the topic area using brainstorming and other techniques. Additionally, after the morning warm-up exercise, participants will be asked to identify the range of training approaches that were used on the previous day – and comment on their effectiveness.

2. REFLECTIONS

After a full day of activities, take time to look over what has been done and examine what it means to everyone individually. This is a method to explore how what we have learnt can be applied in a broader setting. The "Reflections" activity is an opportunity to make these analyses. It is also an opportunity for the trainers and participants to share feedback on the training-activities and to identify areas that need reinforcement or further discussion.

For the first session of "Reflections," each participant should answer the following questions and share responses with the group:

1. What did I like about today and why?
2. What did I not like about today and why?
3. What did I learn and experience today that I will be able to use?

The trainer should:

1. Explain that at the end of the day's activities, how to perform the "Reflections" activity.
2. Make a note of the participant and trainers' feedback, and address ideas and concerns.

3. CLOSED- AND OPEN-ENDED QUESTIONS

Different types of questions are effective in different scenarios.

A) CLOSED-ENDED QUESTIONS

These are questions that elicit short answers, often “yes” or “no.” They can be used to check in with the group, for example, to find out whether or not they understand the material or are ready to move to the next topic. Closed questions can also be useful when the trainer is trying to uncover specific information or make a point.

Examples of closed-ended questions: “Is the meaning of that word clear?”; “Do the practitioners in your facility mainly use surgical techniques?”

B) OPEN-ENDED QUESTIONS

By asking open-ended questions, trainers can elicit in-depth responses, thus engaging learners more fully in discussions and activities. Open-ended questions begin with “how,” “what,” “when” and “tell me about.” They do not have a “yes” or “no” answer. When trainers find that their questions are not eliciting the depth of responses that they desire, they should examine their communication style to determine whether they are using open or closed-ended questions.

Examples of open-ended questions: “What skills are you hoping to learn during this training session?”; “Tell me some possible reasons why this problem is occurring.”

4. MANAGING GROUP DYNAMICS

Group dynamics, as the term suggests, are constantly changing. Nonetheless, a group discussion usually follows a few predictable stages. As a facilitator, it is important to be aware of these stages and to manage them for the discussions to proceed fruitfully. The trainer must exhibit a dynamic flow of various facilitator behaviors according to the given or developing situations. Following are a few of the trainer’s attributes that help run a group harmoniously,

1. Friendly and welcoming
2. Listening for who knows each other, who is new.
3. Observing the group
4. Monitor carefully
5. Observe that the group members don’t get rooted in conflict and unable to move forward
6. At times, mediation tactics are needed to move the group along.
7. They may “agree to disagree” or put issues to a vote, where majority rules.
8. Keep a watchful eye during the norming stage to ensure that the group’s accommodation efforts are all done with tact and diplomacy.

9. Bullying can occur in this stage. What appeared to be accommodation was nothing more than an aggressive member exerting dominance, and submissive members succumbing to the pressure, simply to “keep the peace.”
10. Encourage the group to be successful; reflect to them their strengths as a group.
11. Remind the group that they need not agree about everything to be successful.
12. Summarize examples of how learning will be applied.
13. Express gratitude for the hard work and each other.
14. Encourage the group members to network and keep in touch with each other once they return to their respective jobs. Often, group members can serve as resources and allies to each other once they get back to the workplace.

5. MANAGING SENSITIVE TOPICS

Reproductive health issues are an extremely sensitive group of topics. Often the discussions can become sensitive when people voice strong and differing opinions and are not able to resolve their differences. The socio-cultural contexts and the participant’s backgrounds have a large impact on how people react to sensitive topics.

Trainers may be able to anticipate which topics could be sensitive because of the material being covered or the audience participating in the training, but subjects that create discomfort among participants can also arise unexpectedly, and learners voice their reservations differently.

A trainer may choose to deliberately introduce a sensitive topic for a variety of reasons, including challenging learners to question their beliefs, helping them gain an appreciation for differing opinions or giving them an opportunity to practice handling difficult situations with others. The manner in which a trainer handles a sensitive topic can determine whether the experience becomes a constructive learning opportunity or disruptive to the group’s learning process.

The potential for sensitive topics to disrupt the effective group process underscores the need for a trainer to set group norms or ground rules with learners in the beginning of a training course.

A) CHANGING THE SUBJECT

When a topic arises, and creates discomfort or tension for participants, a trainer has a number of ways in which to handle the situation. The trainer may first assess whether or not there is the potential for a constructive learning opportunity. If the trainer determines that there is no hidden learning opportunity, then she or he needs to make a transition to a less sensitive subject without seeming to ignore or trivialize the topic.

B) USE AS A POTENTIAL FOR LEARNING

The trainer may choose to guide the participants into a structured activity where they are able to process their feelings, understand different viewpoints more fully and come to some kind of resolution about group differences. The trainer should exercise strong group-facilitation skills to include all opinions, regardless of learners' differing abilities to communicate them, keep the discussion constructive, and create a natural, unforced resolution, while still acknowledging individual differences that remain.

Example:

There are several ways in which trainers can manage group dynamics when a participant raises a sensitive topic, including transitioning to another topic, changing the subject or using the topic to create a learning opportunity.

Below is an example of how a trainer might employ these strategies.

Statement

Learner 1: "Women shouldn't be allowed to serve in public office."

Learner 2: "Women are half of the population and should comprise half of our elected officials."

C) CHANGING THE SUBJECT

Trainer: "We have time to hear from two more people in the audience. Let's hear from someone who supports the first statement and then from someone who supports the second. After that we'll need to move on to our next activity so that we can stay on schedule."

Learner 1: "Women shouldn't be allowed to serve in public office."

Learner 2: "Women are half of the population and should comprise half of our elected officials."

D) CREATING A LEARNING OPPORTUNITY

Trainer: "It sounds like we have different opinions in the audience about this topic. I'm going to ask you to vote either to spend 15 more minutes on this topic or move on to our next activity. If the majority wants to spend more time on this topic, I'd like to suggest a debate. We'll randomly divide into two groups: one in favor of women in public office and one against. Each group will have four minutes to brainstorm all of the reasons for or against women in office. Then we'll switch lists and each group will have three minutes to argue the opposing viewpoint persuasively. We'll then discuss as a large group which arguments were the most persuasive and caused us to challenge our own beliefs. We probably won't be able to come to any kind of group consensus on the topic, but we may challenge our opinions and understand other people's better."

MEDICAL ELIGIBILITY CRITERIA(MEC)



TIME 1 HOUR 30 MINUTES

Medical Eligibility Criteria 2015 are a comprehensive set of guidelines by WHO. These are based on latest clinical and epidemiological evidence offering 2000 recommendations for 25 methods, pre-existing medical conditions, personal characteristics and certain health problems. Developed through consensus driven process during 3 consultations and systematic review of scientific evidence, it is a set of excellent up to-date information, available in several languages.



TRAINING OBJECTIVES

1. Discuss various barriers and biases which prevent provision of high-quality FP services.
2. Describe medical barriers to quality service in FP.
3. Discuss and practice the use of recommendations on specific conditions (medical and non-medical) for initiation, continuation or dis-continuation of a specific FP method.
4. Discuss evidence based, authentic management choices for women with a specific medical condition.
5. Demonstrate and practice use of MEC as an important tool in client assessment.



LEARNING OUTCOMES

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

1. Use MEC wheel confidently for assessing safety and suitability of various contraceptive methods for use in presence of specific health conditions
2. Use MEC as a standard reference while counselling clients.
3. Have a clear concept of medical barriers.
4. Know that for high quality service provision all barriers, medical and personal biases, have to be taken down.



TRAINING/ LEARNING METHODS

1. Small and large group discussions
2. Interactive power point
3. Brainstorming
4. Case studies



ADVANCE PREPARATION

1. A red tape at least 4 inches wide and 15 feet long
2. “Cross the line” question list
3. PowerPoint presentation
4. MEC Wheel for trainer and trainees
5. MEC Summary charts for display



CONSTITUTION OF THE SESSION

Five mini sessions will be held

1. What are Medical Eligibility Criteria?	Interactive presentation Cross the line activity	20 Mins 15 Mins
2. Use of the MEC wheel	Activity	30 Mins
3. What is new in MEC 2015?	Interactive presentation	15 Mins
4. Summarize and Wrap up		10 Mins



TRAINING MATERIALS

TRAINER’S MATERIAL	TRAINEE’S MATERIAL
Hand Outs: H6.1, H6.2	Hand Outs: H6.1, H6.2
Activity: A6.1a, A6.1b, A6.2.	Job aid: J6.1, J6.2
Checklists:	
Job aid: J6.1, J6.2	
FAQs:	

SESSION 1

TITLE: WHAT ARE MEDICAL ELIGIBILITY CRITERIA?

(20 MINUTES)

OUTLINE & OBJECTIVES

To discuss the MEC as a tool for provision of high-quality FP services.

METHODOLOGY

MEC wheels are given to the participants and also displayed on the screen via internet. The facilitator uses medical conditions and asks the participants to read out the MEC criteria. All the participants are given the opportunity to practice on the MEC wheel. Any questions related to the above are addressed.

1. Introduce online MEC wheel and let the participants practice it.
2. Distribute paper MEC wheel (both English and Urdu versions).
3. Group work and discussion in the large group.

Handout: (H6.1)

Activity: (A6.1a), (A6.1b)

Job Aid: (J6.1)

WHAT ARE MEDICAL ELIGIBILITY CRITERIA (MEC) ?

HANDOUT (H-6.1)

PURPOSE OF MEC

1. To provide guidance for delivering safe family planning services based on evidence based best practices
2. To address misconceptions regarding who can and cannot safely use contraception
3. To reduce medical barriers
4. To improve access and quality of care in family planning



ACTIVITY (A6.1A)

What are MEC?

Post on the flipchart: **MEC Categories.**

Present each category.

Ask a volunteer to read the definition of Category 1.

Ask what this definition means. Specify the fact that in this situation, there are no risks associated with the use of the contraceptive method.

Ask a volunteer to read the definition of Category 2.

Ask what this definition means. Specify the fact that in this situation, the risks associated with pregnancy (the carriage and delivery, as well as the termination of pregnancy) exceed, in importance, the risks associated with the use of the method.

Category 2 means that the method may be used, but it needs a more careful surveillance of the client's health status.

Ask a volunteer to read the definition of **Category 3.**

Ask what this definition means. Specify the fact that in this situation, the risks associated with the use of the method exceed the benefits, they are greater than the risks associated with a pregnancy.

The patient has a state for that a pregnancy already represents a major risk for her health. The chosen method can be used by the client only in the conditions in which other methods are inaccessible or unacceptable and she needs a very close surveillance.

Ask a volunteer to read the definition of **Category 4.**

Ask what this definition means. Specify that in this situation, the risks associated with the use of the method are unacceptable, thus the method is not to be used under any circumstances.

Emphasize that a woman, according to her health status, can be framed in different categories for different methods. Explain that the use of the guide will be broadly discussed for each contraceptive method.

MEC CRITERIA

JOB AID (J6.1)

CATEGORY	DEFINITION	INTERPRETATION	
		WITH GOOD RESOURCES FOR CLINICAL JUDGMENT	WITH LIMITED RESOURCES FOR CLINICAL JUDGMENT
1	A condition for which there is no restriction for the use of the contraceptive method	Use method in any circumstances	Use the method
2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks	Generally, use the method	
3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method	Use of method not usually recommended unless other more appropriate methods are not available or not acceptable	Do not use the method
4	A condition which represents an unacceptable health risk if the contraceptive method is used	Method not to be used	



ACTIVITY (A6.1B)

Time 15 mins

Cross the line activity:

This is an activity to highlight provider's biases and medical barriers. The facilitator asks the participants to stand on one side of the line which is drawn under floor using a coloured tape. The statement or question is read one by one and the participants are asked to cross the line if they think that it's true.

The facilitator then asks questions to discuss the reasons why the participants crossed or did not cross the line. This forms the basis of an interactive discussion between the participants. It helps to clear various myths and misconceptions.

1. Pill causes weight gain
2. Pill causes Infertility
3. Pill causes Cancer
4. IUCD causes Infection
5. IUCD can migrate to other organs
6. IUCD increases risk of ectopic pregnancy
7. Modern contraceptives use makes the woman healthier and less likely to die
8. Contraception is against your religion

With each question, the participants will either cross the line or not. The trainer asks for a volunteer from each group to state their reasons for moving or not moving. This generates an excellent opportunity for sharing insight into individual behaviours and discussion.

SESSION 2

TITLE: USING THE MEC WHEEL

(20 MINUTES)

OUTLINE & OBJECTIVES

To help participants, use MEC Wheel proficiently

METHODOLOGY

Case Study

Handout: (H6.2)

Activity: (A6.2)

Job Aid: (J6.2)

USING THE MEC WHEEL

HANDOUT (H-6.2)

The wheel matches up the contraceptive methods, shown on the inner disk, with specific medical conditions or characteristics shown around the outer rim. The numbers shown in the viewing slot tell whether the woman is eligible for that particular method or not.

MEC helps a provider to decide whether a particular contraceptive method can be used, in the presence of a given individual characteristic or medical condition. Each condition is defined as representing either an individual's characteristics (e.g., age, history of pregnancy) or known pre-existing medical (diabetes, or hypertension).

MEC WHEEL

JOB AID (J6.2)



For Online access, use this link:

http://www.who.int/reproductivehealth/publications/family_planning/Ex-Summ-MEC-5/en/



ACTIVITY (A6.2)

Distribute MEC wheel and introduce online MEC wheel and let the participants practice it, using following case scenarios:

1. Yesterday (about 24 hours ago) at a local hospital, A 32-year-old woman delivered vaginally a healthy baby girl at 38 weeks' gestation. She is breastfeeding. She would like to space her next birth by at least 3 years. She is interested in the contraceptive implant.
 - a. Is she eligible for the contraceptive implant prior to her discharge from the hospital?
 - b. What other methods can she use?

Yes, the woman is eligible for a LNG/ETG implant insertion. Implants are a category 2 for a breast-feeding woman of this age

2. A 24-year-old woman delivered a healthy baby boy by vaginal delivery at 39 weeks, at the local hospital. She is now 6 weeks post-partum and is breastfeeding. She would like to space her next birth by at least 3 years. She has a history of hypertension during pregnancy.
 - a. Are oral contraceptive methods an appropriate choice for this patient?
 - b. What other methods could she consider?

Yes, this new mother is eligible for certain oral contraceptive methods – progestogen-only pills (POPs).

- a. **History of hypertension is classified as a category 2 condition for the use of combined and progestogen-only pills.**
 - b. **Breastfeeding is a category 2 for POPs 6 weeks after delivery, but use of combined pills is a category 4 at ≤ 6 weeks and category 3 through < 6 months**
3. Your patient is a 26-year-old woman with a history of epilepsy who just delivered her third baby. Her seizure disorder is well-controlled with phenytoin. She is wondering which contraceptive she should start in the postpartum period

Her contraceptive options include: IUCDs, implants, DMPA or NET-EN injectable.

4. A 36-year-old woman who is HIV positive delivered about 30 hours ago. She is not on ARVs. She is breastfeeding. She has fever and foul-smelling lochia. She says that she does not want any more children. She would like to have an IUCD inserted or BTL done immediately.
 - a. Is she eligible for these methods?
 - b. Are there any other methods that she can use?
 - c. What other services/ advise should you provide to this client

Not eligible for BTL or IUCD due to the presence of infection. She can have an implant inserted or use barrier methods until she gets cured and refer her to HIV clinic for treatment

SESSION 3

TITLE: QUICK REFERENCE MEC CHART REVIEW

(10 MINUTES)

2016 WHO Medical Eligibility Criteria for Contraceptive Use: Quick Reference Chart for Category 3 and 4

to initiate or continue use of combined oral contraceptives (COCs), depot-medroxyprogesterone acetate (DMPA), progestin-only implants, copper intrauterine device (Cu-IUD), levonorgestral intrauterine system (LNG-IUS)

CONDITION	Sub-condition	COC	DMPA	Implants	Cu-IUD	LNG-IUS
Pregnancy		NA	NA	NA		
Breastfeeding	Less than 6 weeks postpartum					
	≥ 6 weeks to < 6 months postpartum				See I	See I
	≥ 6 months postpartum					
Postpartum not breastfeeding	< 21 days					
	< 21 days with other risk factors for VTE*				See I	See I
	≥ 21 to 42 days with other risk factors for VTE*					
Postpartum timing of insertion	≥ 48 hours to less than 4 weeks					
	Puerperal sepsis	See I	See I	See I		
Postabortion (immediate post-septic)						
Smoking	Age ≥ 35 years, < 15 cigarettes/day					
	Age ≥ 35 years, ≥ 15 cigarettes/day					
Multiple risk factors for cardiovascular disease						
Hypertension BP = blood pressure	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 thrombotic mutations						
Ischemic heart disease (current or history of)			I	C		I
Stroke (history of)				I	C	
Complicated valvular heart disease						
Systemic lupus erythematosus	Positive or unknown antiphospholipid antibodies					
	Severe thrombocytopenia		I	C		I

Adapted from: Medical Eligibility Criteria for Contraceptive Use, 5th Edition. Geneva: World Health Organization, 2015. Available: http://www.who.int/reproductivehealth/publications/family_planning/en/index.html

This chart shows a complete list of all conditions classified by WHO as Category 3 and 4. Characteristics, conditions, and/or timing that are Category 1 or 2 for all methods are not included in this chart (e.g., menarche to < 18 years, being nulliparous, obesity, high risk of HIV or HIV-infected, < 48 hours and more than 4 weeks postpartum).

- **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.

IC Initiation/Continuation: A woman may fall into either one category or another, depending on whether she is initiating or continuing to use a method. 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. If these methods are accidentally initiated, no harm will result.

i The condition, characteristic and/or timing is not applicable for determining eligibility for the method.

ii Women who use methods other than IUDs can use them regardless of HIV/AIDS-related illness or use of ART.

* Other risk factors for VTE include: previous VTE, thrombophilia, immobility, transfusion at delivery, BMI > 30 kg/m², postpartum hemorrhage, immediately post-caesarean delivery, pre-eclampsia, and smoking.

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



SESSION 4

SUMMARIZE AND WRAP UP

(10 MINUTES)

Ask participants how they might use this information in their work in facilities or in the community.

FURTHER READING

1. Family Planning, A global handbook for providers
2. <http://apps.who.int/iris/bitstream/handle/10665/260156/9780999203705-eng.pdf?sequence=1>
3. World Health Organization (WHO). Medical Eligibility Criteria for Contraceptive Use. 5th ed. Geneva: WHO; 2015.
4. http://www.who.int/reproductivehealth/publications/family_planning/MEC-5/en/
5. Implementation Guide for the Medical Eligibility Criteria and Selected Practice Recommendations for Contraceptive Use Guidelines
6. <http://apps.who.int/iris/bitstream/handle/10665/272758/9789241513579-eng.pdf?ua=1>
7. <https://www.who.int/entity/reproductivehealth/mec-spr-implementation-guide-toolkit/en/index.html>

HEALTHY TIMING & SPACING OF PREGNANCY



TIME: 2 HOURS 30 MINUTES

Health Timing and Spacing of pregnancy (HTSP) is an important concept, based upon the importance of timing of planning the family, in context of a holistic approach. It takes into account the beneficial and adverse effects of planned and untimely pregnancies, respectively, as they affect the mother, children and the whole family.



TRAINING OBJECTIVES

1. Describe the importance of HTSP as a lifesaving intervention for mothers and newborns.
2. Discuss the key HTSP messages.
3. How HTSP can make a big difference in the lives of girls, women, children, and families



LEARNING OUTCOMES

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

1. Understand what is meant by healthy timing and spacing of pregnancy.
2. Understand the advantages of HTSP for women, men, children, and communities.
3. Discuss the three key messages related to HTSP.



ADVANCE PREPARATION

1. Problem tree
2. Power point presentation
3. Case scenarios



TRAINING/ LEARNING METHODS

Designed to actively involve the trainees in the learning process, sessions include:

1. Interactive presentation
2. Brainstorming
3. Group work
4. Case scenarios



CONSTITUTION OF THE SESSION

Five mini sessions will be held:

1. Problem tree activity	Brain storming, interactive discussion / activity	45 Mins
2. HTSP and its importance	Presentation	30 Mins
3. Women at highest risk of pregnancy problems	Group work/feed back	40 Mins
4. HTSP key messages	Group work	25 Mins
5. Summarize and wrap up		10 Mins



TRAINING MATERIALS

Trainer's Material	Trainee's Material
Hand Outs: H7.1, H7.2, H7.3, H7.4	Hand Outs: H7.1, H7.2, H7.3, H7.4
Activity: A7.1a, A7.1b, A7.3a, A7.3b, A7.4	Job aid: J7.1
Job aid: J7.1	

SESSION 1

TITLE: PROBLEM TREE ANALYSIS ACTIVITY

(45 MINUTES)

OUTLINE & OBJECTIVES

To identify the main causes of ill health among mothers, babies and children.

METHODOLOGY

Divide the participants in two groups to identify the root causes and the adverse effects of repeated and unplanned pregnancies.

Handout: (H7.1)

Activity: (A7.1a, A7.1 b)

Job Aid (J7.1)

PROBLEM TREE ANALYSIS

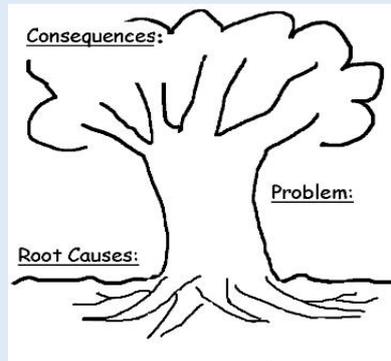
HANDOUT (H-7.1)



ACTIVITY (A7.1A)

Ask the participants to name some of the major health problems in the community. Steer the conversation towards issues of poor maternal and child health. Label one Problem Tree as **Poor Maternal Health** and the second Problem Tree as **Poor Child Health**.

Divide the participants into two groups and allocate one tree to each group



Ask each group to take 15 minutes to brainstorm and fill in their Problem Tree by:

Identifying some of the main causes of the problem and write these causes at the roots of the tree. Where possible, the group may wish to identify additional causes for each of the main causes. Show these as smaller roots coming off the larger roots.

The group should then discuss what happens as a result of the problem, “the consequences”. These consequences are written on the branches of the tree. Where possible, the group may wish to identify their sequelae and show them as smaller branches coming off the larger branches.

Facilitate a short group discussion on the two **Problem Trees**.

If the following points have not been mentioned as root causes, mention the following as contributing to poor maternal and child health.

- a. Closely spaced pregnancies, less than 3 years
- b. Too early pregnancies (under the age of 18)
- c. Too late pregnancies (over the age of 35)
- d. Too many pregnancies (> than four or too frequent)
- e. Unsafe abortions
- f. Socio economic factors

Trainer to present the local, regional or national data which is related to the above and reinforce these points, making them more relevant to participants.



ACTIVITY (A7.1B)

The trainer asks for volunteers in the group to go through the chart and then highlights and discusses the risks associated with closely spaced pregnancies.

Risks of Adverse Health Outcomes after Very Short Interval Pregnancy, compared to the Reference Group Interval Used in the Selected Study **Job Aid (J7.1)**

INCREASED RISKS WHEN PREGNANCY OCCURS 6 MONTHS AFTER A LIVE BIRTH		
Adverse Outcome		Increased Risk
Induced Abortion		650%
Miscarriage		230%
New-born Death (<9 months)		170%
Maternal Death		150%
Preterm Birth		70%
Stillborn		60%
Low Birth Weight		60%
INCREASED RISKS WHEN PREGNANCY OCCURS <6 MONTHS AFTER AN ABORTION OR MISCARRIAGE		
Increased Risk with 1-2 Month Interval		With 3-5 Month Interval
Low Birth Weight	170%	140%
Maternal Anaemia	160%	120%
Preterm Birth	80%	40%

Sources: Conde-Agudelo, et al, 2000, 2005, 2006; Da Vanzo, et al, 2004; Razzaque, et al, 2005; Rutstein, 2005.

SESSION 2

TITLE: WHY IS HEALTHY TIMING AND SPACING OF PREGNANCY IMPORTANT? (30 MINUTES)

OUTLINE & OBJECTIVES:

Discuss benefits of HTSP for women, men, children and communities.

METHODOLOGY:

Brainstorming and group discussion

Handout: (H7.2)

IMPORTANCE OF HTSP HANDOUT (H-7.2)

HTSP is a modern dimension of FP which is about healthy fertility and helping women and families make informed decisions about pregnancy spacing and timing to achieve healthy pregnancy outcomes. To date, the focus of FP has mostly been on lowered fertility. Findings from the WHO technical panel support the role of family planning in achieving healthy fertility and healthy pregnancy outcomes.

Healthy timing and spacing of pregnancy are an approach to family planning that:

Helps women and families delay, space, or limit their pregnancies.

Helps achieve the healthiest outcomes for women, new-borns, infants, and children.

Works within the context of free and informed contraceptive choice.

Takes into account fertility intentions and desired family size

Healthy Timing and Spacing of Pregnancy (HTSP) is an intervention to help women and families delay or space their pregnancies to achieve the healthiest outcomes for women, new-borns, infants, and children, within the context of free and informed choice, taking into account fertility intentions and desired family size.

HTSP encompasses a broader concept of the reproductive cycle starting from healthiest age for the first pregnancy in adolescents, to spacing subsequent pregnancies following a live birth, still birth, miscarriage, or abortion – capturing all pregnancy-related intervals in a woman's reproductive life

BENEFITS FOR MOTHER

HTSP allows the mother more time to care for herself and her baby following delivery, to breastfeed, to engage in educational, economic, and social activities, and to prepare for the next pregnancy. Breastfeeding is beneficial for the mother and the new-born; it helps to protect the mother against breast and ovarian cancer, strengthens the health of the baby, and enhances mother-baby bonding.

BENEFITS FOR FATHER

Men also benefit from HTSP, as it gives them an ability to safeguard the health of their wives and children. Men will have enough resources to support and build a healthy family relationship

BENEFITS FOR THE CHILDREN

A close mother –child bond is imperative for optimal upbringing and development of a child. This requires mother to be healthy, be able to give time and good nutrition to the child. Breast feeding is a crucial component of this, (especially in the local context, where electricity, water and finances are often scarce, this is of utmost importance). With adequate spacing, the mother can breast feed the child for longer and be in good health to raise the child as a healthy and useful individual. Limiting family size also means that the existing children have better educational opportunities

BENEFITS FOR THE FAMILY, COMMUNITY AND COUNTRY

A new pregnancy leads to new costs, including medical care for the mother and the needs of the new baby. With more resources, families spend more on food, clothing, housing and education for themselves and their children. Healthier families inevitably lead to healthier communities. This will also ensure more growth opportunities for children, especially girls.

SESSION 3

TITLE: WOMEN WITH A HIGH-RISK PREGNANCY

(40 MINUTES)

OUTLINE & OBJECTIVES

Highlight how a simple intervention like HTSP can make a difference in lives of girls, women, children and their families.

METHODOLOGY

Experience sharing, group work.

Handout: (H7.3)

Activity: (A7.3a), (A7.3b)

WOMEN WITH A HIGH-RISK PREGNANCY HANDOUT (H-7.3)



ACTIVITY (A7.3A)

Review Contraceptive Options, HTSP and Counselling for Young Married Women and FTPs

The trainer divides the participants into 2 or 3 groups.

Each group is given a different coloured piece of paper. This piece of paper will be used by the group leader to signal that their team has an answer.

Ask each of the questions below, each team should talk amongst themselves and come to an agreement about their collective answer. When the group has reached consensus about an answer, the group leader should raise the coloured piece of paper. The group that raises the paper first has the opportunity to share their answer first.

The team is rewarded with candies for each correct answer

Contraceptive options for young women and First Time Parents (FTPs)

Question 1: Which contraceptive methods are suitable options for young women under the age 25, who have not had children?

Answer: Nearly all contraceptive methods are safe for women of all ages. This includes pills, injectables, implants, IUCDs and condoms. While age is not a clinical contraindication for any method, sterilization is the only method that is considered contraindicated for very young women due to permanent nature of this method.

All women should be told that only male or female condoms alone, or when used with another method (dual protection) offer protection from both unintended pregnancy and STIs, including HIV.

Question 2: When should contraception and HTSP be discussed with a young married woman or first-time parent?

Answer:

1. Before pregnancy
2. Antenatal period
3. Post-partum period
4. During visits to monitor infant health
5. Any contact with health facility
6. Immunization of infants

Counselling on the importance of spacing births should begin even before when the woman is pregnant. If a woman wants to space her next pregnancy, she can select a contraceptive method at this time to begin using during the postpartum period. Visits during the postpartum period and visits to monitor infant health are other good opportunities to provide counselling on HTSP and contraception. Offer couple counselling and if needed family counselling including mother in law



ACTIVITY (A7.3B)

Experience Sharing

Ask participants to identify from their experiences which women are most likely to experience problems during pregnancy and delivery and list their responses. Ensure that the following women are included:

1. Women under the age of 18
2. Women who are less than two years postpartum
3. Women who are less than six months' post-abortion or post-miscarriage
4. Women who are over the age of 35
5. Women who have more than four children
6. Women who have existing health problems.

SESSION 4

TITLE: KEY HTSP MESSAGES

(25 MINUTES)

OUTLINE & OBJECTIVES:

Reinforce and discuss in detail the three key HTSP messages with participants in light of their personal experiences.

METHODOLOGY:

Group discussion and feedback.

Handout: (H7.4)

Activity: (A7.4)

KEY HTSP MESSAGES

HANDOUT (H-7.4)



ACTIVITY (A7.4)

Divide Participants in to Three Small Groups and Assign One HTSP Message to Each Group

Ask the group to take 5 – 10 minutes to discuss what the message means to them, and then discuss how they would present this message to a client in their own words.

Have the small groups return to the larger group and present the main points from their discussion. Answer any questions that the group may have. Be sure to discuss the importance of using a family planning method to effectively delay, space or limit pregnancies.

KEY HTSP MESSAGES

To achieve HTSP outcomes, three take-home messages have been developed all to be discussed in a framework of informed family planning choice, personal reproductive health goals and fertility intention.

1. FOR COUPLES WHO DESIRE NEXT PREGNANCY AFTER A LIVE BIRTH, THE MESSAGES ARE:

- “For the health of the mother and the baby, **wait at least 24 months, (but not more than 59 months or 5 years,)** before trying to become pregnant again.
- Consider using a family planning method of your choice without interruption during that time”.

2. FOR COUPLES WHO DECIDE TO HAVE A CHILD AFTER A MISCARRIAGE OR ABORTION, THE MESSAGES ARE:

- “For the health of the mother and the baby, wait at least **six months** before trying to become pregnant again.
- Consider using a family planning method of your choice without interruption during that time.”

3. FOR ADOLESCENTS, THE MESSAGES ARE:

- “For your health and your baby’s health, wait until you are at least 18 years of age, before trying to become pregnant.
- Consider using a family planning method of your choice without interruption until you are 18 years old.”

SESSION 5

SUMMARIZE AND WRAP UP

(10 MINUTES)

Review the main points of the problem tree analysis and the principles of HTSP. Ask participants how they might use this information in their work in facilities or in the community.

FURTHER READING

1. Report of a WHO Technical Consultation on Birth Spacing. World Health Organization, 2006.
2. <https://www.who.int/pmnch/topics/maternal/htsp101.pdf>
3. <https://knowledgesuccess.org/resources/family-planning-topics/healthy-timing-spacing-pregnancy-low-middle-income-countries/>

FAMILY PLANNING COUNSELING



TIME: 2 HOURS 45 MIN

Counselling refers to a two-way communication, between a skilled provider (bound by code of ethics and practice), and the client. It aims to create awareness of and to facilitate or confirm informed and voluntary sexual and reproductive health decision-making by the client. Privacy and confidentiality are a vital pre-requisite for effective counselling. The health care provider must be knowledgeable and have good command of the subject. It requires empathy, genuineness and the absence of any moral or personal judgment.



TRAINING OBJECTIVES

- 1) Explain the use of GATHER technique for FP.
- 2) Understand the importance of informed choice and voluntary decision making.
- 3) Highlight the rights of clients for family planning.
- 4) Demonstrate FP counseling technique.



LEARNING OUTCOMES

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

- 1) Have complete, evidence based, updated information about family planning methods
- 2) Demonstrate effective counselling skills in order for a woman or couple to understand their reproductive options, choose an FP method that best meets their needs, and use the chosen method safely and effectively.
- 3) Understand and respect the client's rights.
- 4) Understand the benefits and limitations of all contraceptive methods.
- 5) Use a non-judgmental approach, which shows respect and consideration to the client.
- 6) Present information in an unbiased, client-sensitive manner.



ADVANCE PREPARATION

- 1) Counselling techniques handouts
- 2) Counselling checklist

- 3) Observation checklists
- 4) Do's and Don'ts of counselling
- 5) Case scenarios



TRAINING/ LEARNING METHODOLOGY

Designed to actively involve the trainees in the learning process, sessions include:

- 1) Small and large group work
- 2) Interactive presentation
- 3) Role-plays
- 4) Brainstorming
- 5) Group presentations
- 6) Case scenarios



CONSTITUTION OF THE SESSION

Seven mini sessions will be held

1. Introduction to counselling	Lecture/interactive discussion	30 Mins
2. Steps in FP counselling	Activity	25 Mins
3. Informed choice	Group work	25 Mins
4. Characteristics of a good counsellor	Brainstorming	25 Mins
5. Rights of women	Lecture/interactive discussion	25 Mins
6. Dealing with sensitive group	Brainstorming	25 Mins
7. Summarize and Wrap up		10 Mins



TRAINING MATERIALS

Trainer's Material	Trainee's Material
Hand Outs: H8.1, H8.2, H8.3, H8.4, H8.5, H8.6	Hand Outs: H8.1, H8.2, H8.3, H8.4, H8.5, H8.6
Activity: A8.2, A8.4, A8.5, A8.6	Job aid: J8.1a, J8.1b, J8.4, J8.5
Checklist/ Case Study: C8.6	
Job aid: J8.1a, J8.1b, J8.4, J8.5	

SESSION 1

TITLE: INTRODUCTION TO COUNSELLING AND GATHER METHOD (30 MINUTES)

OUTLINE & OBJECTIVES:

To explain the importance of effective FP counselling using GATHER method.

METHODOLOGY:

Lecture/interactive discussion on the role of counselling.

INTRODUCTION TO COUNSELING HANDOUT (H-8.1)

Counselling is a vital part of RH care, and it should be a part of every interaction with the client. The role of FP counselling is to support a client or the couple in choosing the method of FP that suits them best and to support them in solving any problems that could arise in the process of selecting or using their chosen method. Effective counselling is important in order for a client or couple to understand their reproductive options, choose an FP method that best meets their needs, and use the chosen method safely and effectively.

Counselling also offers service providers the opportunity to dispel myths & misconceptions for continued use of FP methods. These myths could be of a general nature, or they might target specific FP methods, as in the following:

- 1) Use of hormonal methods causes infertility or child malformations.
- 2) An IUCD will migrate to the brain or prick the man during intercourse.
- 3) Vasectomies cause impotence.
- 4) Tubal ligation interferes with libido.
- 5) Condoms are laced with viruses.

Counselling should also include information on side effects and warning signs for methods of contraception.

GATHER COUNSELING TECHNIQUE:

The GATHER system, outlined in Table below, is one method used to organize the elements of the counselling process this acronym is designed to help staff remember important points in an effective counselling session.

G Greet

A	Ask
T	Tell
H	Help
E	Explain
R	Return visit/refer

Although GATHER is a useful technique for learning the elements of counselling, in practice counselling should be tailored to the individual circumstances and may follow a different sequence or technique.

GATHER TECHNIQUE

Job Aid (J8.1a)

General counselling includes G, A T, H, E, R



GREET

1. Give client your full attention as soon as you meet her.
2. Be polite, friendly, and respectful: greet her, introduce yourself, and offer them seats.
3. Ask how you can help.
4. Tell her that you will not tell others what they say.
5. Explain what will happen during the visit.
6. Conduct counselling where no one else can hear



ASK HER ABOUT HERSELF

1. Ask clients about their reasons for coming.
2. Help clients decide what decisions they face.
3. Help clients express their feelings, needs, wants, and any doubts, concerns, or questions.
4. Ask clients about their experience with the reproductive health matter that concerns them.
5. Keep questions open, simple, and brief. Look at your client as you speak.
6. Ask clients what *they* want to do.
7. Listen actively to what the client says. Follow where the client leads the discussion.
8. Show your interest and understanding at all times. Express empathy. Avoid judgments and opinions.
9. Ask for any information needed to complete client records.

T**TELL CLIENTS ABOUT THEIR CHOICES**

1. Help clients understand their possible choices. Information should be tailored that is, important to the client's decision. Information should be personalized that is, put in terms of the client's own life.
2. If clients are choosing a family planning method: Ask which methods interest them.
3. If no medical reason prevents it, clients should get the methods they want.
4. Ask what they know about these methods. (If a client has incorrect information, gently explain the facts)
5. Briefly describe the client's preferred method.
6. Be sure to tell about: Effectiveness as commonly used, briefly, how to use the method, advantages, disadvantages, possible side effects and complications.
7. Mention other available methods that might interest the client now or later. Ask if the client wants to learn more.
8. Use samples and other audio-visual materials if possible.
9. Explain that condoms are the only family planning method that offers reliable protection against STIs.

H**HELP CLIENTS CHOOSE THE BEST METHOD**

1. To help clients choose, ask them to think about their plans and family situations.
2. Help clients think about the results of each possible choice.
3. For family planning methods, some key questions may be:
 - “Are you breastfeeding?”
 - “Do you and your husband want (more) children?”
 - “Do you or your husband have sex with anyone else?” (To gauge STI risk)
4. Ask what her husband's views are.
5. Ask if the client wants more clarity. Rephrase and repeat information as needed
6. Explain that some family planning methods may not be safe for people with certain medical conditions. Once a client states a choice, ask about any medical conditions
7. If a method would not be safe, clearly explain why.
8. Then help the client choose another method.
9. Check whether the client has made a clear decision. Specifically ask, “Which method have you decided to use?”
10. Wait for the client to answer.

Specific counselling includes E

E

EXPLAIN WHAT TO DO

After the client has made a choice:

1. Give supplies, if appropriate.
2. If the method or services cannot be given at once, tell her how, when, and where they will be provided.
3. For voluntary sterilization, the client needs to sign a consent form. The form says that the client wants the method, has been given information about it, and understands that information.
4. Help the client understand the consent form before signing.
5. Explain how to use the method or follow other instructions. As much as possible, show how.
6. Describe possible side effects and what to do if they occur.
7. Explain when to come back for routine follow-up or more supplies, if needed.
8. Explain any medical reasons to return.
9. Ask the client to repeat instructions.
10. Make sure the client remembers and understands.
11. If possible, give the client printed material to take home.
12. Mention emergency oral contraception
13. Tell clients to come back whenever they wish, or if side effects bother them, or if there are medical reasons to return.

Consolidated counselling includes R

R

RETURN FOR FOLLOW-UP

At a follow-up visit:

1. Ask if the client has any questions or anything to discuss. Treat all concerns seriously.
2. Ask if the client is satisfied. Have there been problems?
3. Help the client handle any problems.
4. Ask if any health problems have come up since the last visit.
5. Check if these problems make it better to choose another method or treatment.
6. Refer clients who need care for health problems.
7. Check if the client is using the method or treatment correctly.
8. Check whether the client needs STI protection now.
9. If a client is not satisfied with a temporary family planning method, ask if she or he wants to try another method. Help the client choose and explain how to use.
10. Remember—changing methods is normal. No one really can decide on a method without trying it.
11. Also, a person's situation can change, making another method a better choice.

12. If a client wants her IUCD or implants taken out, arrange for this. If she plans pregnancy, suggest where to get prenatal care.

Summary chart for GATHER

Job Aid (J8.1b)

STEPS	ACTIVITIES
GREET the client	<p>Greet the client (or couple) with a warm and personalized welcome.</p> <p>Spend a few minutes putting the client at ease—this will encourage her to relax and reveal more information to you than she would if she were feeling tense and anxious.</p> <p>Many people, particularly the young, feel embarrassed about discussing their method of contraception.</p>
ASK for information	<p>Establish age, marital status, cultural orientation, and motivation for the visit without being judgmental or biased.</p> <p>Encourage the client to discuss any previous experiences of contraceptive methods.</p> <p>How did she find out about them?</p> <p>What did she particularly like or dislike about them?</p> <p>Collect basic medical information to ensure there are no reasons why she should not use a specific method.</p>
TELL her about family planning	<p>Be direct and specific and use simple words.</p> <p>Emphasize the most important points the client needs to remember.</p> <p>Explain all available methods and how they are used.</p> <p>Use support materials such as pamphlets and brochures.</p> <p>Let her handle samples of different methods.</p>
HELP her select a method	<p>Give more details about the selected method and let the client repeat it back to you.</p> <p>Do not decide for her; let the client choose the method.</p>

	<p>After a method is selected, the service provider will confirm the suitability of the method by conducting the appropriate medical assessment.</p> <p>Once this is completed, the chosen contraceptive method is provided.</p>
EXPLAIN how to use the method	<p>Inform the client of the characteristics, benefits, limitations, and side effects of each method.</p> <p>Explain that barrier methods may also be needed to protect against STIs and other STIs, including HBV and HIV/AIDS.</p> <p>Ask the client to repeat all instructions.</p> <p>Encourage her to ask questions or state any remaining concerns.</p>
RETURN	<p>Specific return visit instructions should be provided.</p> <p>Be sure the client knows whom to contact if she has questions.</p> <p>Refer the client to an appropriate clinic for follow-up care as needed.</p> <p>For most women, a clinic near home is the best option.</p>

TIPS ON EFFECTIVE COUNSELING:

- 1) Women may become embarrassed when discussing contraceptive methods. Try to set the tone of the visit in a low-key, non-pressured manner. Assure the client (or couple) that the conversation is confidential.
- 2) Encourage the client to express her views by listening attentively and using nonverbal gestures, such as nodding, to encourage discussion.
- 3) Be patient and never put pressure on the client to finish speaking.
- 4) Use open-ended questions that require more than "yes" or "no" answers to increase the amount of information the client gives to you.
- 5) Be sensitive to any cultural and religious considerations and respect the client's views.
- 6) Repeat the most important information and instructions.
- 7) Give the client written information (if available and appropriate) to remind her of instructions.
- 8) Finally, ask the client to repeat back to you the key points to assure her understanding.

SESSION 2

TITLE: STEPS IN FP COUNSELLING

(25 MINUTES)

OUTLINE & OBJECTIVES:

To explain the steps involved in FP counselling.

METHODOLOGY:

Lecture/interactive discussion on the steps of FP counseling.

Handout: (H8.2)

Activity: (A8.2)

STEPS IN FP COUNSELING

HANDOUT (H-8.2)

THE COUNSELLING PROCESS:

Counseling is an ongoing process that should be included in all aspects of family planning services. The medical and technical information important to effective counseling should not be presented and discussed at just one point in the provision of services. Rather, good counseling techniques should be applied, and appropriate information provided and discussed in an interactive and culturally appropriate manner throughout the client's visit.

Good counseling focuses on the individual's needs and situation, and good counselors are willing to listen to the client's questions and concerns. counseling must be based on trust and respect between the client and the counselor.

Remember: All information exchanged in the counseling session should be treated confidentially.

Several approaches to counselling have been used, including "Greet, Ask, Tell, Help, Explain, and Return" (GATHER); "Rapport, Exploration, Decision making, and Implementation of decision," (REDI); and The Balanced Counselling Strategy Plus (BCS+), which incorporates counselling, screening, and services for STIs, including HIV, within routine FP consultations.

Counseling is a vital part of RH care, and it should be a part of every interaction with the client and or the couple. The role of FP counselling is to support a client or the couple in choosing the method of FP that suits them best and to support them in solving. In general, counselling can be divided into three phases:

COUNSELLING MUST TAKE INTO ACCOUNT THE FOLLOWING:

- 1) Reproductive goals of the client (spacing or timing births).
- 2) Subjective factors including the time, travel costs, pain, or discomfort likely to be experienced.
- 3) Accessibility and availability of other products that may be needed to use the method.
- 4) Benefits and limitations of the method.
- 5) Reversibility.
- 6) Side effects and other problems; and
- 7) Need for protection against STIs, including HBV and HIV/AIDS.

GENERAL ADVICE WHEN COUNSELLING

Clients may become embarrassed when discussing contraceptive methods.

1. Try to set the tone of the visit in a low-key, non-pressured manner.
2. Assure the client (or couple) that the conversation is confidential.
3. Encourage the client to express her views by listening attentively and using nonverbal gestures, such as nodding, to encourage discussion.
4. Be patient and never put pressure on the client to finish speaking.
5. Use open-ended questions that require more than “yes” or “no” answers to increase the amount of information, the client gives to you.
6. Be sensitive to any cultural and religious considerations and respect the client’s views.
7. Repeat the most important information and instructions.
8. Give the client written information (if available and appropriate) to remind her of instructions.
9. Finally, ask the client to repeat back to you the key points to assure her understanding.

COUNSELLING IN FAMILY PLANNING:

In a practical sense, the elements of counseling fit into the three major phases of providing family planning services, namely: initial counseling at reception, individual counseling prior to service provision, and follow-up counseling.

1. Initial counselling:

The provider describes all methods and helps the client to choose the method appropriate for him or her.

- a. Individual, method-specific counseling should take place in a private counseling area or an examination room. During this phase of counseling, the service provider should:

- b. Ask the client about her reproductive goals and assess her need for protection against STIs, including HBV and HIV/AIDS. This should help tailor the range of methods presented to her in more detail.
- c. Ask the client which method(s) interests her and what she knows about the method(s). This gives the service provider the opportunity to correct false rumors and misconceptions, and to provide true information.
- d. Tell the client detail how the method(s) in which she is interested works, its effectiveness, benefits, and limitations.
- e. Help the client choose a method. Based on the client's needs and history, the service provider should advise the client on the suitability of any method in which the client expresses an interest. This process leads to selection of a contraceptive.
- f. Advise the client on the possible need for further medical assessment depending on the method selected.
- g. At this time, the service provider conducts any physical and laboratory investigations, if indicated, to confirm the suitability of the chosen contraceptive method. After completing the client assessment, the selected contraceptive method is provided to the client. If it is not possible to start the method at this time, she should be given an alternative method or instructions on what to do in order not to become pregnant in the interim. If the method can be provided at this time, the service provider should: Explain simply and clearly how to use the method (or in the case of contraceptive implants or the IUCD, explain how it will be inserted) and possible problems.

2. After providing the method:

Prior to and immediately following service provision, the provider instructs the client on using the method and discusses common side effects with him or her.

1. Discuss with the client the need for return visit(s). Depending on the method, emphasis should be placed on the continuing need for supplies and their availability, advice about side effects, detecting problems early (warning signs), and the availability of removal services for LNG implants and IUCDs.
2. Ask the client to repeat all instructions to be sure she understands them. It is important for the service provider to recognize that: Clients are less likely to stop practicing family planning if they have frequent contact with providers.
3. When appropriate reassurance is given, expected symptoms and minor side effects do not lead to discontinuation.
4. Frequent contact builds trust.
5. Regular return visits can allow providers to detect problems unnoticed by clients (e.g., early pregnancy). Follow-Up counselling When clients return for follow-up visits, providers and counselors need to listen carefully and be prepared to answer any questions. Doing this can help a client accept any minor side effects or other problems that may occur.

3. Follow Up counseling:

During the return visit, the provider discusses with the client the use of the method, the client's satisfaction with the method, and any problem that the client might have experienced. Review information provided previously.

- 1) Find out whether the client is satisfied and wants to continue using the method.
- 2) Make sure that the client is using the method correctly and repeat instructions for use, if appropriate.
- 3) Talk to her about the need for protection against STIs, including HBV and HIV/AIDS. Answer the client's questions.
- 4) Reassure and treat minor side effects (if possible).
- 5) Check for any medical problems and refer for evaluation if necessary.
- 6) Help the client switch methods or stop a method if she desires.

HOW TO HELP THE CLIENT REMEMBER THE INFORMATION GIVEN?

Key points in helping the client remember are:

1-Be Brief

Ask the client what she already knows about family planning and specific contraceptive methods. This assists the provider in determining the information the client needs and ensures that the most important matters are emphasized.

2- First Things First

Give the most important instructions first, that is, what the client has to do to use the method effectively.

3- Be Simple

Use short sentences and simple words that clients understand. Avoid technical terms and scientific explanations.

4- Recap

Repeat the most important information and instructions. Ask the client to repeat the instructions. If available (and appropriate), give the client printed material and remind her of the instructions.

5- Give Concise Information in Simple Language

Organize information into categories to make it easier to explain. Use memory aids such as acronyms to remind users of the important information they need to remember.

6- Be Specific

Instructions should be specific and concrete rather than abstract and vague. For example, a vague instruction would be: “Implant is effective for several years.” The more helpful, specific instruction might be: “Implant is effective for up to 3 years. Then the rods should be removed. At the time of removal, either a new set can be inserted, or another contraceptive method selected.”

SESSION 3

TITLE: INFORMED CHOICE/VOLUNTARY DECISION MAKING

(25 MINUTES)

OUTLINE & OBJECTIVES:

To demonstrate the importance of informed choice and voluntary decision making.

METHODOLOGY:

Lecture/interactive discussion on the steps of FP counseling.

Handout: (H8.3)

INFORMED CHOICE/VOLUNTARY DECISION MAKING. HANDOUT (H-8.3)

INFORMED CHOICE:

Informed choice means that a person freely makes a carefully considered decision based on accurate, useful information. An important purpose of FP counselling is to help the client make informed choices about FP and RH.

“INFORMED” MEANS THAT:

- 1) Clients have the clear, accurate, and specific information required to make their reproductive choices, including a choice among FP methods.
- 2) Good-quality FP programs explain each FP method as needed, without overloading clients with information, and helping clients to use the method effectively and safely.

- 3) Clients understand their own needs because they have thought about their own situations through interpersonal communication and through mass-media messages.

“CHOICE” MEANS THAT:

- 1) Clients have a range of FP methods to choose. Health care providers offer different methods to suit clients' needs. If a method cannot be provided, then the clients are referred to another facility.
- 2) Clients make their own decisions. Counsellors help the clients think through their decisions, but do not persuade the clients to make a certain choice.

A voluntary choice or decision based on knowledge of all information relevant to the choice or decision. In order to make an informed choice, the client needs to:

- 1) Be made aware of all the methods available (at the site or by referral)
- 2) Know the advantages and limitations of each method.
- 3) Understand possible side effects of each method.
- 4) Understand risks of not using any method, such as risks associated with pregnancy/childbirth versus risks associated with contraceptive use.
- 5) Know how to use the chosen method safely and effectively,

ROLE OF FP COUNSELING:

In ensuring an informed choice: assist the client to consider all aspects of his/her problem, or need for contraception, and his/her choice in order to choose what suits him /her best.

TO CHOOSE A CONTRACEPTIVE METHOD:

- 1) What the method is
- 2) The relative effectiveness of the method.
- 3) How the method is used?
- 4) The advantages and disadvantages of the method (NB: an advantage for one person may be a disadvantage for another and vice versa).
- 5) Possible secondary effects associated with the method.

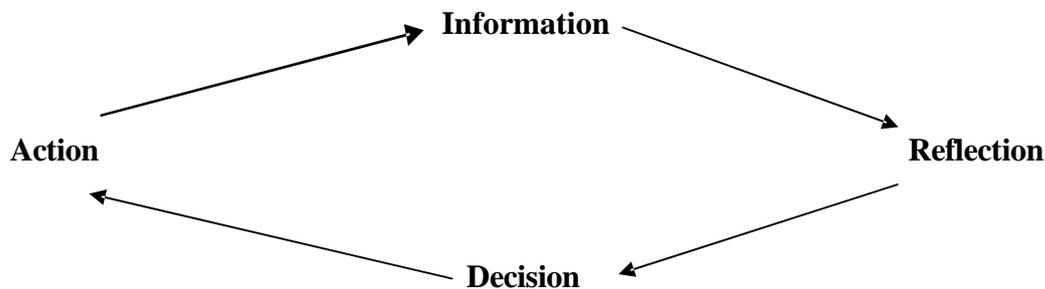
TO USE THE CHOSEN METHOD CORRECTLY AND SAFELY:

- 1) How to use the chosen method.
- 2) Possible secondary effects.
- 3) Warning signs and what to do in case of a warning sign.

DECISION-MAKING PROCESS:

The decision-making process is facilitated by adequate and accurate information. In the diagram below:

1. The service provider helps the client reflect on his/her own information (about his/her situation, problem or needs) and provides the client additional information as necessary. This information must be appropriate to the client's needs; be complete, precise, and clear; and be understood by the client.
2. The client reflects on the information about his/her situation, feelings, alternatives etc. S/he weighs the pros and cons of the situation, anticipates the consequences of his/her decision, asks him/herself questions, and considers the alternatives.
3. The client makes a decision.
4. The client acts on his/her decision.



To facilitate the client's decision-making process, the service provider needs to:

1. Consider the needs of the client based on her experience
2. Help the client express him/herself and listen carefully
3. adapt information to the needs/interests of clients; encourage their questions & reactions (in order to better understand, and respond to, their concerns & needs)
4. Give clients time to reflect on the information before making a decision
5. Ensure follow-up to reduce the risk of problems once the decision is put into action

When service providers do not respect the decision-making process, and instead give information and expect clients to decide immediately what they wish to do (as expressed by 'you should . . . , you ought to . . .' etc.), often clients don't act at all or they make decisions without adequate thought and without conviction; they do not make informed decisions. The client may not accept responsibility for the decision and may even blame the service provider for any negative consequences of the decisions.

SESSION 4

TITLE: CHARACTERISTICS OF A GOOD COUNSELLOR

(25 MINUTES)

OUTLINE & OBJECTIVES:

To highlight the essential features of a good counselling session, inclusive of the knowledge, attitude and skills of the counsellor and the rights of the client.

METHODOLOGY:

- 1) Role play
- 2) Brainstorming
- 3) Group discussion

Handout: (H8.4)

Activity: (A8.4)

Job Aid: (J8.4)

CHARACTERISTICS OF A GOOD COUNSELLOR

HANDOUT (H-8.4)



ACTIVITY (A8.4)

The trainer divides participants into two groups and ask them to write what kind of knowledge, skill and attitude a good counsellor must have. Allow 10 minutes for each group to brainstorm and chart their ideas on a flip chart. The group chooses a representative from within. Allow 5 minutes each for presentation. The trainer then goes through any missing points

Counselling helps to establish a positive interpersonal relationship between service providers and clients. When providers treat clients as valued customers and give them good service by listening to, understanding, and responding to their needs, their clients are more likely to be satisfied. When clients are satisfied with their treatment at a clinic, they will tell their friends

and relatives about their good experience (and conversely, if they are dissatisfied, they will pass along their bad experience, too).

KNOWLEDGE:

A good counsellor should have knowledge of:

- 1) Demographic context: national and global perspective.
- 2) Effects of rapid population growth on the socio-economic infrastructure of the country.
- 3) Follow FP Compliance policy in the country.
- 4) Government policies regarding population.
- 5) Influence of FP on the health of mother and child.
- 6) Common myths, misunderstandings, and misconceptions regarding FP and how they can be countered.
- 7) Local customs and traditions.
- 8) The human reproductive system (anatomy and physiology) Contraceptive technology update.
- 9) Client eligibility criteria, policies, and administrative procedures of the facility.
- 10) Concepts, principles, and goals of counselling.
- 11) Recordkeeping/reporting.
- 12) Follow-up/referral systems and procedures.

SKILLS:

A good counsellor should be able to:

- 1) Build up a good rapport with the clients.
- 2) Deal with clients at their level of education and understanding.
- 3) Show empathy.
- 4) Deal tactfully with sensitive issues.
- 5) Listen patiently to the client's point of view.
- 6) Be discreet and maintain confidentiality.
- 7) Pay full attention to the client's need.
- 8) Help the client to decide.

ATTITUDE:

A good counsellor should:

- 1) Have a positive attitude towards FP.
- 2) Be unbiased towards different population groups.
- 3) Give unbiased information on FP methods.
- 4) Have a desire to work with people. Be punctual.
- 5) Be a hard worker.
- 6) Be pleasant and polite. Be helpful.

- 7) Be attentive to the client's problems. Not ridicule the client over any issue.
- 8) Show tolerance for values that differ from her/his own values.
- 9) Be aware of factors that affect decision-making.
- 10) Provide counselling in local languages.
- 11) Be well-versed in the local language(s) of the client population.
- 12) Show respect for the right and ability of people to make their own decisions.
- 13) Be comfortable with issues related to human sexuality and people's expressions of their feelings.
- 14) The provision of counselling should be part of every interaction with the client.

Information and counselling commonly will come from more than one source.

Therefore, all staff should be knowledgeable about all available contraceptive methods.

Qualities of a Good Counselor

Job Aid (J8.4)

A GOOD COUNSELLOR:
Treats every client respectfully.
Understands and respects the client's rights.
Makes the client feel at ease.
Earns the client's trust. Polite and sincere at all times. Creates a feeling of trust.
Creates a relaxed, friendly, non-judgmental environment.
Assures client privacy and confidentiality.
Listens, and gets to know the women (including their fears, limitations, misconceptions, needs, and situation).
Converses in simple and clear language.

Understands the benefits and limitations of all contraceptive methods.

Remains alert to special needs such as STI protection.

Gives correct and appropriate information.

Allows time for the client to process and clarify information and to ask questions without fear of criticism or judgment.

Makes sure that the client has understood the information correctly

Understands the cultural and emotional factors that affect a client's or a couple's decision to use a particular contraceptive method.

Encourages the client to ask questions.

Uses a non-judgmental approach that shows the client respect and kindness.

Presents information in an unbiased, client-sensitive manner.

Listens to the client's concerns actively.

Understands the effect of nonverbal communication.

Recognizes when to refer the client to an appropriate facility.

Attends to the client as quickly as possible.

SESSION 5

TITLE: RIGHTS OF CLIENTS

(25 MINUTES)

OUTLINE & OBJECTIVES:

To highlight the rights of clients for family planning.

METHODOLOGY:

Lecture/interactive discussion on the rights of clients on FP decision making.

Handout: (H8.5)

Activity: (A8.5)

Job Aid: (J8.5)

RIGHTS OF CLIENT HANDOUT (H-8.5)



ACTIVITY (A8.5)

Divide participants into two groups and ask them to enlist clients' rights, one by one on a flip chart and ask them to explain this right also. Both groups provide feedback on each other's work. At the end of the session, the trainer summarizes and adds any further points.

ALL CLIENTS HAVE CERTAIN RIGHTS, INCLUDING:

- 1) The right to decide whether to practice FP.
- 2) The freedom to choose which method to use.
- 3) The right to privacy and confidentiality.
- 4) The right to refuse any type of examination.
- 5) The freedom to choose where to seek services.

RIGHT TO INFORMATION:

All individuals in the community have a right to information about the benefits of FP for themselves and for their families.

RIGHT TO ACCESS:

All individuals in the community have a right to receive services from FP programs, regardless of their social status, economic situation, religion, political belief, ethnic origin, marital status, geographical location, young people and people with special needs or any other group identity. Including adolescents and people with special needs.

RIGHT OF CHOICE:

Individuals and couples have the right to decide freely whether to practice FP or not. A client's concept of acceptability and appropriateness changes with circumstances. Therefore, the right of choice also involves clients' decisions concerning discontinuation or switching of method.

RIGHT TO SAFETY:

Family planning clients have a right to safety while practicing FP. This right to safety implies the following:

- 1) Clients have a right to protection against any possible negative effect of a contraceptive method on their physical and mental health.
- 2) Since unwanted pregnancies may represent a risk to health, the right of the client to safety also includes the right to effective contraception.
- 3) When receiving FP services, clients also have a right to protection against the possibility of acquiring infection from contact with a contaminated instrument.

RIGHT TO PRIVACY:

When discussing needs or concerns, the client has a right to an environment in which she/he feels confident and relaxed. Auditory and visual (during examination) privacy should be ensured.

RIGHT TO CONFIDENTIALITY:

The client should be assured that any information disclosed, or any details of the services received will not be communicated to others without consent.

RIGHT TO DIGNITY:

FP clients have a right to be treated with courtesy, consideration, and attentiveness, and with full respect of their dignity, regardless of their level of education and social status.

RIGHT TO COMFORT:

The client has a right to comfort. This right of the client is intimately related to adequacy and quality of services (e.g., service delivery sites should have proper ventilation, lighting, seating, and toilet facilities). The environment in which the services are provided should be in keeping with the cultural values, characteristics, and demands of the community.

RIGHT OF CONTINUITY:

Clients have a right to receive contraceptive services and supplies for as long as they need them. The services provided to a client should not be discontinued unless the decision is made jointly between the counsellor and the client.

RIGHT OF OPINION:

Clients have the right to express their positive or negative views (thanks or complaints) about the quality of services they receive at the facility.

Client Type and Corresponding Counselling Tasks

Job Aid (J8.5)

NEW CLIENT WITH A METHOD IN MIND
Counselling Tasks
1. Discuss the client's needs and situation as well as the client's reproductive intent.
2. Determine the correctness and accuracy of the client's knowledge of the method. Clarify any misconceptions.
3. Determine if the client is medically eligible for the method and if the method is suitable to the client's needs and situation.
4. If the client is eligible, discuss the correct use of the method and how to deal with side effects.
5. Provide the method (including any backup as needed).
6. If the client is ineligible, discuss the reasons for the ineligibility, and inform the client of other options.

NEW CLIENT WITH NO METHOD IN MIND
Counselling Tasks

1. Discuss the client's needs and situation and the factors that she considers important in choosing an FP method.

Discuss relevant information about each method and assist the clients in determining the most suitable method. Include in the discussion the client's medical eligibility and ensure that her choice is an informed one.

3. Clarify any misconceptions.

4. Discuss how to correctly use the chosen method and how to handle any side effect.

5. Provide the method

RETURNING CLIENTS WITH NO PROBLEMS

Counselling Tasks

1. Recheck client's knowledge about her chosen contraceptive method. Provide updates if any.

2. Discuss how the client is doing with the current method, including observations that the client may deem too trivial to report but may be important enough to have the method modified.

3. Provide the method.

4. Schedule a follow-up visit.

RETURNING CLIENTS WITH PROBLEMS

Counselling Tasks

1. Perform a thorough probe of the client's concern about the current method.

2. Explain the possible causes and discuss the options available to the client.

3. If a new method is required, educate the client about the appropriate use and the potential side effects. Provide a temporary backup method during the transition if needed.

4. Provide the method.

5. Schedule a follow up visit

SESSION 6

TITLE: DEALING WITH SENSITIVE ISSUES/SPECIFIC GROUP

(25 MINUTES)

OUTLINE & OBJECTIVES:

This session aims to discuss the specific needs of various select groups and how to best offer them the most suitable advice e.g. Hepatitis or HIV positive women or Commercial Sex Workers or wives of men working abroad or with any other risky sexual behaviours.

METHODOLOGY:

- 1) Role plays
- 2) Brain storming session
- 3) Group discussion

Handout: (H8.6)

Activity: (A8.6)

Checklist: (C8.6)

DEALING WITH SENSITIVE ISSUES/SPECIFIC GROUPS

HANDOUT (H-8.6)

SERVICES FOR CLIENTS WITH CHRONIC HEALTH PROBLEMS:

Clients with chronic or serious health problems need access to safe and effective contraception. Providing an appropriate contraceptive method for these clients can be complicated since the health condition may limit the contraceptive choices. The counsellor must know about possible interactions among medical conditions, drugs, and contraceptives, and must be able to provide appropriate counselling. Women who have chronic or serious medical conditions may need medical follow-up and monitoring more often than other women.

In balancing the needs and desires of the client, counsellors must consider that, for women with serious health conditions that make pregnancy dangerous, providing no contraceptive method would be even more dangerous than providing a method with minor side effects. Issues of mentally handicapped clients also need to be addressed through proper counselling of their spouses and family members.

CONTRACEPTION FOR HIV-INFECTED WOMEN:

Women infected with HIV face a variety of RH decisions involving their desire for pregnancy, their contraceptive practices, and choices and decisions if an unintended pregnancy occurs.

HIV-infected women should be allowed to make these decisions freely. Voluntary FP can give these women more control over their reproductive lives and serve as a strategy to prevent perinatal HIV infection. Follow the MEC Wheel 2015 in decision making.

Male condoms used consistently and correctly, are effective in preventing HIV transmission if either husband is infected with HIV. Female condoms also offer significant protection from Sexually Transmitted infections, but their use has been limited by cost and user acceptability. Other methods of contraception such as hormonal contraceptives and IUCDs are effective in preventing unplanned pregnancies, but do not prevent HIV transmission.

SPECIAL NEEDS OF YOUNG WOMEN:

Young and adolescents are a specific group requiring sensitive attitude and care. Generally, they have poor access to health care and especially so for reproductive health issues. There are many taboos surrounding gynaecology problems in young girls and even menstruation.

SPECIAL NEEDS OF ABUSED WOMEN:

Abused women clearly have special needs, including medical, psychological, and legal support, and safe housing for themselves and their children. To be effective, solutions must acknowledge the whole problem. Health care planners and other health care providers are in an excellent position to intervene because they represent one of the few institutions to come in contact with most women during their reproductive lives, the time of highest risk for domestic violence.

FP providers must be aware of power imbalances and the resulting health effects. They cannot do their jobs effectively without being concerned about how the issue of power affects women's reproductive health. The most important contraceptive service for women in violent relationships is counselling, which must include recognition of the client's difficulties with her husband and help in choosing a method that will not make those difficulties worse. Ideally, it will include referral or in-house professional counselling regarding violence issues and the resources available in the community.

Battered women who cannot protect themselves from STIs through condom use may need repeated screening and treatment for STIs. Emergency contraception is also a pressing need for many battered women.

COUNSELLING MEN:

Men have special counselling needs and should receive special attention from health care providers to motivate them to make responsible choices regarding RH practices.

MEN'S SPECIAL COUNSELLING NEEDS:

- 1) Men should be encouraged to support women's use of FP methods or to use FP methods themselves.
- 2) It is important to talk to young men about responsible and safe sex before they become sexually active.
- 3) Men often have less information or are more likely to be misinformed about FP methods, male and female anatomy, and reproductive functions because they tend to talk less about these issues than women.
- 4) Men are often more concerned about sexual performance and desire than women.
- 5) Men often have serious misconceptions and concerns that FP methods will negatively affect their sexual pleasure and/or performance.
- 6) Men are often concerned that women will become promiscuous if they use FP.
- 7) Many men do not know how to use condoms correctly. Health care providers should always demonstrate correct condom use, using a model when possible.
- 8) Men are often not comfortable going to a health facility, especially if it serves women primarily.
- 9) Encourage men to participate in FP. Involving men can be crucial to a continuing client strategy. Men are more likely to support continued contraceptive use when they participate. Group Counselling in 'Mohalla' meetings could be good forum for engaging men in FP.

COUNSELLORS CAN INVOLVE MEN AND SERVE THEM BETTER IF THEY TAKE FOUR STEPS:

- 1) Offer men FP and other RH services.
- 2) Provide men with accurate information about FP.
- 3) Explain how men can assure their own RH as well as that of their husband.
- 4) Encourage couples to talk to each other about FP, as well as talking to health care providers.

Counsellors can often encourage men to talk with their husband about practicing FP and sharing decision-making by appealing to their sense of responsibility in family matters.



Activity (A8.6)

The trainer gives these scenarios to volunteers from the participants. Each group of two chooses to be a client and health care providers and prepares the role plays. They are allowed 15 minutes each to prepare and then up to 10 minutes each to present. The remaining participants are the observers and are requested to provide feedback. The trainer then provides final feedback and adds any information if needed.

1. A client with 8 children. She nearly died from hemorrhage during her last delivery. It is doubtful she would be able to support another pregnancy. She has come in for a consultation for her baby who is 6 months old. You ask her if she is interested in family planning. She responds: "I don't believe in family planning. Those things make you sick. I don't need it."
2. A client 27 years old with 3 children. She has come to ask for a tubal ligation because she doesn't want any more children. When you try to discuss other family planning methods with her, she responds: "I don't want to hear about other methods. I told you that I don't want any more children. And for that reason, I want to be sterilized."
3. A client with 2 children (ages 2 years, and 5 months) came in for family planning services the first time 4 months ago. You prescribed the pill for her. Her husband has just found her pills and thus learned that she is on contraception. He is completely opposed to contraception and has forbid her to continue taking the pills. She tells you: "I don't want more children right now. I don't agree with the position of my husband, but I cannot continue if he doesn't want it."
4. The client has her two-month-old baby in her arms. She has never before used contraception. She is exclusively breastfeeding her baby and her menses have not returned. She has heard of LAM and would like to use it to prevent pregnancy.

Observation Checklist for Counselling Role Play

Checklist (C8.6)

TASK OR ACTION	YES	NO	COMMENTS
Provider assures confidentiality?			
Friendly/welcoming/smiling/respectful?			
Not judgmental or condescending?			
Listens attentively/nods head to encourage and acknowledge client's responses?			
Uses open-ended questions (i.e., not yes/no questions)?			
Uses non-technical terms and language the client can understand?			
Counsels the client using the HTSP messages?			
Asks the client about pressures she may be feeling at home to have a baby and discusses how to deal with those pressures?			
Listens to client's responses closely and patiently?			
Provides encouragement and reassurance?			
Counsels the client on a full range of contraceptive methods, including long-acting methods (i.e., does not just offer one or two methods)?			
Prepares the client to use the method she selects effectively, including thorough discussion of side effects and what the client can expect?			
Responds to client's non-verbal communication (i.e. reassure the client if she seems nervous)?			

Is non-directive (i.e., does not tell the client what to do)?			
Asks the client if she has any questions?			
Answers client's questions?			
Summarizes and ensures a common understanding of the discussion?			

SESSION 7
SUMMARIZE AND WRAP UP
(10 MINUTES)

Ask participants how they might use this information in their work in facilities or in the community.

FURTHER READING

- 1) WHO Global Handbook for Family Planning 2018
- 2) <https://www.gfmer.ch/SRH-Course-2012/family-planning/pdf/Family-planning-counselling-reproductive-rights-Festin-2012.pdf>
- 3) <http://www2.pathfinder.org/pf/pubs/mod3.pdf>
- 4) <https://www.fptraining.org/projects/family-planning-counseling>

INFECTION PREVENTION PRACTICES



TIME: 3 HOURS 10 MINUTES

Infection prevention (IP) and control is one of the essential components of a quality service provision in RH and FP. Preparation, knowledge, attention to details, and rigorous systematic processes are critical elements of an infection prevention program. This session aims at providing up to date, evidence-based information on infection prevention.



TRAINING OBJECTIVES

- 1) Highlight the importance of basic infection prevention and enhance IP knowledge and skills.
- 2) Improve IP practices in health care settings.
- 3) Discuss the benefits of using appropriate IP principles and practices.
- 4) Practice effective, simple and inexpensive IP practices and processes.



LEARNING OUTCOMES

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

- 1) Describe the basic principles of infection prevention.
- 2) Be aware of the conditions that allow infections to be transmitted to others and how to stop the spread of infectious diseases.
- 3) To protect themselves and others from getting infected.
- 4) Use the Personal Protective Equipment (PPE) in an effective way.
- 5) Use Infection Prevention (IP prevention techniques) more effectively.
- 6) Be aware of the waste disposal system in their facility.
- 7) Knowledge about supply chain.



ADVANCE PREPARATION

- 1) Video presentation to highlight the PPE and hand washing practices.
- 2) Handouts.
- 3) Tables with IP materials for demonstration



TRAINING/ LEARNING METHODS

Designed to actively involve the trainees in the learning process, sessions include:

- 1) Power point presentation
- 2) Group discussions
- 3) Individual and group exercises
- 4) Role plays
- 5) Brain Storming
- 6) Table Demonstration



TRAINING MATERIAL

Trainer's Materials	Trainee's Materials
Hand Outs: H9.1, H9.2, H9.3, H9.4, H9.5, H9.6, H9.7	Hand Outs: H9.1, H9.2, H9.3, H9.4, H9.5, H9.6, H9.7
Activity: A9.1, A9.2a, A9.2b, A9.2c, A9.5a, A9.5b, A9.6, A9.7a, A9.7b	Job aid: J9.6, J9.7a, J9.7b, J9.7c, J9.7d, J9.7e
Job aid: J9.6, J9.7a, J9.7b, J9.7c, J9.7d, J9.7e	
PPT: (27)	



CONSTITUTION OF THE SESSION

Eight mini sessions will be held

1) Introduction to Infection prevention	Activity and group work	20 Min
2) Who is at risk of what?	Interactive session/activity	30 Min
3) Steps in infection prevention	Interactive session	20 Min
4) Infection prevention principles & standard precautions	Lecture/ video Presentation	20 Min
5) Using personal protective equipment	Group work / Video / Table demonstration	30 Min
6) Steps in instrument processing, infection prevention in FP clinics	Experience sharing / PowerPoint	30 Min
7) Waste disposal	Interactive lecture	30 Min
8) Wrap up		10 Min

SESSION 1

TITLE: INTRODUCTION TO INFECTION PREVENTION AND SAFE SERVICE PROVISION

(20 MINUTES)

OUTLINE & OBJECTIVES:

To discuss common terms used in context of preventing infection; and to clarify “asepsis, antisepsis, decontamination, cleaning, disinfection, and sterilization”.

METHODOLOGY:

Power point presentation and group discussion

Handout: (H9.1)

Activity: (A9.1)

INTRODUCTION TO INFECTION PREVENTION HANDOUT (H-9.1)



Activity (A9.1)

TERMS

The following terms are written on a piece of paper, which is then folded and put in a basket. The basket is circulated among the participants, while the music is playing. When the music stops, the participant with the basket in hand is asked to pick up a paper, unfold and describe or define the term written on it. All terms are then explained by the trainer. The participants are asked to review the definition of terms and important concepts that will be used during the course, including:

- 1) Microorganisms
- 2) Asepsis
- 3) Antisepsis
- 4) Decontamination
- 5) Cleaning
- 6) HLD
- 7) Sterilization
- 8) Standard precautions
- 9) Personal protective barriers

INTRODUCTION:

Microorganisms that cause infections live everywhere in the environment, in human beings,

animals, plants, soil, air and water. Human beings normally carry them on their skin and in the throat, intestines, and genital tract. All microorganisms become dangerous when favorable environment is present. Microorganisms include bacteria, virus, fungi and parasites. Infections can be spread in health facilities from client to client, client to provider or provider to client due to lack of infection prevention practices and/or through contaminated equipment and instruments. For IP purposes, bacteria can be further divided into three categories: vegetative (staphylococcus), mycobacteria (tuberculosis), and endospores (tetanus), which are the most difficult to kill.

The terms “**asepsis, antisepsis, decontamination, cleaning, disinfection, and sterilization**” often are confusing. For the purpose of this manual, the following definitions will be used:

ASEPSIS:

Are general terms used to describe the combination of efforts made to prevent entry of microorganisms into any area of the body where they are likely to cause infection. The goal of asepsis is to reduce to a safe level, or eliminate, the number of microorganisms on both animate (living) surfaces (skin and tissue) and inanimate objects (surgical instruments and other items).

ANTISEPSIS:

Is the prevention of infection by killing or inhibiting the growth of microorganisms on skin and other body tissues using a chemical agent (an antiseptic).

DECONTAMINATION:

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

CLEANING:

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

DISINFECTION:

Is the process that eliminates most, but not all, disease-causing microorganisms from inanimate objects.

HIGH-LEVEL DISINFECTION (HLD):

HLD by boiling, steaming, or the use of chemicals eliminates **all** microorganisms except some bacterial endospores from inanimate objects.

STERILIZATION:

Is the process that eliminates all microorganisms (bacteria, viruses, fungi, and parasites) **including** bacterial endospores from inanimate objects.

STANDARD PRECAUTIONS:

Are guidelines designed to create barriers between microorganisms and an individual to prevent the spread of infection (i.e., the barrier serves to break the disease transmission cycle). They apply to all clients, patients, and staff at health facilities.

PROTECTIVE BARRIERS:

Infection prevention is achieved by placing a barrier between the human beings and microorganisms. These barriers are called protective barriers that prevent transmission of infection from client to client, client to provider or provider to client. The protective barriers are physical (wearing gloves), mechanical (hand washing), and chemical (antiseptics and disinfectants).

The protective barriers include:

- 1) Hand washing
- 2) Wearing gloves, masks, caps, gowns
- 3) Using antiseptic solutions
- 4) Processing of equipment and other items
- 5) Managing clinical waste

WHAT IS INFECTION PREVENTION?

Infection prevention is the interruption (breaking) of the disease transmission cycle from the infected person to another person. The primary objectives of infection prevention (IP) in family planning facilities are to prevent infections and to minimize the risk of transmitting blood-borne viral infections (including HBV and HIV) to clients, service providers, and other staff, including cleaning and housekeeping personnel



Standard Precautions breaks the chain of infection thus minimizing transmission of infection within the Healthcare environment.

Standard Precautions are guidelines designed to create barriers between microorganisms and an individual to prevent the spread of infection (i.e., the barrier serves to break the disease transmission cycle).

They apply to all clients, patients, and staff at health facilities. Standard Infection Control Precautions are intended for use by all healthcare staff in all healthcare settings at all times whether infection is known to be present or not to ensure the safety of patients, staff and visitors to the healthcare environment.

SESSION 2

TITLE: WHO IS AT RISK?

(30 MINUTES)

OUTLINE & OBJECTIVES:

To bring home the realization that all HCPs are at risk of hospital infections and that all clients have to be treated with proper infection prevention techniques. How are infections transmitted?

METHODOLOGY:

- 1) Experience sharing
- 2) Group discussion
- 3) Lecture to sum up
- 4) Interactive presentation
- 5) Summarize the exercise with the presentation “Preventing Infections in Healthcare Workers.” (10 min.)

Handout: (H9.2)

Activity: (A9.2a, A9.2b, A9.2c)

WHO IS AT RISK?

HANDOUT (H-9.2)



(Activity A9.2a)

To highlight risk of infection to the staff, client, and the community:

Materials

Envelopes (one for each participant)

Pens or pencils (one for each participant) Flipchart paper and markers

Instructions for the Trainer: Prepare the envelopes by marking the letter “A,” “B,” or “C” under the flap of each envelope. The letter “A” should be on 10% of the envelopes (for example, if there are 20 envelopes, only 2 envelopes should have the letter “A” under the flap). “B” and “C” should be evenly distributed among the rest of the envelopes.

Procedure:

- 1- Distribute one envelope to each participant. Ask them to look under the flap of their envelope and remember the letter written there but keep it a secret.
- 2- Have the participants exchange envelopes by passing their envelope to the person on their right. Participants write their secret letter (from the first envelope) next to the letter under the flap of the new envelope passed to them.
- 3- Exchange envelopes again, always passing to the person on the right. Participants again write their secret letter next to the other letters under the flap of the new envelope passed to them.
- 4- Stop the exchange process.
- 5- Tell participants that those holding an envelope with the letter “A” under the flap have now been “exposed” to HIV, HBV, or HCV. Those holding an envelope with the letter “B” or “C” under the flap have not yet been infected.

Ask participants with “A” under the flap of the envelopes to raise their hands and record the number on a flipchart. Ask participants with “B” or “C” to raise their hands and record those numbers.

Discussion questions:

1. How do you feel about continuing with the envelope exchange?
2. How did you feel once you knew you had been exposed to the HIV, HBV, or HCV?
3. What could we do to prevent the transmission of infection? What would you do differently?
4. How is this anonymous contact similar to the work you do in your healthcare setting every day?

Summarize the Main Points

- 1- The person with “A” written on the flap did not know that she was infected until she was told.
- 2- When we are not aware of the risks, we do not protect ourselves.
- 3- Everyone is at risk for exposure to HIV, HBV, or HCV, and you will not always know whether people are infected. The best way to protect ourselves, as healthcare providers, is to consider every person to be potentially infected and use standard precautions with each and every client or patient.



Activity (A9.2b)

INFECTIOUS DISEASE TRANSMISSION CYCLE:

Resources/Materials Needed:

3–5 cards with the names of different infectious diseases.

Flipchart and markers for each group Instructions.

Prepare the cards in advance by selecting diseases.

- 1) Divide participants into three groups. Distribute one card with an infectious disease to each group.
- 2) Ask each group to draw the transmission cycle of their specific disease on a flipchart.
- 3) Ask each group to identify barriers or measures to break the transmission cycle and prevent the spread of the infectious disease.

Samples of Cards:

- 1) Hepatitis C
- 2) Hepatitis B
- 3) Hepatitis A

What can you do to protect yourself when you are working with patients or clients?

A brainstorming session to invite answers from the participants and the trainer to write the answers on the flip chart. A brief session is held to discuss the responses and see how they are applicable to their places of work.

IMMUNIZATIONS:

Immunizations can protect from acquiring a number of diseases. There are many immunizations available to healthcare workers as well as the public.

**(Activity A9.2c)**

Ask the participants which immunizations should every healthcare worker have?

- 1) Hepatitis A
- 2) Hepatitis B
- 3) Influenza
- 4) Pneumococcus
- 5) Tetanus
- 6) Diphtheria
- 7) Chicken pox
- 8) Measles
- 9) Mumps
- 10) Rubella (German measles)

SESSION 3

TITLE: STEPS IN INFECTION PREVENTION

(20 MINUTES)

OUTLINE & OBJECTIVES:

To highlight various techniques and levels of infection prevention.

METHODOLOGY:

- 1) Group discussion to know various methods known to the group
- 2) Power point presentation to discuss steps of infection prevention

Handout: (H9.3)

STEPS IN INFECTION PREVENTION HANDOUT (H-9.3)

BASIC RULES FOR INFECTION CONTROL

- 1) Wash hands (hand washing may be the single most important infection-prevention procedure).
 - 2) Wash hands before and after contact with each client.
 - 3) Use soap and clean running water from a tap or bucket for washing.
 - 4) Wash hands before putting on gloves and whenever they get dirty.
 - 5) Be sure to clean between the fingers and under fingernails.
 - 6) Wash hands after handling soiled instruments and other items or touching mucous membranes, blood, or other body fluids.
 - 7) Wash hands before putting on gloves, after taking off gloves, and whenever hands get dirty. Wash hands when you arrive at work, before and after you use the toilet and when you leave work.
 - 8) Dry hands with a paper towel or a clean, dry cloth towel that no one else uses, or air dry
 - 9) If clean water and soap are not available, a hand sanitizer containing at least 60% alcohol can reduce the number of germs on the hands.
 - 10) Sanitizers do not eliminate all types of germs and might not remove harmful chemicals.
-
- 1) Wear gloves.
 - 2) Wear gloves when there is a chance of contact with blood or other body fluids.
 - 3) Before any procedure with each client, put on a new pair of single-use gloves, if possible.
 - 4) Use sterilized gloves for any surgical procedure.

<ol style="list-style-type: none"> 1) Perform vaginal examinations only when needed or requested (vaginal exams generally are not needed for most contraceptive methods—except for female sterilization, diaphragm, and IUCDs). 2) For vaginal exams, wear either a new pair of single-use gloves or reusable, highly disinfected, or sterile gloves. 3) Perform vaginal exams only when needed—such as for VIA (Visual inspection with acetic acid) and Pap smear or upon suspicion of disease, could help with diagnosis or treatment.
<ol style="list-style-type: none"> 1) Clean the client’s skin (Preferable to ask the woman to wash the area with soap and empty the bladder if relevant) 2) Appropriately clean the client’s skin before an injection or insertion of implants. 3) Use a locally available antiseptic on dirty skin, or have the patient wash the skin with clean water and soap. 4) Antiseptics have minimal effects when used on clean skin.
<ol style="list-style-type: none"> 1) Clean the cervix with antiseptic as part of the “No touch” technique for IUCD insertion.
<ol style="list-style-type: none"> 1) Use a new, single-use needle and syringe. 2) For each injection, use a new, single-use needle
<ol style="list-style-type: none"> 1) After use with each client, reusable instruments, equipment, and supplies should be decontaminated (soaked in 0.5% chlorine solution [bleach] or another disinfectant for 10 minutes. Cleaned with soap and water, and disinfected (by boiling or steaming) or sterilized (by steam or dry heat). 2) Vaginal specula, uterine sounds, gloves for pelvic exams, and other equipment and instruments that touch mucous membranes should be decontaminated, cleaned, and then either high-level disinfected or sterilized, as appropriate. 3) Scalpel holders and other equipment and instruments that touch human tissue beneath the skin should be decontaminated, cleaned, and then sterilized. 4) Disinfected or sterilized objects should not be touched with bare hands. 5) Gloves should be worn when cleaning instruments and equipment. 6) Linens should be washed in warm, soapy water using utility gloves and line dried. 7) After each client, examination tables, bench tops, and other surfaces that will come in contact with unbroken skin should be washed with 0.5% chlorine solution.
<ol style="list-style-type: none"> 1) Decontamination of surfaces in the screening clinic Procedure tables, trolleys, equipment (lamp, etc.) in the screening clinic may be contaminated with body fluids such as vaginal secretions, purulent discharge, blood, etc. 2) While the surface of the procedure table should be decontaminated after each patient procedure, the other surfaces should be decontaminated on a daily basis by wiping with 0.5% chlorine solution, 60-90% ethyl or isopropyl alcohol or other chemical disinfectants such as Iodophors. 3) The clinic floors should also be decontaminated on a daily basis.

SESSION 4

TITLE: INFECTION PREVENTION PRACTICES

(20 MINUTES)

OUTLINE & OBJECTIVES:

To emphasize the importance of Standard Precautions and enlist the steps necessary to create appropriate infection control systems.

METHODOLOGY:

- 1) Lecture and demonstration of various methods displayed on station & discussion.
- 2) Video presentation.

Handout: (H9.4)

STANDARD PRECAUTIONS HANDOUT (H-9.4)

STANDARD PRECAUTIONS IN HEALTH CARE

Standard precautions are meant to reduce the risk of transmission of blood borne and other pathogens from both recognized and unrecognized sources. They are the basic level of infection control precautions which are to be used, as a minimum, in the care of all patients.

Hand hygiene is a major component of standard precautions and one of the most effective methods to prevent transmission of pathogens associated with health care. In addition to hand hygiene, the use of personal protective equipment should be guided by risk assessment and the extent of contact anticipated with blood and body fluids, or pathogens.

In addition to practices carried out by health workers when providing care, all individuals (including patients and visitors) should comply with infection control practices in health-care settings. The control of spread of pathogens from the source is key to avoid transmission. Among source control measures, respiratory hygiene/cough etiquette, developed during the severe acute respiratory syndrome (SARS) outbreak, is now considered as part of standard precautions.

Worldwide escalation of the use of standard precautions would reduce unnecessary risks associated with health care. Promotion of an institutional safety climate helps to improve conformity with recommended measures and thus subsequent risk reduction. Provision of adequate staff and supplies, together with leadership and education of health workers, patients, and visitors, is critical for an enhanced safety climate in health-care settings.

IMPORTANT ADVICE:

- 1) Promotion of a safety climate is a cornerstone of prevention of transmission of pathogens in health care.
- 2) Standard precautions should be the minimum level of precautions used when providing care for all patients.
- 3) Risk assessment is critical. Assess all health-care activities to determine the personal protection that is indicated.
- 4) Implement source control measures for all persons with respiratory symptoms through promotion of respiratory hygiene and cough etiquette.
- 5) Reduce the risk of the transmission of microorganisms from both known and unknown sources of infection when caring for patients or clients in any healthcare setting, as well as at home.

Standard precautions, therefore, apply to all blood and body secretions, excretions, non-intact skin, and mucous membranes for every person. Placing a physical, mechanical, or chemical barrier between you and microorganisms can prevent the acquisition of disease.

Standard universal precautions of infection prevention include:

1) Hand washing or hand hygiene.
2) Ensuring self-protection by wearing gloves and employing other physical barriers Use of personal protective equipment (e.g., gloves, gowns, masks).
3) Safe injection practices and needle stick and sharps injury prevention adopting safe work practices (to prevent injuries from sharps instruments).
4) Maintaining proper methods of environmental cleanliness, cleaning, and disinfection.
5) Safe handling of potentially contaminated equipment or surfaces in the patient environment and ensuring the proper processing of instruments and other items.
6) Following proper waste-disposal practices and handling, transporting, and processing used and/or soiled linens in the recommended and prescribed manner.
7) Respiratory hygiene/cough etiquette.
8) Staff health & safety.

HAND WASHING:

Thorough hand washing and use of protective gloves are key components in minimizing the spread of disease and maintaining an infection-free environment.

WHEN TO WASH HANDS?

HAND WASHING IS INDICATED BEFORE:

- 1) Examining (direct contact with) a client.
- 2) Putting on sterile gloves.

- 3) Wash hands when you arrive at work.
- 4) Routine hand washing should be done before wearing gloves.
- 5) Before and after each patient contact.

HAND WASHING IS INDICATED AFTER:

Any situation in which hands may be contaminated, such as:

- 1) Handling soiled instruments and other items.
- 2) After each contact with a potentially contaminated item, even when wearing gloves.
- 3) After accidentally touching mucous membranes, blood, or other body fluids (secretions or excretions).
- 4) Removing gloves.
- 5) When you leave work.
- 6) After you use the toilet.

Dry hands with a paper towel or a clean, dry cloth towel that no one else uses, or air-dry.
Dry hands with a clean, dry towel or air dry; shared towels quickly become contaminated.

ROUTINE HAND WASHING

Plain or antiseptic soap should be used for routine hand washing. Hands should be rinsed in a stream of running water and dried with a clean personal towel or air-dried. Towels should not be shared. Practices such as using a common basin where a number of people or even one-person washes or dips his/her hand(s) repeatedly is dangerous and must be abandoned.

The vigorous rubbing together of all surfaces of lathered hands mechanically removes and inactivates most organisms. One of the pre-requisites for ensuring the practice of hand washing is the continuous provision of soap and a continual supply of clean water, either from a tap or bucket, and single use towels. Do not use shared towels to dry hands. When no visible blood or mucus is on the hands, an alcoholic hand rub may be used and is as effective as hand washing

TYPES OF HAND WASHING

- 1) Simple hand wash (40-60 seconds) (before and after examining patients, giving injections, pelvic examination and insertion and removal of IUCDs)
- 2) Surgical hand wash (3-5 minutes) (for surgical procedures)

HOW TO DO SIMPLE HAND WASHING

- 1) Simple hand washing is done by scrubbing the hand vigorously with plain soap about 25-30 seconds.
- 2) Air dry by shaking off excess water. If a clean towel is available, use the clean towel

- 3) Collect the used water in a container and discard it.
- 4) It is advisable to avoid using standing water in basins and other containers as microorganisms grow and multiply in moisture.
- 5) Make sure is adequate drainage of water where the soap is kept there.
- 6) Use running water from a tap. If no tap available, use a bucket with a tap or a bucket with a mug, so that the water is not contaminated.

HAND WASHING:

Step 1- Rub Palm together.

Step 2- Rub the back of both hands.

Step 3- Interface fingers and rub the hands together.

Step 4- Interlock fingers and rub the back of fingers of both hands.

Step 5- Rub thumb in a rotating manner followed by the area between index finger and thumb.

Step 6- Rub fingertips on palm for both hands.

Step 7- Rub both wrists in a rotating manner rinse and dry thoroughly.



MICROORGANISMS GROW AND MULTIPLY IN MOISTURE AND IN STANDING WATER.

- 1) If bar soap is used, provide small bars and soap racks that drain.
- 2) Avoid dipping hands repeatedly into basins containing standing water. Even with the addition of antiseptic agents such as Dettol® or Savlon®, microorganisms can survive and multiply in these solutions.

- 3) Choose from several options when running water is not available.
- 4) Use a bucket with a tap that can be turned off to lather hands and turned on again for rinsing, or a bucket and pitcher.
- 5) Use an alcoholic hand rub that does not require water.

LOCALLY MADE HAND SCRUB:

Add 5cc Glycerin into 100cc Rubbing alcohol, this works as quick and easy hand scrub.

SURGICAL SCRUB:

The surgeon and his/her assistant must scrub both their hands and forearms up to the elbows thoroughly with soap and water or antiseptic agents. The entire procedure should be repeated several times so that the scrub lasts for 3 to 5 minutes. The hands and forearms should be dried with a sterile towel only. A small stick or brush should be used for cleaning fingernails.

Ideally, the surgeon and the assistant should scrub thoroughly between each procedure. In high caseload settings, in order to prevent re-colonization of the skin by micro-organisms, the surgical staff should do a three-minute surgical scrub every hour or after every five cases (whichever is earliest), or if the surgeon (and/or the surgical staff) goes out of the OT, or touches any infected item, or if the glove is torn. An alcohol scrub should be done after every procedure.

SESSION 5

TITLE: USING PROTECTIVE BARRIERS (PPE)

(30 MINUTES)

OUTLINE & OBJECTIVES:

- 1) To highlight the importance of personal protective equipment.
- 2) Identify how healthcare workers can decrease risk of exposure to blood and body fluid.
- 3) Explain the different types and use of PPE.

METHODOLOGY:

- 1) Brainstorming/Discussion.
- 2) Ask participants, “What is PPE?” and use of Standard Precautions.
- 3) Video presentation to highlight the PPE.
- 4) Large group discussion to highlight the imitations of drapes (when they don’t work).
- 5) Appropriate use of drapes.
- 6) Demonstration: How to make PPE using locally available supplies (aprons, face shields, etc.).

Handout: (H9.5)

Activity: (A9.5a), (A9.5b)

USING PROTECTIVE BARRIERS (PPE)

HANDOUT (H-9.5)



Activity (A9.5a)

Personal Protective Equipment (PPE)

Objective: Identify how healthcare workers can decrease risk of exposure to blood and body fluid.

Discussion: Show different pictures of PPE to participants and ask them to identify the PPEs used and which could have been used.

Other barriers: Whom do they protect?

Limitations of drapes (when they don’t work)

Appropriate use of drapes Demonstration: How to make PPE using locally available supplies (aprons, face shields, etc.).



WEARING GLOVES AND OTHER PROTECTIVE ATTIRE:

It is important to understand when sterile or high-level disinfected surgical gloves are required and, equally important, when they are not, can reduce costs while maintaining safety for both clients and staff.

SELF-PROTECTION OF HEALTH CARE PROVIDERS

- 1) All doctors, nurses, and other health providers must wear proper gloves during all procedures involving contact with any patients and biological fluids.
- 2) Cleaners and other staff working in sluice rooms and laundries should wear protective heavy-duty gloves and gumboots while cleaning and handling other soiled materials and linen.
- 3) The staff should wear utility gloves when handling and transporting waste and should wash the gloves as well as their hands when finished.
- 4) For female sterilizations, all medical personnel working in the OT must change their shoes, wear theatre gowns/short-sleeved shirts, pyjamas, caps, masks, and surgical gloves.
- 5) For vasectomy procedures that are not done in the OT, all medical personnel must at least wear caps, masks, and surgical gloves.
- 6) Operating surgeons should have short and clean fingernails and should remove all jewellery. The surgical mask should always cover the bridge of the nose.
- 7) Do not use torn or cracked gloves.

WHEN TO WEAR GLOVES

- 1) Gloves should be worn by all staff prior to contact with blood and body fluids from any client.
- 2) A separate pair of gloves must be used for each client to avoid cross-contamination.
- 3) All health workers should wear gloves prior to contact with blood and body fluids, both while providing services to a client (example: during pelvic examination and insertion / removal of IUCD), while handling infected equipment and materials).
- 4) Wear gloves for any procedure that risks touching blood, other body fluids, mucous membranes, broken skin, soiled items, dirty surfaces, or waste.
- 5) Wear surgical gloves for surgical procedures such as insertion of implants, IUCDs and mini laparotomy.
- 6) Wear single-use examination gloves for procedures that touch intact mucous membranes or generally to avoid exposure to body fluids.
- 7) Change gloves between procedures on the same client and between clients.
- 8) Do not touch clean equipment or surfaces with dirty gloves or bare hands.
- 9) Wash hands before putting on gloves. Gloves are not a substitute for hand washing.
- 10) Wear clean utility gloves when cleaning soiled instruments and equipment, handling waste, and cleaning blood or body fluid spills.
- 11) Gloves should be changed between each client to avoid cross contamination.
- 12) The type of gloves used while providing FP services include:
 - Single use/ re-usable gloves (high-level disinfected or sterile) for surgical procedures, insertion/removal of IUCD and pelvic examination.
 - Utility gloves (household gloves) for handling used instruments, cleaning blood and body fluids and handling wastes.



Activity (A9.5b)

ROLE PLAY: MANAGING A SHARPS INJURY

The trainer divides the group into two and task them to brainstorm sharp injuries and their management. Each group will have 10 minutes to prepare Group a Will present on a flip chart and group B will do a role play on “Managing a Sharps Injury.”

Role Play

The group B will decide

- 1) What type of injury was it?
- 2) What to do?
- 3) What is available to treat the injury?
- 4) How to manage “post exposure” to blood and body fluids at their facility?

The trainer then holds a large group discussion and gives feedback on presentations and role play

SAFE HANDLING OF HYPODERMIC NEEDLES AND SYRINGES:

Needle pricks, scalpels and suture needles are the leading source of penetrating injuries. Hypodermic (hollow bore) needles cause the most injuries to health care providers at all levels.

- 1) Surgeons and assistants are most often stuck by hypodermic needles during procedures.
- 2) Cleaning staff are most often stuck by needles when washing soiled instruments.
Housekeeping staff are most often stuck by needles when disposing of infectious waste material.

SAFE WORK PRACTICES:

- 1) Safe handling of sharp instruments during the operation requires using the ‘no touch technique’ by placing them on a small kidney tray.
- 2) Accidental needle-stick injuries occur mostly during the removal of the needle from the syringe or during cap replacement. Therefore, used needles should not be bent, broken, recapped, or removed from the syringe before disposal. Instead, the assembled needle and syringe should be discarded in a puncture-resistant container. If recapping is absolutely necessary, the cap should be held with a clamp while lacing it back over the needle or a one-handed technique should be used (while holding the syringe in one hand, scoop the cap off the flat surface with the needle, and then secure the cap on the needle with the other hand).

- 3) Immediately after use, sharp objects (such as needles, scalpel blades, suture needles, glass ampoules, etc.) should be disposed of in a puncture-resistant container with a lid made of either metal or heavy rigid plastic or cardboard. The container should be sealed and disposed of once three-fourths is filled, either by burying or incinerating.

SAFETY TIPS FOR USING HYPODERMIC NEEDLES AND SYRINGES

- 1) Use needle and syringe only once.
- 2) Do not disassemble the needle and syringe after use.
- 3) Do not recap, bend, or break needles prior to disposal.
- 4) Decontaminate the needle and syringe prior to disposal.
- 5) Dispose of the needle and syringe in a puncture-resistant container.

IF THE NEEDLE HAS TO BE RECAPPED, USE THE ONE-HANDED RECAP METHOD:

- 1) First, place the needle cap on a firm, flat surface; then remove your hand.
- 2) Next, with one hand holding the syringe, use the needle to “scoop” up the cap.
- 3) With the cap now covering the needle tip, turn the syringe upright (vertical) so that the needle and syringe are pointing towards the ceiling.
- 4) Finally, using the forefinger and thumb of your other hand, grasp the cap just above its open end and push the cap firmly down onto the hub (the place where the needle joins the syringe under the cap).

SHARPS CONTAINERS:

Using sharps disposal containers helps prevent injuries from sharps. Sharps containers should be fitted with a cover, and should be puncture-proof, leak-proof, and tamper-proof (difficult to open or break). If plastic or metal containers are unavailable, use containers made of dense cardboard (cardboard safety boxes) that meet WHO specifications. If cardboard safety boxes are unavailable, easily available objects can substitute as sharps containers:

- 1) Tin with a lid.
- 2) Thick plastic bottle.
- 3) Heavy plastic box.
- 4) Heavy cardboard box.

RECOMMENDATIONS FOR SAFE USE OF SHARPS CONTAINERS:

- 1) All sharps containers should be clearly marked "SHARPS" and have pictorial instructions for their use and disposal.
- 2) Place sharps containers away from high-traffic areas and as close as possible to where the sharps will be used.
- 3) Do not place containers near electric switches, overhead fans, or thermostat controls

where people might accidentally put one of their hands into them.

- 4) Attach containers to walls or other surfaces if possible. Position the containers at a convenient height so staff can use and replace them easily.
- 5) Never reuse or recycle sharps containers.
- 6) Mark the containers clearly so that people will not unknowingly use them as garbage receptacles.
- 7) Do not fill the safety box beyond three-quarters of its capacity.
- 8) Avoid shaking a container to settle its contents to make room for more sharps.
- 9) Appropriate waste disposal management.

SHARPS CONTAINERS: DO'S AND DON'TS

Sharps containers are a key component in minimizing injuries from disposable sharps—such as hypodermic needles, scalpels, and suture. When using sharps containers, either commercial or locally produced, here are some DO's and DON'Ts to consider:

DO'S

- DO put sharps containers as close to the point of use as possible and practical, ideally within arm's reach. Also, they should be easy to see, recognize and use.
- DO attach containers to walls or other surfaces if at all possible.
- DO mark them clearly so that people will not unknowingly use them as a garbage container or for discarding cigarettes.
- DO place them at a convenient height so staff can use and replace them easily.
- DO mark the fill line at the three quarters full level.

DON'TS

- DON'T shake a container to settle its contents and make room for more sharps.
- DON'T place containers in high traffic areas (corridors outside patient rooms or procedure rooms) where people could bump into them or be stuck by someone carrying sharps to be disposed of.
- DON'T place containers on the floor or anywhere they could be knocked over or easily reached by a child.
- DON'T place containers near light switches, overhead fans or thermostat controls where people might accidentally put their hand into them.

NEEDLE-STICK INJURIES:

Health care providers could be exposed to HIV through needle sticks or through contact with mucous membranes or broken skin.

- 1) The risk of infection is low (the average risk of HIV infection after a needle-stick exposure to HIV-positive blood is only three infections per 1,000 needle sticks).
- 2) Needle sticks or cuts cause most infections in health care settings. The average risk of HIV infection after a needle-stick exposure to HIV-infected blood is 3 infections per 1,000 needle sticks.
- 3) The risk after exposure of the eye, nose, or mouth to HIV-infected blood is estimated to be about 1 infection per 1,000 exposures. Following universal precautions is the best way that providers can avoid workplace exposure to HIV and other fluid-borne infections. Post-exposure prophylaxis (PEP) with antiretroviral medicines will help to prevent HIV infection if a needle stick might have exposed a provider to HIV.

INDIVIDUALS WHO ARE MOST LIKELY TO GET NEEDLE-STICK INJURIES ARE THE FOLLOWING:

- 1) Surgeons, who are most often stuck by needles in theatre by accidentally sticking themselves during suturing.
- 2) Nurses, who are most often stuck by needles in hospitals, either by accidentally sticking themselves while handling hypodermic needles and syringes or being accidentally stuck by surgeons.
- 3) Cleaning and housekeeping staff, when processing soiled instruments or disposing of waste material such as used needles.
- 4) In the event of a needle-stick injury, PEP should be initiated as soon as possible as prescribed in the National guidelines for Post- Exposure Prophylaxis, and preferably within 26-36 hours after injury.
- 5) Make infection prevention a habit, and always follow universal precautions to avoid workplace exposure to HIV and other fluid- borne infections.

CLEANING UP INFECTIOUS SPILLS:

- 1) Clean spills immediately.
- 2) Always wear gloves.
- 3) Small spills: clean with cloth soaked in chlorine solution.
- 4) Large spills: cover spill with 0.5% chlorine, mop up, and clean again with disinfectant.

IF EXPOSED:

- 1) If exposure caused a bleeding wound, allow to bleed briefly.
- 2) Immediately flush area with clean water.
- 3) Wash wound and skin thoroughly, flush mucous membranes.
- 4) Determine exposure risk.
- 5) Give post-exposure prophylaxis, when available.
- 6) Consult an infectious-disease specialist.

SESSION 6

TITLE: STEPS IN INSTRUMENT PROCESSING

(30 MINUTES)

OUTLINE & OBJECTIVES:

To highlight various techniques and levels of Instrument Processing.

METHODOLOGY:

- 1) Group discussion to know various methods known to the group
- 2) Power point presentation to discuss decontamination, HLD and sterilization

Handout: (H9.6)

Activity: (A9.6)

Job Aid: (J9.6)

STEPS IN INSTRUMENT PROCESSING

HANDOUT (H-9.6)

The four steps in processing are:

- 1) Decontamination.
- 2) Cleaning.
- 3) High-Level disinfection or sterilization.
- 4) Storage.

Steps of Processing Instruments

Decontaminate:

To kill infectious organisms such as HIV and hepatitis B and to make instruments, gloves, and other objects are safer for people who clean them. Soak in 0.5% chlorine solution for 10 minutes. Rinse with clean cool water or clean immediately.

Clean:

To remove body fluids, tissue, and dirt, wash or scrub with a brush with liquid soap or detergent and water. Avoid bar soap or powdered soap, which can stay on the equipment. Rinse and dry. While cleaning, wear utility gloves and personal protective equipment, goggles, mask, apron, and enclosed shoes.

High-level disinfect or sterilize:

High-level disinfect to kill all infectious organisms except some bacterial endospores (a dormant, resistant form of bacteria) by boiling, by steaming, or with chemicals. High-level disinfect instruments or supplies that touch intact mucous membranes or broken skin, such as vaginal specula, uterine sounds, and gloves for pelvic examinations.

Sterilize:

To kill all infectious organisms, including bacterial endospores, with a high-pressure steam autoclave, a dry-heat oven, chemicals, or radiation. Sterilize instruments such as scalpels and needles that touch tissue beneath the skin. If sterilization is not possible or practical (for example, for laparoscopes), instruments must be high-level disinfected

Store

Instruments and supplies to protect them from contamination. They should be stored in a high-level disinfected or sterilized container in a clean area away from clinic traffic. The equipment used to sterilize and high-level disinfect instruments and supplies also must be guarded against contamination.

PROCESSING EQUIPMENT AND OTHER ITEMS:

Processing of equipment that are re-used prevents spread of infections, through these items, to clients as well as to providers.

A 0.5% dilution of chlorine is the standard disinfectant for materials and surfaces contaminated by blood or body fluids as recommended by the World Health Organization.

LOW LEVEL DISINFECTION (DECONTAMINATION):

Is the first step in processing instruments which kills many microorganisms making instruments and other items safer to handle by staff who clean them. Chlorine is the cheapest, most universally available disinfectant, prepare in a plastic bucket with lid. Place all used instruments and reusable gloves in it and soak for 10 minutes and rinse immediately. Wipe surfaces (exam tables) with chlorine solution. The prepared solution can last for 24 hours.

PREPARING 0.5 % CHLORINE SOLUTION:

You can use any type of bleach, no matter what the concentration, to make a 0.5% chlorine solution by using the following formula:

$$[\% \text{ active chlorine in liquid bleach} \div 0.5\%] - 1 = \text{Parts of water for each part bleach}$$

Note that “parts” can be used for any unit of measure (e.g. ounce, litre or gallon) and need not even represent a defined unit of measure (e.g. a pitcher or container may be used).

HIGH LEVEL DISINFECTION (HLD):

High Level Disinfection (HLD) is the process of complete elimination of all microorganisms in or on a device, except for small numbers of bacterial spores.

WAYS OF HIGH-LEVEL DISINFECTION:

- 1) Boiling
- 2) Chemicals
 - Chlorine Solution
 - 2% Glutaraldehyde

HIGH-LEVEL DISINFECTION BY BOILING:

Boil instruments for 20 minutes. Always boil in pot with lid. Start timing when water begins to boil. Do not add anything to pot after timing begins. Air dry before use or storage.

HIGH-LEVEL DISINFECTION WITH CHEMICAL-BLEACH:

A. CHLORINE SOLUTION:

- 1) If boiled water is used to make the solution, 0.1% chlorine may be used for HLD.
- 2) If not, one should use 0.5% solution.
- 3) The contact time required is 20 minutes.
- 4) After disinfection, instruments should be thoroughly rinsed with boiled water and then air-dried or dried with a sterile cloth before use.
- 5) The shelf life of prepared solution is one week.
- 6) Soak instruments for 20 minutes.
- 7) Rinse with boiled and cooled water.
- 8) Air dry before use or storage.

B. 2% CHEMICAL-GLUTARALDEHYDE (CIDEX):

- 1) It must be prepared according to the manufacturer's instructions
- 2) activated 2% solution in a covered container has a shelf life of two weeks
- 3) The contact time is 20 minutes
- 4) As glutaraldehyde forms a residue on instruments, which is toxic to tissues, the instruments must be rinsed thoroughly with sterile water and dried with a sterile cloth before use.

WASTE DISPOSAL:

Waste segregation is the first step by using color coding system

- 1) Domestic waste, like wrappers, newspapers, papers etc.

- 2) Clinical
- 3) Sharps
- 4) Chemicals
- 5) Solid waste

HOUSEKEEPING:

- 1) Everything in the clinic should be clean and dry.
- 2) Use 0.5% chlorine solution or soapy water for cleaning.
- 3) Clean ceiling first, floor last.
- 4) A damp mop works better than dry dusting.
- 5) Use detergents and disinfectants.
- 6) Clean tables between uses.
- 7) Clean floors and equipment when visibly contaminated and at end of day.
- 8) Housekeeping staff are at a high risk of exposure to blood, used sharps and other contaminated objects.

IP PRINCIPLES:

- 1) All equipment should be cleaned regularly.
- 2) Equipment that will contact only intact skin requires cleaning and low-level disinfection.
- 3) Equipment having contact with mucous membranes requires cleaning and high-level disinfection.
- 4) Instruments that penetrate skin or mucosal membranes must be cleaned and then sterilized.

1- DECONTAMINATION:

This is the first step in treating instruments and objects that have come in contact with blood and body fluids to make them safer for handling by personnel before cleaning them. Proper decontamination inactivates the HIV and hepatitis viruses.

Immediately after use, place instruments and other items, such as gloves, in a clean large plastic bucket containing 0.5% chlorine solution for 10 minutes, this effectively decontaminates them. This kills many microorganisms making instruments and other items safer to handle by staff who clean them.

- 1) Chlorine is the cheapest, most universally available disinfectant.
- 2) Prepare solution in a plastic bucket with lid.
- 3) Place all used instruments and reusable gloves in it.
- 4) Soak for 10 minutes and rinse immediately.
- 5) Wipe surfaces (exam tables) with chlorine solution.
- 6) The prepared solution can last for 24 hours but will need to be changed earlier if becomes hazy.

PREPARATION OF CHLORINE SOLUTION:

The 0.5% chlorine solution can be prepared by adding one part of concentrated household bleach (sodium hypochlorite solution, 5% available chlorine) to nine parts of water.

The general formulas for making a dilute solution from a commercial preparation of any given concentration is as follows:

Formula 1:

Concentration of bleach times 2 -1 =Parts of water required

EXAMPLE: Concentration of available Chlorine solution is 5%

5 times 2-1 = 9

Formula 2:

% concentration /% dilution needed -1 = Total parts of water

EXAMPLE: to make a 0.5% dilute solution of chlorine from 5% concentrated liquid household bleach = $[5.0\%/0.5\%] -1 = 10-1 = 9$ parts of water; hence add one part of concentrated bleach to nine parts of water.

FOR CHLORINE POWDER:

If one is using commercially available dry powder chlorine, use the following formula to calculate the amount (in grams) of dry powder required to make 0.5% chlorine solution:

[% dilution needed /% concentrate] x 1000 = Grams of Chlorine powder per litre of water

For example, to make a 0.5% dilute chlorine solution from a dry powder of 35% calcium hypochlorite = $[0.5\%/35\%] \times 1000 = 14.2$ g.

Hence add 14.2 grams of dry powder to 1 litre of water or 142 grams to 10 litres of water.

Precautions:

- 1) Turn off the fan.
- 2) Wear gloves, cap, mask, and eyeglasses to avoid splashing in eyes and preventing irritating effects.
- 3) Always use plastic containers and spoons.
- 4) Make fresh solution, every day; discard the solution if it becomes cloudy.
- 5) Do not expose the solution to direct sunlight.
- 6) The instruments should not be left in dilute bleach for more than 10 minutes and should be cleaned in boiled water immediately after decontamination to prevent discoloration and corrosion of metal.

Steps of Preparation:

- 1) Calculate the amount of water and bleach. Put the calculated parts of clean tap water in a plastic container.
- 2) Add calculated parts of liquid bleach/powder (when preparing with powder, add small amount of water to make the paste and then add the rest of the water).
- 3) Stir well.

2- CLEANING

Cleaning is a crucial step that helps reduce the number of organisms and endospores (such as tetanus) on the instruments and other objects. Cleaning is a crucial step in providing safe, infection-free instruments. Vigorous manual cleaning with running water and liquid soap or detergent removes biological material such as blood, body fluids and tissue remnants. Instruments should be cleaned as soon as possible after use. If biological material is left behind, it can act as a sanctuary for residual microorganisms, protecting them from the effects of disinfection and sterilization.

A thorough cleaning using a soft brush and detergent followed by rinsing helps to physically remove tissues and blood. Organic matter such as blood and tissues trap microorganisms that make it difficult to kill them during high- level disinfection or sterilization. They also inactivate some of the disinfectants making them less effective.

Soapy solution should be made using a detergent (not soap) in lukewarm water. Do not use powders or cakes that are used for scrubbing

Method of Cleaning:

Thorough manual cleaning of instruments with water and detergent to remove all organic material, after decontamination in 0.5% chlorine solution for 10 minutes, is of the utmost importance before to sterilization or HLD. A brush should be used to scrub the instruments free of biological matter. Instruments should be cleaned as soon as possible after use, so that no organic material will dry and stick to the instruments, providing a sanctuary for microbes. The person cleaning should use utility gloves while washing instruments.

Protective glasses or goggles should be worn by the cleaners to protect their eyes from contaminated water. Special attention should be given to instruments with teeth (e.g., biopsy punches), joints and screws (e.g., vaginal specula), to which biological material can become stuck. After cleaning, rinse the instruments thoroughly with boiled water to remove detergent residue.

3A-HIGH-LEVEL DISINFECTION:

- 1) High-level disinfection is effective in destroying microorganisms (including the HIV and hepatitis viruses). The process does not kill endospores. This is the only acceptable alternative when sterilization is not possible.
- 2) High-level disinfection is appropriate for items that do not come in touch with blood stream or tissues under the skin (such as instruments and gloves used for pelvic examination, IUCD insertion).
- 3) The pre-requisite for high-level disinfection is that all instruments and objects that have to be high-level disinfected must be first decontaminated with chlorine solution, cleaned and air-dried.

Types of high-level disinfection:

1. Boiling
2. Chemicals
 - Chlorine Solution
 - Glutaraldehyde

HIGH-LEVEL DISINFECTION BY BOILING:

Boiling plain tap water in a clean vessel offers a cheap and readily accessible form of HLD. The contact time for instruments should be at least 20 minutes after boiling has started. Water in the boiler or the pot should be changed daily. The vessel should be washed and kept dry every day.

- 1) Boil instruments for 20 minutes.
- 2) Always boil in pot with lid.
- 3) Start timing when water begins to boil.
- 4) Do not add anything to pot after timing begins.
- 5) Air dry before use or storage.

CHEMICAL DISINFECTION:

Chemical agents such as 2% glutaraldehyde (Cidex), 0.1% chlorine, and formaldehyde, provide high-level disinfection. The most recommended is 2% glutaraldehyde as it is less toxic and irritating and does not corrode metal. Chemical disinfection is not recommended for needles and syringes, as it is difficult to rinse them effectively. Change chlorine solution daily.

HIGH-LEVEL DISINFECTION BY CHLORINE:

0.1% Chlorine solution is used. If boiled water is used to make the solution, 0.1% chlorine may be used for HLD. If not, one should use 0.5% solution. The contact time required is 20 minutes. The solution is very corrosive to stainless steel. After disinfection, instruments should be

thoroughly rinsed with boiled water and then air-dried or dried with a sterile cloth before use.

Chlorine solution:

- 1) If boiled water is used to make the solution, 0.1% chlorine may be used for HLD.
- 2) If not, one should use 0.5% solution.
- 3) The contact time required is 20 minutes.
- 4) After disinfection, instruments should be thoroughly rinsed with boiled water and then air-dried or dried with a sterile cloth before use.
- 5) Rinse with boiled and cooled water.
- 6) Air dry before use or storage.

HIGH-LEVEL DISINFECTION WITH CHEMICAL 2 % GLUTARALDEHYDE (CIDEX):

Activated 2% solution in a covered container has a shelf life of two weeks. The contact time is 20 minutes. As glutaraldehyde forms a residue on instruments, which is toxic to tissues, the instruments must be rinsed thoroughly with sterile water and dried with a sterile cloth before use.

- 1) It must be prepared according to the manufacturer's instructions.
- 2) The activated 2% solution in a covered container has a shelf life of two weeks
- 3) The contact time is 20 minutes.
- 4) As glutaraldehyde forms a residue on instruments, which is toxic to tissues, the instruments must be rinsed thoroughly with sterile water and dried with a sterile cloth before use.
- 5) To protect yourself from exposure to glutaraldehyde use local exhaust ventilation and use a fume hood where possible.
- 6) Avoid contact with the skin by using nitrile or rubber gloves (latex does not provide adequate protection).
- 7) Always wear appropriate Personal Protective Equipment (PPE) when handling any High-Level Disinfectant.
- 8) Wear goggles and face shields when handling.

3B -STERILIZATION

Sterilization is defined as the process of destroying all microorganisms including endospores on an instrument by exposure to physical or chemical agents. This process kills all forms of microbial life including bacterial spores. In practice, sterility is achieved if the probability of a surviving microorganism is less than one in a million. The sterilization process is fundamental for the safe reuse of instruments in clinical care. It is appropriate for all objects entering the blood vessel. The pre-requisite for sterilization is that all instruments and objects that have to be sterilized must be first decontaminated with chlorine solution, cleaned, and air-dried.

Types of Sterilization:

STEAM STERILIZATION (AUTOCLAVE):

- 1) Clean instruments are opened (forceps and scissors) and double wrapped before autoclave
- 2) Wrapped items are labelled with processing date, initials of team member, content or wrap and date of sterile expiration
- 3) 121⁰C(250⁰F) -133⁰C; 106 kPa (26 lbs./in²) pressure: 20 minutes for unwrapped items, 30 minutes for wrapped items
- 4) Items are removed using sterile pickups and placed on a sterile surface to cool
- 5) Allow all items to dry before removing

DRY-HEAT (OVEN):

- 1) 170⁰C (340⁰F) for 1 hour, or 160⁰C (320⁰F) for 2 hours

CHEMICAL STERILIZATION:

- 1) Soak items in glutaraldehyde for 10 hours.
- 2) Rinse with normal saline or boiled and cooled water.

4-STORAGE OF STERILE AND DISINFECTED ITEMS:

Proper storage is as critical as sterilizing or high-level disinfection:

- 1) Sterile items should be stored in closed containers, properly labelled, away from contaminated areas.
- 2) The sterile items should be handled properly so that they do not get contaminated.
- 3) Sterile containers should not be left on the floor and should be stored in enclosed cabinets to protect from dust and other contaminants.



Storage

- 1) Stored in a sterile container for a maximum of seven days.
- 2) Once opened, content must be used within 24 hours or re-processed.
- 3) Stored packs are kept in dry and closed place.
- 4) Packs are clearly labelled with the date of processing.



Activity (A9.6)

Use the power point slide to play this game to fill the chart through brainstorming by the participants.

Processing instruments and other items for various family planning procedures.

Initially only show the first column, ask the participants to help fill the middle and the last columns. At the end, the trainer will show the full row, so as to clarify the answers in an interactive way.

Instruments/Object	Decontaminate	Clean	Sterilize or High-level Disinfection
Metal instruments for IUCD insertion/ removal and pelvic examination	Soak in 0.5% chlorine for 10 minutes before cleaning	Wear gloves and clean with soap and water until clean. Rinse and air-dry	Sterilize (preferred, not mandatory) Boil for at least 20 minutes or soak for 20 to 30 minutes in 2% glutaraldehyde, then rinse with boiled water

Metal containers for storing instruments and Cheatle forceps	Soak in 0.5% chlorine for 10 minutes before cleaning	Wear gloves and clean with soap and water until clean. Rinse.	Boil for 20 minutes once a week Autoclave or soak interior surface for 20-30 minutes in any disinfectant and rinse
Pelvic examination tabletop	Wearing gloves, wipe the top with 0.5% chlorine solution	NA	NA

HOUSE KEEPING:

Housekeeping staff are at a high risk of exposure to blood, used sharps and other contaminated objects.

- 1) Everything in the clinic should be clean and dry.
- 2) Use 0.5% chlorine solution or soapy water for cleaning.
- 3) Clean ceiling first, floor last.
- 4) A damp mop works better than dry dusting.
- 5) Use detergents and disinfectants.
- 6) Clean tables between uses.
- 7) Clean floors and equipment when visibly contaminated and at end of day.

INFECTION PREVENTION IN THE CLINIC:

Infection-prevention procedures are simple, effective, and inexpensive. Germs (infectious organisms) of concern in the clinic include bacteria (such as staphylococcus), viruses (particularly HIV and hepatitis B), fungi, and parasites. In the clinic, infectious organisms can be found in blood, body fluids with visible blood, and tissue. (Faeces, nasal secretions, saliva, sputum, sweat, tears, urine, and vomit are not considered potentially infectious unless they contain blood.) The organisms can be passed through mucous membranes or broken skin, such as cuts and scratches, and by needle sticks with used needles and other puncture wounds. Infectious organisms can pass from clinics to communities when waste disposal is not proper, or staff members do not wash their hands properly before leaving the clinic.

Risk of HIV Infection in the Clinic

Health care providers may be exposed to HIV through needle sticks, mucous membranes, or broken skin, but the risk of infection is low.

Needle sticks or cuts cause most infections in health care settings. The average risk of HIV infection after a needle-stick exposure to HIV-infected blood is 3 infections per 1,000 needle sticks.

The risk after exposure of the eye, nose, or mouth to HIV-infected blood is estimated to be about 1 infection per 1,000 exposures.

Following universal precautions is the best way that providers can avoid workplace exposure to HIV and other fluid-borne infections. Post-exposure prophylaxis (PEP) with antiretroviral medicines will help to prevent HIV infection if a needle stick might have exposed a provider to HIV.

Basic Rules of Infection Prevention

Job Aid (J9.6)

These rules apply the universal precautions for infection prevention to the family planning clinic.

<p>Wash hands</p>	<p>Hand washing may be the single most important infection-prevention procedure.</p> <ol style="list-style-type: none"> 1. Wash hands before and after examining or treating each client. (Hand washing is not necessary if clients do not require an examination or treatment). 2. Use clean water and plain soap and rub hands for at least 10 to 15 seconds. 3. Be sure to clean between the fingers and under fingernails. 4. Wash hands after handling soiled instruments and other items or touching mucous membranes, blood, or other body fluids. 5. Wash hands before putting on gloves, after taking off gloves, and whenever hands get dirty. Wash hands when you arrive at work, after you use the toilet and when you leave work. 6. Dry hands with a paper towel or a clean, dry cloth towel that no one else uses, or air-dry. 7. If clean water and soap are not available, a hand sanitizer containing at least 60% alcohol can reduce the number of germs on the hands. 8. Sanitizers do not eliminate all types of germs and might not remove harmful chemicals.
<p>Process instruments that will be reused</p>	<ol style="list-style-type: none"> 1. High-level disinfect or sterilize instruments that touch intact mucous membranes or broken skin. 2. Sterilize instruments that touch tissue beneath the skin.

<p>Wear gloves</p>	<ol style="list-style-type: none"> 1. Wear gloves for any procedure that risks touching blood, other body fluids, mucous membranes, broken skin, soiled items, dirty surfaces, or waste. Wear surgical gloves for surgical procedures such as insertion of implants. 2. Wear single-use examination gloves for procedures that touch intact mucous membranes or generally to avoid exposure to body fluids. Gloves are not necessary for giving injections. 3. Change gloves between procedures on the same client and between clients. 4. Do not touch clean equipment or surfaces with dirty gloves or bare hands. 5. Wash hands before putting on gloves. Do not wash gloved hands instead of changing gloves. 6. Gloves are not a substitute for hand washing. 7. Wear clean utility gloves when cleaning soiled instruments and equipment, handling waste, and cleaning blood or body fluid spills.
<p>Do pelvic examinations only when needed</p>	<ol style="list-style-type: none"> 1. Pelvic examinations are not needed for most family planning methods—only for female sterilization, the IUCD, diaphragm, and cervical cap. 2. Pelvic examinations should be done only when there is a reason—such as suspicion of sexually transmitted infections, when the examination could help with diagnosis or treatment.
<p>For injections, use new auto-disable syringes and needles</p>	<ol style="list-style-type: none"> 1. Auto-disable syringes and needles are safer and more reliable than standard single-use disposable syringes and needles. 2. Any disposable syringes and needles are safer than sterilizing reusable syringes and needles. 3. Cleaning the client’s skin before the injection is not needed unless the skin is dirty. If it is, wash with soap and water and dry with a clean towel. 4. Wiping with an antiseptic has no added benefit.
<p>Wipe surfaces with chlorine solution</p>	<ol style="list-style-type: none"> 1. Wipe examination tables, bench tops, and other surfaces that come in contact with unbroken skin with 0.5% chlorine solution after each client.

<p>Dispose of single use equipment and supplies properly and safely</p>	<ol style="list-style-type: none"> 1. Use personal protective equipment—goggles, mask, apron, and closed protective shoes, when handling wastes. 2. Needles and syringes meant for single use must not be reused. 3. Do not take apart the needle and syringe. 4. Used needles should not be broken, bent, or recapped. Put used needles and syringes immediately into a puncture-proof container for disposal. 5. The puncture-proof sharps container should be sealed and either burned, incinerated, or deeply buried when three-fourths full. 6. Dressings and other soiled solid waste should be collected in plastic bags and within 2 days, burned and buried in a deep pit. 7. Liquid wastes should be poured down a utility sink drain or a flushable toilet or poured into a deep pit and buried. 8. Clean waste containers with detergent and rinse with water. 9. Remove utility gloves and clean them whenever they are dirty and at least once every day. 10. Wash hands before and after disposing of soiled equipment and waste.
<p>Wash linens</p>	<ol style="list-style-type: none"> 1. Wash linens (for example, bedding, caps, gowns, and surgical drapes) by hand or machine and line-dry or machine-dry. 2. When handling soiled linens, wear utility gloves, hold linens away from your body, and do not shake them.

SESSION 7

TITLE: SHARP AND WASTE DISPOSAL

(30 MINUTES)

OUTLINE & OBJECTIVES:

- 1) Explain the three main objectives of waste management.
- 2) Identify types of waste and proper disposal.
- 3) Discuss methods used to handle contaminated and non-contaminated waste.
- 4) Describe simple, inexpensive incinerators and burial sites.
- 5) Discuss some of the problems of waste removal.

METHODOLOGY:

- 1) Group work
- 2) Brainstorming to find out how much the participants know of their own facilities and what an ideal waste disposal means

3) Power point presentation and discussion

Handout: (H9.7)

Activity: (A9.7a), (A9.7b)

Job Aid: (J9.7a), (J9.7b), (J9.7c), (J9.7d), (J9.7e)

WASTE DISPOSAL

HANDOUT (H-9.7)



Activity (A9.7a)

The trainer conducts a brain storming session by inviting volunteers to describe and share the waste disposal practices in their places of work

WASTE DISPOSAL

Types of Wastes

DOMESTIC

- Wrappers
- Newspapers
- Papers etc.

CLINICAL

- Sharps
- Chemicals
- Solid waste

Waste from hospitals and health care facilities may be contaminated (potentially infectious) or non-contaminated. Contaminated wastes include blood, pus, urine, stool, and other body fluids,

as well as items that come in contact with them, such as used dressings. Wastes from operating rooms (human tissue, blood or blood-soaked sponges, gauze, or cotton) and laboratories (blood, faeces, sputum, urine specimens, and microbiological cultures) should be considered contaminated. Soiled medical devices or items that can inflict injury (e.g., used needles and scalpel blades) can spread blood-borne diseases such as hepatitis B, hepatitis C, and AIDS and are also considered contaminated waste.

PURPOSE OF WASTE MANAGEMENT:

- 1) Protect people who handle waste items from accidental injury.
- 2) Prevent the spread of infection to health care providers who handle the waste.
- 3) Prevent the spread of infection to the local community.

Open piles of waste should be avoided because they:

- 1) Are risks to those who scavenge and unknowingly reuse contaminated items.
- 2) Allow persons to accidentally step on sharp items and injure themselves.
- 3) Produce foul odours.
- 4) Attract insects and animals.

HANDLING OF CONTAMINATED WASTE:

- 1) Proper handling of contaminated waste minimizes the spread of infection to health care personnel and to the local community.
- 2) Whenever possible, contaminated waste should be collected and transported to disposal sites in leak-proof, covered waste containers.
- 3) Use plastic or galvanized metal containers with tight-fitting covers for contaminated wastes.
- 4) Many facilities now use colour-coded plastic bags to alert handlers to the contents and to keep the general (non-contaminated) waste separate from contaminated waste. Use puncture-resistant sharps containers for all disposable sharps (sharps that will not be reused).
- 5) Place waste containers close to where the waste is generated and where convenient for users (carrying waste from place to place increases the risk of infection for handlers). This is especially important for sharps, which carry the highest risk of injury for health care providers.
- 6) Equipment that is used to hold and transport wastes must not be used for any other purpose in the clinic or hospital. (Contaminated waste containers should be marked.)
- 7) Wash all waste containers with a disinfectant cleaning solution (0.5 percent chlorine solution plus soap) and rinse with water regularly. When possible, use separate containers for combustible and non-combustible wastes prior to disposal. This step prevents workers from having to handle and separate wastes by hand later.

- 8) Use PPE when handling wastes (e.g., heavy-duty utility gloves and closed protective shoes). Wash hands or use a waterless, alcohol-based antiseptic hand rub after removing gloves when handling wastes.

DISPOSAL OF SHARPS:

Disposal of sharp items (hypodermic needles, suture needles, razors, and scalpel blades) require special handling because they are the items most likely to injure health care providers who handle them as well as people in the community if these items go to the municipal landfill.



Figure 1

ENCAPSULATION:

Encapsulation is recommended as the easiest way to safely dispose of sharps. Sharps are collected in puncture-resistant and leak-proof containers. When the container is three-quarters full, a material such as cement (mortar), plastic foam, or clay is poured into the container until it is completely filled. After the material has hardened, the container is sealed and may be land-filled, stored, or buried. It is also possible to encapsulate chemical or pharmaceutical waste together with sharps.

Steps for the Disposal of Sharps

Job Aid (J9.7a)

Steps for the Disposal of Sharps	
Step 1	Do not recap needle or disassemble needle and syringe
Step 2	After use, hold the needle tip under the surface of a 0.5 percent chlorine solution, fill the syringe with solution, and push out (flush) three times.
Step 3	Place assembled needles and syringes to be disposed of in a puncture-resistant sharps container such as a heavy cardboard box, plastic bottle, or tin can with lid. The opening in the lid should be large enough so that items can be easily dropped through it, but small enough that nothing can be removed from inside. (Old intravenous fluid bottles may also be used, but they can break.)
Step 4	When the container is three-quarters full, it should be removed from the procedure area for disposal.

Job Aid (J9.7b)

Disposing of the Sharps Container	
Step 1	Wear heavy-duty utility gloves.
Step 2	When the sharps container is three-quarters full it should be capped, plugged, or taped tightly closed. Be sure that no sharp items are sticking out of the container.
Step 3	Dispose of the sharps container by burning, encapsulating, or burying.
Step 4	Remove utility gloves (wash daily or when visibly soiled, and dry).
Step 5	Wash hands and dry them with a clean cloth or towel or air dry. (Alternatively, if hands are not visibly soiled, apply 5 ml, about 1 teaspoonful, of an antiseptic hand rub and rub the solution vigorously onto hands until dry.)

How to Dispose of Solid Contaminated Waste

Job Aid (J9.7c)

How to Dispose of Solid Contaminated Waste	
Step 1	Wear heavy-duty or utility gloves when handling and transporting solid wastes.
Step 2	Dispose of solid wastes by placing them in a plastic or galvanized metal container with a tight-fitting cover.
Step 3	Collect the waste containers on a regular basis and transport the burnable ones to the incinerator or another area for burning.
Step 4	Remove utility gloves (wash daily or when visibly soiled and dry)
Step 5	Wash and dry hands or use an antiseptic hand rub as described above.

INCINERATION:

Incineration is a high-temperature process that reduces the volume and weight of waste. This process is usually selected to treat waste that cannot be recycled, reused, or disposed of in a sanitary landfill or dumpsite. Incinerators can range from extremely sophisticated, high-temperature ones to very basic units that operate at much lower temperatures. All types of incinerators, if operated properly, eliminate micro-organisms from waste and reduce it to ashes.

Four basic types of incinerators are used for treating waste:

- 1) Double-chamber, high-temperature incinerators are designed to burn infectious waste.
- 2) Single-chamber, high-temperature incinerators are less expensive and are used when double-chamber incinerators are not affordable.
- 3) Rotary kilns operate at high temperatures and are used for destroying cytotoxic substances and heat-resistant chemicals.
- 4) Drum or brick (clay) incinerators operate at lower temperatures and are less effective but can be made locally using readily available materials. Open burning is not recommended because it is dangerous, unsightly, and the wind will scatter the waste. For health care facilities with limited resources and where high-temperature incinerators are not affordable, waste may be incinerated in a drum incinerator. A drum incinerator is the simplest form of single-chamber incinerator. It can be made inexpensively and is better than open burning.

How to Build and Use a Simple Drum Incinerator for Waste Disposal

Job Aid (J9.7d)

Step 1	Where possible, select a site downwind from the clinic.
Step 2	Build a simple incinerator using local materials (mud or stone) or a used oil drum (e.g., a 55-gallon drum). The size depends on the amount of daily waste collected.
Step 3	Make sure the incinerator has: <ul style="list-style-type: none">a) Sufficient air inlets underneath for good combustion.b) Loosely placed fire bars to allow for expansion.c) An adequate opening for adding fresh refuse and removing ashes.d) A long enough chimney to allow for a good draught and evacuation of smoke.
Step 4	Place the drum on hardened earth or a concrete base.
Step 5	Burn all combustible waste, such as paper and cardboard, as well as used dressings and other contaminated wastes. If the waste or refuse is wet, add kerosene so that a hot fire burns all of the waste. Ash from incinerated material can be treated as non-contaminated waste.

How to Make and Use a Small Burial Site for Waste Disposal

Job Aid (J9.7e)

Step 1	Find an appropriate location.
Step 2	Dig a pit 1-meter (3 feet) square and 2 meters (6 feet) deep. The bottom of the pit should be 2 meters (6 feet) above the water table.
Step 3	Dispose of the contaminated waste in the pit and cover the waste with 10–15 cm (4–6 inches) of dirt each day. The final layer of dirt should be 50–60 cm (20–24 inches) and compacted to prevent odours and attraction of insects, and to keep animals from digging up the buried waste. Depending on the volume of waste, the capacity of the pit should last for 30–60 days.

STEPS IN WASTE DISPOSAL:

1. SORTING THE WASTE:

- 1) Sharps to be collected in puncture-proof containers.
- 2) Burnable contaminated and non-contaminated wastes should be collected in covered buckets.
- 3) Human tissues and fluids collected in leak-proof containers.
- 4) Glass collected in separate container.
- 5) Place containers at convenient places so that the wastes need not be carried from one place to the other, which increases the risk of infection.

2. TRANSPORTATION OF WASTE:

- 1) Persons handling wastes should wear heavy-duty gloves to avoid injuries by accidental pricking.
- 2) The waste containers should be emptied when three quarters full or at least once daily. Transport in closed, leak proof containers to the disposal site.

3. DISPOSAL OF WASTE:

- 1) Contaminated waste should be incinerated (most preferred method), burned or buried. Ensure that the pit for burial is deep so that animals cannot dig it out and is at least 50 meters away from water source.
- 2) Wash all the waste containers especially the ones with contaminated waste with 0.5% chlorine and rinse with water.



Activity (A9.7b)

The trainer shows the left side of the column as a power point different and asks the participants to tell their disposal.

TYPES OF WASTE	FOR THE TRAINER
Paper towels, used	Paper basket, municipal waste
Small quantities of pharmaceutical waste (drugs or medicine)	Leak proof container/medical waste; incineration, encapsulation, or safe burial. This waste may also be discharged into the sewer (except cytotoxic and antibiotics) but should not be put into natural rivers, lakes, etc.
Surgical gloves, used	If they will be reprocessed: bucket with 0.5% chlorine solution; send for reprocessing.
	If they will be disposed of bucket with 0.5% chlorine solution and leak proof container/medical waste, incineration, burial, encapsulation.
Mercury from broken thermometer or sphygmomanometer	Put examination gloves on both hands, collect mercury drops with a spoon, place in a small container for re-use or disposal (send back to suppliers, encapsulation).
Thermometer, broken	If no mercury is present, sharp containers
Gauze with blood	Leak proof container/medical waste; incineration, safe burial
Glutaraldehyde (after 14 days of use)	Dilute with water and pour down a drain/utility sink or toilet, flushing with water if it goes to the sewer. Do not put down open drains.
Depo-Provera containers/vials, empty	Sharps container/medical waste. Incineration, safe burial, or encapsulation
Sharps container (¾ full but open)	Close and transport to the proper area for incineration, safe burial, or encapsulation.
Chlorine, 0.5% solution used for decontamination	Pour into a utility toilet, sink, or drain. Flush with water. If powder bleach was used to make the solution, flush with large amounts of water to prevent calcium precipitate from clogging drains.
Bleach bottle, empty	If plastic container: rinse three times with water and dispose of by burning, encapsulating, or burying. Can be reused as a sharp's container.
Bucket with plastic bag, ¾ full of medical waste	Close the container and transport it to the proper place for incineration, safe burial, or encapsulation.

HEALTH-CARE FACILITY RECOMMENDATIONS FOR STANDARD PRECAUTIONS BY WHO

1. HAND HYGIENE

Technique:

- Hand washing (40–60 sec): wet hands and apply soap; rub all surfaces; rinse hands and dry thoroughly with a single use towel; use towel to turn off faucet.
- Hand rubbing (20–30 sec): apply enough product to cover all areas of the hands; rub hands until dry.

Indications:

- Before and after any direct patient contact and between patients, whether or not gloves are worn.
- Immediately after gloves are removed.
- Before handling an invasive device.
- After touching blood, body fluids, secretions, excretions, non-intact skin, and contaminated items, even if gloves are worn.
- During patient care, when moving from a contaminated to a clean body site of the patient.
- After contact with inanimate objects in the immediate vicinity of the patient.

2. GLOVES

- Wear when touching blood, body fluids, secretions, excretions, mucous membranes, non-intact skin.
- Change between tasks and procedures on the same patient after contact with potentially infectious material.
- Remove after use, before touching non-contaminated items and surfaces, and before going to another patient.
- Perform hand hygiene immediately after removal.

3. FACIAL PROTECTION (EYES, NOSE, AND MOUTH)

- Wear a surgical or procedure mask and eye protection (eye visor, goggles)

OR

- A face shield to protect mucous membranes of the eyes, nose, and mouth during activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions

4. GOWN

- Wear to protect skin and prevent soiling of clothing during activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.
- Remove soiled gown as soon as possible, and perform hand hygiene.

5. PREVENTION OF NEEDLE STICK AND INJURIES FROM OTHER SHARP INSTRUMENTS

Use care when:

- Handling needles, scalpels, and other sharp instruments or devices.
- Cleaning used instruments.
- Disposing of used needles and other sharp instruments.

6. RESPIRATORY HYGIENE AND COUGH ETIQUETTE

Persons with respiratory symptoms should apply source control measures:

- Cover their nose and mouth when coughing/sneezing with tissue or mask, dispose of used tissues and masks, and perform hand hygiene after contact with respiratory secretions.
- Health-care facilities should:
- Place acute febrile respiratory symptomatic patients at least 1 metre (3 feet) away from others in common waiting areas, if possible.
- Post visual alerts at the entrance to health-care facilities instructing persons with respiratory symptoms to practise respiratory hygiene/cough etiquette.
- Consider making hand hygiene resources, tissues and masks available in common areas and areas used for the evaluation of patients with respiratory illnesses.

7. ENVIRONMENTAL CLEANING

- Use adequate procedures for the routine cleaning and disinfection of environmental and other frequently touched surfaces.

8. LINENS

Handle, transport, and process used linen in a manner which:

- Prevents skin and mucous membrane exposures and contamination of clothing.
- Avoids transfer of pathogens to other patients and or the environment.

9. WASTE DISPOSAL

- Ensure safe waste management.
- Treat waste contaminated with blood, body fluids, secretions and excretions as clinical waste, in accordance with local regulations.
- Human tissues and laboratory waste that is directly associated with specimen processing should also be treated as clinical waste.
- Discard single use items properly.

10. PATIENT CARE EQUIPMENT

- Handle equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of pathogens to other patients or the environment.
- Clean, disinfect, and reprocess reusable equipment appropriately before use with another patient.

SESSION 8

TITLE: Summarize and Wrap Up

(10 minutes)

Ask participants how they might use this information in their work in facilities or in the community.

FURTHER READING

- 1) <https://www.k4health.org/sites/default/files/infection%20prevention.pdf>
- 2) <http://reprolineplus.org/resources/infection-prevention-guidelines-healthcare-facilities-limited-resources-learning-package>

COMBINED ORAL CONTRACEPTIVES (COCS)



Time: 2 hours 30 minutes

Combined oral contraceptive pills contain low doses of two hormones, a progestin and an oestrogen, like the natural hormones progesterone and oestrogen in a woman's body.

The pills work primarily by preventing ovulation.



Training Objectives:

- 1) Describe classification, mechanism of action, efficacy, reversibility, advantages, and limitations, side-effects of the oral contraceptives, the warning signs and their management.
- 2) Identify the causes of failure encountered in use of COCs.
- 3) Describe medical eligibility criteria (MEC) for the use of COC pills.
- 4) Discuss the missed pills protocols.
- 5) Demonstrate counselling skills for women interested in using COCs.



Learning Outcomes:

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

- 1) Know mechanism of action, various types, efficacy, contraceptive and non-contraceptive advantages and limitations of the COCs
- 2) Used MEC confidently, in helping the woman choose the best suitable method for her
- 3) Understand the side effects of COCs and how to manage them
- 4) Demonstrate effective counselling skills in order for a woman or couple to understand their reproductive options, choose COCs and use the chosen method safely and effectively.
- 5) To dispel myths that discourage the uptake and continued use of COCs.
- 6) To deal with missed pill and their protocols



Training/ Learning Methods:

Designed to actively involve the trainees in the learning process, sessions include:

- 1) Interactive power point presentation
- 2) MEC wheel and Quick Reference Chart for the WHO MEC Criteria for Contraceptive use
- 3) Checklist for “How to Be Reasonably Sure a Woman is Not Pregnant”
- 4) Checklist for Screening Women Who Want to Initiate Combined Oral Contraceptives (includes questions from Pregnancy Checklist)



Advance Preparations:

- 1) Power point presentation
- 2) MEC chart
- 3) Checklist for screening clients who want to initiate COCs
- 4) Quick reference chart for the who medical eligibility criteria for contraceptive use
- 5) The WHO MEC wheel
- 6) Sample tablets



Constitution of Session:

1)	Introduction to Combined Oral Contraceptives (COCs)	Brainstorming/discussion	30 Mins
2)	Woman assessment and MEC	Group work /interactive discussion	40 Mins
3)	Common side effects and their management	Brainstorming / Lecture	30 Mins
4)	Missed pills and trouble shooting	Group work/Feed back	30 Mins
5)	FAQs	Group work /Role play	15 Mins
6)	Wrap up and Summary		5 Mins



Training Materials:

Trainer	Trainee
Hand Outs: H10.1, H10.2A, H10.2B, H10.3, H10.4, H10.5	Hand Outs: H10.1, H10.2A, H10.2B, H10.3, H10.4, H10.5
Activity: A10.1, A10.2a, A10.2b, A10.3, A10.4, A10.5	Job aid: J10.2a, J 10.2b, J10.2c J10.2B-1, J10.2B-2, J10.2B-3, J10.2B-4
Job aid: J10.2a, J10.2b, J10.2c J10.2B-1, J10.2B-2, J10.2B-3, J10.2B-4	

SESSION 1

TITLE: INTRODUCTION TO COMBINED ORAL CONTRACEPTIVES (COCS)

(30 MINUTES)

OUTLINE & OBJECTIVES:

To enable the learners to discuss mechanism of action, various types, efficacy, contraceptive and non-contraceptive advantages and limitations of COCs.

METHODOLOGY:

Brainstorming to enlist the advantages and limitations of COCs.

Various types, mechanism of action, brand names and limitations in small groups, followed by large group discussion.

Handout (H10.1)

Activity (A10.1)

INTRODUCTION TO COMBINED ORAL CONTRACEPTIVES (COCS)

HANDOUT (H-10.1)



ACTIVITY (A10.1)

Divide the participants in three groups. Each group is given a different task. One group is asked to write the types and mechanism of action of COCs and the other group to discuss advantages and efficacy. The third group is tasked to discuss side effects and limitations of COCs

Each group has ten minutes to finish the task, use the flip chart to write their response, should they so wish and choose a representative to present. Each presentation for 5 minutes is followed by a large group discussion moderated by the trainer. Any points left out in the previous discussion are highlighted

COMBINED ORAL CONTRACEPTIVE PILLS:

There are many different formulations of COCs, but the average pack is designed to be taken over a 28-day period. For the first 21 days of the cycle, the woman has to take a pill that contains hormones (oestrogen and progestogen). The last 7 days of the cycle are hormone free days. Some packets only contain 21 pills and users are then advised to take no pills for the following week. Other packets contain 7 additional placebo pills, or biologically inactive pills. Some newer formulations have 24 days of active hormone pills, followed by 4 days of placebo or even 84 days of active hormone pills, followed by 7 days of placebo pills. These are specially designed for women who do not wish to have a period every month.

Doses of component hormones also vary among products, and some pills are monophasic (delivering the same dose of hormones each day) while others are multiphasic (doses vary each day).

MONOPHASIC LOW-DOSE:

COCs contain 20 µg to 35 µg Ethinyl estradiol (EE) and progestogen-like Levonorgestrel (LNG) in all 21 “active tablets.” (“High-dose” COCs that contain 50 µg EE or more plus a high dose of progestogen are only used for special indications.) Each active pill contains the same amount of oestrogen and progestin.

BIPHASIC LOW-DOSE:

COCs contain two combinations of oestrogen and progestogen, for example, in a cycle of 21 active pills, 10 may contain one combination, while 12 contain another combination of the same.

TRIPHASIC LOW DOSE COCS:

Contain the same hormones but in three dose ratios. Out of a cycle of 21 active pills, six might contain one combination, five another combination, while 10 pills contain different combinations of the two hormones.

QUADRIPHASIC PREPARATIONS:

Include four different combinations of estradiol valerate (EV) and dienogest. Although Biphasic and Triphasic contraceptive pills are available in Pakistan they are not in common use. These guidelines address Monophasic pills only. The service provider should verify the types of COC that the woman is taking and give her appropriate instructions.

EFFICACY:

If used correctly and continuously, COCs are an effective method of contraception. This means 0.1 pregnancies in 100 women within the first year of usage. Efficacy of the pill directly depends on correct usage and the woman’s compliance. The COCs are 99.7% effective, when

taken correctly and consistently. The failure rate is 0.3 %with common use and 0.1%with correct use

MECHANISM OF ACTION:

The mechanisms of action include the following:

1. Inhibition of ovulation by suppressing FSH and LH
2. Alternation of endometrium to make it unsuitable for implantation even if the ovum is fertilized.
3. Changes in cervical mucus, which make it hostile to the sperm.

REVERSIBILITY:

The method is rapidly reversible. The woman can become pregnant immediately after giving up the method (or even during incorrect administration, this being a certain proof of immediate reversibility)

USAGE:

In order for the method to have a maximum of efficiency, the pills must be taken daily, approximately at the same hour, for 21 days, with a 7-day break. In the case of 28 pills per package form, there is no break.

It is best to start taking the pill in the first day of the menstrual cycle

1. Start the pill on first day of the menstrual cycle or within the first 5 days, from initiation of the menstruation, if the woman has a regular menstrual cycle; in this case she does not need additional protection.
2. Start the pill start after the fifth day of the menstrual cycle, but in this case, it is strongly recommended that an additional protection method be used or that sexual contact be avoided within the first 7 days after starting to use the pills.
3. At any time of the menstrual cycle, if we can be sure that the woman is not pregnant (hasn't had any sexual contact since her last menstruation or has correctly used an efficient family planning method)

IMPORTANT HEALTH BENEFITS

FERTILITY-RELATED BENEFITS:

1. Prevention of pregnancy
2. Offers protection against ectopic pregnancy

MENSTRUAL BENEFITS:

1. Regulation of menstrual cycle
2. Lesser iron deficiency anaemia due to lighter menstrual cycles
3. Less dysmenorrhea
4. Reduced premenstrual symptoms

PROTECTION FROM SOME CANCERS:

1. Protection against cancers e.g. endometrial, ovarian cancer and colon cancer
2. Protection against benign breast disorders like fibrocystic disease and fibro adenomas.

OTHER POSSIBLE HEALTH BENEFITS:

1. Protection against pelvic inflammatory diseases when compared to non-users
2. Reduces risk of follicular cysts by 50% and corpus luteal cysts by 80%.
3. Past contraceptive use protects women against low bone mineral density, after they reach menopause
4. Reduction in acne
5. Improvement and prevention of anaemia
6. Protection against ovarian, endometrial and colon cancers
7. Treatment for hirsutism
8. Protection against osteoporosis

LIMITATIONS

1. Has to be taken every day and depends on the motivation of the user
2. Does not protect against STIs/ HIV
3. Not appropriate for mothers who are fully or nearly fully breastfeeding infants less than 6 months old
4. Effectiveness of the pill may be decreased in women who are on treatment for tuberculosis (rifampicin), convulsions (phenytoin, carbamazepine, barbiturates, primidone) and on certain antibiotics (griseofulvin).
5. High risk for women who smoke and above 35 years
6. Women who smoke, irrespective of whether they use the pill, are at increased risk for heart attack or stroke.

SIDE EFFECTS:

Minor side effects listed below are most common during the first 3 months of use and these usually disappear with continued use:

1. Amenorrhea
2. Bleeding in between periods or spotting
3. Nausea
4. Headache
5. May raise blood pressure

6. Weight gain
7. Breast tenderness

SESSION 2

TITLE: WOMAN ASSESSMENT AND MEC

(40 MINUTES)

OUTLINE & OBJECTIVES:

Discuss in detail the usage of MEC in helping the woman choose the best suitable method for her in context of COCs. Describe details of counselling and clinical assessment.

METHODOLOGY:

MEC wheel usage in small group

Followed by large group discussion

Interactive power point presentation

Handout (H10.2A) (H10.2B)

Activity (A10.2a, A10.2b)

Job Aid (J10.2a) (J10.2b) (J10.2c) (J10.2B-1), (J10.2B-2), (J10.2B-3), (J10.2B-4)

WOMAN ASSESSMENT FOR COC

HANDOUT (H-10.2A)



(Activity A10.2a)

Instructions

Take a flip chart and ask the participants to write down instructions for the woman about.

1. When to start the pill?
2. How to take the pill regularly?
3. The trainer then conducts a group discussion and adds any missing points

CHART FOR INITIATION OF COCS: (WHO 2018)

Job Aid (J10.2a)

Women's Situation	When to Start
Having menstrual cycles or switching from a non-hormonal method	<p>Any time of the month</p> <ol style="list-style-type: none"> 1. If she is starting within 5 days after the start of her monthly bleeding, no need for a backup method. 2. If it is more than 5 days after the start of her monthly bleeding, she can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills. 3. If she is switching from an IUCD, she can start COCs immediately
Switching from a hormonal method	<ol style="list-style-type: none"> 1. Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. 2. If she is switching from injectables, she can begin taking COCs when the repeat injection would have been given. No need for a backup method.
Fully or nearly fully Breastfeeding: Less than 6 months after giving birth	<ol style="list-style-type: none"> 1. Give her COCs and tell her to start taking them 6 months after giving birth or when breast milk is no longer the baby's main food whichever comes first.
Fully or nearly fully Breastfeeding:(continued) More than 6 months after giving birth	<ol style="list-style-type: none"> 1. If her monthly bleeding has not returned, she can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills. (If not certain use pregnancy checklist) 2. If her monthly bleeding has returned, she can start COCs as advised for women having menstrual cycles
Partially Breastfeeding: Less than 6 weeks after giving birth	<ol style="list-style-type: none"> 1. Give her COCs and tell her to start taking them 6 weeks after giving birth. 2. Also give her a backup method to use until 6 weeks since giving birth if her monthly bleeding returns before this time.
Partially Breastfeeding: More than 6 weeks after giving birth	<ol style="list-style-type: none"> 1. If her monthly bleeding has not returned, she can start COCs any time it is reasonably certain she is not pregnant She will need a backup method for the first 7 days of taking pills

	2. If her monthly bleeding has returned, she can start COCs as advised for women having menstrual cycles
Not breastfeeding: Less than 4 weeks after giving birth	1. She can start COCs at any time on days 21–28 after giving birth. Give her pills any time to start during these 7 days. No need for a backup method (If additional risk of VTE, wait for 6weeks)
Not breastfeeding: More than 4 weeks after giving birth	1. If her monthly bleeding has not returned, she can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills. 2. If her monthly bleeding has returned, she can start COCs as advised for women having menstrual cycles (page 14)
No monthly bleeding (not related to childbirth or BF)	1. She can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills.
After miscarriage or abortion	1. Immediately. If she is starting within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method. 2. If it is more than 7 days after first- or second trimester miscarriage or abortion, she can start COCs any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days of taking pills.
After taking emergency contraceptive pills (ECPs)	<p>After taking progestin only or combined ECPs:</p> <ol style="list-style-type: none"> 1. She can start or restart COCs immediately after she takes the ECPs. No need to wait for her next monthly bleeding. 2. A continuing user who needed ECPs due to pill-taking errors can continue where she left off with her current pack. 3. If she does not start immediately but returns for COCs, she can start at any time if it is reasonably certain she is not pregnant. 4. All women will need to use a backup method for the first 7 days of taking pills. <p>After taking *Ulipristal acetate (UPA) :</p> <ol style="list-style-type: none"> 1. She can start or restart COCs on the 6th day after taking UPA-ECPs. <i>No need to wait for her next monthly bleeding.</i> COCs and UPA interact. If COCs are started sooner, and thus both are present in the body, one or both may be less effective. 2. Give her a supply of pills and tell her to start them on the 6th day after taking the UPA-ECPs. 3. She will need to use a backup method from the time she takes the UPA-ECPs until she has been taking COCs for 7 days. 4. If she does not start on the 6th day but returns later for COCs, she may start at any time if it is reasonably certain she is not pregnant.

*Not available in Pakistan to date

GUIDELINES ON USE OF COCS

Job Aid (J10.2b)

1. Give pills	<ol style="list-style-type: none">1. Give at least 3 months' supply (3 packs) depending on the woman's preference and planned use
2. Explain pill pack	<ol style="list-style-type: none">1. Show which kind of pack, 21 pills or 28 pills. With 28-pill packs, point out that the last 7 pills are a different colour and do not contain hormones (some brands may differ).2. Show how to take the first pill from the pack and then how to follow the directions or arrows on the pack to take the rest of the pills.
3. Give key instructions	<ol style="list-style-type: none">1. Take one pill each day until the pack is empty.2. Discuss cues for taking a pill every day. Linking pill taking to a daily activity such as cleaning her teeth may help her remember.3. Taking pills at the same time each day helps to remember them. It also may help reduce some side effects.
4. Explain starting next pack	<ol style="list-style-type: none">1. 28-pill packs: When she finishes one pack, she should take the first pill from the next pack on the very next day.2. 21-pill packs: After she takes the last pill from one pack, she should wait 7 days and no more and then take the first pill from the next pack.3. It is very important to start the next pack on time. Starting a pack late risks pregnancy.
5. Provide backup method and explain use	<ol style="list-style-type: none">1. Sometimes she may need to use a backup method, such as when she misses pills.2. Backup methods include abstinence, male or female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods.3. Give her condoms, if possible.4. If she misses 3 or more hormonal pills, she can consider ECPs.

How to take the pill correctly?

1. Swallow one pill every day. It is preferable to take it at bedtime. This will help her to remember it every day and prevent any possible discomfort.
2. Follow the arrow to know which pill should be taken next.
3. Do not miss the pill even on a single day, even if she does not have sexual relations.
4. Continue taking the pill even if she is menstruating. Menstruation usually starts while taking the coloured pills.
5. When she finishes one packet, start the next packet the next day starting with the pill where START is marked.
6. She may have some spotting or bleeding between the periods in the beginning. This is not menstrual bleeding and she should not stop the pill. This usually stops after 2-3 months.
7. She may have some nausea, dizziness or headache while taking the pill. These usually disappear after the first two or 3 months. If she takes the pill at bedtime, she may not feel these symptoms.

8. Do not stop the pill without consulting a health worker. If she stops the pill, she should not do it mid cycle as it will cause withdrawal bleeding.



(Activity A10.2b)

Medical Eligibility Criteria for COCs

State the fact that they will use the **WHO Medical Eligibility Criteria for COC**.

Invite one volunteer from each group to present the case and solution. (5 min)

Ask:

- 1) **What investigations are necessary for the safety use of COC?**
- 2) **What does the service provider have to follow when the woman comes in for check-up?**

The trainer lists the responses on the flipchart and clarifies each proposition

As a conclusion to this activity, tell participants that by using the given materials they will find it easier to monitor the COC use safely and will be better able to identify the situations in which a woman should be referred to a senior practitioner.

Ask the woman the questions below about known medical conditions. Examination and tests are not necessary. If she answers “no” to all of the questions, then she can start COCs if she wants. If she answers “yes” to a question, follow the instructions. In some cases, she can still start COCs. (These questions also apply for the combined patch and the combined vaginal ring).

- 1- **Are you breastfeeding a baby less than 6 months old?**

NO YES

If fully or nearly fully breastfeeding: Give her COCs and tell her to start taking them 6 months after giving birth or when breast milk is no longer the baby’s main food, whichever comes first.

If partially breastfeeding: She can start COCs as soon as 6 weeks after childbirth

- 2- **Have you had a baby in the last 3 weeks, and you are not breastfeeding?**

NO YES

Give her COCs now and tell her to start taking them 3 weeks after childbirth. (If there is an additional risk that she might develop a blood clot in a deep vein (deep vein thrombosis, or DVT), then she should not start COCs at 3 weeks after childbirth, but start at 6 weeks instead. These additional risk factors include previous DVT, thrombophilia, caesarean delivery, blood transfusion at delivery, postpartum haemorrhage, pre-eclampsia, obesity (>30 kg/m²), smoking, and being bedridden for a prolonged time.)

3- Do you smoke cigarettes and you are more than 35 years old?

NO YES

If she is 35 years of age or older and smokes, do not provide COCs. Urge her to stop smoking and help her choose another method, but not patch or ring if she smokes fewer than 15 cigarettes a day, and also not monthly injectables if more than 15 cigarettes a day.

4- Do you have cirrhosis of the liver, a liver infection, or liver tumour? Have you ever had jaundice when using COCs?

NO YES

If she reports serious liver disease (such as severe cirrhosis or liver tumour), acute or flare of viral hepatitis, or ever had jaundice while using COCs, do not provide COCs. Help her choose a method without hormones. (She can use monthly injectables if she has had jaundice only with past COC use.)

5- Do you have high blood pressure?

NO YES

If you cannot check blood pressure and she report a history of high blood pressure, or if she is being treated for high blood pressure, do not provide COCs. Refer her for a blood pressure check if possible or help her choose a method without oestrogen.

Check blood pressure if possible:

1. If her blood pressure is below 140/90 mm Hg, provide COCs. No need to retest before starting COCs.
2. If blood pressure is 160/100 mm Hg or higher, do not provide COCs. Help her choose a method without oestrogen, but not a progestin-only injectable.

3. If blood pressure is 140–159/90–99 mm Hg, one measurement is not enough to diagnose high blood pressure. Give her a backup method* to use until she can return for another blood pressure measurement or help her choose another method.
- If her next blood pressure measurement is below 140/90 mm Hg, she can start OCs.
 - However, if her next blood pressure measurement is 140/90 mm Hg or higher, do not provide COCs. Help her choose a method without oestrogen, but not a progestin-only injectable if systolic blood pressure is 160 or higher or diastolic pressure is 100 or higher.
- 6- Have you had diabetes for more than 20 years *or* damage to your arteries, vision, kidneys, or nervous system caused by diabetes?**

NO YES

Do not provide COCs. Help her choose a method without oestrogen but not progestin-only injectables.

- 7- Do you have gallbladder disease now or take medication for gallbladder disease?**

NO YES

Do not provide COCs. Help her choose another method but not the combined patch or combined vaginal ring.

- 8- Have you ever had a stroke, blood clot in your leg or lungs, heart attack, or other serious heart problems?**

NO YES

If she reports heart attack, heart disease due to blocked or narrowed arteries, or stroke, do not provide COCs. Help her choose a method without oestrogen but not progestin-only injectables. If she reports a current blood clot in the deep veins of the legs (not superficial clots) or lungs, help her choose a method without hormones.

- 9- Do you have or have you ever had breast cancer?**

NO YES

Do not provide COCs. Help her choose a method without hormones.

- 10- Do you sometimes see a bright area of lost vision in the eye before a very bad headache (migraine aura)? Do you get throbbing, severe head pain, and often on**

one side of the head that can last from a few hours to several days and can cause nausea or vomiting (migraine headaches)? Such headaches are often made worse by light, noise, or moving about.

NO YES

If she has migraine aura at any age, do not provide COCs. If she has migraine headaches without aura and is age 35 or older, do not provide COCs. Help these women choose a method without oestrogen. If she is under 35 and has migraine headaches without aura, she can use COCs

11- Are you taking medications for seizures? Are you taking rifampicin or rifabutin for tuberculosis or other illness?

NO YES

If she is taking barbiturates, carbamazepine, lamotrigine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, or rifabutin, do not provide COCs. They can make COCs less effective. Help her choose another method but not progestin-only pills, patch, or combined ring. If she is taking lamotrigine, help her choose a method without oestrogen.

12- Are you planning major surgery that will keep you from walking for one week or more?

NO YES

If so, she can start COCs 2 weeks after she can move about again. Until she can start COCs, she should use a backup method.

13- Do you have several conditions that could increase your chances of heart disease (coronary artery disease) or stroke, such as older age, smoking, high blood pressure, or diabetes?

NO YES

Do not provide COCs. Help her choose a method without oestrogen, but not progestin-only injectables. Also, women should not use COCs if they report having thrombogenic mutations or lupus with positive (or unknown) antiphospholipid antibodies.

Be sure to explain the health benefits and risks and the side effects of the method that the woman will use. Also, point out any conditions that would make the method inadvisable, when relevant to the woman. It is advisable to have the blood pressure assessed, although this is not an absolute requirement.

MEC FOR COCS

HANDOUT (H10.2B)

Eligibility for Using COCs:

COCs are safe and appropriate for many women. Other women might take COCs with additional monitoring or care; and some women should not take COCs at all, or only in very limited circumstances.

Women Who Can Use COCs without Restrictions (Includes MEC Category 1)

Job Aid (J10.2B-1.)

This method is recommended and acceptable with no restrictions for sexually active women of reproductive age (from menarche to menopause). It is acceptable in all of the following specific circumstances:

Women of any parity, including women who have never given birth (nulliparous)
Women who want highly effective protection against pregnancy and who feel they can follow a daily routine of pill taking
Post-abortion, the pills may be given on the same day as medical abortion protocol is initiated or the same day as MVA is performed
Women with severe dysmenorrhoea
Women with a history of ectopic pregnancy
Women who suffer from headaches (can initiate pill use [category 1]; but if headaches continue, eligibility changes to category 2)

Women on antibiotics that do not affect effectiveness of COCs
Women with AIDS but not on antiretroviral (ARV) therapy, or those receiving ARVs that do not interfere with effectiveness of COCs
Women at increased risk of STIs, or with a very high individual risk of exposure to STIs
Women at high risk of HIV, or those already infected with HIV
<p>Women with any of the following conditions can use the COCs:</p> <ol style="list-style-type: none"> 1. Malaria 2. Non-pelvic Tuberculosis 3. Thyroid disease 4. Iron-deficiency anaemia 5. Benign breast disease 6. Endometrial or ovarian cancer 7. Cervical ectropion, uterine fibroids without cavity distortion or endometriosis 8. Abnormal vaginal bleeding patterns: irregular, heavy, or prolonged bleeding 9. Chronic hepatitis, carrier state or mild cirrhosis 10. Vaginitis, current purulent cervicitis, chlamydia or gonorrhoea or current PID 11. Other STIs excluding HIV and hepatitis B

Women Who Can Use This Method with Extra Care (Includes MEC Category 2)

Job Aid (J10.2B-2)

Suggested Action		
Condition	When clinical judgement is possible	When clinical judgement is not possible or is limited (e.g., CHW with FP training-CBD)
Women over 40 years of age	Initiate method. Age by itself does not restrict use of any method.	Initiate and re-supply method.
Women who have unexplained vaginal bleeding	Initiate method. Evaluate bleeding, including VIA/ VILI or Pap Smear.	Initiate method and refer for evaluation as soon as possible. Re-supply as needed.
Women who have migraines without aura and are less than 35 years of age	Initiate method and follow-up closely.	Initiate method and refer for evaluation as soon as possible. Re-supply if migraine is not getting more severe.
Women who suffer from obesity, i.e., weight equal or greater than 30kg/ m ² Body Mass Index (BMI)	Use the method, but counsel about small risk and symptoms of thrombosis. Advise follow-up.	Initiate method and refer for evaluation as soon as possible. Re-supply as needed.
Women with gall-bladder disease who are currently asymptomatic	Use the method, follow- up, and discontinue if symptoms develop. (Note: Women on medical treatment for this disease fall in category 3).	May initiate and re-supply as needed, especially where cholecystectomy has been performed.
Women with undiagnosed breast lumps	Initiate method and evaluate the lump or refer as appropriate as soon as possible. After evaluation, women with benign breast disease fall into category 1; women with breast cancer fall into category 4, and COCs should be discontinued.	Refer for evaluation before initiating method.
Women with sickle cell disease	Initiate method and advise regular follow-up.	Initiate method and refer for evaluation as soon as possible if symptoms start. Re-supply as needed.
Women who smoke and are less than 35 years of age	Initiate method and recommend follow-up. Discontinue if symptoms or signs of CVD appear (category 3 or 4).	Initiate method and refer for evaluation as soon as possible. May re-supply, as needed.
Uncomplicated diabetes (no vascular disease or diabetes of less than 20 years duration)	Generally, use the method and recommend follow-up.	Initiate method and refer for follow-up, as soon as possible. Re-supply as needed.

Conditions that warrant extra precautions

Job Aid (J10.2B-3)

Suggested Action		
Condition	When clinical judgement is possible	When clinical judgement is not possible or is limited (e.g., CHW with FP training-CBD)
Women with superficial venous thrombosis	Initiate method and arrange for investigations to rule out deep vein thrombosis (DVT).	Initiate method and refer for follow-up as soon as possible. Re- supply as needed.
Women with a family history of DVT (first-degree relatives)	Initiate method and counsel about DVT symptoms. Warn woman to come back as soon as possible if symptoms arise (Note: Women with a personal medical history of DVT fall into category 4).	Initiate method and refer for evaluation as soon as possible. Re- supply as needed.
Women who have had major surgery but without prolonged immobilization	Initiate method and arrange close follow- up. Discontinue if symptoms of DVT appear.	Initiate method and refer for evaluation as soon as possible. Re- supply as needed.
Women with Systemic Lupus Erythematosus (SLE) who have severe thrombocytopenia or who are on immunosuppressive therapy.	If woman is known to be negative for antiphospholipid antibodies, initiate method and arrange for close follow-up, including referral as appropriate. If antibodies are positive or unknown, these women fall into category 4.	Refer for evaluation before initiating method.
Women with liver tumour	If a woman is known to have focal nodular hyperplasia, initiate method. If the type of liver tumour is not known, evaluate or refer for evaluation prior to initiation. (Women with tumours other than focal nodular hyperplasia are classified as category 4).	Refer for evaluation before initiating method.
Women taking ARVs other than ritonavir or ritonavir-boosted PIs	Initiate method; continue use if not on ritonavir or ritonavir-boosted protease inhibitors (use of ritonavir falls in category 3). Ensure COC preparation contains a minimum of 30 mcg EE. Advise consistent condom to use to prevent HIV and to compensate for any possible reduction in COC effectiveness.	Initiate method and refer for review as soon as possible. Re-supply as needed.

Conditions that qualify as MEC Categories 3 and 4

Job Aid (J10.2B-4)

Condition	MEC Category
Breastfeeding mothers before six weeks postpartum	4
Breastfeeding mothers before six months postpartum or non-breastfeeding mothers before three weeks postpartum	3
Women with current or history of ischaemic heart disease, complicated valvular heart disease or stroke	4
Women with a history of hypertension (where blood pressure [BP] cannot be measured), or moderate hypertension (BP is between 140/90 to 159/99)	3
Women with severe hypertension with BP equal or higher than 160/100, or hypertension complicated by vascular disease	4
Women with diabetes mellitus that is complicated by vascular disease or that is longer than 20 years in duration	4
Women who smoke (less than 15 cigarettes a day) and are 35 years of age or older	3
Women who smoke (more than 15 cigarettes a day) and are 35 years of age or older	4
Women with a history of or current breast cancer	4
Women with symptomatic gall bladder disease including those on medical treatment (who have not undergone cholecystectomy)	3
Women with current or previous history of DVT or pulmonary embolism (PE), acute DVT/PE, DVT/PE and on anticoagulant therapy, or known thrombogenic mutations	4
Women who have had major surgery with prolonged immobilization	4
Women with SLE and positive (or unknown) for antiphospholipid antibodies	3 and 4
Women with acute viral hepatitis or flare	4
Women with severe (decompensated) cirrhosis	4
Women with hepatocellular adenoma or malignancy (hepatoma)	4
Women on ARV therapy who are receiving ritonavir or ritonavir-boosted protease inhibitors	3
Women on certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine, or Lamotrigine)	3
Women on TB therapy who are on Rifampicin or Rifabutin	3

SESSION 3

TITLE: COMMON SIDE EFFECTS AND THEIR MANAGEMENT

(30 MINUTES)

OUTLINE & OBJECTIVES:

The purpose of this session is to discuss common side effects of COC s and their management

METHODOLOGY:

Divide the participants into two groups and let them brainstorm the common side effects and warning signs of COCs. Followed by groups' presentation and large group discussion

Handout (H10.3)

Activity (A10.3)

Job Aid (J10.3)

COMMON PROBLEMS, SIDE EFFECTS AND THEIR MANAGEMENT

HANDOUT (H-10.3)



(Activity A10.3)

Divide participants into 2 groups, Red and Green. The trainer then tasks Green group to enlist side effects and their management. Group Red is asked to prepare the warning signs and their management. Each group 10 mins to prepare and 5 mins to present their work. The trainer moderates the discussion on both presentations and ensure all important points are covered.

LIMITATIONS AND SIDE EFFECTS OF COCS:

- 1) COCs must be taken daily to be effective, preferably at the same time each day.
- 2) Effectiveness of COCs may decrease when certain drugs are taken concurrently (e.g., certain anti- tuberculosis, anti-epileptic, and antiretroviral drugs).
- 3) COCs offer no protection against STIs, including hepatitis B and HIV. Therefore, at-risk individuals should use condoms to ensure protection against STIs.
- 4) Use of COCs may be associated with minor and major side effects.

MINOR SIDE EFFECTS:

- a. Nausea (more common in the first three months)
- b. Spotting or bleeding in between menstrual periods, especially if a woman forgets to take her pills or takes them late (more common in the first three months)
- c. Mild headaches
- d. Breast tenderness
- e. Slight weight gain
- f. Mood changes
- g. Amenorrhoea (some women see amenorrhoea as an advantage)

COMPLICATIONS (RARE, BUT POSSIBLE):

- a) Myocardial infarction
- b) Stroke
- c) Venous thrombosis or embolism, or both

MANAGING ANY PROBLEMS:

If the woman reports any common side effects of low dose COCs:

- 1) Do not dismiss the woman's concerns or take them lightly.
- 2) If the woman is worried, reassure her that side-effects are usually not dangerous.
- 3) If she has just started the method, tell that these side effects usually become less or subside within 3 months.
- 4) Urge her to keep taking the pill each day even if she has these side effects to avoid pregnancy. Skipping pills can risk pregnancy.
- 5) If she is not satisfied after treatment and counselling, help her choose another contraceptive method if she wishes.

Management of Side-effects

Job Aid (J10.3)

<p>Nausea / Vomiting</p> <p>Vomiting (for any reasons) within 2 hours of taking an active (hormone) pill</p> <p>Severe diarrhea and vomiting for more than 24 hours</p>	<p>Recommend taking pills during meals or in the evening before going to bed</p> <p>She should take another active pill</p> <p>She should continue taking pills (if she can) despite her discomfort</p> <p>If severe vomiting or diarrhoea continues for 2 or more days, she should follow the procedure for missed pills</p>
<p>Inter-menstrual bleeding/ spotting</p>	<p>If the woman has started taking COC recently, recommend that she continues with the pill's intake</p> <p>Verify whether the pills are being taken at the same time each day</p> <p>Ask if she has missed any pills. Explain that missing pills can cause bleeding between periods, even when taking pills every day)</p> <p>Ask if she has had vomiting or diarrhoea.</p> <p>Ask if she is taking rifampicin or medicines for seizure, which may make COCs less effective. Encourage her to use condoms or spermicide.</p> <p>Explain that these phenomena naturally disappear after the first 3 months.</p> <p>Verify the existence of other gynaecological disorders.</p>
<p>Slight headache</p>	<p>Measure the arterial pressure</p> <p>Treat with analgesics and re-evaluate after one month. Verify whether headache started after she has started taking COCs. Suggest taking ibuprofen, aspirin, paracetamol, or another non-steroidal anti-inflammatory drug. Review at follow up and refer if necessary</p>
<p>Headaches (migraines)</p>	<p>A woman who develops migraine while using COCs should switch to an alternative method. She should not choose a POP (progesterone only pill) method if she has blurred vision, brief loss of vision, sees flashing lights or has brief trouble in speaking or moving before, during or after the</p>

Breast tenderness	<p>Explain to the woman that this often happens at the beginning when taking COC (verify whether the woman is used to sleeping faced down; these women are usually the ones who complain).</p> <p>Keep taking her pills. Skipping pills may make these side effects worse and also increases the risk of pregnancy</p> <p>Verify to see if she is pregnant.</p> <p>Examine the breasts for nodules and galactorrhoea.</p>
Slight body weight gain	<p>Weigh the woman.</p> <p>Ask if she has changed her lifestyle, if she has been eating more than before she started taking COC.</p> <p>Explain that for some women taking the COC, appetite can increase. Explain that during the first months, even if they do not eat more than before, most women may notice a slight weight gain, of around 1-2 kg, but that the weight will return to its initial value, if the woman will eat the</p>
Amenorrhea (no monthly bleeding period) Common, not usually a sign of pregnancy	<p>Ask if she has had any bleeding (menstrual bleeding may be reduced, which she may not consider menstruation). If so, reassure her.</p> <p>Check whether the woman has correctly taken COC (omitting them might increase the risk of becoming pregnant; taking the pills without taking the break might lead to amenorrhea).</p> <p>Verify whether the woman is pregnant.</p>

Serious complications of the pill are rare. It should be made clear that a woman should see a doctor or nurse or return to the clinic if she has any of the following symptoms or problems:

- 1) Severe, constant pain in belly, chest, or legs
- 2) Severe headaches that start or become worse after she begins to take combined oral contraceptives
- 3) Intermittent loss of vision, seeing flashing lights or zigzag lines (with or without headache)
- 4) Difficulty in speaking or moving arm or leg
- 5) Jaundice (skin and eyes look yellow)

FOLLOW-UP:

The woman can return for more pills at her convenience any time before her supply runs out. A scheduled return visit is not always necessary

SESSION 4

TITLE: MISSED PILLS AND TROUBLESHOOTING

(30 MINUTES)

OUTLINE & OBJECTIVES:

This session is designed to deal with common problem, missed pills and their protocols

METHODOLOGY:

Brainstorming in groups followed by interactive session with power point presentation

Handout: (H10.4)
Activity: (A10.4)
Job Aid: (J10.4)

MISSED PILLS AND TROUBLE SHOOTING HANDOUT (H-10.4)



(Activity A10.4)

Divide the group into two based on saying 'Red' and 'Green'. Ask the Red group to enlist their suggestions if a woman misses her OCP. Ask the Green group to enlist circumstances when the pill may not be effective.

Allow 5 minutes for each group to brainstorm, choose a representative to present and then 5 minutes each to present. The trainer moderates a discussion and then summarises.

IF THE PILLS ARE FORGOTTEN:

- 1) **If the woman forgets one pill**, the woman will take the omitted pill immediately after she reminds and she will continue taking the pills from the package at the usual hour (she can therefore take 2 pills in the same day or at the same hour). She does not need additional protection.
- 2) **If she forgets to take 2-4 pills out of the first 7 active pills** in the package or if she starts a new package two or more days later, the woman will take a pill as soon as she reminds and she will continue taking the pills in the package at the same hour; additionally, in the next 7 days (until the contraceptive protection is regained) she will not engage in sexual contact or she will use an additional protection method (condom or spermicides).

- 3) **If she forgets to take 2-4 pills out of the 8-21 pills** and the package still contains more than 7 pills, she will take the rest of the pills as usual; if the package contains less than 7 pills, the woman will finish the active pills and she will begin a new package, without taking the usual 7-day break. She does not need additional protection.
- 4) **If the woman has digestive disorders, vomiting or diarrhoea:**
- If she vomits after less than 2 hours from administering the pill – she will take another pill, identical to the one vomited, from a back-up package
 - If she has diarrhoea or vomiting for more than 24 hours – she will continue taking the pills and will use an additional protection method or will avoid sexual contact until she will succeed to take 7 active pills, after the diarrhoea or vomiting have ceased (she will not take the seven days break if the package finishes meanwhile)
 - If severe vomiting or diarrhoea continues for two or more days, the woman should follow the procedures for missed pills.
- 5) **If the woman needs a treatment which reduces the efficacy of the pills:**
- She can either reconsider the contraceptive method, if the treatment is long-term
 - She can either continue taking the pills, but she will use an additional protection method (the same as in the case of omitted pills).

Troubleshooting for Missed Pills:

Job aid (J10.4)

Missed COC	Suggested action
Key message	<ol style="list-style-type: none"> 1. Take the missed hormonal pill as soon as possible. 2. Keep taking pills as usual, one each day. (She may take 2 pills at the same time or on the same day.)
Missed 1 or 2 pills or started new pack 1 or 2 days late	<ol style="list-style-type: none"> 1. Take a hormonal pill as soon as possible. 2. Little or no risk of pregnancy.
Missed pills 3 or more days in a row in the first or second week or started new pack 3 or more days late	<ol style="list-style-type: none"> 1. Take a hormonal pill as soon as possible. 2. Use a backup method for the next 7 days. 3. Also, if she had sex in the past 5 days, she can consider ECPs
Missed 3 or more pills in the third week	<ol style="list-style-type: none"> 1. Take a hormonal pill as soon as possible. 2. Finish all hormonal pills in the pack. Throw away the 7 no hormonal pills in a 28-pill pack. 3. Start a new pack the next day. 4. Use a backup method for the next 7 days. 5. Also, if she had sex in the past 5 days, she could consider ECPs

Missed any non-hormonal pills? (last 7 pills in 28-pill pack)	<ol style="list-style-type: none"> 1. Discard the missed non-hormonal pill(s). 2. Keep taking COCs, one each day. Start the new pack as usual.
Severe vomiting or diarrhoea	<ol style="list-style-type: none"> 1. If she vomits within 2 hours after taking a pill, she should take another pill from her pack as soon as possible, then keep taking pills as usual. 2. If she has vomiting or diarrhoea for more than 2 days, follow instructions for 3 or more missed pills, above.

HELPING WOMEN AT ANY ROUTINE RETURN VISIT

- Ask if the woman has any questions or anything to discuss.
- Ask about her experience with the method, whether she is satisfied, and whether she has any problems. Give her any information she needs and invite her to return again any time for help. If she has problems that cannot be resolved, help her choose another method.
- If she has not developed any problems which prevent use of COCs, provide more supplies if needed.
- Plan for the next visit before she will need more pills

SESSION 5

TITLE: FAQs

(15 MINUTES)

OUTLINE & OBJECTIVES:

This session is designed to get the participants to brainstorm about a few questions about the OCPs in a game format

METHODOLOGY:

Peel the cabbage game

Handout (H10.5)

Activity (A10.5)

FREQUENTLY ASKED QUESTIONS

HANDOUT (H-10.5)



(Activity A10.5)

The questions are written on a different coloured piece of paper and folded as a cabbage. Peel the cabbage with music playing. Whoever has the cabbage at the time when music stops, peels a layer and reads the question. If that participant cannot answer the question, she can pass it on to the next one. The trainer ensures all answers are correctly discussed

1- Should a woman take a “rest” from COCs after taking them for a time?

No. There is no evidence that taking a “rest” is helpful. In fact, taking a “rest” from COCs can lead to unintended pregnancy. COCs can safely be used for many years without having to stop taking them periodically.

2- If a woman has been taking COCs for a long time, will she still be protected from pregnancy after she stops taking COCs?

No. A woman is protected only as long as she takes her pills regularly

3- How long does it take to become pregnant after stopping COCs?

Women who stop using COCs can become pregnant as quickly as women who stop other hormonal methods. COCs do not delay the return of a woman’s fertility after she stops taking them. The bleeding patterns a woman had, before she used COCs generally returns after she stops taking them. Some women may have to wait a few months before their usual bleeding pattern returns.

4- Do COCs cause abortion?

No. Research on COCs finds that they do not disrupt an existing pregnancy. They should not be used to try to cause an abortion. They will not do so.

5- Do COCs cause birth defects? Will the fetus be harmed if a woman accidentally takes COCs while she is pregnant?

No. Good evidence shows that COCs will not cause birth defects and will not otherwise harm the fetus if a woman becomes pregnant while taking COCs or accidentally starts to take COCs when she is already pregnant.

6- Do COCs cause women to gain or lose a lot of weight?

No. Most women do not gain or lose weight due to COCs. Weight changes naturally as life circumstances change and as people age. Because these changes in weight are so common, many women think that COCs cause these gains or losses in weight. Studies find, however, that, on average, COCs do not affect weight. A few women experience sudden changes in weight when using COCs. These changes reverse after they stop taking COCs. It is not known why these women respond to COCs in this way.

7- Do COCs lower women’s mood or sex drive?

Generally, no. Some women using COCs report these complaints. The great majority of COC users do not report any such changes, however, and some report that both mood and sex drive improve. It is difficult to tell whether such changes are due to the COCs or to other reasons. Providers can help a woman with these problems.

8- What can a provider say to a woman asking about COCs and breast cancer?

The provider can point out that both COC users and women who do not use COCs can have breast cancer. In scientific studies breast cancer was slightly more common among women using COCs and those who had used COCs in the past 10 years than among other women. Scientists do not know whether or not COCs actually caused the slight increase in breast cancers. It is possible that the cancers were already there before COC use but were found sooner in COC users

9- Can COCs be used as a pregnancy test?

No. A woman may experience some vaginal bleeding (a “withdrawal bleed”) as a result of taking several COCs or one full cycle of COCs, but studies suggest that this practice does not accurately identify who is or is not pregnant. Thus, giving a woman COCs to see if she has bleeding later is not recommended as a way to tell if she is pregnant. COCs should not be given to women as a pregnancy test of sorts because they do not produce accurate results.

10- Must a woman have a pelvic examination before she can start COCs or at follow-up visits?

No. A pelvic examination to check for pregnancy is not necessary. Instead, asking the right questions usually can help to make reasonably certain that a woman is not pregnant. No other condition that could be detected by a pelvic examination rule out COC use.

11- Can women with varicose veins use COCs?

Yes. COCs are safe for women with varicose veins. Varicose veins are enlarged blood vessels close to the surface of the skin. They are not dangerous. They are not blood clots, nor are these veins the deep veins in the legs where a blood clot can be dangerous (deep vein thrombosis). A woman who has or has had deep vein thrombosis should not use COCs.

12- Can a woman safely take COCs throughout her life?

Yes. There is no minimum or maximum age for COC use. COCs can be an appropriate method for most women from onset of monthly bleeding (menarche) to menopause. COCs can be an appropriate method for adolescents. Adolescents may need extra support and encouragement to use COCs consistently and effectively.

13- Can women who smoke use COCs safely?

Women younger than age 35 who smoke can use COCs. Women age 35 and older who smoke should choose a method without oestrogen or, if they smoke fewer than 15 cigarettes a day, monthly injectables. Older women who smoke can take the progestin-only pill if they prefer pills. All women who smoke should be urged to stop smoking.

14- What if a woman wants to use COCs but it is not reasonably certain that she is not pregnant after using the pregnancy checklist?

A woman who answers “No” to all 6 questions on the Pregnancy Checklist (see inside back cover) can still start taking COCs. Ask her to come back for a pregnancy test if her next monthly bleeding is late.

15- Can COCs be used as emergency contraceptive pills (ECPs) after unprotected sex?

Yes. As soon as possible, but no more than 5 days after unprotected sex, a woman can take COCs as ECPs. Progestin-only pills, however, are more effective and cause fewer side effects such as nausea and stomach upset.

16- What are the differences among monophasic, biphasic, and Triphasic pills?

Monophasic pills provide the same amount of oestrogen and progestin in every hormonal pill. Biphasic and Triphasic pills change the amount of oestrogen and progestin at different points of the pill-taking cycle. For biphasic pills, the first 10 pills have one dosage, and then the next 12 pills have another level of oestrogen and progestin. For Triphasic pills, the first 7 or so pills have one dosage, the next 7 pills have another dosage, and the last 7 hormonal pills have yet another dosage. All prevent pregnancy in the same way. Differences in side effects, effectiveness, and continuation appear to be slight.

17- Is it important for a woman to take her COCs at the same time each day?

A woman can take her COCs at different times of day, and they will still be effective. However, taking them at the same time each day can be helpful for 2 reasons. Some side effects may be reduced by taking the pill at the same time each day. Also, taking a pill at the same time each day can help women remember to take their pills more consistently. Linking pill taking with a daily activity also helps women remember to take their pills.

18- Should women who choose COCs and certain other hormonal contraceptives be routinely tested for high blood pressure?

It is desirable for all women to have blood pressure measurements taken routinely before starting a hormonal method of contraception. However, in some settings blood pressure measurements are unavailable. In many of these settings, pregnancy-related morbidity and mortality risks are high, and these methods are among the few methods that are widely available. In such settings women should not be denied use of these methods simply because their blood pressure cannot be measured.

Women with high blood pressure or very high blood pressure should not use combined hormonal methods—COCs, monthly injectable, patch, or combined ring. Where blood pressure cannot be measured, women with a history of high blood pressure should not use these methods. Women with very high blood pressure should not use progestin-only injectable. Women can use progestin-only pills (POPs), implants, and LNG-IUCDs even if they have high or very high blood pressure readings or a history of high or very high blood pressure.

High blood pressure is defined as systolic pressure 140 mm Hg or higher or diastolic pressure 90 mm Hg or higher. Very high blood pressure is defined as systolic pressure 160 mm Hg or higher or diastolic pressure 100 mm Hg or higher.

SESSION 6

TITLE: WRAP UP AND SUMMARY

(5 MINUTES)

The trainer will wrap up and summarize the session and ask participants how they might use this information in their work in facilities or in the community.

FURTHER READING:

WHO Global Handbook for Family Planning 2018

"WHO Model List of Essential Medicines" (PDF). World Health Organization. October 2013. Retrieved 22 April 2014.

Selected practice recommendations for contraceptive use. World Health Organization. *Reproductive Health and Research, World Health Organization, (Third ed.)*. Geneva. 2017-01-12. p. 150. ISBN 9789241565400. OCLC 985676200

Advanced Oral Contraceptive Regimens and Their Management. Available from: https://www.researchgate.net/publication/281437642_Advanced_Oral_Contraceptive_Regimens_and_Their_Management

PROGESTIN-ONLY PILLS (POPS)



Time: 3hours

Progesterone only pills (POPs) are a subset of oral contraceptives, particularly suited for women who for one or the other reason, are not appropriate candidates for combined pills due to their oestrogen component



Training Objectives:

1. Describe the mechanism of action, efficiency, reversibility and advantages of POPs.
2. Discuss doses and regimens.
3. Describe medical eligibility criteria (MEC) for the use of progesterone only pills.
4. Highlight side-effects, warning signs and their management.
5. Discuss the causes of failure encountered in the use of this method.



Learning Outcomes:

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

1. Know mechanism of action, various types, efficacy, contraceptive and non-contraceptive advantages and limitations of POPs.
2. Use MEC confidently in helping the woman choose the best suitable method for her.
3. Understand the side effects of POPs and how to manage them?
4. Demonstrate effective counselling skills to help the woman or couple to understand their reproductive options and use the chosen method safely and effectively.
5. Dispel myths that might discourage the uptake and continued use of POPs.
6. Properly deal with missed pill events and their protocols.



Advance Preparations:

1. Power point presentation
2. MEC chart
3. Checklist for screening women who want to initiate POPs

4. Quick reference chart for the who medical eligibility criteria for contraceptive use
5. WHO MEC wheel



Training/Learning Methods:

- 1) Small and large group discussions
- 2) Power point presentation
- 3) Brainstorming
- 4) Case studies



Constitution of the Session:

Six mini sessions will be held

1. Introduction to Progesterone only pills, effectiveness, advantages, and limitations	Interactive presentation/discussion	40 Mins
2. Woman Assessment, MEC and case studies	Group work/brainstorming	40 Mins
3. Common side effects and their management	Group work/ Role play	40 Mins
4. Missed pills, common problems, and troubleshooting	Group work	30 Mins
5. Frequently Asked Questions	Pass the cabbage	20 Mins
6. Wrap up	Wrap up	10 Mins



Training Materials:

Trainer's Material	Trainee's Material
Hand Outs: H11.1, H11.2, H11.3, H11.4, H11.5	Hand Outs: H11.1, H11.2, H11.3, H11.4, H11.5
Activity: A11.1, A11.2, A 11.3, A11.5	Job aid J11.1, J11.2, J11.3a, J11.3b
Checklists/ Case Study: C11.2	
Job aid: J11.1, J11.2, J11.3a, J11.3b	
FAQs:	

SESSION 1

TITLE: INTRODUCTION TO THE POPS AND THEIR EFFECTIVENESS, ADVANTAGES AND LIMITATIONS

(40 MINUTES)

OUTLINE & OBJECTIVES:

By the end of the session, the participants should be able to discuss mechanism of action, various types, efficacy, contraceptive and non-contraceptive advantages and limitations of POPs.

METHODOLOGY:

Brainstorming in two groups to enlist the advantages and limitations or disadvantages
Discuss mechanism of action
Large group discussion
Power point presentation to summarize.

Handout (H11.1)

Activity (A11.1)

Job aid (J11.1)

INTRODUCTION TO PROGESTIN ONLY PILLS

HANDOUT (H-11.1)

POPs are an important tool for preventing unplanned pregnancies in the post-partum period, a time when unmet need for family planning is at the highest. POPs do not affect the quality of breast milk and help in proper child nutrition, while preventing unwanted pregnancy. A success rate of 99.5% makes POPs an ideal option for breastfeeding mothers.

PROGESTIN-ONLY PILLS (POPS):

As the name suggests, the Progestin-only pills (POPs) contain only one hormone—progestin; they do not contain any oestrogen. Therefore, they do not cause many of the side effects associated with COC use. Progestin does not suppress production of breast milk, which makes POPs an ideal contraceptive method for breastfeeding women.

MECHANISM OF ACTION:

Progestin-only pills (POPs) are also called “mini pills” work primarily by:

- 1- Thickening cervical mucus (this blocks sperm from meeting an egg)
- 2- Disrupting the menstrual cycle, including preventing the release of eggs from the ovaries (ovulation)

EFFICACY:

Effectiveness of POPs depends on the accuracy of use, the woman's breast feeding and menstrual status. For women who have monthly bleeding, risk of pregnancy is greatest if pills are taken late or missed completely.

BREASTFEEDING WOMEN:

With typical use, about 1 pregnancy per 100 women using POPs over the first year. This means that 99 of every 100 women will not become pregnant.

With correct use, less than one pregnancy per 100 women using POPs over the first year i.e. 3 per 1000 women

LESS EFFECTIVE FOR WOMEN NOT BREASTFEEDING:

With typical use, about 7 pregnancies per 100 women using POPs over the first year. This means that 93 of every 100 women will not become pregnant.

With correct use, less than 1 pregnancy per 100 women using POPs over the first year (3 per 1,000 women).



Activity (A11.1)

Brainstorming:

Divide the participants in two groups, Rose and Jasmine and ask them to prepare small presentations on advantages and limitations of POPs. The groups choose a representative and the presentations are done.

The trainer then makes a short presentation about POPs: description, types of POPs, mechanism of action, efficiency, reversibility, and administration.

Job Aid**(J11.1)**

Advantages	Limitations
POPs can be given to a woman at any time to start later. If pregnancy cannot be ruled out, a provider can give her pills to take later, when her monthly bleeding begins.	Changes in the regularity of the menstrual cycles (irregular menstruations, amenorrhea)
POPs are generally safe and have no known health risks.	Inter-menstrual bleeding or spotting
Women return to fertility immediately upon discontinuation.	Headaches (rarely) breast tenderness
A pelvic examination is not required to initiate use.	They do not protect against STIs, including hepatitis B and HIV/ AIDS
POPs are effective.	They provide a slightly lower level of contraceptive protection than COCs
Taking POPs does not affect milk production or breastfeeding. It is safe for breastfeeding women and their babies.	They require strict daily pill-taking, preferably at the same time each day
POPs add to the contraceptive effect of breastfeeding. Together, they provide effective pregnancy protection. Typically, pills lengthen the time during which breastfeeding women have no monthly bleeding.	They may lower effectiveness when certain drugs are taken concurrently (e.g., certain anti-tuberculosis, anti-retroviral and anti-epileptic drugs)

SESSION 2

TITLE: WOMAN ASSESSMENT AND MEC

(40 MINUTES)

OUTLINE & OBJECTIVES:

The objective of this session is to discuss using MEC in helping the woman choose the best suitable method for her in context of POPs. Discuss the details of counselling and woman assessment

METHODOLOGY:

MEC wheel usage in small groups
Followed by large group discussion

Handout	(H11.2)
Activity	(A11.2)
Job Aid	(J11.2)
Checklist	(C11.2)

WOMAN ASSESSMENT, MEC AND CASE STUDIES

HANDOUT (H-11.2)



Activity (A11.2)

Medical Eligibility Criteria for Progestin-Only Pills

Divide participants into 3 groups. Give each group a case study and allow them 10 minutes to check in which WHO category the woman falls, in context of progestogen only pills, by using MEC Wheel

CASE SCENARIOS

- 1) A 38 years old patient wishes to take “pills”, but she has heard that these are harmful for smokers. She usually smokes around 20 cigarettes a day.

What do you tell her?

- 2) A woman who delivered 4 weeks ago and is breastfeeding. Everything is alright with she and her baby; she has enough milk for the infant. She asks you: “What can I do from now on in order to avoid becoming pregnant?”

What do you tell?

- 3) A 21 years old woman, known to have prolapsed mitral valve, just has had an abortion. She wants a modern contraceptive method (until now they used withdrawal and she does not want to go through another abortion).

What do you tell her?

AVOID UNNECESSARY PROCEDURES:

Women can begin using POPs:

- 1) Without a pelvic examination
- 2) Without any blood tests
- 3) Without cervical cancer screening
- 4) Without a breast examination
- 5) Without a pregnancy test. A woman can begin using POPs at any time, even when she is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant

Blood pressure measurement is desirable before starting a hormonal method. However, where the risks of pregnancy are high and few methods are available, a woman should not be denied a hormonal method simply because her blood pressure cannot be measured. If possible, she can have her blood pressure measured later at a time and place convenient for her.

MEDICAL ELIGIBILITY CRITERIA FOR PROGESTIN-ONLY PILLS

Ask the woman the questions below about known medical conditions. Examination and tests are not necessary. If she answers “no” to all of the questions, then she can start POPs if she wants. If she answers “yes” to a question, follow the instructions. In some cases, she can still start POPs.

1. Do you have severe cirrhosis of the liver or liver tumour?

NO YES

If she severe cirrhosis or liver cancer, do not provide POPs. Help her choose a method without hormones.

2. Do you have a serious problem now with a blood clot in your leg or lungs?

NO YES

If she reports a current blood clot in a leg (affecting deep veins, not superficial veins) or in a lung, and she is not on anticoagulant therapy, do not provide POPs. Help her choose a method without hormones.

3. Are you taking medication for seizures? Are you taking rifampicin or rifabutin for tuberculosis or other illness?

NO YES

If she is taking barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, or rifabutin, do not provide POPs. They can make POPs less effective. Help her choose another method but not combined oral contraceptives.

4. Do you have or have you ever had breast cancer?

NO YES

Do not provide POPs. Help her choose a method without hormones.

Also, women should not use POPs if they report having thrombogenic mutations or lupus with positive (or unknown) antiphospholipid antibodies. Be sure to explain the health benefits and risks and the side effects of the method that the woman will use. Also, point out any conditions that would make the method inadvisable, when relevant to the woman.

CORRECTING MISUNDERSTANDINGS:

1. Do not cause a breastfeeding woman's milk to dry up.
2. Must be taken every day, whether a woman has sex that day.
3. Do not make women infertile.
4. Do not cause diarrhoea in breastfeeding babies.
5. Reduce the risk of ectopic pregnancy.

**WOMEN WHO CAN USE THIS METHOD WITHOUT RESTRICTIONS
(MEC CATEGORY 1)**

This method is acceptable for the following sexually active women of reproductive age:

- 1) Are breastfeeding (she can start immediately after childbirth).
- 2) Have or have not had children.
- 3) Are married or are not married.
- 4) Are of any age, including adolescents and women over 40 years old.
- 5) Have just had an abortion, miscarriage, or ectopic pregnancy.
- 6) Smoke cigarettes, regardless of woman's age or number of cigarettes smoked.
- 7) Have anaemia now or had in the past.
- 8) Have varicose veins.

9) Are living with HIV, whether or not on antiretroviral therapy.

Job Aid

(J11.2)

Woman's Condition	Where clinical judgement is possible
History of ectopic pregnancy	Method can be used but advise the woman to report to the clinic without delay if she develops any symptoms suggestive of ectopic pregnancy.
Currently receiving ARV treatment	Method can be used unless Ritonavir or Ritonavir-boosted treatment is used. For all other regimens, advise condom use, which prevents HIV transmission and compensates for any possible reduction in effectiveness.
Diagnosis of SLE with or without severe thrombocytopenia or receiving immunosuppressive therapy	Method can be used (unless they have positive or unknown antiphospholipid antibodies). Ensure regular follow-up at clinic and discontinue method use if symptoms get worse.
Migraine without aura at any age	Method can be initiated. Ensure regular follow-up at clinic. Discontinue method use if symptoms get worse.
History of DVT and Pulmonary Embolism, or prolonged post-op immobilization.	Method can be initiated. Ensure regular follow- up at clinic.
Gall bladder disease: asymptomatic, medically ^[1] treated, or after cholecystectomy.	Method can be initiated. Ensure regular follow- up at clinic
At risk for cardiovascular disease: current and history of ischaemic heart disease and stroke (CVA)	Method can be initiated. Ensure careful evaluation in consultation with responsible clinician and regular follow-up at clinic. Discontinue if condition worsens.

Women with irregular, heavy or unexplained vaginal bleeding	Initiate method. Woman should be evaluated (including VIA/ VILI and Pap Smear).
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COUNSELING ON HOW TO USE POPs

Checklist (C11.2)

1. Give pills	<ul style="list-style-type: none"> Give as many packs as possible—even as much as a year’s supply
2. Explain pill pack	<ul style="list-style-type: none"> Show the pack to the woman Explain that all pills in POP packs are the same colour and all are active pills, containing a hormone that prevents pregnancy Show how to take the first pill from the pack and then how to follow the directions or arrows on the pack to take the rest of the pills
3. Give key instructions	<ul style="list-style-type: none"> Take one pill each day, until the pack is empty. Women who are not breastfeeding should take a pill at the same time each day. Taking the pill more than 3 hour late, makes it less effective.
4. Explain starting next pack	<ul style="list-style-type: none"> When she finishes one pack, she should take the first pill from the next pack on the very next day. Starting a pack late risks pregnancy.
5. Provide backup method and explain use	<ul style="list-style-type: none"> Sometimes she may need to use a backup method, such as when she misses pills or is late taking a pill. Backup methods include abstinence, male or female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. Give her condoms, if possible.
6. Explain that effectiveness decreases when breastfeeding stops	<ul style="list-style-type: none"> Without the additional protection of breastfeeding itself, POPs are not as effective as most other hormonal methods. When she stops breastfeeding, she can continue taking POPs if she is satisfied with the method, or she is welcome to come back for another method.
7. Take one pill each day—until the pack is empty.	<ul style="list-style-type: none"> Women who are not breastfeeding should take a pill at the same time each day. Taking a pill more than 3 hours late, makes it less effective.

8. Discuss cues for taking a pill every day.

- Linking pill-taking to a daily activity, such as cleaning her teeth may help her remember.

GENERAL ADVICE

When she finishes one pack, she should take the first pill from the next pack, the very next day.

It is important to start the next pack on time. Starting a pack late risks pregnancy.

Sometimes she may need to use a backup method, such as when she misses pills or is late taking a pill.

Backup methods include abstinence, male or female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. Give her condoms, if possible.

Come Back Any Time:” Reasons to Return

Assure every woman that she is welcome to come back any time, if she;

- 1) Has any problems, questions, or wants another method.
- 2) A major change in health status.
- 3) She thinks she might be pregnant.
- 4) She has stopped breastfeeding and wants to switch to another method.

GENERAL HEALTH ADVICE:

Anyone who suddenly feels that something is seriously wrong with her health should immediately seek medical care from a nurse or doctor. Her contraceptive method is most likely not the cause of the condition, but she should tell the nurse or doctor what method she is using.

SESSION 3

TITLE: COMMON SIDE EFFECTS AND THEIR MANAGEMENT

(40 MINUTES)

OUTLINE & OBJECTIVES:

Discuss the common side effects of POPs and their management.

METHODOLOGY:

Brainstorming followed by presentation and large group discussion.

Handout (H11.3)
Activity (A11.3)
Job Aid (J11.3a) (J11.3b)

COMMON SIDE EFFECTS AND THEIR MANAGEMENT

HANDOUT (H-11.3)

SIDE-EFFECTS

- 1) Changes in the menstrual cycle: inter-menstrual bleeding, spotting or amenorrhea
- 2) Weight gain
- 3) Acne
- 4) Headache
- 5) Breast tenderness.

GIVING ADVICE ON SIDE EFFECTS:

Describe the most common side effects	<ol style="list-style-type: none">1. Breastfeeding women normally do not have monthly bleeding for several months after giving birth. POPs lengthen this period of time.2. Women who are not breastfeeding may have frequent or irregular bleeding for the first several months, followed by regular bleeding or continued irregular bleeding.3. Headaches, dizziness, breast tenderness, and possibly other side effects
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Explain about these side effects	<ol style="list-style-type: none"> 1. Side effects are not signs of illness. Lack of bleeding does not mean pregnancy. 2. Usually become less or stop within the first few months of using POPs. Bleeding changes, however, usually persist. 3. Common, but some women do not have them
Explain what to do in case of side effects	<ol style="list-style-type: none"> 1. Keep taking POPs. Skipping pills risks pregnancy. 2. Try taking pills with food or at bedtime to help avoid nausea. 3. The client can come back for help if side effects bother her or if she has other concerns.



(Activity A11.3)

Divide the participants into two groups on the basis of saying “Yes” and “No” and let them brainstorm the common side effects in their practice and their management. Ask the two groups to take 10 minutes to prepare and choose a representative to speak.

Let the two groups present and then the trainer moderates the discussion and highlights any missing points

Job Aid

(J11.3a)

SIDE EFFECTS	MANAGEMENT
No monthly bleeding	<p>Breastfeeding women:</p> <p>Reassure her that this is normal during breastfeeding. It is not harmful.</p> <p>Women not breastfeeding:</p>

<p>Irregular bleeding (bleeding at unexpected times that bothers the woman)</p>	<p>Reassure her that many women using POPs experience irregular bleeding whether breastfeeding or not. (Breastfeeding itself also can cause irregular bleeding.) It is not harmful and sometimes becomes less or stops after the first several months of use. Some women have irregular bleeding the entire time they are taking POPs.</p> <p>Rule out other possible causes of irregular bleeding</p> <p>Ask her if she had vomiting or diarrhoea or taking anticonvulsants or rifampicin</p> <p>To reduce irregular bleeding:</p> <p>For modest short-term relief, she can try 400 mg ibuprofen 2- 3 times daily after meals for 5 days, or other nonsteroidal anti-inflammatory drug (NSAID), beginning when irregular bleeding starts. NSAIDs provide some relief of irregular bleeding for implants, progestin-only injectables, and IUCDs, and they may also help POP users.</p> <p>If she has been taking the pills for more than a few months and NSAIDs do not help, give her a different POP formulation, if available. Ask her to try the new pills for at least 3 months.</p> <p>If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use</p>
<p>Heavy or prolonged bleeding (twice as much as usual or longer than 8 days)</p>	<p>Reassure her that some women using POPs experience heavy or prolonged bleeding. It is generally not harmful and usually becomes less or stops after a few months.</p> <p>For modest short-term relief, she can try NSAIDs, beginning when heavy bleeding starts.</p> <p>To help prevent anaemia, suggest she takes iron tablets and tell her it is important to eat foods containing iron, such as red meat and poultry (especially beef and liver), green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).</p> <p>If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or underlying pathology is suspected, consider underlying conditions unrelated to method use.</p>
<p>Ordinary headaches (non-migrainous)</p>	<p>Suggest ibuprofen (200–400 mg), paracetamol (500–1000 mg), or other pain reliever.</p> <p>Any headaches that get worse or occur more often during POP use should be evaluated.</p>

<p>Mood changes or changes in sex drive</p>	<p>Ask about changes in her life that could affect her mood or sex drive, including changes in her relationship with her husband. Give her support as appropriate.</p> <p>Some women experience depression in the year after giving birth. This is not related to POPs. Women with serious mood changes such as major depression should be referred for care.</p> <p>Consider locally available remedies.</p>
<p>Breast tenderness</p>	<p>Women not breastfeeding:</p> <p>Recommend that she wear a supportive bra (including during strenuous activity and sleep).</p> <p>Try hot or cold compresses.</p> <p>Suggest ibuprofen (200–400 mg), paracetamol (500–1000 mg), or other pain reliever.</p> <p>Consider locally available remedies.</p>
<p>Severe pain in lower abdomen</p>	<ul style="list-style-type: none"> • Slight or occasional abdominal pain may be due to various problems, such as enlarged ovarian follicles or cysts. A woman can continue to use POPs during evaluation and treatment. Reassure the woman that they usually disappear on their own. • To be sure the problem is resolving, see the woman again in 6 weeks, if possible. • Severe abdominal pain be particularly alert for additional signs or symptoms of ectopic pregnancy, which is rare and not caused by POPs, but it can be life-threatening. • In the early stages of ectopic pregnancy, symptoms may be absent or mild, but eventually they will become severe. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy: <ul style="list-style-type: none"> -Unusual abdominal pain or tenderness
<p>Nausea or dizziness</p>	<p>For nausea, suggest taking POPs at bedtime or with food.</p> <p>If symptoms continue, consider locally available remedies.</p>

New Problems That May Require Switching Methods	
Unexplained vaginal bleeding (that suggests a medical condition not related to the method)	<ul style="list-style-type: none"> • Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate. • She can continue using POPs while her condition is being evaluated. • If bleeding is caused by a sexually transmitted infection or pelvic inflammatory disease, she can continue using POPs during treatment.
Starting treatment with anticonvulsants, rifampicin, or rifabutin	<ul style="list-style-type: none"> • Barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, rifampicin, rifabutin, and ritonavir may make POPs less effective. If using these medications long-term, she may want a different method, such as progestin-only injectables or a copper-bearing IUCD or LNG-IUCD. • If using these medications short-term, she can use a backup method along with POPs.
Migrainous headaches	<ul style="list-style-type: none"> • A woman who has migraine headaches with or without aura can safely start POPs. • If she develops migraine headaches without aura while taking POPs, she can continue to use POPs if she wishes. • If she develops migraine aura while using POPs, stop POPs. Help her choose a method without hormones.
Certain serious health conditions (suspected blood clots in deep veins of legs or lungs, liver disease, or breast cancer).	<ul style="list-style-type: none"> • Tell her to stop taking POPs. • Give her a backup method to use until the condition is evaluated. • Refer for diagnosis and care if not already under care.

<p>Heart disease due to blocked or narrowed arteries (ischemic heart disease) or stroke</p>	<ul style="list-style-type: none"> • A woman who has one of these conditions can safely start POPs. • If, however, the condition develops after she starts using POPs, she should stop. Help her choose a method without hormones. • Refer for diagnosis and care if not already under care.
<p>Suspected pregnancy</p>	<ul style="list-style-type: none"> • Assess for pregnancy, including ectopic pregnancy. • Tell her to stop taking POPs if pregnancy is confirmed. • There are no known risks to a foetus conceived while a woman is taking POPs

SESSION 4
TITLE: MISSED PILLS, COMMON PROBLEMS AND TROUBLESHOOTING
(30 MINUTES)

OUTLINE & OBJECTIVES:

This session is deigned to deal with common problems encountered while taking POPs, missed pills and their management protocol will be discussed

METHODOLOGY:

Brainstorming in groups followed by interactive session with power point presentation

Handout (H11.4)

MISSED POPS & TROUBLE SHOOTING

HANDOUT (H-11.4)

If a woman is 3 or more hours late in taking a pill (12 or more hours late taking a POP containing desogestrel 75 µg), or if she misses a pill completely, she should follow the instructions f or breastfeeding women.

For breast feeding women, whether missing a pill places her at risk of pregnancy depends on whether her monthly bleeding has returned.

KEY MESSAGE

- 1) Take a missed pill as soon as possible.
- 2) Keep taking pills as usual, one each day. (She may take 2 pills at the same time or on the same day.

If the woman's menses have returned and she misses one or more pills by more than three hours (or 12 hours in the case of the 75 µg desogestrel- containing pill), regardless of whether she is breastfeeding.

- 1) Take one pill as soon as possible and continue taking the pills as usual, one each day.
- 2) Abstain from sex or use a back-up method (e.g., a condom) for the next two days.
- 3) Also, if she had sex in the past 5 days, she can consider taking ECPs

Woman is breastfeeding and is amenorrheic, and she misses one or more pills by more than three hours (or 12 hours in the case of the 75 µg desogestrel-containing pill).

- 1) Take one pill as soon as possible and continue taking the pills as usual, one each day.
- 2) If she is less than six months postpartum, no back up method is needed.

Severe vomiting or diarrhoea

- 1) If she vomits within 2 hours after taking a pill, she should take another pill from her pack as soon as possible, and keep taking rest of the pills as usual.

SESSION 5

TITLE: FREQUENTLY ASKED QUESTIONS

(20 MINUTES)

OUTLINE & OBJECTIVES:

This session is designed to get the participants to brainstorm about POPs and summarize the information provided

METHODOLOGY:

Pass the cabbage game

Handout (H11.5)

Activity (A11.5)

FREQUENTLY ASKED QUESTIONS

HANDOUT (H-11.5)



(Activity A11.5)

The questions are written on a different coloured piece of paper and folded as a cabbage. The participants are asked to stand in a circle and play 'pass the parcel' with music playing. Whoever has the cabbage at the time when music stops, peels a layer and reads the question. If that participant cannot answer the question, she can pass it on to the next one. The trainer ensures all answers are correctly discussed

1. Can a woman who is breastfeeding safely use POPs?

The recent WHO recommendation to allow a woman to use progestin-only pills after childbirth regardless of how recently she gave birth. POPs are safe for both the mother and the baby and do not affect milk production.

2. What should a woman do when she stops breastfeeding her baby? Can she continue taking POPs?

A woman who is satisfied with using POPs can continue using them when she has stopped breastfeeding. However, she is less protected from pregnancy than when breastfeeding. She

can switch to another method if she wishes.

3. Can a woman take POPs at any age?

Yes. There is no minimum or maximum age for POP use. POPs can be an appropriate method for adolescents. Adolescents who are breastfeeding have the same need for an effective way to space births as older women. They may need extra support and encouragement to use POPs consistently and effectively.

4. Do POPs cause birth defects? Will the fetus be harmed if a woman accidentally takes POPs while she is pregnant?

No. Good evidence shows that POPs will not cause birth defects and will not otherwise harm the fetus if a woman becomes pregnant while taking POPs or accidentally takes POPs when she is already pregnant.

5. How long does it take to become pregnant after stopping POPs?

Women who stop using POPs can become pregnant as quickly as women who stop non-hormonal methods. POPs do not delay the return of a woman's fertility after she stops taking them. The bleeding pattern a woman had before she used POPs generally returns after she stops taking them. Some women may have to wait a few months before their usual bleeding pattern returns.

6. If a woman does not have monthly bleeding while taking POPs, does this mean that she is pregnant?

Probably not, especially if she is breastfeeding. If she has been taking her pills every day, she is probably not pregnant and can keep taking her pills. If she is still worried after being reassured, she can be offered a pregnancy test, if available, or referred for one. If not having monthly bleeding bothers her, switching to another method may help—but not to another progestin-only method. These methods sometimes stop monthly bleeding.

7. Must the POP be taken every day?

Yes. All of the pills in the POP package contain the hormone that prevents pregnancy. If a woman does not take a pill every day—especially a woman who is not breastfeeding—she could become pregnant. (In contrast, the last 7 pills in a 28-pill pack of combined oral contraceptives are not active. They contain no hormones.)

8. Can POPs be used as emergency contraceptive pills (ECPs) after unprotected sex?

Yes. As soon as possible, but no more than 5 days after unprotected sex, a woman can take POPs as ECPs. Depending on the type of POP, she will have to take 40 to 50 pills. This is many pills, but it is safe because there is very little hormone in each pill.

9. Do POPs lower women’s mood or sex drive?

Generally, no. Some women using POPs report these complaints. The great majority of POP users do not report any such changes, however, and some report that both mood and sex drive improve. It is difficult to tell whether such changes are due to the POPs or to other reasons. Providers can help a woman with these problems there is no evidence that POPs affect women’s sexual behavior.

10. Do POPs increase the risk of ectopic pregnancy?

No. On the contrary, POPs reduce the risk of ectopic pregnancy. Ectopic pregnancies are rare among POP users. The rate of ectopic pregnancy among women using POPs is 48 per 10,000 women per year. On the uncommon occasions that POPs fail and pregnancy occurs, 5 to 10 of every 100 of these pregnancies are ectopic. Thus, the great majority of pregnancies after POPs fail are not ectopic. Still, ectopic pregnancy can be life-threatening, and so a provider should be aware that ectopic pregnancy is possible if POPs fail.

SESSION 5

TITLE: WRAP UP AND SUMMARY

(10 MINUTES)

The trainer will wrap up and summarize the session and ask participants how they might use this information in their work in facilities or in the community.

FURTHER READING:

Family Planning, A Global Handbook for Providers

<https://www.nhs.uk/conditions/contraception/the-pill-progestogen-only/>

EMERGENCY CONTRACEPTION



Time: 2hr 45 mins

Emergency contraception (EC) is an important component of the FP armamentarium. This is specifically useful for women who have had an episode of contraceptive method failure or did not use any FP method and in case of sexual assault.



TRAINING OBJECTIVES

- 1) Discuss the value of emergency contraception in preventing unintended pregnancies
- 2) Provide detailed information on the types, dosage, mechanism of action, adverse events, indications and timelines for usage of EC
- 3) Practice counselling skills for emergency contraception
- 4) Use MEC for EC confidently



LEARNING OUTCOMES

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

- 1) Demonstrate detailed knowledge of EC usage, both pills and IUCD.
- 2) Discuss precautions and considerations concerning the use of emergency contraceptive pills (ECPs) and IUCD.
- 3) Discuss types, mechanism of action, dosage and regimens, appropriate use and effectiveness of ECPs.
- 4) Providing ECPs in advance, to women at risk of unintended pregnancy.
- 5) Demonstrate how to manage potential side effects of EC.
- 6) Demonstrate non-judgmental attitude and respect for the woman in providing EC services.



TRAINING/ LEARNING METHODS

- 1) Power point presentation
- 2) Brainstorming

- 3) Small group discussion and presentation
- 4) Handouts
- 5) Group activity



ADVANCE PREPARATIONS

- 1) Sample contraceptive methods.
- 2) WHO Family planning: A global handbook for providers, 2018.



CONSTITUTION OF THE SESSION

Six mini sessions will be held

1) The need for emergency contraception	Brainstorming/discussion	25 Mins
2) ECP types, their mechanism of action indications & regimens	Lecture/interactive discussion	30 Mins
3) Using IUCD as EC	Brainstorming / Lecture	25 Mins
4) Common side effects and problems	Group work/Feed back	30 Mins
5) Counselling for EC	Group work /Role play	45 Mins
6) Wrap up		10 Mins



TRAINING MATERIALS

Trainer' Material	Trainee's Material
Hand Outs: H12.1, H12.2, H12.3, H12.4, H12.5. H12.6	Hand Outs: H12.1, H12.2, H12.3, H12.4, H12.5. H12.6
Activity: A12.1. A12.4, A12.5, A12.6	Job aid: J12.2, J 12.5
Checklists: 12.1,12.5	Checklist C12.1.C12.5
Job aid: J12.2, J 12.5	

SESSION 1

TITLE: THE NEED FOR ECP

(25 MINUTES)

OUTLINE & OBJECTIVES:

Discuss unintended pregnancy as an important issue faced by women. Clarify the need and indications for ECP usage. Highlight the role of ECP in prevention of unintended pregnancies.

METHODOLOGY:

Brain storming, group discussion and experience sharing

Experience sharing, group work

Handout (H12.1)

Activity (A12.1)

Checklist (C12.1)

THE NEED FOR EC

HANDOUT (H-12.1)



ACTIVITY (A12.1)

Indications for EC

Post on the flipchart “**Unintended pregnancy and Emergency Contraception**”. Divide the group into two on basis of saying A or B alternatively

Ask group A to discuss the unintended pregnancies and the ripple effect that follows

Ask participants in the group B to discuss “Why or when would someone need EC?”

Ask participants to identify from their experiences which women are most likely to have the need for EC. The two groups brainstorm for 5 minutes each, choose a representative, who presents their discussion in 5 minutes each. Highlight the need to help stop the unintended pregnancies as an important intervention for better health and wellbeing of women, babies

and families

Discuss and complement participant responses with the information below.

UNINTENDED PREGNANCY

Unintended pregnancy is “a pregnancy that is unwanted or mistimed at conception”. Unintended pregnancy does not mean unwanted births or children. However, it does mean less opportunity to prepare and less time for:

- 1) Pre-pregnancy risk identification.
- 2) Management of pre-existing conditions.
- 3) Changes in diet and vitamins.
- 4) Avoidance of alcohol, toxic exposure, and smoking.
- 5) Ensuring the financial resources needed to deliver and support a new child.

EACH YEAR IN THE WORLD:

- 1) Seventy-five million women experience an unintended pregnancy.
- 2) Thirty million women experience contraceptive failure.
- 3) Approximately **40-50 million** abortions occur, of which twenty million are unsafe.

CONSEQUENCES OF UNINTENDED PREGNANCIES CAN BE SIGNIFICANT:

- 1) Health risks to mother.
- 2) Reliance on abortion to end pregnancy.
- 3) Discontinuation of schooling (for adolescents).
- 4) Emotional distress.
- 5) Economic hardship.
- 6) Disapproval from the family and community
- 7) Possible health risks to infants, including birth injuries, lower birth weight, and a lower chance of survival.

Emergency contraception is the only currently available contraceptive method that prevents pregnancy **after** sexual intercourse and **before** implantation. Because there is no perfect form of contraception and there are very few perfect contraceptive users, it is important to remember that even those couples using contraception faithfully and correctly, can experience contraceptive failure.

1. **Emphasize** that this type of contraception should not be used as routine (in

place of regular family planning methods), but only in emergency situations (when unprotected sex has occurred or there is a method failure and the woman wants to avoid pregnancy).

2. Add the fact that frequent use of the method is not recommended due to the higher hormonal doses that it contains, in comparison to regular use of oral contraceptives; and that if a woman repeatedly requests emergency contraception, she needs a regular family planning method and she should be counselled for choosing one.

It is not recommended for a service provider to refuse to a woman emergency contraception (even if she is not for the first time in this situation), if she is at risk of an unwanted pregnancy.

Indications for emergency contraception

Checklist (C12.1)

If a couple recently had sex without using contraception (within 5 days)
Miscalculation of the fertile period when using periodic abstinence or failure to abstain or use a barrier method on the fertile days of the cycle when using fertility awareness-based methods
Condom breakage, slippage, or incorrect use
If a woman using oral contraceptive pills missed three or more pills.
More than 3 hours late from the usual time of intake of the progestogen-only pill (minipill), or more than 27 hours after the previous pill;
More than 12 hours late from the usual time of intake of the desogestrel-containing pill (0.75 mg) or more than 36 hours after the previous pill
More than 2 weeks late for the Norethisterone enanthate (NET-EN) progestogen-only injection;
More than 4 weeks late for the depot-medroxyprogesterone acetate (DMPA) progestogen-only injection
More than 7 days late for the combined injectable contraceptive (CIC)
Dislodgment, breakage, tearing, or early removal of a diaphragm or cervical cap
Failure of a spermicide tablet or film to melt before intercourse
Expulsion of hormonal contraceptive implant
If a woman thinks that her diaphragm or cervical cap slipped.
If a woman experienced a spontaneous IUCD expulsion
If sex was forced (rape)
Failure of withdrawal method when ejaculation has occurred in the vagina or on the external genitalia.

An advance supply of ECPs may be given to a woman to ensure that she will have them available, when needed and can take them as soon as possible after unprotected intercourse

MEC FOR EMERGENCY CONTRACEPTIVE PILLS

All women can use ECPs safely and effectively, including women who cannot use ongoing hormonal contraceptive methods. Because of the short-term nature of their use, there are no medical conditions that make ECPs unsafe for any woman.

WHEN TO TAKE ECP?

1. As soon as possible, within 3 days after unprotected sex. The sooner ECPs are taken after unprotected sex, the better they are at preventing pregnancy.
2. Can help to prevent pregnancy when taken any time up to 5 days after unprotected sex.

HOW EFFECTIVE?

If 100 women each had sex once during the second or third week of the menstrual cycle without using contraception, 14 women would be likely to become pregnant.

1. If all 100 women used Ulipristal acetate ECPs, less than one woman would likely become pregnant.
2. If all 100 women used progestin only ECPs, one woman would be likely to become pregnant.
3. If all 100 women used combined oestrogen and progestin ECPs, 2 women would be likely become pregnant.

COMMON MISPERCEPTIONS:

Misconceptions

- Emergency contraception is a form of abortion.
- Emergency contraception promotes irresponsible and or promiscuous sexual behavior.
- Emergency contraception is targeted mainly at unmarried adolescents and may undermine parental authority and community morals.
- Women or couples may stop using regular contraception if emergency contraception is easily available
- Men may be less willing to use condoms if they know that their wives can use emergency contraception

SESSION 2

TITLE: ECP TYPES, THEIR MECHANISM OF ACTION & REGIMENS

(30 MINUTES)

OUTLINE & OBJECTIVES:

Discuss pills and IUCDs as methods for EC. Indications for EC, mechanism of action, types, regimens, and effectiveness.

METHODOLOGY:

Interactive lecture session about the main types of EC and their effectiveness. The regimes and time bars will be discussed. Both pill and IUCD usage as EC will be discussed. Their relative effectiveness will be brought to light. Transition to a regular method of contraception will also be discussed

Handout (H12.2)

Job aid (J12.2)

TYPES, INDICATIONS, MECHANISM OF ACTION AND EFFECTIVENESS

HANDOUT (H-12.2)

There are **two types of EC**: EC Pills and IUCD insertion

EMERGENCY CONTRACEPTIVE PILLS:

Emergency contraceptive pills (ECPs) are higher doses of the same hormones found in ordinary birth control pills. ECPs should be taken as soon as possible after unprotected intercourse. The sooner they are taken, the more effective they are but they can be taken up to 5 days after unprotected sex. ECPs are sometimes referred to as the “morning after pill”. Recommended dosage differs depending on the type of ECP that is taken.

ECPs can be provided to women **before** they need them. Contraceptives failure may happen and sometimes women are unable to use a contraceptive method. Therefore, it may be important for women to have ECPs available at home in the event that they have unprotected intercourse and do not want to get pregnant. Having ECPs at home will help ensure that they are easily available and can be used soon after intercourse when they are most effective.

Emergency contraception sometimes is confused with medical abortion. Medical abortion is used to terminate an existing pregnancy, whereas emergency contraception is effective only before a pregnancy is established. Emergency contraception can prevent pregnancy after sexual intercourse and is ineffective after implantation. Studies of high-dose oral contraceptives indicate that hormonal emergency contraception confers no risk to an established pregnancy or harm to a developing embryo.

MECHANISM OF ACTION OF EC PILLS:

No single mechanism of action has been established for emergency contraception; Timing plays a key role in how ECPs work. Of particular importance is:

1. Cycle day on which intercourse occurred.
2. Cycle day on which she visits the health facility.

Statistical evidence suggests that ECPs must work through more than one mechanism of action or they could not be as effective as they are:

1. Research has shown that ECPs can inhibit or delay ovulation. Emergency contraceptive pills prevent pregnancy by preventing or delaying ovulation and they do not induce an abortion.
2. ECPs may prevent implantation (i.e., the implanting of the fertilized egg in the lining of the uterus) by altering the endometrium (the lining of the uterus). However, the evidence for endometrial effects of ECP treatment is mixed, and it is not clear that the endometrial changes would inhibit implantation.
3. It is possible that ECPs inhibit fertilization through thickening of the cervical mucus resulting in trapping of sperm
4. ECP may interfere with ovum and sperm transport

Ulipristal acetate and Levonorgestrel-only regimen have been shown to inhibit or delay ovulation. Levonorgestrel delays follicular development when administered before the level of luteinizing hormone increases. Ulipristal acetate inhibits follicular rupture even after the level of luteinizing hormone has started to increase.

Review of the evidence suggests that emergency contraception is unlikely to prevent implantation of a fertilized egg. **Emergency contraception cannot interrupt an established pregnancy or harm a developing embryo**

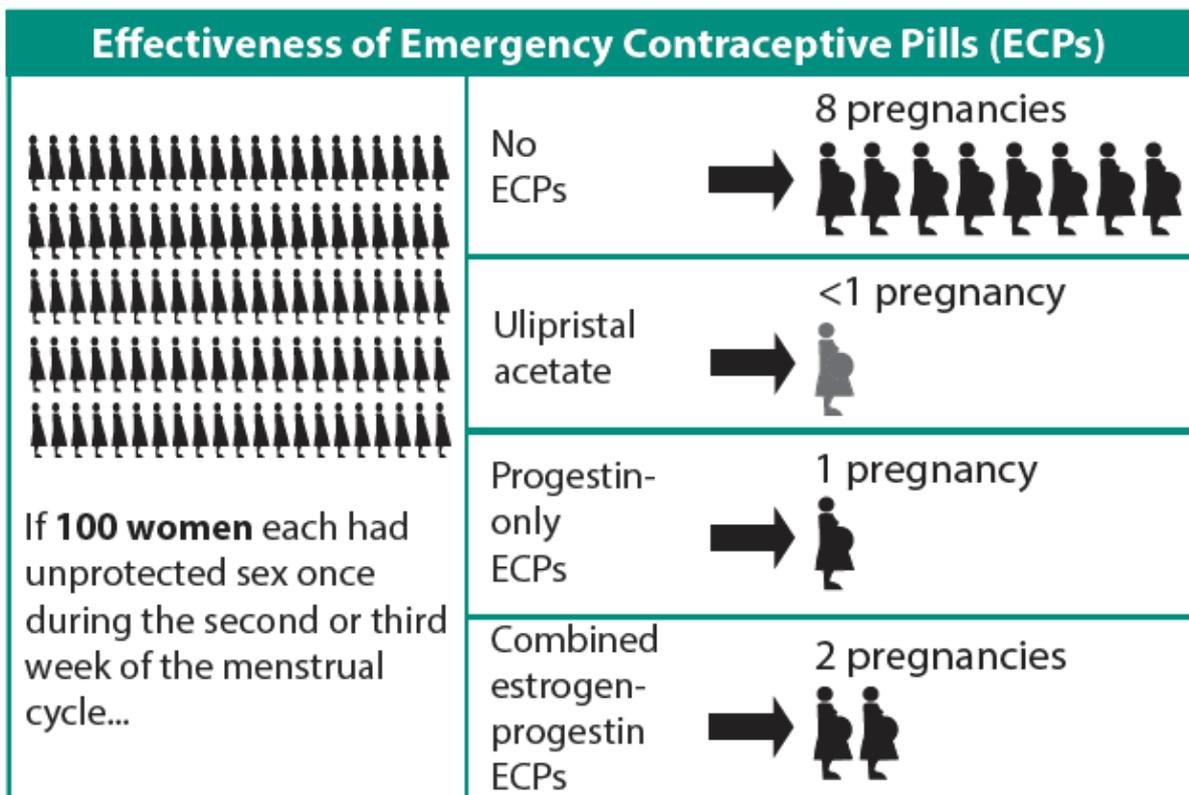
EFFECTIVENESS OF TWO EMERGENCY CONTRACEPTIVE PILL REGIMENS

There are two types of ECPs currently in use that will be discussed in this module. Each type or regimen is defined by the type of hormone or active ingredients used.

- 1) The progestin-only regimen consists of 1.5mg Levonorgestrel (or 3.0 Norgestrel) taken in a single dose as soon as possible after unprotected intercourse. It can be taken up to 120 hours or five days after unprotected intercourse. It is important to take the pills as soon as possible because their effectiveness decreases over time.
- 2) Oestrogen and Progestin (the combined regimen, or the Yuzpe regimen), is Ethinyl Estradiol plus Levonorgestrel (or Norgestrel). The first dose has to be taken as soon as possible after unprotected intercourse and the second dose 12 hours later. It can be taken up to 120 hours or five days after unprotected intercourse. It is important to take the pills as soon as possible because the effectiveness decreases over time.

Note: The two doses of the combined ECP regimen should NOT be taken at one time because of the increased risk of nausea and vomiting.

EFFECTIVENESS OF ECS



The differences in both effectiveness and side effects between the two methods are significant. The progestin-only method is more effective and produces fewer side effects.

Regimen	Effectiveness	Side effects
Progestin-only	Reduces the risk of pregnancy by 149 percent .	Nausea in 23 percent of women and vomiting in 6 percent.
Combined Estrogen and Progestin	Reduces the risk of pregnancy by 75 percent .	Nausea present in 43 percent of women using this regimen and vomiting in 16 percent.

If vomiting occurs within one hour after taking a dose, take another dose as soon as possible. If vomiting occurs more than one hour after taking ECPs, you do not need to repeat the dose.

Neither method will work if a woman is already pregnant

Body weight influences the effectiveness of oral emergency contraception. Levonorgestrel emergency contraception may be less effective in women who are overweight (body mass index [BMI] 25–29.9 kg/m²) or obese (BMI of 30 kg/m² or greater). Ulipristal acetate has lower effectiveness among obese women. The efficacy of the copper IUCD is not affected by body weight. Therefore, consideration should be given to use of a copper IUCD as an alternative to oral emergency contraception in obese women.

Dosage Card

Job Aid (J12.2)

WHO recommends any of the following drugs for emergency contraception:

- ECPs with UPA, taken as a single dose of 30 mg;
- ECPs with LNG taken as a single dose of 1.5 mg, or alternatively, LNG taken in 2 doses of 0.75 mg each, 12 hours apart.
- COCs, taken as a split dose, one dose of 100 µg of Ethinyl estradiol plus 0.50 mg of LNG, followed by a second dose of 100 µg of Ethinyl estradiol plus 0.50 mg of LNG 12 hours later. (Yuzpe method)

SESSION 3

TITLE: IUCD AS EMERGENCY CONTRACEPTION

(25 MINUTES)

OUTLINE & OBJECTIVES:

To highlight and discuss the IUCD usage as a method of emergency contraception

METHODOLOGY:

Small interactive talk about the IUCD as EC

Handouts: (H12.3)

IUCD AS AN EC

HANDOUT (H-12.3)

WHO recommends that a copper-bearing IUCD, when used as an emergency contraceptive method, be inserted within 5 days of unprotected intercourse. This method is particularly appropriate for women who would like to start using a highly effective, long acting, and reversible contraceptive method.

IUCD INSERTION AS EMERGENCY CONTRACEPTION

IUCD insertion within **7 days** of unprotected sex is an effective form of EC and has the added benefit of providing the woman with a long-term contraceptive method. Providers not trained in IUCD insertion can refer women to trained health care providers for this procedure.

However, this must occur within the time frame mentioned above. A copper IUCD used for EC reduces the risk of pregnancy after unprotected intercourse by 99 percent. If inserted for EC, IUCDs can be retained (for up to 10 years in case of Cu-380A) or removed during the woman's next menstruation. Screening for IUCD as an EC method should follow regular IUCD screening criteria. In addition, the provider should ascertain that the unprotected intercourse occurred within 7 days of seeking treatment.

EFFECTIVENESS:

When inserted within 120 hours of unprotected intercourse, a copper-bearing IUCD is more than 99% effective in preventing pregnancy. This is the most effective form of emergency

contraception available. Once inserted, women can continue to use the IUCD as an ongoing method of contraception or may choose to change to another contraceptive method.

MODE OF ACTION OF IUCD:

1. The copper IUCD prevents fertilization by affecting sperm viability and function. It also may affect the oocyte and endometrium
2. If fitted within 5 days of fertilization, will prevent implantation
3. Effective immediately after insertion

Please remember:

- ✚ Emergency contraception does not protect against STIs (in the case of IUCD, this risk could even be increased).
- ✚ Screening for an IUCD as an EC method should follow regular IUCD screening criteria.
- ✚ In addition, the provider should ascertain that the unprotected intercourse occurred within 7 days of seeking treatment.
- ✚ A copper-bearing IUCD is a safe form of emergency contraception. It is estimated that there may be less than 2 cases of Pelvic Inflammatory Disease (PID) per 1000 users. The risks of expulsion or perforation are low.

Advantage

The woman who has accepted the IUCDs as an emergency contraception has the option to continue to use the same IUCDs as a regular contraceptive thereby contributing to the reproductive health of the woman.

COMPARISON OF EC METHODS:

Yuzpe Method	POPs	IUCDs
<ul style="list-style-type: none">• 75% effective• More chances of nausea and vomiting	<ul style="list-style-type: none">• 94% effective• Less chances of nausea and vomiting	<ul style="list-style-type: none">• 99% Effective• no chances of nausea and vomiting

MEDICAL ELIGIBILITY CRITERIA

Eligibility criteria for general use of a copper IUCD also apply for use of a copper IUCD for emergency purposes. Women with a condition classified as MEC category 3 or 4 (for example,

with current PID, puerperal sepsis, unexplained vaginal bleeding, cervical cancer, or severe thrombocytopenia) for the copper IUCD should not use a copper IUCD for emergency purposes.

In addition, a copper-bearing IUCD should not be inserted for emergency contraception following sexual assault as the woman may be at high risk of a sexually transmitted infection such as chlamydia and Gonorrhoea. A copper-bearing IUCD should not be used as emergency contraception when a woman is already pregnant.

The *WHO Medical eligibility criteria for contraceptive use* states that IUCD insertion may further increase the risk of PID among women at increased risk of sexually transmitted infections (STIs), although limited evidence suggests that this risk is low. Current algorithms for determining increased risk of STIs have poor predictive value. Risk of STIs varies by individual behaviour and local STI prevalence. Therefore, while many women at increased risk of STIs can generally have an IUCD inserted, some women at a very high likelihood of STIs should generally not have an IUCD inserted.

The important screening questions for ECP use following recent unprotected intercourse are:

- 1) Do you want to prevent pregnancy?
- 2) Have you had unprotected sex during the last 5 days (120 hours)?
 - If “yes” then the woman may be eligible for ECPs. Effectiveness will be lower the longer a woman takes to take ECPs.
- 3) Was the last menstrual period less than 4 weeks ago?
- 4) Was this period normal in both its length and timing?
 - If “yes” to the previous two questions, ECPs may be provided.
- 5) Is there reason to believe you may be pregnant?
 - If the woman is not pregnant, ECPs may be given.
 - If the woman’s pregnancy status is unclear, ECPs may still be given, with the explanation that the method will not work if she is already pregnant.

SESSION 4

TITLE: COMMON SIDE EFFECTS OF EC AND HOW TO MANAGE THEM?

(30 MINUTES)

OUTLINE & OBJECTIVES:

This second session on EC s will help clarify the common side effects and their management

METHODOLOGY:

Brain storming and group discussion

Divide the group in three parts, each group to discuss the side effects of medical methods and IUCD usage for emergency contraception

Handouts (H12.4)

Activity (A12.4)

SIDE EFFECTS, LIMITATIONS AND THEIR MANAGEMENT

HANDOUT (H-12.4)



Activity (A12.4)

Divide participants into 3 groups, give each group a chart and a marker and ask them to write down the side effects, limitations, and management of side effects of EC Pills and IUCD. Let them brainstorm and after that let them choose a group leader and present their work. Open questions from other groups can be part of this activity

SIDE EFFECTS OF ECPS:

Side effects are similar to what women face in the first weeks of starting oral contraceptive pills:

- 1) Nausea and Vomiting
- 2) Irregular uterine bleeding

- 3) Breast tenderness
- 4) Headache
- 5) Dizziness
- 6) Fatigue

SIDE EFFECTS OF IUCD AS EC:

- 1) Irregular bleeding
- 2) Spotting
- 3) Insertion pain
- 4) Risks of infection in 3 weeks post insertion
- 5) Risks of expulsion, perforation, ectopic pregnancy (CEU Guidance IUC Apr 2015)

These side effects generally do not last more than one to two days. It is seen that about 20% women may experience nausea and 6% may have vomiting with ECPs. Overall ECPs are well tolerated.

CONTRA-INDICATIONS OF CU- IUCD:

Use of IUCD for EC has same contraindications as routine insertion. Risk of STIs, previous ectopic, age, null parity are not contraindications.

LIMITATIONS:

The closer a woman is to ovulation at the time of unprotected intercourse, higher is the pregnancy risk and lower is the efficacy of the ECPs. Failure of EC to prevent pregnancy beyond the time frame of efficacy window (72-120 hours) following unprotected intercourse may limit its use in women who usually report later than this interval.

MANAGEMENT OF SIDE EFFECTS

- 1) If vomiting occurs within two hours of taking the dose of ECPs, repeat the full dose.
- 2) Women with irregular bleeding and spotting after taking with ECPs should be counselled that this is normal. They should be assured that there is nothing to worry about, also that it should not be confused with menses. Women should be told that ECPs do not necessarily bring on menses immediately (a common misconception among users of ECPs); most women will have their menstrual bleeding on time or slightly early or 2-3 days later than the expected date.
- 3) If menstruation is delayed beyond one week from scheduled date, tests should be conducted to exclude the possibility of pregnancy.

- 4) In about 10-15% of women, emergency contraceptive pills change the amount, duration, and timing of the next menstrual period. These effects are usually minor and do not need any treatment.
- 5) Side effects such as breast tenderness, headache, dizziness, and fatigue are not common and do not generally last more than 24 hours. Paracetamol or Aspirin or Ibuprofen tablets can be safely recommended for breast tenderness and headache.

Plan Continuation Contraception

If emergency contraceptive pills were to be used frequently, the failure rate during a full year of use would be higher than that of regular hormonal contraceptives. This is just one reason why emergency contraceptive pills are inappropriate for regular use.

FOLLOW-UP

Women should be strongly advised to come for follow-up if the menses are delayed for more than one week from the expected date, or if she has lower abdominal pain, heavy bleeding or is concerned and worried. If it is not practical to offer a designated follow-up appointment for everyone, the women should be advised to contact a family planning service provider in case there is:

- 1) Severe pain
- 2) Abnormal bleeding or
- 3) Subsequent period is unusually light, heavy, and short or absent.

At the follow-up, details of the post-treatment menstrual period should be recorded to ensure that the treatment was successful.

- 1) If pregnancy is suspected, a pelvic examination is recommended, and a pregnancy test should be done. If pregnancy is diagnosed, it should be managed as any other unintended pregnancy.
- 2) Women provided with EC pills are counselled for use of regular contraception depending on individual preference.
- 3) The woman is provided information on prevention of STIs and HIV/AIDS.

SESSION 5

TITLE: COUNSELLING SKILLS FOR ECPS

(40 MINUTES)

OUTLINE & OBJECTIVES:

To highlight specific counselling skills for ECPs so as to help the woman make an informed decision

METHODOLOGY:

Role play and interactive group discussion

The participants will be allocated to do role plays as woman and HCP to emphasize and point out the essentials of good counselling. Feedback will be taken from the whole group and in the end the essentials of a good counselling session will be highlighted

Handout (H12.5)

Activity (A12.5)

Checklist (C12.5)

Job Aid (J12.5)

COUNSELLING FOR EC HANDOUT (H-12.5)

Counselling on emergency contraceptive pills is no different from counselling for other family planning methods. As it is a relatively new back-up method, and most women do not know much about it, it is important that women are fully informed and properly counselled.

METHOD SPECIFIC COUNSELLING:

This is done for women who have requested for emergency contraceptive pills after unprotected intercourse. Before providing ECP inform her about:

1. Correct use of ECP
2. How it works
3. Not effective as a 'regular' family planning method when used frequently
4. Its efficacy and failure rates
5. Side effects and their management
6. When she should come back for follow-up?

FOLLOW-UP COUNSELLING:

There is no need for follow-up in case of ECP use. However, the woman should come back to the service provider if:

- 1) Her period is late by more than 7 days of the expected date.
- 2) Menstrual bleeding is too scanty in amount or too short in duration.
- 3) She wants to use regular FP method.
- 4) She needs some clarification about ECP use.

STEPS FOR EFFECTIVE COMMUNICATION:

1. Confirm that the woman does not want to become pregnant, but she understands that there is still a chance of pregnancy even after using ECPs. She needs to be told that ECPs would cause no harm to the foetus, if it fails to prevent pregnancy.
2. Ensure that the dosage schedule is understood i.e. LNG 0.75mg, 2 pills pack taken as a single dose within 72 to 120 hours of the unprotected sexual act. It should be emphasized that the course should be started as early as possible for better effectiveness.
3. Explain that pills are to be taken with water, milk or a snack as it helps to curb the nausea.
4. Explain that taking extra pills, more than the prescribed dose does not increase effectiveness rather, it induces side effects.
5. Make sure to emphasize to the woman that if she vomits within 2 hours of taking the dose, then she must repeat one tablet.
6. Explain the common side effects and their management.
7. Explain that she should not expect to menstruate immediately after taking the pills.
8. Ensure that the woman understands that ECPs offer no protection from pregnancies resulting from continued unprotected intercourse.
9. Counsel for regular contraception. If the timing is not appropriate for any method, then advise condoms until her next menstrual cycle. Demonstrate the use of condoms and ask the woman to repeat it.
10. Explain that ECPs do not protect from STIs/HIV and highlight the need to use condoms if the woman or the husband is at risk.

Stress the importance of follow-up visit in the following situations:

1. Delay in menses by more than one week of the expected date
2. To initiate regular use of a contraceptive immediately after menstruation
3. Uncontrolled side effects

ADOLESCENTS AND ECPS:

The adolescents usually

1. Are unaware of the availability of ECPs.
2. Lack confidence or are embarrassed to ask for ECPs.
3. Are unaware that some providers can help them.
4. Are anxious about judgmental attitudes of providers.

The following recommendations can help increase adolescent women' awareness of EC:

1. Routinely advise women about ECPs as a backup to contraceptive accidents.
2. Make EC information materials available and actively refer women to them.
3. Encourage women to obtain advance-of-need ECPs, if appropriate.
4. Display youth-friendly posters, signs, or other logos.



Activity A12.5

Counselling for ECP and IUCD as Emergency Contraception

Ask for a pair of volunteers, ask them to prepare role play for ECP and IUCD as an emergency contraception. Tell them to use the checklist for counselling given below. Give them 10 minutes to prepare and 5 minutes to do the role play

Counselling skill checklist for ECP

Checklist (C12.5)

COUNSELLING SKILL OBSERVED	YES	NO	COMMENTS
1. Greets the woman in friendly and helpful manner.			
2. Introduces self.			
3. Asks woman why she has come to you or what makes her think she needs ECPs.			
4. Ensures confidentiality.			
5. Enquires about the date of unprotected sex and last menstruation.			
6. Tells the woman about ECPs (how they work, effectiveness, and possible side effects).			
7. Allows the woman to ask questions and asks woman if he/she has any questions.			
8. Discusses the possibility of having an IUCD inserted, in case where the woman is keen for a long-term contraceptive			
9. Counsels about IUCD, if the woman prefers			
10. Explains correct use of ECPs and asks woman to summarize instructions.			
11. Shows ECPs to the woman and gives her correct number of pills.			
12. Explains how to manage possible side effects and tells her to return or go to a clinic or hospital if there are any problems or concerns.			
13. Tells the woman that her menstrual period is likely to be within one week before or after the normal expected date.			
14. Asks woman about ongoing contraceptive method and asks if he/she would like to discuss other contraception options.			
15. Explains to the woman that she and her husband may be at risk of an STI.			
16. Provides referral information for community health services.			
17. Demonstrates a non-judgmental attitude and respect for woman.			
18. Offers the woman an opportunity to ask any questions			

After a woman is screened for ECPs and given instructions on how to use them, it is important to ask if she has any further questions about ECPs

When to Start or Restart Contraception after ECP Use

Job Aid (J12.5)

<p>1. Hormonal methods (Combined oral contraceptives, progestin-only pills, progestin-only injectables, monthly injectables, implants, combined patch, combined vaginal ring)</p>	<p>1- After taking progestin-only or combined ECPs:</p> <ol style="list-style-type: none">Can start or restart any method immediately after she takes the ECPs. No need to wait for her next monthly bleeding.The continuing user of oral contraceptive pills who needed ECPs due to error can resume use as before. She does not need to start a new pack.Patch users should begin a new patch.Ring users should follow the instructions for late replacement or removal.All women need to abstain from sex or use a backup method* for the first 7 days of using their method.If she does not start immediately, but instead returns for a method, she can start any method at any time if it is reasonably certain she is not pregnant. <p>2- After taking ulipristal acetate (UPA) ECPs:</p> <ol style="list-style-type: none">She can start or restart any method containing progestin on the 6th day after taking UPA-ECPs.No need to wait for her next monthly bleeding. (If she starts a method containing progestin earlier, both the progestin and the UPA could be less effective.)If she wants to use oral contraceptive pills, vaginal ring, or patch, give her a supply and tell her to start on the 6th day after taking UPA-ECPs. If she wants to use injectables or implants, give her an appointment to return for the method on the 6th day after taking UPA-ECPs or as soon as possible after that.All women need to use a backup method from the time they take UPA-ECPs until they have been using a hormonal method for 7 days (or 2 days for progestin-only pills).If she does not start on the 6th day, but instead returns later for a method, she may start any method at any time if it is reasonably certain she is not pregnant.
<p>2. Levonorgestrel intrauterine device</p>	<p>1- After taking progestin only or combined ECPs:</p> <ol style="list-style-type: none">She can have the LNG-IUS inserted at any time when it can be determined that she is not pregnantShe should use a backup method* for the first 7 days after LNG-IUS insertion <p>2- After taking UPA-ECPs:</p> <ol style="list-style-type: none">She can have the LNG-IUS inserted on the 6th day after taking UPA-ECPs if it can be determined that she is not pregnant. <p>If she wants to use the LNG-IUCD, give her an appointment to return to have it inserted on the 6th day after taking UPA-ECPs or as soon as possible after that.</p>

	<ul style="list-style-type: none"> b. She will need to use a backup method from the time she takes UPA-ECPs until 7 days after the LNG-IUS is inserted. c. If she does not have the LNG-IUS inserted on the 6th day, but instead returns later, she can have it inserted at any time if it can be determined she is not pregnant.
3. Copper-bearing intrauterine device	<p>1- After taking progestin-only, combined, or UPA-ECPs:</p> <ul style="list-style-type: none"> a. If she decides to use a copper-bearing IUCD after taking ECPs, she can have it inserted on the same day she takes the ECPs. No need for a backup method. b. If she does not have it inserted immediately, but instead returns for the method, she can have the copper-bearing IUCD inserted any time if it can be determined that she is not pregnant. <p>Note: The copper-bearing IUCD can be used for emergency contraception. A woman who wants to use the IUCD for regular contraception can have it inserted for emergency contraception within the first 5 days after unprotected sex and then continue using it.</p>
4. Female sterilization	<p>1- After taking progestin-only, combined, or UPA-ECPs:</p> <p>The sterilization procedure can be done within 7 days after the start of her next monthly bleeding or any other time if it is reasonably certain she is not pregnant. Give her a backup method to use until she can have the procedure</p>
5. Male and female condoms, spermicides, diaphragms, cervical caps, withdrawal	<p>1. After taking progestin-only, combined, or UPA-ECPs:</p> <p>Immediately.</p>
6. Fertility awareness methods	<p>1- After taking progestin-only, combined, or UPA-ECPs:</p> <ul style="list-style-type: none"> a. Standard Days Method: With the start of her next monthly bleeding. b. Symptoms-based methods: Once normal secretions have returned. c. Give her a backup method to use until she can begin the method of her choice

SESSION 6

TITLE: FREQUENTLY ASKED QUESTIONS

(15 MINUTES)

OUTLINE & OBJECTIVES:

This session is designed to get the participants to brainstorm about a few questions about the ECs in a game format

METHODOLOGY:

Pass the bucket

Handout (H12.6)

Activity (A12.6)



Activity (A12.6)

The trainer prints the FAQs one each on a piece of paper, in different colours and place them all in a basket. The pass on the basket is played with music playing. The participant who has the basket when the music stops, picks up a colour of her liking and answers the question A candy is given for the right answer

1- How to use emergency contraceptive pills?

For the progestin-only regimen, take a single dose of 1.5 mg Levonorgestrel as soon as possible within 120 hours after unprotected intercourse.

For the oestrogen and progestin regimen, take the first dose as soon as possible within 120 hours after unprotected intercourse and take the second dose 12 hours later.

2- Do ECPs disrupt an existing pregnancy?

No. ECPs do not work if a woman is already pregnant.

3- Will ECPs harm the foetus if a woman accidentally takes them while she is pregnant?

No. Evidence shows that ECPs do not cause birth defects or otherwise harm the foetus if a woman is already pregnant or if ECPs fail to prevent pregnancy.

4- How long do ECPs protect a woman from pregnancy?

Women who take ECPs should understand that they could become pregnant the next time they have sex unless they begin to use another method of contraception at once. Because ECPs delay ovulation in some women, she may be most fertile soon after taking ECPs.

If she wants ongoing protection from pregnancy, she must start using another contraceptive method by the next day, including a backup method if starting her continuing method requires it. A woman who has taken UPA-ECPs should wait until the 6th day to start a hormonal contraceptive. She should use a backup method during this period.

5- Can ECPs be used more than once?

Yes. If needed, ECPs can be taken again, even in the same cycle. A woman who needs ECPs often may want to consider a longer acting and more effective family planning method.

6- Should women use ECPs as a continuing method of contraception?

A woman can use ECPs whenever she needs them, even more than once in the same cycle. However, relying on ECPs as an ongoing method should not be advised. It is not certain that ECPs, taken every time after sex, would be as effective as regular, continuing methods of contraception.

Also, women who often take ECPs may have more side effects. Repeated use of ECPs poses no known health risks. It may be helpful, however, to screen women who take ECPs often for health conditions that can limit use of hormonal contraceptives.

7- Are ECPs safe for women living with HIV? Can women on antiretroviral therapy safely use ECPs?

Yes. Women living with HIV & those on antiretroviral therapy can safely use ECPs.

SESSION 7

TITLE: WRAP UP AND SUMMARY

(5 MINUTES)

- 1) Many women are not informed about EC.
 - 2) Providers can help expand knowledge and use of this important contraceptive method.
 - 3) Advance distribution can improve woman access to and effective use of ECPs.
-

FURTHER READING

- (<http://www.worldometers.info/>)
- Family planning: a global handbook for providers 2015 Update Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs and World Health Organization
- Glasier A, Cameron ST, Bliethe D, Scherrer B, Mathe H, Levy D, et al. Can we identify women at risk of pregnancy despite using emergency contraception? Data from randomized trials of ulipristal acetate and levonorgestrel. *Contraception*. 2011 Oct;84(4):363-7. doi: 10.1016/j.contraception.2011.02.009. Epub 2011 Apr 2.
- Effect of BMI and body weight on pregnancy rates with LNG as emergency contraception: analysis of four WHO HRP studies. Festin MP, Peregoudov A, Seuc A, Kiarie J, Temmerman M. *Contraception*. 2017 Jan;95(1):50-54. doi: 10.1016/j.contraception.2016.08.001. Epub 2016 Aug 12
- Gemzell-Danielsson K, Berger C, Lalitkumar PG. Emergency contraception -- mechanisms of action. *Contraception* 2013; 87:300–8.
- Kapp N, Abitbol JL, Mathe H, Scherrer B, Guillard H, Gainer E, et al. Effect of body weight and BMI on the efficacy of levonorgestrel emergency contraception. *Contraception* 2015; 91:97–104.

INJECTABLE CONTRACEPTION



TIME: 2 HOURS 30 MINS

Injectable contraceptives are an important component of FP services, yet this method remains underutilized in Pakistan. The convenience and efficacy of this method makes it attractive to women, but many myths and misconceptions exist. This training session is designed to help remove these myths and ensure a better access to this reliable method of contraception.



TRAINING OBJECTIVES

- 1) Discuss the types of injectables available locally, their effectiveness and mechanism of action.
- 2) Highlight the common side effects and their management.
- 3) Demonstrate counselling skills for injectable contraception.
- 4) Describe medical eligibility for injections.



LEARNING OUTCOMES

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

- 1) Describe injectables as an effective FP method.
- 2) Counsel and screen clients seeking injectable contraception.
- 3) Respond to rumours and misconceptions about injections effectively.
- 4) Recognize and manage common side effects and complications.
- 5) Provide follow up care for injectable acceptors.



ADVANCE PREPARATIONS

- 1) Dummy arm for hands on practice
- 2) MEC wheel and MEC charts
- 3) Sayana Press pictorial
- 4) Picture chart



TRAINING/ LEARNING METHODS

- 1) Power point presentation
- 2) Brainstorming exercise
- 3) Group discussion
- 4) Model practice
- 5) Videos



TRAINING MATERIALS

Trainer' Material	Trainee's Material
Hand Outs: H13.1, H13.2, H13.3, H13.4, H13.5, H13.6	Hand Outs: H13.1, H13.2, H13.3, H13.4, H13.5, H13.6
Activity: A13.1a, A13.1b, A13.2, A13.3, A13.6	Job aid: J13.4a, J13.4b, J13.4c, J13.5
Job aid: J13.4a, J13.4b, J13.4c, J13.5	Checklist: C13.2, C13.4
Checklist: C13.2, C13.4	
PPT: (13)	



CONSTITUTION OF SESSION

Seven mini sessions will be held

1. Introduction to the Injectable contraceptives	Brainstorming/discussion	30 Mins
2. MEC/ Client Assessment	Group work/Role play	20 Mins
3. Common side effects and troubleshooting	Lecture/Group discussion	30 Mins
4. Administration of Injection	Group work	30 Mins
5. Missed or late injections	Interactive group work	20 Mins
6. FAQs	Pass the Parcel Game	15 Mins
7. Wrap up		05 Mins

SESSION 1

TITLE: INTRODUCTION TO THE INJECTABLE CONTRACEPTIVES

(30 MINUTES)

OUTLINE & OBJECTIVES:

This session will reinforce the basic details about the injectable contraceptives with discussion about their types and mechanism of action. The schedules will also be discussed and the local brands will be highlighted

METHODOLOGY:

Power point presentation with discussion

Handout: (H13.1)
Activity: (A13.1a, A13.1b)

INTRODUCTION TO THE INJECTABLE CONTRACEPTIVES

HANDOUT (H-13.1)



Activity (A13.1a)

The trainer to initiate and moderate a brainstorming session on the injectable contraceptives

1. Various type available in Pakistan
2. Their dosages and regimens are discussed

All the information is written on a flip chart by the trainer. The trainer then makes a short interactive presentation to highlight the details and any missed points

DESCRIPTION:

Injectable contraceptives contain one or two contraceptive hormones and provide protection from pregnancy for one, two, or three months, (depending on the type). The most widely used injectable methods contain only a progestin (Progestin only Injectable Contraceptives or POIC). Less common methods are those that contain both progestin and oestrogen (Combined Injectable Contraceptives or CIC).

A. PROGESTIN-ONLY INJECTABLE CONTRACEPTIVES (POICS)

The most widely available injectable contraceptives are the three months interval (13 weeks) Depo Provera (Depot- medroxyprogesterone acetate-DMPA) and the two months interval Noristerat (Norethisterone enanthate-NET-EN). Both of these injectable are given by an intramuscular (IM) injection. DMPA has also been formulated for sub-cutaneous injection at three-month intervals (DMPA-SC).

Because they all contain only progestin, they do not have oestrogen-associated side effects. In addition, because progestin does not suppress production of breast milk, these injectable can be used by breastfeeding women postpartum.

MECHANISM OF ACTION:

The injectable provides effective protection against pregnancy mainly by:

- 1) Suppressing ovulation.
- 2) Thickening cervical mucus making it difficult for the sperm to enter the uterus.
- 3) Making the endometrium thin and less suitable for implantation of the fertilized ovum.

EFFECTIVENESS:

- 1) Very effective when the injections are taken regularly (the effectiveness is 99.7%).
- 2) Very effective: 0.3 pregnancies per 100 women in the first year of use, if are correctly administered.

RETURN TO FERTILITY:

It may take about 7-9 months from the first missed injection.

DOSAGE:

The dosages for the different injectable are provided below:

- 1) Depot-medroxyprogesterone acetate (DMPA), 150mg is given every three months (12 weeks), but it can be given as much as two weeks (14 days) earlier or four weeks (28 days) later. A dose of 150 mg in 1 ml of the suspension is given by deep intramuscular injection at regular, 12-weeks intervals to protect the woman from unwanted pregnancy.

- 2) Norethisterone enanthate (NET-EN): 200 mg is given every two months, but it can be given as much as two weeks (14 days) earlier or two weeks (14 days) later.
- 3) Depo-sub, Q Provera 104 (also called DMPA-SC) is a new, lower- dose formulation of DMPA that is injected sub-cutaneously instead of intramuscularly. It contains 104 mg of DMPA instead of the 150 mg in the IM formulation. Like the IM formulation, DMPA-SC is given at three-month intervals.

B. COMBINED INJECTABLE CONTRACEPTIVES (CICS):

The CICs consist of a natural oestrogen plus a progestogen. They prevent pregnancy mainly through the inhibition of ovulation. The dosages for these injectable are provided below:

- 1) Medroxyprogesterone acetate 25mg plus estradiol cypionate 5mg, is given once every 30 days, but it could be given as much as three days earlier or later.
- 2) Norethisterone enanthate 50mg plus estradiol valerate 5mg, is given once every 30 days, but it could be given as much as three days earlier or later.
- 3) NET 50mg /ml with Estradiol valerate 5mg/ml, works for 1 month



Activity (A13.1b)

Divide the participants into two groups and give each group the task of brainstorming advantages and limitations of Progesterone Only Injectable Contraceptives.

Let the groups present their discussions and the trainer then holds a large group discussion to cover any missing points

CONTRACEPTIVE BENEFITS

As a method of contraception, injectables have many benefits:

They are highly effective and safe.

A pelvic exam is not required to initiate use.

POIC contain no estrogen, so they do not have the cardiac and blood-clotting effects, which are associated with estrogen- containing pills and injectable.

These are long-acting methods.

Privacy, no one else can tell that a woman is using it.
Does not interfere with sex.
No daily pill-taking.
One injection prevents pregnancy for 2-3 months.
Is reversible.
Allows some flexibility in return visit; client can return for next injection up to 4 weeks late for DMPA and 2 weeks late for NET-EN.
Does not affect the quantity and quality of breast milk, can be used by nursing mothers as soon as 6 weeks after childbirth.
One of the most effective methods when taken regularly.
Rapidly effective (within 24 hours of taking the injection).
Unobtrusive and easy to use (women may take the decision to use DMPA on her own ^[11] _[SEP] without spouse/family members knowing about it).
Few method related risks compared to the pill.

LIMITATIONS

The limitations associated with Injectable contraceptives include the following:

Need to contact a health worker every 3 months.

They offer no protection against STIs, including hepatitis B and HIV; individuals at risk for these should use condoms in addition to injectable contraceptives.

Return of fertility may be delayed for about four months or longer after discontinuation. The return of fertility can be delayed after stopping the injection-an average of 10 months for DMPA and 6 months for NET-EN.

This method is provider-based, so a woman must go to a health care facility regularly.

Use of injectable could be associated with the following side effects:

- 1) Menstrual changes, such as irregular bleeding, heavy and prolonged bleeding, light spotting or bleeding, amenorrhea, especially after one year of use.
- 2) Weight gain –Headache- Dizziness.
- 3) Mood swings and Abdominal bloating.
- 4) Menstrual changes like spotting and irregular bleeding are common in the first few months of use with both Norigest and Depo-Provera/Megestron.
- 5) Amenorrhoea after prolonged use may occur.
- 6) Cannot be easily discontinued or removed from the body if complications develop or if pregnancy is desired.

SESSION 2

TITLE: CLIENT ASSESSMENT AND MEC FOR INJECTABLE CONTRACEPTIVES

(30 MINUTES)

OUTLINE & OBJECTIVES:

To discuss the various health conditions that make the injections a suitable option or otherwise

METHODOLOGY:

MEC wheel exercise and review of the MEC charts.

Brainstorming exercise to enlist the indications and contra indications for injectable contraceptives.

Small group discussions to enlist conditions that would make using an injectable an inappropriate choice, followed by large group discussion.

Handout: (H13.2)

Activity: (A13.2)

Checklist: (C13.2)

CLIENT ASSESSMENT AND MEC FOR INJECTABLE CONTRACEPTIVES

HANDOUT (H-13.2)



Activity (A13.2)

Divide participants into three groups and ask them to write

1. Limitations of injections
2. Contraindications
3. MEC using MEC wheel

Let the groups take 5 minutes each to prepare and then their chosen leader presents their work in 5 minutes each

Trainer to hold large group discussion and then add any missing points.

History Taking Checklist for Use of Injectable Contraceptives Checklist (C13.2)

Checklist for History Taking		
1. Date of last menstrual period Suspected pregnancy?	Yes	No
2. Date of last child birth and if less than 6 months, whether breastfeeding	Yes	No
3. History of stroke or deep vein thrombosis	Yes	No
4. History of heart disease	Yes	No
5. History of high blood pressure	Yes	No
6. History of frequent severe headaches	Yes	No
7. History of cancer of the breast	Yes	No
8. History of jaundice now or in the last 6 months or history of liver disease or tumours	Yes	No
9. History of diabetes and years with the disease	Yes	No
10. History of depression	Yes	No

WHO CAN AND CANNOT USE INJECTABLES:

Nearly all women can use monthly injectable safely and effectively, including women who:

- 1) Have or have not had children.
- 2) Are of any age, including adolescents and women over 40 years old.
- 3) Have just had an abortion or miscarriage.
- 4) Smoke any number of cigarettes daily and are under 35 years old.
- 5) Smoke fewer than 15 cigarettes daily and are over 35 years old.
- 6) Have anaemia now or had anaemia in the past.
- 7) Have varicose veins.
- 8) Are living with HIV, whether or not on antiretroviral therapy.

CORRECTING MISUNDERSTANDINGS ABOUT POIS:

- 1) Can stop monthly bleeding, but this is not harmful. It is similar to not having monthly bleeding during pregnancy. Blood is not building up inside the woman.
- 2) Do not make women infertile.

- 3) Do not cause early menopause.
- 4) Do not cause birth defects or multiple births.
- 5) Do not cause itching.
- 6) Do not change women's sexual behaviour.

CLIENT ASSESSMENT AS PER WHO MEC FOR PROGESTIN-ONLY INJECTABLE

Ask the client the questions below about known medical conditions. Examination and tests are not necessary. **If she answers “no” to all of the questions, then she can start monthly injectable if she wants.** If she answers “yes” to a question, follow the instructions. In some cases, she can still start monthly injectable.

1. Are you breastfeeding a baby less than 6 months old?

NO YES

1. If fully or nearly fully breastfeeding: She can start 6 months after giving birth or when breast milk is no longer the baby's main food—whichever comes first
2. If partially breastfeeding: She can start monthly injectable as soon as 6 weeks after giving birth

2. Have you had a baby in the last 3 weeks, and you are not breastfeeding?

NO YES

She can start as soon as 3 weeks after childbirth. (If there is an additional risk that she might develop a blood clot in a deep vein [deep vein thrombosis, or VTE], then she should not start monthly injectable at 3 weeks after childbirth, but can start at 6 weeks instead. These additional risk factors include previous VTE, thrombophilia, caesarean delivery, blood transfusion at delivery, postpartum haemorrhage, pre-eclampsia, obesity BMI [$>_{30}$ kg/m²], smoking, and being bedridden for a prolonged time.)

3. Do you smoke 15 or more cigarettes a day?

NO YES

If she is 35 years of age or older and smokes more than 15 cigarettes a day, do not provide monthly injectable. Urge her to stop smoking and help her choose another method.

4. Do you have severe liver disease, active hepatitis, severe cirrhosis, or liver tumour?

NO YES

If she reports active hepatitis, severe cirrhosis, or liver tumour, do not provide monthly injectable. Help her choose a method without hormones. (If she has mild cirrhosis or gallbladder disease, she can use monthly injectable.)

5. Do you have high blood pressure?

NO YES

If you cannot check blood pressure and she report a history of high blood pressure, or if she is being treated for high blood pressure, do not provide monthly injectable. Refer her for a blood pressure check if possible or help her choose another method without estrogen. Check her blood pressure if possible:

- 1) If blood pressure is below 140/90 mm Hg, provide monthly injectable.
- 2) If systolic blood pressure is 140 mm Hg or higher or diastolic blood pressure is 90 or higher, do not provide monthly injectable. Help her choose a method without estrogen, but not progestin-only injectable if systolic blood pressure is 160 or higher or diastolic pressure is 100 or higher.

One blood pressure reading in the range of 140–159/ 90–99 mm Hg is not enough to diagnose high blood pressure. Provide a backup method* to use until she can return for another blood pressure check, or help her choose another method now if she prefers. If blood pressure at next check is below 140/90, she can use monthly injectable.

- 6. Have you had diabetes for more than 20 years or damage to your arteries, vision, kidneys, or nervous system caused by diabetes?**

NO YES

Do not provide injections. Help her choose a method without estrogen but not progestin-only injectable

- 7. Have you ever had a stroke, blood clot in your leg or lungs, heart attack, or other serious heart problems?**

NO YES

If she reports heart attack, heart disease due to blocked or narrowed arteries, or stroke, do not provide monthly injectable. Help her choose a method without estrogen but not progestin-only injectable. If she reports a current blood clot in the deep veins of the leg (not a superficial clot) or in the lungs, help her choose a method without hormones.

- 8. Do you have or have you ever had breast cancer?**

NO YES

Do not provide monthly injectable. Help her choose a method without hormones.

- 9. Do you sometimes see a bright area of lost vision in the eye before a very bad headache (migraine aura)? Do you get throbbing, severe head pain, and often on one side of the head that can last from a few hours to several days and can cause nausea or vomiting (migraine headaches)? Such headaches are often made worse by light, noise, or moving about.**

NO YES

If she has migraine aura at any age, do not provide monthly injectable. If she has migraine headaches without aura and is age 35 or older, do not provide monthly injectable. Help these women choose a method without estrogen. If she is under age 35 and has migraine headaches without aura, she can use monthly injectable

- 10. Are you planning major surgery that will keep you from walking for one week or more?**

NO YES

If so, she can start monthly injectable 2 weeks after the surgery. Until she can start monthly injectable, she should use a backup method.

- 11. Do you have several conditions that could increase your chances of heart disease (coronary artery disease) or stroke, such as older age, smoking, high blood pressure, or diabetes?**

NO YES

Do not provide the injection. Help her choose a method without estrogen, but not progestin-only injectable.

- 12. Are you taking lamotrigine?**

NO YES

Do not provide monthly injectable. Monthly injectable can make lamotrigine less effective. Help her choose a method without estrogen.

Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.

SESSION 3

TITLE: COMMON SIDE EFFECTS AND TROUBLE SHOOTING

(30 MINUTES)

OUTLINE & OBJECTIVES:

To highlight and clarify the common problems faced by the clients who use injectable contraceptives and how the health care providers can help solve them

METHODOLOGY:

Small group work for brainstorming followed by large group discussion and a recap by the trainer. Handouts will be given to the participants for the FAQs

Handout: (H13.3)

Activity: (A13.3)

COMMON SIDE EFFECTS AND TROUBLE SHOOTING

HANDOUT (H-13.3)



Activity (A13.3)

Divide participants into two groups and ask them to discuss side effects and management and then write them on a Flip chart.in 10 minutes Each group chooses a leader to present in 5 minutes. The trainer then adds any additional information.

Please note thorough counselling about bleeding changes and other side effects must come before giving the injection. Counselling about bleeding changes may be the most important help a woman needs to keep using the method without concern and not discontinue it.

What to do if a woman has menstrual abnormalities or other common problems while using progesterone-only Injectable?	
If the woman has:	Suggestion
Amenorrhoea	Amenorrhoea does not require any medical treatment. Counselling is sufficient. If she is very worried do a pregnancy test If she still finds amenorrhoea unacceptable, discontinue the injectable, and help her choose another method.
Spotting or light bleeding	Spotting or light bleeding is common during POI use, particularly in the first injection cycle, and is not harmful. In women with persistent spotting or bleeding, or women with bleeding after a period of amenorrhoea, exclude gynaecologic problems when clinically warranted. If a gynaecologic problem is identified, treat the condition or refer her to care. If STI or pelvic inflammatory disease (PID) is diagnosed, she can continue her injections while receiving treatment, and be counselled on condom use. If no gynaecologic problems are found, and she finds the bleeding unacceptable, discontinue the injectable, and help her choose another method.
Heavy or prolonged bleeding (more than 8 days or twice as much as her usual menstrual period)	Explain that heavy or prolonged bleeding is common in the first injection cycle. If heavy or prolonged bleeding persists, exclude gynaecologic problems when clinically warranted. If a gynaecologic problem is identified, treat the condition or refer her to health care facility. For modest short-term relief, she can try 400 mg ibuprofen 3 times daily after meals for 5 days, or other NSAID, beginning when heavy bleeding starts. If the bleeding becomes a threat to the health of the woman, or it is not acceptable to her, discontinue the injectable. Help her choose another method. To prevent anaemia, provide an iron supplement and/or encourage foods containing iron.
Weight Gain	Review diet and counsel as needed.
Ordinary headaches (non migrainous)	Suggest aspirin (325–650 mg), ibuprofen (200–400 mg) or paracetamol (325–1000 mg), or other pain reliever. Any headaches that get worse or occur more often during use of Injectable should be evaluated.

SESSION 4

TITLE: ADMINISTRATION OF THE INJECTION

(30 MINUTES)

OUTLINE & OBJECTIVES:

To enlist the necessary steps and precautions in administering the injection.

METHODOLOGY:

Skills Checklist for the proper technique and usage of the injections.

Handout: (H13.4)
Job Aid: (J13.4a), (J13.4b), (J13.4c)
Check List: (C13.4)

ADMINISTRATION OF THE INJECTION

HANDOUT (H-13.4)

GIVING INTERMUSCULAR INJECTION

OBTAIN ONE DOSE OF INJECTABLE, NEEDLE, AND SYRINGE

- 1- DMPA: 150 mg for injections into the muscle (intramuscular injection). NET-EN: 200 mg for injections into the muscle.
- 2- For each injection use a prefilled single-use syringe and needle from a new, sealed package (within expiration date and not damaged).
- 3- If a single-dose prefilled syringe is not available, use single-dose vials. Check expiration date. If using an open multidose vial, check that the vial is not leaking.
 - a) DMPA: A 2 ml syringe and a 21–23-gauge intramuscular needle.
 - b) NET-EN: A 2 or 5 ml syringe and a 19-gauge intramuscular needle. A narrower needle (21–23 gauge) also can be used.

Wash hands with soap and water, if possible. Let your hands dry in the air.

If injection site is dirty, wash it with soap and water.

No need to wipe site with antiseptic

PREPARE VIAL

- 1) DMPA: Gently shake the vial.
- 2) NET-EN: Shaking the vial is not necessary.
- 3) No need to wipe top of vial with antiseptic.
- 4) If vial is cold, warm to skin temperature before giving the injection.

FILL SYRINGE:

Pierce top of vial with sterile needle and fill syringe with proper dose.

INJECT FORMULA:

Insert sterile needle deep into the hip (ventrogluteal muscle), the upper arm (deltoid muscle), or the buttocks (gluteal muscle, upper lateral quadrant), whichever the woman prefers. Inject the contents of the syringe.

Do not massage injection site.



DISPOSE OF DISPOSABLE SYRINGES AND NEEDLES SAFELY

- 1) Do not recap, bend, or break needles before disposal.
- 2) Place in a puncture-proof sharps container.
- 3) Never reuse disposable syringes and needles. They are meant to be destroyed after a single use. Because of their shape, they are very difficult to disinfect. Therefore, reuse might transmit diseases such as HIV and hepatitis.

SC-DMPA

GIVING THE INJECTION WITH SUBCUTANEOUS DMPA IN UNIJECT

GATHER THE SUPPLIES:

- 1) Uniject prefilled injection device at room temperature that has not passed its expiration date
- 2) Soap and clean water
- 3) Cotton swabs or cotton balls, if available
- 4) Safe puncture-proof container for sharps disposal

WASH:

- 1) Wash hands with soap and water, if possible.
- 2) Let your hands dry in the air.
- 3) If injection site is dirty, wash it with soap and water.
- 4) No need to wipe site with antiseptic

ASK WHERE THE CLIENT WANTS THE INJECTION:

You can give the injection just under the skin:

- 1) In the back of the upper arm
- 2) In the abdomen (but not at the navel)
- 3) On the front of the thigh.

OPEN THE POUCH:

Open the foil pouch and remove the device

MIX THE SOLUTION

- 1) Hold the device by the port
- 2) Shake it hard for 30 seconds.
- 3) Check that the solution is mixed (granules distributed throughout the solution) and there is no damage or leaking

CLOSE THE GAP

- 1) Hold the device by the port.
- 2) Take care not to squeeze the reservoir during this step.

- 3) Hold the device with the needle pointed upward to avoid spilling the drug.
- 4) Push the cap into the port
- 5) Continue to push firmly until the gap between the cap and port is closed
- 6) Take off the cap.
- 7) Close the gap and take off the cap

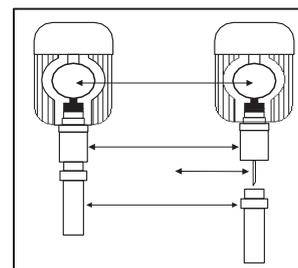
GIVE THE INJECTION

- 1) Gently pinch the skin at the injection site. This helps to make sure that the drug is injected into fatty tissue just under the skin and not into muscle.
- 2) Hold the port. Gently push the needle straight into the skin with the needle pointing down (never upward) until the port touches the skin.
- 3) Squeeze the reservoir slowly. Take 5 to 7 seconds.
- 4) Pull out the needle and then release the skin.
- 5) Do not clean or massage the site after injecting.



DISCARD THE USED DEVICE

- 1- Do not replace the cap
- 2- Place the device in a safety box



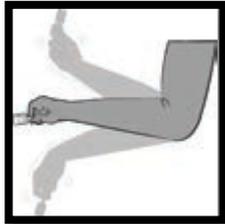
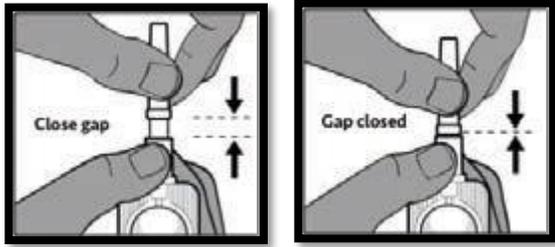
HOW TO SELF-INJECT WITH SAYANA PRESS

1. Choose a correct injection site

Choose either:

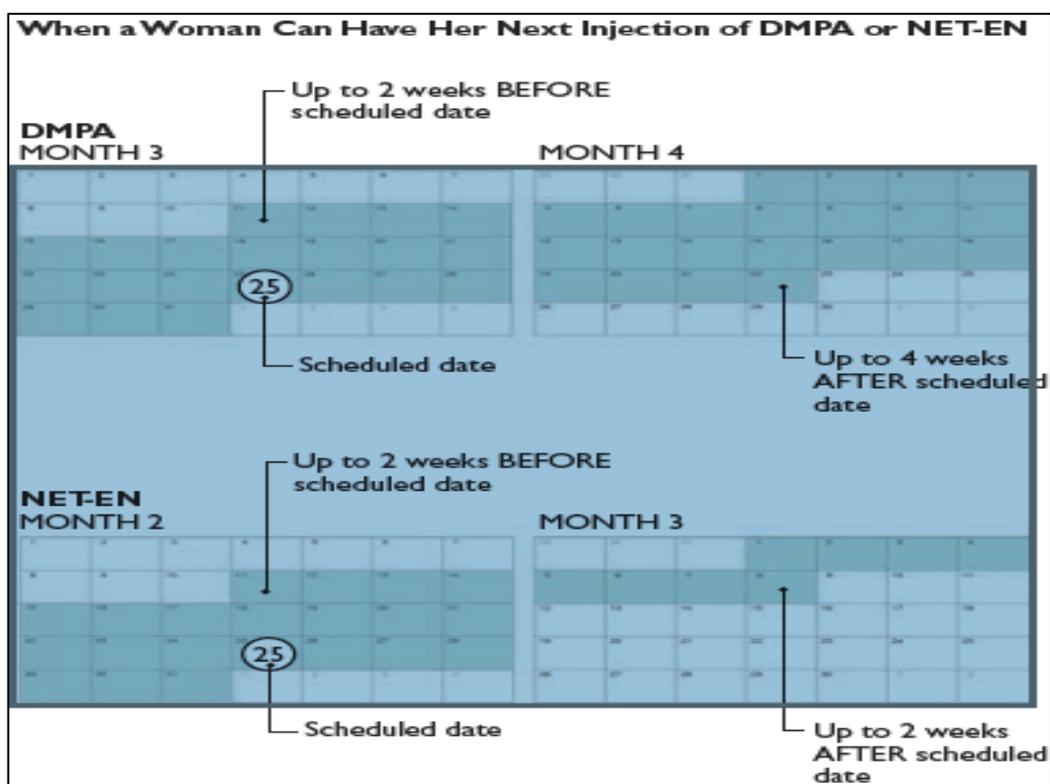
a) The belly (but not the navel) OR The front of the thigh.



<p>2. Mix the solution</p>	<ol style="list-style-type: none"> 1. After washing hands, open the pouch and take out the injection device. 2. Hold the device by the port (not the cap) and shake it hard for about 30 seconds. 3. Make sure the solution is completely mixed 
<p>3. Push the cap and the port together to close the gap</p>	<ol style="list-style-type: none"> 1. Point the needle upward. 2. Hold the cap with one hand and the port with the other hand. 3. Press the cap down firmly until the gap is closed. 
<p>4. Pinch your skin into a “tent”</p>	<ol style="list-style-type: none"> 1. Take the cap off the needle. Hold the device by the port. 2. With the other hand pinch about 4 cm (1½ inches) of skin.
<p>5. Put the needle into the skin, and squeeze the reservoir slowly</p>	<ol style="list-style-type: none"> 1. Press the needle straight into the skin with the needle pointing downward. 2. Press the needle in until the port touches the skin completely. 3. Squeeze the reservoir slowly, for 5 to 7 seconds.

	
6. Dispose of the needle safely steps	<ol style="list-style-type: none"> 1. Pull the needle out and then let go of the skin. 2. Put the device in a container that can be closed and cannot be punctured.
7. Plan for your next injection	<ol style="list-style-type: none"> 1. Mark a calendar or other reminder for the same day of the month 3 months from today. 2. You can give yourself the next injection as early as 2 weeks before that date or as late as 4 weeks after. 3. If more than 4 weeks late, use another contraceptive method and see a health worker. 4. Make sure you have another device for the next injection and that it will not expire before then.

Job Aid (J13.4a)



Competency-Based Checklist for Counselling and Technical Skills for DMPA Injection Checklist (C13.4)

Add case no

Step / tasks		Cases			Comment
Initial interview (client reception area)		1	2	3	
1	Greets woman respectfully, makes her comfortable and establish rapport.				
2	Establishes purpose of the visit and answer questions.				
3	Assures necessary privacy				
4	Provides general information about family planning				
5	Asks client about reproductive goals, to space or limit births. Any method used currently or in past.				
6	Give the woman information about the contraceptive choices available and the risks and benefits for each. Explain the difference between reversible and permanent contraception. Correct rumors or misinformation about all methods.				
7	Helps client to make an informed choice.				
Method specific counselling for DMPA					
8	Asks her if she knows about Injectable contraceptives. Corrects any myths, rumors or misinformation she may express.				
9	Asks her past experience with Injectable (if any)				
10	Explains contraceptive & non-contraceptive benefits of injectable.				
11	Briefly explains how injectable works.				
12	Explains potential common side effects of the injectable contraceptive. Tells her that she may experience few (or possibly none) of these but they can all be managed.				
13	Reassures client that these side effects are not serious and many will decrease or stop after a few months of use.				
14	Describes the injection process and what the client should expect during and after the procedure.				
15	Responds to any questions or concerns the client may have				
Checklist for technical skills					
16	Screens client using 'checklist for screening clients who want to initiate Injectable'.				
DMPA specific tasks					

17	Explains all sites where injection can be administered and asks her preference. (Arm or buttock or thigh)				
18	Shows sealed bottle and expiration date on label to client.				
19	Performs hand hygiene.				
20	Rub bottle between palms or shakes gently. If vial is cold, warm to skin temperature before giving the injection.				
21	Opens 2 ml sterile package of syringe with 21-23-gauge intramuscular needle.				
22	Wipe rubber cover with an antiseptic. Inserts needle into rubber cover of vial				
23	Fill syringe with contents of the bottle. Expels air from syringe.				
24	Locates the exact site for injection preferred by client. Wipe the site with an antiseptic.				
25	Cleans injection site with alcohol or antiseptic swab.				
26	Inserts needle deep into the muscle. Aspirate first to ensure that the needle is not in the vein. Injects the dose.				
27	Gently presses the injection site with a clean cotton ball.				
28	Places the used syringe into the sharps container.				
29	Performs hand hygiene.				
30	Instructs the client not to massage the site.				
Post-injection Tasks					
31	Ensure that vital signs of clients are monitored				
32	Tells the name of injections to client				
33	Calculate reinjection date (3 months or 13 weeks) and agree on a date for next injection.				
34	Assures her she is welcome to come back anytime if she has problems, questions or wants another method.				
35	Ensure that disposal of disposable needles and syringes are as per guideline.				
36	Emphasize on importance of DMPA client card and date of return for injection.				
37	Emphasize on important instructions and asks the client to repeat instructions.				
38	Advise the client not to use hot fomentation.				
39	Instructs client to return early if she has questions or concerns.				
40	Provides back-up method, if appropriate.				
Counselling at the time of repeat Injection Visits					

41	Ask how the client is doing with the method and whether she is satisfied. Ask if she has any questions or anything to discuss.				
42	Ask especially if she is concerned about bleeding changes. Give her any information or help that she needs.				
43	Give her the injection of DMPA if she is up to 4 weeks late or is up to 2 weeks early.				
44	Plan for her next injection. Agree on a date for her next injection (in 3 months or 12 weeks for DMPA. Remind her that she should try to come on time but she should come back no matter how late she is.				
45	Checks her blood pressure, if possible.				
46	Ask a long-term client if she has had any new health problems. Address problems as appropriate.				
For new health problems that may require switching methods,					
47	Ask a long-term client about major life changes that may affect her needs particularly plans for having children and STI/HIV risk. Follow up as needed.				
Counselling a client who is more than 4 months late for injection					
48	A client who is more than 4 weeks late for DMPA, provides injection only if: She has not had sex in the last 2 weeks after she should have had her last injection, or She has used a backup method or has taken emergency contraceptive pills (ECPs) after any unprotected sex in the last 2 weeks after she should have had her last injection.				
If the client is more than 4 weeks late for DMPA and she does not meet above criteria					
49	Takes additional steps to be reasonably certain that she is not pregnant.				
50	Discusses with the client why she was late and provides solutions.				
51	If coming back on time is often a problem, discusses using a backup method when she is late for her next injection, taking ECPs or choosing another method.				

Providing Progestin-Only Injectables (POIs)

Job Aid (J13.4b)

A woman can start injectables any time she wants if it is reasonably certain she is not pregnant.

1. Having menstrual cycles or switching from a nonhormonal method	<ol style="list-style-type: none"> 1. Any time of the month 2. If she is starting within 7 days after the start of her monthly bleeding, no need for a backup method. 3. If it is more than 7 days after the start of her monthly bleeding, she can start injectables any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection. 4. If she is switching from an IUCD, she can start injectables immediately
2. Switching from a hormonal method	<ol style="list-style-type: none"> 1. Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. 2. If she is switching from another injectable, she can have the new injectable when the repeat injection would have been given. No need for a backup method.
3. Fully or nearly fully Breastfeeding	<p>1- Less than 6 months after giving birth</p> <ol style="list-style-type: none"> a) If she gave birth less than 6 weeks ago, delay her first injection until at least 6 weeks after giving birth. b) If her monthly bleeding has not returned, she can start injectables any time between 6 weeks and 6 months. No need for a backup method. c) If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles. <p>2- More than 6 months after giving birth</p> <ol style="list-style-type: none"> a) If her monthly bleeding has not returned, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection. b) If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles
Partially breastfeeding	<p>1- Less than 6 weeks after giving birth: Delay her first injection until at least 6 weeks after giving birth.</p> <p>More than 6 weeks after giving birth</p> <ol style="list-style-type: none"> a) If her monthly bleeding has not returned, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection. b) If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles
4. Not breastfeeding	<p>1- Less than 4 weeks after giving birth. She can start injectables at any time. No need for a backup method</p> <p>2- More than 4 weeks after giving birth If her monthly bleeding has not returned, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection. If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles</p>

5. No monthly bleeding (not related to childbirth or breastfeeding)	She can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.
6. After miscarriage or abortion	Immediately, if she is starting within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method. If it is more than 7 days after first- or second trimester miscarriage or abortion, she can start injectables any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.
7. After taking emergency contraceptive pills (ECPs)	<p>1- After taking progestin-only or combined ECPs:</p> <p>a) She can start or restart injectables on the same day as taking the ECPs. No need to wait for her next monthly bleeding to have the injection.</p> <p>b) She will need to use a backup method for the first 7 days after the injection.</p> <p>c) If she does not start immediately but returns for injectables, she can start at any time if it is reasonably certain she is not pregnant.</p> <p>2- After taking ulipristal acetate (UPA) ECPs:</p> <p>a) She can start or restart injectables on the 6th day after taking UPA-ECPs. No need to wait for her next monthly bleeding to have the injection.</p> <p>b) Injectables and UPA interact. If an injectable is started sooner, and thus both are present in the body, one or both may be less effective.</p> <p>c) Make an appointment for her to return for the injection on the 6th day after taking UPA-ECPs, or as soon as possible after that.</p> <p>d) She will need to use a backup method from the time she takes UPA-ECPs until 7 days after the injection.</p> <p>e) If she does not start on the 6th day but returns later for injectables, she may start at any time if it is reasonably certain she is not pregnant.</p>

FOLLOW UP:

Help the clients at the routine return visit and ask the following questions:

1. Ask if the client has any questions or anything to discuss.
2. Ask the client about her experience with the method, whether she is satisfied, and whether she has any problems. Give her any information or help that she needs and invite her to return any time she has questions or concerns. If she has problems that cannot be resolved, help her choose another method.
3. Ask about her bleeding pattern.
4. If the client has developed heart disease due to blocked arteries, stroke, blood clot (except superficial clots), breast cancer, severe high blood pressure, or active liver disease, help her to choose another method without hormones.
5. If she has not developed any conditions necessitating discontinuation, and she wants to continue with this method, give her an injection and plan for the next visit in 3 months for DMPA.

**When to have repeat Progestogen-only Injectable
Job Aid (J13.4c)**

When to have repeat Progestogen-only Injectable	
The Scenario	Suggestion
Re-injection interval	Provide repeat DMPA injections every 3 months. Provide repeat NET-EN injections every 2 months.
If client is early for an injection	The repeat injection for DMPA and NET-EN can be given up to 2 weeks early.
If client is late for an injection	The repeat injection for DMPA and NET-EN can be given up to 2 weeks late without requiring additional contraceptive protection. If she is more than 2 weeks late for a DMPA or NET-EN repeat injection, she can have the injection, if it is reasonably certain that she is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days. She may wish to consider the use of emergency contraception if appropriate.
Switching between DMPA and NET-EN	Using DMPA and NET-EN injections interchangeably is not recommended. If it becomes necessary to switch from one to the other, the switch should be made at the time the repeat injection would have been given.
For a repeat POI when the previous injectable type and/or timing of injection is unknown	She can have the injection if it is reasonably certain that she is not pregnant. She will need to abstain from sex or use additional contraceptive protection for the next 7 days. She may wish to consider the use of emergency contraception if appropriate.

RETURN TO FERTILITY IN WOMEN USING DMPA OR NET-EN:

Since DMPA is a long-acting contraceptive, it takes some time to wear off after the last injection. Re-establishment of menstruation after an injection of DMPA may be delayed and difficult to predict. It generally **takes 6-8 months after** the last injection for menstruation to become regular. No woman should use DMPA or NET-EN without knowing that there may be a delay in her becoming pregnant after stopping the contraceptive. The providers need to make it clear that conception time cannot be predicted with certainty for any woman. Providers must inform that pregnancy may be delayed by several months.

SESSION 5

TITLE: MISSED OR LATE DOSES AND THEIR MANAGEMENT

(20 MINUTES)

OUTLINE & OBJECTIVES:

This session will emphasize upon the need for regular injections and not to delay the subsequent shots. The strategy in case of a missed injection date will also be discussed. What conditions would a change of choice?

METHODOLOGY:

Power point presentation with group discussion

Handout: (H13.5)

Job Aid: (J13.5)

MISSED OR LATE INJECTIONS

HANDOUT (H-13.5)

Client arrives	Suggested Action
Too soon for her next injection	The repeat injection for both DMPA and NET- EN can be given up to two weeks early.
Late for her injection, up to 4 weeks for DMPA and 2 weeks for NET-EN	The repeat injection for DMPA can be given up to 4 weeks late; and for NET-EN, up to 2 weeks late without requiring additional contraceptive protection.
Late for her injection, more than four weeks for DMPA and more than two weeks for NET-EN or NET-EN	<p>If client is more than 4 weeks late for a DMPA repeat injection, she can have the injection, if it is reasonably certain she is not pregnant (Note: DMPA users may develop amenorrhoea without pregnancy so pregnancy test or pelvic exam might be needed to rule out pregnancy).</p> <p>If she is more than 2 weeks late for a NET-EN repeat injection, she can have the injection if it is reasonably certain she is not pregnant.</p> <p>She will need to abstain from sex or use additional contraceptive protection for the next 7 days after injection.</p> <p>She should consider using emergency contraception if appropriate (e.g., the only sexual intercourse she had since the end of re-injection window was not more than 120 hours ago).</p>

REPEAT INJECTION VISITS:

1. Ask how the client is doing with the method and whether she is satisfied. Ask if she has any questions or anything to discuss.
2. Ask especially if she is concerned about bleeding changes. Give her any information or help that she needs
3. Give her the injection. Injection can be given up to 7 days early or late
4. Plan for her next injection. Agree on a date for her next injection (in 4 weeks). Remind her that she should try to come on time, but she should come back no matter how late she is. She may still be able to have her injection.
5. Every year or so, check her blood pressure if possible
6. Ask a long-term client if she has had any new health problems. Address problems as appropriate.
7. Ask a long-term client about major life changes that may affect her needs—particularly plans for having children and STI/HIV risk. Follow up as needed.

Job Aid (J13.5)

New Problems That May Require Switching Methods

Unexplained Vaginal Bleeding:

Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate. She can continue using monthly injectable while her condition is being evaluated. If bleeding is caused by sexually transmitted infection or pelvic inflammatory disease, she can continue using monthly Injectable during treatment.

Migraine headaches:

Regardless of her age, a woman who develops migraine headaches, with or without aura, or whose migraine headaches become worse while using monthly injectable, should stop using Injectable. Help her choose a method without estrogen.

Circumstances that will keep her from walking for one week or more

If she is having major surgery, or her leg is in a cast, or for other reasons she will be unable to move about for several weeks, she should:

Tell her doctors that she is using monthly Injectable. Stop injections one month before scheduled surgery, if possible, and use a backup method during this period. Restart monthly Injectable 2 weeks after she can move about again.

Certain serious health conditions:

Suspected heart or liver disease, high blood pressure (systolic pressure of 140 mm Hg or higher or diastolic pressure of 90 mm Hg or higher), blood clots in deep veins of legs or lungs, stroke, breast cancer, or damage to arteries, vision, kidneys, or nervous system caused by diabetes).

Do not give the next injection. ^[L]_[SEP]

Give her a backup method to use until the condition is evaluated.

Refer for diagnosis and care if not already under care.

Suspected pregnancy:

Assess for pregnancy.

Stop injections if pregnancy is confirmed.

There are no known risks to the foetus conceived while a woman is using the injections

Starting treatment with lamotrigine:

Combined hormonal methods, including monthly Injectable, can make lamotrigine less effective. Unless she can use a different medication for seizures than lamotrigine, help her choose a method without oestrogen.

SESSION 6

TITLE: FAQs

(15 MINUTES)

OUTLINE & OBJECTIVES:

To assess the knowledge gained by participants

METHODOLOGY:

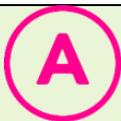
Pass the parcel game

Handout: (H13.6)

Activity: (A13.6)

FREQUENTLY ASKED QUESTIONS

HANDOUT (H-13.6)



Activity (A13.6)

Pass the parcel game for FAQs

The trainer runs a pass the parcel session with a different question on a different coloured piece of paper. The music plays and the participants pass the parcel. Where the music stops, the participant answers the question, if she can't, she can pass it on to her next person. The trainer reinforces the correct answers and clarifies others

1- Can women who could get sexually transmitted infections (STIs) use progestin-only injectables?

Yes. Women at risk for STIs can use progestin-only injectables.

The few studies available have found that women using DMPA were more likely to acquire chlamydia than women not using hormonal contraception. The reason for this difference is not known. There are few studies available on use of NET-EN and STIs. Like anyone else at risk

for STIs, a user of progestin-only injectables who may be at risk for STIs should be advised to use condoms correctly every time she has sex. Consistent and correct condom use will reduce her risk of becoming infected with an STI

2- Can women at high risk for HIV use progestin-only injectables?

Yes. Women at high risk of HIV infection can use any contraceptive method, including progestin-only injectables, except spermicide or diaphragm with spermicide. In late 2016 a WHO assessment observed that some research finds that women who are at high risk of HIV infection and use a progestin only injectable are slightly more likely to get HIV. It is not clear why studies find this. The injectable may or may not be responsible for increasing a woman's chances of becoming infected if exposed to HIV.

An expert group convened by WHO concluded, "Women should not be denied the use of progestogen-only injectables because of concerns about the possible increased risk" of HIV infection. WHO classified progestin-only injectables, such as DMPA (including Sayana Press) and NET EN, as Medical Eligibility Criteria (MEC) category 2 for high risk of HIV. This classification means that women at high risk of HIV can generally use the method. WHO advises that, in countries and populations where HIV is common, providers should clearly inform women interested in progestin-only injectables about these research findings and their uncertainty, as well as how to protect themselves from HIV, so that each woman can make a fully informed choice. In keeping with the MEC 2 classification, women should be told clearly that they can choose and use a progestin-only injectable if they wish. Women also should be told that other long acting and effective methods are available if they would like to consider a different method.

3- If a woman does not have monthly bleeding while using progestin-only injectables, does this mean that she is pregnant?

Probably not, especially if she is breastfeeding. Eventually, most women using progestin-only injectables will not have monthly bleeding. If a woman has been getting her injections on time, she is probably not pregnant and can keep using injectables. If she is still worried after being reassured, she can be offered a pregnancy test, if available, or referred for one. If not having monthly bleeding bothers her, switching to another method may help.

4- Can a woman who is breastfeeding safely use progestin-only injectables?

Yes. This is a good choice for a breastfeeding mother who wants a hormonal method. Progestin-only injectables are safe for both the mother and the baby starting as early as 6 weeks after childbirth.

They do not affect milk production.

5- How much weight do women gain when they use progestin-only injectables?

Women gain an average of 1–2 kg per year when using DMPA. Some of the weight increase may be the usual weight gain as people age. Some women, particularly overweight adolescents, have gained much more than 1–2 kg per year. At the same time, some users of progestin-only injectables lose weight or have no significant change in weight. Asian women in particular do not tend to gain weight when using DMPA.

6- Do DMPA and NET-EN cause abortion?

No. Research on progestin-only injectables finds that they do not disrupt an existing pregnancy. They should not be used to try to cause an abortion. They will not do so.

7- Do progestin-only injectables make a woman infertile?

No. There may be a delay in regaining fertility after stopping progestin only injectables, but in time the woman will be able to become pregnant as before, although fertility decreases as women get older.

The bleeding pattern a woman had, before she used progestin-only injectables generally returns several months after the last injection even if she had no monthly bleeding while using injectables.

8- How long does it take to become pregnant after stopping DMPA or NET-EN?

Women who stop using DMPA wait about 4 months longer on average to become pregnant than women who have used other methods. This means they become pregnant on average 10 months after their last injection. Women who stop using NET-EN wait about one month longer on average to become pregnant than women who have used other methods, or 6 months after their last injection. These are averages. A woman should not be worried if she has not become pregnant even as much as 12 months after stopping use. The length of time a woman has used injectables makes no difference to how quickly she becomes pregnant once she stops having injections.

After stopping progestin-only injectables, a woman may ovulate before her monthly bleeding returns—and thus can become pregnant. If she wants to continue avoiding pregnancy, she should start another method before monthly bleeding returns.

9- Does DMPA cause cancer?

Many studies show that DMPA does not cause cancer. DMPA use helps protect against cancer of the lining of the uterus (endometrial cancer). Findings of the few studies on DMPA use and breast cancer are similar to findings with combined oral contraceptives: Women using DMPA were slightly more likely to be diagnosed with breast cancer while using DMPA or within 10 years after they stopped. It is unclear whether these findings are explained by earlier detection of existing breast cancers among DMPA users or by a biologic effect of DMPA on breast cancer.

A few studies on DMPA use and cervical cancer suggest that there may be a slightly increased risk of cervical cancer among women using DMPA for 5 years or more. Cervical cancer cannot develop because of DMPA alone, however. It is caused by persistent infection with human papillomavirus (see Cervical Cancer, p. 340). Little information is available about NET-EN. It is assumed to be as safe as DMPA and other contraceptive methods containing only a progestin, such as progestin only pills and implants.

10- Can a woman switch from one progestin-only injectable to another?

Switching injectables is safe, and it does not decrease effectiveness. If switching is necessary due to shortages of supplies, the first injection of the new injectable should be given when the next injection of the old formulation would have been given. Clients need to be told that they are switching, the name of the new injectable, and its injection schedule.

11- How does DMPA affect bone density?

During use, DMPA decreases bone mineral density slightly. This may increase the risk of developing osteoporosis and possibly having bone fractures later, after menopause. WHO has concluded that this decrease in bone mineral density does not place age or time limits on use of DMPA.

12- Do progestin-only injectables cause birth defects? Will the foetus be harmed if a woman accidentally uses progestin-only injectables while she is pregnant?

No. Good evidence shows that progestin-only injectables will not cause birth defects and will not otherwise harm the foetus if a woman becomes pregnant while using progestin-only injectables or accidentally starts injectables when she is already pregnant.

13- Do progestin-only injectables lower women's mood or sex drive?

Generally, no. Some women using injectables report these complaints.

The great majority of injectables users do not report any such changes, however. It is difficult to tell whether such changes are due to progestin-only injectables or to other reasons. Providers can help a client with these problems. There is no evidence that progestin-only injectables affect women's sexual behaviour.

14- What if a woman returns for her next injection late?

A woman can have her next DMPA injection even if she is up to 4 weeks late, without the need for further evidence that she is not pregnant. A woman can receive her next NET-EN injection if she is up to 2 weeks late. Some women return even later for their repeat injection, however. Whether a woman is late for reinjection or not, her next injection of DMPA should be planned for 3 months later, or her next injection of NET-EN should be planned for 2 months later, as usual.

SESSION 7

SUMMARIZE AND WRAP UP

(5 MINUTES)

FURTHER READING:

- <http://srhr.org/postpartumfp/methods/progestogen-only>

INTRAUTERINE DEVICES (IUCDS)



TIME: 4HOURS 30 MINUTES

IUCD is an integral component of Long Acting Reversible Contraception (LARCs). Available as Levonorgestrel Intra uterine System (LNG-IUS) and Copper (Cu T) versions, it is an effective, woman independent, long term and reversible contraceptive option. Works well for both spacing and limiting family size.



TRAINING OBJECTIVES

- 1) Update and refresh knowledge and skills regarding IUCDs effectiveness, types, mechanism of action and advantages.
- 2) Demonstrate method-specific counselling for IUCDs, appropriate infection prevention and techniques of IUCD insertion and removal.
- 3) Describe routine follow-up care, manage side effects and problems related to IUCDs.
- 4) Describe the latest technical information in line with WHO medical eligibility criteria (MEC).



LEARNING OUTCOMES

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

- 1) Discuss basic information on IUCDs including types, mechanism of action, advantages, and effectiveness.
- 2) Appropriately counsel a client interested in using Cu-380A, Multiload and LNG-IUS as a contraceptive method and give post-insertion instructions.
- 3) Use the WHO Medical Eligibility Criteria confidently.
- 4) Perform client assessment, including medical history and pelvic examination relevant to the provision of the Cu380-A and LNG-IUS.
- 5) Demonstrate infection prevention measures relevant to the provision of IUCD services.
- 6) Demonstrate proper techniques of IUCD insertion and removal.
- 7) Explain follow-up care of IUCD clients.



ADVANCED PREPARATIONS

- 1) Power point presentation.
- 2) Basic instruments and supplies for IUCD insertion and removal.
- 3) Pelvic models for simulated practice for all types of IUCDs.
- 4) IUCD insertion and removal kits.
- 5) Copper IUCDs and LNG-IUS in sterile packages.



TRAINING METHODOLOGY

- 1) Illustrated lectures.
- 2) Group discussions.
- 3) Simulated practice with anatomic (pelvic) models.
- 4) Guided clinical activities (counselling and IUCD insertion and removal)
- 5) Videos.



TRAINING MATERIAL

Trainer's Material	Trainee's Material
Hand Outs: H14.1, H14.2, H14.3, H14.4, H14.5, H14.6, H14.6a	Hand Outs: H14.1, H14.2, H14.3, H14.4, H14.5, H14.6, H14.6a
Activity: A14.1, A14.2a, A14.2b A14.5, A14.6, A14.6. a	Job aid: J14.1a, J14.1b, J14.2a, J14.2b, J14.3, J14.5a, J14.5b, J14.5c, J14.6
Job aid: J14.1a, J14.1b, J14.2a, J14.2b, J14.3, J14.5a, J14.5b, J14.5c, J14.6	Checklist: C14.2, C14.3a, C14.3b, C14.3c
Checklist: C14.2, C14.3a, C14.3b, C14.3c	
PPT: PPT (14)	



CONSTITUTION OF THE SESSION

Seven mini sessions will be held:

1. Introduction to Intrauterine devices and their types, advantages and limitations	Group discussion	25 Mins
2. Client Assessment / MEC	Group work	30 Mins
3. Insertion and Removal of Intrauterine Device	Hands on sessions with models, Videos	120 Mins
4. Infection Prevention	Table demo /presentation	25 Mins
5. Side effects of IUCDs	Group work	40 Mins
6. Follow-Up Care & Management of Potential Problems	Interactive power point/ group work	20 Mins
7. Wrap up and Summarize		10 Mins

SESSION 1

TITLE: INTRODUCTION TO IUCDS, VARIOUS TYPES AND MECHANISM OF ACTION

(25 MINUTES)

OUTLINE & OBJECTIVES:

Discuss the mechanism of action and types of IUCD with their advantages and limitations.

METHODOLOGY:

- 1) Power point presentation and discussion to highlight the various types of IUCDs, Cu and LNG and their mechanism of action along with their effectiveness.
- 2) Group discussion to highlight the advantages and limitations of IUCDs.

Handout: (H14.1)

Activity: (A14.1)

Job aid: (J14.1a) (J14.1b)

INTRODUCTION TO VARIOUS TYPES OF IUCDS AND MECHANISM OF ACTION

HANDOUT (H-14.1)



Activity (A14.1)

- 1) Ask the group about advantages and disadvantages of IUCDs. In two groups. Ask the groups to choose a representative to present. Also task each group to compare IUCDs to the concept of “the ideal contraceptive”.
- 2) Trainer to give a short presentation of the information regarding IUCD, (mechanism of action, efficiency, reversibility).

An intrauterine device is a small, flexible plastic frame which is inserted into the woman's uterus through her vagina. Almost all brands of IUCDs available in Pakistan have strings or threads, tied to them. The strings hang through the opening of the cervix into the vagina.

The intrauterine devices (IUCDs) offer almost complete protection from pregnancy. The newer IUCDs have a longer lifespan and are more effective. The CuT-380A and other currently available IUCDs such as Multiload-375 and the LNG-IUS.



THE IUCDS AVAILABLE IN PAKISTAN ARE:

1- Copper-bearing IUCDs:

Made of plastic with copper sleeves and or copper wire on plastic, such as Cu-380A & Cu- 375.

2- Hormone-releasing IUCDs:

Made of plastic, steadily released small amounts of hormone progesterone or LNG-IUS Progestin such as LNG.



COPPER-BEARING IUCDS:

It contains 380 mm² copper surface area supplied by a sleeve of solid copper on each of the arms (together 32 cm in width) and wrapped by a copper wire along the 36-mm vertical stem. Monofilament polyethylene thread is tied through the base creating two white tail strings.

measuring 10.5 cm in length. This is meant to facilitate detection and removal of the device. The CuT-380A IUCD is designed to be used in women whose uterine cavities sound to a depth of 6–9 cm. The copper CU T-380A IUCD is approved for a 10-year interval for contraception. After 10 years, the device should be removed, and a new device inserted if the patient desires to continue with the method.

MULTILOAD

Multiload is an IUD, an intrauterine device, used for contraception. It is a small plastic rod, called stem, with two small flexible side-arms. The plastic is a mixture of high-density polyethylene, ethylene vinyl acetate copolymer and barium sulphate in a weight ratio 44/36/20. A copper wire is wound around the stem. A nylon thread with two ends is attached to the bottom end of the stem. Multiload is intended for single use only.

MECHANISM OF ACTION:

Copper-containing IUCDs release free copper and copper salts without any measurable increase in serum copper levels. In fact, the amount of copper released daily is less than the average daily intake in a normal diet. It produces a foreign body reaction in the endometrium. The resulting changes in the intrauterine environment and cervical mucus act to immobilize sperm or prevent their migration to the fallopian tubes. The copper IUCD also appears to directly affect oocytes, perhaps lessening or inhibiting their ability to be fertilized. This would help to explain why the copper IUCD also protects against ectopic pregnancy.

ADVANTAGES:

Copper IUCDs are a safe and reliable method of contraception and it offers several advantages as listed below.

1) Highly effective.
2) Immediately effective after insertion.
3) Long term action.
4) Does not interfere with sexual intercourse.
5) No continued effort to use the method regularly.
6) One-time insertion procedure and does not require supplies regularly.
7) Cost effective as no expenses for supplies.
8) Does not affect breastfeeding.
9) Does not interact with any medicines the client may be taking.
10) Can be removed when required by qualified staff as desired by the client.
11) Return of fertility immediately after removal.

LIMITATIONS:

- 1) Intrauterine devices are to be provided only by trained providers (community midwives, nurses, midwives and doctors) in facilities that have the adequate equipment for inserting the device.
- 2) Does not protect against STIs /HIV.
- 3) Cannot be used by women who suffer from STIs.
- 4) Longer and heavy menstrual periods.
- 5) Bleeding or spotting between periods.
- 6) More cramps or pain during period.

(Menstrual changes common in early months but are reduced after 3 months.)

Correcting Misunderstandings:

- 1) Can be used by women of any age, including adolescents.
- 2) Can be used by women who have had children and those who have not.
- 3) Rarely lead to PID.
- 4) Do not increase the risk of contracting STIs, including HIV.
- 5) Do not increase the risk of miscarriage when a woman becomes pregnant after the IUCD is removed.
- 6) Do not make women infertile.
- 7) Do not cause birth defects.
- 8) Do not cause cancer.
- 9) Do not move to the heart or brain.
- 10) Do not cause discomfort or pain for the woman or the man during sex.
- 11) Substantially reduce the risk of ectopic pregnancy.

LEVONORGESTREL-IUS:

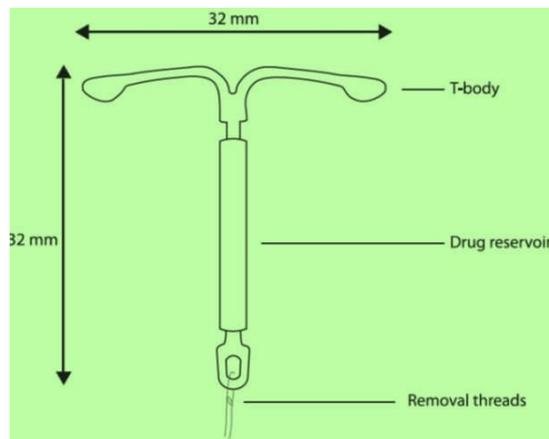
IUS is one of the newest forms of hormone releasing IUCDs. The IUS consists of a plastic T-shaped frame. Each of the IUSs is composed of a T-shaped polyethylene radiopaque frame measuring 32 mm × 32 mm with an inserter tube diameter 4.75 mm(4.4mm) Encircling the stem is a hormone cylinder composed of a mixture of 52 mg LNG and silicone (polydimethylsiloxane).

Controlling the rate of release of LNG from this reservoir is a semi-opaque silicone (polydimethylsiloxane) membrane. A monofilament polyethylene thread is attached to a hook

at the end of the vertical stem creating two tail strings that are useful to reassure the woman of the IUCD's continued presence and to facilitate removal. The release rate of Levonorgestrel is approximately 20 micrograms/24 hours for at least 5 years.

A three year (LNG-IUS 8) became available three years ago. LNG-IUS 8 is a 3-year, smaller device that releases lower levels of hormone and is placed using a narrower diameter tubing. The lower hormone levels result in lower prevalence of amenorrhea, which may appeal to women who do not want increasing blood loss (as with copper IUCD), but do not want amenorrhea (LNG-IUS 20).

More recently, the LNG-IUS 12 has been added. This new IUCD shares a smaller frame, narrow inserter and lower rate of amenorrhea with the LNG-IUS 8, but it offers the five years of contraceptive protection of the LNG-IUS 20.



MECHANISM OF ACTION OF IUS:

Multiple mechanisms have been postulated for the IUS,

- 1) The most important mechanism is thickening of the cervical mucus to blocking the entry of sperm into the upper genital tracts; ovulation is suppressed in only ~50% of cycles in the first year of use and in significantly fewer cycles in later years-Studies show that sperm can penetrate through the cervix mucus by only 2–3 mm in LNG-IUS users at the time of ovulation-and that this impact persists throughout the life of the IUCD.
- 2) The primary mechanism of action for all progestin IUSs is always local. Progestin also slows tubal motility, which might explain the increased risk of an ectopic implantation when pregnancy occurs with LNG-IUS use.
- 3) LNG-IUCD appears to work at the level of endometrium, where high dose of local progestogen causes decidualization, epithelial atrophy and direct vascular changes. It thins out the endometrium hampering implantation Alteration of endometrial receptivity,

suppression of endometrial proliferation and causes local inflammatory reaction (foreign body reaction).

- 4) Apart from preventing pregnancy, it also makes periods lighter, shorter and less painful. When it is removed, fertility returns immediately.

LNG-IUS is particularly useful for the following groups of women:

- 1) Women who have been pregnant and do not want to any more children for the next few years.
- 2) Women in their 30s and 40s who have completed their families and want a reliable long-term method of contraception which they can use and then forget about it for 5 years at a time.
- 3) Women with heavy periods who require contraception.
- 4) Women who have had a copper IUCD which caused heavy periods.

ADVANTAGES:

1) More effective than copper-bearing IUCDs.
2) The LNG IUS actual makes periods lighter than usual.
3) Pelvic infection is less common with LNG IUCD than copper-bearing IUCDs.
4) The studies have shown that the LNG-IUS has had a lower ectopic pregnancy rate than most copper IUCDs.
5) Safe and Suitable for Nearly all women.

Most women can use IUCDs safely and effectively, including women who:

- a. Have or have not had children
- b. Are of any age, including adolescents and women over 40 years old
- c. Have just had an abortion or miscarriage (if no evidence of infection)

Are breastfeeding
Do hard physical work
Have had ectopic pregnancy

Have had pelvic inflammatory disease (PID)
Have vaginal infections
Have anaemia
Have HIV clinical disease that is mild or with no symptoms whether or not they are on antiretroviral therapy

LIMITATIONS:

- 1) Only trained health care professionals can insert and remove the IUCD s
- 2) It is costlier than copper-bearing IUCDs.
- 3) Can cause irregular bleeding or spotting in the first six months of use.
- 4) Not suitable for women who are at risk of sexually transmitted infections or ectopic pregnancy

Correcting Misunderstandings:

- 1) Can be used by women of any age, including adolescents.
- 2) Can be used by women who have had children and those who have not.
- 3) Do not increase the risk of contracting STIs, including HIV.
- 4) Do not increase the risk of miscarriage when a woman becomes pregnant after the IUCD is removed.
- 5) Do not make women infertile.
- 6) Do not cause birth defects.
- 7) Do not cause cancer.
- 8) Do not move to the heart or brain.
- 9) Do not cause discomfort or pain for the woman or the man during sex.

AVOID UNNECESSARY PROCEDURES:

Women can begin using IUCDs:

- 1) Without cervical cancer screening
- 2) Without a breast examination
- 3) Without a blood pressure check
- 4) A pelvic examination is essential.
- 5) When available, a Haemoglobin test and laboratory tests for STIs including HIV can contribute to safe and effective use.

**When to start an IUCD?
Job Aid (J14.1a and 1b)**

<p>Having menstrual cycles</p>	<p>Any time of the month</p> <ul style="list-style-type: none"> • If she is starting within 12 days after the start of her monthly bleeding, no need for a backup method. • If it is more than 12 days after the start of her monthly bleeding, she can have the IUD inserted any time if it is reasonably certain she is not pregnant. No need for a backup method
<p>Switching from another method</p>	<ul style="list-style-type: none"> • Immediately, if she has been using the method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. • If she is switching from an injectable, she can have the IUD inserted when the next injection would have been given. No need for a backup method
<p>Soon after childbirth (regardless of breastfeeding status)</p>	<ul style="list-style-type: none"> • Any time within 48 hours after giving birth, including by caesarean delivery. (Provider needs specific training in postpartum insertion by hand or using a ring forceps.) • If it is more than 48 hours after giving birth, delay until 4 weeks or more after giving birth.
<p>Fully or nearly fully breastfeeding Less than 6 months after giving birth</p>	<ul style="list-style-type: none"> • If the IUD is not inserted within the first 48 hours and her monthly bleeding has not returned, she can have the IUD inserted any time between 4 weeks and 6 months after giving birth. No need for a backup method. • If her monthly bleeding has returned, she can have the IUD inserted as advised for women having menstrual cycles
<p>Fully or nearly fully breastfeeding (continued) More than 6 months after giving birth</p>	<ul style="list-style-type: none"> • If her monthly bleeding has not returned, she can have the IUD inserted any time it is reasonably certain she is not pregnant. No need for a backup method. • If her monthly bleeding has returned, she can have the IUD inserted as advised for women having menstrual cycles
<p>Partially breastfeeding or not breastfeeding More than 4 weeks after giving birth</p>	<ul style="list-style-type: none"> • If her monthly bleeding has not returned, she can have the IUD inserted <i>if it can be determined that she is not pregnant.</i> • No need for a backup method. • If her monthly bleeding has returned, she can have the IUD inserted as advised for women having menstrual cycles
<p>No monthly bleeding (not related)</p>	<ul style="list-style-type: none"> • Any time if it can be determined that she is not pregnant. • No need for a backup method

to childbirth or breastfeeding)	
After miscarriage or abortion	<ul style="list-style-type: none"> • Immediately, if the IUD is inserted within 12 days after first- or second-trimester abortion or miscarriage and if no infection is present. No need for a backup method. • If it is more than 12 days after first- or second trimester miscarriage or abortion and no infection is present, she can have the IUD inserted any time if it is reasonably certain she is not pregnant. No need for a backup method. • If infection is present, treat or refer, and help the client choose another method. If she still wants the IUD, it can be inserted after the infection has completely cleared. • IUD insertion after second-trimester abortion or miscarriage requires specific training. If not specifically trained, delay insertion until at least 4 weeks after miscarriage or abortion
For emergency contraception	<ul style="list-style-type: none"> • Within 5 days after unprotected sex. • When the time of ovulation can be estimated, she can have an IUD inserted up to 5 days after ovulation. Sometimes this may be more than 5 days after unprotected sex.
After taking emergency Contraceptive pills (ECPs)	<ul style="list-style-type: none"> • The IUD can be inserted on the same day that she takes the ECPs (progestin-only, combined, or ulipristal acetate ECPs). No need for a backup method. • If she does not have it inserted immediately, but returns for an IUD, she can have it inserted any time <i>if it can be determined that she is not pregnant</i>

**When to start LNG IUS?
Job Aid (J14.1b)**

<p>Having menstrual cycles or switching from a nonhormonal method</p>	<ul style="list-style-type: none"> • Any time of the month • If she is starting within 7 days after the start of her monthly bleeding, no need for a backup method. • If it is more than 7 days after the start of her monthly bleeding, she can have the LNG-IUD inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion
<p>Switching from a hormonal method</p>	<ul style="list-style-type: none"> • Immediately, if she has been using the method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. • If she is starting within 7 days after the start of her monthly bleeding, no need for a backup method. • If it is more than 7 days after the start of her monthly bleeding, she will need a backup method* for the first 7 days after insertion. • If she is switching from an injectable, she can have the LNG-IUD inserted when the repeat injection would have been given. No need for a backup method.
<p>Soon after childbirth (regardless of breastfeeding status)</p>	<ul style="list-style-type: none"> • Any time within 48 hours after giving birth (requires a provider with specific training in postpartum insertion by hand or using a ring forceps). • After 48 hours, delay until at least 4 weeks.
<p>Fully or nearly fully breastfeeding Less than 6 months after giving birth</p>	<ul style="list-style-type: none"> • If the LNG-IUD is not inserted within the first 48 hours and her monthly bleeding has not returned, she can have the LNG-IUD inserted any time between 4 weeks and 6 months. No need for a backup method. • If her monthly bleeding has returned, she can have the LNG-IUD inserted as advised for women having menstrual cycles
<p>More than 6 months since giving birth</p>	<ul style="list-style-type: none"> • If her monthly bleeding has not returned, she can have the LNG-IUD inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion. • If her monthly bleeding has returned, she can have the LNG-IUD inserted as advised for women having menstrual cycles
<p>Partially breastfeeding or not breastfeeding Less than 4 weeks after giving birth</p>	<ul style="list-style-type: none"> • If the LNG-IUD is not inserted within the first 48 hours, delay insertion until at least 4 weeks after giving birth
<p>More than 4 weeks after giving birth</p>	<ul style="list-style-type: none"> • If her monthly bleeding has not returned, she can have the LNG-IUD inserted any time if it can be determined that she is not pregnant. She will need a backup method for the first 7 days after insertion.

	<ul style="list-style-type: none"> • If her monthly bleeding has returned, she can have the LNG-IUD inserted as advised for women having menstrual cycles
No monthly bleeding (not related to childbirth or breastfeeding)	<ul style="list-style-type: none"> • Any time if it can be determined that she is not pregnant. She will need a backup method for the first 7 days after insertion
After miscarriage or abortion	<ul style="list-style-type: none"> • Immediately, if the LNG-IUD is inserted within 7 days after first- or second-trimester abortion or miscarriage and if no infection is present. • No need for a backup method. • If it is more than 7 days after first- or second trimester miscarriage or abortion and no infection is present, she can have the LNG-IUD inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion. • If infection is present, treat or refer and help the client choose another method. If she still wants the LNG-IUD, it can be inserted after the infection has completely cleared. • LNG-IUD insertion after second-trimester abortion or miscarriage requires specific training. If not specifically trained, delay insertion until at least 4 weeks after miscarriage or abortion.
After taking progestin-only, combined, or ulipristal acetate (UPA) emergency contraceptive pills (ECPs)	<ul style="list-style-type: none"> • She can have the LNG IUD inserted when it can be determined that she is not pregnant, for example, after the start of her next monthly bleeding. • Give her a backup method or oral contraceptive pills to use until she can have the IUD inserted. • She should not have the LNG-IUD inserted in the first 6 days after taking UPA-ECPs. These drugs interact. If the LNG-IUD is inserted sooner, and thus both LNG and UPA are present in the body, one or both may be less effective.

SESSION 2

TITLE: CLIENT ASSESSMENT/MEC FOR IUCD

(30 MINUTES)

OUTLINE & OBJECTIVES:

Use the MEC wheel and ME Criteria to provide best suitable services to the appropriate client and to help remove medical barriers.

METHODOLOGY:

- 1) Group discussion while using the MEC wheel and rule out the contra indications and discuss the medical or reproductive conditions that make IUCD an unsuitable choice.
- 2) Group work to get the participants to work out the contra indications for IUCD insertion with a specific emphasis on high risk groups

Handout: (H14.2)

Activity: (A14.2a), (A14.2b)

Job Aid: (J14.2a), (J14.2b)

Checklist: (C14.2)

CLIENT ASSESSMENT AND MEC

HANDOUT (H14.2)

MEDICAL ELIGIBILITY CRITERIA FOR COPPER-BEARING IUCDS

Ask the client the questions below about known medical conditions.

If she answers “no” to all of the questions, then she can have an IUCD inserted if she wants. If she answers “yes” to a question, follow the instructions. In some cases, she can still have an IUCD inserted.

1- Did you give birth more than 48 hours ago but less than 4 weeks ago?

NO YES

Delay inserting an IUCD until 4 -6 weeks after childbirth.

2- Do you have an infection following childbirth or abortion?

NO YES

If she currently has infection of the reproductive organs during the first 6 weeks after childbirth (puerperal sepsis) or she just had an abortion-related infection in the uterus (septic abortion),

do not insert the IUCD. Treat or refer if she is not already receiving care. Help her choose another method or offer a backup method* after treatment, re-evaluate for IUCD use.

3- Are you having vaginal bleeding that is unusual for you?

NO YES

If she has unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition, use of an IUCD could make diagnosis and monitoring of any treatment more difficult. Help her choose a method to use while being evaluated and treated (but not a hormonal IUCD, progestin- only injectable, or implant). After treatment, re-evaluate for IUCD use.

4- Do you have any female conditions or problems (gynaecologic or obstetric conditions or problems), such as genital cancer or pelvic tuberculosis? If so, what problems?

NO YES

Known current cervical, endometrial, or ovarian cancer; gestational trophoblast disease; pelvic tuberculosis: Do not insert an IUCD. Treat or refer for care if she is not already receiving care. Help her choose another method. In case of pelvic tuberculosis, re-evaluate for IUCD use after treatment.

5- Do you have HIV or AIDS? Do you have any health conditions associated with HIV infection?

NO YES

If a woman has HIV infection with severe or advanced clinical disease, do not insert an IUCD. In contrast, a woman living with HIV who has mild clinical disease or no clinical disease can have an IUCD inserted, whether or not she is on antiretroviral therapy.

6- Assess whether she is at very high individual risk for STIs.

Women who have a very high individual likelihood of STI infection should not have an IUCD inserted unless Gonorrhoea and chlamydia are ruled out by lab tests.

7- Rule out pregnancy.

Ask the client the questions in the Pregnancy Checklist. If she answers “yes” to any of these questions, you can be reasonably certain that she is not pregnant, and she can have an IUCD inserted. If the Pregnancy Checklist cannot rule out pregnancy, use another tool before inserting an IUCD.

MEDICAL ELIGIBILITY CRITERIA FOR LEVONORGESTREL IUDS:

1- Did you give birth more than 48 hours ago but less than 4 weeks ago?

NO YES

Delay inserting an LNG-IUD until 4 or more weeks after childbirth

2- Do you have an infection following childbirth or abortion?

NO YES

If she currently has infection of the reproductive organs during the first 6 weeks after childbirth (puerperal sepsis) or she just had an abortion-related infection in the uterus (septic abortion), do not insert the LNG-IUD. Treat or refer if she is not already receiving care. Help her choose another method or offer a backup method. After treatment, re-evaluate for LNG-IUD use

3- Do you now have a blood clot in the deep veins of your leg or lungs?

NO YES

If she was recently diagnosed with a blood clot in legs (affecting deep veins, not superficial veins) or in a lung, and she is not on anticoagulant therapy, help her choose a method without hormones.

4- Do you have severe cirrhosis or severe liver tumour?

NO YES

If she reports severe cirrhosis or severe liver tumour such as liver cancer, do not provide the LNG-IUD. Help her choose a method without hormones

5- Do you have or have you ever had breast cancer

NO YES

Do not insert the LNG-IUD. Help her choose a method without hormones

6- Are you having vaginal bleeding that is unusual for you?

NO YES

If she has unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition, use of an LNG-IUD could make diagnosis and monitoring of any treatment more difficult. Help her choose a method to use while being evaluated (but not a copper bearing IUD, progestin-only injectable, or implant) and, if indicated, treated. After diagnosis/treatment, re-evaluate for IUD use.

7- Do you have any female conditions or problems (gynaecologic or obstetric conditions or problems), such as genital cancer, pelvic tuberculosis, or gestational trophoblastic disease.

NO YES

If she has current cervical, endometrial, or ovarian cancer; pelvic tuberculosis; or gestational trophoblastic disease, do not insert an LNG-IUD. Treat or refer for care if she is not already receiving care. Help her choose another method. In case of pelvic tuberculosis, re-evaluate for LNG-IUD use after treatment.

8- Do you have HIV or AIDS? Do you have any health conditions associated with HIV infection?

NO YES

If a woman has HIV infection with severe or advanced clinical disease, do not insert an LNG-IUD. In contrast, a woman living with HIV who has mild clinical disease or no clinical disease can have an IUD inserted, whether she is on antiretroviral therapy

9- Assess whether she is at extremely high individual risk for STIs.

Women who have an extremely high individual likelihood of STIs should not have an LNG-IUD inserted unless gonorrhoea and chlamydia are ruled out by lab tests

10- Rule out pregnancy

Ask the client the questions in the Pregnancy Checklist. If she answers “yes” to any of these questions, you can be reasonably certain that she is not pregnant, and she can have an LNG-IUD inserted. If the Pregnancy Checklist cannot rule out pregnancy, use another tool before inserting an LNG-IUD. Also, women should not use LNG-IUDs if they report having systemic lupus erythematosus with positive (or unknown) antiphospholipid antibodies but are not receiving immunosuppressive treatment.

Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable, when relevant to the client.

**Pregnancy Checklist
(C14.2)**

NO		YES
	1 Did your last monthly bleeding start within the past 7 days?*	
	2 Have you abstained from sexual intercourse since your last monthly bleeding, delivery, abortion, or miscarriage?	
	3 Have you been using a reliable contraceptive method consistently and correctly since your last monthly bleeding, delivery, abortion, or miscarriage?	
	4 Have you had a baby in the last 4 weeks?	
	5 Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no monthly bleeding since then?	
	6 Have you had a miscarriage or abortion in the past 7 days?*	

* If the client is planning to use a copper-bearing IUD, the 7-day window is expanded to 12 days.

↑

If the client answered **NO** to *all of the questions*, pregnancy cannot be ruled out using the checklist.

Rule out pregnancy by other means.

↑

If the client answered **YES** to *at least one of the questions*, you can be reasonably sure she is not pregnant.

Also, women should not use the IUCD if they report having systemic lupus erythematosus with severe thrombocytopenia. Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable, when relevant to the client.

* Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.

SCREENING QUESTIONS FOR IUCD/IUS INSERTION

BEFORE IUCD INSERTION:

A pelvic examination and STI risk assessment should be done before IUCD insertion. When performing the pelvic examination, asking yourself the questions below helps you check for signs of conditions that would rule out IUCD insertion. If the answer to all of the questions is “no,” then the client can have an IUCD inserted. If the answer to any question is “yes,” do not insert an IUCD.

For questions 1 through 5, if the answer is “yes,” refer for diagnosis and treatment as appropriate. Help her choose another method and counsel her about condom use if she faces any risk of sexually transmitted infections (STIs). Give her condoms, if possible. If an STI or pelvic inflammatory disease (PID) is confirmed and she still wants an IUCD, it may be inserted as soon as she finishes treatment, if she is not at risk for reinfection before insertion.

1- Is there any type of ulcer on the vulva, vagina, or cervix?

NO YES

Possible STI.

2- Does the client feel pain in her lower abdomen when you move the cervix?

NO YES

Possible PID

3- Is there tenderness in the uterus, ovaries, or fallopian tubes (adnexal tenderness)?

NO YES

Possible PID

4- Is there a purulent cervical discharge?

NO YES

Possible STI or PID.

5- Does the cervix bleed easily when touched?

NO YES

Possible STI or cervical cancer

6- Is there an anatomical abnormality of the uterine cavity that will prevent correct IUCD placement?

NO YES

If an anatomical abnormality distorts the uterine cavity, proper IUCD placement may not be possible. Help her choose another method.

7- Were you unable to determine the size and/or position of the uterus?

NO YES

Determining the size and position of the uterus before IUCD insertion is essential to ensure

high placement of the IUCD and to minimize risk of perforation. If size and position cannot be determined, do not insert an IUCD. Help her choose another method.

ASSESSING WOMEN FOR RISK OF SEXUALLY TRANSMITTED INFECTIONS

A woman who has Gonorrhoea or chlamydia now, should not have an IUCD inserted. Having these sexually transmitted infections (STIs) at the time of insertion may increase the risk of pelvic inflammatory disease. These STIs may be difficult to diagnose clinically, however, and reliable laboratory tests are time-consuming, expensive, and sometimes unavailable.

Without clinical signs or symptoms and without laboratory testing, the only indication that a woman might already have an STI is whether her behaviours or her situation places her at extremely high individual likelihood of infection. If the risk for the individual client is extremely high, she generally should not have an IUCD inserted (Local STI prevalence rates are not a basis for judging individual risk).

There is no universal set of questions that will determine if a woman is at extremely high individual risk for STIs. Instead of asking questions, providers can discuss with the client the personal behaviours and situations in their community that are most likely to expose women to STIs.

In contrast, if a current IUCD user's situation changes and she finds herself at extremely high individual risk for Gonorrhoea or chlamydia, she can keep using her IUCD

Possibly risky situations include:

- 1) Her husband has STI symptoms such as pus coming from his penis, pain or burning during urination, or an open sore in the genital area
- 2) She or her husband was diagnosed with an STI recently



Activity (A14.2a)

Divide participants into three groups and ask them to write

- 1. Limitations**
- 2. Contraindications**
- 3. MEC using the wheel**

Let the groups take 5 minutes each to prepare and then their chosen leader presents their work in 5 minutes each

Trainer to hold large group discussion and then add according to the trainer handout



Activity (A14.2b)

Unfold the parcel

The trainer makes a rolled-up parcel of different coloured papers with a question on each. The participants are asked to stand in an oval and music is played. The point where the music stops the participant with the parcel in hand opens it and reads the question out loud and then answers it.

- 1) Which WHO category means use of the method is generally not recommended, and you should only use it if no other method is available or acceptable?
- 2) A woman has diabetes. What is the WHO category of this condition for IUCD use?
- 3) List six of the WHO category 4 conditions for IUCD insertion.
- 4) A woman has Herpes. What is the WHO category of this condition for IUCD use?
- 5) A woman is nulliparous and would like the IUCD for several years of protection. What is the WHO category?

Contraindications to use of LNG IUS, based on the WHO Medical Eligibility Criteria Job Aid (J14.2a)

Category 4 – do not use	Category 3 – risk outweighs benefit
Pregnancy	Insertion 48 hours to less than 4 weeks postpartum
Puerperal sepsis	Acute venous thromboembolism
Immediately post-septic abortion	Current/history of ischemic heart disease (continuation of an LNG IUS)
Unexplained vaginal bleeding that has not been adequately investigated	SLE with unknown or positive antiphospholipid antibodies
GTN and increasing β -HCG levels	Migraines with aura (continuation)
Cervical cancer awaiting treatment (insertion)	GTN and stable or decreasing β -HCG levels
Current breast cancer	Past breast cancer (more than 5 years and no evidence of disease)
Endometrial cancer (insertion)	Increased risk of STI (two out of three) (insertion)
Ovarian cancer (insertion)	Advanced HIV/AIDS (insertion)

Category 4 – do not use	Category 3 – risk outweighs benefit
Uterine leiomyoma with distortion of cavity	Pelvic tuberculosis (continuation)
Distortion of the uterine cavity that is incompatible with IUCD insertion	Severe cirrhosis
Current PID or mucopurulent cervical discharge (insertion)	Malignant hepatoma
Pelvic tuberculosis (insertion)	Hepatocellular adenoma

IUCDs and HIV Job Aid (J14.2b)

Method	HIV
Intrauterine device (copper bearing IUCD or LNG-IUS)	<p>A woman with HIV clinical disease that is mild or with no symptoms, including a woman on ARV therapy, can have an IUCD inserted.</p> <p>Generally, a woman with HIV advanced or severe clinical disease should not have the IUCD inserted</p> <p>A woman using an IUCD can keep the IUCD in place but should be closely monitored for PID</p> <p>Strongly urge women with HIV, or who are at risk of HIV to use condoms, along with the IUCD.</p>

SESSION 3

TITLE: INSERTION AND REMOVAL OF IUCDS

(120 MINUTES)

OUTLINE & OBJECTIVES:

This session describes the steps for inserting and removing a copper-bearing IUCD and for preventing infection during insertion and removal.

METHODOLOGY

- 1) Skills Checklist on IUCD Insertion and Removal.
- 2) Instrument trays.
- 3) Steps of insertion and removal checklists.
- 4) Practice on models, observations of master clinicians.
- 5) Supervised practice is necessary for the provider to be skilful in the IUCD insertion and removal procedures.

Handout: (H14.3)

Checklist: (C14.3a), (C14.3b), (C14.3c)

INSERTION AND REMOVAL OF INTRAUTERINE DEVICE

HANDOUT (H-14.3)

The intrauterine device (IUCD) discussed in this chapter is Copper T 380A. Copper T 380 A is shaped like a T and has copper on the stem and the arms. A thread is attached to the lower end of the vertical stem. The Copper T is inserted in the uterus with an applicator through the opening of the cervical canal.

SUCCESSFUL IUCD INSERTION REQUIRES:

1- Explaining the procedure: to the client and responding to her questions and concerns. This helps the client relax, making insertion easier and less painful.

2- Infection prevention: procedure includes use of high-level disinfected instruments and cleaning of cervix with a water-based antiseptic such as Chlorhexidine Gluconate or Iodophors. This minimizes the chances of uterine infection following insertion. Particularly useful is the no-touch technique which includes loading sterile packaged IUCDs in their inserters, while both IUCD and inserter are still in the sterile packaging.

3- Speculum examination and bimanual examination: The speculum examination should come first, to check for signs of genital tract infection. The bimanual examination determines the size, position, consistency, and mobility of the uterus and identifies any tenderness which might indicate infection. A retroverted uterus requires special care during insertion.

4- Sounding of uterus: It should be done slowly and gently to determine its depth and direction. This reduces the risk of uterine perforation, cervical laceration, and other complications. As per national guidelines health workers should not insert IUCD in the uterus less than 6 cm in depth. All such cases should be referred to medical officers.

5- IUCD placement high in the uterus: The IUCD should be placed at the fundus of the uterus. This minimizes expulsions, accidental pregnancies, and bleeding.

6- Follow the manufacturer's instructions: for insertion. Most IUCDs are inserted by the withdrawal technique. The inserter tube, loaded with the IUCD, is inserted to the depth indicated by sounding. Then the inserter tube is withdrawn while the inner plunger is held steady. This leaves the IUCD in position. Then the plunger is withdrawn.

7- Position: The IUCD insertion is best performed in the dorsal lithotomy position

INSTRUCTIONS FOR INSERTION OF COPPER T 380

- 1) Explain to the client where to go for the Copper T insertion (in case of referrals)
- 2) Explain the timing of procedure:
 - a. Within 12 days of menstruation
 - b. At 6 weeks, post-partum
 - c. After 2 weeks of abortion
 - d. Any other time provided the client is sure she is not pregnant
- 3) Show the Copper T to the client and explain once again that the Copper T will be inserted using the white plastic rod. Make the client feel the thread.
- 4) Explain that during the insertion, the client may feel pain.
- 5) Explain that the Copper T is immediately effective after insertion.
- 6) Explain the likely problems after insertion and that the Copper T can be removed anytime time if there are major problems and if so desired by the client.
- 7) Explain the importance of checking the thread to see whether the Copper T is in place and explain how to check the thread.
- 8) Emphasize to contact the health worker immediately in case of warning signs
- 9) Record the insertion of Copper T.
- 10) It is advisable to follow up the clients who are using Copper T to reassure them and to find out if they are having any problems.

POST INSERTION INSTRUCTIONS:

- 1) Plan with the client for a return visit in 3 to 6 weeks – for example, after a menstrual period for check-up and pelvic examination, to make sure that her IUCD is still in place and that no infection has developed. The visit can be at any time convenient to the client

when she is not menstruating. After this one return visit, no further routine visits are required.

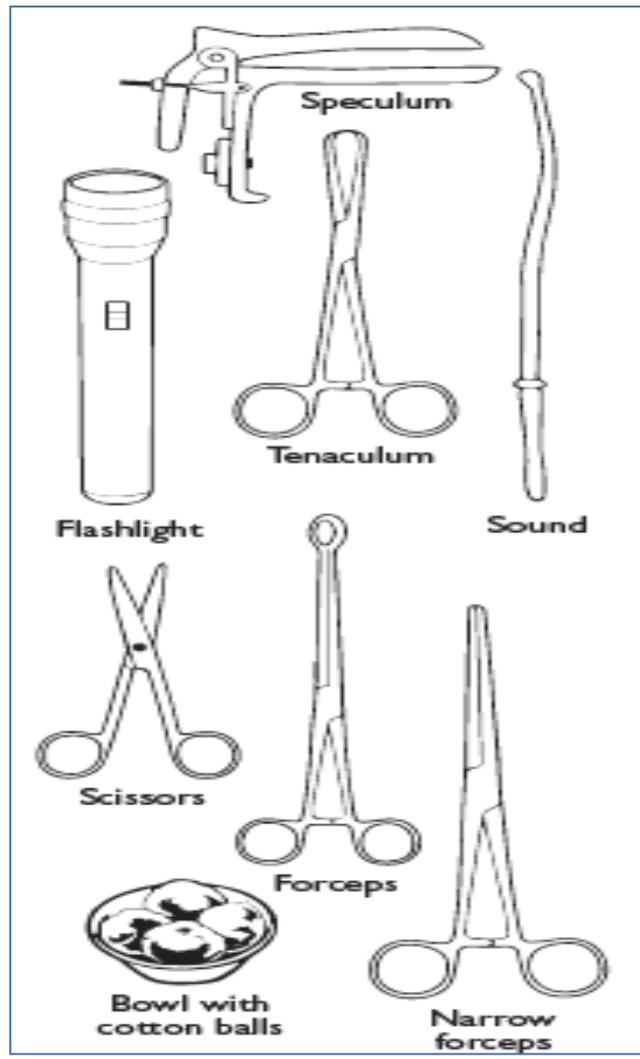
- 2) Make sure she knows:
- a) Exactly what kind of IUCD she has and how it looks like.
 - b) When to have IUCD removed or replaced (for TCu-380A IUCD, 14 years after insertion).
 - c) Discuss how to remember the year to return for removal or change
 - d) If she wants a new IUCD, it can be inserted as soon as the old IUCD is removed.
 - e) When she visits health care providers, she should tell them that she has an IUCD.

Important: Provide the client with a written record of the month and year of IUCD insertion and the month and year of when it should be removed.

GIVE SPECIFIC INSTRUCTIONS:

A woman who chooses an IUCD should know what will happen during the insertion procedure. She also should understand that she can expect:

Some cramping pain for first day or two after insertion.	She can take some NSAIDs for this.
Some vaginal discharge for a few weeks after insertion.	Normal.
Heavier menstrual periods. Possible bleeding between menstrual periods, especially during the first few months after IUCD insertion.	Normal. The HCP may prescribe iron supplements, Trans amine and Ponstan Forte



Explaining how to use the IUCD: Insertion of Copper T Checklist (C14.3a)

Rate the performance of each step or task observed using the following rating scale:

Place a “Y” in the case box if the step/task is performed satisfactorily, an “N” if it is not performed satisfactorily, or an “X” if it is not observed.

Satisfactory: Perform the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

All participants must observe 3 cases, do 5 under supervision and then 5 independently

Checklist for Regular Copper T 380 A, IUCD Counselling and Clinical Skills	
Pre-Insertion Counselling	
1- Greet the client respectfully and with kindness.	
2- Rule out pregnancy by asking the six questions to be reasonably sure that the woman is not pregnant.	
3- If the client has already identified a method, provide focused counseling on that method. Otherwise, ask the following four questions and eliminate cards according to the client's response: <ul style="list-style-type: none"> a. Does the client want more children in the future? b. Is she breastfeeding an infant < 6 months old? c. Will her husband use condoms? d. Has she not tolerated a family planning method in the past? 	
4- Continue with balanced counseling, using the cards to: <ul style="list-style-type: none"> a. Give information about the methods on the cards that are left. b. Discuss side effects and efficacy. c. Help the client choose a method. d. Confirm the client's method choice. 	
5- Review medical eligibility: <ul style="list-style-type: none"> a. Read from the client brochure in language the client understands (e.g., "Method not advised if you ..."). 	
6- Review Client Screening Checklist to determine if the IUCD is an appropriate choice for the client.	
7- Perform (or refer for) further evaluation, if indicated.	
8- Assess the woman's knowledge about the major side effects of IUCDs. <ul style="list-style-type: none"> a. Confirm that the client accepts possible menstrual changes with IUCDs. 	
9- Describe the insertion procedure and what to expect.	
IUCD INSERTION PRE-INSERTION CLIENT ASSESSMENT STEPS	
Client Assessment:	
1- Review the client's medical and reproductive history.	
2- Ensure that equipment and supplies are available and ready to use.	
3- Ask the client to empty her bladder and wash her perineal area.	
4- Help the client onto the examination table.	

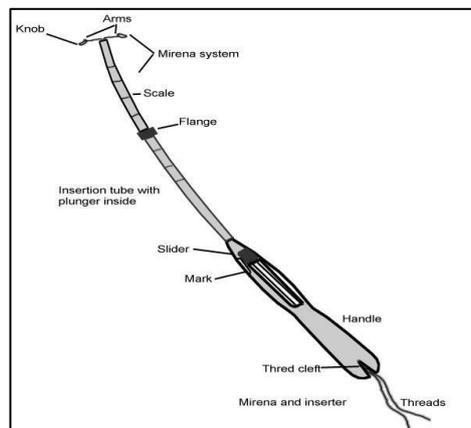
5- Tell the client what is going to be done and ask her if she has any questions.	
6- Wash hands thoroughly and dry them.	
7- Palpate the abdomen	
8- Wash hands thoroughly and dry them again .	
9- Put clean gloves on both hands.	
10- Inspect the external genitalia.	
Note:	
If findings are normal, perform the bimanual exam first and the speculum exam second.	
If there are potential problems, perform the speculum exam first and a bimanual exam second.	
11a. Perform a bimanual exam (see note above).	
11b. Perform rectovaginal exam only if indicated.	
11c. If rectovaginal exam is performed, change gloves before continuing.	
12- Perform a speculum exam if indicated. (Note: If laboratory testing is indicated and available, take samples now.)	
INSERTION STEPS (using aseptic, no-touch technique throughout)	
1- Give the client an overview of the insertion procedure. Remind her to let you know if she feels any pain.	
2- Gently insert the high-level-disinfected (HLD) or sterile speculum to visualize the cervix (if not already done), and cleanse the cervical os and vaginal wall with antiseptic.	
3- Gently grasp the cervix with an HLD (or sterile) tenaculum and apply gentle traction.	
4- Insert the HLD (or sterile) sound using the no-touch technique to fundus. Place ring forceps next to uterine sound at the cervix and carefully remove both sound and forceps together. Note where the ring forceps is on the uterine sound to determine uterine measurement.	
5- Load the IUCD in its sterile package.	
6- Set the blue depth-gauge to the measurement of the uterus.	

7- Carefully insert the loaded IUCD and release the arms of the IUCD into the uterus using the withdrawal technique.	
8- Gently push the insertion tube upward again until you feel a slight resistance (to ensure arms of IUCD are in fundus).	
9- Withdraw the rod, and partially withdraw the insertion tube until the IUCD strings can be seen.	
10- Use HLD (or sterile) sharp Mayo scissors to cut the IUCD strings to 3 - 4 cm length if needed.	
11- Gently remove the tenaculum and speculum and place in 0.5% chlorine solution for 10 minutes for decontamination.	
12- Examine the cervix for bleeding.	
13- Ask how the client is feeling and begin performing the post-insertion steps.	
Post-Insertion Steps	
1- Before removing the gloves, place all used instruments in 0.5% chlorine solution for 10 minutes for decontamination.	
2- Properly dispose of waste materials.	
3- Process gloves according to recommended IP practices.	
4- Wash hands thoroughly and dry them.	
5- Provide post-insertion instructions (key messages for IUCD users): <ul style="list-style-type: none"> • Basic facts about her IUCD (e.g., type, how long effective, when to replace/remove) • No protection against STIs; need for condoms if at risk • Possible side effects • Warning signs (PAINS) • How to check for possible IUCD expulsion • When to return to clinic 	

INSERTION PROCEDURE FOR LNG IUS:

A woman who has chosen the LNG-IUCD needs to know what will happen during insertion. The following description can help explain the procedure to her. Learning LNG-IUCD insertion requires training and practice under direct supervision. Therefore, this description is a summary and not detailed instructions.

- | |
|---|
| 1) The provider uses proper infection- prevention procedures. |
| 2) The provider conducts a pelvic examination to determine the position of the uterus and assess eligibility. The provider first does the bimanual examination and then inserts a speculum into the vagina to inspect the cervix. |
| 3) The provider cleans the cervix and vagina with appropriate antiseptic. |
| 4) The provider slowly inserts the tenaculum through the speculum and closes the tenaculum just enough to gently hold the cervix and uterus steady. |
| 5) The provider slowly and gently passes the uterine sound through the cervix to measure the depth of the uterus. |
| 6) The provider slowly and gently passes the inserter through the cervix, re-releases the LNG-IUCD inside the uterine cavity, and removes the inserter. |
| 7) The provider cuts the strings on the IUCD, leaving about 3 centimetres hanging out of the cervix. |
| 8) After the insertion, the woman rests. She remains on the examination table until she feels ready to get dressed. |



<p>Talk with the client before the procedure</p>	<p>Explain the insertion procedure</p> <p>Show her the speculum, tenaculum, and the IUCD and inserter in the package.</p> <p>Tell her that she will experience some discomfort or cramping during the procedure, and that this is to be expected.</p> <p>Ask her to tell you any time that she feels discomfort or pain.</p> <p>Ibuprofen (200–400 mg), paracetamol (325– 1000 mg), or other</p>
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	pain reliever may be given 30 minutes before insertion to help reduce cramping and pain. Do not give aspirin, which slows blood clotting.
Talk with the client during the procedure	Tell her what is happening, step by step, and reassure her. Alert her before a step that may cause pain or might startle her. Ask from time to time if she is feeling pain.
Talk with the client after the procedure	Ask her how she is doing. Tell her that the procedure was successful and that the IUCD is in place. Tell her that she can rest for a while and then slowly sit up before getting up and dressing. Remind her that the two of you will be discussing next steps and follow-up.

PREPARATION FOR INSERTION

- 1) Exclude pregnancy and confirm that there are no other contraindications to the use of LNG-IUS.
- 2) Ensure that the patient understands the contents of the Patient Information Booklet
- 3) Obtain the signed patient informed consent located on the last page of the Patient Information Booklet.
- 4) With the patient comfortably in lithotomy position, do a bimanual exam to establish the size, shape and position of the uterus.
- 5) Gently insert a speculum to visualize the cervix.
- 6) Thoroughly cleanse the cervix and vagina with a suitable antiseptic solution.
- 7) Prepare to sound the uterine cavity. Grasp the upper lip of the cervix with a tenaculum forceps and gently apply traction to stabilize and align the cervical canal with the uterine cavity.
- 8) Perform a paracervical block if needed. If the uterus is retroverted, it may be more appropriate to grasp the lower lip of the cervix. The tenaculum should remain in position and gentle traction on the cervix should be maintained throughout the insertion procedure.
- 9) Gently insert a uterine sound to check the patency of the cervix, measure the depth of the uterine cavity in centimetres, confirm cavity direction, and detect the presence of any uterine anomaly.

- 10) In case of difficulty or cervical stenosis, use gentle dilatation, and not force, to overcome resistance.
- 11) If cervical dilatation is required, consider using a paracervical block.
- 12) The uterus should sound to a depth of 6 to 10 cm.
- 13) Insertion of LNG-IUS into a uterine cavity less than 6 cm by sounding may increase the incidence of expulsion, bleeding, pain, perforation, and possibly pregnancy.

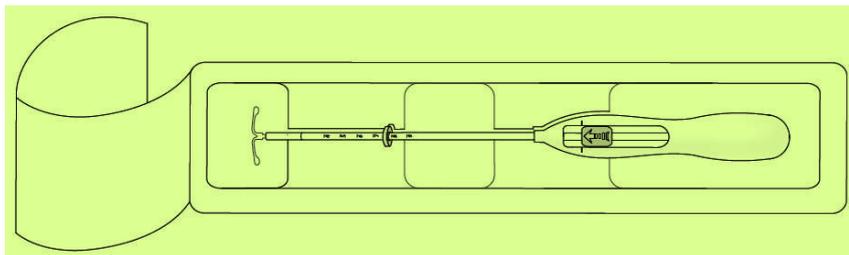
TRAY NEEDED FOR INSERTION

- 1) Gloves
- 2) Speculum
- 3) Sterile uterine sound
- 4) Sterile tenaculum
- 5) Antiseptic solution,
- 6) The LNG-IUS
- 7) Sterile gloves
- 8) Sterile, sharp curved scissors
- 9) Mirena with inserter in sealed package
- 10) Instruments and anaesthesia for paracervical block, if anticipated
- 11) Consider having an unopened backup Mirena available

INSERTION PROCEDURE:

Proceed with insertion only after completing the above steps and ascertaining that the patient is appropriate for LNG IUS. Ensure use of aseptic technique throughout the entire procedure

Step 1– Opening of the package.

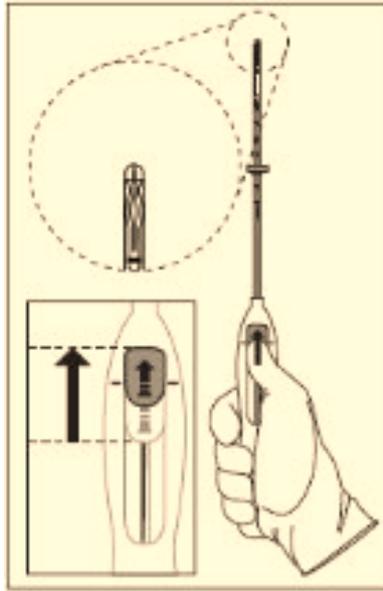


Using sterile gloves lift the handle of the sterile inserter and remove from the sterile package.

Step 2 – Load IUS into the insertion tube

Push the slider forward as far as possible in the direction of the arrow thereby moving the insertion tube over the Mirena T-body to load Mirena into the insertion tube (**Figure**

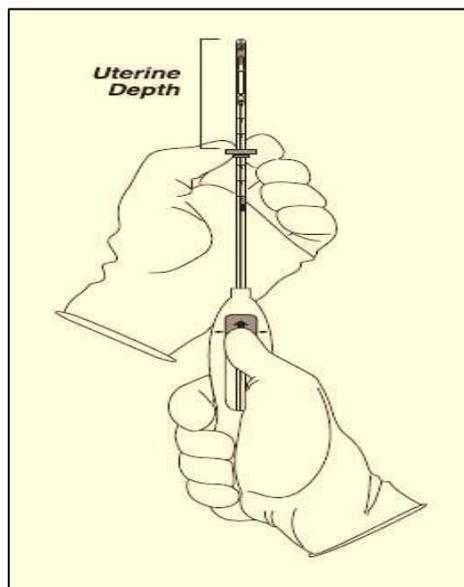
2). The tips of the arms will meet to form a rounded end that extends slightly beyond the insertion tube.



Maintain forward pressure with your thumb or forefinger on the slider. **DO NOT** move the slider downward at this time as this may prematurely release the threads of Mirena. Once the slider is moved below the mark, Mirena cannot be re-loaded.

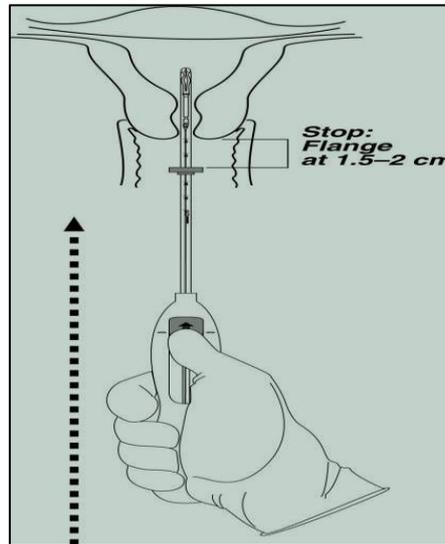
Step 3–Setting the flange

Holding the slider in this forward position, set the upper edge of the flange to correspond to the uterine depth (in centimetres) measured during sounding ([Figure 3](#)).



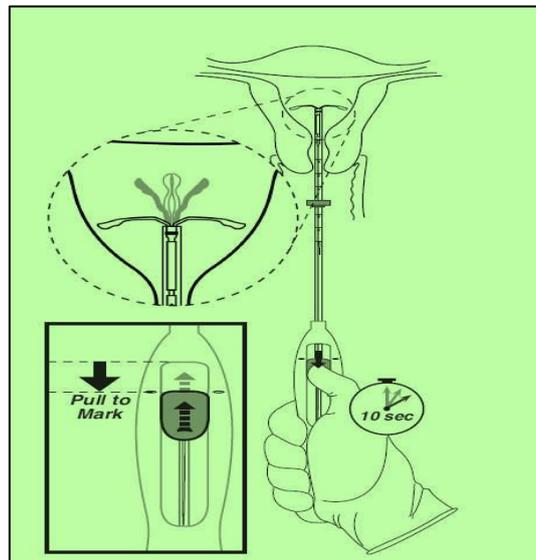
Step 4—Mirena is now ready to be inserted

Continue holding the slider in this forward position. Advance the inserter through the cervix until the flange is approximately 1.5–2 cm from the cervix and then pause. Do not force the inserter. If necessary, dilate the cervical canal.



Step 5—Open the arms

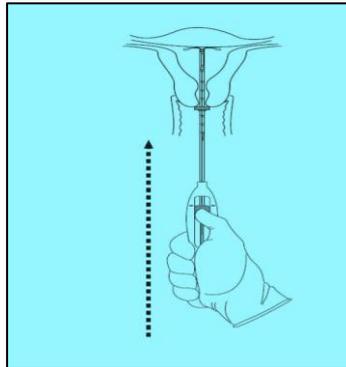
While holding the inserter steady, move the slider down to the mark to release the arms of Mirena (**Figure 5**). Wait 10 seconds for the horizontal arms to open completely.



Step 6—Advance to fundal position

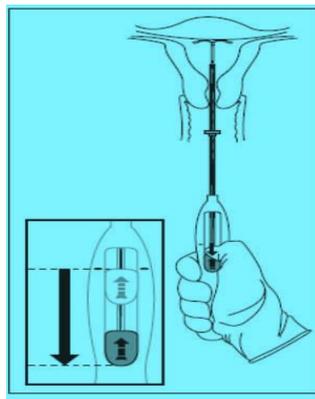
Advance the inserter gently towards the fundus of the uterus until the flange touches the cervix. If you encounter fundal resistance do not continue to advance. Mirena is

now in the fundal position (**Figure 6**). Fundal positioning of Mirena is important to prevent expulsion.



Step 7–Release the IUS and withdraw the inserter

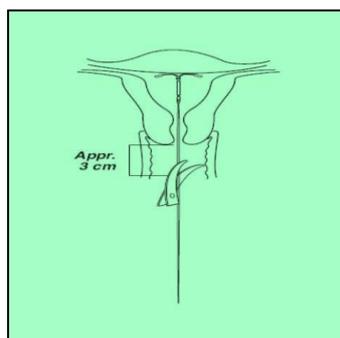
Holding the entire inserter firmly in place, release the IUS by moving the slider all the way down



Step 8 –Cut the thread

Continue to hold the slider all the way down while you slowly and gently withdraw the inserter from the uterus.

Using a sharp, curved scissor, cut the threads perpendicular, leaving about 3 cm visible outside of the cervix [cutting threads at an angle may leave sharp ends (**Figure 8**)]. Do not apply tension or pull on the threads when cutting to prevent displacing Mirena.



POST-INSERTION COUNSELLING:

Counsel the client after insertion. Provide the following information (in case of referrals, it is advisable to provide the information before being referred).

- 1) The IUCD/IUS is immediately effective after insertion.
- 2) There may be slight bleeding or spotting for a week. If the bleeding is profuse or prolonged, contact the health workers.
- 3) It is normal to have slight cramping in the first 48 hours. Take some pain killer if needed. The cramping should not last longer than 48 hours. If it becomes severe, contact the health workers.
- 4) Check for the strings to be sure that the IUCD/IUS is still inside the uterus as instructed below.
 - (Use the cut end of the string to make the client feel the texture of the string):
 - First wash hands to reduce chances of introducing infection.
 - Sit in a squatting position and reach into the vagina as far as back as possible and feel for the strings. Do not pull the thread as it might dislodge the device.
 - Wash hands again.
- 5) Check for the string after each menstrual period
- 6) Check menstrual cloth for Copper T as sometimes it is expelled with menstrual blood.
 - There may be spotting or increased bleeding during menstrual period for the first 2-3 months, but the periods become normal thereafter. If the problem continues, contact health worker.
- 7) The device can be removed if so desired.
- 8) Discuss the warning signs in detail:
 - Report immediately to health workers if any of the following happens (warning signs):
 - Missed periods, abnormal bleeding or spotting
 - Abdominal pain, pain with intercourse
 - Exposure to STIs, abnormal discharge per vagina
 - String is missing, getting longer or shorter or something felt inside the vagina or has been expelled.

Return after a month or after the first periods for follow up.

GIVING SPECIFIC INSTRUCTIONS:

Expect cramping and pain	<ol style="list-style-type: none">1. She can expect some cramping and pain for a few days after insertion 2. Suggest ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever as needed.
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	<p>3. Also, she can expect some bleeding or spotting immediately after insertion.</p>
Length of pregnancy protection	<p>Discuss how to remember the date to return for removal or replacement.</p> <p>Give each woman the following information in writing on a reminder card, like the one shown below, if possible, and explain:</p> <ul style="list-style-type: none"> a) The type of IUCD she has b) Date of IUCD insertion c) Month and year when IUCD will need to be removed or replaced. (For the MIRENA and KYLEENA LNG-IUCDs, 5 years after insertion. For the LILETTA, SKYLA, and JAYDESS LNG-IUCDs, 3 years after insertion.) d) Where to go if she has problems or questions about her IUCD
Follow-up visit	<p>A follow-up visit after her first monthly bleeding or 3 to 6 weeks after IUCD insertion is recommended. No woman should be denied an IUCD, however, because follow-up would be difficult or not possible.</p>

REMOVAL OF IUCDS/IUS:

- 1) Remove IUCD/IUS by applying gentle traction on the threads with forceps.
- 2) If the threads are not visible, determine location of IUCD/ LNGIUS by ultrasound
- 3) If LNG-IUS is found to be in the uterine cavity on ultrasound exam, it may be removed using some narrow forceps, such as an alligator forceps. This may require dilation of the cervical canal. Misoprostol tablets, 600 mcg (3 tablets) can be used sublingually, 45 minutes or so prior to the removal. It helps in comfortable removal, by softening the cervix.
- 4) Removal may be associated with some pain and/or bleeding or vasovagal reactions (for example, syncope, or a seizure in an epileptic patient).

**Explaining how to remove the IUCD: REMOVAL of Copper T
Checklist (C14.3b)**

All participants must observe 3 cases, do 5 under supervision and then 5 Independently

IUCD REMOVAL	
Pre-Removal Steps	
1. Greets the woman with respect	
2. Ask the woman her reason for having the IUCD removed.	
3. Determine whether she will have another IUCD inserted immediately, start a different method, or neither.	
4. Review the client's reproductive goals and need for STI protection, and counsel as appropriate.	
5. Describes the procedure and what is going to be done to the woman	
6. Encourages her to ask any questions, she may have	
7. Ensure that equipment and supplies are available and ready to use.	
8. Ask the client to empty her bladder and wash her perineal area.	
9. Help the client onto the examination table.	
10. Wash hands thoroughly and dry them.	
11. Put new HLD gloves on both hands.	
12. Arranges the instruments	
Removing the IUCD	
1. Give the client an overview of the removal procedure. Remind her to let you know if she feels any pain.	
2. Gently insert the HLD (or sterile) speculum to visualize the strings, and cleanse the cervical os and vaginal wall with antiseptic.	
3. Alert the client immediately before you remove the IUCD.	
4. Grasp the IUCD strings close to the cervix with an HLD (or sterile) haemostat or other narrow forceps.	
5. Apply steady but gentle traction, pulling the strings toward you, to remove the IUCD. Do not use excessive force.	
6. Show the IUCD to client.	
7. Place the IUCD in 0.5% chlorine solution for 10 minutes for decontamination.	
8. If the woman is having a new IUCD inserted, insert it now if appropriate. [If she is not having a new IUCD inserted, gently remove the speculum and place it in 0.5% chlorine solution for 10 minutes for decontamination.]	

Checklist for Post Removal Steps of Regular Copper T 380a IUCD

Checklist (C14.3c)

Post-Removal Steps	
1) Before removing the gloves, place all used instruments and the IUCD in 0.5% chlorine solution for 10 minutes for decontamination.	
2) Properly dispose of waste materials.	
3) Process gloves according to recommended IP practices.	
4) Wash hands thoroughly and dry them.	
5) If the woman has had a new IUCD inserted, review key messages for IUCD users. [If the woman is starting a different method, provide the information she needs to use it safely and effectively (and a back-up method, if needed)]	
6) Records the IUCD removal in the woman's records	

SESSION 4

TITLE: INFECTION PREVENTION

(25 MINUTES)

OUTLINE & OBJECTIVES:

To highlight the importance of proper infection prevention protocols in ensuring a high-quality service provision

METHODOLOGY:

- 1) Brainstorming session
- 2) Encourage sharing their own workplace experiences and knowledge about infection prevention.
- 3) Power point presentation to illustrate the IP practices.

INFECTION PREVENTION

HANDOUT (H-14.4)

PREVENTING INFECTION IN IUCD

Proper insertion technique can help prevent many problems, such as infection, expulsion, and perforation.

- Follow proper infection-prevention procedures.
- Use high-level disinfected or sterile instruments. High-level disinfect by boiling, steaming, or soaking them in disinfectant chemicals.
- Use a new, pre sterilized IUD that is packaged with its inserter.
- The “no-touch” insertion technique is safest. This includes not letting the loaded IUD or uterine sound touch any unsterile surfaces (for example, hands, speculum, vagina, tabletop). The no-touch technique involves:
 - Loading the IUD into the inserter while the IUD is still in the sterile package, to avoid touching the IUD directly
 - Cleaning the cervix thoroughly with antiseptic before IUD insertion
 - Being careful not to touch the vaginal wall or speculum blades with the uterine sound or loaded IUD inserter
 - Passing both the uterine sound and the loaded IUD inserter only once each through the cervical canal
 - Giving antibiotics routinely is generally not recommended for women at low risk of STIs.

PREVENTING INFECTION IN LNG-IUS INSERTION

Proper insertion technique can help prevent many problems, such as infection, expulsion, and perforation.

- 1) Follow proper infection-prevention procedures.
- 2) Use high-level disinfected or sterile instruments. High-level disinfection can be done^[11] by boiling, steaming, or soaking instruments in disinfectant chemicals.
- 3) Use a new, pre-sterilized LNG-IUCD that is packaged with its inserter.
- 4) The “no-touch” insertion technique is safest. This includes not letting the loaded IUCD or uterine sound touch any unsterile surfaces (for example, hands, speculum, vagina, tabletop). The no-touch technique involves:
 - a) Cleaning the cervix thoroughly with antiseptic before IUCD insertion
 - b) Being careful not to touch the vaginal wall or speculum blades with the uterine sound or loaded IUCD inserter
 - c) Passing both the uterine sound and the loaded IUCD inserter only once each through the cervical canal.

Infection risk of infection is minimal. It is highest within the first 3 weeks after IUCD insertion and is thought to be related to either insertion technique (resulting from a lack of proper infection prevention practices) or a pre-existing infection, rather than to the IUCD itself. After the first 3 weeks, the risk of infection among IUCD users appears to be comparable to that among non-IUCD users.

SESSION 5

TITLE: SIDE EFFECTS AND THEIR MANAGEMENT

(40 MINUTES)

OUTLINE & OBJECTIVES:

To discuss and elaborate upon the common problems faced by women after insertion of IUCDS

METHODOLOGY:

- 1) Brainstorming for experience sharing of the health care providers, preferably real-life stories.
- 2) Short presentation covering side effects and warning signs.

Handout: (H14.5)

Activity: (A14.5)

Job Aid: (J14.5a), (J14.5b), (J14.5c)

SIDE EFFECTS AND THEIR MANAGEMENT

HANDOUT (H-14.5)



Activity (A14.5)

The trainer divides the participants into two groups by asking them to say an odd and an even number. Each group is asked to brainstorm and write side effects and complications respectively and their management in 10 minutes. Each group chooses a group leader for presentation. 5 minutes each for presentation and the trainer sums up with any additional information.

GIVING ADVICE ON SIDE EFFECTS

IMPORTANT: Thorough counselling about bleeding changes must come before IUCD insertion. Counselling about bleeding changes may be the most important help a woman needs to keep using the method without concern.

Describe the most common side effects **and explain about these in detail**

Irregular bleeding followed by lighter bleeding, fewer days of bleeding, infrequent bleeding, and then no monthly bleeding. Acne, headaches, breast tenderness and pain, and possibly other side effects with IUS.

Bleeding changes usually are not signs of illness.

Lack of bleeding does not mean pregnancy.

Bleeding irregularities usually become less within 3 to 6 months after insertion. Many women have no bleeding at all after using the LNG-IUS for a year or two. Other side effects also become less after the first several months following insertion.

Reassure her that she can come back for help if side effects bother her or if she has other concerns.

GIVING ADVICE ON SIDE EFFECTS

Job Aid (J14.5a)

Side Effect/Problem	Assessment	Management
Spotting or bleeding	Find out whether the client is having spotting or bleeding Ask whether associated with lower abdominal pain and if so the severity of the pain Perform pelvic examination to rule out infection, intrauterine pregnancy or ectopic pregnancy. (Additional tests like Beta HCG levels and pelvic ultrasound scan may be needed for accurate diagnosis)	If intrauterine pregnancy, evidence of ectopic pregnancy, vaginal, cervical or pelvic infection or any pathology (fibroid), refer to a specialist. If less than 3 months and no evidence of pregnancy or pathology, counsel to continue using Copper T and ask the client to return if situation worsens. Refer to specialist if the problem continues beyond 3 months If more than 3 months after insertion, refer to specialist even if no evidence of pathology
Lower abdominal pain	Find out whether the cramps are mild or severe Do a pelvic examination to rule out infection or displacement of Copper T.	If mild pain, give paracetamol and instruct to contact if no relief or pain worsens If severe pain, refer to a specialist.
Vaginal discharge	Pelvic examination. Rule out pelvic tenderness.	Refer to a specialist

Amenorrhea	Ask about last menstrual period, Ask whether she felt the strings after the periods Ask for symptoms of pregnancy Do a pelvic examination to find out whether the Copper T is in situ and rule out pregnancy	If no evidence of pregnancy and Copper T is in situ, counsel for continuation of the method If pregnant or Copper T is missing, refer to a specialist
Missing Copper T strings	Ask when the client last felt for the string and whether there is any evidence that the Copper T expelled Do a pelvic examination to confirm whether the Copper T is expelled and to rule out pregnancy	If the Copper T is expelled and there is no evidence of pregnancy or infection, counsel for re- insertion. If strings visible, no evidence of pregnancy, gently remove the Copper T. If strings visible and there is evidence of pregnancy, refer to a specialist.

**WARNING SIGNS
JOB AID (J14.5b)**

WARNING SIGNS: PAINS

- P-** Periods late, spotting, bleeding
- A-** Abdominal pain, pain with intercourse, severe cramp
- I-** Infection: discharge, exposure to STIs
- N-** Not feeling well, fever, chills along with lower abdominal pain
- S-** String missing, shorter or longer

Switching From the LNG-IUS and Copper IUCD to another Method

Job Aid (J14.5c)

These guidelines ensure that the client is protected from pregnancy without interruption when switching from the LNG-IUCD to another method. See also When to Start for each method.

Switching to	When to start
Hormonal methods: Combined oral contraceptives (COCs), progestin only pills (POPs), progestin-only injectables, monthly injectables, combined patch, combined vaginal ring, or implants	<ul style="list-style-type: none"> • If starting during the first 7 days of monthly bleeding (first 5 days for COCs and POPs), start the hormonal method now and remove the IUCD. No need for a backup method. • If starting after the first 7 days of monthly bleeding (after the first 5 days for COCs and POPs) and she has had sex since her last monthly bleeding, start the hormonal method now. It is recommended that the IUCD stay in place until her next monthly bleeding. • If starting after the first 7 days of monthly bleeding (after the first 5 days for COCs and POPs) and she has not had sex since her last monthly bleeding, the IUCD can stay in place and be removed during her next monthly bleeding, or the IUCD can be removed and she can use a *backup method for the next 7 days (2 days for POPs).
Male or female condoms, spermicides, diaphragms, cervical caps, or withdrawal	<ul style="list-style-type: none"> • The next time she has sex after the IUCD is removed.
Fertility awareness methods	<ul style="list-style-type: none"> • In the cycle that the IUCD is removed.
Female sterilization	<ul style="list-style-type: none"> • If during the first 7 days of monthly bleeding, remove the IUCD and perform the female sterilization procedure. No need for a backup method. • If after the first 7 days of monthly bleeding, perform the sterilization procedure. Ideally, the IUCD should stay in place until her follow-up visit or her next monthly bleeding. If a follow-up visit is not possible, remove the IUCD at the time of sterilization. No need for a backup method.
Vasectomy	<ul style="list-style-type: none"> • Any time • The woman can keep the IUCD until a test of her husband's semen shows that the vasectomy is working, or for 3 months, when the vasectomy will be fully effective.

*Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her

that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms

MANAGING PROBLEMS

May or may not be due to the method.

- 1) Problems with side effects or complications affect women's satisfaction and use of IUCDs. They deserve the provider's attention. If the client reports any side effects or complications, listen to her concerns, give her advice and support, and, if appropriate, treat. Make sure she understands the advice and agrees.
- 2) Offer to help her choose another method—now, if she wishes, or if problems cannot be overcome.

IRREGULAR BLEEDING OR SPOTTING: (BLEEDING AT UNEXPECTED TIMES THAT BOTHERS THE CLIENT)

- 1) Reassure her that some women using IUCDs experience irregular bleeding. It is not harmful and usually becomes less or stops after the first several months of use.
- 2) If irregular bleeding starts after several months of no bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use
- 3) Evidence of infection or other abnormalities:
- 4) Conduct a pelvic examination to look for cervical disease, ectopic pregnancy, or PID. Refer if appropriate.
- 5) She can continue using her IUCD while her condition is being evaluated.
- 6) If there is no evidence of infection or other abnormalities, less than 3 months since IUCD insertion and bleeding is within normal and expected range, then:
Reassure her that changes in menstrual bleeding are normal and will probably lesson over time.

Suggest that she eat more food containing iron if possible. If possible, give her iron tablets.

- 1) Ask if she wants to keep her IUCD:
- 2) If she does want to retain, ask her to return in about 3 months for another check-up.
- 3) If the client wishes or if the bleeding or pain is severe, remove the IUCD and help her choose another method.
- 4) If an abnormal condition is causing irregular or heavy bleeding, treat or refer to care.

If there is very heavy bleeding, check for signs of severe anaemia—pale under fingernails and inside eyelids. If found:

Give her enough iron supplements for 3 months

If she does not want to retain the IUCD help her choose another method.

- 1) she can continue using her IUCD while her condition is being evaluated.
- 2) Evaluate and treat her underlying medical problem or refer her to senior opinion.

NO MONTHLY BLEEDING:

- 1) Reassure her that many women eventually stop having monthly bleeding when using the LNG-IUCD, and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not pregnant or infertile. Blood is not building up inside her. (Some women are happy to be free from monthly bleeding.)
- 2) If monthly bleeding stops very soon after insertion of the LNG-IUCD, assess for pregnancy or other underlying condition.

HEAVIER OR PROLONGED BLEEDING: (LONGER THAN 8 DAYS)

- 1) Reassure her that some women using the IUCDs experience heavier or prolonged bleeding. It is generally not harmful and usually becomes less or stops after the first several months of use.
- 2) Provide iron tablets if possible and tell her it is important for her to eat foods containing iron.
- 3) If heavier or prolonged bleeding continues or starts after several months of no bleeding, or if you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.

CRAMPING AND PAIN:

- 1) She can expect some cramping and pain for the first day or 2 after IUCD insertion.
 - a) Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever. If she also has heavy or prolonged bleeding, aspirin should not be used because it may increase bleeding.
- 2) If cramping continues beyond the first 2 days, evaluate for partial expulsion or perforation.

ACNE:

- 1) If the client wants to stop using the LNG-IUCD because of acne, she can consider switching to COCs. Many women's acne improves with COC use.
- 2) Consider locally available remedies.

ORDINARY HEADACHES: (NON-MIGRAINOUS)

- 1) Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.
- 2) Any headaches that get worse or occur more often during LNG-IUCD use should be evaluated.

BREAST TENDERNESS:

- 1) Recommend that she wear a supportive bra (including during strenuous activity and sleep)
- 2) Try hot or cold compresses.

- 3) Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.
- 4) Consider locally available remedies.

WEIGHT CHANGE:

Review diet and counsel as needed.

NAUSEA OR DIZZINESS:

Consider locally available remedies.

MOOD CHANGES:

- 1) Clients who have serious mood changes such as major depression should be referred for care.
- 2) Consider locally available remedies.

HUSBAND CAN FEEL IUCD STRINGS DURING SEX

- 1) Explain that this happens sometimes when strings are cut too short. If her husband finds the strings bothersome, describe and discuss this option:
- 2) Strings can be cut even shorter, so they are not coming out of the cervical canal. Her partner will not feel the strings, but it will make the removal procedure somewhat more difficult (may require a specially trained provider). Document in her notes

SEVERE PAIN IN LOWER ABDOMEN SUSPECTED PELVIC INFLAMMATORY DISEASE (PID)

- 1) Some common signs and symptoms of PID often also occur with other abdominal conditions, such as ectopic pregnancy. If ectopic pregnancy is ruled out, assess for PID.
- 2) If possible, do abdominal and pelvic examinations.
- 3) If a pelvic examination is not possible, and she has a combination of the following signs and symptoms in addition to lower abdominal pain, suspect PID:
 - Unusual vaginal discharge
 - Fever or chills
 - Pain during sex or urination
 - Bleeding after sex or between monthly bleeding
 - Nausea and vomiting
 - A tender pelvic mass.
 - Pain when the abdomen is gently pressed (direct abdominal tenderness) or when

- gently pressed and then suddenly released (rebound abdominal tenderness).
- 4) Treat PID or immediately refer for treatment:
 - Because of the serious consequences of PID, health care providers should treat all suspected cases, based on the signs and symptoms above. Treatment should be started as soon as possible. Treatment is more effective at preventing long-term complications when appropriate antibiotics are given immediately.
 - Treat for gonorrhoea, chlamydia, and anaerobic bacterial infections. Counsel the client about prevention and treatment of STIs and about condom use. If possible, give her condoms.
 - There is no need to remove the IUCD if she wants to continue using it. If she wants it removed, take it out after starting antibiotic treatment. (If the IUCD is removed, consider emergency contraceptive pills and discuss choosing another method.)
 - 5) If the infection does not improve, consider removing the IUCD while continuing antibiotics. If the IUCD is not removed, antibiotics should still be continued. In both cases the woman's health should be closely monitored.

SEVERE PAIN IN LOWER ABDOMEN (SUSPECTED OVARIAN CYST)

- 1) Abdominal pain may be due to various problems, such as enlarged ovarian follicles or cysts.
- 2) A woman can continue to use the LNG-IUCD during evaluation and treatment.
- 3) There is no need to treat enlarged ovarian follicles or cysts unless they grow abnormally large, twist, or burst. Reassure the client that they usually disappear on their own. To be sure the problem is resolving, see the client again in 6 weeks, if possible.

SEVERE PAIN IN LOWER ABDOMEN (SUSPECTED ECTOPIC PREGNANCY)

- 1) Many conditions can cause severe abdominal pain. Be particularly alert for additional signs or symptoms of ectopic pregnancy, which is rare but can be life-threatening. The LNG-IUCD reduces the risk of ectopic pregnancy, but it does not eliminate the risk altogether.
- 2) In the early stages of ectopic pregnancy, symptoms may be absent or mild, but eventually they will become severe. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy:
 - Unusual abdominal pain or tenderness
 - Abnormal vaginal bleeding or no monthly bleeding—especially if this is a change from her current bleeding pattern
 - Light-headedness or dizziness
 - Fainting
- 3) If ectopic pregnancy or other serious health condition is suspected, refer at once for immediate diagnosis and care.
- 4) If the client does not have these additional symptoms or signs, assess for pelvic

inflammatory disease.

COMPLICATIONS AT THE TIME OF INSERTION

Complications from IUCD placement are relatively rare. The most common complication is IUCD expulsion, which occurs in approximately 2-10% of cases.^[5] Patients should be encouraged to feel for their IUCD strings on a regular basis at home to ensure correct placement.

Placement in the immediate postpartum period is associated with a higher expulsion rate than delayed postpartum insertion. Similarly, insertion immediately following first and second trimester spontaneous or elective abortion is also associated with a higher expulsion rate than delayed insertion. There are, however, numerous advantages to post procedural and postpartum insertion, which may outweigh the risk of expulsion

SUSPECTED UTERINE PERFORATION

This is an uncommon complication and occurs in 0.1% of cases. Severe pain or loss of resistance with sounding for IUCD insertion are signs of perforation. If perforation is suspected, the procedure should be stopped and postponed. The patient's vital signs should be assessed to identify and signs of haemorrhage. If any of these signs are evident, the patient should be transported to an emergency facility rapidly.

Observe the client in the clinic carefully:

- For the first hour, keep the woman at bed rest and check her vital signs (blood pressure, pulse, respiration, and temperature) every 5 to 10 minutes.
- If the woman remains stable after one hour, check for signs of intra- abdominal bleeding, such as low hematocrit or hemoglobin or rebound on abdominal examination, if possible, and her vital signs. Observe for several more hours. If she has no signs or symptoms, she can be sent home, but she should avoid sex for 2 weeks. Help her choose another method.
- If she has a rapid pulse and falling blood pressure, or new pain or increasing pain around the uterus, refer her to a higher level of care.
- If uterine perforation is suspected, based on clinical symptoms, within 6 weeks or more after insertion, refer the client for evaluation to a clinician experienced at removing such IUCDs

IUCD PARTIALLY COMES OUT (PARTIAL EXPULSION)

If the IUCD partially comes out, remove the IUCD. Discuss with the client whether she wants another IUCD or a different method. If she wants another IUCD, she can have one inserted immediately if it is reasonably certain she is not pregnant. If the client does not want to continue using an IUCD, help her choose another method.

IUCD COMPLETELY COMES OUT (COMPLETE EXPULSION)

If the client reports that the IUCD came out, discuss with her whether she wants another IUCD or a different method. If she wants another IUCD, she can have one inserted at any time if it is reasonably certain she is not pregnant.

If complete expulsion is suspected (for example, if strings are not found on pelvic exam) and the client does not know whether the IUCD came out, refer for ultrasound (or x-ray, if pregnancy can be ruled out) to assess whether the IUCD might have moved to the abdominal cavity. Give her a backup method to use in the meantime.

METHOD FAILURE

Method failure is an exceedingly uncommon complication of IUCD use. The Levonorgestrel-releasing intrauterine system has a failure rate of 0.2% in the first year of use. The copper T380A IUCD has a 1-year failure rate of 0.8%.

PREGNANCY WITH IUCD IN SITU

When pregnancy does occur following IUCD placement, the pregnancy is more likely to be ectopic. The World Health Organization recommends IUCD removal if pregnancy occurs. Pregnancies that persist with an IUCD in place are associated with high risk of complications, including spontaneous abortion and septic abortion.

MISSING STRINGS

- 1) Ask the client:
 - Whether and when she saw the IUCD come out.
 - When she had her last monthly bleeding.
 - If she has any symptoms of pregnancy.
 - If she has used a backup method since she noticed that the IUCD came out.
- 2) Always start with minor and safe procedures and be gentle. Check for the strings in the folds of the cervical canal with forceps. About half of missing IUCD strings can be found in the cervical canal.

If strings cannot be located in the cervical canal, either they have gone up into the uterus or the IUCD has been expelled unnoticed. Refer for ultrasound (or x-ray, if pregnancy can be ruled out). Give her a backup method to use in the meantime, in case the IUCD came out.

SESSION 6

TITLE: MYTHS AND MISCONCEPTIONS ABOUT IUCD:

(20 MINUTES)

OUTLINE & OBJECTIVES:

To discuss and clarify the common misperceptions about IUCDs both Cu 380 A and LNG IUS.

METHODOLOGY:

- 1) Divide group in two halves, one group will enlist the myths and the other group will answer them.
- 2) Large group discussion.

Handout: (H14.6), (H14.6a)

Activity: (A14.6), (A14.6a)

Job Aid: (J14.6)

FOLLOW-UP CARE & MANAGEMENT OF POTENTIAL PROBLEMS

MYTHS AND MISCONCEPTIONS ABOUT IUCD

HANDOUT (H-14.6)

GIVE SPECIFIC INSTRUCTIONS:

A woman who chooses an IUCD should know what will happen during the insertion procedure. She also should understand that she can expect:

- 1) Some cramping pain for first day or two after insertion. She can take some NSAIDs for this.
- 2) Some vaginal discharge for a few weeks after insertion, which is normal.
- 3) Heavier menstrual periods. Possible bleeding between menstrual periods, especially during the first few months after IUCD insertion.
- 4) Checking the IUCD: Sometimes IUCDs come out, especially in the first month or so after insertion or during a menstrual period. An IUCD can come out without the woman knowing about it.

A woman should check that her IUCD is in place:

- 1) Once a week during the first month after insertion.

- 2) After noticing any possible symptoms of serious problems.
- 3) After a menstrual period, from time to time. IUCDs are more likely to be dislodged with menstrual blood.

To check her IUCD, a woman should:

- 1) Wash her hands.
- 2) Sit in the squatting position.
- 3) Insert 1 or 2 fingers in her vagina as far as she can until she feels the strings. She should return to the health care provider if she thinks the IUCD might be out of place.
- 4) Wash hands again.
- 5) She should not pull the strings, as the IUCD may be dislodged.

It is important to offer the women, the option of not checking for strings, especially in the context of post-abortion and post-partum IUCD insertions.

EXPLAIN SPECIFIC REASONS TO SEE A HEALTH CARE PROVIDER:

Describe the specific symptoms of serious problems that require medical attention. Serious complications of IUCD are rare. Still a woman should see a doctor or health worker if she has any of these symptoms or more serious problems, which may or may not be caused by the IUCD.

Missed menstrual cycle which could lead to confusion about pregnancy, especially if she also has symptoms of ectopic pregnancy, abnormal vaginal bleeding, abdominal pain or abdominal tenderness and fainting. A woman who develops these symptoms must seek care at once.

If she thinks that she might have been exposed to sexually transmitted infections or has HIV/AIDS.

When checking her IUCD strings, feels that the IUCD might be out of place. For example, she finds:

- 1) Strings missing or strings seen shorter or longer.
- 2) Something harder in her vagina at the cervix. It may be part of the IUCD.
- 3) Increasing or severe pain in the lower abdomen, especially if there is also fever and/or bleeding between menstrual periods (signs and symptoms of PID).

OTHER REASONS TO RETURN TO THE CLINIC:

- 1) Her husband feels the IUCD strings during sex and this bothers him. At the clinic, she can have the strings cut shorter.
- 2) Heavy or prolonged bleeding that bothers the client.
- 3) Copper-bearing or hormonal IUCD has reached the end of its effectiveness, and she needs it removed or replaced.
- 4) She wants the IUCD to be removed for any reason.

- 5) She has questions.
- 6) She wants to opt for another family planning method.

FOLLOW-UP:

Helping clients at the routine return visit (3 to 6 weeks after IUCD insertion)

- 1) Conduct a pelvic examination as appropriate
- 2) Definitely conduct a pelvic examination if you suspect:
 - Pelvic inflammatory disease or sexually transmitted infection
 - The IUCD is out of place

ASK QUESTIONS:

- 1) Ask if the client has any questions or anything to discuss.
- 2) Ask the client about her experience with the IUCD, whether she is satisfied and whether she has any problems. Give her any information or help that she needs and invite her to return again any time she has questions or concerns. If she has problems that cannot be resolved, help her to choose another method.
- 3) Remind her of the reasons for returning.
- 4) Remind her how long her IUCD will keep working and when it should be removed.
- 5) Ask if she has had any health problems since her last visit.
- 6) If she has developed any condition that means she should not use an IUCD, take out the IUCD. Help her choose another method.

SHE MAY BE ABLE TO KEEP USING THE IUCD, HOWEVER IF SHE HAS DEVELOPED:

- 1) Unexplained vaginal bleeding that may suggest pregnancy (possible abortion) or an underlying medical condition or
- 2) Cervical, endometrial, or ovarian cancer.



Activity (A14.6)

The trainer reads out the problems and a small ball is passed among the participants. The participant who drops the ball answers the question or music is played and whoever has the ball when the music stops answers the questions

HOW TO MANAGE ANY PROBLEMS (Job aid J14.6)

COPPER IUCD & LNG IUS

New Problems That May Require Switching Methods

May or may not be due to the method.

<p>Unexplained vaginal bleeding (that suggests a medical condition not related to the method)</p>	<ol style="list-style-type: none"> 1. Refer or evaluate by history or pelvic examination. Diagnose and treat as appropriate. 2. She can continue using the IUCD while her condition is being evaluated. 3. If bleeding is caused by sexually transmitted infection or pelvic inflammatory disease, she can continue using the IUCD during treatment
<p>Heart disease due to blocked or narrowed arteries (ischemic heart disease) ^[11]_{SEP}</p>	<ol style="list-style-type: none"> 1. A woman who has this condition can safely start the LNG-IUCD. If, however, the condition develops while she is using the LNG-IUCD: 2. Remove the IUCD or refer for removal 3. Help her choose a method without hormones 4. Refer for diagnosis and care if not already under care.
<p>Migraine headaches</p>	<ol style="list-style-type: none"> 1. If she has migraine headaches without aura, she can continue to use the LNG-IUCD if she wishes 2. If she develops migraine with aura, remove the LNG-IUCD. Help her choose a method without hormones
<p>Certain serious health conditions (blood clots in deep veins of legs or lungs, breast cancer, gestational trophoblast disease, or pelvic tuberculosis).</p>	<ol style="list-style-type: none"> 1. Remove the IUCD or refer for removal. 2. Give her a backup method to use until the condition is evaluated. 3. Refer for diagnosis and care if not already under care.

SUSPECTED PREGNANCY

- 1) Assess for pregnancy, including ectopic pregnancy.
- 2) Explain that exposure of the foetus to an LNG-IUCD does not increase the risk of birth defects. However, an IUCD in the uterus during pregnancy increases the risk of preterm delivery or miscarriage, including infected (septic) miscarriage during the first or second trimester, which can be life-threatening.
- 3) If the woman does not want to continue the pregnancy, counsel her according to

program guidelines.

- 4) If she continues the pregnancy:
 - a) Advise her that it is best to remove the IUCD
 - b) Explain the risks of pregnancy with an IUCD in place
 - c) Early removal of the IUCD reduces these risks, although the removal procedure itself involves a small risk of miscarriage
- 5) If she agrees to removal
 - a) Gently remove the IUCD or refer for removal
 - b) Explain that she should return at once if she develops any signs of miscarriage or septic miscarriage (vaginal bleeding, cramping, pain, abnormal vaginal discharge, or fever).
 - c) If she chooses to keep the IUCD, a nurse or doctor should follow her pregnancy closely. She should see a nurse or doctor at once if she develops any signs of septic miscarriage.
- 6) If the IUCD strings are not visible and cannot be found in the cervical canal, the IUCD cannot be safely retrieved. Refer for ultrasound, if possible, to determine whether the IUCD is still in the uterus. If it is, or if ultrasound is not available, her pregnancy should be followed closely. She should seek care at once if she develops any signs of septic miscarriage.

QUESTIONS AND ANSWERS ABOUT THE COPPER-BEARING IUCD

HANDOUT (H-14.6 A)



Activity (A14.6a)

Pass the Parcel

The trainer runs a 'pass the parcel' session with a different question on a different coloured piece of paper. The music plays and the participants pass the parcel. Where the music stops, the participant answers the question, if she can't, she can pass it on to her next person. The trainer reinforces the correct answers and clarifies others

1- Does the IUCD cause pelvic inflammatory disease (PID)?

By itself, the IUCD does not cause PID. Gonorrhoea and chlamydia are the primary direct causes of PID. IUCD *insertion* when a woman has gonorrhoea or chlamydia may lead to PID, however. This does not happen often. When it does, it is most likely to occur in the first 20 days after IUCD insertion. It has been estimated that, in a group of clients where STIs are

common and screening questions identify half the STI cases, there might be 1 case of PID in every 666 IUCD insertions (or less than 2 per 1,000).

2- Can young women and older women use IUCDs?

Yes. There is no minimum or maximum age limit. An IUCD should be removed after menopause has occurred within 12 months after her last monthly bleeding

3- If a current IUCD user has a sexually transmitted infection (STI) or has become at very high individual risk of infection with an STI, should her IUCD be removed?

No. If a woman develops a new STI after her IUCD has been inserted, she is not especially at risk of developing PID because of the IUCD. She can continue to use the IUCD while she is being treated for the STI. Removing the IUCD has no benefit and may leave her at risk of unwanted pregnancy. Counsel her on condom use and other strategies to avoid STIs in the future.

4- Does the IUCD make a woman infertile?

No. A woman can become pregnant once the IUCD is removed just as quickly as a woman who has never used an IUCD, although fertility decreases as women get older. Good studies find no increased risk of infertility among women who have used IUCDs, including young women and women with no children. Whether or not a woman has an IUCD, however, if she develops PID and it is not treated, there is some chance that she will become infertile.

5- Can a woman who has never had a baby use an IUCD?

Yes. A woman who has not had children generally can use an IUCD, but she should understand that the IUCD is more likely to come out because her uterus may be smaller than the uterus of a woman who has given birth.

6- Can the IUCD travel from the woman's uterus to other parts of her body, such as her heart or her brain?

The IUCD never travels to the heart, brain, or any other part of the body outside the abdomen. The IUCD normally stays within the uterus like a seed within a shell. Rarely, the IUCD may come through the wall of the uterus into the abdominal cavity. This is most often due to a mistake during insertion. If it is discovered within 6 weeks or so after insertion or if it is causing symptoms at any time, the IUCD will need to be removed by laparoscopic or open surgery. Usually, however, the out-of-place IUCD causes no problems and should be left where it is. The woman will need another contraceptive method.

7- Should a woman have a "rest period" after using her IUCD for several years or after the IUCD reaches its recommended time for removal?

No. This is not necessary, and it could be harmful. Removing the old IUCD and immediately inserting a new IUCD poses less risk of infection than 2 separate procedures. Also, a woman

could become pregnant during a “rest period” before her new IUCD is inserted.

8- Should antibiotics be routinely given before IUCD insertion?

No, usually not. Most recent research done where STIs are not common suggests that PID risk is low with or without antibiotics. When appropriate questions to screen for STI risk are used and IUCD insertion is done with proper infection-prevention procedures (including the no-touch insertion technique), there is little risk of infection. Antibiotics may be considered, however, in areas where STIs are common and STI screening is limited.

9- Must an IUCD be inserted only during a woman’s monthly bleeding?

No. For a woman having menstrual cycles, an IUCD can be inserted at any time during her menstrual cycle if it is reasonably certain that she is not pregnant. Inserting the IUCD during her monthly bleeding may be a good time because she is not likely to be pregnant, and insertion may be easier. It is not as easy to see signs of infection during monthly bleeding, however.

10- Do IUCDs increase the risk of ectopic pregnancy?

No. On the contrary, IUCDs greatly reduce the risk of ectopic pregnancy. Ectopic pregnancies are rare among IUCD users. The rate of ectopic pregnancy among women with IUCDs is **12** per **10,000** women per year. The rate of ectopic pregnancy among women in the United States using no contraceptive method is 65 per 10,000 women per year.

On the rare occasions that the IUCD fails and pregnancy occurs, **6 to 8** of every **100** of these pregnancies are ectopic. Thus, the great majority of pregnancies after IUCD failure are not ectopic. Still, ectopic pregnancy can be life-threatening, and so a provider should be aware that ectopic pregnancy is possible if the IUCD fails.

11- How is the LNG-IUCD different from the copper-bearing IUCD?

The LNG-IUCD and the copper-bearing IUCD are similar, but they have important differences. Both the LNG-IUCD and the copper-bearing IUCD are very effective, but the LNG-IUCD is slightly more effective. The LNG-IUCD has different side effects from those of the copper-bearing IUCD. LNG-IUCD users usually experience lighter bleeding (regular or irregular) or no bleeding at all, while copper-bearing IUCD users usually have regular but sometimes heavier or longer bleeding. In addition, LNG-IUCD users may experience hormonal side effects (for example, headaches), which are not side effects of copper-bearing IUCDs. The duration of use is shorter—3 or 5 years for the LNG-IUCD, depending on brand, versus 12 years for the copper-bearing IUCD. Also, the LNG-IUCD costs more than the copper-bearing IUCD.

12- How is the LNG-IUCD different from other hormonal methods?

The LNG-IUCD continuously releases a small amount of hormone into the uterus. Because the hormone is released directly into the uterus, the amount in the bloodstream is lower than with

other hormonal methods. Thus, women experience fewer side effects. The LNG-IUCD requires no action by the woman once it is inserted, unlike pills that a woman must take every day or injections that a woman must have every one to three months. The LNG-IUCD must be inserted into the uterus, while most other hormonal methods come in the form of pills, injections, or implants under the skin.

13- What are the other benefits of the LNG-IUCD, besides contraception?

The LNG-IUCD is an effective treatment for heavy monthly blood loss. It is the most effective nonsurgical approach for this condition. Also, the LNG-IUCD decreases bleeding for women with fibroids. Reduced blood loss can help women with anaemia as well. Additionally, the LNG-IUCD may help to treat endometriosis, endometrial hyperplasia, endometrial cancer, and peri-menopausal menstrual disturbances.

SESSION 7

TITLE: WRAP UP AND SUMMARIZE

(10 MINUTES)

The trainer will wrap up and summarize the session and ask participants how they might use this information in their work in facilities or in the community.

FURTHER READING

1. Compendium of WHO Recommendations for Postpartum Family Planning
2. Ortiz ME¹, Croxatto HB, Bardin CW. Mechanisms of action of intrauterine devices.
3. *Obstet Gynecol Surv.* 1996 Dec;51(12 Suppl):S42-51.
4. Ortiz ME, Croxatto HB: The mode of action of IUCDs. *Contraception* 36:37-53, 1987.
5. María Elena Ortiz, M.S.Horacio B. Croxatto, M.D.The mode of action of IUCDs July 1987 Volume 36, Issue 1, Pages 37–53
6. Lewis RA, Taylor D, Natavio MF, Melamed A, Felix J, Mishell D Jr. Effects of the levonorgestrel-releasing intrauterine system on cervical mucus quality and sperm penetrability. *Contraception.* 2010;82(6):491–496.
7. http://apps.who.int/iris/bitstream/handle/10665/70511/WHO_RHR_10.21_eng.pdf

CONTRACEPTIVE IMPLANTS



TIME: 5.5 HOURS

Contraceptive implants are an important component of the Long Acting Reversible Contraceptives (LARCs) group. Implants have the potential to significantly reduce the unmet need for contraception. However, the insertion and removal of implants requires specific training skills.



TRAINING OBJECTIVES

- 1) Highlight the importance of LARCs and implants, as an important tool in FP.
- 2) Describe benefits, safety profile, efficacy, and mechanism of action of contraceptive implants.
- 3) Describe medical eligibility criteria for implants.
- 4) Describe the side effects, complications, and warning signs.
- 5) Reinforce insertion and removal techniques for implants.



LEARNING OUTCOMES

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

- 1) Know the mechanism of action of implants and their importance as a LARC.
- 2) Use the WHO Medical Eligibility Criteria confidently in identifying client conditions regarding suitability for implant insertion.
- 3) Discuss the limitations and health risks associated with implants.
- 4) Demonstrate infection prevention measures relevant to the provision of implant services.
- 5) Counsel a client interested in using implants as a contraceptive method.
- 6) Practice insertion and removal of Implants through simulation using the training arm model.
- 7) Provide post-insertion counselling on care and follow-up.



ADVANCE PREPARATIONS

- 1) Instrument trays for implant insertion and removal.
- 2) Implant samples.
- 3) Arm model.
- 4) PowerPoint slides.
- 5) Videos for insertion and removal of implants.



TRAINING/LEARNING METHODS

- 1) Interactive Power Point Presentation
- 2) Group discussion
- 3) Brainstorming Activity
- 4) Role play
- 5)



CONSTITUTION OF THE SESSION

Eleven mini sessions will be held:

1) Introduction to implants, advantages, mechanism of action	Brainstorming/PowerPoint	30 Mins
2) Client assessment using MEC	Lecture/ Demonstration	30 Mins
3) Counselling for implants and post procedure counselling	Role play /small group discussion	40 Mins
4) Myth Busters	Brainstorming	30 Min
5) Insertion of implants	Activity with checklist/Model practice	90 Mins
6) Removal of Implants	Checklist /Videos/ Hands on session with models	30 Mins
7) Infection prevention	Demonstration	20 Mins

8) Common side effects and complications of implants and management of potential problems	Group work presentation Group work / Brain storming & Interactive group work	30 Mins
9) Post procedure care and follow-up	Discussion	20 Mins
10) FAQs	Pass the Parcel game	15 Mins
11) Wrap up		05 Mins



TRAINING MATERIAL

Trainer's Material	Trainee's Material
Hand Outs: H15.1, H15.2, H15.3, H15.4, H15.5, H15.6, H15.7, H15.8. H15.9, H15.10	Hand Outs: H15.1, H15.2, H15.3, H15.4, H15.5, H15.6, H15.7, H15.8. H15.9, H15.10
Activity: A15.1, A15.2a, A15.2b, A15.3, A15.4, A15.8, A5.9a, A15.9b, A15.10	Job aid: J15.2, J15.8
Job aid: J15.2, J15.8	Checklist: C15.5a, C15.5b, C15.6
Checklist: C15.5a, C15.5b, C15.6	
PPT: (15)	

SESSION 1

TITLE: INTRODUCTION TO IMPLANTS

(30 MINUTES)

OUTLINE & OBJECTIVES:

Detailed discussion of the mechanism of action, types, time schedule and effectiveness of the implants.

METHODOLOGY:

- 1) Brainstorming followed by power point presentation
- 2) Share real life stories with participants

Handout: (H15.1)

Activity: (A15.1)

INTRODUCTION TO IMPLANTS, ADVANTAGES, MECHANISM OF ACTION

HANDOUT (H-15.1)



Activity (A15.1)

Interactive Discussion: Ask learners about LARCs and then shift emphasis to implants.

(Prepare in advance) Write the following three questions at least four times, each on a different piece of paper. Prepare at least 15 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. Write each of these three questions on a different flipchart page, and tape up each page for all to see.

- 1) Name one practice that you follow to determine if a woman can safely receive implants.
- 2) Name one approach to ruling out pregnancy prior to inserting implants.
- 3) Name one health condition that prevents women from having implants inserted.

- 4) Invite the participants to discuss their current practices for screening women who wish to start using implants.

Toss “the cabbage” to one of the participants. The person who catches the cabbage should peel off the top “layer,” read the question aloud, and answer it. After answering the question, the participant “tosses the cabbage” to another participant, who answers the next question. If a question is repeated, participants must come up with a different response. Continue tossing the cabbage until all the questions are answered.

Possible answers are given below.

- 1) Name one practice that you follow to determine if a woman can safely receive implants.**

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

- 2) Name one approach to ruling out pregnancy prior to inserting implants.**

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

- 3) Name one health condition that prevents women from having implants inserted.**

Breast cancer, serious liver disease, etc.

The trainer then moderates a brainstorming session to summarize and add any missing points.

INTRODUCTION:

Contraceptive implants are small, matchstick sized flexible rods which are inserted under the skin of a woman’s upper arm to release the hormone progestin slowly, at a controlled rate and prevent pregnancy. Contraceptive implants, which are also called sub-dermal implants, do not contain oestrogen; therefore, they are free from the side effects associated with that hormone.) These implants release progestin at a controlled rate and thus provide very small doses to achieve the desired contraceptive effect.

Three preparations of subdermal implants are available:

- 1) The single-rod system (Implanon) releases etonogestrel and has a life span of three years. This implant is 40 mm long with a 2-mm diameter and contains 68 mg of etonogestrel and provides contraception for 3 years.

- 2) The Nexplanon implant is 40 mm X 2.0 mm and consists of one non-biodegradable rod of 40% ethylene vinyl acetate and 60% etonogestrel covered with a rate-controlling ethylene vinyl acetate membrane 0.06 mm thick.

The rod contains 68 mg etonogestrel that is slowly released: initially at 60–70 µg/day, decreasing to 35–45 µg/day at the end of the first year, to 30–40 µg/day at the end of the second year, and then to 25 to 30 µg/day at the end of the third year. The high initial rate of absorption is probably due to a significant amount of etonogestrel released from the uncovered ends of the implant. Peak serum concentrations (266 pg/mL) of etonogestrel are achieved within 1 day after insertion, suppressing ovulation, which requires only 90 or more pg/mL. Implanon NXT or Nexplanon also contains 15 mg barium sulphate; this radiopaque ENG implant is bioequivalent to the nonradiopaque Implanon. Nexplanon is radio opaque, which means it can be seen on X-ray, which is useful for checking the location of the implant.

The two-rod system containing 75 mg of Levonorgestrel is effective for up to five years. This implant is 43 mm long, with each rod consisting of a drug-releasing core. For the first 6-15 months of use Jadelle release a total of about 80 mg of Levonorgestrel every 24 hours, giving a plasma concentration of 0.35 ng/mL. After the first year, the release rate gradually declines to a relatively constant rate of 30–35 mg/day. At 5 years, the overall release rate is 25 mg/day, with corresponding Levonorgestrel levels of 0.25–0.35 ng/mL.

Norplant, a six-capsule implantable system containing 216 mg of Levonorgestrel, was used in the past but the distributor withdrew it from the market in 2002.

After contraceptive implants are removed, the hormone levels drop quickly, and normal fertility returns promptly.

ADVANTAGES OF IMPLANTS

1) Highly effective (less than 1 pregnancy per 100 women in the first year of use).
2) Long-term method.
3) Does not require daily intake.
4) Does not interfere with intercourse.
5) Effective within 24 hours after insertion.
6) Easy to use and require no further action other than follow-up visits and return for removal; do not interfere with normal daily activities.
7) Comfortable—once the insertion site has fully healed (about 1 week), the rods should not cause any pain and are not noticeable in most women.
8) One of the lowest doses of any hormonal contraceptive and contains no estrogen.
9) Long-term pregnancy protection, but reversible. A single decision can lead to very effective contraception for up to 3-5 years.
10) Increased sexual enjoyment because no need to worry about pregnancy.
11) Fertility returns almost immediately after implants are removed.
12) They offer continuous, long-term protection.
13) Implants do not affect breastfeeding.
14) They reduce menstrual flow.
15) They help prevent ectopic pregnancy (but do not eliminate the risk altogether).
16) They protect against iron-deficiency anaemia.
17) They help protect from symptomatic PID.
18) They do not affect the quantity and quality of breast milk.
19) No oestrogenic side effects.
20) May help prevent endometrial cancer.
21) May make sickle cell crises less frequent and less painful.
22) One-time insertion.

SESSION 2

TITLE: CLIENT ASSESSMENT USING MEC WHEEL

(30 MINUTES)

OUTLINE & OBJECTIVES:

Screen clients requesting implants and determine whether further medical evaluation is needed.

METHODOLOGY:

- 1) Small group work using the MEC wheel to identify any contra indications for the use of the implants.
- 2) Group work to identify and discuss the specific needs of various groups such as adolescents, post-partum women.
- 3) Large group discussion and review of the MEC.

Handout: (H15.2)

Activity: (A15.2a, A15.2b)

Job Aid: (J15.2)

CLIENT ASSESSMENT USING MEC WHEEL AND MEC CHARTS

HANDOUT (H-15.2)

WHO CAN AND CANNOT USE IMPLANTS

Safe and Suitable for Nearly All Women

Nearly all women can use implants safely and effectively, including women who:

- 1) Have or have not had children.
- 2) Are of any age, including adolescents and women over 40 years old.
- 3) Have just had an abortion, miscarriage, or ectopic pregnancy.
- 4) Smoke cigarettes, regardless of woman's age or number of cigarettes smoked.
- 5) Are breastfeeding.
- 6) Have anemia now or in the past.
- 7) Have varicose veins.
- 8) Are living with HIV, whether or not on antiretroviral therapy.

CONTRA-INDICATIONS FOR IMPLANT INSERTION

The contraceptive implant should not be used in the following situations:

- Pregnancy
- Liver disease, including severe cirrhosis or liver tumours
- Personal history of breast cancer
- Undiagnosed abnormal vaginal bleeding
- Allergy or hypersensitivity to any of the implant materials



Activity (A15.2a)

Questions in a bucket:

Write question on strips of coloured paper and circulate the basket to every participant to take one and answer it. The trainer reinforces the correct answer and adds on as needed.

1. Do you have severe cirrhosis of the liver or a severe liver tumour?

NO YES

If she reports severe cirrhosis or severe liver tumour, such as liver cancer, do not provide implants. Help her choose a method without hormones

2. Do you have a serious problem now with a blood clot in your leg or lungs?

NO YES

If she reports a current blood clot in legs (affecting deep veins, not superficial veins) or in a lung and she is not on anticoagulant therapy, do not provide implants. Help her choose a method without hormones

3. Are you having vaginal bleeding that is unusual for you?

NO YES

If she has unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition, implants could make diagnosis and monitoring of any treatment more difficult. Help her choose a method to use until the condition is evaluated (not progestin-only injectable or a copper-bearing or LNG-IUS). After evaluation, reconsider the use of implants.

4. Do you have or have you ever had breast cancer?

NO YES

Do not provide implants. Help her choose a method without hormones.

Also, women should not use implants if they report having lupus with positive (or unknown) antiphospholipid antibodies and are not on immunosuppressive therapy.



Activity (A15.2b)

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 implant 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.**

Ask participants to use the green and red pencils or markers to colour in the rectangles to the right of the conditions listed on the chart. Choose a maximum of four conditions, such as diabetes, high blood pressure, HIV/AIDS, and endometrial cancer.

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 colour 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 coloured pencils or markers are available, have participants write a “G” for green or an “R” for red in the rectangles.)

Now, distribute copies of the colour 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 colour version has four colours, one for each category. To make this activity simpler, only two colours are being used instead of four. Explain to participants that light red/pink is RED and light green is GREEN.

Ask volunteers to share which colour or category they assigned to each condition. Correct any misinformation as you go along.

USING CLINICAL JUDGMENT IN SPECIAL CASES:

Usually, a woman with any of the conditions listed below should not use implants. In special circumstances, however, when other, more appropriate methods are not available or acceptable to her, a qualified provider who can carefully assess a specific woman's condition and situation may decide that she can use implants. The provider needs to consider the severity of her condition and, for most conditions, whether she will have access to follow-up.

- Acute blood clot in deep veins of legs or lungs.
- Unexplained vaginal bleeding before evaluation for possible serious underlying condition.
- Had breast cancer more than 5 years ago, and it has not returned.
- Severe cirrhosis of the liver or liver tumour.
Systemic lupus erythematosus with positive (or unknown) antiphospholipid antibodies, and not on immunosuppressive therapy.

PROVIDING IMPLANTS

A woman can start using implants any time she wants if it is reasonably certain she is not pregnant. To be reasonably certain she is not pregnant, use the Pregnancy Checklist.

No tests or examinations are necessary before starting implants, although blood pressure measurement is desirable.

When to Start

Job Aid (J15.2)

Woman's situation	When to start
<p>Having menstrual cycles or switching from a nonhormonal method</p>	<p>Any time of the month</p> <ul style="list-style-type: none"> • If she is starting within 7 days after the start of her monthly bleeding, no need for a backup method. • If it is more than 7 days after the start of her monthly bleeding, she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method* for the first 7 days after insertion.
<p>Switching from another hormonal method</p>	<ul style="list-style-type: none"> • Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. • If she is switching from a progestin-only or monthly injectable, she can have implants inserted when the repeat injection would have been given. No need for a backup method.
<p>Fully or nearly fully breastfeeding</p> <p>Less than 6 months after giving birth</p>	<ul style="list-style-type: none"> • If her monthly bleeding has not returned, she can have implants inserted any time between giving birth and 6 months. No need for a backup method. • If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles.
<p>More than 6 months after giving birth</p>	<ul style="list-style-type: none"> • If her monthly bleeding has not returned, she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion. • If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles.
<p>Partially breastfeeding</p> <p>If her monthly bleeding has not returned</p>	<ul style="list-style-type: none"> • She can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion
<p>If her monthly bleeding has returned</p>	<ul style="list-style-type: none"> • If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles
<p>Not breastfeeding</p> <p>Less than 4 weeks after giving birth</p>	<ul style="list-style-type: none"> • She can have implants inserted at any time. • No need for a backup method

<p>More than 4 weeks after giving birth</p>	<ul style="list-style-type: none"> • If her monthly bleeding has not returned, she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion. • If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles
<p>No monthly bleeding (not related to childbirth or breastfeeding)</p>	<ul style="list-style-type: none"> • She can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion.
<p>After miscarriage or abortion</p>	<ul style="list-style-type: none"> • Immediately. If implants are inserted within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method. • If it is more than 7 days after first- or second trimester miscarriage or abortion, she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion
<p>After taking emergency Contraceptive pills (ECPs)</p>	<ul style="list-style-type: none"> • After taking progestin-only or combined • ECPs: • Implants can be inserted on the same day as she takes the ECPs. • She will need to use a backup method for the first 7 days. • If she does not start immediately, but returns for an implant, she can start at any time if it is reasonably certain she is not pregnant. • After taking ulipristal acetate ECPs: • Implants can be inserted on the 6th day after taking UPA-ECPs. No need to wait for her next monthly bleeding. Implants and UPA interact. • If an implant is inserted sooner, and thus both are present in the body, one or both may be less effective.
	<ul style="list-style-type: none"> • Make an appointment for her to return on the 6th day to have the implant inserted, or as soon as possible after that • She will need to use a backup method from the time she takes UPA-ECPs until 7 days after the implant is inserted • If she does not start on the 6th day but returns later for implants, she can start at any time if it is reasonably certain she is not pregnant

SESSION 3

TITLE: COUNSELLING FOR IMPLANTS AND POST PROCEDURE COUNSELLING

(40 MINUTES)

OUTLINE & OBJECTIVES:

To highlight and reinforce proper follow up care and advice and to ensure informed consent

METHODOLOGY:

- 1) Brainstorming in two groups, large group discussion, and power point presentation.
- 2) Divide into two groups, one group to discuss pre-procedure counselling, and second group to do post procedure counselling. Follow on with role play.
- 3) Large group discussion.
- 4) Power point presentation to highlight specific counselling for implants.

Handout: (H15.3)

Activity: (A15.3)

COUNSELLING FOR IMPLANTS

HANDOUT (H-15.3)

Effective counselling improves user satisfaction and increases the successful use of any contraceptive method. This is particularly important in the case of contraceptive implants because the woman depends entirely on the service provider for both insertion and removal. Effective counselling also allows the woman (or couple) to arrive at an informed choice after having carefully considered the benefits and limitations of available methods.

Thorough counselling also helps to prevent clients from removing the implant due to misunderstandings surrounding side effects. For adolescents, targeted counselling, structured to focus on the most effective methods, then on to less effective methods, has been proven to improve the likelihood that they will choose and continue use of long-acting, reversible contraceptives (LARCs).

COUNSELLING ABOUT CONTRACEPTIVE IMPLANTS SHOULD COVER THE FOLLOWING POINTS.

- 1) A reasonable certainty that the client is not pregnant.
- 2) A quick overview on how contraceptive implants prevent pregnancy and efficacy.

METHOD BENEFITS INCLUDE:

- 1) It has a long effective life (whether 5 years for two rod implants and 3 years for one-rod implants).
- 2) It is very effective. Less than one woman in 100 will become pregnant while using contraceptive implants.
- 3) It is suitable for nearly all women.
- 4) It is easy to use.
- 5) It is convenient, comfortable, and reversible.
- 6) It is easy to insert and remove.
- 7) It allows immediate return to fertility after removal.
- 8) Side effects resolve immediately after removal.
- 9) Complications are few.
- 10) Continuation rates are high.

COMMON SIDE EFFECTS (PARTICULARLY THOSE RELATED TO CHANGES IN THE MENSTRUAL BLEEDING PATTERN) INCLUDE:

- 1) Changes in menstrual bleeding patterns.
- 2) In the first several months.
- 3) Lighter bleeding and fewer days of bleeding.
- 4) Irregular bleeding.
- 5) Infrequent bleeding.
- 6) No monthly bleeding.

AFTER ABOUT 1 YEAR:

- 1) Lighter bleeding and fewer days of bleeding.
- 2) Irregular bleeding.
- 3) Infrequent bleeding.

STEPS IN COUNSELLING FOR IMPLANTS

COUNSELLING AT THE TIME OF SERVICE PROVISION:

Counselling is not complete once the method is chosen. Throughout the process of providing contraceptive implants, there are a number of times when counselling is used to ensure provision of high-quality of care and reinforce important messages.

PRE-INSERTION:

- 1) Describe the insertion and removal procedures and what the woman should expect during and afterwards.

- 2) Review client assessment data to determine if the client is an appropriate candidate for implants and/or if she has any problems that should be monitored more frequently while they are in place.

POST-INSERTION:

- 1) Give post-insertion counselling, including how she should care for the insertion site and what to do if she experiences any problems or side effects. Special emphasis should be given to menstrual bleeding changes.
- 2) Provide information on warning signs for medical problems and the need to return to the clinic immediately should any occur.
- 3) Assure the client that she can return to the same clinic at any time, (during working hours) to receive advice and medical attention and, if desired, to have the rod(s) removed. Tell the client to return for a follow-up visit per national guidelines for an incision check and the location(s) of where she should go to have the rod(s) removed.
- 4) Have the client repeat all instructions back to you.
- 5) Answer any remaining client questions and check whether the client is satisfied.
- 6) Inquire about problems and respond to concerns about side effects or any problems.
- 7) Reassure the client that the rod(s) can be removed at any time if desired.
- 8) Review the warning signs that indicate the need to return to the clinic.
Repeat instructions regarding the need for removal and replacement (if desired) with a new set after 5 years for two rod implants and 3 years for one-rod implants.

Keep arm dry	<ul style="list-style-type: none"> • The user should keep the insertion area dry for 4 days. She can take off the gauze after 2 days and the adhesive bandage and surgical tape when the incision heals, usually after 3 to 5 days
Expect soreness, bruising	<ul style="list-style-type: none"> • After the aesthetic wears off, her arm may be sore for a few days. She also may have swelling and bruising at the insertion site. This is common and will go away without treatment
Length of pregnancy protection	<ul style="list-style-type: none"> • Explain that it is important to have implants removed before they start to lose effectiveness. • She can have a new set of implants inserted if she wants. • Discuss how to remember the date to return for implant removal and possible replacement. • Give each woman the following information in writing on a reminder card, like the one shown below, if possible, and explain: <ul style="list-style-type: none"> – The type of implant she has and in which arm – Date of insertion – Month and year when implants will need to be removed or replaced – Where to go if she has problems or questions about her implants

FIRST FOLLOW UP VISIT:

- 1) Repeat the information about implants.
- 2) Consider seriously any complaint or problems faced by the user and make every attempt to take care of them.
- 3) Treat minor complaints and refer her to the physician for any major ones.
- 4) Reassure her that removal is available whenever she wants it.
- 5) Ensure that she understands that the implants must be removed after the effective period is over.
- 6) Advise her to return to the same centre for removal after this period, if possible. Otherwise, give her the name and address of other implants centre.
- 7) Check the insertion site to see whether it has healed.
- 8) Check that the implants are in place.

IMPLANT REMOVAL:

Following the above

**Activity (A15.3)**

Divide into two groups, one group to practice pre-procedure counselling, and second group to practice post procedure counselling. Each group will have 10 minutes to prepare and then 5 minutes each to present. In the next 20 minutes get the people to reverse their groups i.e. pre-procedure counselling will do a role play on post procedure counselling and vice versa

Let the groups give feedback to each other followed by the trainer moderating the session.

- 1) Remove the implant
- 2) Insert a new set of implants if the client desires.
- 3) Maintain the following minimum record for use in the clinic and for follow-up of the client.
- 4) Give her the card with details as below

CLIENT RECORD CARD:

Give the card to the client after entering the following information.

- 1) Name and location of clinic.
- 2) Name of client and full address.
- 3) Client registration number.
- 4) Date of implant insertion.
- 5) Date of expiry/removal due.
- 6) Name of inserting physician.
- 7) Address of the place where implant will be removed.

SESSION 4

TITLE: MYTH BUSTERS

(30 MINUTES)

OUTLINE & OBJECTIVES:

To clarify the common myths and misconceptions around implants.

METHODOLOGY:

Brainstorming

Handout: (H15.4)

Activity: (A15.4)

MYTHS BUSTERS

HANDOUT (H-15.4)



Activity (A15.4)

Brain storming session, trainer will narrate rumours and ask participants to give response on it.

ADDRESSING RUMORS AND MISCONCEPTIONS:

Correcting false rumours and misinformation is an important job of health care providers. When talking to the client about rumours and misinformation, do not just say that what she has heard is not true. Always politely explain or show her why it is not true and **explain what is true**. Be careful not to embarrass the client because she has a mistaken idea or belief. The following are some of the more common mistaken ideas:

1- Rumour: Contraceptive implants weaken the woman because they increase menstrual bleeding.

Response: Although bleeding may occur more frequently, the amount of blood loss is less because frequently the woman experiences spotting and not actual menstruation. In several studies, Haemoglobin levels (a blood test measuring iron, a necessary element in blood) have

increased with continued use.

2- Rumour: Implants are not appropriate for adolescents.

Response: Adolescents can safely use implants without effect on future fertility. For adolescents who request implants and accept probable menstrual bleeding changes, implants may be a method of choice since there is no need to take pills daily or return for injections. Dual protection is advised to prevent STIs and HIV.

3- Rumour: The rods can move around within her body.

Response: No, they remain under the skin in her arm, where they were placed, until they are removed. Each rod is surrounded by a small sheath of fibrous tissue that prevents it from moving.

4- Rumour: Women living with HIV/AIDS cannot safely use implants because ART interferes with their efficacy.

Response: Women living with HIV/AIDS can safely use implants while on ART, though some medications used for HIV/AIDS, most likely protease inhibitors, the non-nucleoside reverse transcriptase inhibitors efavirenz and nevirapine, and cobicistat-boosted elvitegravir, may potentially reduce the effectiveness of combined oral contraceptives and possibly also of contraceptive implants. Women on ART should receive counselling on the potential reduced effectiveness of implants when used simultaneously with certain ART regimens. During counselling, the woman should be offered alternative methods for consideration. However, when the woman decides to initiate or continue with implants, it is recommended that she be counselled on the consistent use of condoms to compensate for any possible reduction in the effectiveness of the implants.

5- Rumour: The procedure for inserting the rods is painful.

Response: No, because a local anaesthetic is used, there will be little or no pain. There may be a slight stinging sensation when the local anaesthetic is first injected. While there may be some pain after the anaesthetic wears off, this is usually easily managed with aspirin or other analgesics.

6- Rumour: The rods are implanted permanently

Response: No, they can be removed at any time the client wishes and should be removed no later than 5 years for Jadelle, 4 years for Sino-implant (II), and 3 years for one-rod implants.

7- Rumour: The rods never need to be replaced.

Response: No, they should be replaced at the end of their effective life if the client wishes to continue using contraceptive implants. Service providers must put the best interest of the client before any other concerns. It is both ethically and programmatically important that providers pay close attention to the needs of clients. Over the long term, programs are more likely to attract and keep clients when they offer services that meet clients' needs.

SESSION 5

TITLE: INSERTION OF IMPLANTS

(90 MINUTES)

OUTLINE & OBJECTIVES:

Insert two-rod and one-rod implants through simulation using the training arm model before moving to clinical practice with clients.

METHODOLOGY:

Hands on using the arm model (60 minutes)

Skills Checklist Insertion (20 minutes)

Video to demonstrate the correct technique for insertion (10 minutes)

Handout: (H15.5)

Checklist: (C15.5a, C15.5b)

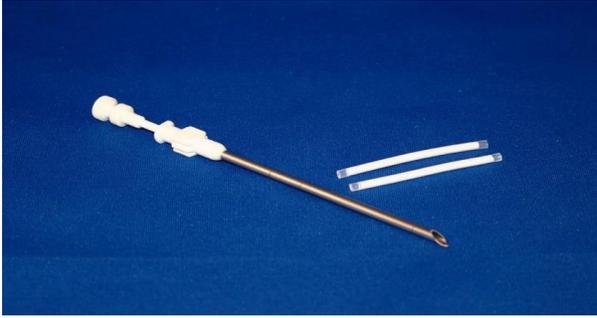
INSERTION OF THE IMPLANTS

HANDOUT (H-15.5)

Ensure a prepared clean instrument tray is Available:

All the necessary equipment should be laid out on a clean tray aseptically.

Open the sterile instrument pack.



SET UP REQUIRED FOR IMPLANT:

- | |
|---|
| 1. Examination table, arm rest, small pillow, clean sheet for table, |
| 2. Sterile surgical drapes (optional) and gloves |
| 3. Antiseptic solution (e.g. povidone iodine, chlorhexidine gluconate, isopropyl alcohol) |
| 4. Local anaesthetic, lignocaine 1or 2% and syringe 3CC |
| 5. Implanon applicator or introducer for Jadelle |
| 6. Skin closure, [Saniplast] |
| 7. Sterile gauze pack, and Nichiban tape |

For Jadelle and Sino-Implant (II), carefully open the sterile pouch containing the implants by pulling apart the sheets of the pouch and without touching the rods, allowing them to fall into a sterile cup or bowl. Once the provider is well trained, it is preferable to take the rod directly from the package an, which the assistant opens partially

For Implanon, remove the sterile applicator with the preloaded implant from the package by allowing it to fall on the sterile tray without touching it.

INSERTING IMPLANTS:

The entire procedure should be explained to the woman after ensuring she that she wishes to have the implant as her method of choice and that it is the best option for her medically.

Informed consent must be taken. Strict adherence to infection prevention is essential for a trouble-free insertion and post insertion period.

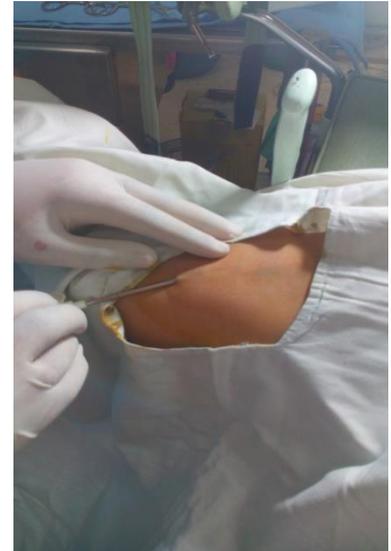
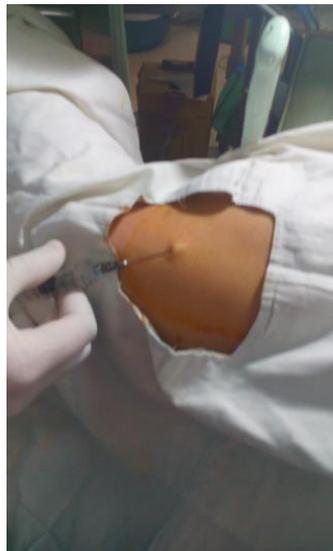
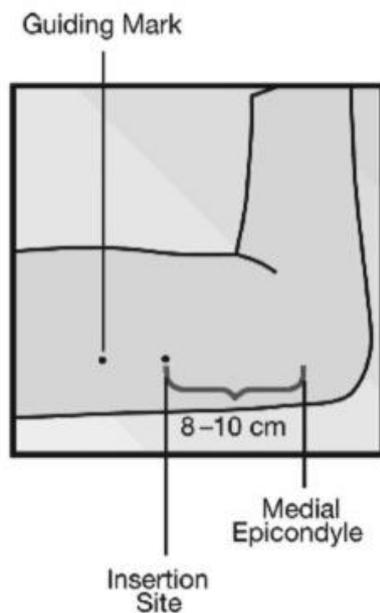
- 1) Greet the woman.
- 2) Have her wash her entire non-dominant arm and hand (with soap and water, and dry

with clean towel or air-dry).

- 3) Cover the procedure table and arm support with a clean cloth.
- 4) Get the woman to lie comfortably on the couch so that the arm in which the implants will be placed is turned outwards and bent at the elbow and is well supported.

The patient is placed in a supine position with the full length of her arm exposed. The manufacturer suggests positioning the upper inner arm by bending the elbow to 90 degrees and rotating the arm out. Some providers find the procedure is easier when the arm is extended, allowing full exposure of the insertion site at the crease between the biceps and triceps muscles. Adequate support under the arm should be provided to ensure comfort with, e.g., a thick book.

An insertion site approximately four fingerbreadths superior and lateral to the medial epicondyle of the humerus is identified. The site should be at least 6 cm and no more than 10 cm from the medial epicondyle (Figure 2). The optimum site depends upon an individual woman's anatomy, such as the length of the upper arm (avoid placing the end of the implant too near the axilla) and the area where the crease between the biceps and triceps muscles is clearest.



CHECKLIST FOR TWO-ROD IMPLANTS [JADELLE AND SINO-IMPLANT (II)]:

INSERTION

Checklist (C15.5a)

All participants must observe 3 cases, do 5 under supervision and then 5 independently

CHECKLIST FOR TWO-ROD IMPLANTS [JADELLE AND SINO-IMPLANT (II)]: <i>PRE-INSERTION</i>					
STEP/TASK	CASES				
PRE-INSERTION COUNSELING					
1- Greet the client respectfully and with kindness.					
2- Rule out pregnancy by asking the six questions to be reasonably sure that the woman is not pregnant.					
3- Discuss if the woman has already identified a method, provide focused counseling on that method. Otherwise, ask the following four questions and eliminate cards according to her response: Does she want more children in the future? a. Is she breastfeeding an infant < 6 month? b. Will her partner use condoms? c. Has she not tolerated an FP method in the past?					
4- Continue with counselling: Give information about the methods on the cards that are left. a. Discuss side effects and efficacy. b. Help the client to choose a method. c. Confirm method choice.					
5- Review medical eligibility: Read from the client brochure in language the client understands (e.g., “Method not advised if you)					
6- Review Client Screening Checklist to determine if two-rod implants are an appropriate choice for the client.					
7- Perform (or refer for) further evaluation, if indicated.					
8- Assess the woman’s knowledge about implants’ major side effects: Confirm that the client accepts possible menstrual changes with implants.					
9- Describe insertion procedure and what to expect.					
Getting Ready					
1- Determine that required sterile or high-level disinfected instruments and two implant rods are present.					
2- Wash hands thoroughly and dry them.					
3- Check to be sure that the client has thoroughly washed and rinsed her entire arm.					
4- Tell the client what is going to be done and encourage her to ask questions.					

**CHECKLIST FOR TWO-ROD IMPLANTS [JADELLE AND SINO-IMPLANT (II):
INSERTION
(Checklist C15.5b)]**

CHECKLIST FOR TWO-ROD IMPLANTS [JADELLE AND SINO-IMPLANT (II): INSERTION]				
STEP/TASK	CASES			
1- Position the woman's arm and place a clean, dry cloth under her arm.				
2- Mark position on arm for insertion of rods 6 cm to 8 cm above the elbow folder (this should form a "V" pattern).				
3- Put on sterile pair of hand gloves.				
Pre-Insertion Tasks				
1- Set up sterile field and place implant rods and trocar on it.				
2- Prep insertion site with antiseptic solution.				
3- Place sterile or high-level disinfected drape over arm (optional).				
4- Inject 2 ml of 1% lidocaine applied just under the skin, raising a wheal at the insertion point and advancing up to 5 cm along the insertion track. Gently massage the area of infiltration.				
5- Advance needle about 4–5 cm and inject 1 ml of local anaesthetic in each of two subdermal tracks.				
6- Check for anaesthetic effect before making skin incision.				
Insertion				
1- Insert trocar directly sub dermally superficially.				
2- While tenting the skin, advance trocar and plunger to mark (1) nearest hub of trocar.				
3- Remove plunger and load first rod into trocar with gloved hand or forceps.				
4- Reinsert plunger and advance it until resistance is felt.				
5- Hold plunger firmly in place with one hand and slide trocar out of incision until it reaches plunger handle.				
6- Withdraw trocar and plunger together until mark (2) nearest trocar tip, just clear of incision (do not remove trocar from skin).				
7- Move tip of trocar away from end of rod and hold rod out of the path of the trocar.				
8- Redirect trocar about 15° and advance trocar and plunger to mark (1).				
9- Insert the second rod using the same technique.				
10- Palpate rods to check that two rods have been inserted in a V-distribution.				
11- Palpate incision to check that both rods are 5 mm clear of incision.				
12- Remove trocar only after insertion of second rod.				
13- Optionally ask the client to palpate the two rods prior to dressing.				

CHECKLIST FOR ONE ROD IMPLANTS INSERTION

(Checklist C15.5c)

All participants must observe 3 cases; do 5 under supervision and then 5 independently

CHECKLIST FOR ONE-ROD IMPLANTS INSERTION				
ACTIVITY / STEPS	CASES			
Pre-Insertion Tasks				
1- Prep insertion site with antiseptic solution.				
2- Inject 1 ml of 1% lidocaine applied just under the skin, raising a wheal at the insertion point and advancing up to 5 cm along the insertion track. Gently massage the area of infiltration.				
3- Check for anaesthetic effect before applying the sharp needle.				
Insertion				
1- Using no-touch technique, remove the sterile disposable one-rod implant applicator from its blister pack and remove the needle shield. (Make sure not to touch the part of the needle to be introduced into the body.)				
2- Visually verify the presence of the implant inside the metal part of the needle.				
3- Stretch the skin around the insertion site with thumb and index finger or alternatively , stretch the insertion site skin by slightly pulling with thumb.				
4- Using the needle, puncture the skin at a 20° angle and insert only up to the bevel of the needle.				
5- Release the skin. Lower the applicator to a horizontal position.				
6- Gently advance, while lifting the skin, forming a tent, until inserting the full length of the needle without using force. Keep the applicator parallel to the surface of the skin.				
7- Break the seal of applicator. Turn the obturator 90 degrees.				
8- Fix the obturator with one hand against the arm and with the other hand slowly pull the needle out of the arm; never push against the obturator.				
9- Remove the needle, and apply pressure to the opening site.				
10- Palpate to check that the rod is in place. Optionally ask the client to palpate the implant prior to dressing.				
Post-Insertion Tasks				
1- Wipe the client's skin with alcohol.				
2- Bring edges of incision together and close it using surgical tape, then cover it with a Band-Aid or tape on a sterile gauze (2x2).				
3- Apply pressure dressing snugly.				

4- Before removing gloves, dispose materials by: Placing used needle (without capping) and trocar in sharps container, and Placing waste materials in leak-proof container or plastic bag.				
5- Remove gloves by turning inside out and place in leak-proof container or plastic bag.				
6- Wash hands thoroughly and dry them.				
7- Complete client record, including drawing position of rod.				
POST-INSERTION COUNSELING				
1- Instruct the client regarding wound care and make return visit appointment, if necessary.				
2- Discuss what to do if the client experiences any problems following insertion or side effects.				
3- Assure the client that she can have implant removed at any time if she desires.				
4- Ask the client to repeat instructions and answer client's questions.				
5- Complete client card indicating which implant she received and by when she needs to return for removal.				
6- Observe the client for at least 15–20 minutes before sending her home.				

Implant Reminder Card	
Client's name:	_____
Type of implant:	_____
Date inserted:	_____
Remove or replace by:	Month: <input type="text"/> Year: <input type="text"/>
If you have any problems or questions, go to:	
<small>(name and location of facility)</small>	

SESSION 6

TITLE: REMOVAL OF IMPLANT

(30 MINUTES)

OUTLINE & OBJECTIVES:

Remove two-rod and one-rod implants through simulation using the training arm model before moving to clinical practice with clients.

METHODOLOGY:

- 1) Hands on using the arm model (10 minutes).
- 2) Skills Checklist on Removal (10 minutes).
- 3) Video to demonstrate the correct technique for removal (10 minutes).

Handout: (H15.6)

Checklist: (C15.6)

REMOVAL OF THE IMPLANTS

HANDOUT (H-15.6)

REMOVING IMPLANTS:

Have a detailed conversation with the client.

It is not necessary that every woman who comes with a request for implant removal has side effects. Some may come for removal because she just wishes to have it removed. We as care providers can only guide them but cannot impose our opinions on her.

CHECKLIST FOR IMPLANT: *REMOVAL*

Checklist (C15.6)

All participants must observe 3 cases, do 5 under supervision and then 5 independently

CHECKLIST FOR IMPLANT: <i>REMOVAL</i>					
STEP/TASK	CASES				
PRE-REMOVAL COUNSELING					
1- Greet the client respectfully and with kindness.					

2- Listen carefully to the client's response for reason for removal to determine if she wants another method, is hoping to get pregnant, or wants to replace her implant.					
3- Confirm with the client what her intentions are. Provide FP counselling if appropriate.					
4- Describe the removal procedure and what to expect. If she intends to have another implant, discuss with her where it will be inserted.					
5- Ensure that the client is not allergic to the topical antiseptic or the local anaesthetic that is available.					
REMOVAL OF IMPLANT ROD(S)					
Getting Ready					
1- Determine that sterile instruments and other required materials for removal are available. Make sure a new implant is available if reinserting a new implant.					
2- Check that the client has thoroughly washed and rinsed her arm.					
3- Tell the client what is going to be done and encourage her to ask questions.					
4- Position the woman's arm and place a clean, dry cloth under her arm.					
5- Palpate the rod(s) to determine point for removal.					
6- With a waterproof marker, mark the client's arm where the tip of the rod(s) is palpated.					
Pre-Removal Tasks					
1- Wash hands thoroughly and dry them.					
2- Put sterile gloves on both hands.					
3- Arrange instruments and supplies.					
4- Prep removal site with antiseptic solution twice.					
5- Inject small amount of local aesthetic (1% without epinephrine) at the incision site and under the end of the rod(s).					
6- Check for aesthetic effect before making skin incision.					
Removal					
1- Push down the proximal end of the implant to stabilize it; a bulge may appear indicating the distal end of the implant.					
2- Make a small (2 mm) incision below ends of rod(s).					
3- Push end of rod toward the incision to remove it.					
4- Grasp end of rod with curved (mosquito) forceps.					
5- Clean off fibrous tissue sheath that covers tip of rod with sterile gauze (or scalpel— dull side)					

6- Grasp exposed end of rod with second forceps, gently remove and inspect to ensure that the rod is intact before placing rod in bowl containing 0.5% chlorine solution for decontamination					
7- Ensure that the complete rod has been removed; show to the client.					
8- If this is a two-rod system, repeat steps 1–7.					
Re-Inserting Implant (one or two rods)					
9- The new implant rod(s) can be re-inserted along the same track as the recently removed implant (if the woman chose to have a new implant inserted)					
10- Provide additional local anaesthesia by infiltrating 1% lignocaine along the track (so of the previously removed implant(s).					
11- Wait for 1-2 minutes for the aesthetic to take effect					
12- Insert the one- or two-rod implant as per insertion steps (including post-insertion steps and post-insertion counselling).					
Post-Removal Tasks					
1- Wipe the client’s skin with alcohol.					
2-Bring edges of incision together and close it is using surgical tape, then cover it with a Band-Aid or tape on a sterile gauze (2x2).					
1- Apply pressure dressing snugly.					
2- Before removing gloves, dispose materials by: a. Placing used needle (without capping) and trocar in sharps container, and b. Placing waste materials in leak-proof container or plastic bag.					
3- Remove gloves by turning inside out and place in leak-proof container or plastic bag.					
4- Wash hands thoroughly and dry them.					
5- Complete client record					
POST-REMOVAL COUSELING					
1- Instruct the client regarding wound care and make return visit appointment, if needed.					
2- Discuss what to do if any problems occur and answer any questions					
3- Counsel the client regarding new contraceptive method and provide one, if desired					
4- Observe the client for at least 15–20 minutes before sending her home					

Supplies Needed for the One-Day Activity

Training Supplies:

- 1) Appropriate room in which to conduct one-day activity, arranged with tables and chairs as appropriate.
- 2) If available, computer and projector for viewing Implanon NXT videos
- 3) Simulation Implant Training Arms
- 4) Implanon NXT

Consumable Supplies:

- 1) Povidone-iodine
- 2) Surgical gloves
- 3) Sterile Band-Aid/Elastoplast
- 4) 1% lignocaine (without epinephrine)
- 5) Sterile, distilled water for injection (in case of 2% lignocaine)
- 6) Sterile gauze
- 7) 5 cc syringes and 21-gauge needle
- 8) Small gauze bandage

Support Equipment:

Implant removal kits

- 1) Kidney dish (1)
- 2) Surgical blade size 10 with handle (1)
- 3) Gallipot (1)
- 4) Small mosquito forceps straight (1)
- 5) Small mosquito forceps curved (1)
- 6) Fenestrated towel (1)

Implant insertion kits

- 1) Kidney tray (1)
- 2) Gallipot (1)
- 3) Fenestrated towel

Examination couch

Sphygmomanometer (or blood pressure monitor)

Infection Control Materials:

- 1) Autoclave with power source (or boiler for high-level disinfection).
- 2) Waste disposal mechanism in place (assorted bins with liners).
- 3) Running water.
- 4) Hand washing soap.
- 5) Heavy duty gloves.
- 6) Chlorine (for decontamination).
- 7) Safety box.

SESSION 7

TITLE: INFECTION PREVENTION

(20 MINUTES)

OUTLINE & OBJECTIVES:

Use recommended infection prevention practices that minimize the risk of post-insertion/post-removal infections and transmission of serious diseases.

METHODOLOGY

- 1) Discuss the infection prevention protocols and or problems faced by the participants in their own workplace followed by a presentation on the best Infection prevention techniques.
- 2) Power point presentation.
- 3) Table demonstration of various methods of infection prevention.
- 4) Interactive group discussion.

Handout: (H15.7)

INFECTION PREVENTION

HANDOUT (H-15.7)

The two primary objectives of infection prevention (IP) in family planning facilities are:

- 1) To prevent infection when providing subdermal implants
- 2) To minimize the risk of transmitting blood-borne viral infections (including HCV, HBV and HIV/AIDS) to clients, service providers, and other staff, including cleaning and housekeeping personnel.

Aseptic and gentle technique must be used for implant insertion and removal to prevent infections. Infections at the incision site are usually minor, however, they can lead to client dissatisfaction and are one of the reasons for early removal. Infection also may result in spontaneous expulsion of the implant rods.

To reduce the risk of infection, standard universal precautions must be followed, contaminated waste must be properly disposed of and instruments and other items should be decontaminated, thoroughly cleaned, and sterilized by autoclaving (high-pressure steam) or dry heat. If sterilization is not possible, high-level disinfection (by boiling, steaming, or soaking in disinfectant) is the only acceptable alternative.

INFECTION PREVENTION IN IMPLANT INSERTION AND REMOVAL:

Any outpatient clinic or minor surgery room is a suitable area for insertion or removal of implant rods. If possible, the room should be located away from heavily used areas of the clinic or hospital and should:

- 1) Have adequate lighting.
- 2) Have tile or concrete floors to make cleaning easier.
- 3) Be kept free of dust and insects; and
- 4) Be well-ventilated. (If windows need to be open for ventilation, they should have tight-fitting screens.)
- 5) There should be adequate hand washing facilities including a supply of clean water (i.e., clear, not cloudy or with sediment) and a toilet or latrine nearby.

INFECTION PREVENTION FOR IMPLANT INSERTION AND REMOVAL:

To minimize the client's risk of infection after insertion or removal, clinic staff should strive to maintain an infection-free environment. To do this, the clinician should have the client wash her **entire arm thoroughly with soap and water and rinse well to be sure all traces of soap have been removed.** (Residual soap decreases the effectiveness of some antiseptics.) This step is particularly important when client hygiene is poor.

Wash hands thoroughly with soap and water. For insertion or removal of implants, a brief hand washing with plain soap for about 10–15 seconds followed by rinsing in a stream of clean water is sufficient. Alternatively, use an alcoholic hand rub and rub for 15–30 seconds.

To prepare for infiltration, prepare syringe prior to putting on gloves if working alone. After infiltrating, drop syringe into the safety box. Put appropriate type of gloves on both hands (A separate pair of gloves must be worn for each client to avoid cross-contamination.)

Prepare the insertion or removal site with an antiseptic by holding the cotton or gauze swab with a sterile or high-level disinfected sponge forceps. (If the swab is held with a gloved hand, care must be taken **not** to contaminate the glove by touching any un-prepped skin.)

A surgical linen such as an eye sheet maybe draped over the insertion/removal site to minimize touching un-prepped skin.

SESSION 8

TITLE: COMMON SIDE EFFECTS AND COMPLICATIONS OF IMPLANTS AND MANAGEMENT OF POTENTIAL PROBLEMS

(30 MINUTES)

OUTLINE & OBJECTIVES:

To discuss and clarify the common side effects and complications of implants and how to manage potential problems.

METHODOLOGY:

- 1) Brainstorming in two groups
- 2) Large group discussion
- 3) Follow on with role play
- 4) Large group discussion
- 5) Power point presentation to highlight specific counselling for implants

Handout: (H15.8)

Activity: (A15.8)

Job Aid: (J15.8)

COMMON SIDE EFFECTS AND COMPLICATIONS OF IMPLANTS AND MANAGEMENT OF POTENTIAL PROBLEMS

HANDOUT (H-15.8)



Activity (A15.8)

Divide into two groups, one group to discuss side effects and the second group to do complications. Both groups to do brainstorming session and choose a leader to present their work. Both groups are given opportunity to present their work and a large group discussion is then held to discuss and add any missing points.

MANAGEMENT OF OTHER HEALTH PROBLEMS

Job Aid (J15.8)

Clients may present with health problems that may or may not be method related. The assessment and management of these problems are presented below.

<p>Irregular bleeding (bleeding at unexpected times that bothers the client)</p>	<ul style="list-style-type: none"> • Reassure her that many women using implants experience irregular bleeding. • It is not harmful and usually becomes less or stops after the first year of use. • For modest short-term relief, she can take 800 mg ibuprofen or 500 mg mefenamic acid 3 times daily after meals for 5 days, beginning when irregular bleeding starts. • If these drugs do not help her, she can try one of the following, beginning when irregular bleeding starts: <ul style="list-style-type: none"> ▪ Combined oral contraceptives that contain the progestin Levonorgestrel. Ask her to take one pill daily for 21 days. ▪ 50 µg Ethinyl oestradiol daily for 21 days. • If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use
<p>No monthly bleeding</p>	<ul style="list-style-type: none"> • If she has no monthly bleeding soon after implant insertion, rule out pregnancy. She might have been pregnant at the time of insertion. If she is pregnant, remove the implant. • Reassure her that some women stop having monthly bleeding when using implants, and this is not harmful. It is similar to not having monthly bleeding during pregnancy because of the effect of the hormones. She is not pregnant or infertile. Blood is not building up inside her. (Some women are happy to be free from monthly bleeding.) Also, not bleeding can have health benefits, for example, reducing the risk of anaemia.
<p>Heavy or prolonged bleeding (twice as much as usual or longer than 8 days)</p>	<ul style="list-style-type: none"> • Reassure her that some women using implants experience heavy or prolonged bleeding. It is generally not harmful and usually becomes less or stops after a few months. • For modest short-term relief, she can try any of the treatments for irregular bleeding, above, beginning when heavy bleeding starts. Combined oral contraceptives with 50 µg of Ethinyl oestradiol may work better than lower-dose combined pills. • To help prevent anaemia, suggest she take iron tablets and tell her it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas). • If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use

Ordinary headaches (nonmigrainous)	<ul style="list-style-type: none"> • Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol • (325–1000 mg), or other pain reliever. • Any headaches that get worse or occur more often during use of • implants should be evaluated
Mild abdominal pain	<ul style="list-style-type: none"> • Suggest paracetamol (325–1000 mg), aspirin (325–650 mg), ibuprofen • (200–400 mg), or other pain reliever. • Consider locally available remedies.
Acne	<ul style="list-style-type: none"> • Consider locally available remedies. • If client wants to stop using implants because of acne, she can consider switching to COCs. Many women’s acne improves with COC use.
Weight change	<ul style="list-style-type: none"> • Review diet and counsel as needed.
Breast tenderness	<ul style="list-style-type: none"> • Recommend that she wear a supportive bra (including during strenuous activity and sleep). • Try hot or cold compresses. • Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol • (325–1000 mg), or other pain reliever. • Consider locally available remedies
Mood changes or changes in sex drive	<ul style="list-style-type: none"> • Ask about changes in her life that could affect her mood or sex drive, including changes in her relationship with her partner. Give her support as appropriate. • Clients who have serious mood changes such as major depression should be referred for care. • Consider locally available remedies
Nausea or dizziness	<ul style="list-style-type: none"> • Consider locally available remedies
Pain after insertion or removal	<ul style="list-style-type: none"> • For pain after insertion, check that the bandage or gauze on her arm is not too tight. • Put a new bandage on the arm and advise her to avoid pressing on the site for a few days. • Give her aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.
Infection at the insertion site (redness, heat, pain, pus)	<ul style="list-style-type: none"> • Do not remove the implants. • Clean the infected area with soap and water or antiseptic. • Give oral antibiotics for 7 to 10 days. • Ask the client to return after taking all antibiotics if the infection does not clear. If infection has not cleared, remove the implants or refer for removal. • Expulsion or partial expulsion often follows infection. Ask the client to return if she notices an implant coming out.
Abscess (pocket of pus under the skin due to infection)	<ul style="list-style-type: none"> • Do not remove the implants. • Clean the area with antiseptic. • Cut open (incise) and drain the abscess. • Treat the wound.

	<ul style="list-style-type: none"> • Give oral antibiotics for 7 to 10 days. • Ask the client to return after taking all antibiotics if she has heat, redness, pain, or drainage of the wound. If infection is present when she returns, remove the implants, or refer for removal.
<p>Expulsion (when one or more implants begin to come out of the arm)</p>	<ul style="list-style-type: none"> • Rare. Usually occurs within a few months of insertion or with infection. • If no infection is present, after explanation and counselling replace the expelled rod or capsule through a new incision near the other rods or capsules or refer for replacement.
<p>Severe pain in lower abdomen</p>	<ul style="list-style-type: none"> • Abdominal pain may be due to various problems, such as enlarged ovarian follicles or cysts. <ul style="list-style-type: none"> ○ A woman can continue to use implants during evaluation. ○ There is no need to treat enlarged ovarian follicles or cysts unless they grow abnormally large, twist, or burst. Reassure the client that they usually disappear on their own. To be sure the problem is resolving, see the client again in 6 weeks, if possible. • With severe abdominal pain, be particularly alert for additional signs or symptoms of ectopic pregnancy. Ectopic pregnancy is rare and not caused by implants, but it can be life-threatening. In the early stages of ectopic pregnancy, symptoms may be absent or mild, but eventually they will become severe. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy: <ul style="list-style-type: none"> ○ Unusual abdominal pain or tenderness ○ Abnormal vaginal bleeding or no monthly bleeding—especially if this is a change from her usual bleeding pattern ○ Light-headedness or dizziness ○ Fainting • If ectopic pregnancy or other serious health condition is suspected, refer at once for immediate diagnosis and care.

NEW PROBLEMS THAT MAY REQUIRE SWITCHING METHODS

<p>Unexplained vaginal bleeding (that suggests a medical condition not related to the method)</p>	<ul style="list-style-type: none"> • Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate. • If no cause of bleeding can be found, consider stopping implants to make diagnosis easier. Provide another method of her choice to use until the condition is evaluated and treated (not progestin-only injectable or a copper-bearing or hormonal IUD). • If bleeding is caused by sexually transmitted infection or pelvic inflammatory disease, she can continue using implants during treatment
<p>Migraine headaches</p>	<ul style="list-style-type: none"> • If she has migraine headaches without aura, she can continue to use implants if she wishes. • If she has migraine aura, remove the implants. Help her choose a method without hormones
<p>Certain serious health conditions (suspected blood clots in deep veins of legs or lungs, serious liver disease, or breast cancer)</p>	<ul style="list-style-type: none"> • Remove the implants or refer for removal. • Give her a backup method to use until her condition is evaluated. • Refer for diagnosis and care if not already under care.
<p>Heart disease due to blocked or narrowed arteries (ischemic heart disease) or stroke</p>	<ul style="list-style-type: none"> • A woman who has one of these conditions can safely start implants. If, • however, the condition develops while she is using implants: <ul style="list-style-type: none"> ○ Remove the implants or refer for removal. ○ Help her choose a method without hormones. ○ Refer for diagnosis and care if not already under care
<p>Suspected pregnancy</p>	<ul style="list-style-type: none"> • Assess for pregnancy, including ectopic pregnancy • Remove the implants or refer for removal if she will carry the pregnancy to term. • There are no known risks to a foetus conceived while a woman has implants in place

SESSION 9

TITLE: POST PROCEDURE CARE AND FOLLOW UP

(20 MINUTES)

OUTLINE & OBJECTIVES:

To highlight and reinforce proper follow up care and advice. To ensure warning signs are discussed and explained to the woman along with appropriate follow up.

METHODOLOGY:

- 1) Brainstorming in two groups.
- 2) Large group discussion.
- 3) Power point presentation.

Handout: (H15.9)

Activity: (A15.9a), (A15.9b)

POST PROCEDURE CARE AND FOLLOW UP

HANDOUT (H-15.9)

Long-term success, as defined by satisfied clients and high continuation rates, will occur only if clinic staff recognize the importance of providing follow-up care (including counselling) and prompt management of side effects as well as other problems, should they occur.



Activity (A15.9a)

Divide into two groups, each group to prepare a small presentation regarding immediate care and follow up and longer-term care and follow up for the client who has had an implant inserted

Followed by large group discussion and a brief power point presentation to ensure no points are missed.

POST INSERTION CARE AND ADVICE:

- 1) The woman should be counselled regarding the care and precautions in detail.

- 2) She should be advised to keep her arm dry for around 5 days. The elastic bandage or gauze can be removed after 2 days and the adhesive bandage after 5 days.
- 3) She should be told to void strenuous activity with the index arm.
- 4) She should be given a simple analgesic to cover the soreness in her arm.
- 5) Help her how to remember the date to return.
- 6) Give each woman the following information in writing on a reminder card.

It is a good idea to have it laminated as usually the women feel it is an important card to keep.



Activity (A15.9b)

The trainer runs a pass the parcel session with a different Myth on a different coloured piece of paper. The music plays and the participants pass the parcel. Where the music stops, the participant answers the question, if she can't, she can pass it on to her next person. The trainer reinforces the correct answers and clarifies others.

FOLLOW-UP CARE:

The client does not need to return until the implant reaches the end of its effective life, unless she has decided to have the rods removed because she:

- 1) Thinks she might be pregnant.
- 2) Wants the implant removed for any reasons.
- 3) Wants to have a baby.
- 4) Has any problems with the method that worry her.
- 5) Wants to switch to another contraceptive method; or
- 6) Has started any new medication that might decrease the effectiveness of the implants.

IMPLANTS FOR ADOLESCENTS:

An option worth considering for healthy timing and spacing of pregnancy

The long-acting contraceptive implant is often considered for use in women who have chosen to stop childbearing or who are unsure of whether they want any children in the future. However, implants can be appropriate for all women, including adolescents who want to delay or space childbearing to ensure healthy timing and spacing of pregnancy.

IMPLANTS ARE CONVENIENT, SAFE AND EFFECTIVE FOR ADOLESCENTS:

According to the World Health Organization, implants are safe and suitable for nearly all women, including adolescents. The implant is effective for three to five years, and for young women who want to become pregnant, fertility returns immediately once the rods are removed. The implant is discreet and easy to use. Unlike pills and condoms, the implant does not depend

on the regular compliance of the user. Adolescents are less likely to have certain medical conditions that preclude them from using the implants.

SESSION 10

TITLE: FREQUENTLY ASKED QUESTIONS

(20 MINUTES)

FREQUENTLY ASKED QUESTIONS

HANDOUT (H-15.10)



(Activity A15.10)

Pass the Parcel:

Give participants a paper ball and ask them to pass it on to next participant until the music is playing. The moment music stops, person holding paper ball will answer a question asked by trainer. The correct answer is rewarded with a candy

1- Do women need to return for a follow-up visit after having contraceptive implants inserted?

There is no need for the client to return for follow-up unless she has a complaint or experiences a problem.

2- Do other drugs interact with the hormones in contraceptive implants?

Certain drugs increase the ability of the liver to break down the hormone, thereby making the method less effective in preventing pregnancy. Such drugs include: rifampicin, used to treat tuberculosis; griseofulvin⁷; and drugs used for epilepsy (seizure disorders) such as barbiturates (e.g., phenobarbital), phenytoin (e.g., Dilantin), and carbamazepine (e.g., Tegretol), but **not** valproic acid (Angle, Huff, and Lea 1991).

Remember: Counsel the woman to tell the health care provider that she is using implants whenever a new drug is given to her.

3- Should a woman be concerned if her menstrual period is delayed?

Although contraceptive implants are highly effective, pregnancies occur occasionally. If a woman's period is delayed (> 6 weeks) after an interval of regular cycles, she should be evaluated for pregnancy (If she is not pregnant, counsel her that there is no harm to her health if she doesn't get her menstrual period (i.e., there is no "build-up" of blood in the uterus) and that not having menses will have no harmful effect on her future fertility.

4- Should a woman with prolonged bleeding (with or without anaemia) have the implant removed?

Not usually. If the woman wants to continue using a two-rod or one-rod contraceptive, she should be checked to be sure there are no other causes for the bleeding. Following this, the **first approach** should be counselling and reassurance that **prolonged spotting or moderate bleeding** (equivalent to normal menstruation but longer in duration) is common and expected during implant use. If reassurance is not sufficient for the woman, use of a low-dose COC or ibuprofen can be tried.

For anaemia, give nutritional advice on the need to increase iron intake. Use oral iron treatment (one tablet containing at least 100 mg of elemental iron, FeSO₄, daily for 1–3 months) if haemoglobin is ≤ 9 g/dl or haematocrit ≤ 27 .

Because griseofulvin, which increases progestin metabolism, usually is used only for a short period of time (2–4 weeks), women taking it for fungal infections can use contraceptive implants. They should use a backup method while taking griseofulvin and until the start of the next menstrual period after stopping the antibiotic.

5- What are the warning signs of problems?

The client should return to the clinic if she has any of the following problems:

- a. Delayed menstrual period after several months of regular cycles (may be a sign of pregnancy)
- b. Severe lower abdominal pain (may be a symptom of ectopic pregnancy)
- c. Heavy bleeding (twice as long or twice as much as normal)
- d. Pus or bleeding at the insertion site
- e. Expulsion of a rod
- f. Migraine (vascular) headaches, repeated very painful headaches, or blurred vision

6- When should two-rod implants be removed?

Two-rod implants should be removed by the end of 5 years if Jadelle, or by the end of 4 years if Sino-implant (II). The rods can, however, be removed any time before then if the user wishes to stop the method for either a personal or medical reason. The rods should be removed by a service provider trained in removal. If the client wants to continue using contraceptive implants, she may receive a new set of rods in the same arm immediately after the old set is

removed. Clients weighing over 80 kg may wish to have their implants removed a year early because the implant may lose effectiveness earlier for them.

7- When should one-rod implants be removed?

One-rod implants should be removed by the end of 3 years. The implant can, however, be removed before 3 years if the user wishes to stop the method for either a personal or medical reason. The rod should be removed by a service provider trained in removal. If the client wants to continue using contraceptive implants, she may receive a new of rod in the same arm immediately after the old set is removed.

8- Where should the client go to have the rods removed?

The client should return to the same clinic where the rods were inserted, or to another clinic where contraceptive implants are provided. The counsellor should be sure the client knows that she has access to removal. If removals are not done every day, the clinic should post a schedule of the regular days of the week when removals are performed.

9- What should a woman do if she cannot or does not want to have the implant removed at the end of its effective life?

Because of the increased risk of intrauterine and ectopic pregnancy, every effort should be made to help convince the woman to have the rods removed. In the interim, the woman should use a reliable contraceptive method (COCs, injectables, or an IUCD) until the rods can be removed.

10- What happens if contraceptive implant rods are left in for too long?

The effectiveness of two-rod implants may decrease somewhat after 5 years and, therefore, the chance of becoming pregnant (either intrauterine or ectopic) may increase. Likewise, the effectiveness of one-rod implants may decrease after 3 years, and the chance of pregnancy may increase. If the implant is left longer than the recommended length of time, those women who do become pregnant are more likely to have an ectopic pregnancy.

11- How long does removal take?

The removal process usually takes 5–10 minutes but may take longer if the rod(s) were not inserted correctly or is difficult to locate.

SESSION 11

TITLE: SUMMARIZE AND WRAP UP

(5 MINUTES)

FURTHER READING:

1. <https://www.fphandbook.org/>
2. https://www.who.int/entity/reproductivehealth/publications/family_planning/MEC-5/en/index.html
3. http://reprolineplus.org/system/files/resources/Providing%20Contraceptive%20Implants_Learner%20Handbook_2015.pdf
4. http://resources.jhpiego.org/system/files/resources/Providing_Contraceptive_Implants_Ref_Man_2015.pdf

