



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)

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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

LACTATIONAL AMENORRHEA METHOD (LAM)



TIME: 1 HOUR 30 MINUTES

Lactational amenorrhoea method (LAM) is the use of breastfeeding while fulfilling specific criteria, as a method of post-partum family planning. It provides natural protection against pregnancy and encourages the starting of another method at the proper time.



TRAINING OBJECTIVES

- 1) Discuss LAM as a temporary but reliable method of contraception for the new mothers who are breast feeding.
- 2) Highlight the benefits of LAM for mother and the baby.
- 3) Describe the three criteria for LAM.
- 4) Discuss LAM as an integrating opportunity for FP and women's and child's health.



LEARNING OUTCOMES

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

- 1) Describe LAM as a highly effective, temporary method of contraception for postpartum women who are breastfeeding.
- 2) Explain the basic mechanism of action and the three LAM criteria and why each is important, as well as the importance of timely transition to another modern method of contraception.
- 3) Discuss the effectiveness of LAM.
- 4) List advantages and limitations of LAM.
- 5) Discuss opportunities for integrating LAM counselling with other services.



TRAINING METHODOLOGY

- 1) Illustrated lectures and group discussions.
- 2) Individual and group exercises.
- 3) Power Point Presentations.



ADVANCE PREPARATION

- 1) Handouts
- 2) Case scenarios
- 3) Power point presentation
- 4) Global Handbook for Family Planning 2018



CONSTITUTION OF THE SESSION

Five mini sessions will be held

1. What is LAM, its importance and three criteria	Brainstorming/discussion/activity	25 Mins
2. Advantages and limitations of LAM	Lecture/Group discussion	20 Mins
3. Counselling for using LAM as a transitional method	Group work/ Role play	40 Mins
4. Wrap up		5 Mins



TRAINING MATERIALS

Trainer' Material	Trainee's Material
Hand Outs: H16.1, H16.2, H16.3	Hand Outs: H16.1, H16.2, H16.3
Activity: A16.2. A16.3	Job aid: J16.3
Job aid: J16.3	
PPT: (16)	

SESSION 1

TITLE: WHAT IS LAM, ITS IMPORTANCE AND THE THREE CRITERIA

(25 MINUTES)

OUTLINE & OBJECTIVES:

This session highlights the importance of LAM as an important choice in post-partum period and explain the need for immediate post-partum contraception. The pre-requisites of LAM for it to be the reliable contraceptive, the three criteria will be discussed in detail

METHODOLOGY:

- 1) PowerPoint presentation showing all postpartum choices including LAM
- 2) Group work
- 3) Brainstorming to identify the three criteria for LAM

Handout: (H16.1)

WHAT IS LAM AND WHAT IS ITS IMPORTANCE AND THREE CRITERIA

HANDOUT (H-16.1)

The breastfeeding method of family planning, the Lactational Amenorrhea Method (LAM), considered a modern method of family planning, yields all of the nutritional benefits of exclusive breastfeeding, and thus can directly influence new-born and infant nutritional status. Scaling up correct LAM use globally could bring tremendous nutritional benefits to new-borns and infants and prevent unwanted pregnancy among postpartum women for 6 months, before transitioning to another modern method.

MECHANISM OF ACTION:

LAM stops ovulation because breastfeeding changes the rate of release of natural hormones.

EFFECTIVENESS OF LAM:

- 1) **Effective as commonly used:** 2 pregnancies per 100 women in the first 6 months after childbirth. This means that 98 of every 100 women relying on LAM will not become pregnant.
- 2) **Very effective when used correctly and consistently:** Less than 1 pregnancy per 100 women in the first 6 months after childbirth.

- 3) **Women Who Should Not Rely on LAM:** In the following circumstances, a woman should not rely on this method:
- The woman is not exclusively breastfeeding.
 - The menstruation has resumed.
 - The baby is more than six months of age.
 - Couples need highly effective protection against pregnancy (e.g., the woman has conditions that make pregnancy dangerous).

The risk of transmitting HIV to the infant is reduced by exclusive breastfeeding compared to mixed feeding, but it is still greater than with exclusive alternative feeding

THE CRITERIA FOR LAM:

LAM requires 3 conditions. All 3 must be met:

Criteria 1- Exclusive Breast Feeding

Criteria 2- Amenorrhea

Criteria 3- The baby is less than 6 months' old

EXCLUSIVE BREAST FEEDING:

- 1) Baby is being **only** breastfed.

The baby is not receiving any other solid food or liquids; only breast milk.

- 2) Breastfeeding on demand or
- No more than 4 hours between feeds during day.
 - No more than 6 hours between feeds at night.

AMENORRHEA:

Defined as the absence of the menses. Menses return is defined as the first two sequential days of bleeding or spotting which may occur after two months postpartum.

AGE OF BABY:

Baby is less than six months

- 1) Biologically appropriate cut off point.
- 2) WHO recommends supplementing after six months.
- 3) Supplemental foods decrease suckling.

If any of these conditions is not true, the woman should:

- 1) Use another method for effective family planning, one that does not interfere with breastfeeding.
- 2) Keep breastfeeding her baby, if possible, even while starting to give the other baby food.

SESSION 2

TITLE: ADVANTAGES AND LIMITATIONS OF LAM

(20 MINUTES)

OUTLINE & OBJECTIVES:

To highlight the advantages and limitations of LAM.

METHODOLOGY

Power point presentation

Group discussion

Handout: (H16.2)

Activity: (A16.2)

ADVANTAGES AND LIMITATIONS OF LAM

HANDOUT (H-16.2)



(Activity A16.2)

Divide Participants into two groups and task them to enlist advantages and limitations of LAM. Each group has 5 minutes to brainstorm and 5 minutes to present their work

The trainer then holds a large group discussion and adds any missing points

Health Benefits for Infant

LAM provides the complete nutritional needs of the infant for up to six months Improves infant growth and development

Enhances infant's immune system (less diarrhoea and acute respiratory infections)

Provides passive immunity and protects against infections

Is a source of Vitamin A, proteins, iron, minerals and essential fatty acids. This decreases exposure to contaminants in water, in other milk or formulas, or on utensils
Adapts to nutritional needs of growing infant
Is more easily digested than other milk or formulas
Promotes optimal brain development
Provides some protection against allergies
Strengthens mother–baby bond

Advantages for mother
1. Is more than 98% effective as a contraceptive, when used properly
2. Is provided and controlled by the woman
3. Can be started immediately postpartum
4. Promotes HTSP
5. Motivates users to exclusively breastfeed throughout the first six months postpartum
6. Facilitates transition by allowing time for decision to use/adoption of another modern contraceptive method during the postpartum period
7. Facilitates modern contraceptive method use by previous non-users
8. Supports and builds on new-born and infant feeding recommendations for exclusive breastfeeding for the first six months
9. Suckling action in the immediate postpartum stimulates uterine contractions, leading to decreased blood loss
10. Builds on established cultural and religious practices
11. Is non-invasive; does not require a gynaecological examination
12. Has no side effects
13. Does not require supplies or procedures
14. Mother–baby relationship enhanced
15. LAM does not interfere with sexual activity.

16. It has no known health risks.
17. Return to fertility is immediate.
18. Counselling for LAM encourages women in transition to start a follow-on method at six months post-delivery.
19. LAM is affordable, it has no direct costs.
20. Promotes involution (return of uterus to pre-pregnancy state)

Limitations of LAM
Is only effective for six months
Exclusive breastfeeding might be inconvenient or difficult for some women, especially working mothers.
Offers no protection against sexually transmitted infections (STIs)/HIV
This method is effective only as long as all three LAM criteria are met.
Breastfeeding can transmit HIV from a mother to her baby.
A woman might not breastfeed because she is taking certain drugs (e.g., mood altering drugs, reserpine, ergotamine, antimetabolites, cyclosporine, cortisone, bromocriptine, radioactive drugs, lithium, or certain anticoagulants).

SESSION 3

TITLE: COUNSELLING FOR LAM USING LAM AS A TRANSITIONAL METHOD

(40 MINUTES)

OUTLINE & OBJECTIVES:

This session aims to discuss how a woman should be guided to switch over to an appropriate method of contraception following LAM.

METHODOLOGY:

The pictorial chart will be used to initiate small group discussions followed by a large group discussion.

Handout: (H16.3)

Job Aid: (J16.3)

Activity: (A16.3)

COUNSELLING FOR USING LAM AS A TRANSITIONAL METHOD

HANDOUT (H-16.3)

A woman can switch to another method any time she wants while using LAM. If she still meets all 3 LAM criteria, it is reasonably certain she is not pregnant. She can start new method with no need for a pregnancy test, examinations, or evaluation. To continue contraception, a woman *must* switch to another method as soon as any one of the 3 LAM criteria no longer applies.

If a woman is using LAM, when should she transition to another FP method?

- 1) If all components are met:
 - a. Help a woman transition to use another method by 6 months
- 2) If any component of LAM is not met:
 - a. Help her transition as soon as component not met
- 3) Help a woman add another method whenever she is ready
- 4) LAM can be seen as a “gateway” to use of any modern method

Which contraceptive methods can be used while a woman is breastfeeding?

A woman is only preventing pregnancy through breastfeeding if the baby is less than 6 months old, the baby is exclusively breastfed (no other food or liquid is given to the baby, not even water), and the woman's monthly bleeding has not returned.

A woman/couple can use the mini-pill (progestin-only pills), implants, IUCDs, and male and female condoms during the postpartum period and while breastfeeding. The IUCD can be inserted within 48 hours postpartum. After the 48-hour postpartum window, delay insertion until 4 weeks postpartum.

Progestin-only pills and implants can be used immediately postpartum in breastfeeding women. Injectable contraceptives can be used by breastfeeding women from 6 weeks after childbirth.

Case Studies / role plays for transition to help participants learn when various methods of contraception can be initiated for the postpartum mother

Case Study- 1

Maria has a four-month-old baby, is exclusively breastfeeding and has been using LAM to prevent pregnancy. Her menses returned last week and she is not sure which family planning method would be best for her while she continues breastfeeding. She has been told that hormonal methods are bad for milk production.

1) Can this woman continue to rely on LAM? Why or why not?

No, she can no longer rely on LAM because she has had menstrual bleeding.

2) Based on the information provided, what are some methods that may be appropriate for her at this time and/or what counsel would you provide?

Review the methods that are compatible with breastfeeding, which include progestin-only methods, IUCD and condoms. Combined oral contraceptives could not be started until the baby is six months old if the woman plans to continue breastfeeding. And because she is concerned about hormonal methods affecting her milk, the non-hormonal methods may be the best option for her. Vasectomy and tubal ligation are possibilities if the couple does not want to have more children.

Case Study- 2

For the last six months (since delivery), Mrs. Fareed has exclusively breastfeeding her baby. She believes that breastfeeding will continue to protect her from pregnancy until her menstrual bleeding returns.

1- Can this woman continue to rely on LAM? Why or why not?

No, she can no longer use LAM because her baby is six months old, as weaning must be started at this time

2- Based on the information provided, what are some methods that may be appropriate for her at this time and/or what counsel would you provide?

Discuss the benefits of continuing breastfeeding even though the baby should be starting on complementary foods. Discuss the return of fertility and the benefits of waiting until the baby is at least two years old before trying to become pregnant again. Advise the woman that she should begin another contraceptive immediately if she does not want to become pregnant. Based on the information provided, she can use any method she chooses.

Case Study- 3

Kausar had her baby two weeks ago and has been using LAM. She is returning to work and will no longer be only/exclusively breastfeeding the baby.

1- Can this woman continue to rely on LAM? Why or why not?

No, she cannot use LAM for contraception because she will no longer be only/exclusively breastfeeding her baby.

2- Based on the information provided, what are some methods that may be appropriate for her at this time and/or what counsel would you provide?

Discuss the benefits of continuing to breastfeed, even when using another modern method of contraception (other than LAM). She can use condoms and other barrier methods. At this time, however, she cannot use combined oral contraceptives or an IUCD, nor can she have a tubal ligation. She can use implant and have it inserted straight away. If she chooses the IUCD, she should use condoms now and return in two weeks to have the IUCD inserted. If she does not plan to have more children, her husband can have a vasectomy now or she can return at six weeks postpartum for a tubal ligation.

Case Study- 4

Salma is the mother of three children; her youngest is 3 months old. She was using LAM to space her pregnancies, but she began to give the baby a daily bottle of formula when he was two months old. She has not yet had any menstrual bleeding. Salma plans to continue breastfeeding but seems confused about LAM. She is not sure how much longer she will be protected from pregnancy.

1- Can this woman continue to rely on LAM? Why or why not?

No, she cannot rely on LAM because she is no longer only/exclusively breastfeeding.

2- Based on the information provided, what are some methods that may be appropriate for her at this time and/or what counsel would you provide?

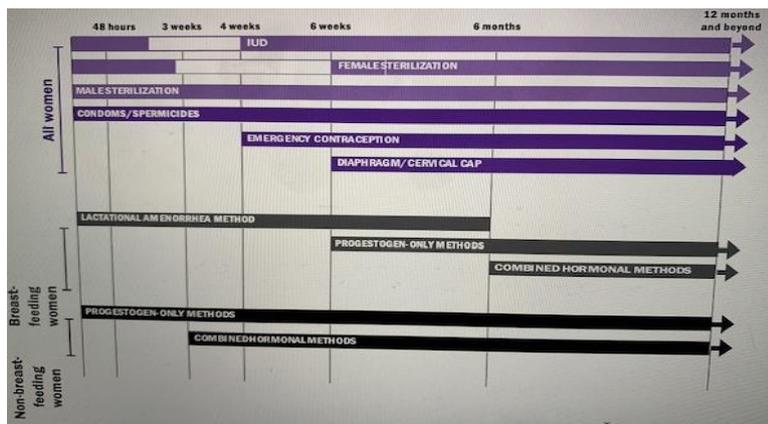
Advise the woman that she should begin another contraceptive immediately if she does not want to become pregnant. (You may use a pregnancy test to be sure she is not pregnant. However, if a pregnancy test is not available and you are reasonably sure that she is not pregnant, she can begin using another method.) Based on the information provided, she can use any method except combined oral contraceptives.

3- Based on the information provided, what are some methods that may be appropriate for her at this time and/or what counsel would you provide?

She can be given condoms to use at any time. Or if she chooses progestin-only pills, the pills can be given to her with instructions not to begin them until after the baby is six weeks old. Counsel her that whichever method she chooses; she should start it IMMEDIATELY when one of the criteria is no longer met.

Post-partum FP Options

Job Aid (J16.3)



(Activity A16.3)

Unfold the parcel

The trainer makes a rolled-up parcel of different coloured papers with a question on each. Pass the parcel is played, while the participants are asked to stand in an oval and music is played. When the music stops, the participant with the parcel in hand opens the paper and reads the question out loud and then answers it.

QUESTIONS AND ANSWERS ABOUT THE LACTATIONAL AMENORRHEA METHOD

1) Can LAM be an effective method of family planning?

Yes. LAM is effective if the woman's monthly bleeding has not returned, she is fully or nearly fully breastfeeding, and her baby is less than 6 months old.

2) When should a mother start giving her baby other foods besides breast milk?

Ideally, when the baby is 6 months old. Along with other foods, breast milk should be a major part of the child's diet through the child's second year or longer.

3) Can women use LAM if they work away from home?

Yes. Women who are able to keep their infants with them at work or nearby and are able to breastfeed frequently can rely on LAM as long as they meet all 3 criteria for LAM. Women who are separated from their infants can use LAM if breastfeeds are less than 4 hours apart. Women can also express their breast milk at least every 4 hours, but pregnancy rates may be slightly higher for women who are separated from their infants. The one study that assessed use of LAM among working women estimated a pregnancy rate of 5 per 100 women during the first 6 months after childbirth, compared with about 2 per 100 women as LAM is commonly used.

4) What if a woman learns that she has HIV while she is using LAM? Can she continue breastfeeding and using LAM?

If a woman is newly infected with HIV, the risk of transmission through breastfeeding may be higher than if she was infected earlier, because there is more HIV in her body. The breastfeeding recommendation is the same as for other HIV-infected women, however. HIV-infected mothers and their infants should receive the appropriate ARV therapy, and mothers should exclusively breastfeed their infants for the first 6 months of life, and then introduce appropriate complementary foods and continue breastfeeding for the first 12 months of life. At 6 months or earlier, if her monthly bleeding has returned or she stops exclusive breastfeeding, she should begin to use another contraceptive method in place of LAM and continue to use condoms.

5) What is the Lactational Amenorrhea Method (LAM) of family planning?

LAM is a modern method of contraception that is based on the natural postpartum infertility that occurs when a woman has not yet resumed menstrual bleeding (is amenorrhoeic) and is only/exclusively breastfeeding her baby (i.e., breastfeeding the baby day and night, not giving any other food, water or liquids except for medicine, vitamins or vaccines). It may be effective up to six months after the birth of the baby.

6) How does LAM work (mechanism of action)?

The infant's suckling triggers a signal to the mother's brain that interferes with the production of the hormones needed for ovulation. Ovulation is necessary for pregnancy to occur.

7) What are the criteria that must be met to use LAM?

The three criteria for LAM effectiveness are:

1. The woman's menstrual bleeding has not returned since her baby was born
2. The baby is "only/exclusively breastfed," meaning the woman breastfeeds her baby day and night and does not give any other food, water or liquids (except for medicine, vitamins or vaccines)
3. The baby is less than six months old.

8) How do you determine whether postpartum vaginal bleeding is menstrual bleeding?

For the purpose of determining whether the first LAM criterion is met (i.e., the mother's menstrual bleeding has not returned), consider any bleeding after two months postpartum to be menses/menstrual bleeding. Bleeding that occurs before two months postpartum may be considered normal postpartum discharge.

9) How effective is LAM as a method of contraception (to prevent pregnancy)?

LAM is a very effective method of contraception. As commonly used, it is more than 98% effective for the first six months postpartum.

SESSION 4

TITLE: WRAP UP AND SUMMARY

(5 MINUTES)

FURTHER READING:

- Bongiovanni A. et al. 2005. "Promoting the Lactational Amenorrhea Method (LAM) in Jordan Increases Modern Contraception Use in the Extended Postpartum Period" LINKAGES Project. Washington, DC: Academy for Educational Development.
- <http://srhr.org/postpartumfp/methods/lactational-amenorrhea>
- Compendium of WHO Recommendations for Postpartum Family Planning
- Family Planning: A Global Handbook for Providers (2007).

CONTRACEPTIVE PATCH AND VAGINAL RING



TIME: 2 HOURS



TRAINING OBJECTIVES

- 1) Discuss benefits and limitations of the contraceptive skin patch and the vaginal ring.
- 2) Describe mechanism of action, efficacy, side effects and complications.
- 3) Demonstrate counselling skills for the above.
- 4) Describe proper application and usage



LEARNING OUTCOMES

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

- 1) Have knowledge about the contraceptive patch and vaginal ring.
- 2) Know their effectiveness, side effects, limitations and common problems.
- 3) Be aware of the proper usage, application and counselling for patch and ring.



TRAINING/LEARNING METHODS

- 1) PowerPoint presentation.
- 2) Brain storming.
- 3) Group discussions.



ADVANCE PREPARATIONS

- 1) Sample patches.
- 2) Vaginal Ring.
- 3) MEC Wheel.



TRAINING MATERIAL

Trainer' Material	Trainee's Material
Hand Outs: H17.1, H17.2, H17.3, H17.4, H17.5,	Hand Outs: H17.1, H17.2, H17.3, H17.4, H17.5,
Activity:	Job aid:
Job aid: J17.4	Checklist: C17.2a, C17.2b
Checklist: C17.2a, C17.2b	
FAQs:	
PPT: (17)	



CONSTITUTION OF THE SESSION

Five mini sessions will be held

1) Combined patch, effectiveness, and side effects	Interactive presentation	20 Mins
2) How to use patch and follow up	Brainstorming	25 Mins
3) Combined vaginal ring and its effectiveness	Interactive presentation	20 Mins
4) Steps in vaginal ring, insertion and removal	Interactive presentation	25 Mins
5) Overview of Progesterone vaginal ring	Group discussion	20 Mins
6) Wrap up	Brainstorming	10 Mins

SESSION 1

TITLE: COMBINED PATCH, EFFECTIVENESS AND SIDE EFFECTS

(20 MINUTES)

OUTLINE & OBJECTIVES:

This session highlights the combined patch and its effectiveness with side effects.

METHODOLOGY:

- 1) Brain storming session.
- 2) Group work.
- 3) Interactive power point presentation and discussion.

Handout: (H17.1)

COMBINED PATCH, ITS EFFECTIVENESS AND SIDE EFFECTS

HANDOUT (H-17.1)

The patch is a small, thin, square of flexible plastic applied on the skin. This continuously releases 2 hormones, a progestin and an oestrogen, like the natural hormones progesterone and oestrogen in a woman's body. Works directly through the skin into the bloodstream. The woman puts on a new patch every week for 3 weeks, then no patch for the fourth week. During this fourth week, the woman will have monthly bleeding. It works primarily by preventing ovulation. Combined patch is a convenient and effective method for contraception for women, who do not wish to have tablets or injections.

EFFECTIVENESS:

Effectiveness depends on the user:

- 1) Risk of pregnancy is greatest when a woman is late to change the patch.
- 2) As commonly used, about 7 pregnancies per 100 women using the combined patch over the first year. This means that 93 of every 100 women using the combined patch will not become pregnant.
- 3) When no mistakes are made with use of the patch, less than 1 pregnancy per 100 women using a patch over the first year (3 per 1,000 women).
- 4) Pregnancy rates may be slightly higher among women weighing 90 kg or more.

- 5) No delayed return of fertility after patch use is stopped.
- 6) Do not protect against sexually transmitted infections.

SIDE EFFECTS:

Some users report the following:

- 1) Skin irritation or rash where the patch is applied.
- 2) Changes in bleeding patterns:
 - a) Lighter bleeding and fewer days of bleeding.
 - b) Irregular bleeding.
 - c) Prolonged bleeding.
 - d) No monthly bleeding.
- 3) Headaches.
- 4) Nausea.
- 5) Vomiting.
- 6) Breast tenderness and pain.
- 7) Abdominal pain.
- 8) Flu symptoms/upper respiratory infection.
- 9) Irritation, redness, or inflammation of the vagina (vaginitis).

KNOWN HEALTH BENEFITS AND HEALTH RISKS:

Long-term studies of the patch are limited, but researchers expect that its health benefits and risks are like those of combined oral contraceptives.

Medical eligibility criteria guidelines for when to start and helping continuing users for the combined patch are the same as for combined oral contraceptives and the combined vaginal ring.

MEDICAL ELIGIBILITY CRITERIA:

MEC for the combined patch are same as for combined oral contraceptives and combined vaginal ring

SESSION 2

TITLE: HOW TO USE COMBINED PATCH AND FOLLOW UP

(25 MINUTES)

OUTLINE & OBJECTIVES:

This session includes steps of using combined patch and follow up care provider should explain to client.

METHODOLOGY:

- 1) Brain storming
- 2) Small presentation

Handout: (H17.2)

Checklist: (C17.2a), (C17.2b)

HOW TO USE COMBINED PATCH AND FOLLOW UP

HANDOUT (H-17.2)

How to use Combined Patch Checklist (C17.2a)

1- Explain how to remove the patch from the pouch and remove backing	<ol style="list-style-type: none">1) Explain to the user that she should tear the foil pouch along the edge.2) She should then pull out the patch and peel away the backing without touching the sticky surface.
2- Show her where and how to apply the patch	<ol style="list-style-type: none">1) Explain that she can apply it on the upper outer arm, back, stomach, abdomen, or buttocks, but not on the breasts and the skin needs to be clean and dry2) She must press the sticky, medicated part against her skin for 10 seconds. She should run her finger along the edge to make sure it sticks.3) The patch will stay on even during work, exercise, swimming, and bathing.

3- She must change the patch every week for 3 weeks in a row	<ol style="list-style-type: none"> 1) She should apply each new patch on the same day of each week—the “patch-change day.” For example, if she puts on her first patch on a Sunday, all of her patches should be applied on a Sunday. 2) Explain that to avoid irritation, she should not apply the new patch to the same place on the skin where the previous patch was
4- She should not wear a patch on the fourth week	<p>She will probably have monthly bleeding this week.</p>
5- After the patch-free week, she should apply a new patch	<p>She should never go without wearing a patch for more than 7 days. Doing so risks pregnancy.</p>

Instructions for Late Replacement or Removal, or if the Patch Comes Off Checklist (C17.2b)

1- Forgot to apply a new patch after the 7-day patch-free interval?	<ol style="list-style-type: none"> 1) Apply a new patch as soon as possible. 2) Keep the same patch-change day. 3) If late by only 1 or 2 days (48 hours or less), there is no need for a backup method. 4) If more than 2 days late (more than 48 hours) (that is, no patch was worn for 10 days or more in a row), use a backup method* for the first 7 days of patch use. 5) Also, if more than 2 days late and unprotected sex occurred in the past 5 days, consider taking emergency contraceptive pills
2- Late changing the patch at the end of week 1 or 2?	<ol style="list-style-type: none"> 1) If late by only 1 or 2 days (48 hours or less), apply a new patch as soon as possible. Keep the same patch change day. No need for a backup method. 2) If more than 2 days late (more than 48 hours), apply a new patch as soon as possible. This patch will begin a new 4-week patch cycle, and this day of the week will become the new patch-change day. Also use a backup method for the next 7 days. 3) Also, if more than 2 days late and unprotected sex occurred in the past 5 days, consider taking emergency contraceptive pill

3- Late taking off the patch at the end of week 3?	<ol style="list-style-type: none"> 1) Remove the patch. 2) Start the next cycle on the usual patch-change day. 3) No need for a backup method.
4- The patch came off and was off for less than 2 days (48 hours or less)?	<ol style="list-style-type: none"> 1) Apply a new patch as soon as possible. (The same patch can be re-used if it was off less than 24 hours.) 2) No need for a backup method. 3) Keep the same patch change day.
5- The patch came off and was off for more than 2 days (more than 48 hours)	<ol style="list-style-type: none"> 1) Apply a new patch as soon as possible. 2) Use a backup method* for the next 7 days. 3) Keep the same patch-change day. 4) If during week 3, skip the patch-free week and start a new patch immediately after week 3. If a new patch cannot be started immediately, use a backup method* and keep using it through the first 7 days of patch use. 5) If during week one and unprotected sex occurred in the past 5 days, consider taking emergency contraceptive pills

*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: COMBINED VAGINAL RING AND ITS EFFECTIVENESS

(20 MINUTES)

OUTLINE & OBJECTIVES:

To discuss the use and need of combined vaginal ring, highlighting its effectiveness

METHODOLOGY:

- 1) Interactive presentation
- 2) Brainstorming
- 3) Group discussion

Handout: (H17.3)

COMBINED VAGINAL RING AND ITS EFFECTIVENESS-

HANDOUT (H-17.3)

This is a flexible ring, which a woman inserts in her vagina. The ring continuously releases 2 hormones, a progestin and an oestrogen, like the natural hormones progesterone and oestrogen in a woman's body. Hormones are absorbed through the wall of the vagina directly into the bloodstream. She leaves the ring in place for 3 weeks, then removes it for the fourth week. During the fourth week, the woman will have monthly bleeding. It works primarily by preventing ovulation.

EFFECTIVENESS:

Effectiveness depends on the user:

- 1) Risk of pregnancy is greatest when a woman is late to start a new ring.
- 2) As commonly used, about 7 pregnancies per 100 women using the combined vaginal ring over the first year. This means that 93 of every 100 women using the combined vaginal ring will not become pregnant.
- 3) When no mistakes are made with use of the combined vaginal ring, less than 1 pregnancy per 100 women using the combined vaginal ring over the first year (3 per 1,000 women).
- 4) There is no delay in return of fertility after discontinuation.
- 5) No protection against sexually transmitted infections.

SIDE EFFECTS:

Some users report the following:

1. Changes in bleeding patterns, including:
 - a) Lighter bleeding and fewer days of bleeding.
 - b) Irregular bleeding.
 - c) Infrequent bleeding.
 - d) Prolonged bleeding.
 - e) No monthly bleeding.
2. Headaches.
3. Irritation, redness, or inflammation of the vagina (vaginitis).
4. White vaginal discharge.

KNOWN HEALTH BENEFITS AND HEALTH RISKS:

Long-term studies of the vaginal ring are limited, but researchers expect that its health benefits and risks are like those of combined oral contraceptives

MEDICAL ELIGIBILITY CRITERIA:

MEC for the combined ring are same as for combined oral contraceptives and combined patch

SESSION 4

TITLE: STEPS IN COMBINED VAGINAL RING USAGE

(25 MINUTES)

OUTLINE & OBJECTIVES:

To learn steps of using vaginal ring including removal and replacement

METHODOLOGY:

Small presentation

Handout: (H17.4)

Job Aid: (J17.4)

STEPS IN VAGINAL RING REMOVAL AND REPLACEMENT HANDOUT (H-17.4)

1- Explain how to insert the ring	<ol style="list-style-type: none">1) The user can choose the position most comfortable for her, for example, standing with one leg up, squatting, or lying down.2) She should press opposite sides of the ring together and gently push the folded ring entirely inside the vagina.3) The exact position is not important, but inserting it deeply helps it to stay in place, and she is less likely to feel it. The muscles of the vagina naturally keep the ring in place.
2- Explain that the ring must be left in place for 3 weeks	<ol style="list-style-type: none">1) She should leave the ring in place at all times, every day and night for 3 weeks.2) She can take the ring out at the end of the third week and dispose of it in a waste receptacle.
3- She should take out the ring for the fourth week	<ol style="list-style-type: none">1) To remove the ring, she can hook her index finger inside it, or squeeze the ring between her index and middle fingers and pull it out.2) She will probably have monthly bleeding this week.3) If she forgets and leaves the ring in for as long as a fourth week, no special action is needed.
4- Ring should never be left out for more than 48 hours until the fourth week	<ol style="list-style-type: none">1) The ring can be removed for sex, cleaning, or other reasons, although removing it is not necessary and is not recommended because some women forget to put it back within 48 hours.2) If the ring slips out, she should rinse it in clean water and immediately reinsert it.

PICTORIAL TO HELP THE WOMAN IN INSERTION Job Aid (J17.4)

Squeeze the ring between your thumb and index finger (figure 1).

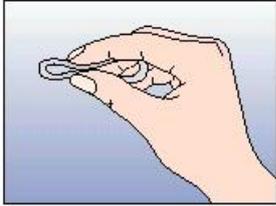


FIGURE 2

Gently insert the ring into your vagina (figure 2). It doesn't have to be in any exact position. If it feels uncomfortable, slide it further into your vagina. Your vaginal muscles will keep it in place, even during exercise and sex

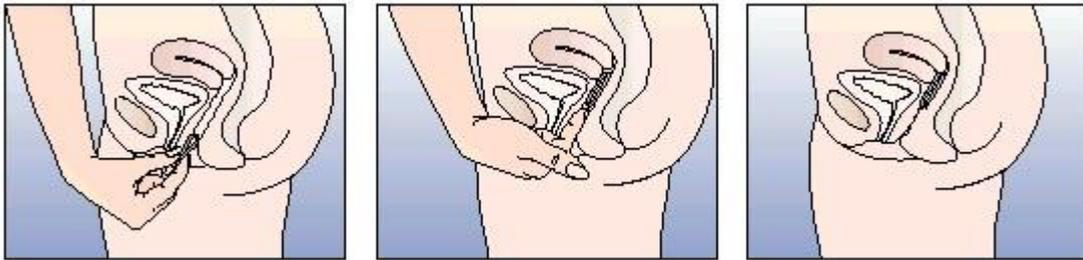


FIGURE 3

To remove the ring simply put your finger into your vagina, hook it around the ring and pull it out (figure 3).

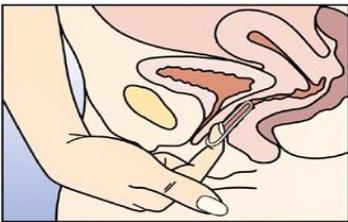


FIGURE 4

INSTRUCTIONS FOR LATE REPLACEMENT AND REMOVAL

<p>Left ring out for 48 hours or less during weeks 1 through 3?</p>	<ul style="list-style-type: none"> • Put the ring back in as soon as possible. • No need for a backup method.
<p>Left ring out for more than 48 hours during weeks 1 or 2?</p>	<ul style="list-style-type: none"> • Put the ring back in as soon as possible. • Use a backup method* for the next 7 days. • If the ring was left out for more than 48 hours in the first week and unprotected sex occurred in the previous 5 days, consider taking emergency contraceptive pills
<p>Left ring out for more than 48 hours during week 3?</p>	<ul style="list-style-type: none"> • Put the ring back in as soon as possible. • Use a backup method* for the next 7 days. • Start a new ring at the end of the third week and skip the ring-free week. If unable to start the new ring at the end of the third week, use a backup method and keep using it through the first 7 days after starting a new ring.
<p>Forgot to insert a new ring at beginning of the cycle?</p>	<ul style="list-style-type: none"> • Insert a new ring as soon as possible. If late by only 1 or 2 days (48 hours or less)—that is, the ring is left out no longer than 9 days in a row—no need for a backup method. • Keep the same ring removal day. • If the new ring is inserted more than 2 days (more than 48 hours) late—that is, the ring is left out 10 days or more in a row—use a backup method for the first 7 days of ring use. • Also, if unprotected sex occurred in the past 5 days, consider taking emergency contraceptive pills
<p>Kept ring in longer than 3 weeks?</p>	<ul style="list-style-type: none"> • If the same ring is used for up to 28 days (4 weeks), no backup method is needed. She can take a ring-free week or start a new ring immediately. • If the same ring is used for 28 to 35 days (more than 4 weeks but less than 5 weeks), insert a new ring and skip the ring-free week. No backup method is needed.

SESSION 5

TITLE: OVERVIEW OF PROGESTERONE RELEASING VAGINAL RING

(10 MINUTES)

OUTLINE & OBJECTIVES:

To learn steps of using progesterone releasing vaginal ring including removal, replacement, and its effectiveness.

METHODOLOGY:

- 1) Brain storming.
- 2) Small presentation.

Handout: (H17.5)

OVERVIEW OF PROGESTERONE RELEASING VAGINAL RING

HANDOUT (H-17.5)

A smooth, soft, flexible silicone ring placed in the vagina to prolong lactational amenorrhea and help breastfeeding women space pregnancies. It continuously releases natural progesterone hormone, like that in a woman's body from inside the ring. The hormone passes through the wall of the vagina directly into the bloodstream. This ring does not contain oestrogen.

The progesterone vaginal ring is suitable for post-partum women, who are actively breast feeding, at least 4 times per day. The ring is a suitable option for women who have a 4 weeks old baby and who are planning to breast feed and whose menstrual cycles have not returned 4weeks after giving birth.

Each ring is kept in place for 90 days. The woman can then replace it with a new ring immediately. Up to 4 rings can be used, one after another, with no breaks. Works by preventing ovulation

EFFECTIVENESS:

- 1) One or 2 pregnancies per 100 women using the progesterone releasing vaginal ring for a year.
- 2) No delay in return of fertility after discontinuation.
- 3) No protection against sexually transmitted infections.

SIDE EFFECTS:

Some users report the following:

- 1) Spotting or irregular bleeding.
- 2) Low abdominal pain.
- 3) Breast pain.
- 4) Vaginal discharge.

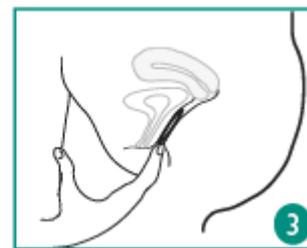
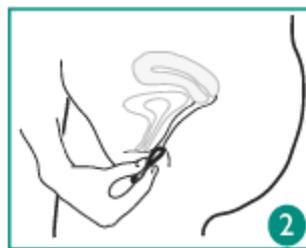
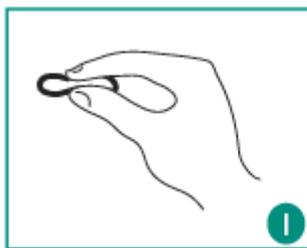
HEALTH BENEFITS

- 1) No change in breast milk production or composition; the method supports continued breastfeeding and healthy infant nutrition.
- 2) Safe and effective, based on several 1-year studies, its health risks may be like those of progestin-only pills.
- 3) Women who are actively breastfeeding and are at least 4 weeks postpartum can safely use the progesterone-releasing vaginal ring (MEC Category 1).

PROVIDING THE PROGESTERONE RELEASING VAGINAL RING

1- Explain how to insert the ring	<ol style="list-style-type: none">1. The user can choose the position most comfortable for her, for example, standing with one leg up, squatting, or lying down.2. She should press opposite sides of the ring together and, with her index finger, gently push the ring entirely inside the vagina as far as she can.3. The exact position of the ring in the vagina is not important, but inserting it deeply helps it to stay in place and the user is less likely to feel it. The muscles of the vagina naturally keep the ring in place.4. The woman should not feel the ring after she places it in the vagina. If she feels uncomfortable or can feel the ring, she might not have placed it far enough. Instruct her to use a clean finger to gently push the ring as far as she can, in the vaginal canal.5. Reassure her that there is no risk of pushing it too far up.
2- Explain that the ring must be left in place for 90 days	<ol style="list-style-type: none">1) She should keep the ring in place at all times to maintain effectiveness.2) To continue avoiding pregnancy, the user can take the ring out at the end of the 90 days and replace it immediately with a new ring. She can use 4 rings, for up to one year of use in the postpartum period.3) The ring can be disposed of in a waste receptacle.4) Disposing of the ring in a flush toilet is not recommended.

3- The ring should never be left out for more than 2 hours	<ol style="list-style-type: none"> 1) The ring should be left in place always. Some women may remove the ring for sex or for cleaning, but this is not necessary and not recommended because some women forget to put it back within 2 hours. 2) If the ring slips out completely, she should rinse it in clean water and immediately put it back in place.
4- Explain that her husband may be able to feel the ring	<ol style="list-style-type: none"> 1) This generally does not interfere with sex or decrease sexual pleasure.



Left the ring out for more than 2 hours	<ul style="list-style-type: none"> • Put the ring back in the vagina as soon as possible. • Contact your health care provider to discuss any concerns.
Left the ring out for more than 24 hours	<ul style="list-style-type: none"> • Put the ring back in as soon as possible. Use a condom if you have sex in the next 48 hours. • Contact your health care provider to discuss any concerns
Feel the ring slipping	<ul style="list-style-type: none"> • Use a clean finger to push the ring up as far into the vagina as possible
After one year of use or if no longer breastfeeding at least 4 times per day	<ul style="list-style-type: none"> • For longer birth spacing, she can plan ahead to switch to another family planning method. At least 2 years between giving birth and the next pregnancy is healthy for both mother and child.

SESSION 6

TITLE: SUMMARIZE AND WRAP UP

(10 MINUTES)

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

Highlight that although these methods are not used commonly in Pakistan. The service providers must have working knowledge about these as some clients may already be using them when they present.

FURTHER READING:

- Family Planning, a Global Handbook for Providers
- <https://www.fpnsw.org.au/health-information/contraception/vaginal-ring-nuvaring>
- <https://www.everydayhealth.com/womens-health/fda-approves-annovera-new-vaginal-ring-contraception/>

BARRIER METHODS



TIME 2 HOURS 40 MINUTES



TRAINING OBJECTIVES

The main objective of this session is to highlight the importance of barrier methods. These methods are used by a large proportion of our population but inconsistent usage results in a high failure rate. Male condom is the commonly used barrier method in Pakistan.



LEARNING OUTCOMES

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

1. Discuss various types of barrier methods and their efficacy.
2. Be able to counsel and guide the client in a competent manner.
3. Deal with the common problems associated with using male condoms.
4. Demonstrate the correct use of the condom and highlight proper disposal.
5. Understand the importance of emergency contraception as a backup method in case of failure, run out episode or accident.



ADVANCE PREPARATION

- 1) Power point presentation
- 2) Case scenarios



TRAINING/ LEARNING METHODS

1. Power Point Presentation
2. Interactive Discussion
3. Brainstorming Activity
4. Group Activity
5. Demonstration on Model



TRAINING MATERIALS

Trainer' Material	Trainee's Material
Hand Outs: H18.1, H18.2, H18.3, H18.4, H18.5a, H18.5b, H18.5c, H18.5d	Hand Outs: H18.1, H18.2, H18.3, H18.4, H18.5a, H18.5b, H18.5c, H18.5d
Activity: A18.1, A18.2, A18.3, A18.4	Job aid: J18.1
Job aid: J18.1	
PPT: PPT (18)	



CONSTITUTION OF THE SESSION

Six mini sessions will be held

1. What are the barrier methods and their effectiveness?	Lecture/interactive discussion	30 Mins
2. How to use a condom properly?	Brainstorming Activity and discussion	30 Mins
3. Advantages and disadvantages of male condoms	Group work/Feed back	25 Mins
4. Side Effects and Management	Group Work	25 Mins
5. A review of other barrier methods	Lecture/interactive discussion	40 Mins
6. Wrap up	Group work	10 mins

SESSION 1

TITLE: WHAT ARE THE BARRIER METHODS AND THEIR EFFECTIVENESS?

(30 MINUTES)

OUTLINE & OBJECTIVES:

A brief presentation including discussion about the various barrier methods. Highlight the male condom as it is freely available in Pakistan

METHODOLOGY:

Interactive power point presentation and discussion to highlight the details

Handout: (H18.1)

Activity: (A18.1)

Job Aid: (J18.1)

WHAT ARE THE BARRIER METHODS AND THEIR EFFECTIVENESS? HANDOUT (H-18.1)



(Activity 18.1)

The Condom

Give a condom to the first participant on your right side and ask about her feelings, reactions towards this “object”; after the first person has expressed her point of view, she will pass it on to the neighbor on his/her right and so on until all participants will have had the occasion of sharing their opinions regarding the condom (10 min).

Pay attention to the trainees’ non-verbal messages during this exercise; it helps to identify their attitudes towards the condom.

Barrier methods prevent the sperm from gaining access to the upper reproductive tract and making contact with the egg. They have been used since ancient times in various forms e.g. sheep gut

These methods include:

1. Male and female condoms
2. Spermicides
3. Diaphragms
4. Cervical caps.

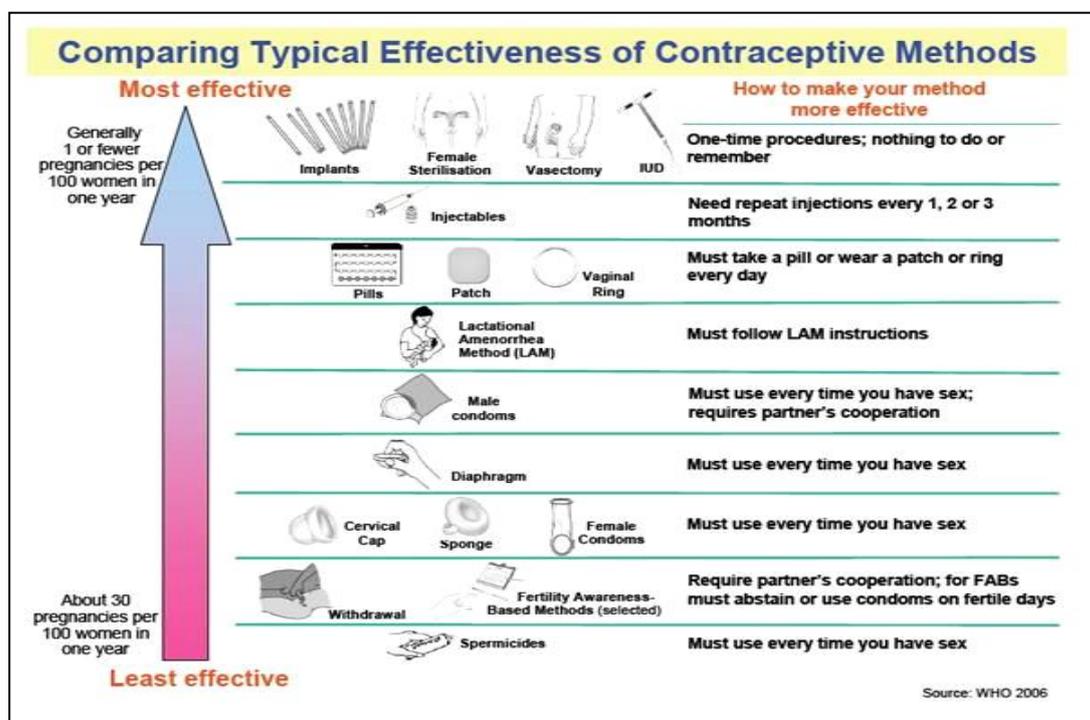
Male condoms are the commonly used method in Pakistan, the rest of the methods are detailed for knowledge purposes. Whereas condoms, diaphragms, and cervical caps are mechanical barriers, spermicides are chemicals that interfere with the movement of the sperm and its ability to fertilize the egg.

EFFECTIVENESS:

The effectiveness of barrier methods is largely dependent on the way in which they are used. For example, condoms are only moderately effective in typical use (18 percent pregnancy rate), but much more effective when used consistently and correctly (2 percent pregnancy rate).

Male and female condoms help prevent both pregnancy and most STIs (including HIV), because when used correctly, the condoms keep sperm and any disease organisms in semen out of the vagina; also, they prevent any disease organisms in the vagina from entering the penis. Another advantage of barrier method is that, with the exception of the male condom, all the barrier methods are controlled by women, and almost every woman can use them. Barrier methods can be used without restriction (i.e., they are included in MEC category 1)

Effectiveness of Contraceptive Methods Job Aid (J18.1)



FEMALE CONDOMS:

The Female Condom (FC) is a viable option for women to protect themselves from pregnancy and STIs including HIV. Female condom is the only currently available method which woman

can initiate and in some ways control, which provides dual protection from both unwanted pregnancy and STIs including HIV.

The female condom is a thin, soft, loose-fitting polyurethane plastic pouch-like device that lines the vagina. It has two flexible rings, an inner ring at the closed end, used to insert the device inside the vagina and hold it in place, and an outer ring which remains outside the vagina and covers the external genitalia.

CERVICAL CAPS:

A soft, deep, latex or plastic rubber cup that snugly covers the cervix. It comes in different sizes; requires fitting by a specifically trained provider.

SPERMICIDE:

Sperm-killing substances inserted deep in the vagina, near the cervix, before sex. Available in foaming tablets, melting or foaming suppositories, cans of pressurized foam, melting film, jelly, and cream in some private sectors. Spermicides work by causing the membrane of sperm cells to break, killing them or slowing their movement. This keeps sperm from meeting an egg.

DIAPHRAGMS:

A soft latex cup that covers the cervix. Plastic and silicone diaphragms may also be available. The rim contains a firm, flexible spring that keeps the diaphragm in place. Used with spermicidal cream, jelly, or foam to improve effectiveness.

Diaphragms come in different sizes and require fitting by a specifically trained provider. A one-size-fits-all diaphragm is now available. It does not require seeing a provider for fitting. Works by blocking sperm from entering the cervix; spermicide kills or disables sperm. Both keep sperm from meeting an egg.

Currently in Pakistan, the use of diaphragms, cervical caps, and spermicides is negligible

WHAT ARE MALE CONDOMS?

Sheaths, or coverings, that fit over a man's erect penis. Also called rubbers, "raincoats," "umbrellas," "skins" or "ghubaras"; known by many different brand names. Most are made of thin latex rubber. Some condoms are coated with a lubricant or with spermicide. Condoms may be available in different size, shapes, colours and textures. Work by forming a barrier that keeps sperm out of the vagina, preventing pregnancy. Also keep infections in semen, on the penis, or in the vagina from infecting the other husband.

Condom is a simple but highly effective method of contraception if used correctly and consistently. It holds a special place among the contraceptives due to the dual protection it provides both from unwanted pregnancy as well as sexually transmitted infections. It is one of the methods of contraception which ensures male involvement in preventing unwanted births. The higher failure rate of condoms is mostly due to its inappropriate use by the clients, which in turn is partly due to inadequate client instructions by the FP providers.

1- How effective are condoms:

If the husband of 100 women start using condoms, with typical use there is likelihood of 14 of these women getting pregnant in the first year of use of condoms. With correct and consistent use every time, there are 3 pregnancies per 100 women in the first year of use.

2- Prevent transmission of sexually transmitted infections:

Condoms are the best protection against catching STIs or transmitting STIs to one's husband. Condoms can stop sexual transmission of many diseases including HIV/AIDS, Gonorrhoea, Syphilis, Chlamydia, and Trichomoniasis. Condoms probably protect somewhat, but not as well, against herpes, genital wart virus (HPV), and other diseases that can cause sores on the skin not covered by condoms.

COUNSELLING:

Couples desiring to use condoms often benefit from specific instructions. It is helpful to use a model and actual condom. Counsel new users about:

- 1) Options among condom types
- 2) Storage for safety and ready access
- 3) How to negotiate condom use with husband
- 4) When to place condom on
- 5) How to use the condom correctly
- 6) Both husband and wife must agree to use condoms

If the condom breaks, the clients must use emergency contraception to prevent pregnancy.

Provide the following information on care for condoms:

- 1) Store condoms in a cool, dark place, if possible as heat and light damage condoms.
- 2) If possible, use lubricated condoms that come in square wrappers and are packaged so that light does not reach them.
- 3) Water based lubrication may help prevent tears.
- 4) Handle condoms carefully, fingernails and rings can tear them.
- 5) Do not unroll condoms before use, this may weaken them. Also, an unrolled condom is difficult to put on.
- 6) Don't use condom if more than 5 years of date of manufacture or damaged package, is

uneven or changed in colour, feels brittle, dried out, or very sticky.

- 7) Do not use the same condom for multiple sexual contacts or multiple times with same sexual contact

MEDICAL ELIGIBILITY:

Only one condition prevents use of condoms - severe allergy to latex rubber (severe redness, itching swelling after condom use). If the client is at risk of STIs or HIV, she/he should continue to use condoms during sexual intercourse despite the allergy. In general, anyone can use condoms safely and effectively if not allergic to latex

SESSION 2

TITLE: HOW TO USE A CONDOM PROPERLY?

(TIME 30 MINUTES)

OUTLINE & OBJECTIVES:

Demonstration of proper use of condom

METHODOLOGY:

Steps in condom use through cards and demonstration on model eg by using a banana. Discuss lubricants, which type not to be used

Handout: (H18.2)

Activity: (A18.2)

HOW TO USE A CONDOM PROPERLY?

HANDOUT (H-18.2)



(Activity A18.2)

Steps in proper condom usage

Hand each participant a card containing a “step” in the condom use. Ask participants to get up from their chairs and to find the right place, in a logical time frame, forming a circle. **(10 min)**

If the number of trainees does not correspond to the number of cards, you might ask them to work in small groups, each group receiving a set of cards; within each group, the cards will be placed in order according to the correct steps in condom use.

The trainer then closes the discussion with any additions needed

CARD FOR STEPS IN CONDOM USAGE

Eliminate the air from the tip of the condom	Sexual intercourse	Open the package
The penis becomes erect	Man ejaculates	Carefully remove the condom
Throw the condom in the garbage can	Withdraw the penis before it becomes flaccid	Place the unrolled condom on the tip of the penis
Bend the penis and carefully remove the condom	Check the expiry date	Maintain the condom at the base of the penis
Both husband and wife are sexually aroused	Tie a knot at the end of the condom	Unroll the condom all the way to the base of the penis

Explain why using a condom every time is important

- 1) Just one unprotected act of sexual intercourse can lead to pregnancy or transmission of STIs.
- 2) Looking at a person cannot tell you if he/she has STIs. A person with STIs and HIV can look perfectly healthy.
- 3) A person cannot always tell if he or she has STI, including HIV.

Whenever possible, show the client how to put on and take off a condom. Use a model, a stick or banana or 2 fingers to demonstrate putting on condom. Suggest to a new user (wife or husband) user that the husband should practice putting on the condom by himself before he has next sexual intercourse.

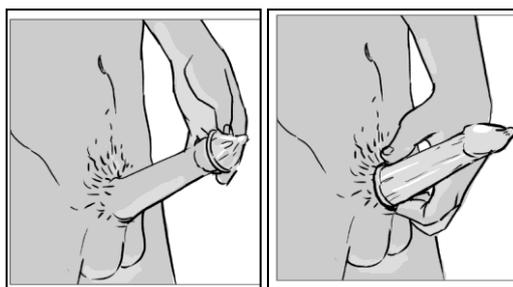


FIGURE 5 (c)

FIGURE 1(D)

Give the following specific instructions:

- 1) Put the condom on the erect penis before the penis touches the vagina:
 - a. Hold the pack at its edge and open by tearing from a ribbed edge.
 - b. Hold the condom so that the rolled rim is facing up, away from penis.
 - c. Place the condom on the tip of penis.
 - d. Unroll the condom all the way to the base of the penis. The condom should unroll easily. If it does not, it is probably backwards. If more condoms are available, throw this one away and use a new condom.
- 2) Most of the condoms are already lubricated; hence there is no need to apply any additional lubricant, this may damage the condom.
- 3) After sexual intercourse (ejaculation), hold the rim of the condom to the base of the penis so it will not slip. The man should pull his penis out of the vagina before completely losing his erection.
- 4) Move away from vagina and take off the condom without soiling semen on the vaginal opening.
- 5) Tie a knot at the rim of the condom.
- 6) Dispose it off by throwing into the garbage
- 7) Do not leave it where children will find it.
- 8) Never use a male condom more than once.

IF THE CONDOM BREAKS

Using an additional method of birth control is necessary as a backup measure in case the condom breaks. However, the best way would be to use emergency contraceptive pills to prevent pregnancy. Emergency contraceptive pills should be a part of the initial counselling of the couple who intend to use condoms. If not, washing both penis and vagina with soap and water should reduce the risk of STIs and pregnancy. If spermicide is available, immediately insert a spermicide into the vagina.

SESSION 3

TITLE: ADVANTAGES AND DISADVANTAGES OF MALE CONDOMS

(25 MINUTES)

OUTLINE & OBJECTIVES:

Reinforce and discuss in detail the advantages and disadvantages of male condoms

METHODOLOGY:

Brainstorming, feedback, and group discussion

Handout: (H18.3)

Activity: (A18.3)

ADVANTAGES AND DISADVANTAGES OF MALE CONDOMS

HANDOUT (H-18.3)



(Activity A18.3)

–

Ask participants to list advantages and disadvantages of male condoms
Write down each statement on a flipchart paper divided into two columns, one for advantages and the other for disadvantages.

Review the elements proposed by the participants, offer additional information, corrections if necessary

ADVANTAGES:

- 1) Does not involve the use of hormones.
- 2) Condoms offer contraception only when needed.
- 3) Condoms are easy to obtain, can be purchased from a chemist's shop and can be used without seeing a health care provider.

- 4) Helps prevent the pathological states caused by STIs – pelvic inflammatory disease, chronic pain, infertility, cervical cancer. They may be used during pregnancy for STIs prevention.
- 5) They do not have side-effects; they are harmless.
- 6) They may be used by women while breastfeeding.
- 7) Freely available.
- 8) If a pregnancy is desired, the usage can be simply discontinued.
- 9) Helps prevent premature ejaculation.
- 10) Involves the man in contraception decisions.
- 11) Can be used soon after childbirth.
- 12) Safe, no hormonal side effects.
- 13) Offer occasional contraception with no daily upkeep.
- 14) Easy to keep at hand in case sex occurs unexpectedly.
- 15) Can be used by men of any age.
- 16) Can be used as a regular, temporary, or backup method.
- 17) Condoms are easy to use with a little practice.
- 18) There is no health risk associated with this method.
- 19) Condoms do not interfere with the act of intercourse.
- 20) No method related health risk.
- 21) Readily reversible birth control method for men.
- 22) Protection against STIs. By using a condom, which essentially creates a barrier preventing exchange of bodily fluids, many common sexually transmitted diseases such as HIV/AIDS can be avoided. This is a major advantage for those not in a committed relationship.
- 23) Condoms do not physically alter the fertility of the person using them. They are a single time “use and throw” contraception method. There is no hindrance to the person being able to conceive the very next time they want to have sex.

LIMITATIONS:

- 1) Efficacy is low and user dependent.
- 2) Latex condoms may cause itching for a few people who are allergic to latex. Also, some people may be allergic to the lubricant on some brands of condoms.
- 3) The couple must take the time to put the condom on the erect penis before sex.
- 4) Small possibility that condom might slip off or break during sexual intercourse.
- 5) If not properly stored or if used with oil-based lubricants, condoms can go weak and break.
- 6) Some people are allergic to latex or spermicides. They can use lambskin or polyurethane condoms, which are not as effective and not commonly available in Pakistan.
- 7) May break or slip off during intercourse if not used correctly, or with not enough lubricant.

- 8) A new condom must be used with each act of intercourse.
- 9) Condoms cannot be used with oil-based lubricants, only water-based ones. Oil-based lubricants can cause the latex material of the condoms to disintegrate and the condom may tear during actual intercourse.
- 10) They may decrease sensations during sexual intercourse.
- 11) High level of motivation is required to use a condom consistently and correctly.
- 12) The man's cooperation is needed.
- 13) Requires proper disposal.
- 14) For some women discussion with the husband regarding the use of condoms may be embarrassing.

SESSION 4

TITLE: SIDE EFFECTS AND MANAGEMENT

(25 MINUTES)

OUTLINE & OBJECTIVES:

Reinforce and discuss in detail the side effects and management of male condoms

METHODOLOGY:

Brain storming, and group discussion

Handout: (H18.4)

Activity: (A18.4)

SIDE EFFECTS AND MANAGEMENT

HANDOUT (H-18.4)



Activity (A18.4)

Divide participants into two groups and ask them to list possible side effects of male condoms and their management. Review the elements proposed by the participants, offer additional information, corrections if necessary.

SIDE EFFECT OR PROBLEM	MANAGEMENT
Condom broken before or after use	<p>Before use: advise to use a new condom.</p> <p>After use: advise to wash the genitalia with soap and water immediately. Provide emergency contraception.</p>
Local irritation to penis or vagina	If allergic to latex, counsel for another method.
Diminished sexual pleasure	Counsel for another method.
Allergy or irritation (very rare)	<p>In case of a latex allergy, advise couple to use another method. Rule out infection.</p> <p>If the lubricant is a cause of irritation, suggest using water as a lubricant.</p> <p>Note: Clients at risk of STI and HIV/AIDS should be counselled to continue to use condoms despite discomfort as long as they are at risk. If irritation is unacceptable to the client, assist in choosing another method, including the female condom, which is made of polyurethane.</p>
In case of spillage or breakage	Offer ECP and counsel on HIV/AIDS and STIs.
Man cannot maintain an erection while putting on or using a condom	<p>Often due to embarrassment. Discuss how to make condom use more enjoyable and less embarrassing. If a woman put on condom for a man, this may make use more enjoyable. Explain that, with experience, more couples are less embarrassed.</p> <p>Suggest a small amount of water or water-based lubricant on the penis and extra lubricant on the outside. This may increase sensation and help maintain an erection.</p>

SESSION 5

TITLE: A REVIEW OF OTHER BARRIER METHODS

(40 MINUTES)

OUTLINE & OBJECTIVES:

A brief presentation including discussion about other barrier methods. Highlighting the female condoms, cervical caps and diaphragms, their effectiveness

METHODOLOGY:

Group discussion

Handout: (H18.5a), (H18.5b), (H18.5c), (H18.5d)

FEMALE CONDOMS-

HANDOUT (H-18.5 A)

A female condom is a thin sheath or lining that fit loosely inside a woman's vagina. It is made of thin, transparent, soft film of soft transparent polyurethane plastic, about 7 cm to 8 cm in diameter and 17 cm long. It has two flexible rings. One ring has a smaller diameter and found at the closed end of the condom, which aids the woman in inserting it high within the vagina near the cervix; the other is wider and found at the open end covering the vulva when properly positioned.

Female condoms are made of various materials, such as latex, polyurethane, and nitrile. A female condom works by forming a barrier that keeps sperms out of the vagina, thus preventing pregnancy, STIs, HIV/AIDS and Hepatitis C.

HOW EFFECTIVE IS THE FEMALE CONDOM?

The effectiveness of this method depends on the user.

- 1) When typically used, about 21 per 100 women using female condoms become pregnant over the first year of use.
- 2) When used correctly with every sexual intercourse, about 5 of 100 women using female condoms become pregnant over the first year of use.

WHAT COUNSELLING TIPS SHOULD BE PROVIDED TO A CLIENT WHO CHOOSES TO USE THE FEMALE CONDOM?

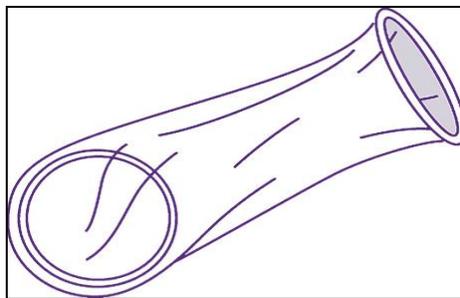
- 1) Reuse of the female condom is not recommended. Always use a new female condom every sexual intercourse.
- 2) Help the client to choose another method if she is not comfortable with using a female condom.
- 3) For clients at risk of STIs and HIV, urge the continued use of female condoms despite discomfort.
- 4) Ensure that the client understands the correct use of female condoms. Ask the client to demonstrate while explaining the basic steps in using a female condom.
- 5) Explain why using a new condom with every sexual intercourse is important and that one unprotected sexual intercourse can lead to pregnancy, STI, or both. Encourage the client to always use a condom as an FP method or as a protection against STIs, including HIV.
- 6) Discuss the different approaches or skills that can be applied for negotiating condom use with husband.

HOW IS THE FEMALE CONDOM USED?

A client can start the method any time she wants. The following steps must be followed by the user when using a condom before sexual intercourse:

- 1) Check the female condom package for any damage, including the expiry date. Do not use a female condom past its expiration date. It is preferable if she can wash her hands with mild soap and clean water before inserting the female condom into the vagina.
- 2) Insert the condom into the vagina before any physical contact.
- 3) Insert the condom within 8 hours before sex. To achieve the most protection, insert the condom before the penis comes into contact with the vagina.
- 4) Assume a position that is comfortable for insertion: squatting, raising one leg, sitting, or lying down.
- 5) Rub the sides of the female condom gently together to spread the lubricant evenly.
- 6) Grasp the ring at the closed end, and squeeze it so it becomes long and narrow.
- 7) With the other hand, separate the outer lips of the vagina (labia), and locate the vaginal canal.
- 8) Gently push the inner ring into the vagina as far up as it will go. Insert a finger into the condom to push it in into place. Allow about 2 cm to 3 cm of the condom and the outer ring to cover the outside the vagina.
- 9) Ensure that the penis enters the condom and stays inside the condom during sexual intercourse.

- 10) The man or woman should carefully guide the tip of the penis inside the condom, not between the condom and the wall of the vagina. If the penis goes outside the condom, withdraw, and try again.
- 11) If the condom is accidentally pulled out of the vagina or pushed into it during sex, put the condom back in place.
- 12) After the man withdraws his penis, hold the outer ring of the condom, twist to seal in fluids, and gently pull it out of the vagina.
- 13) The female condom does not need to be removed immediately after sex.
- 14) Remove the condom before standing up, to avoid spilling the semen.
- 15) If the couple has sex again, they should use a new condom.
- 16) Reuse of female condoms is not recommended.
- 17) Wrap the used condom in its package, and put it in the rubbish



FEMALE CONDOM

WHO CAN AND CANNOT USE THE FEMALE CONDOM?

Except for allergy to the condom material, no medical conditions prevent the use of this method.

THE HEALTH BENEFITS OF THE FEMALE CONDOM

Known health benefits of female condoms include protection against risk of pregnancy and STIs, including HIV.

SIDE EFFECTS OF THE FEMALE CONDOM

- 1) Mild irritation in or around the vagina
- 2) Apply lubricant on the part of the condom that comes into contact with the vaginal wall.
- 3) If symptoms persist, assess and refer the client to a specialist for the treatment of possible vaginal infection or STI.

WHAT SHOULD BE INQUIRED FROM OR ADVISED TO THE CLIENT DURING FOLLOW-UP?

- 1) Ask how the client is doing with the method and whether she is satisfied.
- 2) Ask if she has any questions or anything to discuss.
- 3) Ask if she has any trouble using a female condom correctly every time, she has sex.
Give her any information or help that she needs.
- 4) Enquire from a long-term client any major life changes that may affect her needs, particularly plans for having children and about the risk of STIs or HIV.
- 5) Follow up as needed.

MEDICAL ELIGIBILITY CRITERIA FOR FEMALE CONDOMS

- 1) All women can use female condoms, except those with severe allergic reaction to latex.
- 2) In special circumstances, such as high risk of STIs or HIV, if non-latex condoms are not available, a qualified provider who can carefully assess the woman's or man's condition and situation may decide that she or he can use latex condoms.
- 3) Condoms made from materials other than latex do not cause allergic reactions.

MANAGING ANY PROBLEMS

PROBLEMS WITH USE

May or may not be due to the method:

Problems with condoms affect clients' satisfaction and use of the method. They deserve the provider's attention. If the client reports any problems, listen to her concerns and give advice and support. Make sure she understands the advice and agrees. Offer to help the client choose another method now, if she wishes, or if problems cannot be overcome unless condoms are needed for protection from STIs, including HIV.

1) **Difficulty inserting the female condom:**

Ask the client how she inserts a female condom. If a model is available, ask her to demonstrate and let her practice with the model. If not, ask her to demonstrate using her hands. Correct any errors.

2) **Inner ring uncomfortable or painful**

Suggest that she reinsert or reposition the condom so that the inner ring is tucked back behind the pubic bone and out of the way.

3) Condom squeaks or makes noise during sex

Suggest adding more lubricant to the inside of the condom or onto the penis.

4) Condom slips, is not used, or is used incorrectly:

- a. ECPs can help prevent pregnancy
- b. Refer for possible post-exposure prophylaxis against HIV and possible presumptive treatment against other STIs. If the client has signs or symptoms of STIs after having unprotected sex, assess or refer.
- c. If a client reports slips, she may be inserting the female condom incorrectly. Ask her to show how she is inserting the condom, using a model or demonstrating with her hands. Correct any errors.

5) Difficulty persuading husband to use condoms or not able to use a condom every time

Discuss ways to talk with her husband about the importance of condom use for protection from pregnancy and STIs.

6) Mild irritation in or around the vagina or penis (itching, redness, or rash)

- a. Usually goes away on its own without treatment.
- b. Suggest adding lubricant to the inside of the condom or onto the penis to reduce rubbing that may cause irritation.

If symptoms persist, assess and treat for possible vaginal infection or STI, as appropriate.

1. If there is no infection, help the client choose another method unless the client is at risk for STIs, including HIV.
2. For clients at risk of STIs, including HIV, suggest using male condoms. If using male condoms is not possible, urge continued use of female condoms despite discomfort.
3. If neither husband has an infection, a mutually faithful sexual relationship provides STI protection without requiring condom use but does not protect against pregnancy.

SUSPECTED PREGNANCY:

- 1- Assess for pregnancy
- 2- A woman can safely use female condoms during pregnancy for continued STI protection

DIAPHRAGM

HANDOUT (H18.5 B)

WHAT IS A DIAPHRAGM?

A diaphragm is a soft latex cup that covers the cervix when used as an FP method.

The cup is provided with a rim that is firm with a flexible spring that keeps the diaphragm in place. It is used with a spermicidal cream, jelly, or foam to improve effectiveness. It comes in different sizes and requires fitting by a trained provider.

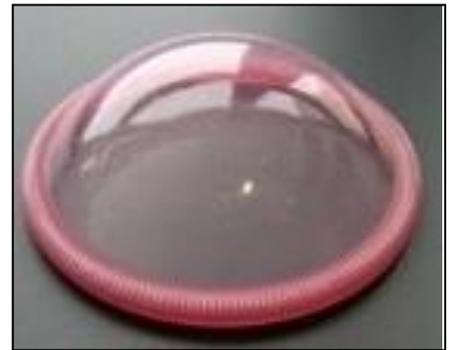
A one-size-fits-all diaphragm is becoming available. It does not require seeing a provider for fitting. It works by blocking sperm cells from entering the cervix while the spermicide kills or disables the sperm from meeting the egg.

HOW EFFECTIVE IS THE DIAPHRAGM?

The effectiveness of this method depends on the user.

The risk of pregnancy is greatest when the diaphragm with spermicide is not used during every sexual intercourse.

- 1) When typically used, about 17 of 100 women who use the diaphragm with spermicide become pregnant over the first year. This means that 83 of every 100 women using the diaphragm will not become pregnant.
- 2) When used correctly with every sexual intercourse, about 16 of 100 women who use the diaphragm with spermicide become pregnant over the first year.
- 3) A diaphragm may provide some protection against certain STIs but should not be relied on as the only protection against STIs.



HOW IS THE DIAPHRAGM USED?

A client can use a diaphragm any time but must wait for six weeks if the client had a full-term delivery or had a second trimester abortion. The provider of this method must observe the following steps:

- 1) Use proper infection prevention procedures.
- 2) Instruct the client to assume a lithotomy position for a pelvic examination, and assess for conditions (e.g., uterine prolapse) that may make the diaphragm improper to use.
- 3) Perform an internal examination to assess the cervix and determine the diaphragm size.

- 4) Insert a special fitting diaphragm into the client's vagina, and apply it to cover the cervix, making sure that the diaphragm fits properly and does not come out easily.

The following steps must be observed by the user when using a diaphragm:

- 1) Check the diaphragm for any damage, including the expiration date of the spermicide. Insert the diaphragm less than six hours before having sex.
- 2) After hand washing with soap and water, squeeze a spoonful of spermicidal cream, jelly, or foam into the diaphragm and around the rim.
- 3) Press the rim together to ease the insertion of the device into the vagina. Assume a position that is comfortable for insertion: squatting, raising one leg, sitting, or lying down. While holding the diaphragm with the fingers pressing on the rim, insert the diaphragm into the vagina until the cervix is felt, and then apply it to cover the cervix.
- 4) Feel the diaphragm and the rim to make sure that it covers the entire cervix, fits properly, and does not come out easily.
- 5) Keep the diaphragm in place for at least 6 hours after having sex but no longer than 24 hours. For multiple sexual intercourse, make sure that the diaphragm is in the correct position, and insert additional spermicide in front of the cap before each sexual intercourse.
- 6) To remove the diaphragm, wash hands with soap and water, insert finger to feel for the rim, then gently slide a finger under the rim of the diaphragm to pull it down and out.
- 7) Wash the diaphragm with mild soap and water and dry it after each use.

CORRECTING MISUNDERSTANDINGS

- 1) Do not affect the feeling of sex. A few men report feeling the diaphragm during sex, but most do not.
- 2) Cannot pass through the cervix. They cannot go into the uterus or otherwise get lost in the woman's body.
- 3) Do not cause cervical cancer.

WHO CAN AND CANNOT USE DIAPHRAGMS:

Safe and Suitable for Nearly All Women Nearly all women can use the diaphragm safely and effectively.

MEDICAL ELIGIBILITY CRITERIA FOR DIAPHRAGMS

Ask the client the questions below about known medical conditions. Examinations and tests are not necessary. If she answers "no" to all of the questions, then she can start using the

diaphragm if she wants. If she answers “yes” to a question, follow the instructions. In some cases, she can still start using the diaphragm. These questions also apply to the cervical cap

1- Have you recently had a baby or second trimester abortion? If so, when?

NO YES

The diaphragm should not be fitted until 6 weeks after childbirth or second-trimester abortion, when the uterus and cervix have returned to normal size. Give her a backup method* to use until then.

2- Are you allergic to latex rubber?

NO YES

She should not use a latex diaphragm. She can use a diaphragm made of plastic.

3- Do you have HIV infection? Do you think you are at high risk of HIV infection? (Discuss what places a woman at high risk for HIV—for example, her husband has HIV.)

NO YES

Do not provide a diaphragm. For HIV protection, recommend using condoms alone or with another method.

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.

USING CLINICAL JUDGMENT IN SPECIAL CASES OF DIAPHRAGM USE

Usually, a woman with any of the conditions listed below should not use the diaphragm. 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 the diaphragm with spermicide. The provider needs to consider the severity of her condition and, for most conditions, whether she will have access to follow-up.

- 1) History of toxic shock syndrome
- 2) Allergy to latex, especially if the allergic reaction is mild
- 3) HIV infection

WHAT ARE THE HEALTH BENEFITS, RISKS, AND COMPLICATIONS OF DIAPHRAGM USE?

The diaphragm protects against the risk of pregnancy.
The known health risks include:

- 1- Urinary tract infection

- 2- Bacterial vaginosis
- 3- Candidiasis.

The side effects may include vaginal lesions or irritation in or around the vagina or penis.

HOW ARE THE SIDE EFFECTS ADDRESSED?

- 1) Women with allergic reactions to a latex rubber-made diaphragm should use a plastic-made diaphragm.
- 2) The provider can counsel the client to use other effective methods.

WHAT IMPORTANT INFORMATION SHOULD BE PROVIDED TO THE CLIENT WHO CHOOSES TO USE THE DIAPHRAGM?

- 1) Ensure that the client understands the correct use of the diaphragm by allowing her to repeat how and when to insert and remove the diaphragm.
- 2) Explain that the procedure becomes easier with time, i.e., the more practice she has with inserting and removing the diaphragm, the easier it will get.
- 3) Describe common side effects, such as itching and irritation in or around the vagina or penis and how to go about it.
- 4) Clarify that a diaphragm that becomes thin, damaged, or stiff should not be used and should be replaced. The diaphragm should be replaced every two years.

WHAT SHOULD BE INQUIRED FROM OR ADVISED TO THE CLIENT DURING FOLLOW-UP?

- 1) Ask how the client is doing with the method and whether she is satisfied.
- 2) Ask if she has questions or anything to discuss.
- 3) Ask if she has any trouble using a diaphragm correctly every time she has sex. Give her any information or help that she needs.
- 4) Ask a long-term client if she has had any new health problems since her last visit. Address problems accordingly.
- 5) Inquire from a long-term client any major life changes that may affect her needs, particularly plans for having children and about the risk of STIs or HIV.

EXPLAINING HOW TO USE THE DIAPHRAGM

Whenever possible, show the woman the location of the pubic bone and cervix with a model or a picture. Explain that the diaphragm is inserted behind the pubic bone and covers the cervix.

Explain the 5 Basic Steps to Using a Diaphragm. This can be demonstrated on pelvic model or mannequin

- 1) **Squeeze a spoonful of spermicidal cream, jelly, or foam into the diaphragm and around the rim:**
 - a. Wash hands with mild soap and clean water, if possible.
 - b. Check the diaphragm for holes, cracks, or tears by holding it up to the light.
 - c. Check the expiration date of the spermicide and avoid using any beyond its expiration date.

- 2) **Press the rim together; push into the vagina as far as it goes**
 - a. Insert the diaphragm less than 6 hours before having sex.
 - b. Choose a position that is comfortable for insertion squatting, raising one leg, sitting, or lying down.

- 3) **Feel diaphragm to make sure it covers the cervix**
 - a. Through the dome of the diaphragm, the cervix feels like the tip of the nose.
 - b. If the diaphragm feels uncomfortable, take it out and insert it again.

- 4) **Leave in place for at least 6 hours after sex**
 - a. Leave the diaphragm in place at least 6 hours after having sex but no longer than 24 hours.
 - b. Leaving the diaphragm in place for more than one day may increase the risk of toxic shock syndrome. It can also cause a bad odour and vaginal discharge. (Odour and discharge go away on their own after the diaphragm is removed.)
 - c. For multiple acts of sex, make sure that the diaphragm is in the correct position and insert additional spermicide in front of the diaphragm before each act of sex.

- 5) **To remove, slide a finger under the rim of the diaphragm and pull it down and out**
 - a. Wash hands with mild soap and clean water, if possible.
 - b. Insert a finger into the vagina until the rim of the diaphragm is felt.
 - c. Gently slide a finger under the rim and pull the diaphragm down and out. Use care not to tear the diaphragm with a fingernail.
 - d. Wash the diaphragm with mild soap and clean water and dry it after each use.

MANAGING ANY PROBLEMS:

Problems Reported as Side Effects or Problems with Use
May or may not be due to the method.

- 1) Side effects or problems with diaphragms affect women's satisfaction and use of the method. They deserve the provider's attention. If the client reports side effects or problems, 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 the client choose another method now, if she wishes, or if problems cannot be overcome

DIFFICULTY INSERTING OR REMOVING DIAPHRAGM:

Give advice on insertion and removal. Ask her to insert and remove the diaphragm in the clinic. Check its placement after she inserts it. Correct any errors.

DISCOMFORT OR PAIN WITH DIAPHRAGM USE

- 1) A diaphragm that is too large can cause discomfort. Check if it fits well. – Fit her with a smaller diaphragm if it is too large.
- 2) If fit appears proper and different kinds of diaphragms are available, try a different diaphragm.
- 3) Ask her to insert and remove the diaphragm in the clinic. Check the diaphragm's placement after she inserts it. Give further advice as needed.

CHECK FOR VAGINAL LESIONS:

- 1) If vaginal lesions or sores exist, suggest she use another method temporarily (condoms or oral contraceptives) and give her supplies. Lesions will go away on their own if she switches to another method.
- 2) Assess for vaginal infection or sexually transmitted infection (STI). Treat or refer for treatment as appropriate

IRRITATION IN OR AROUND THE VAGINA OR PENIS:

- 1) She or her husband has itching, rash, or irritation that lasts for a day or more
- 2) Check for vaginal infection or STI.
- 3) Treat or refer for treatment as appropriate.
- 4) If no infection, suggest trying a different type or brand of spermicide.

URINARY TRACT INFECTION:

(Burning or pain with urination, frequent urination in small amounts, blood in the urine, back pain)

- 1) Treat with Cotrimoxazole 240 mg orally once a day for 3 days, or trimethoprim 100 mg orally once a day for 3 days, or nitrofurantoin 50 mg orally twice a day for 3 days.
- 2) If infection recurs, consider refitting the client with a smaller diaphragm.

BACTERIAL VAGINOSIS:

(Abnormal white or gray vaginal discharge with unpleasant odor;

- 1) May also have burning during urination and/or itching around the vagina)
- 2) Treat with metronidazole 2 g orally in a single dose or metronidazole 400–500 mg orally twice a day for 7 days.

CANDIDIASIS:

(Abnormal white vaginal discharge that can be watery or thick and chunky);

- 1) May also have burning during urination and/or redness and itching around the vagina
- 2) Treat with fluconazole 180 mg orally in a single dose, miconazole 200 mg vaginal suppository once a day for 3 days, or Cotrimoxazole 100 mg vaginal tablets twice a day for 3 days.

MICONAZOLE:

Suppositories are oil-based and can weaken a latex diaphragm. Women using miconazole vaginally should not use latex diaphragms or condoms during treatment. They can use a plastic female or male condom or another method until all medication is taken. (Oral treatment will not harm latex.)

SUSPECTED PREGNANCY:

- 1) Assess for pregnancy.
- 2) There are no known risks to a foetus conceived while a woman is using spermicides.

NEW PROBLEMS THAT MAY REQUIRE SWITCHING METHODS

May or may not be due to the method.

RECURRING URINARY TRACT INFECTIONS OR VAGINAL INFECTIONS (SUCH AS BACTERIAL VAGINOSIS OR CANDIDIASIS)

- 1) Consider refitting the client with a smaller diaphragm.

LATEX ALLERGY (REDNESS, ITCHING, RASH, AND/OR SWELLING OF GENITALS, GROIN, OR THIGHS [MILD REACTION]; OR HIVES OR RASH OVER MUCH OF THE BODY, DIZZINESS, DIFFICULTY BREATHING, LOSS OF CONSCIOUSNESS [SEVERE REACTION])

Tell the client to stop using a latex diaphragm. Give her a plastic diaphragm, if available, or help her choose another method, but not latex condoms.

TOXIC SHOCK SYNDROME (SUDDEN HIGH FEVER, BODY RASH, VOMITING, DIARRHEA, DIZZINESS, SORE THROAT, AND MUSCLE ACHES).

- 1) Treat or refer for immediate diagnosis and care. Toxic shock syndrome can be life-threatening.
- 2) Tell the client to stop using the diaphragm. Help her choose another method but not the cervical cap.

CERVICAL CAPS

HANDOUT (H-18.5 C)

A cervical cap is a cup-shaped device made of soft rubber that fits over the cervix and is held in place at least partially by suction between its firm flexible rim and the surface of the cervix at the upper vaginal wall. It is one of the least effective methods of FP.

EFFECTIVENESS:

- 1) The effectiveness of this method depends on the user. The risk of pregnancy is greatest when the method is not used during every sexual intercourse.

- 2) When typically used, about 32 per 100 women who use the cervical cap with spermicide become pregnant over the first year of use. This statistic indicates that 68 of every 100 women using the cervical cap will not become pregnant.
- 3) When used correctly with every sexual intercourse, about 20 per 100 women who use the cervical cap become pregnant over the first year of use.

HOW IS THE CERVICAL CAP USED?

A client can use the cervical cap any time but have to wait for six weeks if the client has had a full-term delivery or a second trimester abortion. The provider of this method must observe the following steps:

- 1) Use proper infection prevention procedures.
- 2) Instruct the client to assume a lithotomy position for a pelvic examination, and assess for conditions (e.g., uterine prolapse) that may make the cervical cap impossible to use.
- 3) Perform an internal examination to assess the cervix and determine the cervical cap size.
- 4) Insert a special fitting cervical cap into the client's vagina, and apply it to cover the cervix, making sure that the cervical cap fits properly and does not come out easily.



INSERTING THE CERVICAL CAP:

- 1) Check the cervical cap for any damage, including the expiration date of the spermicide used. Insert the cervical cap at any time up to 42 hours before having sex.
- 2) After hand washing with soap and water, fill one third of the cap, including around the rim, with spermicidal cream, jelly, or foam.
- 3) Press the rim of the cap around the cervix until it is completely covered, and then press gently on the dome of the cap to apply suction and seal the cap.
- 4) Feel the cervical cap and the rim to make sure it covers the entire cervix, fits properly, and does not move out easily.
- 5) Insert the cervical cap any time up to 42 hours before having sex.
- 6) For multiple sexual intercourse, make sure that the cap is in the correct position and insert additional spermicide in front of the cervical cap before each sexual intercourse.

REMOVING THE CERVICAL CAP:

- 1) Leave the cervical cap for at least 6 hours after the sexual intercourse but not more than 48 hours from the time it was inserted.
- 2) Leaving the cap in place for more than 48 hours may increase the risk of toxic shock syndrome and can cause a bad odour and vaginal discharge
- 3) Tip the cap rim sideways to break the seal on the cervix, and then gently pull the cap down and out of the vagina.
- 4) Wash the cervical cap with mild soap and water and dry it after each use.

WHO CAN AND CANNOT USE THE CERVICAL CAP?

- 1) Nearly all women can use the cervical cap safely and effectively.
- 2) Women who develop lesions on the cervix when in contact with the cervical cap cannot use this method.
- 3) Women with HIV infection or at high risk of HIV infection are advised not to use the cervical cap.

WHAT ARE THE HEALTH BENEFITS, RISKS, AND COMPLICATIONS OF CERVICAL CAP USE?

- 1) The cervical cap protects against the risk of pregnancy.
- 2) The known health risks include urinary tract infection, bacterial vaginosis, or candidiasis.
- 3) The side effects may include vaginal lesions or irritation in or around the vagina or penis.

HOW TO MANAGE THE SIDE EFFECTS OF CERVICAL CAP?

Women with allergic reactions to cervical cap may discontinue its use. The provider can counsel her to use other effective methods.

WHAT IMPORTANT INFORMATION SHOULD BE PROVIDED TO THE CLIENT WHO CHOOSES TO USE THE CERVICAL CAP?

- 1) Ensure that the client understands the correct use by allowing her to repeat how and when to insert and remove the cervical cap.
- 2) Explain that the procedure becomes easier with time, i.e., the more practice she has with inserting and removing the cervical cap, the easier it will get.
- 3) Describe common side effects, such as itching and irritation in or around the vagina or penis and how to go about it.

- 4) Clarify that a cervical cap that becomes thin, damaged, or stiff should not be used and should be replaced. The cervical cap should be replaced every two years.

SPERMICIDES

HANDOUT (H-18.5 D)

WHAT ARE SPERMICIDES?

- 1) Spermicides are chemical substances that kill the sperms and are available in different forms, such as gel, aerosol foam, foam tablet, film tablet, and cream.
- 2) Vaginal spermicides are sperm-killing substances, nonoxynol-9 is the most widely used substance. Others include, Benzalkonium chloride, chlorhexidine, octoxynol-9, and sodium docusate, which are inserted deep in the vagina, near the cervix, before sex.
- 3) Spermicides work by causing the membrane of sperm cells to break, killing them or slowing their movement.
- 4) Available in foaming tablets, melting, or foaming suppositories, cans of pressurized foam, melting film, jelly, and cream.
- 5) Jellies, creams, and foam from cans can be used alone, with a diaphragm, or with condoms.
- 6) Films, suppositories, foaming tablets, or foaming suppositories can be used alone or with condoms.



HOW EFFECTIVE IS THE SPERMICIDE?

The effectiveness of the method depends on the user. Risk of pregnancy is greatest when spermicides are not used with every act of sex. It is one of the least effective FP methods. When typically used, about 29 per 100 women who use spermicides become pregnant during the first year. This statistic indicates that 71 of every 100 women using spermicide will not become pregnant. When used correctly with every sexual intercourse, about 16 per 100 women who use spermicides become pregnant over the first year.

HOW ARE SPERMICIDES USED?

Spermicides can be used any time the client wants. The provider of this method must observe the following steps:

A- Explain the process of inserting spermicides into the vagina. Check first the expiration date and avoid using spermicides that are past their expiration date.

- 1) For foam or cream: shake can of foam; squeeze spermicide from the can or tube into a

plastic applicator. Insert the applicator deep into the vagina, near the cervix, and push the plunger.

- 2) For tablets, suppositories, jellies: insert the spermicide deep into the vagina, near the cervix, with an applicator or with fingers.

B- Explain when to insert spermicide into the vagina.

- 1) Foam or cream can be inserted any time less than one hour before sex.
- 2) Tablets, suppositories, jellies, and film can be inserted between 10 minutes and 1 hour before sex, depending on type.

C- Explain use of spermicide for multiple sexual acts. Instruct the client to insert additional spermicide before each act of vaginal sex.

Foam or cream: Shake cans of foam hard. Squeeze spermicide from the can or tube into a plastic

- 1) Douching is not recommended because it will wash away the spermicide and increase the risk of sexually transmitted infections.
- 2) If she must douche, she should wait for at least 6 hours after sex before doing so.

WHO CAN AND CANNOT USE SPERMICIDES?

- 1) Nearly all women can use spermicides.
- 2) Those who cannot use the method include persons who are at high risk for HIV infection and those who have HIV/AIDS.

WHAT ARE THE BENEFITS OF SPERMICIDE USE?

- 1) This method can be used without seeing a healthcare provider.
- 2) It can be inserted ahead of time; thus, it does not interrupt sex.
- 3) Use is controlled by the client.

HOW ARE THE SIDE EFFECTS OF SPERMICIDE USE ADDRESSED?

- 1) Some users report irritation in or around the vagina or penis. Vaginal lesions are the other possible physical changes.
- 2) Clients deserve provider's attention if side effects or problems with spermicide affect their satisfaction with and use of the method.
- 3) The provider should listen to the client's concerns, give her advice, and treat if necessary.
- 4) The provider should also help the client to choose another method if she wishes or if problems cannot be resolved.

MEDICAL ELIGIBILITY CRITERIA FOR SPERMICIDES:

All women can safely use spermicides except those who:

- 1) Are at high risk for HIV infection
- 2) Have HIV infection
- 3) Women who are at high risk for HIV infection or who have HIV should use another method.

SUPPORTING THE SPERMICIDE USER

1) Ensure client understands correct use:

Ask the client to repeat how and when to insert her spermicide.

2) Describe the most common side effects

Itching and irritation in or around the vagina or penis.

3) Explain about emergency contraceptive pills (ECPs)

Explain ECP use in case the spermicide is not used at all or is not used properly.

Give her ECPs.

4) Explain about storage

Spermicides should be stored in a cool, dry place, if possible, out of the sun. Suppositories may melt in hot weather. If kept dry, foaming tablets are not as likely to melt in hot weather.

SUMMARIZE AND WRAP UP

(10 MINUTES)

FURTHER REFERENCE:

- Family Planning: A Global Handbook for Providers, WHO, 2018

NATURAL FAMILY PLANNING METHODS



TIME: 3 HOURS

These methods use body's natural physiological changes and symptoms to identify the fertile and infertile phases of the menstrual cycle. Such methods are also known as fertility awareness methods.



TRAINING OBJECTIVES

- 1) Discuss characteristics and types of fertility awareness methods.
- 2) Discuss natural methods of family planning including withdrawal.
- 3) Describe method-specific counselling.



LEARNING OUTCOMES

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

- 1) Discuss in detail the various types of natural methods including fertility awareness and withdrawal methods.
- 2) Describe advantages, limitations, and counselling skills.
- 3) Provide factual information to clarify the myths.



ADVANCE PREPARATIONS

- 1) The Global handbook for Family planning, 2018
- 2) Cycle Beads
- 3) BBT chart



TRAINING/LEARNING METHODS

- 1) Power point presentation
- 2) Brainstorming
- 3) Group discussions/activity



TRAINING MATERIAL

Trainer' Material	Trainee's Material
Hand Outs: H19.1, H19.2, H19.3, H19.4	Hand Outs: H19.1, H19.2, H19.3, H19.4
Activity: A19.1, A19.2, A19.3, A19.4	Job aid: J19.1, J19.2
Job aid: J19.1, J19.2	
PPT: (19)	



CONSTITUTION OF THE SESSION

Five mini sessions will be held:

1) Natural family planning methods	Lecture/interactive discussion	40 Mins
2) NFP advantages and disadvantages	Brainstorming / Activity	40 Mins
3) Fertility awareness methods, types, and details	Lecture/interactive discussion	50 Mins
4) MEC for symptom-based method	Group work	40 Mins
5) Wrap up and Summary		10 Mins

SESSION 1

TITLE: NATURAL FAMILY PLANNING METHODS

(40 MINUTES)

OUTLINE & OBJECTIVES:

This session will highlight the various types of natural or fertility awareness-based methods and their efficacy.

METHODOLOGY:

- 1) Interactive power point presentation to highlight the importance of fertility awareness-based methods.
- 2) Small interactive PowerPoint presentation to review the new evidence regarding SDM.

Handout: (H19.1)

Activity: (A19.1)

Job Aid: (J19.1)

NATURAL FAMILY PLANNING METHODS (NFMS)

HANDOUT (H-19.1)



Activity (A19.1)

Brainstorm activity to identify various kinds of natural family planning methods

The trainer writes the title, Natural Family Planning Methods and invites suggestions from the participants.

As they speak, the co- trainer writes on the flip chart.

NATURAL FAMILY PLANNING METHODS INCLUDE:

- 1) Fertility awareness methods,
- 2) With drawl method and

3) Lactational amenorrhea Method

1 FERTILITY AWARENESS METHODS

“Fertility awareness” means that a woman knows when the fertile time of her menstrual cycle starts and ends. Sometimes called periodic abstinence or natural family planning. A woman can use several ways, alone or in combination, to know when her fertile period begins and ends.

Are based on practice of voluntarily avoiding sexual intercourse during the fertile period of a woman’s cycle to avoid pregnancy. Communication and understanding between spouses are critical for effective use of these methods. In the following conditions, it is difficult to assess the fertile period as the woman is ^[1]~~[SEP]~~not having periods or has irregular periods:

- 1) Breast feeding women who are less than 6 months post-partum.
- 2) Post abortion (delay till after next period).
- 3) Irregular periods.

In this method, the woman monitors and records different fertility signals during her menstrual cycle to work out when she's likely to get pregnant. Natural family planning involves identifying the signs and symptoms of fertility during your menstrual cycle so you can plan or avoid pregnancy.

There are 3 different fertility signals the client can monitor and record for natural family planning. These are:

- 1) The length of her menstrual cycle.
- 2) Daily readings of her body temperature.
- 3) Changes to her cervical secretions (cervical mucus).

It's best to record these measures together to give her a more accurate picture of when she is likely to be most fertile. She can use fertility charts to record and track her measurements over the course of each menstrual cycle. Smartphone apps are also available for tracking.

These include calendar-based methods and symptom-based methods

A) CALENDAR-BASED METHODS:

Involve keeping track of days of the menstrual cycle to identify the start and end of the fertile time, for example

- 1) 1 Standard Days Method
- 2) 2 Calendar rhythm method.

B) SYMPTOMS-BASED METHODS DEPEND ON OBSERVING SIGNS OF FERTILITY:

- 1) Two-day method
- 2) Cervical Mucus or Billings method
- 3) Basal body temperature method
- 4) Sympto-thermal method (Cervical mucus + BBT)

HOW EFFECTIVE ARE NFMS?

Effectiveness depends on the user: Risk of pregnancy is greatest when couples have unprotected intercourse during the fertile days without using another method.

As commonly used, in the first year about 15 pregnancies per 100 women using periodic abstinence. This means that 85 of every 100 women relying on periodic abstinence will not become pregnant.

Reliable effectiveness rates are not available for the calendar rhythm method or the basal body temperature method. In general, abstaining during fertile times is more effective than using another method during fertile times

PROVIDER INSTRUCTIONS:

- 1) Find out the menstrual cycle pattern of the client and advise on the period of fertility based on the menstrual cycle pattern. [1] [SEP]
- 2) Use coloured illustrations (if possible) to explain the menstrual cycle and fertile period. [1] [SEP] Provide condoms as back up method and demonstrate the use of condoms. Ensure that [1] [SEP] the client has understood the use of condoms.
- 3) Ensure that the woman understands the period of fertility

USER INSTRUCTIONS:

- 1) Count the 8th day of menstrual cycle (counting the first day of onset of bleeding/spotting as day 1).
- 2) Avoid sexual intercourse from the 8th to the 19th day. This is the time when the ovum is released, and the risk of pregnancy is high.
- 3) If sex cannot be avoided, use a condom.
- 4) From the 20th day onwards, it is the infertile period

2 WITHDRAWAL METHOD:

In this method, just before ejaculation, the man withdraws his penis from his wife's vagina and ejaculates outside the vagina, keeping his semen away from her external genitalia. Also known as coitus interruptus and "pulling out." Works by keeping sperm out of the woman's body.

HOW EFFECTIVE?

Effectiveness depends on the willingness and ability of the couple to use withdrawal with every act of intercourse. Risk of pregnancy is greatest when the man does not withdraw his penis from the vagina before he ejaculates with every act of sex. **One of the least effective methods, as commonly used.**

As commonly used, about 20 pregnancies per 100 women whose partners use withdrawal over the first year. This means that 80 of every 100 women whose partners use withdrawal will not become pregnant.

When used correctly with every act of sex, about 4 pregnancies per 100 women whose partners use withdrawal over the first year.

Key Points for Providers and Clients

Job Aid (J19.1)

1) One of the least effective contraceptive methods. Some men use this method effectively, however. Offers better pregnancy protection than no method at all.
2) Always available in every situation.
3) Can be used as a primary method or as a backup method.
4) Requires no supplies and no clinic or pharmacy visit.
5) Promotes male involvement and couple communication.

GIVING ADVICE ON USE:

- 1) Learning proper use can take time
- 2) Suggest that the couple also use another method until the man feels that he can use withdrawal correctly with every act of sex. Greater protection from pregnancy is available.
- 3) Suggest an additional or alternative family planning method. (Couples who have been using withdrawal effectively should not be discouraged from continuing.) Some men may have difficulty using withdrawal
- 4) Men who cannot sense consistently when ejaculation is about to occur.
- 5) Men who ejaculate prematurely.
- 6) If the man has ejaculated recently before sex, he should urinate and wipe the tip of his penis to remove any semen remaining.

7) Explain ECP use in case a man ejaculates before withdrawing

WHO CAN AND CANNOT USE WITHDRAWAL:

- 1) All men can use withdrawal.
- 2) No medical conditions prevent its use.
- 3) Withdrawal may be especially appropriate for couples who:
 - a. Have no other method available at the time.
 - b. Are waiting to start another method.
 - c. Have sex infrequently.
 - d. Have objections to using other methods.

3 LACTATIONAL AMENORRHOEA METHOD (LAM):

Used correctly and consistently, less than **2 in 100** women who use LAM will get pregnant in the **first 6 months**. However, take care to use the method correctly. All 3 criteria for LAM must be fulfilled

The LAM **efficiency** is very high if all the enumerated conditions are respected: 0.5 pregnancies/ 100 women within the first 6 months after birth. In common use, the efficiency is of 2pregnancies/ 100 women within the first 6 months after birth.

For details please refer to Module No 19 LAM

SESSION 2

TITLE: NFM ADVANTAGES AND DISADVANTAGES

(40 MINUTES)

OUTLINE & OBJECTIVES:

The objective of the session is to discuss the specific counselling for various groups of women for whom this method is appropriate.

METHODOLOGY:

- 1) Brainstorming session to discuss advantages and disadvantages
- 2) Large group discussion
- 3) Interactive power point presentation and discussion to highlight the effectiveness of the NFM including Fertility Awareness methods and withdrawal

Handout: (H19.2)

Activity: (A19.2)

Job Aid: (J19.2)

NFM ADVANTAGES AND LIMITATIONS

HANDOUT (H-19.2)



Activity (A19.2)

Post on flip chart Description of advantages and disadvantages.

The trainer divides the participants in two groups and asks them to discuss within their groups the advantages and disadvantages of NFM and then choose a representative to present it in front of the group.

The trainer then adds up on the information and discusses the method characteristics and the advantages and disadvantages.

**Job Aid
(J19.2)**

Advantages:	Disadvantage
No side effects.	Natural family planning does not protect against STIs such as chlamydia or HIV.
Acceptable to all faiths and cultures.	She'll need to avoid sex, or use contraception such as condoms, during the time you might get pregnant, which some couples can find difficult.
Most women can use natural family planning, as long as they're properly trained by a fertility awareness teacher.	If she decides to abstain, there can sometimes be up to 16 days during which the couple cannot have sex, depending on her cycle.
Once she has learned the techniques, there is no need for input from health professionals.	It can be much less effective than other methods of contraception if the methods aren't followed accurately.
Natural family planning can be used either to avoid pregnancy or to become pregnant.	It won't work without continued commitment and practice.
It doesn't involve chemicals or physical products.	It can take several menstrual cycles before she become confident in identifying your fertile time. During this time, she'll have to use barrier contraception, such as condoms.
It can help her recognize normal and abnormal vaginal secretions, so you can be aware of possible infection.	She'll need to keep a daily record of her fertility signs. If she uses the emergency contraceptive pill, she'll need to wait for 2 complete cycles before relying on natural family planning again.
It involves both partners in the process, which can help increase feelings of closeness and trust.	Stress, illness, travel, lifestyle and hormonal treatments can disrupt fertility signs.

KEY POINTS ABOUT FAMS FOR PROVIDERS AND CLIENTS:

1. Fertility- awareness-based methods require partners' cooperation.

2. Couples must be committed to abstaining from unprotected vaginal intercourse on fertile days.
3. The woman must stay aware of her body's changes or keep track of her days, according to the rules of the specific method

SESSION 3

TITLE: FERTILITY AWARENESS METHODS, TYPES AND DETAILS

(50 MINUTES)

OUTLINE & OBJECTIVES:

This session outlines the Fertility Awareness Methods, types and details

METHODOLOGY:

- 1) Brainstorming session
- 2) Interactive power point presentation and discussion to highlight

Handout: (H19.3)

Activity: (A19.3)

FERTILITY AWARENESS METHODS, TYPES AND DETAILS

HANDOUT (H-19.3)

INTRODUCTION:

Fertility awareness-based methods (FAMs), also referred to as natural family planning (NFP) methods, require abstinence from intercourse during the fertile time of a woman's menstrual cycle, thereby avoiding conception. To achieve this, the woman must be able to recognize her fertile period. This is managed through several approaches, either singly or in combination, which include calendar-based methods and symptoms-based methods.

Success in the practice of FAMs is largely dependent on the motivation of the learner and, for some methods (e.g., **Cervical Mucus, Ovulation, BBT, and Sympto-thermal**), the competence of the teacher. **Newer FAM options**, such as the **Standard Days Method® (SDM) and Two-Day Method® (TDM)**, require less reliance on the provider, as they are offered and learned in one client-provider contact.

CALENDAR-BASED METHODS:

In the calendar-based methods, the couple keeps track of the days in the menstrual cycle to identify the start and end of the fertile time. Include calendar-based rhythm methods and Standard Days Methods

1 CALENDAR BASED RHYTHM METHODS:

Woman needs to keep an evidence of her menstrual cycles over a period of minimum 6 months. The first day of the menstrual cycle is the day in which the menstrual bleeding occurs (Day 1). Then the days are numbered consequently (Day 2, Day 3, etc.) until the last day before the next menstruation. A menstrual cycle means the interval of time between the first day of menstruation (Day 1 of the menstrual cycle) and the first day of the next cycle; it can vary from 25 to 35 days. Out of the shortest menstrual cycle subtract 18; the number obtained is the day in which the fertile period begins.

Out of the longest menstrual cycle subtract 11; the number obtained is the day in which the fertile period ends.

2 THE STANDARD DAYS METHOD (SDM):

The SDM is based on the fact that there is a fertile window during the woman's menstrual cycle when she can become pregnant. Typically, this window occurs several days before ovulation and a few hours after. To prevent pregnancy, couples avoid unprotected sex or abstain between days **8-19** of the menstrual cycle. This formula is based on computer analysis of some **7,500** menstrual cycles. An efficacy trial **44** found that the SDM was more than 95-percent effective with correct use, and more than **88-percent** effective with typical use among women who reported regular recent cycles of **23-32 days**. Most women who get their periods about once a month fall within this range.

The SDM is appropriate for women who can avoid unprotected sex on fertile days and usually have cycles between 23-32 days long (approximately 80 percent of cycles are in this range)

MECHANISM OF ACTION:

Prevents pregnancy by avoiding sexual intercourse during fertile periods when ovum is released.

EFFECTIVENESS:

The effectiveness (in preventing pregnancy) is 91-98% when the method is used correctly and consistently.

ADVANTAGES:

- 1) No exposure to side effects from pharmacological or mechanical methods of contraception not provider dependent.
- 2) Does not affect breastfeeding.
- 3) No side effects.

DISADVANTAGES:

- 1) Dependent on a person's self-control to avoid sexual intercourse during fertile period.
- 2) High failure rate.
- 3) Does not protect from STI/HIV.

METHOD-SPECIFIC COUNSELLING:

- 1) Counselling is critical for couples who want to practice fertility awareness method.
- 2) Ensure the spouse is present.
- 3) Ensure the client/couple understands the fertile period.
- 4) Provide condoms as back up method and demonstrate the use of condoms.

ELIGIBILITY:

The following are eligible to use the method:

- 1) Couples who can abstain from sexual intercourse during fertile periods.
- 2) Women with **regular** menstrual cycles.
- 3) Women who want to practice contraception using non-mechanical or chemical methods.
- 4) Women who have contraindications for other methods.



CYCLE BEADS

Serve as a visual tool to help women use the SDM correctly. On the day she starts her period, the woman moves the ring to the red bead to begin a new cycle and marks that day on her calendar. To keep track of her cycle days and know whether she is on a fertile day, the woman moves a rubber ring one bead every day. To monitor her cycle length, the woman knows that if her period starts before she moves the ring to the darker brown bead, her cycle is shorter than 19 days. If she doesn't start her period by the day after she moves the ring to the last brown bead, her cycle is longer than 32 days. If she has a cycle shorter than 19 days or longer than 32 days more than once in a year, the SDM will not be effective for her.

RETURN TO YOUR HEALTH CARE PROVIDER OR FACILITY IF:

- 1) You are not happy with the method.
- 2) You think you are pregnant.
- 3) You want information about or want to start using another family planning method.
- 4) You think there is any chance you may have been exposed to HIV infection or any other sexually transmitted infection (STI).

SYMPTOMS-BASED METHODS:

Symptoms-based methods depend on observation of signs of fertility, such as the presence or absence of cervical mucus, changes in the amounts and characteristics of the cervical mucus, changes in body temperature, a combination of the latter two, or use of specific ovulation detection kits. Once trained, a woman or couple usually can begin using symptoms-based methods at any time. Women not using a hormonal method can practice monitoring their fertility signs before they start using symptoms-based methods. Give clients who cannot start immediately another method to use until they can start.

Symptom based methods include:

- 1) Two-day method
- 2) Cervical Mucus or Billings method
- 3) Basal body temperature method
- 4) Sympto-thermal method (Cervical mucus + BBT)

1) TWO-DAY METHOD (TDM):

The two-day method (TDM) is a simple, symptom-based method by which women check for the presence or absence of cervical secretions as the sign of fertility. The TDM does not require interpretation of the quality or quantity of secretions. A woman who uses the TDM asks herself two questions:

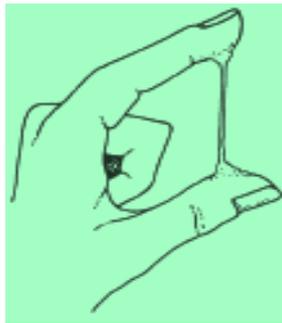
- (1) "Did I note secretions today?" and
- (2) "Did I note secretions yesterday?"

She should consider herself fertile today if she notices cervical secretions of any type today, or if she noticed them yesterday. Women who use the TDM are instructed to avoid unprotected intercourse on these days to prevent pregnancy. Most users are able to learn the method in one short counselling session.

The TDM is 96-percent effective in preventing pregnancy when used correctly, and 86 percent effective with typical use. Women can start using the TDM at any time in their cycles. To use the method, a woman pays attention to her secretions every day starting at a particular time. Women can check for secretions by seeing them or touching them in their underwear or on toilet paper. She may also touch her genitals. Later, as women become more familiar with their body, they identify secretions simply by sensation. In TDM counselling, women purposely are not taught to distinguish normal cervical secretions from infectious or other abnormal vaginal discharge. However, the users are taught that if they notice secretions for more than 14 consecutive days, they should consult with their health care provider for diagnosis, treatment, and referral, if necessary. Clients might consider using another method until their situation is resolved.

2) OVULATION METHOD, CERVICAL MUCUS, OR BILLINGS OVULATION METHOD:

In this method, the days of infertility, possible fertility, and maximum fertility of the menstrual cycle are defined by observation of changes in the cervical mucus. The woman identifies the fertile time by observing the characteristics of the cervical mucus.



CORRECT USE:

The woman checks daily the presence, quality as well as the quantity of the cervical secretions. A few days after the menstruation, the secretion is reduced/ non-existent. Afterwards, the secretion becomes more and more abundant, the woman has the sensation of wetness and she can observe the mucus on her fingers, toilet paper or underwear.

The woman checks for cervical secretions every afternoon and/or evening, on fingers, underwear, or tissue paper or by sensation in or around the vagina. As soon as she notices any secretions of any type, colour, or consistency, she considers herself fertile that day and the following day.

Avoid sex as soon as she notices any secretions. The fertile phase of the menstrual cycle begins with the appearance of a mucus secretion, which changes as the days go by, becoming more stretchy and slippery.

Recognize evidence of ovulation (peak day), when the mucus is very clear, stretchy (Spinnbarkeit's sign), and slippery.

The couple avoids vaginal sex or uses condoms or a diaphragm on each day with secretions and on each day following a day with secretions. They can also use withdrawal or spermicides, but these are less effective.

The couple can have unprotected sex again after the woman has had 2 dry days (days without secretions of any type) in a row.

Continue to avoid sex for three more days after peak day, even if secretions completely disappear before three days have expired. The couple can resume sex on the fourth day after the peak day and until her next monthly bleeding. The client should be taught to apply the method rules appropriately. A major advantage of this method is that it can be used by women wanting to achieve a pregnancy by identifying her fertile days.

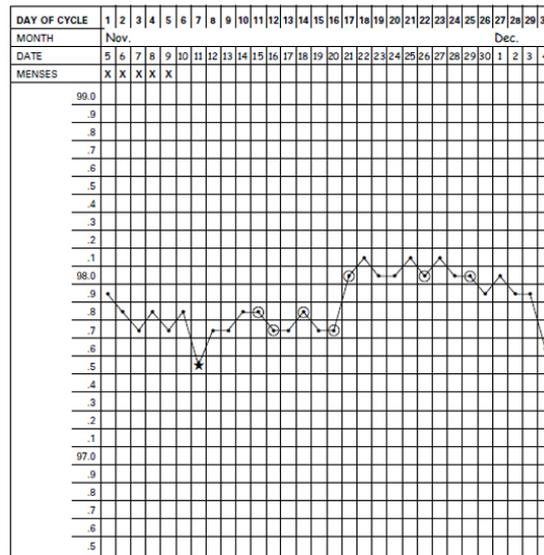
3) BASAL BODY TEMPERATURE (BBT):

With this method, the woman is instructed to take her body temperature either orally, rectally, or vaginally at the same time each morning before getting out of bed and before eating anything. The routine for taking the temperature must be the same for the entire cycle. She watches for her temperature to rise slightly—0.2° to 0.5°C (0.4° to 1.0°F)—just after ovulation (usually about midway through the menstrual cycle).

The temperature readings are recorded on a special graph paper, which makes it easy to identify small changes in temperature readings. The woman's temperature rises by 0.20C - 0.50 C, around the time of ovulation (about midway through the menstrual cycle for many women). The couple avoids sex from the first day of the period until three days after the woman's

temperature has risen above her regular temperature. ^[L]_{SEP} The couple should be taught to apply method rules appropriately.

Sample BBT chart



The temperature method is used because there is a small rise in body temperature after ovulation. The woman takes her body temperature at the same time each morning before she gets out of bed and before she eats anything. She records her temperature on a special graph.

The couple avoids vaginal sex or uses condoms or a diaphragm from the first day of monthly bleeding until 3 days after the woman’s temperature has risen above her regular temperature. They can also use withdrawal or spermicides, but these are less effective.

When the woman’s temperature has risen above her regular temperature and stayed higher for 3 full days, ovulation has occurred and the fertile period has passed. The couple can have unprotected sex on the 4th day and until her next monthly bleeding begins.

4 SYMPTO-THERMAL METHOD (CERVICAL MUCUS + BBT) & OTHER FERTILITY SIGNS

In this method, the pre-ovulatory and post-ovulatory infertile phases of the menstrual cycle are identified by a combination of the above techniques (the cervical mucus and BBT shift), as well as other signs and symptoms around ovulation.

The signs and symptoms used in the Sympto-thermal method include:

- 1) Thermal shift (BBT).
- 2) Cervical mucus changes (BILLINGS).
- 3) Cervical changes (consistency, position, openness, or closure).
- 4) Other appropriate signs and symptoms, such as sharp lower abdominal pain (mittelschmerz), breast tenderness, increased libido, or intermenstrual bleeding.

The couple avoids unprotected sex between the first day of monthly bleeding and either the fourth day after peak cervical secretions or the third full day after the rise in temperature (BBT), whichever happens later.

NEW APPROACHES:

To enhance the efficacy of FAMs and make the methods easier for couples to use, several new technologies for identifying fertility signs have been developed. These items provide a more precise way to detect ovulation:

- 1) Advanced thermometers for detection of BBT shift
- 2) Hand-held electronic devices that record multiple signs to predict ovulation
- 3) Ovulation-detection kits that measure levels of luteinizing hormone (LH) in urine
- 4) Cycle Beads that help women keep track of their cycle days when using the SDM

KEY POINTS FOR PROVIDERS AND CLIENTS:

Fertility- awareness-based methods require partners' cooperation. Couples must be committed to abstaining from unprotected vaginal intercourse on fertile days. The woman must stay aware of her body's changes or keep track of her days, according to the rules of the specific method.



Activity (A19.3)

FAQs

About Fertility Awareness Methods

The trainer writes one question each on a different coloured paper. The papers are folded and placed in a basket. The basket is circulated with music playing. When the music stops, the participant with the basket in hand answers the question.

Pick the colour of your choice, read the question inside and answer it.

1- Can only well-educated couples use fertility awareness methods?

No. Couples with little or no formal schooling can and do use fertility awareness methods effectively. Couples must be highly motivated, well-trained in their method, and committed to avoiding unprotected sex during the fertile time.

2- Are fertility awareness methods reliable?

For many couples, these methods provide reliable information about the fertile days. If the couple avoids vaginal sex or uses condoms or a diaphragm during the woman's fertile time, fertility awareness methods can be effective. Using withdrawal or spermicides during the fertile time is less effective.

3- What is different about the newer fertility awareness methods, the Standard Days Method and the two-day Method?

These fertility awareness methods are easier to use correctly than some of the older ones. Thus, they could appeal to more couples and be more effective for some people.

They are like older methods, however, in that they rely on the same ways of judging when a woman might be fertile—by keeping track of the days of the cycle for the Standard Days Method and by cervical secretions for the two-day Method

In a clinical trial of the two-day Method as it was commonly used, there were 14 pregnancies per 100 women over the first year of use. This rate is based on those who remained in the study. Women who detected secretions on fewer than 5 days or more than 14 days in each cycle were excluded.

4- How likely is a woman to become pregnant if she has sex during monthly bleeding?

During monthly bleeding, the chances of pregnancy are low but not zero. Bleeding itself does not prevent pregnancy, and it does not promote pregnancy, either. In the first several days of monthly bleeding, the chances of pregnancy are lowest. For example, on day 2 of the cycle (counting from the first day of bleeding as day 1), the chance of getting pregnant is extremely low (less than 1%). As the days pass, the chances of pregnancy increase, whether she is still bleeding. The risk of pregnancy rises until ovulation. The day after ovulation the chances of pregnancy begin to drop steadily. Some fertility awareness methods that depend on cervical secretions advise avoiding unprotected sex during monthly bleeding because cervical secretions cannot be detected during bleeding and there is a small risk of ovulation at this time.

5- How many days of abstinence or use of another method might be required for each of the fertility awareness methods?

The number of days varies based on the woman's cycle length. The average number of days a woman would be considered fertile and would need to abstain or use another method with each method is: Standard Days Method, 12 days; two-day Method, 13 days; sympto-thermal method, 17 days; ovulation method, 18 days.

SESSION 4

TITLE: MEC FOR SYMPTOM BASED METHODS

(40 MINUTES)

OUTLINE & OBJECTIVES:

To discuss the Medical eligibility criteria for Symptom based method

METHODOLOGY:

- 1) Brainstorming
- 2) Interactive power point presentation and discussion to highlight
- 3) Game to answer questions

Handout: (H19.4)

Activity: (A19.4)

ELIGIBILITY FOR SBM

HANDOUT (H-19.4)



Activity (A19.4)

The trainer divides the group into three, each group is given the task of brainstorming any conditions which:

1. Women can use SBMs.
2. Use these methods with caution.
3. Should not use SBMs.

Each group is given 10 minutes to prepare their answers and then 5 minutes each to present their answers. The trainer then holds a large group discussion and clarifies the correct answer.

SYMPTOMS-BASED METHODS:

All women can use symptoms-based methods. No medical conditions prevent the use of these methods, but some conditions can make them harder to use effectively.

- 1) **Caution** means that additional or special counselling may be needed to ensure correct use of the method.
- 2) **Delay** means that use of a particular fertility awareness method should be delayed until the condition is evaluated or corrected. Give the client another method to use until she can start the symptoms-based method.

In the following situations, use caution with symptoms-based methods:

- 1) Recently had an abortion or miscarriage
- 2) Menstrual cycles have just started or have become less frequent or stopped due to older age. (Menstrual cycle irregularities are common in young women in the first several years after their first monthly bleeding and in older women who are approaching menopause. Identifying the fertile time may be difficult.)
- 3) A chronic condition that raises her body temperature (for basal body temperature and sympto-thermal methods).

In the following situations, delay starting symptoms-based methods:

- 1) Recently gave birth or is breastfeeding. (**Delay** until normal secretions have returned—usually at least 6 months after childbirth for breastfeeding women and at least 4 weeks after childbirth for women who are not breastfeeding. For several months after regular cycles have returned, use with **caution**.)
- 2) An acute condition that raises her body temperature (for basal body temperature and sympto-thermal methods).
- 3) Irregular vaginal bleeding.
- 4) Abnormal vaginal discharge.
- 5) Taking any drugs that change cervical secretions, for example, antihistamines, or drugs that raise body temperature, for example, antibiotics.
- 6) Menstrual cycles have just started or have become less frequent or stopped because of older age. Menstrual cycle irregularities are common in young women in the first several years after the menarche and in women who are nearing the menopausal period.

In the following situations, delay starting symptoms-based methods:

- 1) Taking any mood-altering drugs, such as anti-anxiety therapies (except benzodiazepines), antidepressants, and antipsychotics (including chlorpromazine and haloperidol)
- 2) Long-term use of certain antibiotics
- 3) Long-term use of any nonsteroidal anti-inflammatory drug (e.g., aspirin and ibuprofen) Paracetamol, or antihistamines

Women Who Should Not Use This Method:

This method would not be appropriate for the following:

- 1) Women who dislike touching their genitals.
- 2) Women whose partners will not cooperate.
- 3) Couples who want highly effective protection against pregnancy (e.g., the woman has conditions that can be made worse by pregnancy).

SESSION 5**TITLE: SUMMARIZE AND WRAP UP****(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) Family Planning, A Global Handbook for Providers
- 2) World Health Organization Family Planning Fact Sheet No 351. Updated May 2013, Available at:
- 3) <http://www.who.int/mediacentre/factsheets/fs351/en/>
- 4) Singh S, Darroch J, Ashford L. adding it up: the costs and benefits of investing in sexual and reproductive health. New York: Guttmacher Institute and United Nations Population Fund; 2014 [Available at: [http:// www.unfpa.org/sites/default/files/pub-pdf/Adding% 20It% 20Up-Final11.18.14.pdf](http://www.unfpa.org/sites/default/files/pub-pdf/Adding%20It%20Up-Final11.18.14.pdf),

TUBAL LIGATION (FEMALE STERILIZATION)



TIME: 2 HOURS 30 MINUTES

Female sterilization provides permanent contraception for women whom desired family size has been achieved. It is a safe and simple surgical procedure. Mini laparotomy is the commonly performed procedure in Pakistan and can usually be done with just local anaesthesia and light sedation. Complications are rare and occur in less than 1% of all procedures. Moreover, the likelihood of failure is very low, at less than 2%, even 10 years after the surgery.



TRAINING OBJECTIVES

- 1) Discuss the procedure, advantages, and limitations of procedure.
- 2) Describe equipment, types, and steps of procedure.
- 3) Discuss risks and benefits, indications, and contraindications.
- 4) Demonstrate use of MEC for clinical assessment.



LEARNING OUTCOMES

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

Describe the voluntary surgical sterilization, tubal ligation in detail:

- 1) Mechanism of action.
- 2) Efficacy.
- 3) Counselling.
- 4) Advantages and limitations.
- 5) Side-effects.
- 6) Possible complications and their management.
- 7) Be competent in using MEC.



TRAINING/LEARNING METHODS

- 1) Power Point Presentations.
- 2) Brain storming.
- 3) Group Work.
- 4) Role Play.



ADVANCED PREPARATIONS

1. WHO MEC wheel.
2. WHO MEC chart.



TRAINING MATERIAL

Trainer' Material	Trainee's Material
Hand Outs: H20.1, H20.2, H20.3, H20.4, H20.5, H20.6	Hand Outs: H20.1, H20.2, H20.3, H20.4, H20.5, H20.6
Activity: A20.1a, A20.1b, A20.2, A20.3a, A20.3b, A20.4	
Job aid: J20.2	Job aid: J20.2
Checklist: C20.2, C20.3	Checklist: C20.2, C20.3
PPT: (20)	



CONSTITUTION OF THE SESSION

Seven mini sessions will be held

1) Introduction to female sterilization and methods	Brainstorming/discussion	30 Mins
2) Informed consent/counselling	Group work/Brainstorming	30 Mins
3) MEC /myths /advantages /limitations	Role play Lecture/Demonstration	30 Mins
4) Side effects and complications	Group work /Videos/Models	20 Mins
5) Infection prevention	Interactive group work	25 Mins
6) FAQs	Pass the parcel Game	10 Mins
7) Wrap up		5 Mins

SESSION 1

TITLE: INTRODUCTION TO THE FEMALE STERILIZATION METHODS, EFFICACY, ADVANTAGES AND LIMITATIONS

(30 MINUTES)

OUTLINE & OBJECTIVES:

To discuss in detail, the female sterilization methods, laparoscopic and mini laparotomy and their efficacy advantages and disadvantages.

METHODOLOGY:

- 1) Small group work.
- 2) Short interactive PowerPoint presentation.

Handout: (H20.1)

Activity: (A20.1a), (A20.1b)

INTRODUCTION TO THE FEMALE STERILIZATION METHODS, EFFICACY, ADVANTAGES AND LIMITATIONS

HANDOUT (H-20.1)



Activity (A20.1a)

Invite the participants to share their views about the female sterilization and various methods. Make a short presentation of the methods, mechanism of action, Emphasize that this is a permanent, irreversible method of contraception. Follow on with power point presentation to highlight the above.

FEMALE VOLUNTARY SURGICAL CONTRACEPTION?

It is a safe and simple surgical procedure that provides permanent contraception for women who do not want more children. The procedure, also known as bilateral tubal ligation (BTL), involves cutting or blocking the two fallopian tubes. Although this section also presents laparoscopic approaches to BTL, the standard procedure in Pakistan is mini laparotomy under local anesthesia with light sedation.

Techniques of Female Sterilization: To perform female sterilization, training and practice under direct supervision are required. All health care providers should understand these procedures and be able to discuss them with clients.

THE MINI LAPAROTOMY PROCEDURE:

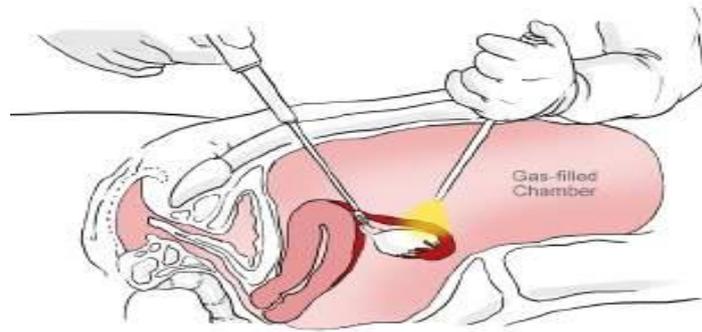
1. The provider uses proper infection-prevention procedures at all times
2. The provider performs a physical examination and a pelvic examination. The pelvic examination is to assess the condition and mobility of the Uterus.
3. The provider inserts a special instrument (uterine elevator) into the vagina, through the cervix, and into the uterus to raise each of the 2 fallopian tubes so they are closer to the incision. This may cause discomfort.
4. The woman usually receives light sedation and analgesia to relax her. She stays awake. Local anaesthetic is injected above the pubic hair line. She will not experience serious pain.
5. The provider makes a small horizontal incision (2–5 centimetres) in the anesthetized area. This usually causes little pain. (For women who have just given birth, the incision is made at the lower edge of the navel.)
6. Each tube is tied and cut or else closed with a clip or ring
7. The provider closes the incision with stitches and covers it with an adhesive bandage.
8. The woman receives instructions on what to do after she leaves the clinic or hospital. She usually can leave in a few hours.

ADVANTAGES OF MINILAPAROTOMY:

Minilaparotomy requires simple, inexpensive, and easily maintained surgical equipment.
The procedure can be performed by any health care provider with basic surgical ability and skills (after special training in the technique).
Performing the procedure requires a health facility with basic surgical capacity.
The procedure requires a few inexpensive surgical instruments and two special ones—a tubal hook (for suprapubic and subumbilical procedures) and a uterine elevator (for suprapubic procedures).
Minilaparotomy is appropriate for suprapubic and subumbilical procedures.
Postoperative abdominal pain may occur.
Recovery time is slightly longer than with laparoscopy
Minilaparotomy can be used for postpartum sterilization
Minilaparotomy involves low start-up and continuing costs.

THE LAPAROSCOPY PROCEDURE:

Through the use of a specialized tool called a laparoscope, the doctor is able to view the insides of a woman’s abdominal cavity and block both tubes.



The provider always uses proper infection-prevention procedures

- 1) The provider performs a physical examination and a pelvic examination. The pelvic examination is to assess condition and mobility of the uterus.
- 2) The woman usually receives light sedation and analgesia to relax her. She stays awake. Local anaesthetic is injected under her navel. She will not experience serious pain.
- 3) The provider places a special needle into the woman's abdomen and, through the needle, inflates (insufflates) the abdomen with gas or air. This raises the wall of the abdomen away from the pelvic organs.
- 4) The provider makes a small incision (about one centimetre) in the anesthetized area and inserts a laparoscope. A laparoscope is a long, thin tube containing lenses. Through the lenses the provider can see inside the body and find the 2 fallopian tubes.
- 5) The provider inserts an instrument through the laparoscope (or, sometimes, through a second incision) to close off the fallopian tubes.
- 6) Each tube is closed with a clip or a ring, or by electric current applied to block the tube (electrocoagulation).
- 7) The provider then removes the instrument and laparoscope. The gas or air is let out of the woman's abdomen. The provider closes the incision with stitches and covers it with an adhesive bandage.
- 8) The woman receives instructions on what to do after she leaves the clinic or hospital.
- 9) She usually can leave in a few hours.

COMPARISON OF MINILAPAROTOMY AND LAPAROSCOPY FOR FEMALE STERILIZATION

CONSIDERATION	MINILAP	LAPAROSCOPY
Surgical skills and expertise	The procedure can be performed by any health care provider with basic surgical ability and skills (after special training in the technique).	The procedure is restricted to specially trained surgeons and gynaecologists.
Setting	Performing the procedure requires a health facility with basic surgical capacity.	Performing the procedure requires a health facility with comprehensive surgical capacity.
Instruments and equipment	The procedure requires a few inexpensive surgical instruments and two special ones—a tubal hook (for suprapubic and sub umbilical procedures) and a uterine elevator (for suprapubic procedures).	The procedure requires delicate and expensive endoscopic equipment. (Ongoing maintenance and spare parts must be available.)
Timing	Mini laparotomy is appropriate for suprapubic and sub umbilical procedures.	Laparoscopy is appropriate only for interval and first-trimester post- abortion procedures.
Postoperative pain	Postoperative abdominal pain may occur.	Postoperative abdominal pain is slight. Chest and shoulder pain may result from abdominal insufflation.
Recovery time	Recovery time is slightly longer than with laparoscopy.	Recovery time is short.

Recovery time *Sources:* Engender Health, 2002; WHO, 1992; WHO, 2002.

EFFECTIVENESS:

Female sterilization is 99.5% effective with perfect and typical use.

BTL is a permanent FP method (reversal cannot be assured). Hence, a client needs thorough and careful counselling before she decides to have this procedure. A consent form must be signed by the client in all cases before the procedure is undertaken. In the case of a mentally challenged client, the surgeon may, after consultation with a professional colleague, obtain the written consent of the parent or guardian.

In the first year after the procedure:

- 1) 0.5 pregnancies per 100 women.
- 2) Within 10 years of the procedure: 1.8 pregnancies per 100 women. Effectiveness depends partly on how the tubes are blocked.

Major morbidity appears to be a rare outcome for both laparoscopy and mini laparotomy. It is important to note that laparoscopy carries a greater risk than mini laparotomy of major morbidity (such as bowel or vascular injury) that may be life-threatening or may require additional surgery. However, mini laparotomy is associated with a greater risk of minor morbidity (such as uterine perforation or wound infection)

POST PARTUM TUBAL LIGATION

Postpartum tubal ligation is one of the most effective female sterilization techniques.

- 1) In the first year after the procedure there are 0.05 pregnancies per 100 women.
- 2) Within 10 years after the procedure, 0.75 pregnancies per 100 women.



Activity (A20.1b)

Divide participants into two groups based on saying 'yes' or 'no'.

The trainer then gives tasks each group to brainstorm advantages and disadvantages of female sterilization. Allow 5 minutes for the two group's representatives to present and then the trainer moderates a large group discussion and highlights any points that were missed.

ADVANTAGES:

- 1) Highly effective method of contraception.
- 2) Permanent. A single procedure leads to lifelong, safe, and highly effective family planning.
- 3) Nothing to remember (as in many other methods), no supplies needed, and no repeated clinic visits required.
- 4) No interference with sex.
- 5) No effect on breast feeding.
- 6) No known side effect or health risks.
- 7) Mini laparotomy can be performed within 7 days of birth and after 42 days of delivery.
- 8) Helps protect against ovarian cancer.

LIMITATIONS:

- 1) Usually painful at first, but pain recedes after a day or two.
- 2) Uncommon complications of surgery:
 - a) Infection or bleeding at the incision.
 - b) Internal infection or bleeding.
 - c) Injury to internal organs.
 - d) Anaesthesia risk.
- 3) In the rare cases that pregnancy occurs, it is likely to be ectopic than in a woman who used no contraception.
- 4) Requires physical examination and minor surgery by a specially trained provider.
- 5) Reversal surgery is difficult, expensive unavailable in most areas. Successful reversal is not guaranteed. Women who want to be pregnant in the future should choose a different method.
- 6) No protection against STIs and HIV/AIDS.

PROVIDING FEMALE STERILIZATION:

When to Perform the Procedure: If there is no medical reason to delay, a woman can have the female sterilization procedure any time she wants if it is reasonably certain she is not pregnant and there are no medical conditions that limit when, where, or how the female sterilization procedure should be performed.

Sterilization Is Permanent: As sterilization is a permanent procedure, a woman or man considering sterilization should think carefully: “Could I want more children in the future?” Health care providers can help the client think about this question and make an informed choice. If the client is considering having more children, another family planning method would be a better choice.

SESSION 2

TITLE: INFORMED CONSENT/COUNSELLING/CLIENT ASSESSMENT

(30 MINUTES)

OUTLINE & OBJECTIVES:

This session will highlight the importance of informed consent and the value of counselling the patient appropriately.

METHODOLOGY:

- 1) Small group work.
- 2) Large group discussion.
- 3) Short presentation.

Handout: (H20.2)

Activity: (A20.2)

Job Aid: (J20.2)

Checklist: (C20.2)

INFORMED CONSENT/COUNSELLING/CLIENT ASSESSMENT

HANDOUT (H-20.2)

WHAT COUNSELING TIPS SHOULD BE PROVIDED TO A CLIENT?

Sterilization should not be offered only to women who have had a certain number of children or who have reached a certain age. Each woman must be allowed to decide whether she will want more children and whether or not to undergo sterilization.

Female sterilization is permanent. Thus, the FP counsellor must ensure informed choice. A friendly counsellor who listens to a woman's concerns, answers her questions, and gives clear, practical information about the procedure (especially its permanence) will help a woman make an informed choice. Informed choice results in a satisfied user without later regret.

Counselling must include the six elements of informed consent. When the client desires to undergo female sterilization, she signs an informed consent form that proves that the six elements have been discussed.

In general, people who are most likely to regret sterilization are those who:

- 1) Are young.
- 2) Have few or no children.

- 3) Are not married.
- 4) Are having marital problems.
- 5) Have a partner who opposes sterilization.
- 6) Have just given birth or undergone an abortion.

Although these periods are convenient and safe for BTL. Women undergoing the procedure at these times may be more likely to regret doing so later.

Thorough counselling during pregnancy, especially during antenatal visits, and a decision made before labour and delivery help avoid regrets. Involving the client's spouse in counselling is helpful, as spousal consent is now being required by service providers. However, FP service providers should ensure that the decision to undergo sterilization is voluntarily made (not pressured or forced) by the client.



Activity (A20.2)

Ask 2 participants to volunteer for role play as client and counsellor. Counsellor or surgeon needs to address before and after procedure cautions to the client and answer his queries as she opts for tubal ligation as contraception.

7 POINTS OF INFORMED CONSENT

Counselling must cover all 7 points of informed consent. In some programs, the client and the counsellor also sign an informed consent form. To give informed consent to sterilization, the client must understand the following points:

1) Temporary contraceptives also are available to the client, including long-acting reversible contraceptives.
2) Voluntary sterilization is a surgical procedure.
3) There are certain risks of the procedure as well as benefits. (Both risks and benefits must be explained in a way that the client can understand.)
4) If successful, the procedure will prevent the client from ever having any more children.
5) The procedure is considered permanent and probably cannot be reversed.
6) The client can decide against the procedure at any time before it takes place (without losing rights to other medical, health, or other services or benefits).
7) The procedure does not protect against sexually transmitted infections, including HIV.

HOW CAN THE HUSBAND HELP?

The client's partner is welcome to participate in counselling and learn about the method and what support he can give to his partner. A male partner can:

- 1) Understand that female sterilization is permanent.
- 2) Discuss with his partner whether they will want more children.
- 3) Support her decision to end her fertility if they will not want more children.
- 4) Discuss the alternative of vasectomy.
- 5) Show understanding and support her through the procedure and recovery.
- 6) Use condoms consistently in addition to female sterilization if he has an STI/HIV or thinks he may be at risk of an STI/HIV.

EXPLAINING SELF-CARE FOR FEMALE STERILIZATION:

1 BEFORE THE PROCEDURE THE WOMAN SHOULD

- Use another contraceptive until the procedure.
- Not eat anything for 8 hours before surgery. She can drink clear liquids until 2 hours before surgery.
- Not take any medication for 20 hours before the surgery (unless she is told to do so).
- Wear clean, loose-fitting clothing to the health facility if possible.
- Not wear nail polish or jewellery.
- If possible, bring her partner, a friend, or a relative to help her go home afterwards.

2 AFTER THE PROCEDURE, THE WOMAN SHOULD:

- Rest for 2 days and avoid vigorous work and heavy lifting for a week.
- Keep the incision clean and dry for 1 to 2 days.
- Avoid rubbing the incision for 1 week.
- Not have sex for at least 1 week, and then only when she feels comfortable having sex

3 WHAT TO DO ABOUT THE MOST COMMON PROBLEMS:

- She may have some abdominal pain and swelling after the procedure. It usually goes away within a few days. Suggest ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever. She should not take aspirin, which slows blood clotting. Stronger pain reliever is rarely needed. If she had laparoscopy, she may have shoulder pain or feel bloated for a few days.

4 PLAN THE FOLLOW-UP VISIT:

- Following up within 7 days or at least within 2 weeks is strongly recommended. No woman should be denied sterilization, however, because follow-up would be difficult or not possible.
- A health care provider checks the site of the incision, looks for any signs of infection, and

- removes any stitches. This can be done in the clinic, in the or at any other health center.

PROVIDING FEMALE STERILIZATION:

WHEN TO PERFORM THE PROCEDURE:

If there is no medical reason to delay, a woman can have the female sterilization procedure any time she wants if it is reasonably certain she is not pregnant and there are no medical conditions that limit when, where, or how the female sterilization procedure should be performed. To be reasonably certain she is not pregnant, use the Pregnancy Checklist.

Pregnancy Checklist

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.

Checklist (C20.2)

Providing Female Sterilization Job Aid (J20.2)

Women's Situation	When to Perform
Having menstrual cycles or switching from another method	<p>Any time of the month</p> <ol style="list-style-type: none"> Any time within 7 days after the start of her monthly bleeding. No need to use another method before the procedure. If it is more than 7 days after the start of her monthly bleeding, she can have the procedure any time it is reasonably certain she is not pregnant.

	<ol style="list-style-type: none"> 3) If she is switching from oral contraceptives, she can continue taking pills until she has finished the pill pack to maintain her regular cycle. 4) If she is switching from an IUCD, she can have the procedure immediately.
No Monthly Bleeding	Any time if it is reasonably certain she is not pregnant.
After childbirth	<ol style="list-style-type: none"> 1) Immediately or within 7 days after giving birth, if she has made a voluntary, informed choice in advance. 2) Any time 6 weeks or more after childbirth if it is reasonably certain she is not pregnant.
After miscarriage or abortion	Within 48 hours after uncomplicated abortion, if she has made a voluntary, informed choice in advance
After using emergency contraceptive pills (ECPs)	<ol style="list-style-type: none"> 1) 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. 2) Give her a backup method or oral contraceptives to start the day after she finishes taking the ECPs, to use until she can have the procedure.

THE DECISION ABOUT STERILIZATION BELONGS TO THE CLIENT ALONE:

A man or woman may consult a partner and others about the decision to have sterilization and may consider their views, but the decision cannot be made for that person by a partner, another family member, a health care provider, a community leader, or anyone else. Family planning providers have a duty to make sure that the decision for or against sterilization is made by the client and is not pressured or forced by anyone.

“COME BACK ANY TIME”: REASONS TO RETURN

Assure every client that she is welcome to come back any time—for example, if she has problems or questions, or she thinks she might be pregnant. (A few sterilizations fail and the woman becomes pregnant.) Also, if:

- 1) She has bleeding, pain, pus, heat, swelling, or redness of the wound that becomes worse or does not go away.
- 2) She develops high fever (greater than 38° C/101° F).
- 3) She experiences fainting, persistent light-headedness, or extreme dizziness in the first 4 weeks and especially in the first week.

SESSION 3

TITLE: MEC- MEDICAL ELIGIBILITY CRITERIA, ASSESSMENT AND MYTHS AROUND FEMALE STERILIZATION

(30 MINUTES)

OUTLINE & OBJECTIVES:

This session is about the use of medical eligibility criteria and clarify the common myths and misconceptions around female sterilization.

METHODOLGY:

- 1) Group Activity.
- 2) Followed by a large group discussion.
- 3) Review of the medical eligibility criteria.

Handout: (H20.3)
Activity: (A20.3a), (A20.3b)
Checklist: (C20.3)

MEC / MYTHS AROUND FEMALE STERILIZATION

HANDOUT (H-20.3)

Client Assessment Checklist (C20.3)

Client Assessment as per World Health Organization Medical Eligibility Criteria for Female Sterilization

Ask the client the questions below. If the client answers “no” to all the questions, then the female sterilization procedure can be performed in a routine setting without delay. If the answer is “yes” to a question below, follow the instructions.

- 1- Does the client have any gynaecological/obstetric conditions or problems such as pregnancy, infection, or cancer? DELAY female sterilization and treat if appropriate or refer in case of:**

- 1) Pregnancy
- 2) Postpartum or after second-trimester abortion (7–42 days)

- 3) Serious postpartum or post abortion complications (such as infection or haemorrhage) except uterine rupture or perforation
- 4) Unexplained vaginal bleeding that suggests a serious condition
- 5) Pre-eclampsia/eclampsia
- 6) Pelvic inflammatory disease (PID) within the past 3 months
- 7) Current STIs
- 8) Pelvic cancers

Malignant trophoblastic disease, REFER her to a Centre with experienced staff and equipment that can handle potential problems:

- Fixed uterus due to previous surgery or infection
 - Endometriosis
 - Hernia (umbilical or abdominal wall)
 - Postpartum uterine rupture or perforation or post abortion uterine perforation
- CAUTION:**
- Past PID since last pregnancy
 - Current breast cancer
 - Uterine fibroids
 - Previous abdominal or pelvic surgery

2- Does the client have any cardiovascular conditions, such as heart problems, stroke, high blood pressure, or diabetes? DELAY female sterilization:

- 1) Acute heart disease. Deep vein thrombosis or pulmonary embolism.
- 2) REFER to a centre with experienced staff and equipment that can handle potential problems:
- 3) Moderate or severe high blood pressure (160/100 mm Hg or higher)
- 4) Vascular disease
- 5) Complicated valvular heart disease **CAUTION:**
 - Mild high blood pressure (140/90 mm Hg–159/99 mm Hg)
 - History of high blood pressure that can be evaluated and adequately controlled
 - Past stroke or heart disease

3- Does the client have any lingering, chronic diseases or any other conditions? Which ones?

DELAY female sterilization in case of:

- 1) Gall bladder disease with symptoms
- 2) Active viral hepatitis
- 3) Severe iron deficiency anaemia (haemoglobin less than 7 g/dl)
- 4) Acute lung disease (bronchitis or pneumonia)
- 5) Systemic infection or significant gastroenteritis
- 6) Abdominal skin infection

- 7) Abdominal surgery due to acute abdomen
- 8) Immobilization due to major surgery
- 9) Post-surgical wound infection

Current AIDS-related acute illness REFER her to a centre with experienced staff and equipment that can handle potential problems:

- 1) Severe cirrhosis of the liver
- 2) Diabetes for more than 20 years
- 3) Hyperthyroidism
- 4) Bleeding disorders
- 5) Chronic lung disease

Pelvic tuberculosis CAUTION:

- 1) Epilepsy or taking medicine for seizures (phenytoin, carbamazepine, barbiturates, primidone)
- 2) Taking the antibiotics rifampicin or griseofulvin
- 3) Diabetes without vascular disease
- 4) Hypothyroidism
- 5) Mild cirrhosis of the liver, liver tumours, or schistosomiasis with liver fibrosis
- 6) Moderate iron deficiency anaemia (haemoglobin 7–10 g/dl)
- 7) Sickle cell disease
- 8) Inherited anaemia (thalassemia)
- 9) Kidney disease
- 10) Diaphragmatic hernia
- 11) Severe malnutrition
- 12) Obesity
- 13) Elective abdominal surgery at time sterilization is desired
- 14) Young age
- 15) Mental disorder

Be sure to explain the health benefits and risks and side effects of the method that the client will use. Also point out any conditions that would make the method inadvisable. In general, most clients who want sterilization can have safe and effective procedures in routine settings. With proper counselling and informed consent, sterilization can be used in any circumstances by female clients who:

- 1) Just gave birth (within 7 days)
- 2) Are breastfeeding

Also, clients with the following conditions can have sterilization in a routine setting in any circumstances:

- 1) Past ectopic pregnancy
- 2) Benign ovarian tumours
- 3) Irregular or heavy vaginal bleeding patterns, painful menstruation
- 4) Vaginitis without purulent cervicitis
- 5) Varicose veins
- 6) HIV-positive or high risk of HIV or other STIs
- 7) Uncomplicated schistosomiasis
- 8) Malaria
- 9) Tuberculosis (non-pelvic)

MEDICAL ELIGIBILITY CRITERIA FOR FEMALE STERILIZATION:

All women can have female sterilization. No medical conditions prevent a woman from using female sterilization. This checklist asks the client about known medical conditions that may limit when, where, or how the female sterilization procedure should be performed. Ask the client the questions below. If she answers “no” to all of the questions, then the female sterilization procedure can be performed in a routine setting without delay. If she answers “yes” to a question, follow the instructions, which recommend caution, delay, or special arrangements.

In the checklist below:

Caution means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition.

Delay means postpone female sterilization. These conditions^[1] must be treated and resolved before female sterilization can be performed. Help the client choose another method to use until the procedure can be performed.

Special means special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anaesthesia, and other backup medical support. For these conditions, the capacity to decide on the most appropriate procedure and anesthesia regimen also is needed. Help the client choose another method to use until the procedure can be performed.

1- Do you have or have you ever had any female conditions or problems, such as infection or cancer? If so, what problems?

NO YES

If she has any of the following, use **caution**:

- 1) Previous abdominal or pelvic surgery.
- 2) Past pelvic inflammatory disease since last pregnancy.
- 3) Uterine fibroids.
- 4) Breast cancer.

If she has any of the following, **delay** female sterilization

RELATED TO PREGNANCY:

- 1) Current pregnancy.
- 2) 7–42 days postpartum.
- 3) Postpartum after a pregnancy with severe pre-eclampsia or eclampsia.
- 4) Serious postpartum or post abortion complications (such as infection, haemorrhage, or trauma) except uterine rupture or perforation (**special**; see below).
- 5) Hematometra (a large collection of blood in the uterus).

UNRELATED TO PREGNANCY:

- 1) Unexplained vaginal bleeding that suggests an underlying medical condition.
- 2) Purulent cervicitis, chlamydia, or gonorrhoea.
- 3) Pelvic inflammatory disease.
- 4) Pelvic cancers (treatment may make her sterile in any case).
- 5) Malignant trophoblast disease.

If she has any of the following, make **special** arrangements:

- 1) Fixed uterus due to previous surgery or infection.
- 2) Endometriosis.
- 3) Hernia (abdominal wall or umbilical).
- 4) Post-partum or post abortion uterine rupture or perforation).

2- Do you have any heart problems, stroke, high blood pressure, diabetes, or complications of diabetes? If so, what?

NO YES

If she has any of the following, use **caution**:

- 1) Uncontrolled high blood pressure.
- 2) Mild high blood pressure (140/90 to 159/99 mm Hg).
- 3) Past stroke or heart disease without complications.
- 4) Diabetes without damage to arteries, vision, kidneys, or nervous system.

If she has any of the following, **delay** female sterilization:

- 1) Heart disease due to blocked or narrowed arteries.
- 2) Blood clots in deep veins of legs or lungs.

If she has any of the following, make **special** arrangements:

- 1) Several conditions together that increase chances of heart disease or stroke, such as older age, smoking, high blood pressure, or diabetes.
- 2) Moderately high or severely high blood pressure (160/100 mm Hg or higher).
- 3) Diabetes for more than 20 years *or* damage to arteries, vision, kidneys, or nervous system caused by diabetes.
- 4) Complicated valvular heart disease.

3- Do you have any lingering, long-term diseases or any other conditions? If so, what?

NO YES

If she has any of the following, use **caution**:

- 1) Moderate iron-deficiency anaemia (haemoglobin 7–10 g/dl).
- 2) Severe lack of nutrition (Is she extremely thin?).
- 3) Sickle cell disease.
- 4) Inherited anaemia (thalassemia).
- 5) Diaphragmatic hernia.
- 6) Epilepsy.
- 7) Hypothyroidism.
- 8) Mild cirrhosis of the liver, liver tumour, or schistosomiasis with liver fibrosis.
- 9) Kidney disease.
- 10) Obesity (Is she extremely overweight?).
- 11) Elective abdominal surgery at time sterilization is desired.
- 12) Depression.
- 13) Young age.
- 14) Uncomplicated lupus with negative antiphospholipid antibodies.

If she has any of the following, **delay** female sterilization:

- 1) Gallbladder disease with symptoms.
- 2) Active viral hepatitis.
- 3) Severe iron-deficiency anaemia (haemoglobin less than 7 g/dl).
- 4) Lung disease (bronchitis or pneumonia).

- 5) Systemic infection or significant gastroenteritis.
- 6) Abdominal skin infection.
- 7) Undergoing abdominal surgery for emergency or infection, or major surgery with prolonged immobilization.

If she has any of the following, make **special arrangements**:

- 1) Severe cirrhosis of the liver.
- 2) Hyperthyroidism.
- 3) Coagulation disorders (blood does not clot).
- 4) Chronic lung disease (asthma, bronchitis, emphysema, lung infection).
- 5) Pelvic tuberculosis.
- 6) HIV with advanced or severe clinical disease.
- 7) Lupus with positive (or unknown) antiphospholipid antibodies, with severe thrombocytopenia, or on immunosuppressive treatment.

STERILIZATION FOR WOMEN WITH HIV:

Women who are living with HIV or are on antiretroviral (ARV) therapy can safely undergo female sterilization. Special arrangements are needed to perform female sterilization on a woman with advanced or severe clinical disease. The procedure may need to be delayed if she has an HIV-related illness.

Urge these women to use condoms in addition to female sterilization. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.

No one should be coerced or pressured into having female sterilization, and that includes women with HIV.

Because female sterilization involves a surgical procedure and the administration of local anaesthesia (with or without mild sedation and analgesia), the client must undergo a careful, comprehensive yet focused clinical assessment. This assessment is important in every case, but it is even more important when the procedure is performed in hard-to-reach areas, in an outreach service, or in facilities far from supporting higher-level health services.

METHOD OF USE

The client can have a female sterilization procedure at any time when the desired family size is achieved:

- 1) If it is certain that she is not pregnant.
- 2) Immediately after childbirth, ideally within 48 hours postpartum but allowable within 7 days after delivery (mini laparotomy procedure only).

- 3) At any time 6 weeks or more after childbirth if it is reasonably certain she is not pregnant.
- 4) At any time after an uncomplicated abortion or miscarriage that is of approximately 12 weeks or less gestational age. In pregnancies that are over 12 weeks of gestational age, the procedure can be safely performed within the first 48 hours after pregnancy termination if there are no associated complications, or after 6 weeks.
- 5) Any other time, but not between 7 days and 6 weeks postpartum.



Activity (A20.3a)

The trainer will draw a list of medical conditions and ask one by one from the participants to check MEC wheel and tell if the client is eligible for sterilization or not

WOMEN WHO CAN USE BTL (INCLUDES MEC CATEGORY A)

BTL is considered appropriate and safe for the following:

1. Women of reproductive age.
2. Women who are certain that they have achieved the desired family size.
3. Clients in whom pregnancy would pose a serious health risk.
4. Women who understand and voluntarily consent to the procedure. In certain situations, the procedure may be performed on a mentally challenged person after consultation with a professional colleague, and with the written consent of a responsible parent or guardian.
5. Women who want a permanent method.
6. Women who are less than seven or more than 42 days postpartum.
7. Women who have had uncomplicated abortions.
8. Smokers.
9. Women with a history of DVT or PE, a family history of DVT or PE, or who have had major or minor surgery without prolonged immobilization.
10. Women with superficial venous thrombosis.
11. Women with headaches, with or without aura.
12. Women with irregular, heavy, or prolonged bleeding patterns or women with severe dysmenorrhea.
13. Women with benign ovarian tumors, benign gestational trophoblast disease, cervical ectropion, or cervical intra epithelial neoplasia.
14. Women with an undiagnosed breast lump, benign breast disease, or a history of breast

cancer.

15. Women with previous history of PID and STIs who have had a subsequent pregnancy.
16. Women at high risk of HIV or who are already HIV-positive (use of condoms is strongly recommended following sterilization).
17. Women with non-pelvic tuberculosis.
18. Women with gall-bladder disease (asymptomatic or symptomatic and treated by either cholecystectomy or by medications).
19. Women who are viral hepatitis carriers.
20. Women with chronic viral hepatitis, benign focal nodular hyperplasia and mild (compensated) cirrhosis.



Activity (A20.3b)

The trainer reads out the statements and the participants raise the cards saying MYTH or FACT, in response to the questions. One of them is then asked to explain the answer.

MYTHS REGARDING FEMALE STERILIZATION:

Contrary to popular beliefs, female sterilization does NOT

- 1) Makes women weak.
- 2) Cause lasting pain in back, uterus, or abdomen.
- 3) Remove a woman's uterus or lead to a need to have it removed.
- 4) Cause hormonal imbalances.
- 5) Cause heavier bleeding or irregular bleeding or otherwise change women's menstrual cycles.
- 6) Cause any changes in weight, appetite, or appearance.
- 7) Change women's sexual behaviour or sex drive.
- 8) Increase the risk of ectopic pregnancy.
- 9) Cause prolonged soreness and weakness.

SESSION 4

TITLE: SIDE EFFECTS AND COMPLICATIONS OF FEMALE STERILIZATION

(20 MINUTES)

OUTLINE & OBJECTIVES:

This session highlights possible side effects and complications female sterilization. The warning signs will also be discussed.

METHODOLOGY:

- 1) Group Activity
- 2) Small group discussions followed by a short interactive presentation
- 3) Brainstorming in large discussion

Handout: (H20.4)

Activity: (A20.4)

SIDE EFFECTS AND COMPLICATIONS OF FEMALE STERILIZATION

HANDOUT (H-20.4)



Activity (A20.4)

Divide participants into three groups and assign each group side effects, complications and warning signs respectively. Let them brainstorm and follow with group discussion group

SIDE EFFECTS AND LIMITATIONS:

- 1) Some discomfort is common after the operative procedure. This discomfort can be relieved with analgesics.
- 2) In laparoscopic ligation, chest and shoulder pain may occur for 1 or 2 days because of trapped gas remaining in the abdominal cavity. This pain can be relieved with analgesics.
- 3) Some women complain of heavy or irregular periods after BTL. These are not related to the procedure. If the complaint is troublesome, the client should be referred to a

gynaecologist.

- 4) BTL is generally irreversible. The success of reversal surgery cannot be guaranteed.
- 5) Side effects include:
 - Minimal risks and side effects of anaesthesia.
 - Risks associated with surgical procedures.
 - Some pain for several days after the procedure.
- 6) In rare cases when pregnancy occurs, it is more likely to be ectopic (although overall, female sterilization greatly reduces the risk for ectopic pregnancy compared to women who use no contraception).
- 7) Only a trained provider can perform the procedure.
- 8) BTL does not protect against STIs, including HIV/AIDS and hepatitis B.

MANAGING ANY PROBLEMS:

PROBLEMS REPORTED AS COMPLICATIONS:

Problems affect women's satisfaction with female sterilization. They deserve the provider's attention. If the client reports complications of female sterilization, listen to her concerns, give advice and support, and, if appropriate, treat. Make sure she understands the advice and agrees.

WOUND INFECTION:

Infection at the incision site (redness, heat, pain)

- 1) Clean the infected area with soap and water or antiseptic.
- 2) Give oral antibiotics for 7 to 10 days.
- 3) Ask the client to return after taking all antibiotics if the infection has not cleared.

Abscess (a pocket of pus under the skin caused by infection)

- 1) Clean the area with antiseptic.
- 2) Cut open (incise) and drain the abscess.
- 3) Treat the wound.
- 4) Give oral antibiotics for 7 to 10 days.
- 5) Ask the client to return after taking all antibiotics if she has heat, redness, pain, or drainage of the wound.

SEVERE PAIN IN LOWER ABDOMEN:

- 1) If the surgical procedure was recently performed, assess for any other problem that may indicate that the condition is related to the surgery, such as bleeding, lack of appetite, lack of bowel transit, lack of urination, or fever. If any of these are present, rapidly refer

- the client to a higher- level facility with surgical capability.
- 2) If the surgery took place some months or years ago, suspect an ectopic pregnancy.

SUSPECTED PREGNANCY:

- 1) Assess for pregnancy, including ectopic pregnancy.

MANAGING ECTOPIC PREGNANCY:

- 1) Ectopic pregnancy is any pregnancy that occurs outside the uterine cavity. Early diagnosis is important. Ectopic pregnancy is rare but could be life-threatening.
- 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 a woman’s usual bleeding pattern
- 4) Light-headedness or dizziness
- 5) Fainting

RUPTURED ECTOPIC PREGNANCY:

Sudden sharp or stabbing lower abdominal pain, sometimes on one side and sometimes throughout the body, suggests a ruptured ectopic pregnancy (when the fallopian tube breaks due to the pregnancy). Right shoulder pain may develop due to blood from a ruptured ectopic pregnancy pressing on the diaphragm. Usually, within a few hours the abdomen becomes rigid and the woman goes into shock.

CARE:

Ectopic pregnancy is a life-threatening, emergency condition requiring immediate surgery. If ectopic pregnancy is suspected, perform a pelvic examination only if facilities for immediate surgery are available. Otherwise, immediately refer and/or transport the woman to a facility where definitive diagnosis and surgical care can be provided.

COMPLICATIONS:

UNCOMMON TO EXTREMELY RARE:

Female sterilization is a safe method of contraception. It requires surgery and anaesthesia, however. Like other minor surgeries, female sterilization carries some risks, such as infection or abscess of the wound. Serious complications are uncommon. Death, due to the procedure or anaesthesia, is extremely rare.

The risk of complications with local anaesthesia, with or without sedation and analgesia, is significantly lower than with general anaesthesia.

Complications can be kept to a minimum if appropriate techniques are used and if the procedure is performed in an appropriate setting by a skilled provider.

INSTRUCT THE CLIENT TO REPORT TO THE APPROPRIATE HEALTH FACILITY IF, CLIENT EXPERIENCES ANY OF THE FOLLOWING:

- 1) High fever ($> 38^{\circ}\text{C}$) in the first four weeks.
- 2) Pus or bleeding from the wound.
- 3) Pain, heat, swelling, or redness of the wound that worsens or does not subside.
- 4) Abdominal pain, cramping, or tenderness that worsens.
- 5) Fainting or extreme dizziness.
- 6) If the client thinks she might be pregnant with symptoms of:
 - a) A missed period
 - b) Nausea
 - c) Breast tenderness
- 7) If she has signs of ectopic pregnancy, such as:
 - a) Lower abdominal pain or tenderness on one side
 - b) Abnormal or unusual vaginal bleeding
- 8) Faintness (indicating shock).

SESSION 5

TITLE: INFECTION PREVENTION

(25 MINUTES)

OUTLINE & OBJECTIVES:

This session highlights infection prevention measures to be followed during the procedure.

METHODOLOGY:

- 1) Session will be held on different stations presenting steps of infection prevention.
- 2) Group discussions will be done.

Handout: (H20.5)

INFECTION PREVENTION

HANDOUT (H-20.5)

Preventing infections following a surgical procedure is a complex process. Applying basic principles of antisepsis in the OR should be a priority for every member of the surgical team. OT, when not in use should be locked and cleaned weekly by scrubbing top to bottom with 0.5% chlorine solution and detergent.

The entry of people and their movement inside the OT should be minimal. Proper processing of instruments and other reusable items minimizes the risk of transmission of infection. Wearing proper surgical attire, keeping OR doors closed, and traffic to a minimum are simple measures that decrease airborne contamination.

Surgical aseptic techniques are designed to create such an environment by controlling the four main sources of infectious organisms: the patient, surgical staff, equipment and the operating room environment. Although the patient is often the source of surgical infections, the other three sources are also important.

Specific techniques required to establish and maintain surgical asepsis and make the surgical environment safer include the following:

PATIENT CONSIDERATIONS:

Skin cleaning pre-operatively, skin antisepsis and wound covering

SURGICAL STAFF CONSIDERATIONS:

Hand hygiene (handwashing and/or hand rub and hand rubbing with waterless, alcohol-based antiseptic agents)

Use and removal of gloves and gowns

EQUIPMENT AND ROOM PREPARATION CONSIDERATIONS:

Traffic flow and activity patterns as well as housekeeping practices (and decontamination, cleaning and either sterilization or high-level disinfection of instruments, gloves, and other items)

ENVIRONMENTAL CONSIDERATIONS:

Maintaining an aseptic operating field and using safer operating practices and techniques. Because traffic flow, equipment processing and room preparation requirements are discussed in other chapters, the focus of this chapter will be on improving the surgical environment (operating room), especially the practices and techniques that make surgery safer for both the patient and staff.

THE SURGICAL ENVIRONMENT

The operating room has special characteristics that increase the chance of accidents. For example, staff often use and pass sharp instruments without looking or letting the other person know what they are doing. The workspace is confined and the ability to see what is going on in the operative field for some members of the team (scrub nurse or assistant) may be poor. There is, moreover, the need for speed and the added stress of anxiety, fatigue, frustration and occasionally even anger.

Finally, there is the fact that exposure to blood often occurs without the person's knowledge, usually not until the gloves are removed at the end of the procedure, which prolongs the duration of exposure. The fact that fingers are frequently the site of minor scratches and cuts further increases the risk of infection with blood borne pathogens. Ideally, the used needles should not be bent, broken, recapped or removed from the syringe. If recapping is necessary, use one hand technique. Immediately after use, sharp objects should be disposed of in a puncture-resistant container. In case, despite best efforts, accidental exposure to needle pricks or cuts occurs, follow the local PEP guidelines.

Asepsis protocols should be followed at all the facilities. 0.5% chlorine solution and detergent should be used for scrubbing of procedure rooms from top to bottom and before surgery and

after surgery, operating table, table/countertop and light handles with a cloth. 0.5% chlorine solution should be used for cleaning floor and managing spills.

WHICH INSTRUMENTS CAUSE INJURIES

Most sharps injuries in hospitals occur in the operating room, and most are due to scalpel and suture-needle injuries, which is not surprising given that these are the two most frequently used sharps during operations. Many other items can also cause sharps injuries and glove tears resulting in exposure to blood. Some of the most important are:

- Hypodermic needles
- Laparoscopy and Needle point cautery tips
- Skin hooks and towel clips
- Sharp-pointed scissors and sharp-tipped mosquito forceps
- Dissecting forceps
- Sharp-toothed tenacula

WHEN DO INJURIES OCCUR SCALPEL INJURIES MOST OFTEN OCCUR WHEN:

- Putting on and taking off the disposable blade
- Passing the scalpel hand to hand between team members
- Cutting (e.g., in using fingers to hold or spread tissue or cutting toward the fingers of the surgeon or assistant)
- Before and after using the scalpel: leaving it on the operative field, dropping it on your own or the assistant's foot, and reaching for scalpels sliding off the drapes
- Placing the scalpel in an over-filled sharps container or a poorly located container

NEEDLE INJURIES MOST OFTEN OCCUR WHEN:

- Loading or repositioning it in the needle holder
- Passing the needle hand to hand between team members
- Suturing: using fingers to hold tissue or to guide the needle, sewing toward the surgeon or assistant and holding back other tissues by the surgeon or assistant
- Tying with the needle still attached or left on the operative field
- Before and after using the needle: leaving it on the operative field, dropping it on your own or the assistant's foot, and reaching for suture needles or needles loaded in the needle holder sliding off the drapes
- Placing needles in an over-filled sharps container or a poorly located container

STEPS TO REDUCE SHARPS INJURIES:

- Use a small Mayo forceps (not fingers) when holding the scalpel blade, when putting it on or taking it off or loading the suture needle

- Always use tissue forceps, not fingers, to hold tissue when using a scalpel or suturing.
- Use a “hands-free” technique to pass or transfer sharps (scalpel, needles and sharp-tipped scissors) by establishing a Safe or Neutral Zone in the operative field (see below).
- Always remove sharps from the field immediately after use.
- Make sure that sharps containers are replaced when they are only three-quarters full and place containers as close to where sharps are being used as conveniently possible (i.e., within arm’s reach).

THE “HANDS-FREE” TECHNIQUE FOR PASSING SURGICAL INSTRUMENTS:

A safer method of passing sharp instruments (scalpels, suture needles and sharp scissors) during surgery, called the “hands-free” technique, has recently been recommended. This technique for sharps is inexpensive, simple to use, and ensures that the surgeon, assistant or scrub nurse never touches the same instrument at the same time. Instruments passed with the hands-free technique include anything sharp enough to puncture a glove (e.g., scalpel, sharp-tipped mosquito forceps and loaded needle holders).

Using the hands-free technique, the assistant or scrub nurse places a sterile or high-level disinfected kidney tray, or another suitable small container, on the operative field between her/himself and the surgeon.

The container is designated as the Safe or Neutral Zone in which sharps are placed before and immediately after use. For example, the assistant or scrub nurse alerts the surgeon that a sharp instrument has been placed in or on the Safe Zone, with the handle pointing toward the surgeon, by saying “scalpel” or “sharp” while placing it there. The surgeon then picks up the instrument and returns it to the container after use, this time with the handle pointing away from her/him.

Another way to do this is to have the assistant or scrub nurse place the instrument in a container and pass it to the surgeon. The surgeon lifts the instrument out of the container, which is left on the field until the surgeon returns the instrument to it. The assistant or scrub nurse then picks up the container and returns it to the stand.

SAFE HANDLING OF HYPODERMIC NEEDLES AND SYRINGES

In the operating room, scalpels and suture needles are the leading source of penetrating injuries. Hypodermic (hollow bore) needles, however, cause the most injuries to health workers at all levels. Surgeons and assistants are most often stuck by hypodermic needles during procedures. 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.

SAFETY TIPS FOR USING HYPODERMIC NEEDLES AND SYRINGES

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

IF THE NEEDLE MUST BE RECAPPED

Use the “one-handed” recap method:

First, place the needle cap on a firm, flat surface; then remove hand.

Next, with one hand holding the syringe, use the needle to “scoop” up the cap

With the cap now covering the needle tip, turn the syringe upright (vertical) so the needle and syringe are pointing toward the ceiling.

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).

PROCESSING LAPAROSCOPES

Laparoscopes and accessories should be sterilized or should undergo HLD using the chemical method by soaking in 2% glutaraldehyde solution. All steps of the decontamination and cleaning process must be followed before the laparoscopes and accessories are put in the chemical solution.

DECONTAMINATION:

Immediately after use, gently wipe the laparoscope, fibre- optic light source, and cable and plastic tubing using a cloth soaked in 60–90% ethyl or isopropyl alcohol to remove all blood and organic material.

CLEANING:

Place the dissembled parts of the laparoscope in a basin of clean water. Wash all outer surfaces using a soft cloth. Clean the inner channels with a clean brush supplied with the laparoscopic kit.

HIGH-LEVEL DISINFECTION:

Put clean and dried disassembled equipment in a basin containing 2% glutaraldehyde solution for 20 minutes. For the disinfection to be effective, all parts of the laparoscope must be fully immersed, and the disinfectant must touch all the surfaces of the instrument. Rinse twice with water boiled for 20 minutes and cooled to remove all traces of the disinfectant.

STERILIZATION:

To sterilize, soak the clean and dried disassembled laparoscope in 2% glutaraldehyde solution for 8 to 10 hours. Rinse twice with sterile water to completely remove all traces of the disinfectant and store in a sterile covered container.

DISPOSAL OF WASTE, NEEDLES, AND OTHER MATERIALS:

Contaminated waste is a potential source of infection for the staff as well as the local community. Therefore, waste should be disposed of properly.

- 1) Waste should be buried or burnt. Burning should preferably be done in an incinerator or steel drum as opposed to open burning.
- 2) If burning is not possible, then the waste should be put in a pit and buried, but it should never be thrown outside or left in open pits.
- 3) For waste that is to be picked by the municipal authorities, these should be placed in closed dumpsters prior to removal.
- 4) Solid waste, including dressings and other items contaminated with blood and organic material, should be disposed of in leak-proof washable containers conveniently located in the OT/procedure house.
- 5) Liquid waste should be poured down a utility drain or into a toilet or latrine with a flush; or else it should be buried. Avoid splashing when disposing of liquid waste.
- 6) Sharp objects (hypodermic needles, scalpel blades, suture needles) should be disposed of in a puncture-resistant container with a lid made of either metal or heavy rigid plastic or cardboard.
- 7) Containers with needles and sharp objects should be disposed of by burning or burying on site.

SESSION 6

TITLE: FREQUENTLY ASKED QUESTIONS

(10 MINUTES)

FREQUENTLY ASKED QUESTIONS

HANDOUT (H-20.6)



Activity (A20.6)

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

QUESTIONS AND ANSWERS ABOUT FEMALE STERILIZATION

1) Will sterilization change a woman's monthly bleeding or make monthly bleeding stop?

No. Most research finds no major changes in bleeding patterns after female sterilization. If a woman was using a hormonal method or IUCD before sterilization, her bleeding pattern will return to the way it was before she used these methods. For example, women switching from combined oral contraceptives to female sterilization may notice heavier bleeding as their monthly bleeding returns to usual patterns. Note, however, that a woman's monthly bleeding usually becomes less regular as she approaches menopause.

2) Will sterilization make a woman lose her sexual desire? Will it make her fat?

No. After sterilization a woman will look and feel the same as before. She can have sex the same as before. She may find that she enjoys sex more because she does not have to worry about getting pregnant. She will not gain weight because of the sterilization procedure.

3) Should sterilization be offered only to women who have had a certain number of children, who have reached a certain age, or who are married?

No. There is no justification for denying sterilization to a woman just because of her age, the

number or sex of her living children, or her marital status. Health care providers must not impose rigid rules about age, number of children, age of last child, or marital status. Each woman must be allowed to decide for herself whether she will want more children and whether or not to have sterilization.

4) Is it not easier for the woman and the health care provider to use general anaesthesia? Why use local anaesthesia?

Local anaesthesia is safer. General anaesthesia is riskier than the sterilization procedure itself. Correct use of local anaesthesia removes the single greatest source of risk in female sterilization procedures, the use of general anaesthesia. Also, after general anaesthesia, women usually feel nauseous. This does not happen as often after local anaesthesia. When using local anaesthesia with sedation and analgesia, however, providers must take care not to overdose the woman with the sedative. They also must handle the woman gently and talk with her throughout the procedure. This helps her to stay calm. With many clients, sedatives can be avoided, especially with good counselling and a skilled provider.

5) Does a woman who has had a sterilization procedure ever have to worry about getting pregnant again?

Generally, no. Female sterilization is highly effective at preventing pregnancy and is intended to be permanent. It is not 100% effective, however. Women who have been sterilized have a slight risk of becoming pregnant: About 5 of every 1,000 women become pregnant within a year after the procedure. The small risk of pregnancy remains beyond the first year and until the woman reaches menopause.

6) Pregnancy after female sterilization is rare, but why does it happen at all?

Most often it is because the woman was already pregnant at the time of sterilization. In some cases, an opening in the fallopian tube develops. Pregnancy also can occur if the provider makes a cut in the wrong place instead of the fallopian tubes.

7) Can sterilization be reversed if the woman decides she wants another child?

Generally, no. Sterilization is intended to be permanent. People who may want more children should choose a different family planning method. Surgery to reverse sterilization is possible for only some women—those who have enough fallopian tube left. Even among these women, reversal often does not lead to pregnancy. The procedure is difficult and expensive, and providers who are able to perform such surgery are hard to find. When pregnancy does occur after reversal, the risk that the pregnancy will be ectopic is greater than usual. Thus, sterilization should be considered irreversible.

8) Is it better for the woman to have female sterilization or for the man to have a vasectomy?

Each couple must decide for themselves which method is best for them. Both are very effective, safe, permanent methods for couples who know that they will not want more children. Ideally,

a couple should consider both methods. If both are acceptable to the couple, vasectomy would be preferable because it is simpler, safer, easier, and less expensive than female sterilization.

9) Will the female sterilization procedure hurt?

Yes, a little. Women receive local anaesthetic to stop pain, and, except in special cases, they remain awake. A woman can feel the health care provider moving her uterus and fallopian tubes. This can be uncomfortable. If a trained anaesthetist or anaesthesiologist and suitable equipment are available, general anaesthesia may be chosen for women who are very frightened of pain. A woman may feel sore and weak for several days or even a few weeks after surgery, but she will soon regain her strength.

10) How can health care providers help a woman decide about female sterilization?

Provide clear, balanced information about female sterilization and other family planning methods, and help a woman think through her decision fully. Thoroughly discuss her feelings about having children and ending her fertility. For example, a provider can help a woman think how she would feel about possible life changes such as a change of partner or a child's death. Review The 7 Points of Informed Consent to be sure the woman understands the sterilization procedure

11) Does female sterilization increase the risk of ectopic pregnancy?

No. On the contrary, female sterilization greatly reduces the risk of ectopic pregnancy. Ectopic pregnancies are very rare among women who have had a sterilization procedure. The rate of ectopic pregnancy among women after female sterilization is 6 per 10,000 women per year. On the rare occasions that sterilization fails, and pregnancy occurs, 33 of every 100 (1 of every 3) of these pregnancies are ectopic. Thus, most pregnancies after sterilization failure are not ectopic. Still, ectopic pregnancy can be life-threatening, so a provider should be aware that ectopic pregnancy is possible if sterilization fails.

12) Where can female sterilization be performed?

If no pre-existing medical conditions require special arrangements:

1. Mini laparotomy can be provided in maternity centres and basic health facilities where surgery can be done. These include both permanent and temporary facilities that can refer the woman to a higher level of care in case of emergency.
2. Laparoscopy requires a better-equipped centre, where the procedure is performed regularly, and an anaesthetist is available.

SESSION 7

TITLE: SUMMARIZE AND WRAP UP

(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:

- 2018 edition 2018 - Family Planning fphandbook.org/sites/default/files/global-handbook-2018-full-web.pdf

VASECTOMY (MALE STERILIZATION)



TIME: 2 HOURS 30 MINUTES

Vasectomy or male sterilization is the surgical process of cutting and tying the vas deferens in order to prevent spermatozoa from mixing with semen. Consequently, when ejaculation occurs, the semen will not have any sperms. The operation is performed under a local anaesthetic and is one of the most effective methods of contraception.



TRAINING OBJECTIVES

- 1) Discuss the vasectomy procedure, counselling, client assessment and client follow up.
- 2) Demonstrate counselling skills for vasectomy.
- 3) Describe the use MEC for vasectomy.
- 4) Discuss post-procedure care and management of potential problems.



LEARNING OUTCOMES

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

- 1) Describe the vasectomy procedure in detail, with its effectiveness, advantages, and limitations.
- 2) Discuss side-effects and possible complications with their management.
- 3) Improve their counselling skills for vasectomy.
- 4) Be aware of the WHO recommendations for client assessment for vasectomy.



ADVANCE PREPARATIONS

- 1) WHO MEC Wheel 2015.
- 2) WHO Family Planning- Global Handbook for Providers 2018.



TRAINING/LEARNING METHODS

- 1) Power point presentation
- 2) Handouts
- 3) Role-play
- 4) Brainstorming
- 5) Working in small groups and pairs



TRAINING MATERIAL

Trainer's Material	Trainee's Material
Hand Outs: H21.1, H21.2, H21.3, H21.4, H21.5	Hand Outs: H21.1, H21.2, H21.3, H21.4, H21.5
Activity: A21.2a, A21.2b, A21.4, A21.5	Job Aids: J21.2, J21.4
Checklists: C21.3	Checklists: C21.3
Job aid: J21.2, J21.4	
PPT: (21)	



CONSTITUTION OF THE SESSION

Six mini sessions will be held

1. Introduction to Vasectomy, types and effectiveness	Brainstorming/discussion/power point	30 Mins
2. Advantages and disadvantages, Counselling / Informed consent	Brainstorming / group work	30 Mins
3. Client Assessment medical eligibility criteria /myths /cautions/ follow Up	Role play/Group work/MEC Wheels	30 Mins
4. Side-effects /complications	Group work/ PPT	30 Mins
5. FAQs	Basket Game	20 Mins
6. Summarize and wrap up		10 Mins

SESSION 1

TITLE: INTRODUCTION TO VASECTOMY, TYPES AND EFFECTIVENESS

(30 MINUTES)

OUTLINE & OBJECTIVES:

This section outlines details of the procedure, its effectiveness and health benefits.

METHODOLOGY:

Small group discussion followed by a short interactive PowerPoint presentation.

Handouts (H21.1)

INTRODUCTION TO VASECTOMY, TYPES AND EFFECTIVENESS

HANDOUT (H-21.1)

Vasectomy, a method of male sterilization, is a simple, minor surgical procedure that takes 5-15 minutes to perform. It requires 5-10 minutes of pre-operative preparation and administration of local anaesthesia. It is one of the safest and most effective family planning methods and is one of the few contraceptive options available to men.

A small opening is made in the man's scrotum and the vas deferens on either side is closed off. This keeps sperms out of the semen. The man can still have erection and ejaculate semen, but his semen no longer makes a woman pregnant because it has no sperms in it.

The option of vasectomy is a good option when a woman has some medical conditions that hinder the use of any female method of contraception. For this method to be effective, correct use is essential. Correct use means using condoms or another effective family planning method consistently for at least the first 3 months, post procedure, or until the sperms completely disappear from the semen.

HOW EFFECTIVE?

Vasectomy is one of the most effective methods, with a small risk of failure:

- 1) Among the husbands of women who have vasectomies, far less than 1 in every 100 will become pregnant in the first year of use of the method. In fact, less than 2 women in every 1,000 will become pregnant. This means that 998 or 999 of 1,000 women whose husband have had vasectomy will not become pregnant.

- 2) It is important to have the semen examined at 3 months after the procedure to see if it still contains sperms. If no sperms are found, 1 woman in every 1,000 of these men's husband will become pregnant in the first year.
- 3) Among husbands of women who do not have their semen examined, pregnancies are slightly more common, but still less than 2 per 1,000 women.
- 4) Vasectomy is not fully effective for 3 months after the procedure. Some pregnancies occur within the first year because the couple does not use condoms or another effective method consistently and correctly in the first 3 months, before the vasectomy is fully effective.
- 5) A small risk of pregnancy remains beyond the first year after the vasectomy and until the woman reaches menopause. 3 years of use: About 4 pregnancies per 1,000 women.

If the wife of a man who has had a vasectomy becomes pregnant, it may be because:

1. The couple did not always use another method during the first 3 months after the procedure.
2. The provider made a mistake.
3. The cut ends of the vas deferens grew back together.

The procedure is intended to be permanent. Reversal surgery is difficult, expensive, and not available in most areas. When performed, reversal surgery often does not lead to pregnancy

VASECTOMY TECHNIQUES:

REACHING THE VAS: NO-SCALPEL VASECTOMY:

No-scalpel vasectomy is the recommended technique for reaching each of vas deferens that carries sperm to the penis. It is becoming the standard technique around the world. Differences from conventional procedure using incisions:

- 1) Uses one small puncture instead of 1 or 2 incisions in the scrotum.
- 2) No stitches required to close the skin.
- 3) Special anaesthesia technique needs only one needle puncture instead of 2 or more.

ADVANTAGES:

- 1) Less pain and bruising and quicker recovery.
- 2) Fewer infections and less collection of blood in the tissue (hematoma).
- 3) Total time for the vasectomy is shorter, around 15 minutes.

Both no-scalpel and conventional incision procedures are quick, safe, and effective.

BLOCKING THE VAS:

For most vasectomies ligation and excision is used. This entails cutting and removing a short piece of each tube and then tying both remaining cut ends of the vas. This procedure has a low failure rate. Applying heat or electricity to the ends of each vas (cauterizing) has an even lower failure rate than ligation and excision. The chances that vasectomy will fail can be reduced further by enclosing a cut end of the vas, after the ends have been tied or cauterized, in the thin layer of tissue that surrounds the vas (fascial interposition). If training and equipment are available, cautery and/or fascial interposition are recommended. Blocking the vas with clips is not recommended because of higher pregnancy rates.

Please add picture from page 232 and 239

PERFORMING THE VASECTOMY PROCEDURE:

EXPLAINING THE PROCEDURE:

A man who has chosen a vasectomy needs to know what will happen during the procedure. The following description can help to explain the procedure to him. Learning to perform a vasectomy takes training and practice under direct supervision. Summary of the steps of the procedure are as follows:

- 1) The provider uses proper infection-prevention procedures at all times.
- 2) The man receives an injection of local anaesthetic in his scrotum to prevent pain (he stays awake throughout the procedure).
- 3) The provider feels the skin of the scrotum to find each vas deferens, the 2 tubes in the scrotum that carry sperms.
- 4) The provider makes a puncture or incision in the skin:
 - Using the no-scalpel vasectomy technique, the provider grasps the tube with specially designed forceps and makes a tiny puncture in the skin at the midline of the scrotum with a special sharp surgical instrument.
 - Using the conventional procedure, the provider makes 1 or 2 small incisions in the skin with a scalpel.

1. The provider lifts out a small loop of each vas from the puncture or incision. Most providers then cut each tube and tie one or both cut ends closed with thread. Some close off the tubes with heat or electricity. They may also enclose one end of the vas in the thin layer of tissue that surrounds the vas.

2. The puncture is covered with an adhesive bandage, or the incision may be closed with stitches.

The man receives instructions on what to do after he leaves the clinic or hospital. The man may feel lightheaded briefly after the procedure. He should stand first with help, and he should rest for 15 to 30 minutes. He usually can leave within an hour.

SESSION 2

TITLE: ADVANTAGES, DISADVANTAGES AND COUNSELLING ABOUT THE PROCEDURE

(30 MINUTES)

OUTLINE & OBJECTIVES:

This section highlights the importance of counselling and informed consent for vasectomy.

METHODOLOGY:

- 1) Role play, client and health care provider
- 2) Group Discussion
- 3) Short presentation

Handouts: (H21.2)

Activity: (A21.2a, 21.2b)

Job Aid: (J21.2)

ADVANTAGES, DISADVANTAGES AND COUNSELLING HANDOUT (H-21.2)



Activity (A21.2a)

The participants are divided into two groups, based on their birthdays falling in the first or second half of the year. Task them to list the advantages or benefits and disadvantages or limitations of Vasectomy and write them on flip chart in 10 minutes each.

Allow 5 minutes for the two group representatives to present and then the trainer moderates a large group discussion and highlights any points that were missed.

ADVANTAGES OF VASECTOMY:

- 1) Highly effective, three months after the procedure.
- 2) Permanent, safe, simple, and easy to perform.
- 3) Can be performed in a clinic, office, or at a primary care centre.
- 4) No resupplies or repeated clinic visits.

- 5) It does not need medical follow-up after it has been performed, neither re-supply.
- 6) No long-term health risks.
- 7) The user doesn't depend on something; he doesn't need to remember anything particular (with the exception of waiting for 3 months).
- 8) A reasonable option for couples where wives cannot not undergo a method for permanent contraception.
- 9) Does not result in the loss of sexual ability, erection, and ejaculation.
- 10) It does not interfere with the sexual act.
- 11) Allows the client to have sex as before but without fear of pregnancy, which may also result in better sex and increased sexual satisfaction, because there is no longer the worry about pregnancy.
- 12) No health risks, neither long-term side-effects.
- 13) The cost-efficiency ratio is low (it costs at most once).
- 14) Permanent. A small, quick procedure leads to lifelong, safe and very effective family planning.
 1. Compared to voluntary female sterilization, probably slightly more effective.
 2. Can be tested for effectiveness at any time.

LIMITATIONS OF VASECTOMY:

- 1) The man is usually uncomfortable for 2 or 3 days.
- 2) Pain in scrotum, swelling and bruising.
- 3) Brief feeling of faintness after the procedure.
- 4) Bleeding or infection at the incision site or inside the incision.
- 5) Rarely blood clots in the scrotum.
- 6) Requires minor surgery by a trained provider.
- 7) Not immediately effective.
- 8) The couple must use another contraceptive method for at least the first 3 months after the surgery, or until sperms are cleared from semen.
- 9) Semen analysis, where available, can confirm contraceptive effectiveness after the 3-month waiting period.
- 10) Reversal surgery is difficult, expensive, and not available in settings that are poor in resource.
- 11) No protection against STIs including HIV.

There is little evidence for a causal association between prostate cancer and vasectomy and experts after reviewing available evidence have concluded that no change was necessary in the practice of vasectomy.

COUNSELLING

Since vasectomy is intended to be a permanent method of contraception, it should be provided only to men who have decided on their own that they do not want children anymore. Clients

should be counselled about other available methods of contraception before deciding on sterilization.

INFORMED CONSENT:

The surgeon should verify that the client has signed the informed consent form before beginning the procedure. Although the purpose of signing the form is to document informed consent, the principle focus should be on confirming that the client has made an informed choice of vasectomy as a contraceptive method.

Counseling must cover all 7 points of informed consent. To give informed consent to vasectomy, the client must understand the following points:

- 1) Temporary contraceptives also are available to the client.
- 2) Voluntary vasectomy is a surgical procedure.
- 3) There are certain risks of the procedure as well as benefits. (Both risks and benefits must be explained in a way that the client can understand.)
- 4) If successful, the procedure will prevent the client from ever having any more children.
- 5) The procedure is considered permanent and cannot be reversed.
- 6) The client can decide against the procedure at any time before it takes place (without losing rights to other medical, health, or other services or benefits).
- 7) The procedure does not protect against sexually transmitted infections, including HIV.

INSTRUCTIONS TO THE CLIENT:

Men undergoing vasectomy should receive clear instructions about post-operative care, the anticipated side effects, action to be taken if complications occur, sites where they can access emergency care, the need for post-operative semen analysis and the time and place for making a follow-up visit.



Activity (A21.2b)

Ask 2 participants to volunteer for role play as client and counsellor. Counsellor or surgeon needs to address pre-and post-procedure care and should highlight the side effects and complications. The permanent and irreversible nature of the procedure must be discussed. The surgeon should answer his queries as the client opts vasectomy.

Both are given 10 minutes to prepare and role play is carried out and feedback from the participants and trainer is used for discussion.

BEFORE THE PROCEDURE, THE MAN SHOULD:

- 1) Bathe thoroughly, especially cleaning the genital area and upper inner thighs.
- 2) Wear clean and loose-fitting clothing.
- 3) Not take any medicines for 24 hours prior to the procedure, unless the health care provider performing the procedure tells him to do so.

Explaining Self-Care for Vasectomy Job Aid (J21.2)

Supporting the User	
1. Before the procedure the man should	Wear clean, loose-fitting clothing to the health facility.
2. After the procedure the man should	<ol style="list-style-type: none"> 1) If possible, put cold compresses on the scrotum for the first 4 hours, which may decrease pain and bleeding. 2) He will have some discomfort, swelling, and bruising. These should go away within 2 to 3 days. 3) Rest for 2 days if possible 4) Wear snug underwear or pants for 2 to 3 days to help support the scrotum. This will lessen swelling, bleeding, and pain. 5) Keep the puncture/incision site clean and dry for 2 to 3 days. He can use a towel to wipe his body clean but should not soak in water. 6) Wear snug underwear or pants for 2-3 days to help support the scrotum. This will lessen swelling, bleeding and pain. 7) Use condoms or another effective family planning method for 3 months after the procedure. (The previously recommended alternative, to wait for 20 ejaculations, has proved less reliable than waiting 3 months and is no longer recommended.) 8) Take Paracetamol or another safe, locally available pain-relief medication as needed. He should not take aspirin or ibuprofen, which slow blood clotting. 9) He can have sex within 2-3 days after the procedure if he is not uncomfortable, but he needs to use condoms. 10) He can expect his sexual performance to be unchanged. 11) In most cases, using good surgical technique to minimize the trauma and limit bleeding, practicing aseptic techniques, and giving clients good post-operative instructions, can prevent bleeding, hematoma, and infection
3. What to do about the most common problems	<ol style="list-style-type: none"> 1) Discomfort in the scrotum usually lasts 2 to 3 days. Suggest ibuprofen (200–400 mg), paracetamol (500–1000 mg), or other pain reliever. 2) He should not take aspirin, which slows blood clotting.

4. Plan the follow-up visit

Ask him to return in 3 months for semen analysis, if available.
No man should be denied a vasectomy, however, because follow-up would be difficult or not possible.

SESSION 3

TITLE: CLIENT ASSESSMENT, MEC, MYTHS AND FOLLOW UP

(30 MINUTES)

OUTLINE & OBJECTIVES:

This session involves discussion regarding the medical eligibility criteria and will clarify the misconceptions about the procedure

METHODOLOGY

- 1) Group discussion.
- 2) MEC wheel.

Handouts (H21.3)

Checklist: (C21.3)

CLIENT ASSESSMENT, MEC, MYTHS AND FOLLOW UP

HANDOUT (H-21.3)

CLIENT ASSESSMENT:

Vasectomy is a safe and simple procedure when undertaken with proper screening. Prior to vasectomy, a medical history should be taken and a limited physical examination should be done including genital examination; the penis, scrotum and the inguinal region should be inspected visually; and the scrotum should be palpated. Routine laboratory tests are not needed but should be reserved for specific cases in which the provider suspects a condition that would make it necessary to make extra preparation.

MEDICAL ELIGIBILITY CRITERIA FOR VASECTOMY:

All men can have vasectomy. No medical conditions prevent a man from having vasectomy. This checklist asks the client about known medical conditions that may limit where, or how the vasectomy procedure should be performed.

Ask the client the questions below.

If he answers “no” to all of the questions, then the vasectomy procedure can be performed in a routine setting without delay. If he answers “yes” to a question below, follow the instructions, which recommend caution, delay, or special arrangements.

MEC QUESTIONS FOR VASECTOMY

1- Do you have any problems with your genitals, such as infections, swelling, injuries, or lumps on your penis or scrotum? If so, what problems?

NO YES

If he has any of the following, use **caution**:

- Previous scrotal injury.
- Swollen scrotum due to swollen veins or membranes in the spermatic cord or testes (large varicocele or hydrocele).
- Undescended testicle—one side only. (Vasectomy is performed only on the normal side. Then, if any sperm are present in a semen sample after 3 months, the other side must be done, too.)

If he has any of the following, **delay** vasectomy:

- Active sexually transmitted infection.
- Swollen, tender (inflamed) tip of the penis, sperm ducts (epididymis), or testicles.
- Scrotal skin infection or a mass in the scrotum.

If he has any of the following, make **special** arrangements:

- Hernia in the groin. (If able, the provider can perform the Vasectomy at the same time as repairing the hernia. If this is not possible, the hernia should be repaired first.)
- Undescended testicles—both sides.

2- Do you have any other conditions or infections? If so, what?

NO YES

If he has the following, use **caution**:

- Diabetes.
- Depression.
- Young age.
- Lupus with positive (or unknown) antiphospholipid antibodies or on immunosuppressive treatment.

If he has any of the following, **delay** vasectomy:

- Systemic infection.
- Gastroenteritis.
- Filariasis or elephantiasis.

If he has any of the following, make **special** arrangements:

- HIV with advanced or severe clinical disease.
- Coagulation disorders.
- Lupus with severe thrombocytopenia.

In the checklist below:

Caution means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition.

Delay means postpone vasectomy. These conditions must be treated and resolved before vasectomy can be performed. Give the client another method to use until the procedure can be performed.

Special means special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anaesthesia and other backup medical support. For these conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen is also needed. Help the client choose another method to use until the procedure can be performed.

**Classification of Medical Condition According to Precautionary Measures
Needed for Male Sterilization
Checklist (C21.3)**

(C) CAUTION	(D) DELAY	(S) SPECIAL
1) Single men, men with no living children, men below 18 years of age: counsel carefully and allow extra time to make informed decision	1) Local skin infection: treat prior to procedure	1) Coagulation disorders if present increased risk of bleeding and postoperative hematoma: might need additional medical support
2) Depressive disorders	2) Any local infection, including active STI, balanitis, epididymitis or orchitic: treat prior to procedure	2) AIDS (see below): might require special care depending on the man's health status. Also delay might be warranted in the presence of acute AIDS-related illness
3) Diabetics could have increased risk of postoperative wound infection.	3) Systemic infection or gastroenteritis: treat prior to procedure	3) Previous scrotal injury, large varicocele, large hydrocele: might require an extensive surgery to locate the vas

<p>4) Follow- up and treat with antibiotics if any signs of infection are present.</p> <p>5) Inguinal hernia: vasectomy can be performed at the time of hernia repair.</p>	<p>4) Filariasis, elephantiasis: if condition involves the scrotum, it may be difficult to palpate the spermatic cord. Delay until treated and corrected</p>	<p>4) Crypto-orchidism (undescended testicle): might require an extensive surgery to locate the vas</p> <p>5) Intra-scrotal mass: might be difficult to palpate the spermatic cord. Rule out underlying disease; delay procedure until treated and corrected. (D/S)</p>
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VASECTOMY FOR MEN WITH HIV:

- 1) Men who are living with HIV or are on antiretroviral (ARV) therapy can safely have a vasectomy. Special arrangements are needed to perform vasectomy on a man who has advanced or severe clinical disease.
- 2) Vasectomy does not prevent transmission of HIV.
- 3) Urge these men to use condoms in addition to vasectomy. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.
- 4) No one should be coerced or pressured into getting a vasectomy, and that includes men with HIV.

“COME BACK ANY TIME”: REASONS TO RETURN:

Assure every client that he is welcome to come back any time, for example, if he has problems or questions, or his wife thinks she might be pregnant. (A few vasectomies fail and the wives may become pregnant.) Also, if he has bleeding, pain, pus, heat, swelling, or redness in the genital area that becomes worse or does not go away.

GENERAL HEALTH ADVICE:

Anyone who suddenly feels that something is seriously wrong with his health after a vasectomy procedure should immediately seek medical care from a nurse or doctor. After a surgical procedure, any health problem must be assessed carefully and considered to be related to the procedure until it is medically demonstrated that it is not.

CORRECTING MYTHS ABOUT VASECTOMY:

1) Does not remove the testicles. In vasectomy, the tubes carrying sperm from the testicles are blocked. The testicles remain in place.
2) Does not decrease sex drive.
3) Does not affect sexual function.
4) Does not cause a man to grow fat or become weak, less masculine, or less productive.
5) Does not cause any diseases later in life.
6) Does not prevent transmission of sexually transmitted infections, including HIV.

VASECTOMY IS SAFE FOR ALL MEN:

With proper counselling and informed consent, any man can have a vasectomy safely, including men who:

- 1) Have no or few children
- 2) Are married or unmarried
- 3) Do not have wife's permission
- 4) Are young
- 5) Have sickle cell disease
- 6) Are at high risk of infection with HIV or another STI
- 7) Are living with HIV, whether on antiretroviral therapy

Careful counselling is important to make sure the man will not regret his decision

AVOID UNNECESSARY PROCEDURES:

Men can have vasectomy:

- 1) Without any blood tests or routine laboratory tests.
- 2) Without a blood pressure check.
- 3) Without haemoglobin check.
- 4) Without a cholesterol or liver function check.
- 5) Even if the semen cannot be examined by microscope later to see if it still contains sperms.

FOLLOW UP:

FIRST FOLLOW-UP:

Seven days after the surgery, the client should come for removal of stitches (in cases of conventional vasectomy), to have the wound examined and to have his questions answered.

SECOND FOLLOW-UP:

The client should undergo semen analysis after three months.

EMERGENCY VISIT:

This can be done at any time after the surgery if:

- 1) His wife misses her menstrual period or thinks she is pregnant.
- 2) He has questions or problems of any kind.
- 3) If he has high fever (greater than 380C) in the first 4 weeks and especially in the first week.
- 4) If he has bleeding or pus from the wound
- 5) If he has pain, heat, swelling, or redness at an incision that becomes worse or does not stop (signs of infection).
- 6) If the clinic cannot be reached quickly, he should go to another doctor or health care provider at once.

AT ANY ROUTINE VISIT ASK THESE QUESTIONS:

- 1) Ask if the client has any questions or anything to discuss.
- 2) Ask the client about his experience with vasectomy, whether he is satisfied or whether he has any problems.
- 3) Give him any information or help that he needs and invite him to return any time he has questions or problems.

SESSION 4

TITLE: SIDE-EFFECTS AND COMPLICATIONS

(30 MINUTES)

OUTLINE & OBJECTIVES:

To highlight and discuss the side-effects and possible complications of vasectomy.

METHODOLOGY

Small group discussions followed by a short interactive presentation.

Handouts: (H21.4)

Activity: (A21.4)

Job Aid: (J21.4)

SIDE-EFFECTS AND COMPLICATIONS

HANDOUT (H-21.4)



Activity (A21.4)

Divide the participants into two groups by asking all participants to say YES and NO in a sequential way and then remember what they said. Ask all YES and NO groups to and brainstorm the side effects and complications of Vasectomy, respectively.

Give each one of the groups a Flip chart and a marker to write down the results.

Tell them that they have 10 minutes to complete each task. By the end of the exercise, each group empowers a representative to present their results. Each group will present the side-effects and complications.

After each presentation, ask participants of the other groups to give feedback and discuss. The trainer then discusses the details and adds any missing points in the discussion.

Problems affect men's satisfaction with vasectomy. They deserve the provider's attention. If the client reports complications of vasectomy, listen to his concerns, give advice and support, and if appropriate, treat. Make sure he understands the advice and agrees.

Managing Any Problems

Job Aid (J21.4)

Bleeding or blood clots after the procedure	<ol style="list-style-type: none">1) Reassure him that minor bleeding and small uninfected blood clots usually go away without treatment within a couple of weeks.2) Large blood clots may need to be surgically drained.3) Infected blood clots require antibiotics and hospitalization.
Infection at the puncture or incision site (redness, heat, pain, pus)	<ol style="list-style-type: none">1) Clean the infected area with soap and water or antiseptic.2) Give oral antibiotics for 7 to 10 days.3) Ask the client to return after taking all antibiotics if the infection has not cleared
Abscess (a pocket of pus under the skin caused by infection)	<ol style="list-style-type: none">1) Clean the area with antiseptic.2) Cut open (incise) and drain the abscess.3) Treat the wound.4) Give oral antibiotics for 7 to 10 days.5) Ask the client to return after taking all antibiotics.6) To return if he has heat, redness, pain, or drainage of the wound.
Pain lasting for months	<ol style="list-style-type: none">1) Suggest elevating the scrotum with snug underwear or pants or an athletic supporter.2) Suggest soaking in warm water.3) Suggest aspirin (321–650 mg), ibuprofen (200–400 mg), paracetamol (321–1000 mg), or other pain relievers.4) Provide antibiotics if infection is suspected.5) If pain persists and cannot be tolerated, refer for further care.

SESSION 5

TITLE: FREQUENTLY ASKED QUESTIONS

(20 MINUTES)

OUTLINE & OBJECTIVES:

To highlight and discuss the side-effects and possibly complications from this procedure

METHODOLOGY:

Basket game

Handouts: (H21.5)

Activity: (A21.5)

FREQUENTLY ASKED QUESTIONS

HANDOUT (H-21.5)



Activity (A21.5)

The trainer runs a “Pass the basket session” with a basket full of questions on a different coloured piece of paper. Alternatively, the papers can be shaped into a cabbage, and the participants peel off a layer each. 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 and any missing points are added. A small prize like a pencil or candy is given.

FREQUENTLY ASKED QUESTIONS

1- Will vasectomy make a man lose his sexual ability? Will it make him weak or fat?

No. After vasectomy, a man will look and feel the same as before. He can have sex the same as before. His erection will be as hard and last if before, and ejaculations of semen will be the same. He can work as hard as before, and he will not gain weight because of the vasectomy.

2- Will there be any long-lasting pain from vasectomy?

Some men report having chronic pain or discomfort in the scrotum or testicles that can last from 1 to 5 years or more after a vasectomy. In the largest studies, involving several thousand men, less than 1% reported pain in the scrotum or testicles that had to be treated with surgery. In smaller studies, of about 200 men, as many as 6% reported severe pain in the scrotum or testicles more than 3 years after the vasectomy. In a similar group of men who did not have vasectomies, however, 2% reported similar pain

3- Does a man need to use another contraceptive method after a vasectomy?

Yes, for the first 3 months. If his partner has been using a contraceptive method, she can continue to use it during this time. Not using another method in the first 3 months is the main cause of pregnancies among couples relying on vasectomy.

4- Is it possible to check if a vasectomy is working?

Yes. A provider can examine a semen sample under a microscope to see if it still contains sperm. If the provider sees no moving (motile) sperm, the vasectomy is working. A semen examination is recommended at any time after 3 months following the procedure, but it is not essential.

If there is less than one non-motile sperm per 10 high-power fields (less than 100,000 sperm per millilitre) in the fresh sample, then the man can rely on his vasectomy and stop using a backup method for contraception. If his semen contains more moving sperm, the man should continue to use a backup method and return to the clinic monthly for semen analysis. If his semen continues to have moving sperm, he may need to have a repeat vasectomy.

5- What if a man's wife gets pregnant after he underwent vasectomy?

Every man having a vasectomy should know that vasectomies sometimes fail, and his wife could become pregnant as a result. He should not assume that his wife was unfaithful if she becomes pregnant. If a man's wife becomes pregnant during the first 3 months after his vasectomy, remind the man that for the first 3 months they needed to use another contraceptive method. If possible, offer a semen analysis and if sperm are found, a repeat vasectomy.

6-Will the vasectomy stop working after a time?

Generally, no. Vasectomy is intended to be permanent. In rare cases, however, the tubes that carry sperm grow back together and the man will require a repeat vasectomy.

7-Can a man have his vasectomy reversed if he decides that he wants another child?

Generally, no. Vasectomy is intended to be permanent. People who may want more children should choose a different family planning method. Surgery to reverse vasectomy is possible for only some men, and reversal often does not lead to pregnancy. The procedure is difficult and expensive, and providers who can perform such surgery are hard to find. Thus, vasectomy should be considered irreversible.

8-Is it better for the man to have a vasectomy or for the woman to have female sterilization? Each couple must decide for themselves which method is best for them. Both are highly effective, safe, permanent methods for couples who know that they will not want more children. Ideally, a couple should consider both methods. If both are acceptable to the couple, vasectomy would be preferable because it is simpler, safer, easier, and less expensive than female sterilization.

9-How can health care providers help a man decide about vasectomy?

Provide clear, balanced information about vasectomy and other family planning methods, and help a man think through his decision fully. Thoroughly discuss his feelings about having children and ending his fertility. For example, a provider can help a man think how he would feel about possible life changes such as a change of partner or a child's death. Review The 7 Points of Informed Consent to be sure the man understands the vasectomy procedure.

10-Should vasectomy be offered only to men who have reached a certain age or have a certain number of children?

No. There is no justification for denying vasectomy to a man just because of his age, the number of his living children, or his marital status. Health care providers must not impose rigid rules about age, number of children, age of last child, or marital status. Each man must be allowed to decide for himself whether he will want more children and whether to have a vasectomy.

11-Does vasectomy increase a man's risk of cancer or heart disease later in life?

No. Evidence from large, well-designed studies shows that vasectomy does not increase risks of cancer of the testicles (testicular cancer) or cancer of the prostate (prostate cancer) or heart disease.

12-Can a man who has a vasectomy transmit or become infected with sexually transmitted infections (STIs), including HIV?

Yes. Vasectomies do not protect against STIs, including HIV. All men at risk of STIs, including HIV, whether they have had vasectomies, need to use condoms to protect themselves and their partners from infection.

13-Where can vasectomies be performed?

If no pre-existing medical conditions require special arrangements, vasectomy can be performed in almost any health facility, including health care centres, family planning clinics, and the treatment rooms of private doctors. Where other vasectomy services are not available, mobile teams can perform vasectomies and any follow-up examinations in basic health facilities and specially equipped vehicles, so long as basic medications, supplies, instruments, and equipment can be made available.

SESSION 6

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.

FURTHER READING:

- 1) Family Planning, A Global Handbook for Providers.
- 2) <https://www.plannedparenthood.org/learn/birth-control/vasectomy/how-effective-vasectomy>.

POST PARTUM FAMILY PLANNING



TIME 1 HOUR 30 MINUTES

Family planning during the first postpartum year has the potential to reduce a significant proportion of unintended pregnancies, as the maximum unmet need exists in this period



TRAINING OBJECTIVES

- 1) Describe the importance of effective contraception and high unmet need in post partum period.
- 2) Discuss various postpartum family planning options.
- 3) Stress upon the benefits of PPFPP for mothers, children , families and community.
- 4) Medical eligibility for various contraceptive options in post partum period.



LEARNING OUTCOMES

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

- 1) Discuss the rationale for postpartum family planning.
- 2) Explain the benefits of birth spacing.
- 3) Describe postpartum return of fertility.
- 4) Describe all post-partum contraceptive options.
- 5) Understand and apply MEC for post-partum contraception effectively.



TRAINING/LEARNING METHODS

- 1) Power point presentation
- 2) Group discussion
- 3) Small group presentation
- 4) Handouts
- 5) Group activity
- 6) Brainstorming



ADVANCE PREPARATIONS

- 1) MEC wheel
- 2) MEC charts
- 3) Power point presentation
- 4) WHO post-partum contraception Compendium



CONSTITUTION OF THE SESSION

Four mini sessions will be held

1) Overview of the unmet need for contraception in the post-partum period	Brainstorming / discussion/ PowerPoint	30 Mins
2) Introduction to various options available for PPF	Group work /discussion/ PowerPoint	35 mins
3) Using MEC for postpartum period	Group work, discussion	15 mins
4) Summarize and wrap up		10 Mins



TRAINING MATERIALS

Trainer' Materials	Trainee's Materials
Hand Outs: H22.1, H22.2	Hand Outs: H22.1, H22.2
Activity: A22.1, A22.2, A22.3	Job aid: J22.2
Job aid: J22.2	
Checklist:	
FAQs:	
PPT: (PPT 22)	

SESSION 1

TITLE: OVERVIEW OF THE UNMET NEED FOR CONTRACEPTION IN THE POST-PARTUM PERIOD & OPTIONS FOR PFP

(30 MINUTES)

OUTLINE & OBJECTIVES:

By the end of the module, the participants will have a clear understanding of the high unmet need in the post-partum period. The importance of contraception in Post-partum period and various available options will be highlighted.

METHODOLOGY:

- 1) Brainstorming
- 2) Power point presentation
- 3) Large group discussion

Handout (H22.1)
Activity (A22.1)

OVERVIEW OF THE UNMET NEED FOR CONTRACEPTION IN THE POST-PARTUM PERIOD & PFP OPTIONS

HANDOUT (H-22.1)



(Activity A22.1)

Importance of PFP

Brainstorming session

Participants are divided into two groups based on saying 1 and 2 in sequence. The trainer asks both to brainstorm about the **importance, need** and **benefits** of PFP and choose a group leader to present their discussion.

A large group discussion is moderated by the trainer and any missing points are discussed.

At the end, trainer will present the benefits and types of Post-partum family planning

THE NEED AND IMPORTANCE OF POSTPARTUM FAMILY PLANNING

While family planning (FP) is important throughout an individual's and couple's reproductive life, postpartum family planning (PPFP) focuses on the prevention of unintended and closely spaced pregnancies through the first 12 months following childbirth

Unmet need for family planning is extremely high among women in the postpartum period. More than 90% of postpartum women in developing countries desire to space or limit a subsequent pregnancy, yet 61% are not using a family planning method. Integrating family planning services into maternal health services is an effective strategy for taking advantage of women's increased contacts with the health care system in the time around childbirth.

More importantly, increasing the uptake of PPFP has the potential to protect and empower women at a crucial time in their lives, establish healthy birth spacing practices, and reduce maternal and child morbidity and mortality. Increasing PPFP uptake would also make a large contribution towards Family Planning 2020's (FP2020) goals of increasing rights-based contraceptive access and use in its focus countries and ensuring universal access to sexual and reproductive health and rights by 2030, as laid out in Sustainable Development Goals 3 and 5.

The role of postpartum family planning (PPFP) in improving the health of mothers and babies and in decreasing both maternal and neonatal mortality rates is well documented. A wide range of contraceptive methods is appropriate for postpartum women and can be safely used also by the breastfeeding mother. Systematic and routine provision of family planning (FP) counselling in the antenatal and postpartum periods is critically important for the timely initiation of FP following childbirth, miscarriage, and abortion.

Globally, FP is recognized as a key life-saving intervention for mothers and their children. PPFP has an important role to play in strategies to reduce the unmet need for FP. Postpartum women are among those with the greatest unmet need for FP. Yet they often do not receive the services they need to support longer birth intervals or reduce unintended pregnancy and its consequences. PPFP addresses the needs of those who wish to have children in the future (referred to as 'spacers'), as well as those who have reached their desired family size and wish to avoid future pregnancies (referred to as 'limiters').

Further rationale for PPFP include the following:

- According to an analysis of Demographic and Health Surveys data from 27 countries, 95% of women who are 0–12 months postpartum want to avoid a pregnancy in the next 24 months; but 70% of them are not using contraception
- FP can avert more than 30% of maternal deaths and 10% of child mortality if couples space their pregnancies more than 2 years apart

- Closely spaced pregnancies within the first year postpartum are the riskiest for mother and baby, resulting in increased risks for adverse outcomes, such as preterm, low birth weight and small for gestational age
- Risk of child mortality is highest for very short birth-to-pregnancy intervals (<12 months). If all couples waited 24 months to conceive again, under-five mortality would decrease by 13%. If couples waited 36 months, the decrease would be 25%

THE UNIQUE FAMILY PLANNING NEEDS OF POSTPARTUM WOMEN

The purpose of PPF is to help women to decide on the contraceptive they want to use, to initiate that contraceptive, and to continue contraceptive use for 2 years or longer, depending on the reproductive intentions of the woman or couple. There are unique considerations for providing PPF services to women during the 12-month postpartum period:

- A comprehensive PPF intervention entails continuity of care for the woman and her baby at many points of contact in the health system over a relatively long-time horizon (i.e. from the antenatal period to 12 months after birth).
- Following birth, postpartum women experience amenorrhea for varying lengths of time, depending on their breastfeeding practices. For women who are not breastfeeding, pregnancy can occur within 45 days of giving birth.
- Among women who do not exclusively breastfeed, pregnancy can also occur before menses resumes. Screening for pregnancy following a checklist published within WHO's *Selected practice recommendations for contraceptive use guideline* (SPR) (WHO 2008) or by performing a biochemical pregnancy test (if available) can be done to ensure that postpartum women are not turned away from FP services.
- Sociocultural norms and expectations about resumption of sexual activity following a birth.
- Briefly, WHO recommends the following regarding the use of contraception among women during the first year postpartum and beyond:

Immediately after birth and for up to 6 months following a birth, a woman who is exclusively breastfeeding can use the lactational amenorrhea method (LAM) and several other methods safely. If a mother chooses LAM, she should transition from LAM to another modern contraceptive method by the time the infant reaches 6 months of age, or sooner if LAM criteria (WHO 2009) are not met. She should be provided information in a timely manner to enable her to choose another modern contraceptive method.

RETURN OF FERTILITY IN POSTPARTUM PERIOD

The return of fertility in postpartum is unpredictable and may occur before menses returns. PPFPP counselling with selection of an appropriate method by the client during pregnancy or shortly after childbirth.

1) FOR BREASTFEEDING WOMEN:

The period of infertility is longer for women who practice LAM correctly. After 6 months, when the infant is taking complementary foods and breastfeeds less, return of fertility becomes unpredictable and ovulation may occur prior to menses.

2) FOR NON-BREASTFEEDING WOMEN: NEED TO CHECK

Menses will resume on an average of 4-6 weeks after delivery. Women may ovulate as early as 21 days. Pregnancy is therefore possible prior to the return of menstruation.

3) FOR WOMEN AFTER MISCARRIAGE OR ABORTION:

Ovulation may occur as early as in 7-10 days after a miscarriage or abortion.

Female sterilization: tubal ligation:

SESSION 2

TITLE: INTRODUCTION TO VARIOUS OPTIONS AVAILABLE FOR PFP

(25 MINUTES)

OUTLINE & OBJECTIVES:

By the end of the module, the participants will have up to date information about the various options available for PFP.

METHODOLOGY:

- 1) Brainstorming
- 2) Power point presentation
- 3) Large group discussion

Handout: (H22.2)

Activity: (A22.2)

Job aid: (J22.2)

OPTIONS AVAILABLE FOR PFP

HANDOUT (H-22.2)



(Activity A22.2)

Divide participants into three groups and allot them topics of “LAM, PPIUCD and other methods of post-partum contraception” for brief presentation, let them brain storm for 5 minutes and ask them to choose a group leader and present the discussion. Each group has 5 minutes to present. The trainer then briefly discusses all post-partum options and summarizes by using an interactive presentation

The chart below is used to review various options

RECOMMENDED METHODS

LACTATIONAL AMENORRHEA METHOD (LAM)

This temporary contraceptive method is a good option because it provides an ongoing and safe contraceptive that a fully breastfeeding woman can employ up to **six months** after giving birth. LAM is based on the natural effect of breastfeeding against ovulation. It is reliable and effective provided that three conditions are met:

1. The woman's menses has not yet resumed after giving birth.
2. Breastfeeding is exclusive (full), and the baby is fed often both day and night ("exclusive" means that no other source of food or water is employed).
3. The baby is under six months' old.

PPIUCD (POST-PARTUM INTRA UTERINE CONTRACEPTIVE DEVICE):

A reliable intervention with lower incidence of expulsion if insertion is performed immediately postpartum, within first 10 minutes of delivery of the placenta and with correct technique.

THE POST-PARTUM IUCD TIMELINE

- Post-placental-Within the first 10 minutes after delivery of the placenta
- Immediate postpartum-Within 48 hours after delivery
- Early postpartum-From 48 hours up to 4 weeks after delivery
- Extended postpartum-From 4 weeks up to 1 year after delivery

PROGESTIN-ONLY CONTRACEPTIVES:

Implants and POPs can be initiated on the day of delivery and POIC can be initiated at 6 weeks post-partum

Surgical sterilization can be performed within seven days of childbirth or during the time of a caesarean section procedure or 6 weeks post-delivery or within 48 hours of abortion.

MALE STERILIZATION: VASECTOMY:

The woman's husband can undergo vasectomy any time during the woman's postpartum period.

BARRIERS METHODS:

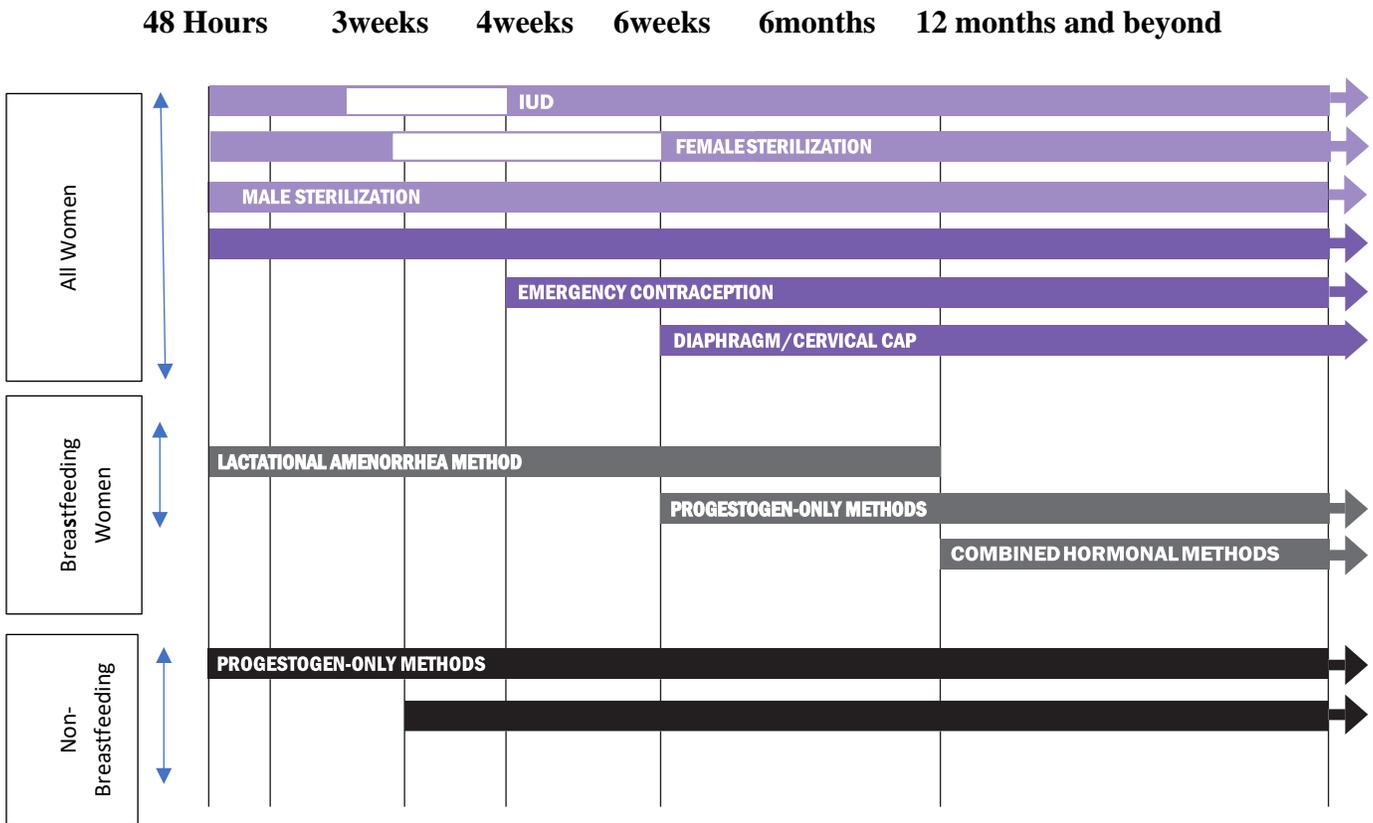
1. Male condoms are recommended options any time postpartum (MEC)
2. Diaphragms and cervical caps are recommended at six weeks postpartum and beyond.

Post-partum contraceptive initiation chart

Job Aid (J22.2)

POSTPARTUM CONTRACEPTIVE OPTIONS (TIMING OF METHOD INITIATION AND BREASTFEEDING CONSIDERATIONS)

Figure 3 provides WHO's recommendations for method use during the first year postpartum (and beyond) within the *Medical eligibility criteria for contraceptive use* (MEC) (WHO 2009). Note that these recommendations are also applicable to women living with HIV. (This document will be kept up to date electronically in accordance with WHO guidance.)



A copper-bearing intrauterine contraceptive device (IUD) can be inserted immediately or up to 48 hours after birth, or any time after 4 weeks postpartum. A female sterilization procedure or tubal occlusion (TO) can be performed immediately or up to 4 days after birth, or any time after 6 weeks postpartum.

For non-breastfeeding women, in addition to IUD and TO, progestogen-only methods can be initiated immediately following birth. Combined oral contraceptives can be initiated starting at 3 weeks after birth.

For breastfeeding women, all progestogen-only methods – progestogen-only pills, injections, implants – can be initiated at 6 weeks following birth, as per WHO MEC. Combined oestrogen and progestin pills cannot be initiated until 6 months after birth.

All women, breastfeeding or not, can initiate use of condoms immediately after birth, emergency contraception after 4 weeks, and the diaphragm or cervical cap after 6 weeks.

SESSION 3

TITLE: OVERVIEW OF THE WHO MEDICAL ELIGIBILITY CRITERIA

(25 MINUTES)

OUTLINE & OBJECTIVES:

Using MEC wheel for post-partum contraceptive options

METHODOLOGY:

Group work, participants to be divided in two groups and present, answer to questions, MEC wheel for various scenarios

Large group discussion

Activity (A22.3)



(Activity A22.3)

The trainer uses the MEC wheel on internet and the participants brainstorm various given case scenarios. All participants should have their MEC wheels handy and the trainer may ask different questions about post-partum contraceptive options.

All participants are encouraged to download the MEC wheel app on their phones

SESSION 4

TITLE: WRAP UP AND SUMMARY

(10 MINUTES)

The recommended family planning methods that may be used during the first year postpartum and beyond based on the MEC for Contraceptive Use.

FURTHER READING

1. High Impact Practices in Family Planning (HIPs). Family planning high impact practices list. Washington, DC: United States Agency for International Development; 2017. Available from: <http://www.fphighimpactpractices.org/high-impact-practices-in-family-planning-list>.
2. World Health Organization (WHO). Medical Eligibility Criteria for Contraceptive Use. 5th ed. Geneva: WHO; 2015. WHO/RHR/15.0. http://www.who.int/reproductivehealth/publications/family_planning/MEC-5/en/.
3. WHO post-partum contraception Compendium. (<http://srhr.org/postpartumfp>)
4. Ross J, Winfrey W. Contraceptive use, intention to use and unmet need during the extended postpartum period. *International Family Planning Perspectives*. 2001;27:20–27

POST ABORTION FAMILY PLANNING



TIME: 2 HOURS

Post abortion family planning is the initiation and use of family planning methods at the time of management of an abortion and or post abortion complications. World Health Organization estimates that globally, around 230 million women become pregnant each year, of which 75 million pregnancies end in either induced or spontaneous abortions or still births. Majority of these women do not want to become pregnant again in the near future. WHO also recommends spacing of at least 6 months between abortion and next pregnancy. Post abortion contraception is important as an integral part of Post abortion care (PAC) provides an opportunity to prevent future unplanned pregnancies.



TRAINING OBJECTIVES

- 1) Discuss the importance of unsafe abortion in contributing to maternal mortality and morbidity
- 2) Describe the role of FP in context of post abortion contraception to save lives from unsafe abortion and capturing the ‘missed opportunity’ to enhance CPR
- 3) Comprehend and fulfil the contraceptive needs of the girls and women presenting with abortion of all types, missed, incomplete and induced
- 4) Discuss various choice available for effective post abortion contraception



LEARNING OUTCOMES

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

- 1) Understand the importance and need for PAFP
- 2) Identify goals of post abortion contraceptive counselling and method provision
- 3) Identify and practice the five key elements of Post abortion care
- 4) Explain long-acting, reversible contraceptives (LARCs) and the importance of offering them as options
- 5) Understand the importance of informed choice in the post abortion contraceptive

counselling

- 6) Assess all women's and girls' medical eligibility for contraceptive methods following abortion-related care



ADVANCE PREPARATIONS

1. Sample contraceptive methods, including EC.
2. WHO's Family planning: A global handbook for providers, 2018
3. Contraceptive counselling skills checklist.
4. Timeline of initiation of the contraceptive methods in post abortion care



TRAINING/LEARNING METHODS

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

*Hands on training is discussed in detail in the respective modules



CONSTITUTION OF THE SESSION

Five mini sessions will be held:

1) The value of FP services in women presenting with abortion of all sorts and in context of maternal mortality and morbidity	Brainstorming /discussion Lecture	30 Mins
2) Options and Initiation of post abortion FP services	Brainstorming /Group work	30 Mins
3) Counselling skills in FP services in PAC	Role play/Discussion	30 Mins
4) PAC in crisis circumstances	Group work /Discussion	20 Mins
5) Wrap up		10 Mins



TRAINING MATERIAL

Trainer's Material	Trainee's Material
Hand Outs: H23.1, H23.2, H23.3, H23.4	Hand Outs: H23.1, H23.2, H23.3, H23.4
Activity: A23.1a, A23.1b, A23.2, A23.3, A23.4	Job Aids: J23.2a, J23.2b
Job Aids: J23.2a, J23.2b	
PPT: (23)	

SESSION 1

TITLE: THE NEED AND VALUE OF FP SERVICES IN WOMEN PRESENTING WITH ABORTION OF ALL SORTS AND IN CONTEXT OF MATERNAL MORTALITY AND MORBIDITY

(30 MINUTES)

OUTLINE & OBJECTIVES:

To sensitize the participants to real-life scenarios where lack of FP leads to unsafe abortion and hence contributes to maternal mortality and morbidity
Highlight the importance of the five elements of PAC

METHODOLGY:

- Brainstorming
- Short interactive power point presentation
- Real life stories, case studies
- Group discussion
- Short presentation about the country context of unsafe abortions as a contributory factor towards maternal mortality and morbidity

Handout: (H23.1)

Activity: (A23.1a, A23.1b)

THE VALUE OF FP SERVICES IN WOMEN PRESENTING WITH ABORTION OF ALL SORTS AND IN CONTEXT OF MATERNAL MORTALITY AND MORBIDITY

HANDOUT (H-23.1)



ACTIVITY (A23.1a)

The trainer starts a discussion about unplanned pregnancies and unsafe abortion in Pakistan. Invite the participants to share a real-life story in the above context.

The trainer then divides the participants into two groups by asking the participants to say 1 and 2 consecutively. The participants are asked to remember their number and then the two groups are asked to join in two different areas for discussion.

One group is asked to prepare a small presentation on the topic of unplanned pregnancies in Pakistan and the other group is asked to prepare the topic of the importance of the post abortion contraception. Both groups are given a Flip chart to write the salient features of their work.

The group is also asked to nominate a presenter and are given 10 minutes each to prepare the presentation, five minutes write and five minutes to present their work
The flipchart presentations are left in the front.

The groups' feedback is invited, and any queries answered. The trainer then goes to any important points mentioned followed by a short PowerPoint presentation to sensitize the participants to unsafe abortion as a significant preventable cause of maternal mortality and morbidity.

RATIONALE:

Following an early pregnancy loss, fertility may return within ten days. Hence the importance of providing timely contraceptive services is of paramount importance. Post abortion family planning can avert unintended pregnancies and abortion associated problems. Abortions account for approximately 6-13% of maternal mortality in Pakistan. Women receiving abortion services at a facility often do not return for family planning services, even though they do not want to become pregnant again in the near future, immediate post abortion period when the woman is still at the facility or in contact with the health care provider is the opportune time to provide family planning counselling and services.

BACKGROUND:

9 Million Pregnancies occur in Pakistan every year and around 45% are unintended. There are 2.2 million abortions each year of which, nearly 679,000 women report to health facilities with a complication (ref: guttmacher.org).

When women cannot access safe abortion, they often turn to unskilled providers or attempt self-inflicted abortions, increasing the risk of an incomplete abortion. Left untreated, an incomplete abortion can lead to the woman's death or disability. In some developing countries, as much as 50% of obstetric complications and maternal hospital care expenditures are due to complications from unsafe abortion.

Post abortion family planning services need to be provided immediately after an induced or spontaneous abortion or treatment of complications, because fertility returns very quickly, as early as 7-10 days. Voluntary post abortion contraception is recommended to reduce unintended pregnancies and repeat abortions and to reduce the risks of adverse maternal and perinatal outcomes for pregnancies following induced or spontaneous abortion (miscarriage).

Post abortion clients are women and girls with a clear need for family planning. Even if a woman wants to have a child immediately, WHO guidelines recommend she wait at least six months after an abortion before getting pregnant again. Strong evidence demonstrates the feasibility, acceptability, and effectiveness of providing family planning services at the same time and location as post abortion services. Despite this evidence, many post abortion clients leave facilities without providers offering them family planning counselling or services. Stress on the importance of strengthening family planning as an integral component of post abortion services and it can contribute to national programs.

Post abortion family planning is one of several high-impact practices in family planning (HIPs) identified by a technical advisory group of international experts. When scaled up and institutionalized, HIPs will maximize investments in a comprehensive family planning strategy. Post abortion family planning is the second missed opportunity

WHAT IS POST ABORTION CONTRACEPTION?

Post abortion family planning is the initiation and use of family planning methods at the time of management of an abortion or before fertility returns (as early as ten days) after the abortion. The World Health Organization estimates that globally, around 230 million women become pregnant each year, of which 75 million pregnancies end in either induced or spontaneous abortions or still births. Majority of these women do not want to become pregnant again in the near future. WHO also recommends spacing of at least 6 months between abortion and next pregnancy. Therefore, providing family planning services as a part of post-abortion care can improve contraceptive acceptance and help break the cycle of repeated unwanted pregnancies. Increasing PAFP uptake would also make a large contribution towards Family Planning 2020's (FP2020) goals of increasing rights-based contraceptive access and use in its focus countries and ensuring

universal access to sexual and reproductive health and rights by 2030, as laid out in Sustainable Development Goals 3 and 5.



(Activity A23.1b)

Elements of Post Abortion Care (PAC) and return of fertility following abortion:

Small brainstorming session to identify and discuss the 5 essential components of PAC.
Discuss return of fertility following abortion. The trainer highlights that post abortion contraception is an integral component of the PAC elements.
Power point to endorse the same.

POST ABORTION CARE:

Post-abortion care (PAC) is treatment given to a woman who presents at a health center or hospital with complications, usually bleeding or infection, due to an incomplete abortion or miscarriage. Medical care, including medication or MVA (Manual Vacuum Aspiration), is given to the woman to evacuate the uterus and to save her life.

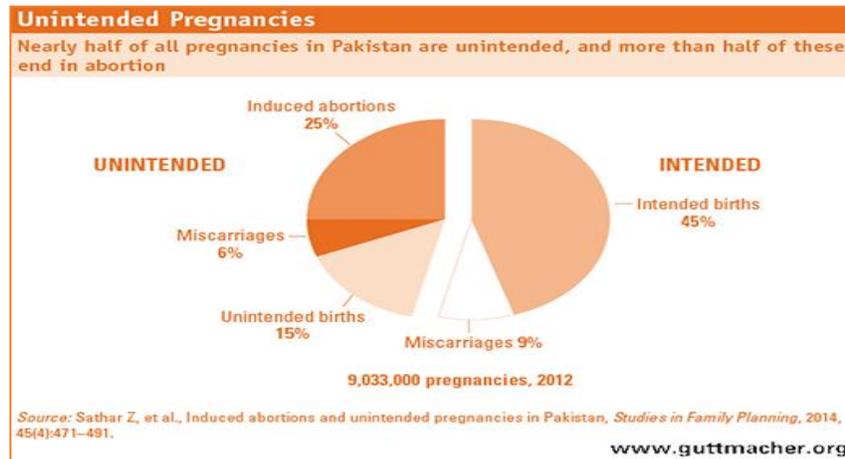
In settings where abortion is legally restricted or access to services is limited, women with unintended pregnancies often resort to unsafe abortions and subsequently require urgent medical attention to treat complications. Women may also suffer incomplete spontaneous abortions (miscarriages) or complications from a safe abortion that require medical attention.

Post abortion care, a term originated by IPAS in the early 1990s, is an approach for reducing deaths and injuries from incomplete and unsafe abortions and their related complications.

Post abortion care is an integral component of **comprehensive abortion care** and includes five essential elements:

1. **Treatment** of incomplete and unsafe abortion and complications
2. **Counselling** to identify and respond to women's emotional and physical health needs
3. **Contraceptive and family-planning services** to help women prevent future unwanted pregnancies and abortions
4. **Reproductive and other health services** that are preferably provided on-site or via referrals to other accessible facilities

5. **Community and service-providers** to prevent unwanted pregnancies and unsafe abortions, to mobilize resources to ensure timely care for abortion complications, and to make sure health services meet community expectations and needs.



WHY IS POST ABORTION CARE (PAC) IMPORTANT?

- 1- Abortions and miscarriages or spontaneous abortions are common.
- 2- Unmet need for family planning is high among Post abortion care clients.
- 3- Unsafe abortion is a major contributor to maternal morbidity and mortality in developing countries.
- 4- Women are at risk of pregnancy almost immediately after abortion.
- 5- Spacing between pregnancies is important for women's and children's health.

THE DYNAMICS OF POST ABORTION CONTRACEPTION:

- 1- Post abortion family planning increases contraceptive acceptance in varied settings.
- 2- Post abortion family planning reduces unplanned pregnancy and repeat abortion.
- 3- Task shifting and task sharing is important, mid-level providers should be trained to provide safe post abortion care counselling and services
- 4- Ensure equitable access to family planning services, regardless of the uterine evacuation method used.

ELEMENTS OF SUCCESSFUL POST ABORTION FAMILY PLANNING PROGRAMS:

- 1) Facility management and staff sensitized on the importance of Post abortion family planning

- 2) Services organized to facilitate family planning provision and to engage male husband with clients' consent
- 3) Job descriptions modified as necessary to expand access to Post abortion family planning
- 4) Service delivery guidelines or clinical protocols aligned with international standards
- 5) Information systems, forecasting, procurement, and supply chain created or updated to ensure a steady supply of contraceptive methods, IEC materials, and consumables
- 6) Engage men, mothers in law (MILs) and support networks. Many women want their husbands or other support person present for PAC counselling. Likewise, many husbands want more information about their wife's condition during PAC and about family planning. Counselling husbands about follow-up care, contraceptive side effects and complications, and return to fertility can increase contraceptive use and strengthen physical and emotional support for PAC patients during recovery
- 7) It is important that FP services are available at the same service delivery points where PAC services are being given

FACTORS CONTRIBUTING TO FAILURE OF POST ABORTION FAMILY PLANNING SERVICES PROVISION

1. Lack of family planning skills and knowledge among maternal health staff
2. Lack of consistent contraceptive supplies, especially at the place of PAC service provision
3. Provider bias and/or resistance to providing family planning to Post abortion clients due to abortion-related stigma and cultural barriers
4. Women disempowered to make decisions regarding contraceptive use
5. Unnecessary medical barriers to family planning provision
6. Failure to build teamwork between maternal health and family planning staff

It is accepted globally that family planning and post abortion family planning is not the job of a specific cadre of health care providers' levels of staff from consultants to residents, specialists and generalists, mid-level providers, including community health workers and lady health workers. Adequate training LHWs to raise awareness about Post abortion care and to counsel women about family planning can increase both the number of women using PAC services and of those using contraception.

It is important that all providers and facilities treating women for incomplete abortion offer immediate and on-site family planning counselling and services as an integral part of Post abortion care regardless of the uterine evacuation method. The contraceptives which can be used after surgical or medical uterine evacuation treatment are the same, and most can be initiated on the day of treatment of an incomplete abortion with a few exceptions.

POST ABORTION CONTRACEPTION: WHEN AND WHAT TYPE

- Following vacuum aspiration), hormonal and non-hormonal contraception, including intrauterine device (IUCD) placement and female sterilization, may be initiated immediately.
- Hormonal methods, including pills, patches, rings, injectables and implants may be started on the day of the first dose of Misoprostol of medical abortion. IUCD placement and female sterilization should be performed when it is reasonably certain the woman is no longer pregnant.
- Male sterilization (vasectomy) is safe and effective and can be performed at any time.
- Long-acting contraceptive methods have higher continuation rates and lower pregnancy rates compared to short-acting methods.
- People, including adolescents, should be able to choose whether to use a contraceptive method, and to select their preferred method, based on accurate contraceptive information and their personal needs and preferences.

Fertility return

Following induced abortion at less than 13 weeks' gestation, women will typically ovulate within three to four weeks, however women can ovulate in as little as eight days. There is no difference in time to ovulation following medical abortion compared to vacuum aspiration.

Given the rapid return to fertility, all women who wish to begin contraception should receive their preferred method at the time of their abortion. If a woman's preferred method is not available, she should be provided a referral and, if desired, an interim method.

Contraceptive start

Following vacuum aspiration or medical abortion where pregnancy expulsion occurs in a facility, all hormonal and non-hormonal contraceptive methods, including IUCD insertion and female sterilization, may be initiated immediately.

Fertility awareness-based methods may be initiated once a woman has had at least one post-abortion menses. Male sterilization (vasectomy) may be performed at any time.

For medical abortion where pregnancy expulsion is expected to occur at home, most forms of contraception (including pills, injectables and implants) may be started with the first pill of the medical abortion if there are no medical contraindications.

IUCDs may be inserted and sterilization performed as soon as it is reasonably certain that a woman is no longer pregnant.

Safety and acceptability of post abortion contraception

For adult women, WHO 2015 *Medical Eligibility Criteria for Contraceptive Use* classifies all contraceptive methods as category one, or safe for immediate use, following first-trimester uncomplicated abortion; recommendations do not differ based on the type of abortion. Female sterilization is classified as acceptable after an uncomplicated abortion.

Similarly, the *Medical Eligibility Criteria for Contraceptive Use* (WHO, 2015) classifies all contraceptive methods as category one, or safe for immediate use, following uncomplicated second-trimester abortion—except IUCDs. Due to an increased risk of expulsion when used after abortion at or after 13 weeks' gestation, IUCDs are classified as category two, meaning the advantages of using the method generally outweigh the risks. Female sterilization is classified as acceptable after an uncomplicated abortion at or after 13 weeks' gestation.

Two of these recommendations differ for adolescent women: Depot medroxyprogesterone acetate (DMPA) injection is classified by WHO as a category two for women under 18 years of age, due to theoretical concerns about bone mineral density. Sterilization may be performed on young women, but special precautions may need to be taken due to the increased risk of regret (WHO, 2015).

In comparison to short-acting methods, long-acting methods of contraception such as implants and IUCDs have higher continuation rates and lower pregnancy and abortion rates; Uptake of long-acting methods is higher after surgical abortion as compared to medical abortion

INFORMED DECISION-MAKING:

WHO recommends that sexual and reproductive health services, including contraceptive services, be delivered in a way that ensures fully informed decision making, respects dignity, autonomy, privacy and confidentiality, and is sensitive to individuals' needs and perspectives. People should be able to choose or refuse contraception based on their personal needs and preferences. Evidence-based, comprehensive contraceptive information, non-directive contraceptive counselling and support should be accessible for all people, including adolescents, so that patients are able to make an informed decision. Ideally a range of contraceptive methods should be available, appropriate referrals for methods not available on site should be offered, and these services should be integrated with abortion and post abortion care.

SESSION 2

TITLE: OPTIONS AND INITIATION OF POST ABORTION CONTRACEPTION

(30 MINUTES)

OUTLINE & OBJECTIVES:

To clearly identify various appropriate options for PAC contraception provision

METHODOLOGY:

Brainstorming / Group work

Handout: (H23.2)

Activity: (A23.2)

Job Aid: (J23.2a, J23.2b)

OPTIONS AND INITIATION OF POST ABORTION CONTRACEPTION

HANDOUT (H-23.2)



ACTIVITY (A23.2)

Time of initiation of various Contraceptive method in PAC

The trainer uses the list to go through various options (the first column of the chart below)

All the options are written on a different coloured paper and the basket game is played with the music. Where the music stops, that participant picks up a paper of his/her choice and answers the question. The answer is then discussed in the large group and the trainer fills in any left-out information.

Chart to be discussed in detail for various scenarios.

Generally, almost all methods of contraception can be initiated immediately following a surgical or medical abortion. Immediate start of contraception after MVA refers to the same day as the procedure, and for medical abortion refers to the day the first pill of a medical abortion regimen is taken. As with the initiation of any method of contraception, the woman's medical eligibility for a method should be verified.

**Post-abortion medical eligibility recommendations for female surgical sterilization
Job Aid (J23.2a)**

POST-ABORTION CONDITION	FEMALE SURGICAL STERILIZATION
Uncomplicated	A
Post-abortal sepsis or fever	D
Severe post-abortal haemorrhage	D
Severe trauma to the genital tract; cervical or vaginal tear at the time of abortion	D
Uterine perforation	S
Acute hematometra	D

Definition of categories

- **A = (accept):** there is no medical reason to deny sterilization to a person with this condition
- **C = (caution):** the procedure is normally conducted in a routine setting, but with extra preparation and precautions
- **D = (delay):** the procedure is delayed until the condition is evaluated and/or corrected; alternative temporary methods of contraception should be provided
- **S = (special):** the procedure should be undertaken in a setting with an experienced surgeon and staff, and equipment is needed to provide general anaesthesia and other back-up medical support. For these conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen is also needed. Alternative temporary methods of contraception should be provided, if referral is required or there is otherwise any delay.

CONTRACEPTIVE METHODS AND MEDICAL ELIGIBILITY AFTER ABORTION

- **Hormonal methods (including pills, injections, implants, the patch and vaginal ring)** may be started immediately after any abortion, including septic abortion.
- **IUCDs** may be inserted immediately after first- or second-trimester abortion; however, the expulsion risk is slightly higher following second-trimester abortions than following first-trimester abortions. IUCDs may be inserted after a medical abortion has been deemed complete.

IMPORTANT

An IUCD should not be inserted immediately after septic abortion.

- **Condom** use may start with the first act of sexual intercourse after abortion, including septic abortion.
- **Diaphragm or cervical cap** use may start with the first act of sexual intercourse after abortion, including septic abortion. Use should be postponed for 6 weeks following abortion beyond 14 weeks' gestation.
- **Fertility-awareness-based methods** should be delayed until regular menstrual cycles return.
- **Female surgical sterilization** can be performed immediately after uncomplicated abortions. However, it should be delayed if abortion is complicated with infection, severe haemorrhage, trauma or acute hematometra.
- **Vasectomy** can be performed at any time.
- **Emergency contraception:** women may use emergency contraceptive pills or an IUCD within 5 days (120 hours) of an act of unprotected sexual intercourse, to decrease pregnancy risk.
- **Withdrawal** use may start with the first act of sexual intercourse, after abortion, including septic abortion.

Overview of Post Abortion Family Planning Methods

Job Aid (J23.2b)

After First-trimester Abortion		
	Family Planning Method	Time of Initiation after Abortion
Complete spontaneous abortion or vacuum aspiration (for incomplete / induced)	Combined pills	Can be started immediately
	Progestin only pills	Can be started immediately
	Injection DMPA	Can be started immediately
	Condoms	Can be started immediately by the male husband
	IUCD	Can be inserted immediately, when infection and injury to the genital tract are ruled out or resolved

	Female sterilization	Can be performed concurrently or within 7 days post abortion provided woman is eligible for the mini lap as well as laparoscopic methods.
After medical abortion with misoprostol	Combined oral contraceptive pills	Can be started on the same day as giving Misoprostol tablets as long as there are no medical contraindications.
	Progestin only Pills	
	Injection DMPA	Can be started on the 3rd day of medical abortion protocol.
	Condoms	Can be used by the male husband as soon as sexual activity is resumed.
	IUCD	Can be inserted once it is confirmed that the abortion is complete (uterus is empty) and the presence of infection is ruled out.
	Implants	Can be inserted at the same day as giving Misoprostol
	Female sterilization	Can be performed after the first menstrual cycle.
After Second-trimester Abortion		
	Family Planning Method	Time of Initiation after Abortion
Spontaneous abortion or dilatation and evacuation	Combined oral contraceptive pills	Can be started immediately
	Progestin only pills	Can be started immediately
	Injection DMPA	Can be started immediately
	Condoms	Can be started immediately
	IUCD	Can be inserted immediately, when infection and injury to the genital tract are ruled out by a specially trained provider as per postpartum IUCD
	Implants	Can be inserted immediately, on the day of starting medical management or the day of doing the MVA

	Female sterilization	Can be performed concurrently or within 7 days post abortion (uncomplicated abortion), if she has made a voluntary, informed choice in advance. In this case the woman is eligible for sterilization by mini lap method only. (Laparoscopic tubal occlusion is contraindicated as there are chances of injury to the fallopian tubes/uterus since the tubes are oedematous. There is also the possibility of slipping of the rings from the tubes leading to failures).
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SESSION 3

TITLE: COUNSELLING FOR FP IN PAC

(30 MINUTES)

OUTLINE & OBJECTIVES:

To highlight the importance of good counselling skills and specific points related to FP counselling in PAC.

METHODOLOGY:

Role plays demonstrating a good and a bad counselling scenario
Feedback from the groups
Large group discussion

Handout: (H23.3)

Activity: (A23.3)

COUNSELLING FOR FP IN PAC

HANDOUT (H-23.3)



Activity (A23.3)

COUNSELLING FOR CONTRACEPTION IN PAC

The trainer briefly discusses and refreshes the counselling skills

The participants are now divided into two groups by giving pink and blue coloured pieces of ribbon and asked to sit together based on the colour of the ribbon

The pink groups brainstorm the counselling points for a client who has come for advice regarding post abortion contraception

Blue group prepares a role play for the same. The two groups give each other feedback, followed by the trainer summarizes and highlights any missing points

COUNSELLING FOR POST ABORTION CONTRACEPTION:

Counselling is a critical component in providing quality post-abortion family planning services and involves communication between a service provider/ counsellor and a client. It helps the client to understand the essential concept of family planning, to have options for contraceptive methods and to choose a method based on her needs and preference.

TIMING OF COUNSELLING:

Before the abortion procedure, it should be checked that the woman's physical condition and emotional situation is appropriate for counselling on contraception. Provider/Counsellor should respect her right to accept or refuse post abortion contraception and services are provided accordingly. Counselling before the abortion procedure offers the woman options of adopting various contraceptive methods. Thus, she would have a chance for immediate IUCD insertion procedure or sterilization procedure while she is still on the table after the completion of abortion. After the abortion procedure once the woman settles down, counselling on available contraceptive methods may also be provided.

ASSESS INDIVIDUAL SITUATION:

The service provider should consider both, the woman's clinical condition and personal situation and discuss any potential barriers to the successful adoption of contraception in a sensitive manner.

INFORMATION ON METHODS:

The service provider should explain the characteristics, use (how it works), side effects and effectiveness of the available methods.

METHOD SPECIFIC COUNSELLING:

The service provider/Counsellor should aid/support the woman in selecting the contraceptive method which best suits her.

POST ABORTION FAMILY PLANNING COUNSELLING MESSAGES

1. **She should wait at least 6 months before trying to conceive again** as it reduces the chances of low birth weight, premature birth, and maternal anaemia.
2. **Fertility returns quickly**, as early as 7-10 days after first trimester abortion or miscarriage and within 4 weeks after a second trimester abortion or miscarriage.

3. **She can choose from available family planning methods that can be started at once.**
4. **If a woman decides not to use contraceptives at this time, providers can offer information on all available methods** and from where to obtain them. Also, providers can offer condoms, oral contraceptives, or emergency contraceptive pills for women to take home and use later.
5. **To avoid infection, she should not have intercourse until bleeding stops** if being treated for infection or vaginal/ cervical injury; she should wait until she is fully healed.
6. **Method specific counselling should follow** if she chooses any family planning method.

EFFECTIVE POST-ABORTION CONTRACEPTION SERVICES:

Post-abortion contraception must be provided routinely as an essential component of comprehensive abortion care. Contraception must be discussed during all the visits (pre-abortion, recovery post-abortion and all follow-up visits), even if the circumstances only permit a few words. Give or prescribe emergency contraception, and explain that this is not an abortive method but alters the ovulation process.

If contraception is not started, make an appointment for the initiation of contraception (if required), and give condoms. Stress the need to use contraception as soon as sexual activity is resumed. Refer, if necessary, although offering an integrated service is preferable.

Given the rapid return to fertility, all women who wish to begin contraception should receive their preferred method at the time of their abortion. If a woman's preferred method is not available, she should be provided a referral and, if desired, an interim method

ENSURE THE WOMAN UNDERSTANDS THE FOLLOWING:

A woman has important choices to make after receiving post abortion care. To make decisions about her health and fertility, she needs to know:

- Fertility returns quickly—within 2 weeks after a first-trimester abortion or miscarriage and within 4 weeks after a second-trimester abortion or miscarriage. She can become pregnant again before the next menstruation. Therefore, she needs protection from pregnancy almost Immediately.
- She can choose among many different family planning methods that she can start at once (see next page). Methods that women should not use immediately after giving birth pose no special risks after treatment for abortion complications.
- If she wants to become pregnant again soon, encourage her to wait. Waiting at least 6 months may reduce the chances of low birth weight, premature birth, and maternal anaemia.
- A woman receiving post abortion care may need other reproductive health services. A provider can help her consider if she might have been exposed to sexually transmitted infections.
- Why did the contraception fail?
- Offer to talk to the woman's husband.

IMPORTANT:

- 1) All women must be made aware of condoms, and the need to protect themselves from sexually transmitted infections.
- 2) She can wait before choosing a contraceptive for ongoing use, but she should consider using a backup method* in the meantime if she has sex. If a woman decides not to use contraceptives at this time, providers can offer information on available methods and where to obtain them. Also, providers can offer condoms, oral contraceptives, and also emergency contraceptive pills for women to take home and use later.
- 3) To avoid infection, she should not have sex until bleeding stops—about 5 to 7 days. If being treated for infection or vaginal or cervical injury, she should wait to have sex again until she has fully healed.
- 4) Emergency contraception must be discussed and made available (or given in advance whenever possible).
- 5) Ensure conditions for continued use of the chosen method (for example access to repeat injections, to resupply of pills as well as affordable costs).
- 6) The client needs information on all the methods she is interested in and, particularly for the one she chooses, the advantages and disadvantages, correct use, side-effects, risks and where to go if problems arise.
- 7) Long-term methods such as intrauterine devices or implants have the best continuation rates and might be preferred for that reason. Injectables can also be a good choice for longer term use.
- 8) Providing leaflets on contraceptive methods is recommended. It is bad practice to give a prescription for a method that the woman cannot afford to buy.

** Backup methods include abstinence, male or female condoms, spermicides, and withdrawal. She can use spermicides if she has no vaginal or cervical injury. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.*

MEC FOR POST-ABORTION HORMONAL CONTRACEPTIVES, INTRAUTERINE DEVICES AND BARRIER CONTRACEPTIVE METHODS

Generally, almost all methods of contraception can be initiated immediately following a surgical or medical abortion. Immediate start of contraception after surgical abortion refers to the same day as the procedure, and for medical abortion refers to the day the first pill of a medical abortion regimen is taken. As with the initiation of any method of contraception, the woman's medical eligibility for a method should be verified.

POST-ABORTION CONDITION	FIRST TRIMESTER	SECOND TRIMESTER	IMMEDIATE POST-SEPTIC ABORTION
COC	1	1	1
CIC	1	1	1
Patch & vaginal ring	1	1	1
POP	1	1	1
DMPA, NET-EN	1	1	1
LNG/ENG implants	1	1	1
Copper-bearing IUCD	1	2	4
LNG-releasing IUCD	1	2	4
Condom	1	1	1
Spermicide	1	1	1
Diaphragm	1	1	1

CIC, combined injectable contraceptive; COC, combined oral contraceptive; DMPA/NET-EN, progestogen-only injectables: depot medroxyprogesterone acetate/Norethisterone enanthate; IUCD, intrauterine device; LNG/ENG, progestogen-only implants: Levonorgestrel/Etonorgestrel; POP, Progestogen-only pill.

WHO RECOMMENDATIONS WHEN TO START CONTRACEPTIVE METHODS:

- Combined oral contraceptives, progestin-only pills, progestin-only injectables, monthly injectables, combined patch, implants, male condoms, female condoms, and withdrawal can be started immediately in every case, even if the woman has injury to the genital tract or has a possible or confirmed infection.
- IUDs, female sterilization, and fertility awareness methods can be started once infection is ruled out or resolved.
- IUDs, combined vaginal ring, spermicides, diaphragms, cervical caps, female sterilization, and fertility awareness methods can be started once any injury to the genital tract has healed.

Special considerations:

- IUD insertion immediately after a second-trimester abortion requires a specifically trained provider.
- Female sterilization must be decided upon in advance, and not while a woman is sedated, under stress, or in pain. Counsel carefully and be sure to mention available reversible methods
- The combined vaginal ring, spermicides, diaphragms, and cervical caps can be used immediately, even in cases of uncomplicated uterine perforation.

- The diaphragm must be refitted after uncomplicated first-trimester miscarriage or abortion. After uncomplicated second-trimester miscarriage or abortion, use should be delayed 6 weeks for the uterus to return to normal size, and then the diaphragm should be refitted.
- Fertility awareness methods: A woman can start symptoms-based methods once she has no infection-related secretions or bleeding due to injury to the genital tract. She can start calendar-based methods with her next monthly bleeding if she is not having bleeding due to injury to the genital tract.

SESSION 4

TITLE: SPECIAL PAC NEEDS OF DIVERSE GROUPS OF WOMEN AND HUMANITARIAN CRISIS

(20 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. young and adolescent girls, and women in emergency settings.

METHODOLOGY:

Brain storming session by dividing the group into two, each covering different scenarios
Crisis situation

Handout: (H23.4)

Activity: (A23.4)

SPECIAL NEEDS OF DIVERSE GROUPS AND CIRCUMSTANCES HANDOUT (H-23.4)



Activity (A23.4)

Brain storming session by dividing the group into two, each covering Crisis situation.

During emergencies, women have an increased risk of unwanted pregnancies due to lack of access

to contraceptives, lack of control over their situation, and sexual violence. In these situations, women opting to terminate a pregnancy often are forced to resort to unskilled providers in unsafe and unhygienic conditions, putting them at great risk. The United Nations Population Fund (UNFPA) estimates that 23-50 percent of maternal deaths in refugee settings are due to complications of unsafe abortion.

The risk is particularly acute during conflicts in which rape is used as a weapon and tactic of war, as has been the case in 36 recent conflicts. When providing humanitarian aid, nongovernmental organizations (NGOs) and governments often do not meet the need for RH services. The recommended interventions in the minimum initial service package (MISP), for reproductive health (RH), including family planning and post-abortion care, may be unavailable because other emergency needs received.

***Detail in the relevant module diverse chapters and crisis.**

SESSION 5

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:

- https://www.who.int/entity/reproductivehealth/publications/family_planning/mec-wheel-5th/en/index.html
- <https://www.who.int/news-room/detail/28-09-2017-worldwide-an-estimated-25-million-unsafe-abortions-occur-each-year> HIV
- <https://www.who.int/en/news-room/fact-sheets/detail/preventing-unsafe-abortion>
- <http://apps.who.int/iris/bitstream/10665/254662/1/WHO-RHR-17.04-eng.pdf?ua=1>
- <https://www.ipas.org/clinical-updates/postabortion-care/IUCD-use/>
- <https://www.ipas.org/clinical-updates/postabortion-care/contraception>
- <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5752610/>
- <https://iawg.net/wp-content/uploads/2017/08/1.-Ipas-WCCACTRNE14.pdf>

POST PARTUM INTRA UTERINE CONTRACEPTIVE DEVICE



TIME: 5.5 HOURS

A huge proportion of recently delivered mothers do not wish to get pregnant at least in the first year but often contribute to the huge unmet need pool. PPIUCD is an intervention with a huge potential for improving the health and lives of mothers and new-borns by getting a long term, safe, reliable, reversible and woman independent method on board, prior to her discharge from the hospital.



SESSION OBJECTIVES

- 1) Discuss differences about IUCD insertion in the postpartum context, counselling, timing, and technique of insertion.
- 2) Provide evidence-based facts in response to frequently asked questions about the PPIUCD.
- 3) Discuss the characteristics and advantages of PPIUCD.
- 4) Describe the conditions when insertion of PPIUCD will be inappropriate in light of MEC.
- 5) Describe and demonstrate PPIUCD insertion and removal using models.
- 6) Highlight removal, after care, side effects, complications, and warning signs.
- 7) Demonstrate appropriate counselling and assessment of women requesting postpartum IUCDs.



LEARNING OUTCOMES

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

- 1) Discuss basic information on PPIUCD including mechanism of action, types, effectiveness, return to fertility, possible side effects, health benefits and potential, health risks, address common misconceptions about the PPIUCD.
- 2) Use the WHO Medical Eligibility Criteria and the WHO MEC Checklist in identifying client conditions regarding who are suitable for PPIUCD insertion.
- 3) Perform client assessment, including medical history and pelvic examination relevant to

the provision of PPIUCD

- 4) Demonstrate proper techniques of PPIUCD insertion and removal with checklists on uterine model.
- 5) Counsel a client interested in using PPIUCD as a contraceptive method and giving post-insertion instructions.
- 6) Demonstrate infection prevention measures relevant to the provision of PPIUCD services.
- 7) Explain the procedures in doing follow-up care of PPIUCD clients.
- 8) Explain proper management of potential problems with PPIUCD use.
- 9) Explain the indications on when to remove the PPIUCD.
- 10) Explain what to do about abnormal findings.



ADVANCE PREPARATIONS

- 1) MEC wheels
- 2) Skills Checklists
- 3) Hands on instrument trays.
- 4) Cu 380 A.
- 5) MAMA U model or sponge uterus
- 6) PowerPoint slides.
- 7) Videos



TRAINING/LEARNING METHODS

- 1) Power point presentation.
- 2) Brainstorming.
- 3) Group activity.
- 4) Small and large group discussions.
- 5) Role-plays.
- 6) FAQ pass the parcel game.



TRAINING MATERIAL

Trainer' Material	Trainee's Material
Hand Outs: H24.1A and B, H24.2, H24.3, H24.4, H24.5, H24.6, H24.7, H24.8, H24.9	Hand Outs: H24.1 A and B, H24.2, H24.3, H24.4, H24.5, H24.6, H24.7, H24.8, H24.9
Activity: A24.2, A24.6, A24.8a, A24.8b, A24.8c, A24.9	Job aid: J24.1, J24.5, J24.6
Job aid: J24.1, J24.2, J24.6	Checklists: C24.3a, C24.3b, C24.4, C24.5a, C24.5b, C24.5c, C24.6
Checklists: C24.3a, C24.3b, C24.4, C24.5a, C24.5b, C24.5c, C24.6	
PPT: (24)	



CONSTITUTION OF THE SESSION

1) Overview of the need & options for PPIUCD	Brainstorming/discussion/PowerPoint	40 Mins
2) Counselling for PPIUCD	Group work/Role play	30 Mins
3) Client Assessment for PPIUCD	Group Discussion	20 Mins
4) Overview of the WHO Medical Eligibility Criteria	Group work/Brainstorming /game	20 Mins
5) Insertion of PPIUCD	Demonstration by trainer Model Practice by participants under supervision	30 Mins 90 Mins
6) Removal of Intrauterine Device /Missing strings	Group work /Videos/Models/Hands on	20 Mins
7) Infection Prevention	Table demonstration, brainstorming	20 Mins
8) Follow-Up Care & Management/Identification and management of side effects and complications	Interactive group work	30 Mins
9) FAQs	Questions	20 Mins
10) Wrap up and Summary		10 Mins

SESSION 1

TITLE: OVERVIEW OF PPIUCD

(40 MINUTES)

OUTLINE & OBJECTIVES:

By the end of the module, the participants will have the following information about the postpartum IUCD:

- 1) How it works?
- 2) Its effectiveness.
- 3) Characteristics and types, Cu 380 A and LNG IUS.
- 4) Recommended timings for insertion.
- 5) Discuss the benefits to the woman of postpartum contraceptive methods, including the postpartum IUCD.
- 6) Describe the key components of the fundamentals of care related to postpartum IUCD service delivery.

METHODOLOGY:

- 1) Brainstorming.
- 2) Power point presentation.
- 3) Large group discussion.
- 4) Group work.
- 5) Pass the basket game.

Handout: (H24.1A and B)

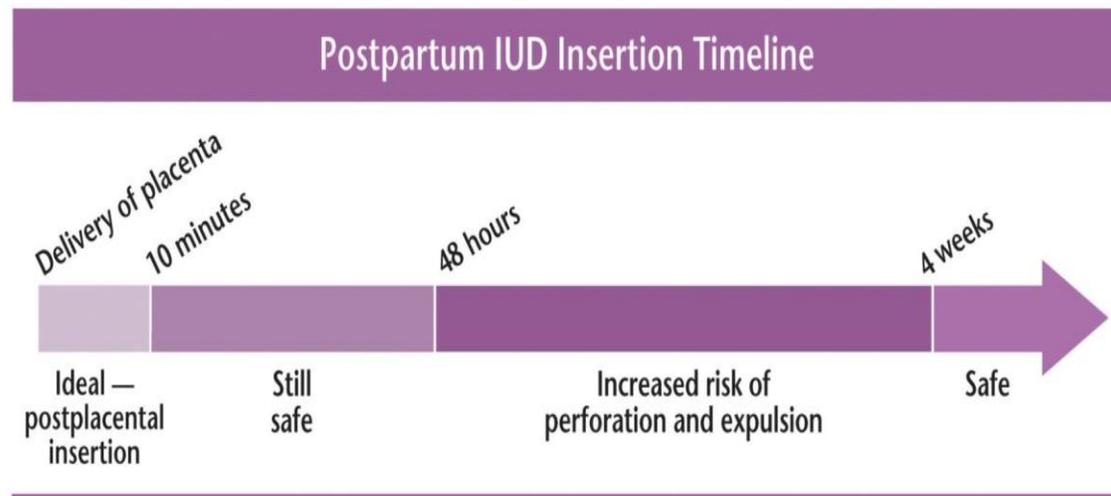
Job aid: (J24.1)

OVERVIEW OF THE NEED, OPTIONS AND PPIUCD

HANDOUT (H-20.1 A)

Post-partum contraceptive options timeline

Job aid (J24.1)



PPIUCD

HANDOUT (H-24.1 B)

Taking advantage of the immediate postpartum period for counselling on family planning and IUCD insertion, overcomes multiple barriers to service provision. The increased institutional deliveries are the opportunity to provide women easy access to immediate PPIUCD services. TheCuT-380A is approved for immediate postpartum insertion as a method of contraception.

The PPIUCD must only be placed after the woman is counselled and gives informed consent. Counselling should take place in the antenatal period, in early labour or immediately postpartum. Counselling for informed consent should not take place during the active phase of labour.

The PPIUCD can be placed immediately following delivery of the placenta, during caesarean section (Trans-caesarean) or alternatively within 48 hours following vaginal birth.

The IUCD must be inserted only by a service provider who has been trained to competency in Immediate PPIUCD service provision according to national standards. PPIUCD insertion must be done in a health care facility that provides delivery services and has acceptable standards of infection prevention.

TIMING OF IUCD INSERTION:

The recommended timings are:

- 1) Immediate, post placental: Insertion within 10 minutes after expulsion of the placenta following a vaginal delivery on the same delivery table.
- 2) Within 48 hours after delivery: Insertion within 48 hours of delivery and prior to discharge from the postpartum ward.
- 3) Intra-caesarean: Insertion that takes place during a caesarean delivery, after removal of the placenta and before closure of the uterine incision.
- 4) Extended Postpartum/Interval: Insertion any time after 6 weeks postpartum.

The IUCD should NOT be inserted from 48 hours to 4 weeks following delivery because there is an increased risk of infection, expulsion and perforation

OVERVIEW OF IUCDS:

There are 2 types of IUCDs available in Pakistan

- 1) Copper-bearing IUCDs, made of a small inert plastic frame covered with copper sleeves^[LSEP]
- 2) Progestin-releasing IUCDs which continuously release a small amount of Levonorgestrel.

MODE OF ACTION:

The IUCD interferes with the ability of sperm to survive and to ascend the fallopian tubes where fertilization occurs. It alters or inhibits sperm migration, ovum transport and fertilization. It stimulates a sterile foreign body reaction in endometrium potentiated by copper.

EFFECTIVENESS:

The CuT-380A is a highly effective (>99% effective). There are 0.6 to 0.8 pregnancies per 100 women in first year of use.

The CuT-380A is effective for 10 years of continuous use. However, many studies have shown that it is effective up to 12 years.

ADVANTAGES:

The specific advantages of an IUCD placed in the immediate postpartum period include: ^[LSEP]

ADVANTAGES FOR THE WOMAN:

- 1) Has no risk of uterine perforation because of the thick wall of the uterus.
- 2) Reduced perception of initial side effects (bleeding and cramping).
- 3) Reduced chance of heavy bleeding, especially among lactational amenorrhea method (LAM) users since they are experiencing amenorrhea.
- 4) No effect on amount or quality of breast milk.
- 5) The woman has an effective method for contraception before discharge from hospital.

ADVANTAGES FOR THE SERVICE PROVIDER OR THE SERVICE DELIVERY SITE:

- 1) Certainty that the woman is not pregnant.
- 2) Saves time as performed on the same delivery table for post placental/ Intra caesarean insertions. Additional evaluations and separate clinical procedure are not required.
- 3) Need for minimal additional instruments, supplies and equipment.
- 4) Convenience for clinical staff; helps relieve overcrowded outpatient facilities thus allowing more women to be served.

LIMITATIONS:

The specific limitations of an IUCD placed in the immediate postpartum period include:

- 1) Increased risk of spontaneous expulsion. The skilled clinicians with right technique of insertion are associated with lower expulsion rates.
- 2) Requires special training of SBAs.
- 3) The other limitations of the immediate PPIUCD are the same as the interval IUCD.

SESSION 2

TITLE: COUNSELLING FOR PPIUCD

(30 MINUTES)

OUTLINE & OBJECTIVES:

At the end of the session, the participants will be able to practice counselling skills satisfactorily in light of the MEC and to answer myths and misconceptions of the women effectively.

METHODOLOGY:

Role play to allow learners to practice counselling and client assessment

Discussion to highlight various points

Handout: (H24.2)

Activity: (A24.2a, A24.2b)

COUNSELLING FOR PPIUCD

HANDOUT (H-24.2)

All pregnant and postpartum women should have access to PFP counselling and services. To ensure timely initiation of an FP method appropriate to the woman's breastfeeding status and fertility intentions, FP counselling (including information about HTSP) should be provided to pregnant women and their families wherever they receive medical care: FP clinics, antenatal clinics, birthing facilities, postpartum and postnatal care facilities, and other facilities like Basic Health Units and Family Welfare Centres where mothers receive routine health care.

Basic postpartum FP care and services should:

- 1) Promote HTSP
- 2) Encourage exclusive breastfeeding and the lactational amenorrhoea method (LAM)
- 3) Counsel on return to fertility
- 4) Offer a wide range of contraceptive choices
- 5) Integrate FP with other maternal and child health programs, including childhood immunization and the prevention of mother-to-child transmission of HIV (PMTCT).

This module reviews informed choice and family planning counselling (more specifically, counselling for postpartum contraceptive use), with an emphasis on postpartum IUCD use. Even when the provider conducts only part of the counselling, he or she is ultimately responsible for ensuring that a client has been adequately counselled and has made an informed choice *before the method is provided*.

- 1) **General family planning counselling:** focus on assisting client in choosing a method
- 2) **Method-specific counselling:** focus on ensuring client's safe and effective use of method chosen
- 3) **Follow-up counselling:** focus on assessing client's satisfaction or problems with method chosen

The provider must also review post insertion instructions with the client to ensure that she knows what to expect and what to do in case of complications and for follow-up.

COUNSELLING FOR PPIUCD CAN TAKE PLACE:

- 1) During **ANC (See Checklist-24.3A)**
- 2) During the early stage of labour (latent phase) (**See Checklist -24.3B**)
- 3) During hospitalization for an ANC complication
- 4) While preparing for a scheduled caesarean section
- 5) During the first 2 days, postpartum

WHILE COUNSELLING FOR PPIUCD DISCUSS KEY CHARACTERISTICS OF THE IUCD

- 1) **Effectiveness:** prevents 99% of pregnancies for up to 12 years (approved for 10 years)
- 2) **Mechanism of action** causes a chemical change that damages the sperm before the sperm and egg meet.
- 3) **How the IUCD is used:** inserted after delivery and then requires no additional care
- 4) **Removal and return to fertility:** IUCD can be removed at any time by a trained provider and fertility will return immediately
- 5) **Return instructions:** the woman should come back 6 weeks' post-partum.

DISCUSS ADVANTAGES

- 1) Immediate placement after delivery
- 2) No action required by the woman
- 3) Immediate return of fertility upon removal
- 4) Does not affect breastfeeding
- 5) Does not affect sexual intercourse.
- 6) Long acting and reversible: Can be used to prevent pregnancy for a short time, as little as a month or as long as 10-12 years

DISCUSS LIMITATIONS

- 1) Heavy and painful menses, especially first few cycles.
- 2) Does not protect against STIs, including HIV/AIDS.
- 3) Small risk of perforation.
- 4) More chance of expulsion when inserted postpartum.



(ACTIVITY A24.2)

ROLE PLAY SCENARIOS:

Provider Instructions for Role Plays

Pretend that you are meeting the client for the first time. Ask the client for his or her name and age. Pretend that there is a health centre nearby to which you can refer the client, if needed.

Remember to:

- 1) Assess the client's reproductive health (RH) goals, concerns, and fertility intentions.
- 2) Address the primary and secondary reasons for the client's visit.
- 3) Facilitate the client's decision-making process.
- 4) Integrate information and services related to other RH issues, as appropriate.
- 5) Help the client act on her or his decision(s).
- 6) Apply your prior experience along with what you have learned from the training and use job aids and tools, as appropriate, to address the client's concerns.

Observer Instructions for Role Plays

Before the start of the interaction:

Review the Counselling **Checklists 8.6** so that you are familiar with the behaviours that you are observing and where they appear on the checklist.

While observing the interaction between the provider and client, remember to:

Use the Counselling Checklist to take notes on what happens during the interaction.

Record how well the provider addresses the case-specific issues in the space provided.

Be prepared to give feedback to the provider regarding how well he or she addressed the client's needs.

Pay particular attention to whether the provider:

Helped the client deal with anxiety

Facilitated communication with a partner
Allowed the client to make an informed decision
Ensured that the client met the medical eligibility criteria for the method she chose.
Helped the client carry out her decision

Client Instructions for Role Plays

Before the start of the interaction:
Read the Client Information Sheet in the Scenarios and make sure you understand your character's situation.
Pick a name for your character. Tell the provider your name, age, and whether you are male or female.
During the interaction, offer information only when the provider asks relevant questions. Use the information given in your Client Information Sheet to respond to the provider's questions.
Feel free to ask questions of the provider.

PPIUCD Scenario 1— Client Information Sheet	PPIUCD Scenario 1— Observer Information Sheet
<p>Client Description: Samina is 24 years old and her husband is a farmer. She delivered a baby boy last night at the hospital. She learned from the health counsellor there about benefits of spacing her births for her own health, as well as that of her children; she also received information about a variety of contraceptives. She and her husband are interested in IUCDs.</p> <p>Offer this information only when the provider asks relevant questions:</p> <ol style="list-style-type: none"> 1) They have been married for 4 years. 2) Her mother-in-law is not in favour of using any contraceptive. 3) Samina does not want to become pregnant again immediately. 4) She used condoms before, but worries about condom slippage and breakage. 5) She is breastfeeding her baby. 6) Her husband and mother-in-law are sitting outside. 	<p>Make note of whether the provider performs these case-specific tasks:</p> <ol style="list-style-type: none"> 1) Assesses the client’s reproductive health goals, fertility intentions, and life plans 2) Offers couples counselling 3) Ensures that the client understands her contraceptive options, including postpartum IUCD and implant 4) Inform her about contraceptive options available during immediate postpartum period 5) Screens client for medical eligibility using the WHO MEC Wheel and Job Aid: WHO MEC Quick Reference Chart. 6) Discuss in detail about using contraceptive (IUCD) immediately after delivery 7) Outlines insertion and follow-up procedures 8) Emphasizes the benefits of using condoms even though both partners are HIV-negative 9) Gets client’s consent for the PPIUCD <p>Methods for which the client is eligible:</p> <ol style="list-style-type: none"> 1. IUCD 2. LNG-IUS

PPIUCD Scenario 2— Client Information Sheet	PPIUCD Scenario 3— Observer Information Sheet
<p>Client Description: Meena has one son who is 1-year-old. She and her husband have been using condoms and abstinence to prevent pregnancy. Her mother-in-law advised her that she will not become pregnant as long as she breastfeeds her baby, but now she finds that she is 4 months pregnant. The couple is quite concerned because, although they definitely want two children, they were not planning to have them so close together.</p> <p>Offer this information <u>only</u> when the provider asks relevant questions:</p> <ol style="list-style-type: none"> 1) Meena has been married for 2 years. 2) She and her husband do not want to have more children. 3) They want to have female sterilization once the children have grown up. 4) She has heard about the PPIUCD but she is scared the IUCD might travel up. <p>She has many questions about the PPIUCD.</p>	<p>Make note of whether the provider performs these case-specific tasks:</p> <ol style="list-style-type: none"> 1) Assesses the client’s reproductive health goals, fertility intentions, and life plans 2) Ensures that the client understands her contraceptive options. 3) Offers couple counselling 4) Encourages her to continue with current pregnancy 5) Counsels and informs about different contraceptive options available during immediate postpartum period 6) If the client is interested in any method, then mentions in the antenatal card. Provides a brochure about contraceptive methods <p>Methods for which the client is eligible: Implants IUCDs (Copper and LNG)</p>

SESSION 3
TITLE: CLIENT ASSESSMENT FOR PPIUCD
(30 MINUTES)

OUTLINE & OBJECTIVES:

To discuss the various times and opportunities for counselling and screening for PPIUCD

METHODOLGY

Experience sharing with large group to see what their practices are
 Power point presentation to highlight the screening cascade

- Handout:** (H24.3)
Checklist: (C24.3a, C24.3b)

CLIENT ASSESSMENT FOR PPIUCD
HANDOUT (H-24.3)

(ANTENATAL COUNSELLING)
CHECKLIST C24.3A

PPIUCD Counselling (Antenatal)					
Step/Task	Cases				
General Family Planning Counselling					
1. Greets the woman respectfully and with kindness					
2. Introduces herself/himself					
3. Ensures privacy and confidentiality					
4. Obtains biographic information (name, address, etc.)					
Antenatal Counselling					

1. Explains the health benefits—for the mother and the baby—of using family planning to space births and delay the next pregnancy by at least 24–36 months.					
2. Asks the client if she and her partner would like to have more children after their upcoming delivery.					
3. Ask the client: a. How long do she and her husband want to wait for the next pregnancy? b. Will she be breastfeeding her baby? c. Does her partner support her in family planning? d. Does she have any medical conditions, or is she taking any medication? e. Are there any methods she does not want to use or has not tolerated in the past?					
4. Tells her the advantages of postpartum family planning; discusses pre-discharge methods a. Tells her that it is easier for the mother to receive a permanent or long-acting method when she is in the health facility for childbirth, before going home b. Tells her about the advantages of exclusive breastfeeding and using the lactational amenorrhea method (LAM) as a contraceptive.					
5. Based on the client’s responses, a. Starts showing the counselling cards/Flip book beginning with the most effective b. Reads the back of the card and places it down in front of the client, with the picture facing the client.					
6. If the client expresses an interest in using PPIUCD after the delivery, continues with the next steps.					
7. Discusses the benefits of long-acting methods: a. Can be inserted immediately or prior to discharge b. Are greater than 99% effective in preventing pregnancy c. Have no impact on breastfeeding d. Can be removed when she and her husband are ready to have another pregnancy					

<p>8. If the client expresses an interest in using IUCD/LNG-IUS/:</p> <p>a. Displays the IUCD, LNG-IUS method specific cards, asks the client if she is interested in using any of these methods soon after the delivery or prior to discharge (within 48 hours).</p>					
<p>9. If the client expresses an interest in using the copper IUCD (Copper T 380A)/ Levonorgestrel intrauterine system (LNG-IUS), describes postpartum IUCD/LNG-IUS insertion and timing of insertion:</p> <p>Can be inserted immediately after delivery, prior to discharge</p> <p>a. Copper IUCD is effective for up to 12 years</p> <p>b. Copper IUCD contains no hormones</p> <p>c. The LNG-IUS is effective up to 3-5 years*, it contains low doses of hormones, and is safe for breastfeeding women</p> <p>d. Talks upfront about side-effects and changes to be expected in the bleeding patterns initially. Tells her that these are not harmful, and she can come back to the provider if it is of concern to her.</p> <p>*The effectiveness period varies with the type of LNG-IUS used.</p>					
<p>10. Reviews WHO MEC Wheel or WHO MEC Quick Reference Chart to verify whether there is any contraindication. If any contraindication is present, goes back to choose another method.</p>					
<p>11. Asks the client if she has any question or needs clarification about the method.</p>					
<p>12. Allows the client to make a final decision by herself (informed choice) without any coercion.</p>					
<p>13. Confirms the client's understanding by asking open-ended questions.</p>					
<p>14. Tells her that she can change her decision at any time and inform the provider about it.</p>					
<p>15. Documents the family planning method chosen on the ANC record card and or use the stamp on her notes so the next attending doctor is aware</p>					

<p>16. If the client does not make a decision at the end of the session, provides her with some method brochures/leaflets (if available)</p> <ul style="list-style-type: none"> a. Tells her to read these brochures at home, and that she can come back to ask any questions b. Guides her in obtaining family planning services later. 					
<p>17. Conducts systematic screening for other services (if service available)</p> <ul style="list-style-type: none"> a. Asks the client when she last had a cervical and breast cancer screening, and offers to perform these if the last check was more than 3 years ago b. Follows national guidelines for prevention of mother-to-child transmission (PMTCT) of HIV and screening for syphilis c. Discusses sexually transmitted infection (STI)/HIV transmission and prevention and detection with the client, using the counselling cards d. Offers condoms for dual protection. 					
<p>18. Thank the client for completing the counselling session.</p>					

(POSTNATAL COUNSELLING)**CHECKLIST- C20.3B**

Counselling (Postpartum)					
Step/Task	Cases				
General Family Planning Counselling					
1. Greets the woman respectfully and with kindness					
2. Introduces herself/himself a rapport by asking about how she and her baby are?					
3. Ensures privacy and confidentiality					
4. Congratulate her for the new baby and give some time to recover and rest					
Immediate Post-Partum Counselling					
1. Helps the woman put the baby to breast within one hour of birth. a. Explains the need for the exclusive breast feeding of the baby on demand, day and night, for the first six months of life.					
2. Asks the woman about her reproductive goals: a. Does she want more children in the future? b. How long do she and her husband want to wait for the next pregnancy? c. Has she used any FP method in the past? Was she happy with the method? d. Was she informed of any PPFM methods during the Antenatal check-ups? e. Does she have any FP method in mind? f. Does she plan to exclusively breastfeed her infant? g. Will her partner support her in family planning? h. Tells her the advantages of postpartum family planning; discusses pre-discharge methods i. Tells her that it is easier for the mother to receive a long-acting method while she is in the health facility and before going home.					

<p>3. Based on the client's responses, talks about methods that are appropriate for her:</p> <ul style="list-style-type: none"> a. Starts showing the counselling cards or the Flip book beginning with the most effective method. b. Reads the back of the card or flip book and places it in front of the client, with the picture facing the client. 					
<p>4. If the client expresses an interest in using LARC methods, discusses the benefits of long-acting methods:</p> <ul style="list-style-type: none"> a. Can be inserted immediately or prior to discharge b. Are greater than 99% effective in preventing pregnancy c. Have no impact on breastfeeding d. Can be removed when she wants another baby or is having any concerns e. Does not need any daily action. 					
<p>5. If the client expresses an interest in using the Copper IUCD/LNG-IUS: Describes postpartum IUCD/LNG-IUS insertion and timing of insert:</p> <ul style="list-style-type: none"> a. Is effective for up to 12 years b. The Copper IUCD contains no hormones c. The LNG-IUS contains low doses of hormones and is safe for Breastfeeding women. Some minor changes in the bleeding pattern may happen initially. 					
<p>6. Explains LAM and the 3 Criteria:</p> <ul style="list-style-type: none"> a. The mother's monthly bleeding has not returned b. The baby is fully breastfed day and night c. The baby is less than 6 months old <p>The mother needs to transition to a family planning method of her choice when one of the criteria no longer applies If a breastfeeding-dependent method was chosen, helps her to make a plan for ongoing contraception after she stops breastfeeding.</p>					
<p>7. 8. Describes any other methods of interest for which the client is eligible.</p>					

8. 9. Asks the client if she has any questions or would like the provider to repeat the information.					
9. 10. Allows the client to decide by herself (informed choice) without any coercion. 10. If the client chooses a method to be started later, the provider helps her plan for how and where to obtain that service.					
11. Reviews WHO MEC Wheel or WHO MEC Quick Reference Chart to verify if the chosen method is safe for her. If not helps her choose another method.					
12. Confirms the client's understanding by asking open-ended questions and repeating key information about the chosen method.					
13. Documents the family planning method chosen in the client's record card/chart.					
14. Tells the client that she can change her decision at any time and inform the provider about it.					
15. Counsels and refers client for specialized services like breast/cervical cancer screening or treatment, HIV, etc., if needed.					
16. Repeat key information about PPIUCD					

SESSION 4

TITLE: OVERVIEW OF THE WHO MEDICAL ELIGIBILITY CRITERIA (30 MINUTES)

OUTLINE & OBJECTIVES:

To present new evidence for who can use the PPIUCD and review of the MEC in detail

METHODOLOGY:

- 1) Group activity
- 2) Group presentations
- 3) Large group discussion

Handout: (H24.4)

Checklist: (C24.4)

OVERVIEW OF THE WHO MEDICAL ELIGIBILITY CRITERIA

HANDOUT (H-24.4)



PURPOSE OF MEC:

1. To base guidelines for family planning practices on the best available evidence
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

MEC FOR PPIUCD:

Ask the client the questions below about known medical conditions. If she answers “no” to all of the questions, then she can have an LNG-IUCD inserted. If she answers “yes” to a question, follow the instructions. In some cases, she can still have an LNG-IUCD inserted.

1- Did you give birth more than 48 hours ago but less than 4 weeks ago?

NO YES

Delay inserting an LNG-IUS 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-IUS. 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-IUS 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-IUCD. 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-IUCD. 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-IUCD 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 IUCD, progestin-only injectable, or implant) and, if indicated, treated. After diagnosis/treatment, re-evaluate for IUCD 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-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 LNG-IUCD 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-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.

9- Assess whether she is at very high individual risk for STIs.

Women who have a high individual likelihood of STIs should not have an LNG-IUCD inserted unless gonorrhoea and chlamydia are ruled out by lab tests.

10- Rule out pregnancy.

Ask the client the questions in the Pregnancy Checklist (See below C24.4) 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-IUCD inserted.

If the Pregnancy Checklist cannot rule out pregnancy, use another tool before inserting an LNG-IUCD.

Also, women should not use LNG-IUCDs if they report having systemic lupus erythematosus with positive (or unknown) anti-phospholipid antibodies but are not receiving immunosuppressive treatment. For complete classifications.

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
Checklist (C24.4)

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.

SESSION 5

TITLE: INSERTION OF PPIUCDS, POST-DELIVERY AND INTRA CAESAREAN (30 MINUTES)

OUTLINE & OBJECTIVES:

- 1) This module covers the two types of postpartum IUCD (Cu 380 A and LNG IUS) insertion techniques and when they are used.
- 2) How the techniques differ in terms of timing?
- 3) Discuss key considerations related to insertion techniques and active management of the third stage of labour
- 4) Demonstrate how to insert the Postpartum IUCD Cu 380 A or LNG-IUS correctly using the “no-touch” technique on a model.

METHODOLOGY:

- 1) Group work
- 2) Simulated Hands on practice with anatomic (pelvic) models,
- 3) Divide learners into pairs and instruct the pairs to take turns doing the following:
 - One member practices inserting the PPIUCD on the model.
 - The other member assesses performance using the PPIUCD insertion checklist and provides feedback and suggestions.
 - The two switch roles and repeat the steps.
 - The facilitator observes the pairs as they practice, providing feedback as needed.

Handout: (H24.5)
Job Aid: (J24.5)
Checklist: (C24.5a), (C24.5b), (C24.5c)

PICTORIAL FOR INSTRUMENTAL PPIUCD INSERTION STEPS

Job Aid (J24.5)

INSERTION OF PPIUCD, POST-DELIVERY

HANDOUT (H-24.5)

STEPS OF INSERTION

- 1) Reviews the woman's record to ensure that she has chosen the IUCD after proper counselling.

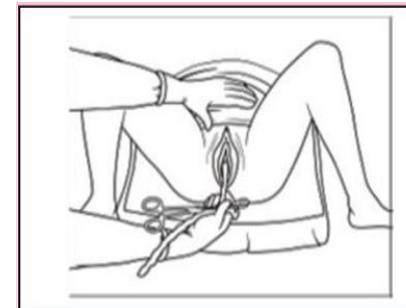


- 2) Confirm that correct sterile instruments, supplies and light source are available for immediate post placental (instrumental) insertion; obtain a sterile IUCD, keeping the package sealed until immediately prior to insertion



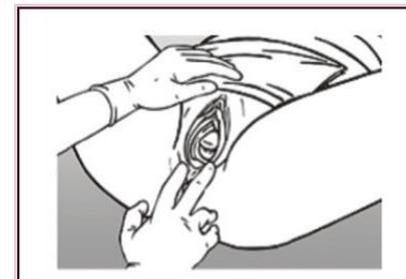
- 3) Change Gloves

- 4) After the delivery including performing AMTSL, screen for delivery related contra indications e.g. PPH, Chorioamnionitis, Pre labour ROM for .18 hours.



- 5) Perform infection prevention measure as appropriate

- 6) Inspect perineum, labia and vaginal walls for lacerations, apply clamp to the bleeding area to stop the bleeding and proceeds with IUCD insertion.

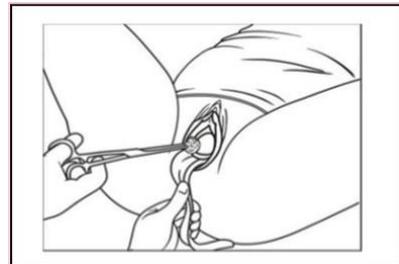


7) Has the PPIUCD kit/tray opened and arrange insertion instruments and supplies in the sterile field. Ensures that IUCD in sterile package is kept to the side of sterile draped area. Places a dry sterile cloth on the woman's abdomen.

8) Gently inserts Simms speculum and visualizes cervix by depressing the posterior wall of vagina.



9) Cleans cervix and vagina with antiseptic solution two times using a separate swab each time.



10) Gently grasps anterior lip of the cervix with the ring forceps. (Speculum may be removed at this time, if necessary). Leaves forceps aside, still attached to cervix.

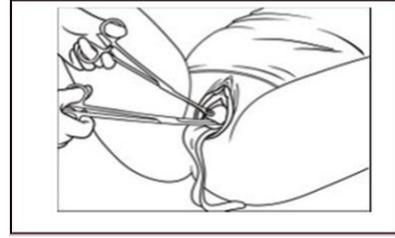
11) Opens sterile package of IUCD from bottom by pulling back plastic cover approximately one-third of the way.

12) With dominant hand, still holding the IUCD from bottom by pulling back plastic cover approximately one-third of the way.



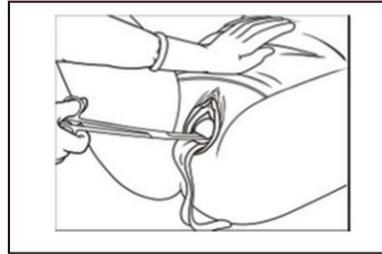
13) With non-dominant hand still holding the IUCD Package, uses dominant hand to remove plunger rod, inserter tube and card from package.

14) Gently lifts anterior lip of cervix using ring forceps.



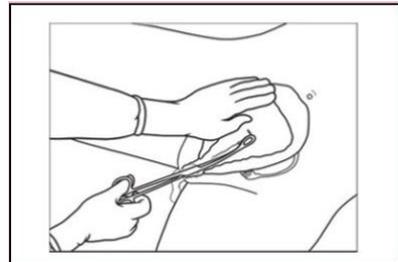
15) Gently inserts and slower advances IUCD (this step overlaps with step 14)

- While avoiding touching walls of the vagina, inserts placental forceps – which are holding the IUCD – through cervix into lower uterine cavity.
- Gently moves IUCD further into uterus toward point where slight resistance is felt against back wall of lower segment of uterus.
- Keeping placental forceps firmly closed, lowers ring forceps, and gently removes them from cervix; leaves them on sterile towel.



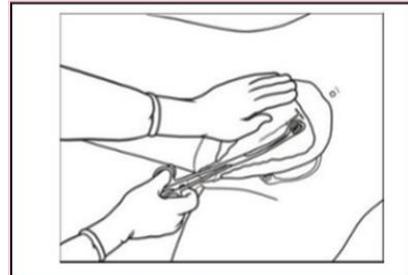
16) (this step overlaps with steps 13 and 15):

- Places base of non-dominant hand on lower part of uterus (midline, just above pubic bone with fingers toward fundus); and
- Gently pushes uterus upward in abdomen to extend lower uterine segment.

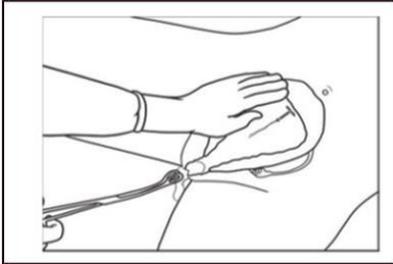


17) Passes IUCD through vagino-uterine angle (this step overlaps with step 14):

- Keeping forceps closed, gently moves IUCD upward toward uterine fundus, in an angle toward umbilicus.
- Lowers the dominant hand (holding placental forceps) down, to enable forceps to easily pass vagino-uterine angle and follow contour of uterine cavity. Takes care not to perforate uterus.



18) Continues gently advancing forceps until uterine fundus is reached when provider feels a resistance. By feeling the uterus through the abdominal wall, conforms with the abdominal hand that IUCD has reached the fundus

19) While continuing to stabilize the uterus, opens forceps, tilting them slightly toward midline to release IUCD at fundus.	
20) Keeping forceps slightly open, gently remove them from uterine cavity by sweeping forceps to the sidewall of uterus and sliding instrument alongside wall of uterus.	
21) Examines cervix to see if any portion of IUCD or strings are visible or protruding from cervix. If IUCD or strings are seen protruding from cervix, removes IUCD using same forceps used for first insertion; position same IUCD with forceps inside sterile package and reinserts.	

POST-INSERTION TASKS
Removes all instruments and places them in 0.5% Chlorine
Allow woman to rest comfortably for a few minutes
Removes/ disposes off waste materials
Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning them inside out and disposing of them
Performs hand hygiene
<p>Tells woman that IUCD has been successfully placed; reassures her and answers any questions she may have. Provides the following instructions.</p> <ol style="list-style-type: none"> a. Reviews IUCD side effects and normal postpartum symptoms. b. Tells woman when to return for PPIUCD/postpartum and new-born check-up(s). c. Emphasizes that she should come back any time she has a concern or experiences warning signs. (PAIN)* d. Reviews how to check for expulsion and what to do in case of expulsion. e. Ensures that the woman understands post-insertion instruction. f. Gives written post-insertion instructions, if possible. g. Provides card showing type of IUCD and date of insertion

Records information in the woman's chart or record. Attaches IUCD cards (which woman will be given at discharge) to woman's record

Records information in the appropriate register(s).

Pains*
 P= Periods
 A= Abdominal Pain
 I= Infection
 N= Not feeling well
 S= Strings

Insertion Checklist (C24.5a)
Post placental Insertion of the IUCD (Copper T 380A)
Within 10 minutes of delivery of placenta

Learner _____ Date Observed _____

All participants must observe 3 cases, do 5 under supervision and then 5 independently

EARLY POSTPARTUM INSERTION OF THE IUCD Within 10 minutes of delivery of placenta					
STEP/TASK	CASES				
Tasks to Perform in Postpartum Ward (prior to Procedure)					
1. Reviews the woman's record to ensure that she has chosen the IUCD.					
2. Ensures that she has been appropriately counselled and screened for PPIUCD insertion.					
3. Greets the woman with kindness and respect.					
4. If she has not been counselled and assessed for postpartum IUCD, provides that service now.					
5. Confirms that the woman still wants IUCD.					
6. Briefly describes procedure. Answers any question the woman might have.					

7. Confirms that correct sterile instruments, supplies, and light source are available for early postpartum insertion; obtains PPIUCD kit/tray.					
8. Confirms that IUCDs are available on labour ward; obtains a sterile IUCD, keeping the package sealed until immediately prior to insertion.					
Pre-Insertions Tasks (in Procedure Room)					
9. Confirms that there are no delivery-related conditions that preclude insertion of IUCD now: <ul style="list-style-type: none"> <input type="checkbox"/> Rupture of membranes for greater than 18 hours <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Puerperal sepsis <input type="checkbox"/> Continued excessive postpartum bleeding <input type="checkbox"/> Genital trauma so severe that repairs would be disrupted by postpartum placement of an IUCD (confirmed by inspection of genitalia, Step 15) 					
10. If any of these conditions exists, speaks with the woman, explains that this is not a safe time for insertion of the IUCD and offers re-evaluation for an IUCD at 6 weeks postpartum. Counsels her and offers her another method for postpartum family planning (at least for temporary use).					
11. Ensures that woman has recently emptied her bladder.					
12. Helps the woman onto table. Drapes her lower abdominal/pelvic area.					
13. Determines level/length of uterus and confirms that there is good uterine tone.					
14. Performs hand hygiene and puts HLD or sterile surgical gloves on both hands.					
15. Inspects genitalia for trauma/repairs.					
Insertion of the IUCD					

16. Confirms that the woman is ready to have the IUCD inserted. Answers any questions she might have and provides reassurance if needed.					
17. Has the PPIUCD kit/tray opened and arranges insertion instruments and supplies in the sterile field. Ensures that IUCD in sterile package is kept to the side of sterile draped area. Places a dry, sterile cloth on the woman's abdomen.					
18. Gently inserts Simms speculum and visualizes cervix by depressing the posterior wall of vagina.					
19. Cleans cervix and vagina with antiseptic solution two times using a separate swab each time.					
20. Gently grasps anterior lip of the cervix with the ring forceps. (Note: Slightly more pressure may be needed to close forceps than with post placental insertion because cervix has become firmer and begun to resume its pre-pregnancy state.) (Speculum may be removed at this time, if necessary.)					
21. Leaves forceps aside, still attached to cervix					
22. Opens sterile package of IUCD from bottom by pulling back plastic cover approximately one-third of the way.					
23. With non-dominant hand still holding the IUCD package (stabilizing IUCD through the package), uses dominant hand to remove plunger rod, inserter tube and card from package.					
24. With dominant hand, uses placental forceps to grasp IUCD inside sterile package. Holds IUCD by the edge, careful not to entangle strings in the forceps.					
25. Gently lifts anterior lip of cervix using ring forceps.					

<p>26. Gently inserts and slowly advances IUCD</p> <ul style="list-style-type: none"> - While avoiding touching walls of the vagina, inserts placental forceps—which are holding the IUCD—through cervix into lower uterine cavity. - Gently moves IUCD further into uterus toward point where slight resistance is felt against back wall of lower segment of uterus. <p>Keeping placental forceps firmly closed, lowers ring forceps and gently removes them from cervix; leaves them on sterile towel.</p>					
<p>27. Elevates” the uterus (this step overlaps with Steps 26 and 28):</p> <ul style="list-style-type: none"> - Places base of nondominant hand on lower part of uterus (midline, just above pubic bone with fingers toward fundus); and - Gently pushes uterus upward in abdomen to extend lower uterine segment. 					
<p>28. Passes IUCD through vagino-uterine angle</p> <ul style="list-style-type: none"> - Keeping forceps closed, gently moves IUCD upward toward uterine fundus, in an angle toward umbilicus. - Lowers the dominant hand (hand holding placental forceps) down, to enable forceps to easily pass vagino-uterine angle and follow contour of uterine cavity. Takes care not to perforate uterus. <p>(Note: Although this step may be more difficult in the early postpartum period, it is essential that the IUCD reach the fundus.)</p>					
<p>29. Continues gently advancing forceps until uterine fundus is reached, when provider feels a resistance. By feeling the uterus through the abdominal wall, confirms with the abdominal hand that the IUCD has reached the fundus.</p>					

30. While continuing to stabilize the uterus, opens forceps, tilting them slightly toward midline to release IUCD at fundus.					
31. Keeping forceps slightly open, gently remove them from uterine cavity by sweeping forceps to the sidewall of uterus and sliding instrument alongside wall of uterus. Takes particular care not to dislodge IUCD or catch IUCD strings as forceps are removed.					
32. Keeps stabilizing uterus until forceps are completely withdrawn. Places forceps aside on sterile towel.					
33. Examines cervix to see if any portion of IUCD or strings are visible or protruding from cervix. If IUCD or strings are seen protruding from cervix, removes IUCD using same forceps used for first insertion; positions same IUCD in forceps inside sterile package					
34. Checks any repairs made, as necessary, to ensure that they have not been disrupted.					
35. Removes all instruments used and places them open in 0.5% chlorine solution so they are totally submerged.					
POST-INSERTION TASKS					
36. Allows the woman to rest a few minutes. Continues routine postpartum and new-born care.					
37. Disposes of waste materials appropriately.					
38. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning them inside out and disposing of them.					
39. Performs hand hygiene.					
CHECKLIST FOR EARLY POSTPARTUM INSERTION OF THE IUCD					
STEP/TASK			CASES		

<p>40. Tells woman that IUCD has been successfully placed; reassures her and answer any questions she may have. Tells her that detailed instructions will be provided prior to discharge, and provides the following instructions:</p> <ul style="list-style-type: none"> - Reviews IUCD side effects and normal postpartum symptoms - Tells woman when to return for IUCD/postnatal/new-born check-up - Emphasizes that she should come back any time she has a concern or experiences warning signs - Reviews warning signs for IUCD (PAINS) - Reviews how to check for expulsion and what to do in case of expulsion - Ensures that the woman understands post-insertion instructions - Gives written post-insertion instructions, if possible - Provides card showing type of IUCD and date of insertion 					
<p>41. Records information in the woman's chart or record. Attaches IUCD card (which women will be given at discharge) to woman's record.</p>					
<p>42. Records information in the appropriate register(s).</p>					

(Checklist C24.5b)
Intra-caesarean Insertion of the IUCD
Immediately after delivery of the placenta

Learner _____ Date Observed _____

All participants must observe 3 cases; do 5 under supervision and then 5 independently

INTRACESAREAN INSERTION OF PPIUCD					
TASKS	CASES				
Tasks to Perform upon Presentation (done prior to performing caesarean section)					
1. Reviews the woman's record to ensure that she has chosen					
2. Checks that she has been appropriately counselled and screened for PPIUCD insertion. (If she has not and she is comfortable and in early/inactive labour, provides that service following the next step.)					
3. Greets the woman with kindness and respect.					
4. Confirms that the woman still wants IUCD.					
5. Explains that the IUCD will be inserted following delivery of the baby and the placenta. Briefly describes procedure. Answers any question the woman might have.					
Tasks to Perform after Presentation but prior to Insertion					
Note: For intra-caesarean insertion, the IUCD is inserted through the uterine incision with the help of a sponge holding forceps. This takes place after birth of baby, delivery of placenta and second screening, but prior to repair of uterine incision.					
6. Confirms that correct sterile instruments, supplies, and light source are available for intra-caesarean insertion; obtains PPIUCD kit/tray.					
7. Confirms that IUCDs are available; obtains a sterile IUCD, keeping the package sealed until immediately prior to insertion.					

<p>Delivers baby and placenta via caesarean section and performs second screening to confirm that there are no delivery-related conditions that preclude insertion of IUCD now:</p> <ol style="list-style-type: none"> 1. Rupture of membranes for greater than 18 hours 2. Chorioamnionitis 3. Unresolved postpartum haemorrhage 					
9. If any of these conditions exists, speaks with the woman, explains that this is not a safe time for insertion of the IUCD and offers re- evaluation for an IUCD at 6 weeks postpartum. Counsels her and offers her another method for postpartum family planning (at least for temporary use).					
10. Inspects uterine cavity for malformations, which could preclude use of IUCD.					
Insertion of the IUCD					
11. Has the PPIUCD kit/tray opened and arranges insertion instruments and supplies in a sterile field. Ensures that IUCD in sterile package is kept to the side of sterile draped area.					
12. Opens sterile package of IUCD from bottom by pulling back plastic cover approximately one-third of the way.					
13. With non-dominant hand, holds IUCD package (stabilizing IUCD through the package); with dominant hand, removes plunger rod, inserter tube and card from package.					
14. With dominant hand, grasps and then holds the IUCD at end of fingers, by gripping the vertical rod between the index and middle fingers. (Alternatively, uses forceps to hold the IUCD. Holds IUCD by the edge, careful not to entangle strings in the forceps.)					
15. Stabilizes uterus by grasping it at fundus, through abdomen, with non-dominant hand.					
16. With dominant hand, inserts IUCD through uterine incision with a sponge holding forceps and moves to fundus of uterus.					
17. Releases IUCD at fundus of uterus.					

18. Slowly removes hand from uterus. Takes particular care not to dislodge IUCD as the forceps is withdrawn.					
19. Points IUCD strings toward lower uterine segment but does not push them through the cervical canal or pull the IUCD from its fundal position.					
20. Closes the uterine incision, taking care not to incorporate IUCD strings into the suture.					
Post-Insertion Tasks					
21. Finished the surgery as usual					
22. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning them inside out and disposing of them.					
23. Performs hand hygiene.					
24. Records information in the woman's chart or record. Attaches IUCD card (which women will be given at discharge) to woman's record. Records information in the appropriate register(s).					
25. Ensures that woman will receive post-insertion instructions on post-operative Day 2 or 3. The discharge provider should: a) Review IUCD side effects and normal postpartum symptoms b) Tell woman when to return for IUCD/postpartum and new-born check-up(s) c) Emphasize that she should come back any time she has a concern or experiences warning signs d) Review warning signs for IUCD (PAINS*) e) Review how to check for expulsion and what to do in case of expulsion f) Ensure that woman understands post-insertion instructions g) Give written post-insertion instructions, if possible h) Provides card showing type of IUCD and date of insertion					

*Period is late, or you have abnormal spotting or sever bleeding; abdominal pain, server cramping or abdominal pain with sexual intercourse; infection with or exposure to a STI or symptoms of a pelvic infection, such as abnormal vaginal discharge; Not feeling well of having a fever of 100.4⁰F (38⁰C) or Higher.

**Post-partum Insertion of the IUCD (Copper T 380A)
Within 48 hours of the delivery
(Checklist 24.5c)**

Learner _____ **Date** _____ **Observed** _____

All participants must observe 3 cases, do 5 under supervision and then 5 Independently

POST PLACENTAL INSERTION OF THE IUCD After 10 minutes and within 48 hours of the delivery					
STEP/TASKS	CASES				
Tasks to Perform upon Presentation (done prior to managing active labour and vaginal delivery)					
1. Reviews the woman's record to ensure that she has chosen the IUCD.					
2. Checks that she has been appropriately counselled and screened for PPIUCD insertion. (Note: If she has not and she is comfortable and in early/inactive labour, provides that service following the next step.)					
3. Greets the woman with kindness and respect.					
4. Confirms that woman still wants IUCD.					
5. Explains that the IUCD will be inserted. Answers any questions she might have.					
Tasks to Perform after Presentation but prior to Insertion					
6. Confirms that correct sterile instruments, supplies and light source are available for immediate post-placental (instrumental) insertion; obtains PPIUCD kit/tray.					
7. Confirms that IUCDs are available on labour ward; obtains a sterile IUCD, keeping the package sealed until immediately prior to insertion.					
9. Reviews her delivery notes and performs second screening to confirm that there is no delivery- related conditions that preclude insertion of IUCD now: 1) Rupture of membranes for greater than 18 hours 2) Chorioamnionitis 3) Unresolved postpartum haemorrhage					

<p>9. If any of these conditions exists, speaks with the woman, explains that this is not a safe time for insertion of the IUCD, and offers re- evaluation for an IUCD at 6 weeks postpartum. Counsels her and offers her another method for postpartum family planning (at least for temporary use).</p>					
Insertion of the IUCD					
<p>10. Confirms that the woman is ready to have the IUCD inserted. Answers any questions she might have and provides reassurance if needed.</p>					
<p>11. Has the PPIUCD kit/tray opened and arranges insertion instruments and supplies in the sterile field. Ensures that IUCD in sterile package is kept to the side of sterile draped area. Places a dry, sterile cloth on the woman’s abdomen.</p>					
<p>12. Gently inserts Simms speculum and visualizes cervix by depressing the posterior wall of vagina.</p>					
<p>13. Cleans cervix and vagina with antiseptic solution two times using a separate swab each time.</p>					
<p>14. Gently grasps anterior lip of the cervix with the ring forceps. (Speculum may be removed at this time, if necessary.) Leaves forceps aside, still attached to cervix.</p>					
<p>15. Opens sterile package of IUCD from bottom by pulling back plastic cover approximately one-third of the way.</p>					
<p>16. With non-dominant hand still holding the IUCD package (stabilizing IUCD through the package), uses dominant hand to remove plunger rod, inserter tube and card from package.</p>					
<p>17. With dominant hand, uses placental forceps to grasp IUCD inside sterile package. Holds IUCD by the edge, careful not to entangle strings in the forceps.</p>					
<p>18. Gently lifts anterior lip of cervix using ring forceps.</p>					
<p>19. Gently inserts and slowly advances IUCD (this step overlaps with Step 22):</p> <ul style="list-style-type: none"> □ While avoiding touching walls of the vagina, inserts placental forceps—which are holding the IUCD—through cervix into lower uterine cavity. □ Gently moves IUCD further into uterus toward point where slight resistance is felt against back wall of lower segment of uterus. □ Keeping placental forceps firmly closed, lowers ring forceps, and gently removes them from cervix; leaves them on sterile towel. 					

20. “Elevates” the uterus (this step overlaps with Steps 21 and 24): a) Places base of non-dominant hand on lower part of uterus (midline, just above pubic bone with fingers toward fundus); and b) Gently pushes uterus upward in abdomen to extend lower uterine segment.					
21. Passes IUCD through vagino-uterine angle (this step overlaps with Step 22): □ Keeping forceps closed gently moves IUCD upward toward uterine fundus, in an angle toward umbilicus. □ Lowers the dominant hand (hand holding placental forceps) down, to enable forceps to easily pass vagino-uterine angle and follow contour of uterine cavity. Takes care not to perforate uterus.					
22. Continues gently advancing forceps until uterine fundus is reached when provider feels a resistance. By feeling the uterus through the abdominal wall, confirms with the abdominal hand that the IUCD has reached the fundus.					
23. While continuing to stabilize the uterus, opens forceps, tilting them slightly toward midline to release IUCD at fundus.					
24. Keeping forceps slightly open, gently remove them from uterine cavity by sweeping forceps to the sidewall of uterus and sliding instrument alongside wall of uterus. Takes particular care not to dislodge IUCD or catch IUCD strings as forceps are removed.					
25. Keeps stabilizing uterus until forceps are completely withdrawn. Places forceps aside on sterile towel.					
26. Examines cervix to see if any portion of IUCD or strings are visible or protruding from cervix. If IUCD or strings are seen protruding from cervix, removes IUCD using same forceps used for first insertion; positions same IUCD in forceps inside sterile package and reinserts.					
27. Repairs any lacerations (episiotomy) as necessary.					
28. Removes all instruments used and places them open in 0.5% chlorine solution so they are totally submerged.					
Post-Insertion Tasks					
29. Allows the woman to rest a few minutes. Supports the initiation of routine postpartum care, including immediate breastfeeding.					
30. Disposes of waste materials appropriately					

31. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning them inside out and disposing of them.					
32. Performs hand hygiene.					
33. Tells woman that IUCD has been successfully placed; reassures her and answers any questions she may have. Advises her that instructions will be reviewed prior to discharge, and provides the following instructions for now: a. Reviews IUCD side effects and normal postpartum symptoms b. Tells woman when to return for PPIUCD/postpartum and new-born check-up(s) c. Emphasizes that she should come back any time she has a concern or experiences warning signs d. Reviews warning signs for IUCD (PAINS ¹) e. Reviews how to check for expulsion and what to do in case of expulsion f. Ensures that the woman understands post-insertion instructions					
34. Records information in the woman's chart or record. Attaches IUCD cards (which woman will be given at discharge) to woman's record.					
35. Records information in the appropriate register(s).					

SESSION 6

TITLE: REMOVAL OF IUCD/MISSING STRINGS

(30 MINUTES)

OUTLINE & OBJECTIVES:

To clarify the issue of missing strings and to go through the steps of removal of IUCD.

METHODOLOGY:

- 1) Group work using the missing strings protocol.
- 2) Demonstrate removal of IUCD on Models using checklists.

Handout: (H24.6)

Activity: (A24.6)

Checklist: (C24.6)

Job aid: (J24.6)

REMOVAL OF IUCD

HANDOUT (H-24.6)

IUCD removal is usually an uncomplicated and relatively painless routine procedure. Unless an IUCD is removed for a medical reason or because the woman wishes to discontinue the method, a new IUCD can be inserted immediately after removing the old, if she so desires.

Appropriate assessment and care, before and after the procedure, depend on the reason for IUCD removal, and whether the woman is having another IUCD inserted or is starting a different method. Use proper infection prevention practices.

BEFORE REMOVING IUCD:

Ask the woman her reason for having the IUCD removed.

1. If the woman wants her IUCD removed for personal reason (or offers no reason at all), remove her IUCD. The woman has a right to discontinue the method at any time, regardless of the reason.

2. If the woman is having her IUCD replaced, (i.e. at the end of its effective life), ensure that she has undergone appropriate assessment to determine whether she is eligible for IUCD reinsertion at this time.
3. If she is having the IUCD removed of the medical reason (e.g., pregnancy, dangerously heavy menstrual bleeding) ensure that she has undergone the appropriate assessment to determine whether routine IUCD removal is safe for her at this time. Referral for special removals, if needed.
4. If she will be starting a different method, ask when her last menstrual period began. This will help determine whether she will need to use a backup method.

Ensure that she understands the following by key points about having her IUCD removed, as appropriate:

1. “You can get pregnant again immediately after IUCD removal”
2. “If you do not want to become pregnant, you should have another IUCD inserted immediately or start another contraceptive method”.
3. No rest period is needed between IUCDs.
4. Review her reproductive goals and need for protection against STIs.
5. Help her choose a different contraceptive method, if appropriate.

REMOVING THE IUCD:

Using gentle, “no touch” Aseptic technique throughout, perform the following steps:

Step-1:

Prepare the Client: Give the woman a brief overview of the procedure, encourage her to ask questions, and provide re assurance as needed.

Remind her to let you know if she feels any pain

Step- 2:

Put New /clean examination or HLD surgical gloves on both hands

Step-3:

Insert an HLD (or sterile) speculum and visualize the cervix and the IUCD string

If the strings cannot be seen, manage as missing string

Step-4:

Clean the cervix and vagina with an appropriate antiseptic: Thoroughly apply appropriate antiseptic (e.g. provide iodine or chlorhexidine) two or more times to the cervix (wiping from inside the is outward) and vagina. If povidone iodine is used, ensure that the woman is not allergic to iodine and wait 2 minutes for the solution to act.

Step-5:

Alert the woman immediately before you remove the IUCD:

Ask her to take slow, deep breath and relax.

Inform her that she may feel some discomfort and cramping, which is normal.

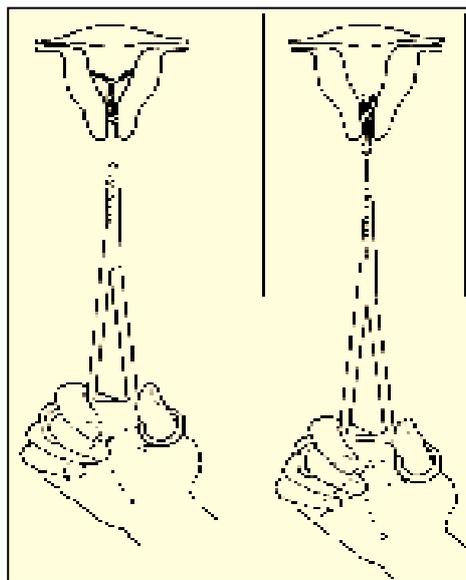
Step-6:

Grasp the IUCD strings and apply gentle traction:

- Grasp the strings of the IUCD with a high-level disinfected (or sterile) narrow forceps
- Apply steady but gentle traction, gently pulling the strings toward you with the forceps (The device can usually be removed without difficulty.)
- If the strings break off but the IUCD is visible, grasp the device with the forceps and remove it. If removal is difficult, do not use excessive force, see box below for guidance on managing this problem.

STEP 7:

Show the woman the IUCD and place it in 0.5% chlorine solution for 10 minutes for decontamination.



Removing the IUCD

STEP 8:

Insert a new IUCD, if the woman so desires and there are no precautions to continued use.

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.

GUIDELINES FOR DIFFICULT IUCD REMOVALS:

If you have partially removed the IUCD but have difficulty drawing it through the cervical canal:

1. Attempt a gentle, slow twisting of the IUCD while gently pulling.
2. Continue if the woman remains comfortable.
3. Using Misoprostol is a good and effective way to soften the cervix to ease any manipulation. This also reduces the discomfort to the woman.
4. If the IUCD can still not be removed, refer the woman to a senior provider.

If there seems to be a sharp angle between the uterus and cervix:

1. Place a high -level disinfected (or sterile) tenaculum on the cervix and apply gentle traction downward and outward.
2. Attempt a gentle, slow twisting of the IUCD while gently pulling.
3. Continue if the woman remains comfortable.
4. If the IUCD can still not be removed, refer the woman to a specially trained provider who can dilate the cervix
5. Using Misoprostol, 3 tablets sublingually 45 minutes or so before the removal can facilitate the removal by softening the cervix and reduces the discomfort to the woman.

AFTER REMOVING THE IUCD:

Ask the woman how she is feeling, and whether she is experiencing any of the following symptoms:

1. Nausea
2. Mild-to-moderate lower abdominal pain/cramping
3. Dizziness or fainting (rare)

If the woman is experiencing any of these symptoms, provide reassurance and allow her to remain on the examination table to rest until she feels better.

Important: Although most women will not experience problems after IUCD removal, all women should remain at the clinic for 15 to 30 minutes before being discharged as a precaution. If the woman is starting a new contraceptive method, it should be provided now along with a back-up method if needed. Identification and management of common side effects and problems encountered at follow up.

CHECKLIST for IUCD removal

Pre-removal Steps

Checklist (C24.6)

All participants must observe 3 cases, do 5 under supervision and then 5 independently

Pre-removal Steps					
1. Greet the woman with kindness and respect and establish purpose of visit.					
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. Counsel as appropriate: <ul style="list-style-type: none"> a) Ensure that she understands that there is immediate return to fertility after b) IUCD removal. c) Review the client's reproductive goals and need for STI protection d) Discuss other contraceptive methods if desired. 					
5. Ensure that a high-level disinfected (HLD) instrument pan (or sterile pack), supplies, and light source are available.					
6. Open the HLD instrument pan (or sterile pack) without touching instruments. Using an HLD (or sterile) pick-up forceps, arrange the instruments and supplies on an HLD pan (or sterile tray), being very careful not to touch parts of the instruments that will go into the vagina or uterus.					
7. Have the client empty her bladder and wash and rinse her perineal area if possible.					
8. Help the client onto the examination table.					
9. Wash your hands thoroughly with soap and water; and dry them with clean, dry cloth or allow them to air dry.					
10. Put new/clean examination or HLD (or sterile) surgical gloves on both hands.					
11. Give the client a brief overview of the procedure, encourage her to ask questions, and provide reassurance as needed. Remind her to let you know if she feels any pain.					

Removing the IUCD					
1. Insert an HLD (or sterile) speculum to visualize the IUCD strings.					
2. Cleanse the cervix (especially the os) and vagina with appropriate antiseptic two or more times.					

3. Alert the client immediately before you remove the IUCD. Ask her to take slow, deep breaths and inform her that she may feel some discomfort and cramping, which is normal.					
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.					
9. Ask the client if she is experiencing nausea, mild to moderate lower abdominal pain/cramping, and dizziness or fainting. If she is experiencing any of these symptoms, provide reassurance and allow her to remain on the examination table until she feels better (she should stay in clinic for at least 15 to 30 minutes).					
Post-removal Steps					
1. Before removing the gloves, place all used instruments in 0.5% chlorine solution for 10 minutes for decontamination. (After the client has left, wipe the examination table with 0.5% chlorine solution.)					
2. Dispose of waste materials (e.g., cotton balls) by placing in a leak-proof container (with a tight-fitting lid) or plastic bag.					
3. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning inside out: <ul style="list-style-type: none"> a) If disposing of gloves, place in the leak-proof container or plastic bag. b) If reusing surgical gloves (not recommended), submerge them in 0.5% chlorine solution for 10 minutes for decontamination. 					
4. Wash hands thoroughly with soap and water; and dry them with a clean, dry cloth or air dry.					
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).]					

* Laboratory Testing (if available and if indicated based on assessment)					
1. Remove speculum after taking samples of vaginal and cervical discharge.					
2. Immerse both gloved hands in 0.5% solution. Remove gloves by turning inside out. a) If disposing of gloves, place in leak-proof container or plastic bag. b) If reusing surgical gloves (not recommended), submerge in 0.5% chlorine solution for 10 minutes for decontamination.					
3. Prepare for saline and KOH wet mounts and Gram staining.					
4. Identify on the wet mounts: a) Vaginal epithelial cells b) Trichomoniasis (if present) c) Monilia (if present) d) Clue cells (if present)					
5. Identify on the Gram stain: a) WBC (polymorphonuclear white cells) (if present) b) Gram-negative intracellular diplococci (GNID) (if present) c) Clue cells (if present)					
6. When testing is done, wash hands thoroughly with soap and water; and dry them with clean, dry cloth or air-dry.					
7. Treat any conditions identified according to national guidelines/local protocols (refer, if needed).					



Activity (A24.6)

Take a flip chart, write steps of protocol for missing string, distribute small cards with advice on each step of evaluation and let participants paste them against each step.

This is followed by a small presentation by the trainer.

MISSING STRING PROTOCOL

Job Aid (J24.6)

Case # _____

Date _____

Protocol for Management of Missing PPIUD Strings*

Situation: Use this protocol when you do not find the strings of the IUD protruding from the cervix on exam of a woman who has returned following postpartum placement of the IUD

Check action taken

1 2

3 4

5 6

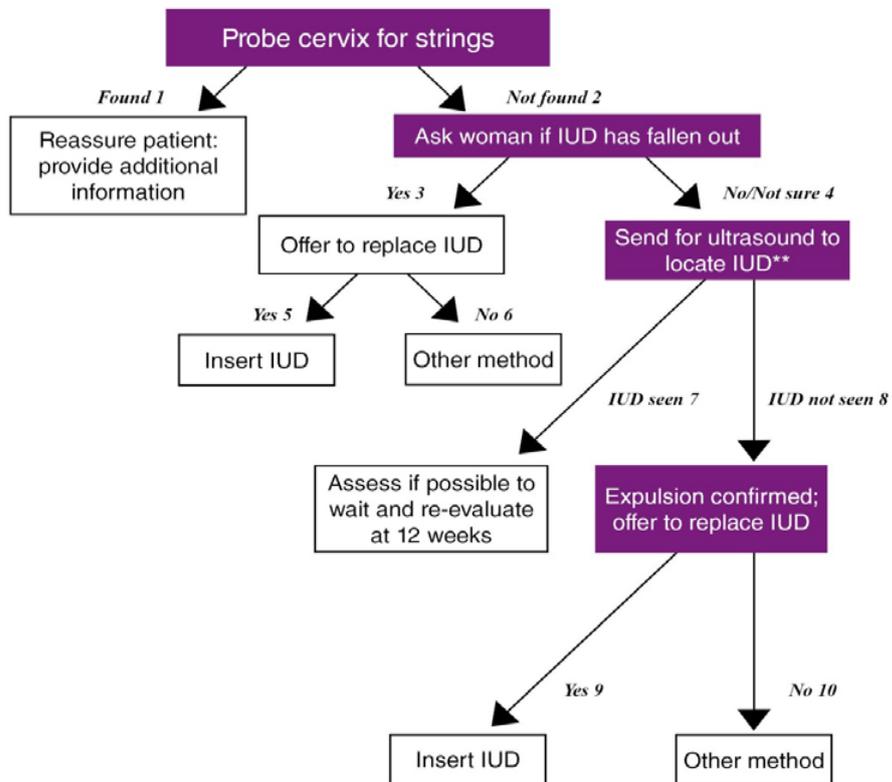
7 8

9 10

11

12

13



* If strings not seen at 3 months, repeat the protocol from start. If strings still not found, either:
 1. Reassure and follow-up 11
 2. Remove IUD with hook and replace 12
 ** Consider X-ray of abdomen instead of, or to augment, findings of ultrasound 13

SESSION 7

TITLE: INFECTION PREVENTION

(30 MINUTES)

OUTLINE & OBJECTIVES:

- 1) Review key terms related to infection prevention
- 2) Define the provider's role in infection prevention for postpartum IUCD insertion (including over-sight of other staff)
- 3) Describe the importance of infection prevention, including the potential consequences of poor infection prevention practices
- 4) Describe infection prevention procedures particularly important to postpartum IUCD insertion

METHODOLOGY:

- 1) Table demonstration,
- 2) Brainstorming
- 3) Experience sharing from their workplaces

Handout: (H24.7)

INFECTION PREVENTION

HANDOUT (H24.7)

Please see Module ---on infection prevention for complete details

An infection prevention table set up is arranged and the participants go through various tables and discuss various methods

Infection Prevention (IP) – practices and procedures that limit the transmission of infectious agents to patients, staff, and the community. Infection Prevention practices are everyone's responsibility

SPECIFIC INFECTION PREVENTION STEPS FOR THE IMMEDIATE PPIUCD PROCEDURE

BEFORE INSERTION:

- 1) Ensure that HLD /sterilized instruments and supplies are available and ready for use. Open all required HLD/sterile instruments and supplies onto a dry, HLD/sterile surface. IUCD should be placed close by in its sterile unopened packet.
- 2) Ensure that the IUCD package is unopened and undamaged and check the expiry date.
- 3) For immediate postpartum insertion within 48 hours of delivery, wash or have the woman wash her perineal area with water before preparing the vagina and cervix. If immediately after delivery, in the absence of frank faecal contamination, cleaning the perineal area gently with a sterile gauze or towel is sufficient.
- 4) Hand washing and wearing of gloves should be done appropriately.
- 5) Using sterile cotton swab and a sterile sponge/ring forceps ensure that the cervix is cleaned with a water based antiseptic solution two times.

DURING INSERTION (AS APPLICABLE):

- 1) Sterile or HLD gloves are used to stabilize the IUCD in its packet when trying to hold it by the placental forceps while the IUCD is still in its packet.
- 2) Throughout the procedure, use “no-touch” technique to reduce the risk of infection. If successful fundal placement is not achieved and the IUCD is dislodged, it may be removed and reinserted once more with all aseptic precautions.

AFTER INSERTION:

- 1) Before removing gloves follow all the steps of decontamination (Refer to Annexure D) and waste management as per health facility protocol.

KEY POINTS:

- 1) As a member of a team providing postpartum IUCD services, you are responsible for the safety of the client and of colleagues, including ensuring that appropriate infection prevention practices are followed in your setting.
- 2) Poor or inconsistent infection prevention practices in postpartum IUCD services can result in exposure to and infection with HIV, hepatitis, staphylococcus, and streptococcus among both clients and staff.
- 3) Standard precautions need to be followed consistently.

SESSION 8

TITLE: FOLLOW UP CARE AND MANAGEMENT OF POTENTIAL PROBLEMS PREVENTION AND MANAGEMENT OF SIDE EFFECTS AND COMPLICATIONS

(30 MINUTES)

This module covers the routine assessment and management of side effects and complications and the prevention of complications.

OUTLINE & OBJECTIVES:

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

- 1) Distinguish between *side effects* and *complications*
- 2) List common side effects and possible complications of postpartum IUCD use
- 3) State how to prevent insertion-related complications
- 4) Describe the clinical management of the most common side effects
- 5) Describe the management of a client presenting with warning signs of potential IUCD-related complications

METHODOLOGY:

- 1) The participants will be divided into two groups for brainstorming session.
- 2) One group will prepare side effects and the other will discuss complications.
- 3) This will be followed by group presentations and large group discussion
- 4) Interactive group work

Handout: (H24.8)

Activity: (A24.8a), (A24.8b), (A24.8c)

FOLLOW UP CARE AND MANAGEMENT OF POTENTIAL PROBLEMS PREVENTION AND MANAGEMENT OF SIDE EFFECTS AND COMPLICATIONS

HANDOUT (H-24.8)



Activity (A24.8a)

Divide Participants into three groups and assign each group side effects, complications and management of PPIUCD.

Allow 10 minutes to each group to put their ideas on a flip chart and choose a representative to present. They have 5 minutes each. The trainer then moderates a large group discussion to highlight the salient features

FOLLOW-UP

WHEN TO RETURN FOR FOLLOW-UP

- 1) Follow-up for women who receive PPIUCD in the immediate or early postpartum period should be integrated with a postpartum care visit at 4 to 6 weeks.
- 2) Follow-up visit at 4 to 6 weeks to reassure the client that the IUCD/IUS is not being expelled.

WARNING SIGNS:

Tell the client to return to the clinic as soon as possible for urgent attention and care if any of the following signs develop:

1. Foul-smelling vaginal discharge (different from the usual postpartum lochia)
2. Heavy vaginal bleeding
3. Lower abdominal pain, especially if accompanied by not feeling well, fever or chills
4. Concerns that the IUCD/LNG-IUS has fallen out

The World Health Organization (WHO) currently recommends at least one postpartum visit by 6 weeks after delivery. This is a good opportunity for women who have had an IUCD inserted in the immediate/early postpartum period to receive postpartum IUCD (PPIUCD) follow-up services because, by 6 weeks postpartum, the uterus has undergone complete involution. In any case, PPIUCD follow-up should happen within the first 3 months postpartum because the majority of expulsions occur during this time.

TAKE-HOME MESSAGES:

PROVIDE REASSURANCE AND ADVISE THE WOMAN TO:

- 1) Expect lochia but take note of heavy bleeding or blood clots.
- 2) Be aware that postpartum symptoms, such as intermittent vaginal bleeding and cramping, are normal for the first 4 to 6 weeks postpartum—and may be hard to distinguish from PPIUCD side-effects.
- 3) Take ibuprofen, paracetamol, or other pain reliever, as needed. (Aspirin is not advised in the early postpartum period because it has an anti-blood-clotting effect.)

REGARDING POSSIBLE PPIUCD EXPULSION:

- 1) Spontaneous expulsion is most likely to occur during the first 3 months postpartum.
- 2) At 6 weeks postpartum, you may be able to feel the PPIUCD strings. It is not necessary to check for them, but if you do, do not pull on them.
- 3) Your provider will check for the strings when you return for your postpartum visit. That is why it is important for you to return to see the same provider, or at least someone in the same clinic, who is aware of PPIUCD services.

GENERAL ADVICE:

- 1) Continue to breastfeed your baby exclusively, as appropriate; the PPIUCD and breastfeeding do not interfere with each other.
- 2) Remember that the PPIUCD does not protect against sexually transmitted infections (STIs) and HIV.
- 3) Resume intercourse at any time you feel ready; the PPIUCD offers full protection against pregnancy immediately upon insertion.
- 4) Return for removal of the PPIUCD at any times you wish (up to 12 years); after the PPIUCD is removed, fertility will return immediately.

ROUTINE FOLLOW-UP CARE FOR PPIUCD CLIENTS:

Key objectives of follow-up care are to:

- 1) Assess the woman's overall satisfaction with PPIUCD
- 2) Identify and manage potential problems
- 3) Address any questions or concerns the woman may have
- 4) Reinforce key messages regarding removal and duration of action.

FOLLOW UP:

Follow-up for women who receive a PPIUCD in the immediate or early postpartum period should be integrated with postpartum care per global standards/local protocols. In addition to the usual elements of the postpartum check-up, the following should be addressed in all women who report (or whose records indicate) PPIUCD insertion:

Ask the client if she has experienced any problems and if she thinks the PPIUCD has fallen out.
Do a clinical assessment for anaemia if she complains of excessive or prolonged bleeding.
If possible, perform a speculum examination to see whether the PPIUCD strings have descended into the vagina. If they appear long, protruding out of vagina or the client complains about it, trim them so that approximately 3–4 cm of string protrudes from the cervix.
Conduct a pelvic examination only if the following conditions are suspected: an STI or pelvic inflammatory disease (PID), suspected partial or complete expulsion, pregnancy. Routine pelvic examination at any subsequent follow-up visit is not required.
Provide counselling and treatment for side-effects, as needed.
Advise the client to return if she is concerned about possible PPIUCD-related problems or if she wants it removed or to change to another family planning method.
Review danger signs that indicate a need to return to the clinic immediately.
Remind the client to keep monitoring for possible PPIUCD expulsion during/after her first few menstrual periods.
Encourage use of condoms for STI protection, as appropriate.

Sample Client Follow-Up Card

Front of Card

Client's Follow-Up Card	
Client Full Name:	_____
Last Menstrual Period:	_____
Type of IUS Inserted:	_____
Date of insertion: Month	_____ Year _____
Provider's Signature:	_____
Date of removal OR replacement: Month	_____ Year _____
If you have any problem or question, go to:	_____

(Name and address of the nearby clinic/centre. Take this card with you.)

Back of Card

Client Follow-Up Visit

Date	Reason/ Complaint	Advise/Treatment Given	Provider

Note: If you are experiencing any of the following warning signs, please return to your clinic immediately.

PAINS

- Period problems or Pregnancy
- Acute abdominal cramping: during the first three to five days after insertion
- Irregular bleeding: Irregular bleeding or pain in every cycle
- Not feeling well: fever and chills, unusual vaginal discharge, or low abdominal Pain
- String problems: missing string

COMPLICATIONS OF IUCD IN POST-PARTUM:

An unexpected condition that requires intervention or management beyond what was planned or what is normally provided.

INSERTION RELATED:

- 1- Uterine Perforation
Perforation of the uterine wall during PPIUCD insertion is rare and is directly related to provider's skill.
- 2- Cervical Perforation
- 3- Severe Pain
- 4- Vasovagal Reaction

POST INSERTION:

1. Infection
2. Expulsion
3. Missing String
4. Intra- and extra uterine pregnancy

SIDE EFFECTS:

1. Bleeding
2. Cramping
3. Spotting or bleeding between periods
4. Heavier menstrual periods
5. Partner complaints about strings



Activity (A24.8. b)

Divide the participants into two groups by asking all participants to say YES and NO in a sequential way and then remember what they said

Ask all YES and NO groups to and brainstorm the **Side effects and complications of PPIUCD**

Give each one of the groups a Flip chart and a marker in order to write down the results.

Tell them that they have 10 minutes to complete each task.

By the end of the exercise, each group empowers a representative to present their results.

After each presentation, ask participants of the other groups whether they have anything to add or if they have other opinions.

The trainer then discusses the details and adds any missed groups in the discussion and refers to the tables below

MANAGEMENT OF SIDE EFFECTS AND COMPLICATIONS OF IUCD

A consequence of a procedure, contraceptive method, or medication other than was intended.

A side effect does not require exceptional intervention, but it may require attention and management.

Problem (Signs/Symptom)	Explanation	Management
<p>Cramping or Pain Increased cramping or pain that may or may not be associated with menstruation</p>	<p>Mild intermittent cramping may occur in the first few weeks after IUCD/LNG-IUS insertion but is generally masked by the usual cramping associated with uterine involution postpartum (“after pains”).</p> <p>Increased cramping and pain may also be noted with return of menstruation and is a common side-effect among IUCD users. Special follow-up is needed if symptoms are bothersome, severe, or associated with other signs/symptoms.</p>	<p>Determine severity of symptoms: how severe is the pain; how long has the pain lasted, when did the pain start; is the pain accompanied by other symptoms (e.g., bleeding, fever); how well is the woman tolerating the pain?</p> <p>Perform an appropriate assessment, including vital signs, abdominal and pelvic examination, and appropriate laboratory studies (pregnancy test, complete blood count [CBC], cultures) to rule out other possible causes of pain or infection, partial IUCD/LNG-IUS expulsion, uterine perforation, pregnancy/ectopic pregnancy, or urinary tract infection.</p> <p>If symptoms and physical findings are mild and consistent with postpartum uterine involution, reassure the woman and counsel her that they are temporary and will settle down in few days. Recommend a short course of NSAIDs immediately before and during menstruation to help reduce menstrual pain and cramping that are bothersome to the client.</p> <p>If cramping or pain is severe, remove the IUCD/LNG-IUS. If the IUCD/LNG-IUS was improperly placed, partly expelled, or appeared to be abnormal/distorted, discuss insertion of a new IUCD/LNG-IUS with the client. If the IUCD/LNG-IUS appeared to be normal and in proper position, counsel the woman regarding alternative forms of family planning.</p> <p>Perform an appropriate assessment, including vital signs, abdominal and pelvic examination, and appropriate laboratory studies (pregnancy test, CBC, cultures) to rule out other problems such as endometritis, appendicitis, partial</p>

<p>Infection</p> <p>Lower abdominal pain</p> <p>Fever</p> <p>Painful intercourse</p> <p>Bleeding after sex or between periods once normal monthly menses have resumed postpartum</p> <p>New onset of pain associated with periods</p> <p>Abnormal vaginal discharge</p> <p>Nausea and vomiting</p>	<p>Although the risk of infection after interval IUCD/LNG-IUS insertion is very low, it is highest within the first 20 days of insertion and is generally thought to be related to concurrent gonorrhoea or chlamydia infection.</p> <p>Similar risk estimates are not available for PPIUCD insertion, but studies suggest the risk is extremely low.</p> <p>Because pelvic infection can lead to infertility and other serious problems, providers should treat all suspected cases.</p> <p>IUCD/LNG-IUS should never be inserted when puerperal infection such as Chorioamnionitis or endometritis is suspected.</p>	<p>Suspect pelvic inflammatory disease (PID) if any of the following signs/symptoms are found and no other causes can be identified:</p> <p>Lower abdominal, uterine, or adnexal tenderness (tenderness in the ovaries or fallopian tubes)</p> <p>Evidence of cervical infection: yellow cervical discharge containing mucus and pus, cervical bleeding when the cervix is touched with a swab, positive swab test</p> <p>Tenderness or pain when moving the cervix and uterus during bimanual exam (cervical motion tenderness)</p> <p>Other possible sign/symptoms: purulent cervical discharge, enlargement or hardening (induration) of one or both fallopian tubes, 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)</p> <p>If endometritis or PID is suspected, begin treatment immediately with an appropriate antibiotic regimen per global standards/local protocols for gonorrhoea, chlamydia, and anaerobic infections. Remove</p>
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<p>IUCD/LNG-IUS String Problems</p> <ul style="list-style-type: none"> • Missing • Long • Short 	<p>Missing, longer, or shorter-than expected strings may indicate a variety of problems, including pregnancy, IUCD/LNG-IUS expulsion, and IUCD/LNG-IUS mispositioning.</p> <p>Sometimes there is no real problem at all—it is simply that the strings have not descended yet. In some circumstances, the IUCD strings may never descend through the cervix into the vagina following postpartum insertion.</p> <p>LNG-IUS strings are longer and can be considered normal if seen at the cervical os after insertion.</p>	<p>Missing Strings</p> <p>Ask the woman if she thinks the IUCD/LNG-IUS has fallen out.</p> <p>Rule out pregnancy by history or laboratory examination.</p> <p>Probe the cervical canal using a high-level disinfected (HLD) or sterile cervical brush or narrow forceps (e.g., Bose, alligator) to locate the strings and gently draw them out so that they are protruding into the vaginal canal.</p> <p>If the strings are not located in the cervical canal, refer the woman for an X-ray or ultrasound to confirm normal intrauterine positioning. Provide a backup method while waiting for results. Manage, as appropriate, based on findings:</p> <p>If the IUCD/LNG-IUS is located inside the uterus and the woman wants to keep the IUCD, do not remove it. Explain to her that the IUCD/LNG-IUS is still protecting her from pregnancy but that she will no longer be able to feel the strings. Review signs and symptoms of spontaneous expulsion.</p> <p>If the IUCD/LNG-IUS is located inside the uterus, reassure her that she is safe and no need to worry. If the woman wants it to be removed, refer her for IUCD/LNG-IUS removal by a specially trained provider.</p> <p>If the IUCD/LNG-IUS cannot be visualized in the uterus or the peritoneal cavity, manage as complete IUCD/LNG-IUS expulsion (below).</p> <p>Long Strings</p> <p>Trim strings, as needed, up to 3–4 cm from cervical os.</p>
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<p>Partial or Complete IUCD/LNG-IUS Expulsion</p> <ul style="list-style-type: none"> • New onset of irregular bleeding and/or cramping • Expelled IUCD/LNG-IUS seen (complete expulsion) • IUCD/LNG-IUS felt/seen in the vaginal canal (partial expulsion) • Delayed or missed menstrual period with IUCD (common with LNG-IUS) 	<p>Partial or complete IUCD/LNG-IUS expulsion can occur “silently” (with no signs/symptoms) or it may be associated with other signs/symptoms, such as:</p> <ul style="list-style-type: none"> • missing or longer than expected IUCD/LNG-IUS strings • A delayed or missed menstrual period. The guidelines on the right address the management of IUCD/LNG-IUS expulsion. 	<p>Conduct an appropriate assessment, including pelvic examination, to rule out other possible causes of symptoms such as infection and pregnancy.</p> <p>When other possible causes of symptoms are ruled out, manage based on findings.</p> <ul style="list-style-type: none"> • If complete expulsion of the IUCD/LNG-IUS is confirmed (e.g., seen by the woman, confirmed by X-ray or ultrasound), replace the IUCD/LNG-IUS immediately, if desired and appropriate (not pregnant or infected), or counsel the client for an alternative family planning method. • If partial IUCD/LNG-IUS expulsion is confirmed (e.g., felt/seen by the woman or clinician), remove the IUCD/LNG-IUS and replace it, if desired and appropriate (not pregnant or infected), or counsel the client for an alternative family planning method. • If the IUCD/LNG-IUS appears to be embedded in the cervical canal and cannot be easily removed in the standard
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<p>Pregnancy with an IUCD/LNG-IUS in Place</p> <p>Delayed or missed menstrual period (with IUCD)</p> <p>Other signs/symptoms of pregnancy</p> <p>Missing strings</p> <p>Strings that are shorter or longer than expected</p>	<ul style="list-style-type: none"> • Although the IUCD/LNG-IUS is one of the most effective forms of reversible contraception, failures can occur. • Approximately one-third of IUCD-related pregnancies are due to undetected partial or complete expulsion of the IUCD. • When pregnancy does occur with an IUCD/LNG-IUS in place, ectopic pregnancy must be ruled out, and the IUCD should be removed. • If the IUCD/LNG-IUS is left in place during pregnancy, there is an increased risk of preterm labour, spontaneous abortion, and septic abortion. 	<p>Confirm pregnancy and trimester. If the woman is in her second or third trimester of pregnancy, manage according to global standards/local protocols and refer to an appropriate provider, if needed.</p> <p>Rule out ectopic pregnancy: sharp/stabbing abdominal pain (which is often unilateral), abnormal vaginal bleeding, light-headedness/dizziness, fainting. If ectopic pregnancy is suspected, immediately refer/transport the woman to a facility with surgical capability.</p> <p>When ectopic pregnancy has been ruled out, and if the pregnancy is in the first trimester:</p> <ul style="list-style-type: none"> • Counsel the woman on the benefits and risks of immediate removal of the IUCD/LNG-IUS. Removing the IUCD/LNG-IUS slightly increases the risk of miscarriage; however, leaving an IUCD/LNG-IUS in place places the woman at greater risk of second trimester miscarriage, infection, and preterm delivery. Removal of an IUCD/LNG-IUS is advisable in a woman who is pregnant. • If the woman requests removal, proceed with immediate removal if the strings are visible and the
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Adapted from: World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Centre for Communication Programs (CCP), INFO Project. 2007. *Family Planning: A Global Handbook for Providers*. WHO and CCP: Geneva and Baltimore, Maryland.

POST PARTUM INTRA UTERINE CONTRACEPTIVE DEVICE

(PPIUCD)



Activity (A24.8c)

Questions in a basket:

Write question on strips of coloured paper, fold them and circulate the basket to every participant to pick up a paper and answer the question. The trainer reinforces the correct answer and adds on as needed

- 1) **Ideally counselling about the use and benefits of a postpartum IUCD (PPIUCD) should be provided:**
 - a. During routine antenatal care visits
 - b. During active labour, so that the IUCD can be placed immediately after delivery of the placenta
 - c. Only during the latent phase of labour, if the woman is comfortable
 - d. Only after 6 weeks of childbirth

- 2) **Which of the following is TRUE about expulsion of the postpartum IUCD/LNG-IUS?**
 - a. To prevent expulsion, women who choose the PPIUCD should not breastfeed.
 - b. The expulsion rate is lowest when the IUCD/LNG-IUS is inserted within 10 minutes of delivery of the placenta.
 - c. Tying knots of catgut on the cross arms of the IUCD/LNG-IUS will reduce expulsion.
 - d. Expulsion is less likely when insertion is performed using an inserter tube.

- 3) **Which of the following is the best technique for inserting an IUCD on the first day after childbirth?**
 - a. Use instruments such as the Kelly placenta forceps.
 - b. Use hands (manually).
 - c. Use an inserter tube and plunger.

d. Use long-toothed forceps.

4) In which of the following women would it be safe to insert an IUCD immediately following delivery of the placenta?

- a. A woman who has a fever of 38°C
- b. A woman who has had ruptured membranes for 12 hours
- c. A woman who is HIV-positive with a low CD4 count
- d. A woman who is having vaginal bleeding

5) In order to minimize the chances of infection during PPIUCD insertion:

- a. Give antibiotic cover.
- b. Autoclave the IUCD/LNG-IUS.
- c. Use sterile gloves only.
- d. Insert the IUCD/LNG-IUS using the “no-touch” technique.

6) The PPIUCD should not be inserted in a client if she:

- a. Has AIDS
- b. Has puerperal sepsis
- c. Has had a caesarean section
- d. Is breastfeeding

7) One of the important prerequisites for inserting an IUCD in the immediate/post placental period is that the woman should:

- a. Be given some anaesthesia before insertion
- b. Take some rest after delivery
- c. Be informed and consented for the PPIUCD prior to insertion
- d. Receive a dose of antibiotics before insertion

8) A woman who has had an IUCD placed in the immediate postpartum period should have a follow-up exam:

- a. Every year to check the strings
- b. Only if she thinks the IUCD has fallen out
- c. At 4 to 6 weeks postpartum to reinforce counselling, answer any questions, and screen for potential problems
- d. Only if she is bleeding

POSTPARTUM INTRAUTERINE DEVICE [ANSWER KEY]

Answer Key:

- 1) Ideally counselling about the use and benefits of a postpartum IUCD (PPIUCD) should be provided:
 - a. **During routine antenatal care visits**
 - b. During active labour, so that the IUCD can be placed immediately after delivery of the placenta
 - c. Only during the latent phase of labour, if the woman is comfortable
 - d. Only after 6 weeks of childbirth

- 2) Which of the following is TRUE about expulsion of the postpartum IUCD/LNG-IUS?
 - a. To prevent expulsion, women who choose the PPIUCD should not breastfeed.
 - b. **The expulsion rate is lowest when the IUCD/LNG-IUS is inserted within 10 minutes of delivery of the placenta.**
 - c. Tying knots of catgut on the cross arms of the IUCD/LNG-IUS will reduce expulsion.
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 - a. **Use instruments such as the Kelly placenta forceps.**
 - b. Use hands (manually).
 - c. Use an inserter tube and plunger.
 - d. Use some long-toothed forceps.

- 4) In which of the following women would it be safe to insert an IUCD immediately following delivery of the placenta?
 - e. A woman who has a fever of 38°C
 - f. **A woman who has had ruptured membranes for 12 hours**
 - a. A woman who is HIV-positive with a low CD4 count
 - b. A woman who is having vaginal bleeding

- 5) In order to minimize the chances of infection during PPIUCD insertion:
 - e. Give antibiotic cover.
 - a. Autoclave the IUCD/LNG-IUS.
 - b. Use sterile gloves only.
 - c. **Insert the IUCD/LNG-IUS using the “no-touch” technique.**

- 6) The PPIUCD/LNG-IUS should not be inserted in a client if she:
- e. Has AIDS
 - a. Has puerperal sepsis**
 - b. Has had a caesarean section
 - c. Is breastfeeding
- 7) One of the important prerequisites for inserting an IUCD in the immediate/post placental period is that the woman should:
- e. Be given some anaesthesia before insertion
 - a. Take some rest after delivery
 - b. Be informed and consented for the PPIUCD prior to insertion**
 - c. Receive a dose of antibiotics before insertion
- 8) A woman who has had an IUCD placed in the immediate postpartum period should have a follow-up exam:
- e. Every year to check the strings
 - f. Only if she thinks the IUCD has fallen out
 - a. At 4 to 6 weeks postpartum to reinforce counselling, answer any questions, and screen for potential problems**
 - b. Only if she is bleeding

SESSION 9
FREQUENTLY ASKED QUESTIONS
(10 MINUTES)

FREQUENTLY ASKED QUESTIONS

HANDOUT (H-24.9)



Activity (A24.9)

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 cannot, she can pass it on to her next person. The trainer reinforces the correct answers and clarifies others.

- 1- According to new evidence, how does the copper IUCD prevent pregnancy?
- 2- How many types of IUCD are available for family planning programs?
- 3- Expulsion rates for IUCDs inserted postpartum are unrelated to the provider’s level of experience. True or false?
- 4- The IUCD is highly effective; if 1,000 women used the copper IUCD, how many women would become pregnant in the first year?
- 5- List five characteristics of the IUCD.
- 6- Offering postpartum IUCD services is cost-effective for family planning programs as well as for clients. True or false?
- 7- Updated evidence from the World Health Organization (WHO) indicates that the IUCD can be used by women who are HIV-positive. True or false?
- 8- Updated evidence from WHO indicates that nulliparous women can use an IUCD. True or false?
- 9- Updated evidence from WHO indicates that the IUCD can be used by women who have had pelvic inflammatory disease in the past. True or false?
- 10- What are the five time periods in which an IUCD can be inserted
- 11- Rates of expulsion for the postpartum IUCD appear to be slightly higher than for interval insertion, but the benefits of providing this highly effective method immediately often outweigh the disadvantages. True or false?
- 12- Women who have AIDS can never use the IUCD. True or false?
- 13- For how many years can the Copper-T 380A be effective in preventing pregnancy?

ANSWERS TO QUESTIONS

1. According to new evidence, how does the copper IUCD prevent pregnancy?
By causing chemical changes in the uterus that make the sperm unable to fertilize the egg

2. How many types of IUCD are available for family planning programs?
Two—Cu 380 A, Multiload

3. Expulsion rates for IUCDs inserted postpartum are unrelated to the provider's level of experience.

True or false?

4. The IUCD is highly effective; if 1,000 women used the copper IUCD, how many women would become pregnant in the first year?

3–8

5. List five characteristics of the IUCD. Possible answers include:

- a. **Highly effective**
- b. **Long-acting, therefore convenient for long-term contraceptive use**
- c. **Quickly reversible**
- d. **Convenient to use, nothing to do at intercourse once the IUCD is in place**
- e. **With copper IUCDs, increased bleeding is common.**
- f. **Uncommon side effects/complications include expulsion and perforation of the uterus.**

6. Offering postpartum IUCD services is cost-effective for family planning programs as well as for clients.

True or false?

7. Updated evidence from WHO indicates that the IUCD can be used by women who are HIV-positive.

True or false?

8. Updated evidence from WHO indicates that nulliparous women can use an IUCD.

True or false?

9. Updated evidence from WHO indicates that the IUCD can be used by women who have had pelvic inflammatory disease in the past.

True or false?

10. What are the five time periods in which an IUCD can be inserted?

- a. **Post placental (10 minutes after delivery of placenta)**
- b. **Within 48 hours of delivery**

- c. **Trans caesarean**
- d. **Post abortion**
- e. **Interval (from four weeks postpartum onward)**

11. Rates of expulsion for the postpartum IUCD appear to be slightly higher than for interval insertion, but the benefits of providing this highly effective method immediately often outweigh the disadvantages.

True or false?

12. Women who have AIDS can never use the IUCD.

True or **false**?

13. For how many years can the Copper –T 380-A be effective in preventing pregnancy?

12 Years

SESSION 10
WRAP UP AND SUMMARIZE
(10 MINUTES)

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

FURTHER READING:

- <https://www.fphandbook.org/>
- https://www.who.int/entity/reproductivehealth/publications/family_planning/MEC-5/en/index.html
- <http://reprolineplus.org/resources/postpartum-intrauterine-contraceptive-device-ppiucd-reference-manual>

CONTRACEPTION FOR DIVERSE HIGH-RISK GROUPS



TIME 4 HOURS 30 MINUTES



TRAINING OBJECTIVES

- 1) Discuss the diverse group of women and girls, whose needs and circumstances are unique and require extra care and compassion
- 2) Highlight the importance of eligibility for helping choose the most suitable contraceptive method for them
- 3) Address their issues, with a positive attitude that is devoid of discrimination and stigma
- 4) Describe specific needs for contraception in particular situations, adolescents, teenagers, premenopausal / peri-menopausal women, smokers, women with disabilities and HIV



LEARNING OUTCOMES

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

- 1) Discuss various unique situations where access to routine FP services is even more difficult.
- 2) Identify the special groups of people who need extra ordinary compassion and competence to deal with their needs.
- 3) Establish possible criteria for the hierarchy of the contraceptive methods for each case (stages of the reproductive life, age, health status, desire to have children or not, number of sexual partners, behaviour, and lifestyle).
- 4) Address the needs of diverse special needs groups.



TRAINING/LEARNING METHODS

- 1) Individual and group exercises
- 2) Power Point Presentations
- 3) Brain storming
- 4) Group Work



ADVANCE PREPARATIONS

- 1) RH in humanitarian crisis
- 2) Provide: Strengthening youth friendly services (IPPF)
- 3) Trainer's Guide



TRAINING MATERIAL

Trainer' Material	Trainee's Material
Hand Outs: H25.1, H25.2, H25.3, H25.4, H25.5, H25.6, H25.7	Hand Outs: H25.1, H25.2, H25.3, H25.4, H25.5, H25.6, H25.7
Activity: A25.1, A25.2a, A25.2b, A25.3, A25.7	Job aid:
Job aid:	
FAQs:	
PPT: (25)	



CONSTITUTION OF THE SESSION

Eight mini sessions will be held

1) What are the various diverse groups with specific contraceptive needs?	Brainstorming with interactive discussion	40 Mins
2) What are the common problems faced by adolescents and young married girls?	Brainstorming Activity and discussion	40 Mins
3) Special needs for peri-menopausal women, smokers and obese women	Group work/Teach back	40 Mins
4) Dealing with people with disabilities	Brainstorming/Discussion	40 Mins
5) Talking to males about effective contraception	Brainstorming/Discussion	40 Mins

6) Women with HIV and multiple partners	Brainstorming, lecture, Case studies Discussion	25 Mins
7) FAQs	Pass the parcel game	25 mins
8) Wrap up		10 mins

SESSION 1

TITLE: WHAT ARE THE VARIOUS DIVERSE GROUPS WITH SPECIFIC CONTRACEPTIVE NEEDS?

(40 MINUTES)

OUTLINE & OBJECTIVES:

This session aims to highlight the specific groups with their unique needs for counselling and method choices will describe the contraceptive methods eligible in specific conditions such as: post-abortion, post-partum, teenagers, premenopausal/peri-menopausal women.

METHODOLOGY:

- 1) Divide the group into three parts and ask each group to prepare a brief presentation to address specific groups and their needs.
- 2) Brainstorming in small groups.
- 3) Followed by interactive discussion.

Handout: (H25.1)

Activity: (A25.1)

WHAT ARE THE VARIOUS DIVERSE GROUPS WITH SPECIFIC CONTRACEPTIVE NEEDS?

HANDOUT (H-25.1)



Activity (A25.1)

The trainer starts the session by inviting participants view to clarify the term ‘high risk’ as applicable in reproductive health settings. Highlight the fact that all girls and women need access to high quality reproductive care, and this is even more important for the high risk or vulnerable groups of population

Divide the participants into two groups by asking all participants to say YES and NO in a sequential way and remember their number. Ask both groups to brainstorm the **possible high-risk situations and times in context of contraceptive service provision, access, and choice**

Give each one of the groups a Flip chart and a marker to write down the results.

Tell them that they have 10 minutes to complete each task.

Tell them to think of as many possible criteria of hierarchy for contraceptive methods for each case (stages of the reproductive life, age, health status, desire to have children or not, number of sexual partners, behaviour, and lifestyle).

By the end of the exercise, each group empowers a representative to present their results.

After each presentation, ask participants of the other groups whether they have anything to add or if they have other opinions.

The trainer then discusses the details and adds any missed points in the discussion

All FP services must be equipped for dealing with the special subsets of population who require specialized services.

TEENAGERS, YOUTH, ADOLESCENTS:

Family planning can save teenage girls’ and young brides’ lives by helping them to delay the first pregnancy. If they become pregnant, girls ages 10 to 14 are five times more likely to^[1]_{SEF} die of pregnancy-related causes than women ages 20 to 24. Although young women are often less tolerant of side-effects, counselling will help adolescents know what to expect and may make them less likely to stop using their methods. Unmarried adolescents may be at increased risk of STIs and HIV transmission. It is important to counsel on dual protection strategies to reduce the risk of STI infection

WOMEN IN PRE-MENOPAUSE AND PERIMENOPAUSE:

Perimenopause) is the period before, during, and after the menopause. Before menopause, the woman enters the transitional phase, which is characterized by on and off episodes of ovulation. Peri-menopausal women have contraceptive needs that may differ from those of younger women.

OBESE WOMEN:

Safe and effective contraception is greatly needed by women with body mass index (BMI) of 25 kg/m and above because of the increased risk of pregnancy-related complications. Obesity often has co-morbid conditions, such as cardiovascular disease, diabetes, gall bladder disease, and cancer. An increase in weight also has the potential to decrease the effectiveness of certain methods like implants.

SMOKERS

Some smoking-related health problems are unique to women. One such problem is the effect of smoking on contraceptive options, specifically those utilizing hormonal agents. Of great importance is the effect of agents, such as combined oral contraceptives (COCs), on the risk of developing cardiovascular diseases, such as stroke, heart attack, and blood clot formation, especially in women smokers 35 years of age and above.

GIRLS AND WOMEN IN CRISIS SITUATION

In crisis settings (emergencies, wars, and refugee camps) there is often a lack of access to SRH services. Yet affected populations have a particular need for these services. Access to contraceptive methods, particularly emergency contraception, and to safe abortion and prophylaxis for STIs and HIV, is of paramount importance to safeguard women's health. Meeting family planning needs in humanitarian emergencies is challenging, but important and could present opportunities for reaching marginalized, remote, or otherwise underserved populations. Violence in humanitarian settings heightens the need to expand access to emergency contraception, long-acting reversible contraception (LARCs), and safe abortion services

INTERNALLY DISPLACED PEOPLE (IDPS):

Internally displaced persons are a high-risk group as they might be staying in the camps, long after the disaster has occurred. Increasing access to RH services, including FP, for IDPs (as well as other displaced persons) needs special attention because a large proportion of them are women and children, and IDP camps are often located far from existing health facilities. Contraceptive use is generally lower in refugee camps than in surrounding settlements.

WOMEN EXPERIENCING VIOLENCE:

Women experiencing violence have special health needs, many of them sexual and reproductive health needs. Providers of reproductive health care are in a good position to identify women who experience violence and to attend to their physical health needs as well as provide psychosocial support

ESPECIALLY ABLED GIRLS AND WOMEN:

This group of girls and women encounter discriminatory practices and stigma within the society, as well as within health facilities. All discrimination constitutes a denial of human rights. FP service providers must ensure that women and men living with disabilities have access to counselling on sexuality and access to appropriate FP options.

AFTER ABORTION:

In case of missed or incomplete abortion, WHO recommends a gap of 6 months before embarking on another pregnancy. Unintended pregnancy is the common reason for seeking a therapeutic abortion. In all situations, it is important that the client is counselled appropriately so that she can go home with a reliable contraceptive on board. For details please refer to Module 21.

AFTER BIRTH:

The postpartum period is a convenient period in which to offer family planning methods to women or couples. Doing so minimizes costs to the client and to the program. For details please refer to Module 18.

MEN

Men are also important as clients. Important family planning methods, male condoms and vasectomy, are used by men. Men also have their own sexual and reproductive health needs and concerns, which should be addressed appropriately.

WOMEN WITH HIV/ STIS AND WOMEN WITH MULTIPLE PARTNERS

Women who have multiple sexual partners (≥ 4) are 2 times more likely to have cervical cancers; women who have 2 sexual partners are 1.1 times more likely to have cervical cancers and women who report having 3 sexual partners are 1.4 times more likely to have cervical cancers compared to women who report having one sexual partner. For details please refer to Module 27.

SESSION 2

TITLE: THE COMMON PROBLEMS FACED BY ADOLESCENTS AND YOUNG MARRIED GIRLS

(40 MINUTES)

OUTLINE & OBJECTIVES:

- 1) To discuss the specific features of talking to an adolescent about FP in keeping with their unique needs.
- 2) Understanding the needs and challenges of young married women and first-time parents (FTPs).
- 3) Discuss the importance of equitable access to information and services for adolescents.
- 4) Attitudes and values related to young married women and FTPs regarding fertility and contraception.

METHODOLOGY:

- 1) Brain storming
- 2) Real life stories and group discussion

Handout: (H25.2)

Activity: (A25.2a, A25.2b)

THE COMMON PROBLEMS FACED BY ADOLESCENTS AND YOUNG MARRIED GIRLS

HANDOUT (H25.2)



Activity (A25.2a)

The trainer writes 'Young and Adolescent' on the flip chart and holds a brainstorming session to invite the possible problems and barriers they experience, to access high quality services. Any problems unique to this group are also discussed

Globally, it is estimated that nearly 10 million adolescent girls get married each year. These young brides are pressured to begin having children even though they are not fully physically developed, and their bodies are not prepared^[1] for pregnancy. Many young girls marry older

men, putting them at higher risk of being infected by their husbands with sexually transmitted infections (STIs), including HIV. 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.

1. Delaying the first pregnancy until a woman is at least 18 years old is healthiest for both the mother and baby.
2. Because pregnancy poses higher risks of complications for women under age 18, these girls need proper health care during pregnancy. They also need a skilled attendant to oversee childbirth and to care for the mother and child after delivery.
3. They must be reassured that a variety of contraceptive options are available for them, will cause no harm to their fertility later and can be stopped whenever they wish.
4. Women's families, including husbands and in-laws, need to be aware that pregnancy and childbirth are often risky for both young mothers and their children. They need to support these young women in postponing pregnancy until they are at least age 18 and their bodies are ready
5. Emergency contraceptive pills can prevent pregnancy when taken within 5 days after unprotected sex, when no method was used, a method was used incorrectly, or a method failed.

CONTRACEPTIVE CONSIDERATIONS FOR ADOLESCENTS:

1. Although young women are often less tolerant of side-effects, counselling will help adolescents know what to expect and may make them less likely to stop using their methods.
2. Unmarried adolescents may be at increased risk of STIs and HIV transmission. Counsel on dual protection strategies to reduce the risk of STI infection.
3. Adolescent girls may have less control than older women over having sex and using contraception. This may increase their need for emergency contraception. Counsel all adolescents who seek emergency contraception on FP methods and give them the option to take extra emergency contraception with them.
4. Young women often prefer methods which they can use without others knowing (such as injectable contraceptives)

Young people can safely use any reversible contraceptive method. Age is not a medical reason for denying any method to adolescents.

LONG-ACTING REVERSIBLE CONTRACEPTIVES—IMPLANTS AND IUCDS

Implants, copper-bearing IUCDs, and LNG-IUCDs may be good choices for many young women because:

- 1) These methods are highly effective—less than 1 pregnancy per 100 women in the first year of use.
- 2) Once in place, these methods do not require any action by the user. She does not have to plan for sex.
- 3) They work for a number of years.
- 4) They are quickly reversible. Once the implant or IUCD is removed, a woman can again become pregnant.
- 5) Are a relatively private contraceptive method
- 6) IUCDs are more likely to come out among women who have not given birth because their uteruses are small.

INJECTABLE CONTRACEPTIVES:

Injectable can be used without others knowing.

ORAL CONTRACEPTIVES:

Some young women find taking a pill every day particularly difficult.

EMERGENCY CONTRACEPTIVE PILLS (ECPS):

Young women may have less control than older women over having sex and using contraception. They may need ECPs more often. It is safe to use ECPs multiple times between monthly bleedings. Using combined oral contraceptives or a long-acting reversible method would be more effective in the long run.

FEMALE STERILIZATION AND VASECTOMY:

Provide with great caution. Young people and people with few or no children are among those most likely to regret sterilization.

MALE AND FEMALE CONDOMS:

Protect against STIs as well as pregnancy. Many young people need protection against both. Readily available, and they are affordable and convenient for occasional sex. Young men may be less successful than older men at using condoms correctly. They may need practice putting condoms on.

DIAPHRAGMS, SPERMICIDES, AND CERVICAL CAPS:

Although among the least effective methods, young women can control use of these methods, and they can be used as needed.

FERTILITY AWARENESS METHODS:

Until a young woman has regular menstrual cycles, fertility awareness methods should be used with caution. Need a backup method or ECPs on hand in case abstinence fails.

WITHDRAWAL:

Requires the man to know when he is about to ejaculate so he can withdraw in time. This may be difficult for some young men. One of the least effective methods of pregnancy prevention, but it may be the only method available—and always available for some young people.

Understand the challenges young married women face and FTPs in seeking reproductive health services

Their needs depend on their situations. Some are unmarried and sexually active, others are not sexually active, while still others are already married. Some already have children. Age itself makes a great difference, since young people mature quickly during the adolescent years. These differences make it important to learn about each client first, to understand why that client has come, and to tailor counselling and the offer of services accordingly.

PREGNANCY AMONG ADOLESCENTS

As defined by the WHO, adolescents are individuals aged 10 to 19 years and pregnancy in this group is associated with several potential medical problems, including the following:

- 1) High health risk
- 2) Unsafe abortion
- 3) Inadequate or lack of prenatal care
- 4) Sexually transmitted disease from unprotected sex

Teen pregnancy also has social consequences, such as loss of educational and employment opportunities as well as emotional and financial unpreparedness for raising a child.

KEY MESSAGES

CONTRACEPTION FOR ADOLESCENTS

All currently available modern contraceptive methods are safe for adolescents

The use of progestogen-only injectables, such as depot medroxyprogesterone acetate (DMPA), for individuals below 18 years old has raised concerns because of their potential effects on bone

density. WHO suggests that such effects must be balanced against the risk of an unplanned pregnancy.
Young people often do not have the medical conditions that limit the use of certain contraceptive methods in older clients.
Certain adolescent groups may be at a high risk for acquiring HIV and other sexually transmitted infections (STIs). This fact should greatly influence the selection of an appropriate contraceptive method for them.
High discontinuation rates in this age group are due to low threshold to tolerance to some side effects. Therefore, members of this age group must be counselled about the temporary nature of these effects to motivate them to continue using the contraception.
For some adolescents, the use of a daily regimen may be inappropriate because of the unpredictable frequency of intercourse and the need for privacy regarding birth control use and sexual practices.
For married or teenage mothers, healthy timing and spacing of pregnancy should be emphasized so that they may opt to use a long-acting reversible contraceptive method.
Educating adolescents on contraceptive methods and FP services should be done to provide correct information and improve knowledge on contraceptive use and appropriateness of contraception. The provision of adequate reproductive health (RH) counselling services for adolescents remains challenging because of the barriers posed by factors such as national policies, culture, misconception, poverty, and lack of education. RH counselling services must be made accessible, available, affordable, and understandable in a supportive and non-judgmental environment.
Just like any client, young individuals must be assured of confidentiality and privacy and must not be subjected to unnecessary procedures before they can avail of the appropriate contraceptive method. Young individuals must be counselled first to delay sexual activity until a later time when they are more capable of starting a family.

RECOMMENDED CONTRACEPTIVE OPTIONS

Combined hormonal contraceptives: combined oral contraceptives, combined contraceptive patch, combined contraceptive vaginal ring, combined injectable contraceptives

These methods can be used by adolescents without restriction (MEC 1).

1. However, daily intake of pills may be difficult for some individuals, particularly for those who value confidentiality and have issues with compliance.
2. Injectables and vaginal rings may effectively address the need for secrecy.
3. COCs containing 20 µg Estradiol have been observed to reduce bone mineral density; however, high formulation shows negligible effects.
4. Both implants and progesterone-only pills can be used without restriction.
5. The potential effect of injectable DMPA (MEC 2) on bone mineral density is waived by its preventive effect on unplanned pregnancy.

6. Studies show that DMPA causes a loss of bone mineral density; however, discontinued use of DMPA allows the recovery of the lost density. Whether DMPA ultimately affects the peak bone mass levels of adolescents in the long run remains unclear.

BARRIERS: CONDOMS, SPERMICIDE, DIAPHRAGM, AND CERVICAL CAP

1. Barrier methods can be used without restrictions.
2. Condoms provide dual protection against sexually transmitted diseases; in addition, they are affordable, readily available, and convenient to use.
3. Young men may need to practice condom application because they are more likely to commit errors than older, more experienced users.
4. Diaphragms and cervical caps are among the least effective methods, may not be as readily available, and may be cost restrictive. However, they can be used for safe and reversible contraception as needed, provided that the user is appropriately counselled and motivated regarding the use of this method.
5. These devices can generally be used (MEC 2), but three factors should be considered:
 - a. Expulsion is likely to occur in nulliparous adolescents who have started sexual activity because of the small size of the uterus.
 - b. The risk of failure is less than the risk of pregnancy.
 - c. This method may not be appropriate for certain adolescents at higher risk for STIs.

FERTILITY-AWARENESS BASED METHODS:

- 1) Adolescents can use this modality if motivated enough to observe strict compliance.
- 2) However, young women, especially those with irregular cycles, must avoid using this method because of its high failure rate.
- 3) Special counselling is necessary for young individuals to ensure correct usage of this method.

METHODS TO AVOID:

Sterilization: tubal ligation, vasectomy

1. These methods must be used with caution for this age group because they are considered permanent.
2. Adolescents who wish to undergo these procedures must be counselled on the availability of other methods that provide safe, long-term, but reversible contraception.
3. Highlight counselling for this group/ special care they need.

As a health care provider trained to work with adolescents and youth, it is important to consider how to best provide SRH counselling to young married women, FTPs, and their husbands (if they accompany the young women to the clinic). The way you communicate with people

determines what they are willing and able to learn from you. If you are speaking to a young woman and you do not think she should be using contraception, this will come across in your actions, in your tone of voice, and in your body language. The counselling skills and principles you have learned in previous adolescent sexual and reproductive health training are all relevant to young married women and FTPs.



Activity (A25.2b)

Story Telling

Read aloud the following story. Tell participants to write down what Salima does well and what she does not do very well.

Salima is a family planning nurse at the health centre. Mariam is 19 years old and has been married to Karim for one and a half years. They have a 6-month-old baby and Mariam is a first-time mother. Mariam is planning to introduce solid foods to her baby and once she does that, she knows that breastfeeding will not protect her from becoming pregnant anymore. She does not want another child right away but does not have much knowledge about contraception. Mariam goes to find out more at the nearest health centre. After waiting 3 hours, it is Mariam's turn to see Salima (the family planning nurse).

Being careful to protect Mariam's privacy, Salima calls Mariam to the consultation room quietly and makes sure the door is closed. Salima sits in front of Mariam and looks at her very kindly. She asks Mariam questions about her health and the health of the baby. Then she asks Mariam why she came to the family planning room. Mariam tells her that she knows that breastfeeding will no longer protect her from pregnancy, and she wants to wait to have another baby and she had heard that there was some medicine that could prevent pregnancies. Salima starts to look angry.

She asks: "Mariam, does Karim know you are here?" Mariam says that she told him she had to come to the clinic to have the child seen by the nurse. Salima says that Mariam does not need to be using contraception now, she only needs to wait 6 months between having a baby and becoming pregnant again, and that it is a perfect time to begin trying to have a baby. Even if she wanted contraception, Salima does not feel comfortable giving it to her without Karim's permission. Salima is friends with Karim's mother and knows that his mother would not approve.

Ask the participants the following questions. Supplement with the answers below.

What did Salima, the nurse, do well?

Possible answers might include:

- 1) Salima closed the door to make sure there was privacy.
- 2) Salima greeted Mariam warmly.
- 3) Salima sat in front of Mariam, at eye-level (not above her).

- 4) Salima asked Mariam open-ended question about her health and the health of her child.

What did Salima do poorly?

Possible answers might include:

- 1) Salima scolded Mariam for wanting to use contraception.
- 2) Salima told Mariam incorrect information about the healthiest spacing of pregnancies.
- 3) Salima should not require Karim's permission to give Mariam contraception.
- 4) Salima should respect Mariam's privacy and should not let her friendship with Karim's mother affect her advice to Mariam.
- 5) Salima should have provided Mariam thorough contraceptive counselling and the contraceptive method of her choice.

GOALS OF YOUTH FRIENDLY SERVICES

- 1) Show young people that you enjoy working with them.
- 2) Offer services that are free or as low cost as possible.
- 3) Offer a wide range of contraceptive methods, including long-acting reversible methods.
- 4) Counsel in private areas where you and the client cannot be seen or overheard. Ensure confidentiality and assure the client of confidentiality.
- 5) Listen carefully and ask open-ended questions such as "How can I help you?" and "What questions do you have?"
- 6) Use simple language and avoid medical terms.
- 7) Use terms that suit young people. Avoid such terms as "family planning," which may seem irrelevant to those who are not married.
- 8) Welcome husbands and include them in counselling if the client desires.
- 9) Try to make sure that a young woman's choices are her own and are not pressured by her husband or her family. If she is being pressured to have sex, help a young woman think about what she can say and do to resist and reduce that pressure. Practice with her the skills to negotiate condom use.
- 10) Speak without expressing judgment (for example, say "You can" rather than "You should"). Do not criticize even if you do not approve of what the young person is saying or doing. Help young clients make decisions that are in their best interest.
- 11) Take time to fully address questions, fears, and misinformation about sex, sexually transmitted infections (STIs), and contraceptives. Many young people want reassurance that the changes in their bodies and their feelings are normal. Be prepared to answer common questions about puberty, monthly bleeding, and genital hygiene.
- 12) Be aware of young people's norms about gender and gently encourage positive, healthful norms. You can help young women feel that they have the right and the power to make their own decisions about sex and contraception. You can help young men to understand the consequences of their sexual behaviour for themselves and for their partners.

SESSION 3

TITLE: THE SPECIAL NEEDS OF PERI-MENOPAUSAL WOMEN, SMOKERS AND OBESE WOMEN

(40 MINUTES)

OUTLINE & OBJECTIVES:

To define menopause and clarify the myths regarding contraceptive needs in this specific group of women

To highlight the importance of FP in the peri-menopausal period

Identify the high-risk status of smokers and obese women

METHODOLOGY:

- 1) Brain storming
- 2) Sharing real life stories and group discussion

Handout: (H25.3)

Activity: (A25.3)

THE SPECIAL NEEDS OF PERIMENOPAUSAL WOMEN, SMOKERS AND OBESE WOMEN

HANDOUT (H-25.3)



Activity (A25.3)

The trainer starts this session by highlighting these three high risk groups of women.

Get the participants to clarify terms like:

- 1) Menopause
- 2) BMI
- 3) Obesity, morbid obesity, and smoking

Types of smokers based on the number of cigarettes they smoke. In Pakistan, in addition to smoking, many girls and women use tobacco in the form of Huqqa and Sheesha.

The trainer should stress that these are also high-risk behaviours

The group is divided into three groups and each group is asked to take 10 minutes to brainstorm the specific issues regarding these groups and choose a representative to present.

The trainer then discusses any points left out and engages the large group in discussion

WOMEN IN PERIMENOPAUSE:

A woman is assumed to have reached menopause if she has gone 12 consecutive months without having any bleeding, or if her follicle stimulating hormone (FSH) level is more than 25-40 mIU/ml. Sexually active women in this age group continue to be at risk for unintended pregnancy unless they use effective methods of contraception until menopause. Women usually enter the menopause at around 45 to 55 years of age. About half of women reach menopause by age 50. By age 55 some 96% of women have reached menopause.

Therefore, protection from an unplanned pregnancy is still required until complete anovulatory menstrual cycle is established because pregnancies in the late reproductive years are associated with high maternal and perinatal morbidity and mortality. The likelihood of certain foetal malformations also increases in pregnancies in this age group.

SPECIFIC NEEDS OF PERI-MENOPAUSAL WOMEN

Peri-menopausal women have contraceptive needs that may differ from those of younger women. Apart from the effectiveness of a family planning method, concerns regarding non-contraceptive benefits may be prominent. These concerns include protection from gynaecologic cancers, osteoporosis, and benign growths (myomas and polyps) as well as control of menstrual cycle irregularities, hot flushes, and other menopausal symptoms.

The peri-menopausal period is also associated with declined sexual intercourse, hence the lack of motivation to use any contraceptive at this time. Women who are conscious of impending menopause may erroneously think that they are already safe from pregnancy. However, the risk of unwanted pregnancy is real.

The need for effective and safe contraception may even be essential for some peri-menopausal women who may already have cardiovascular diseases, hypertension, and diabetes because these conditions increase pregnancy risks. These conditions may also contraindicate the safe use of some contraceptives. Thus, this age group has limited options.

MEDICAL ELIGIBILITY IN PERI MENOPAUSAL GROUP:

COMBINED CONTRACEPTIVES:

Women who are over 35 years of age and have migraine headaches (with or without aura) should not receive COCs, monthly injectables, skin patches, or vaginal rings.

Women who have migraine headaches with aura should not receive oestrogen-containing methods, regardless of age.

Women who are over 35 years of age and use tobacco products should not receive COCs, monthly injectables, skin patches, and/or vaginal rings.

PROGESTIN-ONLY METHODS:

Progesterone only methods (progestin-only pills, progestin-only injectables and implants) A good choice for women who cannot use methods with oestrogen. The injectables can generally be used despite certain theoretical or proven risks (MEC 2).

Concerns regarding the use of DMPA or NET-EN injectables in older women include reduced HDL levels (good cholesterol levels) and hypoestrogenic effects, which may persist for some time after discontinued use. These phenomena may increase the risks for aggravating hypertension, strokes, and ischemic heart conditions.

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.

IUCDS:

1. Intrauterine device (copper-bearing IUCDs and LNG-IUCDs)
2. Expulsion rates fall as women grow older and are lowest in women over 40 years of age.
3. Insertion may be more difficult due to tightening of the cervical canal.
4. Expulsion rates in these women are considerably lower than those in younger women.
5. However, insertion in some cases may be more difficult because of tight cervical canals.

BARRIERS: MALE AND FEMALE CONDOMS, DIAPHRAGMS, SPERMICIDES, CERVICAL CAPS, AND WITHDRAWAL (MEC 1).

- 1) Peri-menopausal women can use these methods without limitations or contraindications
- 2) Some people find these methods to be ideal for protection of older women with decreased frequency of sexual intercourse.
- 3) The higher failure rates of barriers compared with hormonal methods may not be an important concern because of the decreased fertility that occurs in the menopausal transition phases.
- 4) Barrier methods would be a good choice for women in this age group because these methods do not pose proven or theoretical risks as with hormonal agents.

FEMALE STERILIZATION AND VASECTOMY:

- 1) May be a good choice for older women and their partners who know they will not want more children.
- 2) Older women are more likely to have conditions that require delay, referral, or caution for female sterilization.

AVOID FERTILITY AWARENESS-BASED METHODS:

These methods are used with caution in this age group because of increased unreliability resulting from menstrual irregularities that commonly arise at this time, making periods of fertility difficult to establish.

EMERGENCY CONTRACEPTIVE PILLS:

Can be used by women of any age, including those who cannot use hormonal methods on a continuing basis.

RELIEVING SYMPTOMS OF MENOPAUSE:

Women experience physical effects before, during, and after menopause:

Hot flashes, excess sweating, difficulty holding urine, vaginal dryness that can have sex painful, and difficulty sleeping. Providers can suggest ways to reduce some of these symptoms:

- 1) Deep breathing from the diaphragm may make a hot flash go away faster. A woman can also try eating foods containing soy or taking 800 international units per day of vitamin E.
- 2) Eating foods rich in calcium (such as dairy products, beans, fish) and engaging in moderate physical activity helps slow the loss of bone density that comes with menopause.
- 3) Vaginal lubricants or moisturizers can be used if vaginal dryness persists and causes irritation.

WHEN CONTRACEPTION IS NO LONGER NEEDED:

Another concern is determining when contraception can be discontinued for those already on a contraceptive method. The following are the current guidelines:

- 1) Menstruating women can discontinue contraception when they reach menopause (i.e., if 12 months have elapsed without any noticeable bleeding).
- 2) Where hormone levels can be measured, an elevated value of FSH (more than 25-40 mIU/ml) on two occasions, one month apart, is indicative of menopause.
- 3) Hormonal methods affect bleeding, and so it may be difficult to know if a woman using them has reached menopause. She can switch to a no hormonal method. She no longer needs contraception once she has had no bleeding for 12 months in a row.

- 4) If the woman has a copper intrauterine device (IUCD) in place, the device is removed 12 months after the last menstrual period.
- 5) In the case of women who have been using injectable contraceptives such as DMPA and are amenorrhoeic, the following guidelines apply:
 - a. Appearance of symptoms and signs associated with oestrogen deficiency, (e.g., vaginal dryness or hot flashes), are suggestive, but not an absolute indication, of menopause.
 - b. After switching to a method that is not associated with amenorrhoea and no bleeding occurs after 12 months, menopause may be assumed
 - c. Because bleeding does not come every month in the time before menopause, it is difficult for a woman whose bleeding seems to have stopped to know when to stop using contraception. Thus, it is recommended to continue using a family planning method until 12 months with no bleeding have passed.

CONTRACEPTION FOR SMOKERS

The consequences of smoking, such as increased risk of cancer and respiratory diseases, are generally the same for both women and men. However, some smoking-related health problems are unique to women. One such problem is the effect of smoking on contraceptive options, specifically those utilizing hormonal agents of great importance is the effect of agents, such as Combined oral contraceptives (COCs), on the risk of developing cardiovascular diseases, such as stroke, heart attack, and blood clot formation, especially in women smokers 35 years of age and above. Smoking also increases the risk of cervical cancer and early menopause for women and results in adverse pregnancy outcomes, such as low birth weight infants, abortion, stillbirth, and perinatal mortality.

RECOMMENDED METHODS

- 1) These contraceptives include progestin-only pills, depot medroxyprogesterone acetate/Norethisterone enantate, and Levonorgestrel and etonogestrel implants.
- 2) These devices include copper-bearing IUCD and Levonorgestrel-releasing IUCD.
- 3) Barriers include condoms, spermicides, diaphragm, and cervical cap.
- 4) Sterilization includes tubal ligation and vasectomy.
- 5) The absence of estrogen in the above methods make them safe and acceptable options for smokers, regardless of age and number of cigarettes consumed per day (MEC 1).
- 6) Combined hormonal contraceptives (CHCs)
- 7) Women who smoke and are less than 35 years of age can use the following agents (MEC 2): COC pills, combined injectable contraceptives, combined contraceptive patch, and combined contraceptive vaginal rings.

- 8) For women, over 35 years of age who consume less than 15 cigarettes per day, only CICs fall under this category (MEC 2).

METHODS TO AVOID

(Smokers older than 35 years' old who consume 15 or more cigarettes per day)

- 1) For women, over 35 who smoke less than 15 cigarettes daily, COC pills, combined contraceptive patch, and combined vaginal rings should be avoided because risks are greater than the advantages from their use (MEC 3).
- 2) If a woman smokes, at least 15 cigarettes a day, then all four of these methods are unacceptable (MEC 4) because of the higher risks of cardiovascular diseases, such as heart attacks (myocardial infarction). These risks increase with the number of cigarettes consumed per day. In such cases, the woman is encouraged to quit smoking and should be assisted in the selection of safe birth control alternatives

ADDRESSING THE NEEDS OF OBESE WOMEN

Safe and effective contraception is greatly needed by women with body mass indices (BMIs) of 25 kg/m² and above because of the increased risk of pregnancy-related complications. Obesity often has co-morbid conditions, such as cardiovascular disease, diabetes, gall bladder disease, and cancer.

An increase in weight also has the potential to decrease the effectiveness of certain methods. For instance, increased metabolic rate results in the quick elimination of hormonal agents from the body, and increased blood volume that comes with an increase in weight can reduce blood levels of hormones.

This condition potentially compromises contraceptive efficacy. The problem cannot be solved by simply doubling the dose of these hormones because such practice will obviously introduce significant health risks. Another important issue is whether a particular method (e.g., such as the use of oral contraceptive pills) causes further weight gain. Therefore, the selection of the most appropriate options poses a considerable challenge and requires a conscientious review of the current evidence that addresses these issues.

RECOMMENDED METHODS:

These methods are categorized as MEC 1 and can therefore be used without restrictions by women with obesity.

- 1) IUCDs and barriers are categorized as MEC 1 and have no restrictions for use in this population of patients, even among those less than 18 years of age.
- 2) Intra uterine devices include copper-bearing IUCD and Levonorgestrel releasing IUCD.
- 3) Barriers include condoms, spermicides, diaphragm, and cervical cap.

- 4) Progestin-only contraceptives: progestin-only pills, depot medroxyprogesterone acetate (DMPA)/, Levonorgestrel and etonogestrel implants

The following agents are categorized as MEC 2 for women with obesity.

However, for women with obesity who are less than 18 years old, DMPA is categorized as MEC 2, considering the potential but reversible effects on bone mineral density.

- 1) Therefore, women with obesity can generally use these agents with consideration of the potential reversible effects on bone mineral density.
- 2) Evidence suggests the increased likelihood of weight gain among adolescent **DMPA** users with obesity compared with non-users with obesity, combined oral contraceptive (COC) users with obesity, and users with normal weight.
- 3) **Levonorgestrel implant** users who weigh more than 60 kg should be advised to return to their healthcare provider after four years (instead of five years) for implant replacement or for a new contraceptive method. Levonorgestrel blood levels are lower for these women at the end of implant use compared with non-obese users and are inversely related to body weight.
- 4) Etonogestrel implant users who are obese, should also be advised to return after two years for implant replacement or for a new contraceptive method. Etonogestrel blood levels are also lower at the end of implant use for these women compared with non-obese users and are inversely related to body weight.
- 5) **Levonorgestrel** exhibits a rapid decrease in efficacy with increasing weight.
- 6) These methods can generally be given because the advantages of use outweigh the risks.
- 7) Compared with non-users with obesity, however, venous thromboembolism is likely to occur among those using these agents.

Combined hormonal contraceptives (CHCs): COC pills, combined injectable contraceptives, combined contraceptive patch, combined contraceptive vaginal rings

- 1) Acute myocardial infarction, strokes, and weight gain as a result of the use of combined contraceptive pills do not appear to be more frequent for these women.
- 2) The use of COCs and vaginal rings generally does not cause weight gain. For yet unknown reasons, some women do undergo weight changes with COC intake, but these changes appear to reverse upon discontinuation.
- 3) The issue of whether the effectiveness of these methods is influenced by weight or BMI cannot be established at present.
- 4) While the absolute number of women using COCs who suffer from VTE is small, this risk is likely increased for overweight and obese women. In the World Health Organization Collaborative Study of Cardiovascular Disease and Steroid Hormone Contraception, researchers identified a BMI of 25 or greater as an independent risk factor for VTE in COC users. The same holds true for arterial thromboembolic disease.
- 5) The use of the Yuzpe method in women with obesity has not been fully studied; thus, its use for emergency contraception in this population cannot be recommended.

Preferably try and avoid Female Sterilization due to the following reasons

- 1) With severe obesity, caution is recommended before employing a procedure because of technical challenges.
- 2) Additional precautions and preparations should be in place in secondary or tertiary hospitals.
- 3) Fallopian tubes may be difficult to access through small incisions because of abdominal wall thickness.
- 4) Associated complications, such as wound infections and breakdown, may also be increased.
- 5) In addition, general or spinal anaesthesia and its attendant risks are very likely.
- 6) Prevention of airway obstruction and inadequacy of oxygen delivery are particularly challenging in patients with obesity.
- 7) Alternatively, vasectomy can be offered to the partner.

NOTE:

Some overweight women may benefit from employing natural methods of contraception because of the lack of systemic side effects. However, regular monitoring and testing cannot be overemphasized because these methods usually exhibit less effectiveness than other contraceptive options. For this reason, fertility awareness-based methods may not be appropriate for women with conditions that increase risks and dangers during pregnancy. Women with obesity, especially those with co-morbid medical conditions, are all likely to fall under this category.

SESSION 4

TITLE: LOOKING AFTER PEOPLE WITH DISABILITIES

(40 MINUTES)

OUTLINE & OBJECTIVES:

1. To sensitize the participants to the presence of and specific needs of people with mobility restrictions.
2. To discuss ways and means of making their access to quality FP services better.
3. Address their specific needs in light of their medical issues.

METHODOLOGY

- 1) Brainstorming
- 2) Sharing experiences from their workplace
- 3) Real life stories
- 4) Large group discussion to discuss measures to improve service provision

Handout: (H25.4)

LOOKING AFTER PEOPLE WITH DISABILITIES

HANDOUT (H-25.4)

PEOPLE WITH DISABILITIES (PWDS)

WHO estimates that disability affects 10 percent of every population.

The most common forms of disability are physical (35 percent), visual (25 percent), hearing (11 percent), mental (seven percent), and speech (four percent).

These people encounter discriminatory practices and stigma within the society, as well as within health facilities. All discrimination constitutes a denial of human rights. FP service providers must ensure that women and men living with disabilities have access to counselling on sexuality and access to appropriate FP options.

- 1) To care for people with disabilities, programs should make it known in the community that they serve people with disabilities without discrimination
- 2) Service providers need to be familiar with the special needs of this group and be prepared to address them with a positive attitude that is devoid of discrimination and stigma.
- 3) Health facilities should be more user friendly to them and ideally have at least one staff member who is trained in sign language.

- 4) Facilities should be made physically accessible, for example, with ramps for wheelchairs adjustable examination couches and large bathrooms with grab bars.
- 5) Outreach programs should make a special effort to identify and reach people in the community who have limited mobility.
- 6) Print materials should have simple graphics, large print, and Braille, if possible, and information should be available in audio formats, such as CD or cassette tape, as well as in print.
- 7) Providers may need specially to demonstrate actions as well as describing them, to speak slowly, and to pause often and check comprehension.
- 8) Learning to respect the rights of people with disabilities and to care for them should be part of pre-service training for health care providers, and it should be reinforced with in-service training periodically.
- 9) Meeting and talking with people with disabilities can give providers valuable information about how to make services more respectful and accessible. Often, the changes needed are easy.

Advice on contraception should consider the nature of an individual's disability, her specific needs, and the nature of the method. Service providers must ensure that clients make decisions on contraceptive methods based on informed choice. Special consideration should be given to individuals who are mentally challenged or those with psychiatric disorders, who might require specialized counselling or referral for treatment before they decide on contraception. Where the nature of the condition does not allow for informed choice (e.g., severe mental challenge), an FP method should be provided only after full discussion with all parties, including guardians or caregivers. The reproductive rights of the individual must be considered in any such decisions.

In dealing with special people, please remember:

- 1) Health care providers should treat people with disabilities in the same way that they should treat people without disabilities: with respect.
- 2) People with disabilities have the same sexual and reproductive health needs and rights as people without disabilities, but often they are often not given information about reproductive and sexual health or adequate care.
- 3) People with disabilities are more vulnerable to abuse than other people.
- 4) They are at increased risk of being infected with HIV and other STIs.
- 5) Many have been sterilized against their will, forced to have abortions, or forced into unwanted marriages, and many have experienced gender-based violence.

Health care programs, including family planning programs, need to follow the relevant articles of the^[1]UN Convention on the Rights of Persons with Disabilities, especially the articles that address health, family life, and legal rights.

Counselling and supported decision-making:

In supported decision-making, supporters, advocates, or others help people with disabilities to make their own decisions, free of conflict of interest or undue influence, and without giving decision-making power to someone else.

This process may include documenting informed consent.

- 1) To counsel clients with disabilities, health care providers need to consider their preferences and the nature of their disability. For instance, barrier methods may be difficult for some people with a physical disability, and women with an intellectual disability may have trouble remembering to take a pill each day or dealing with changes in monthly bleeding.
- 2) Like all clients, people with disabilities need sexual and reproductive health education to make informed choices.
- 3) People with intellectual disabilities have the same rights as other people to make their own decisions about contraception, including sterilization. They may need special support to do so.
- 4) For a client with an intellectual disability who is unable to communicate her or his preferences clearly, someone whom the client trusts should participate and help to make an informed choice that is as consistent as possible with the client's preference. Especially for the choice of sterilization, health care systems should ensure that a process of supported decision-making is available.

SESSION 5

TITLE: MALE INVOLVEMENT AND TALKING TO THEM

(25 MINUTES)

OUTLINE & OBJECTIVES:

To highlight the importance of involving men in decision making for FP.
To break the taboos and clear the myths and misconceptions which often lead to discontinuation of a method of contraception.

METHODOLOGY

- 1) Group discussion
- 2) Have the small groups return to the larger group and present the main points from their discussion.
- 3) Answer any questions that the group might have about the information you have presented.

Handout: (H25.5)

MALE INVOLVEMENT AND TALKING TO THEM

(H25.5)

IMPORTANT SUPPORTERS, IMPORTANT CLIENTS:

To health care providers, men are important for 2 reasons.

First, they influence women. Many men care about their partner's reproductive health and support them. Others stand in their way or make decisions for them. Thus, men's attitudes can determine whether women can practice healthy behaviours. In some circumstances, such as avoiding HIV infection or getting help quickly in an obstetric emergency, a man's actions can determine whether a woman lives or dies.

Men are also important as clients. Important family planning methods male condoms and vasectomy are used by men. Men also have their own sexual and reproductive health needs and concerns regarding sexually transmitted infections (STIs) which deserve the attention of the health care system and providers.

Many Ways to Help Men:

Providers can give support and services to men both as supporters of women and as clients. The involvement of males in making an informed choice is important

Encourage Couples to Talk:

Couples who discuss family planning with or without a provider's help are more likely to make plans that they can carry out. Providers can:

1. Coach men and women on how to talk with their partners about sex, family planning, and STIs.
2. Encourage joint decision-making about sexual and reproductive health matters.
3. Invite and encourage women to bring their husbands to the clinic for joint counselling, decision-making, and care.
4. Encourage the men to understand and support his wife to choose the contraceptive method she prefers.
5. Encourage men to consider taking more responsibility for family planning, for example, by using condoms or vasectomy.
6. Suggest to women that they tell their husbands about health services for men. Give informational materials to take home, if available.

Possible ways to promote male involvement:

- 1) Encourage women clients to bring their male partners with them to the clinic.
- 2) Create male-friendly FP clinics by providing suitable waiting rooms for men and displaying information, education, and communication (IEC) materials.
- 3) Introduce male FP clinics and organize FP outreaches that target males at their places of work.
- 4) Maintain flexible opening hours at FP clinics.
- 5) Add services that are beneficial to men, (e.g., prostate cancer screening, and male circumcision).

Provide Accurate Information:

- 1) To inform men's decisions and opinions, they need correct information and correction of misperceptions. Topics important to men include:
 - Family planning methods, both for men and for women, including safety and effectiveness
 - STIs including HIV—how they are and are not transmitted, signs and symptoms, testing, and treatment
- 2) The benefits of waiting until the youngest child is 2 years old before a woman becomes pregnant again.
- 3) Male and female sexual and reproductive anatomy and function.
- 4) Safe pregnancy and delivery.
- 5) A whole range of benefits for the family, children, and communities.

Offer Services or Refer:

Important services that many men want include:

- 1) Male condoms and vasectomy services.
- 2) Information and counselling about other contraceptive methods, particularly methods that must have male cooperation, such as fertility awareness-based methods and female condoms.
- 3) Counselling and help for sexual problems.
- 4) STI/HIV counselling, testing, and treatment.
- 5) Infertility counselling.
- 6) Screening for penile, testicular, and prostate cancer.
- 7) Like women, men of all ages, married or unmarried, have their own sexual and reproductive health needs. They deserve good-quality services and respectful, supportive, and non-judgmental counselling.

Male involvement in family planning programs:

- 1) Involve men in FP programs to increase acceptance of the program within the community and to increase recognition of other RH issues, such as the prevention and treatment of STIs and HIV. Considering men's perspectives and motivation is integral to program activities.
- 2) Contraceptive use by men enables them to share the responsibility of family planning with their female partners. FP services may need to be specifically tailored to meet the needs of male users. Activities to encourage men's involvement include couples counselling, condom promotion, and special health facility times for men, peer-group sessions, and RH information at male social groups.
- 3) Improve communication between couples about decisions regarding fertility and FP that would reflect the needs and desires of both men and women.
- 4) Provide men with needed information that would enable them to participate responsibly in FP decision-making. They can get information and learn more about FP by accompanying their partners on clinic visits and by taking advantage of special clinic hours for men where available.
- 5) Organize services for FP for men either through STI/HIV prevention and control clinics or allocating special times in FP clinics when they could receive appropriate information and private services.
- 6) Encourage men to play an important role in preventing STIs by maintaining a monogamous relationship or using condoms to protect their partners and themselves. The condom the most effective method of protection against STIs next to abstinence is a "male method;" men's cooperation is essential to stop the spread of STIs, including AIDS.
- 7) Make information on STI/HIV protection available through several formal and informal channels including at places of work and recreation.
- 8) Allow men to participate in the design and implementation of FP and RH services and to express ways in which they can be encouraged to take more responsibility.

SESSION 6

TITLE: LOOKING AFTER WOMEN WITH MULTIPLE PARTNERS AND OR HIV

(25 MINUTES)

OUTLINE & OBJECTIVES:

To highlight the specific and unique needs of this high risk and vulnerable group of women and girls.

METHODOLOGY:

- 1) Group discussion
- 2) Have the small groups return to the larger group and present the main points from their discussion.
- 3) Answer any questions that the group might have about the information you have presented.

Handout: (H25.6)

WOMEN WITH MULTIPLE PARTNERS AND THOSE WITH HIV

HANDOUT (H25.6)

It is well documented in the literature that sexual promiscuity, low condom usage and early sexual initiation have accounted for an increase in HIV/AIDS, teenage pregnancies and abortions. The reality is promiscuous sexual behaviour and infrequent use of condoms are highly likely to result in sexually transmitted infections, in particular HIV/AIDS and the human papillomavirus (HPV) as well as the increased risk of cervical cancer.

The health of women with multiple partners is a matter of grave concern and elaborate health intervention programs should be developed and implemented for addressing the reproductive health concerns of women with multiple sexual relationships and risky behavioural practices. Poverty hampers economic freedom and choice, and so despite one's willingness to avoid these practices, many realities are circumvented. The poor are held in a vicious cycle of continuous poverty, and on the onset of health conditions poverty could extend to the family.

UNAIDS/WHO estimates that 42 million people are living with HIV/AIDS worldwide and 50% of all adults with HIV infection are women predominantly infected via heterosexual transmission. Women with HIV infection, like other women, may wish to plan pregnancy, limit their family, or avoid pregnancy. Health professionals should enable these reproductive choices by counselling and appropriate contraception provision at the time of HIV diagnosis and during follow up.

CONTRACEPTIVE CHOICES:

Encourage condom use for all HIV-positive people to protect them from STIs and to prevent HIV transmission to sexual partners. If an HIV- positive woman desires more effective pregnancy protection, she may wish to use another contraceptive method in addition to condoms. Women with HIV can use most methods of contraception, with the following considerations:

- 1) An IUCD should **not** be inserted in any woman with a gonorrhoea or chlamydia infection or if a woman is at high individual risk for these infections. HIV-positive women who are clinically well (whether on antiretroviral therapy (ART)) can use an IUCD.
- 2) If a woman is taking rifampicin for tuberculosis, she should not use contraceptive pills, the combined patch, the combined ring or implants, as contraceptive effectiveness may be decreased.
- 3) Spermicides, either alone or in combination with barrier methods, should not be used by women with HIV infection or AIDS.
- 4) Women on ART who are using hormonal methods are advised to also use condoms because some antiretroviral drugs (ARVs) reduce the effectiveness of hormonal methods

CONTRACEPTION CHOICE AND MANAGEMENT FOR WOMEN WITH HIV INFECTION:

Women with HIV infection, like other women, may wish to plan pregnancy, limit their family, or avoid pregnancy. Health professionals should enable these reproductive choices by counselling and appropriate contraception provision at the time of HIV diagnosis and during follow up

BARRIER METHODS:

Male condoms:

A high degree of protection against HIV sexual transmission is provided by consistent correct condom use. Inconsistent or incorrect use is not protective. Most global HIV transmission occurs because condoms are not used at all during sexual intercourse. Condom accidents are reported by 1–12% of users and the method contraceptive failure rate is at least 12%.

Dual protection, the simultaneous use of an effective contraception method with consistent condom use, has been advocated to reduce the risk of unplanned pregnancy, horizontal transmission of HIV to a non-infected partner, transmission of resistant virus to a partner with HIV infection, and the risk of acquisition of other STIs including high risk human papillomavirus (HPV) types.

The female condom:

The female condom is a polyurethane sheath with two flexible rings at each end; one ring is inserted into the upper vagina and the other covers the introitus. The female condom is less likely than male condoms to leak or break during sex, but intrusion of the outer ring into the vagina is reported in 2% of coital episodes. The cumulative probability of vaginal exposure to semen with female condom use has been estimated as 3%, compared to 11.6% with the male condom. The contraceptive failure rate is estimated at 5–21% over 12 months.

Diaphragm, vimules, and caps:

Diaphragms and vimules cover the cervix and parts of the vaginal wall, while caps cover only the cervix. Their use in discordant couples is not recommended, as a relatively large area of vaginal mucosa remains exposed, micro trauma during insertion, and the concomitant use of nonoxynol-9 spermicide may cause epithelial disruption and increase viral transmission risk to the male partner.

Spermicides:

Nonoxynol-9 (N-9) spermicide provides no protection against sexually transmitted infections including HIV and frequent use increases the risk of HIV acquisition. A WHO Contraceptive Research and Development (CONRAD) technical consultation concluded that N-9 should not be used or promoted for the prevention of HIV in women at high risk of infection.

HORMONAL CONTRACEPTION:

Combined oral contraception (COC):

The combined oral contraceptive pill is an effective user dependent contraception with the non-contraceptive benefits of cycle control, reduction in menorrhagia and dysmenorrhea. Absorption can be affected by prolonged undercurrent diarrhoea and vomiting.

The COC is metabolized by the liver and its use is contraindicated in women with abnormal liver function which may be caused by alcohol abuse, acute or chronic viral hepatitis, and adverse events on antiretroviral combinations.

These factors are particularly relevant when making contraception choices for HIV positive women who are current or previous injecting drug users with chronic active hepatitis C infection. Current drug users often have a chaotic lifestyle that precludes effective use of user dependent contraception methods.

Progestogen only pills (POPs):

Progestogen only methods may be used by women with contraindications to oestrogen use. The POP is an effective contraceptive method with correct and consistent use; ovulation is not inhibited in all users, and inconsistent use can result in pregnancy. A new progestogen only pill, Cerazette, which contains 75 µg desogestrel, has recently been introduced, but is not available in Pakistan yet. In studies Cerazette inhibited ovulation in 97% of cycles at 7 and 12 months after initiation; this would suggest enhanced efficacy in comparison with conventional POPs, though as yet unconfirmed by comparative trials.

Injectables:

Depot medroxyprogesterone acetate (DMPA) 150 mg is given by deep intramuscular injection at 12 weekly intervals and Norethisterone oenanthate (Noristerat or Novaject) 200 mg every 8 weeks. These methods have the advantage of not being intercourse related but require regular access to health care for repeat injections.

Implants:

Implants need to be inserted by a trained health professional. Implanon is effective for 3 years, and Jadelle for 5 years; both are highly effective, non-user dependent, and reversible methods of progestogen only contraception.

Combined injectables and patches:

Combined injectables are used in some developing countries and in the United States. The weekly combined contraceptive patch (EVRA) is now licensed in some countries but availability is limited by cost. Transdermal delivery systems bypass first pass liver metabolism; this may reduce effects on clotting factors but the influence on risks of venous thrombosis and embolism is not currently known.

INTRAUTERINE DEVICES:

Copper bearing intrauterine devices:

Copper bearing intrauterine devices (IUCDs) are highly effective, long term (the Safe-T 380 is licensed for 8 years of use) and cost-effective methods of contraception.

Levonorgestrel intrauterine system:

The Levonorgestrel intrauterine system (LNG-IUS) is highly effective with a failure rate of 0.1–0.2 per 100 women years and is licensed for 5 years. The LNG-IUS has a lower rate of ectopic pregnancy (0.06 per 100 women years) and there is some evidence of a lower risk of pelvic inflammatory disease compared to copper bearing IUCDs. The local action of LNG-IUS results in endometrial thinning and irregular vaginal bleeding can occur in the first 3 months of use. By 12 months there is a 94–97% reduction in menstrual loss with amenorrhoea in 10–15% of users, which is beneficial for women with dysmenorrhoea and menorrhagia with associated iron deficiency anaemia.

INTRAUTERINE DEVICE USE BY WOMEN WITH HIV:

The WHO medical eligibility criteria caution against IUCD and LNG-IUS use by women at risk of HIV, HIV positive women, and women with AIDS. This is a grade 3 criterion “theoretical or proved risks generally outweigh the advantages” as opposed to grade 4 which is an “unacceptable health risk.” There are a number of concerns about IUCD use by women with HIV infection relating to contraceptive efficacy, risks of sexual transmission, and acute pelvic inflammatory disease (PID).

The theoretical risk of decreased contraceptive efficacy caused by reduced endometrial inflammatory response in advanced immunosuppression, is based on reports of IUCD failures in renal transplant patients. A review of IUCD failures concluded that reports of increased failure in women on steroids and anti-inflammatory drugs were not convincing and that the

copper content of IUCD types used was more significant. Sexual transmission of HIV in IUCD users may be increased as a result of increased volume and duration of menses, genital inflammation, and micro trauma to the penile epithelium by the IUCD threads.

Where the LNG-IUS is available the additional non-contraceptive benefits and lower failure rate make it the preferred intrauterine method especially for the HIV positive women

MALE AND FEMALE STERILISATION:

Male and female sterilization are both effective “permanent” cost effective methods of contraception. Male sterilization has a failure rate of 1:2000 compared to 1:200 for female sterilization. Sterilisation procedures do not reduce HIV in genital secretions nor is the risk of sexual HIV transmission and the studies show a reduction in consistent condom use in couples after one partner has undergone sterilization.

EMERGENCY CONTRACEPTION:

Emergency contraception is currently available as comprising two tablets of 75 µg Levonorgestrel (LNG). This is most effective when taken within the first 24 hours of unprotected sexual intercourse but can be taken up to 72 hours after unprotected sexual intercourse. Women using condoms alone for contraception must be advised about emergency contraception.

DRUG INTERACTIONS AND HORMONAL CONTRACEPTION

Women with HIV infection, like other women, may wish to plan pregnancy, limit their family, or avoid pregnancy. Health professionals should enable these reproductive choices by counselling and appropriate contraception provision at the time of HIV diagnosis and during follow up.

ANTIRETROVIRAL THERAPY

Antiretroviral drugs that induce cytochromes—for example, ritonavir, nevirapine, increase the hepatic metabolism of hormonal contraception. Inhibitors cause decreased clearance and increased plasma concentrations of substrate drugs. When both drugs are substrates their interaction is more uncertain and may result in increased or decreased plasma concentrations. Some drugs exhibit two or all three of these properties for example, efavirenz.

CONTRACEPTION MANAGEMENT

Women taking enzyme inducing drugs should be advised there is a risk of reduced efficacy of the COC and consideration given to other methods of contraception. If, after counselling, the woman wishes to continue the COC a 50 µg Ethinyl estradiol dosage should be used. This can also be achieved by doubling up on lower dose pills. There is no evidence that efficacy is further increased by tricycling (taking three consecutive packs of COC) with 4 pill free days.

Women on the progestogen only pill should be advised to change to a long acting injectable progestogen or another form of contraception.

It is common practice to reduce the injection interval for DMPA from 12 to 10 weeks' interval but the summary of product characteristics states that no adjustment is necessary.

As the main mode of action of the LNG-IUS is a direct local effect on the endometrium this may be less affected by liver enzyme induction. Women using the subdermal implant may experience breakthrough bleeding and Implanon contraceptive efficacy is reduced. They should be advised to change to a long acting injectable progestogen or to consistently use condoms as additional protection. Women using the combined hormonal patch should be advised to change to a long acting injectable progestogen or another form of contraception.

EC IN WOMEN WITH HIV:

There is little evidence on the effect of enzyme inducers on progestogen only emergency contraception; current advice is to take two tablets (1.5 mg dose) as soon as possible, followed 12 hours later by one tablet (750 µg dose).

A copper IUCD containing >250 mm² can be inserted up to 5 days after the expected date of ovulation in a regular menstrual cycle and may be used for multiple episodes of unprotected sexual intercourse and may be the preferred option for women on liver enzyme inducers after testing for sexually transmitted infection and/or routine antibiotic prophylaxis.

Lactational amenorrhoea is an important and effective means of child spacing in developing countries. HIV positive women avoid breast feeding and will recommence ovulatory cycles earlier; their future contraception needs should be discussed during pregnancy or early in the postnatal period.

Condoms have a significant user and method failure rate. Dual protection, the simultaneous use of an effective contraception method with consistent condom use, is recommended for effective prevention of unplanned pregnancy and HIV sexual transmission. Women continuing to use condoms alone must be advised how to access emergency contraception.

Oral, injectable, and implantable hormonal contraceptive methods and the intrauterine devices are all suitable choices for HIV positive women without medical contraindications to their use—for example, hepatitis C related liver disease. Caution may be required in prescribing hormonal contraception for women taking enzyme inducing drugs including some HAART and anti-TB agents.

For HIV positive women with more advanced disease, menorrhagia or irregular menstrual cycles, and current injecting drug users the Mirena (LNG-IUS) system and injectable progestogens could be recommended as they both reduce user dependency and menstrual loss.

Male and female sterilization should not be forgotten both are effective “permanent” cost effective methods of contraception. Women should be given the opportunity during pregnancy to consider sterilization at the time of their elective caesarean section delivery.

SESSION 7

TITLE: FREQUENTLY ASKED QUESTIONS

(10 MINUTES)

FREQUENTLY ASKED QUESTIONS:

HANDOUT (H25.7)



Activity (A25.7)

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

Which contraceptive methods are contraindicated for young women under age 25 who have not had children?

Nearly all contraceptive methods are safe for women of all ages. This includes pills, injectable, implants, IUCDs, condoms, and more. While age is not a clinical contraindication for any method, sterilization is the only method that is considered contraindicated for young women due to their stage in life and the permanent nature of this method. All clients should be told that only male or female condoms alone or condoms used with another method (dual method use) offer protection from both unintended pregnancy and STIs, including HIV.

Which contraceptive methods can be used while a woman is breastfeeding?

A woman is only preventing pregnancy through breastfeeding if the baby is less than 6 months old, the baby is exclusively breastfed (no other food or liquid is given to the baby, not even water), and the woman's monthly bleeding has not returned. A woman/couple can use the mini-pill (progestin-only pills), implants, IUCDs, and male and female condoms during the postpartum period and while breastfeeding. The IUCD can be inserted within 48 hours postpartum. After the 48-hour postpartum window, delay insertion until 4 weeks postpartum. Progestin-only pills and implants can be used immediately postpartum in breastfeeding women. Injectable contraceptives can be used by breastfeeding women from 6 weeks after childbirth. Providers must consult the (WHO) Medical Eligibility Criteria for more information.

Give 3 examples of times when a provider can discuss contraception and HTSP with a young married woman or first-time parent.

1. During prenatal consultations
2. During postnatal consultations
3. During visits to monitor infant health

Counselling on the importance of spacing births should begin during prenatal consultations. 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. Postpartum checks and child health visits are also a good opportunity to provide counselling on HTSP and contraception.

Give 3 examples of ways in which confidentiality can be maintained during a consultation with a young married woman or first-time parent.

Any 3 of the following:

- 1) Carry out the consultation in a separate or partitioned room.
- 2) Make sure no one other than members of staff required for the consultation are present.
- 3) Keep any notes regarding the consultation in a locked place.
- 4) Do not call out the client's full name or the reason for her visit in the waiting area.
- 5) Do not discuss the consultation with anyone, Young married women often experience significant pressure to conceive, particularly if they have not yet had a child.

Equally, first-time mothers may be expected to have another child very quickly and may therefore experience stigma when seeking contraceptive services. It is therefore important to maintain confidentiality when counselling and treating young married women and first-time parents, to ensure that they are able to make the decisions that are best for their health and lives

SESSION 8
WRAP UP AND SUMMARY
(10 MINUTES)

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

FURTHER READING:

- 1) <http://www.who.int/reproductivehealth/publications/general/9789241598682/en/>
- 2) fphandbook.org/all-contraceptives-are-safe-young-people

FAMILY PLANNING IN CRISIS AND DISASTER SITUATIONS



TIME 2.5 HOURS

In crisis situations, Reproductive Health (RH) problems are a leading cause of women's death and ill-health, globally. FP services within the Minimum Initial Services Package (MISP) are essential services because all girls and women, affected by humanitarian emergencies, have a fundamental human right to RH.



TRAINING OBJECTIVES

- 1) Highlight the importance of high-quality contraceptive and RH services in disaster situations
- 2) Discuss the need for FP services as an integral component of Minimum Initial Service Package (MISP) in crisis situation
- 3) Describe the specific needs for contraception in disaster situations.



LEARNING OUTCOMES

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

- 1) Discuss crisis and disaster situations as unique situations where the access to routine FP services is even more difficult
- 2) Understand that this is a special group of girls and women, who need extra ordinary compassion and competence to deal with their needs
- 3) Properly address the special reproductive needs and problems of girls and women in crisis situation
- 4) Prioritize management of reproductive health issues in crisis situations



TRAINING/LEARNING METHODS

- 1) Individual and group exercises
- 2) Power Point Presentation
- 3) Brain storming
- 4) Group Work



TRAINING MATERIAL

Trainer' Material	Trainee's Material
Hand Outs: H26.1, H26.2, H26.3A, H26.3B, H26.3B-1, H26.3B-2, H26.3B-3	Hand Outs: H26.1, H26.2, H26.3A, H26.3B, H26.3B-1, H26.3B-2, H26.3B-3
Activity: A26.1, A26.2, A26.3	Job aid:
Job aid:	
FAQs:	
PPT: (26)	



CONSTITUTION OF THE SESSION

Four mini sessions will be held:

1) What happens in the situations and what MISP?	Brainstorming with interactive discussion	30 Mins
2) What are the specific contraceptive needs of adolescents and women in crisis?	Brainstorming Activity and discussion	30 Mins
3A) FP services in crisis, caring for IDPs, SGBV, abused women	Group work, discussion Brainstorming	45 Mins
3B) Violence against women in crisis / "LIVES"	Brainstorming/Discussion	30 Mins
4) Wrap up		15 mins

SESSION 1

TITLE: WHAT HAPPENS IN DISASTER SITUATION AND WHAT IS MISP? (30 MINUTES)

OUTLINE & OBJECTIVES:

This session will clarify the concept of MISIP for the participants.

METHODOLOGY:

- 1) Brain storming and group discussion and experience sharing (5 minutes each)
- 2) Group work
- 3) Divide the group into two
- 4) Let the groups discuss the need and concept of MISIP in disaster for 5 minutes each, among themselves
- 5) Discussion (5 minutes) and presentation 5 minutes each
- 6) Large group discussion 15 minutes

Handout: (H26.1A). (H26.1B)

Activity: (A26.1)

DISASTER SITUATIONS AND MISIP

HANDOUT (H26.1A)

Described as a sudden occurrence caused by epidemics, technological or environmental catastrophe, strife, or natural/man-made causes and demanding immediate action humanitarian crises have caused a dramatic rise in the number of displaced populations, both within and across national borders.

According to a recent report by the UN refugee agency UNHCR, across the globe there are an estimated 68.5 million forcibly displaced people in the world, including 25.4 million refugees. Women in these situations may find themselves at much greater risk of an unintended pregnancy. Informed family planning choices is a basic human right and allows both women and couples to take control of their reproductive health choices and more so family size, and more so during hardships and chaos.

WHO has launched a new tool intended for front-line health care providers on 7 December 2018, to help women initiate contraception in humanitarian and emergency settings. This tool is now available to download both as a PDF from this page and also as an App. It is

expected that the App will be of particular and timely use to those working in humanitarian and emergency settings.

The tool, “Contraceptive delivery tool for humanitarian settings” provides guidance regarding “who” can use contraceptive methods and “how” to use these methods safely and effectively. It also includes a checklist for users on how to be reasonably certain that a woman is not pregnant, as well as a clear graphic that compares the effectiveness of different contraceptive methods. The management of missed pills is also covered and information on the provision of emergency contraception is also included. As women are particularly vulnerable to sexual violence in humanitarian and emergency settings, a section has also been included on how to approach the provision of care to women who may have been subjected to it.

The information in the tool draws upon recommendations from the “Medical eligibility criteria for contraceptive use, 5th edition, 2015” and the Selected practice recommendations for contraceptive use, 3rd edition, 2016, with the exception of several adaptations pertinent to humanitarian settings.

In addition to the medical eligibility criteria, the tool draws upon recommendations from the selected practice recommendations for contraceptive use, 3rd edition, 2016. It includes considerations for initiating a contraceptive method; a checklist on how to be reasonably certain that a woman is not pregnant; as well as information on the effectiveness of methods and the management of missed pills. It also provides some guidance on how to respond to a woman who may have been subjected to intimate partner violence or sexual violence.

Improving family planning service delivery in humanitarian crises and violence in humanitarian settings heightens the need to expand access to emergency contraception, long-acting reversible contraception (LARCs), and safe uterine evacuation and post abortion care. Meeting family planning needs in humanitarian emergencies is challenging, but feasible, and presents opportunities for reaching marginalized, remote, or otherwise underserved populations.

INTERNALLY DISPLACED PERSONS (IDPS):

Increasing access to RH services, including FP, for IDPs (as well as other displaced persons) needs special attention because a large proportion of them are women and children and IDP camps are often located far from existing health facilities. Reproductive Health (RH) needs of IDPs include the prevention of unintended pregnancies; the reduction of the transmission of STIs, including HIV; and the prevention and management of the consequences of sexual violence.

Contraceptive use is generally lower in refugee camps than in surrounding settlements

The Family Planning Services package for IDPs should include the following:

- 1) Counselling services that ensure confidentiality and privacy as much as possible. Counselling on dual protection is particularly important for persons living in unstable situations.
- 2) Provision of contraceptive methods, including EC, as appropriate. Some of the clients might be new, but others might already be on a method and could require management of missed doses as described for individual methods in these guidelines.
- 3) Provision of a medical response to survivors of sexual violence, including EC and PEP anti-retroviral therapy, as appropriate.

Emergency contraception (EC) is only available in the context of post-rape care. As in most countries, awareness of EC as a family planning method is low in Pakistan, in comparison to other methods. Existing sexual and gender-based violence (SGBV) programs offer EC to survivors of sexual assault.



Activity (A26.1)

The trainer runs a brain storming session to highlight various RH services vital in the crisis settings. Emphasize that FP services are an essential component of Minimum Initial Service Package (MISP)

MISP and Comprehensive RH Services

In addition to the MISP, the International Agency Working Group (IAWG) has identified additional priority activities related to RH that should be undertaken from the onset of an emergency. These additional priority activities

Priority RH Services (MISP)	Comprehensive RH Services
Family planning services Provide contraceptives such as condoms, pills, injectables and IUCDs to meet demand.	Source and procure contraceptive supplies. Provide staff training. Establish comprehensive family planning programming. Provide community education.
Gender based violence Coordinate mechanisms to prevent sexual violence with health, protection and other sectors/clusters. Provide clinical care for survivors of rape.	Expand medical, psychological, social and legal care for survivors. Prevent and address other forms of GBV, including domestic violence, Forced and early marriage Provide community education. Engage men and boys in GBV programming.
Maternal and new-born care	

<p>Ensure availability of emergency obstetric and new-born care services.</p> <p>Establish a 24/7 referral system for obstetric emergencies.</p> <p>Provide clean delivery packages to visibly pregnant women and birth attendants.</p>	<p>Provide antenatal care. Provide postnatal care.</p> <p>Train skilled attendants (midwives, nurses, doctors) in performing Emergency Obstetrics care (EmOC) and new-born care.</p> <p>Increase access to basic and comprehensive EmOC and new born care.</p>
<p>STIs, HIV prevention</p> <p>Ensure safe blood transfusion practice.</p> <p>Facilitate and enforce respect for standard precautions.</p> <p>Make free condoms available.</p> <p>Make syndromic treatment available as part of routine clinical services for patients presenting for care.</p> <p>Make treatment available for patients already taking ARVs, including for PMTCT, as soon as possible.</p>	<p>Establish comprehensive STI prevention and management services, including partner tracing and STI surveillance systems.</p> <p>Collaborate in establishing comprehensive HIV services as appropriate.</p> <p>Provide care, support and treatment for people living with HIV/AIDS.</p> <p>Raise awareness of prevention, care and treatment services for STIs, including HIV.</p> <p>Provide community education.</p>

MINIMUM INITIAL SERVICE PACKAGE

HANDOUT (H26.1B)

WHAT IS THE MISP?

The Minimum Initial Service Package (MISP) for Reproductive Health (RH) is a coordinated set of priority activities to be implemented from the onset of a humanitarian crisis (conflict or natural disaster), and further scaled up and sustained to ensure equitable coverage throughout protracted crisis and recovery while planning is undertaken to implement comprehensive RH as soon as possible.

MISP aims at:

- 1) Prevention and management of the consequences of sexual violence.
- 2) Prevention of excess maternal and new-born morbidity and mortality.
- 3) Reducing HIV transmission and
- 4) Planning for comprehensive RH services beginning in the early days and weeks of an emergency.

Good quality MISP services must be based on the needs of the population and abide by human rights and humanitarian standards with respect for the religious, ethnic and cultural backgrounds of the affected communities. When implemented in a crisis, the MISP saves lives and prevents illness, especially among women and girls. Neglecting RH in emergencies has serious consequences: preventable maternal and infant deaths; sexual and gender-based violence; unintended pregnancies and unsafe abortions; and the spread of HIV and other STIs.

The MISIP is a standard for humanitarian actors. It outlines which RH components are most important in preventing death and disability, particularly among women and girls, in emergency settings while also building the foundation for the comprehensive RH services that should be initiated as soon as the situation stabilizes and all components of the MISIP have been implemented and can be sustained.

PRIORITY ACTIVITIES:

- Ensure availability of a range of Long-acting reversible and short acting contraceptive methods at primary health care facilities to meet demand
- Provide information through IEC materials and contraceptive counselling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equality, and non-discrimination
- Ensure community is aware of the availability of contraceptive for women, adolescent and men
- Share information about the availability of SRH services and commodities
- Ensure the community is aware of the availability and location of reproductive health services

WHAT ARE THE POSSIBLE CONSEQUENCES OF IGNORING THE MISIP IN AN EMERGENCY SETTING?

The lives of people affected by crises, particularly women and girls, are put at risk when the MISIP is not implemented. For example, women and girls can be at risk of sexual violence when attempting to access food, firewood, water, and latrines. Their shelter may also not be adequate to protect them from intruders or they may be placed in a hostile situation that deprives them of their privacy. Those in power may exploit vulnerable women and girls by withholding access to essential goods in exchange for sex.

In addition, not observing standard precautions in a health care setting may increase the transmission of HIV to patients or health workers and, without a referral system in place to transfer patients in need of basic or comprehensive Emergency Obstetrics and Neonatal Care (EmONC) services to an equipped health facility, women may die or suffer long-term injuries (e.g., obstetric fistula). The MISIP provides an outline of the basic steps to be taken in order to save lives, preserve health and avoid these grave consequences.

WHO IS RESPONSIBLE FOR IMPLEMENTING THE MISIP?

In Pakistan, at the Federal level National Health Emergency Preparedness and Response Network (NHEPRN) under Ministry of National Health Services, Regulation and Coordination and at the provincial levels the concerned Provincial Health Ministry in collaboration with SRH sub cluster under UNFPA are responsible for implementation and ensuring that MISIP objectives are made the part of all priority activities of Department for Disaster Relief (DRR). However, there are few MISIP objectives which have the cross-cutting

responsibility of more than one cluster hence all those cluster will be made responsible for its implementation as SGBV activities to prevent and respond to sexual and gender base violence cut across the protection, food/nutrition, water and sanitation and shelter clusters.

HOW ARE DISPLACED POPULATIONS AND AFFECTED COMMUNITIES INVOLVED?

As a MISP objective No 1, the coordinator should engage all stakeholders including the community. Every effort should be made to ensure crisis- affected populations, including men, women, and adolescents, are involved in the program planning and implementation of MISP services from the onset of an emergency. It is also important to reach out to other groups with vulnerabilities, including persons with diverse sexual orientations and persons with disabilities.

At minimum, affected communities must be informed of the benefits of seeking services, such as clinical care for survivors of sexual violence and EmOC services, and how and where to access these services. On behalf of The Regional Human Rights Commission (RHRC), the Women’s Refugee Commission has developed information, education, communication (IEC) “universal templates” for crisis-affected populations on the importance of seeking care after sexual assault and accessing care for obstetric complications.

WHAT CAN BE DONE TO PREPARE FOR AN EMERGENCY IN DISASTER AND CONFLICT- PRONE COUNTRIES?

Local communities, district and state representatives, and humanitarian and disaster agencies should prioritize SRH in health emergency management policies, including emergency preparedness and contingency plans. Such plans could include: training national, local and community-based health workers and all stakeholders in the MISP; identifying a system to map available services at the onset of an emergency; identifying coordination and communication strategies; emergency human resource planning; and developing logistic plans for stockpiling, ordering and disseminating MISP Kits’ supplies.

SESSION 2

TITLE: WHAT IS THE SPECIFIC REPRODUCTIVE HEALTH (RH) AND CONTRACEPTIVE NEEDS IN CRISIS SITUATIONS?

(30 MINUTES)

OUTLINE & OBJECTIVES:

To address the specific needs of girls and women in crisis situation

To know that contraceptive use is generally lower in refugee camps than in surrounding settlements.

Highlight unintended pregnancy and rape as an important problem in crisis settings

Discuss the value of tailor-made services with emphasis on empathy and respect for confidentiality and privacy especially for young and adolescent girls

METHODOLOGY:

- 1) Brain storming and group discussion and experience sharing
- 2) Group work
- 3) Divide the group into two
- 4) Let the groups discuss the above

Handout: (H26.2)

Activity: (A26.2)

ADOLESCENTS AND WOMEN ARE A HIGH-RISK GROUP IN CRISIS SITUATIONS

HANDOUT (H26.2)



Activity (A26.2)

Activity to sensitize participants about the specific needs and high-risk status of girls and women in context of disaster situations and crisis.

The trainer divides the group into two and tasks Group A to draw a list of risky situations, girls and women face in disasters and their consequences. The group B is asked to write the adverse RH conditions that arise due to being in a disaster situation.

Each group takes 5 minutes to brainstorm and 5 minutes to present their work through a chosen representative.

The trainer then adds any missing points

CONTRACEPTIVES AND SPECIAL CONSIDERATIONS IN DISASTER/ CRISIS:

MALE/FEMALE CONDOMS

- 1) Condoms are suitable in disaster-hit areas because of their easy distribution by any provider, lack of medical contraindications, and prevention of STI transmission, including HIV.
- 2) Failure rates, especially during the first year of use, may be higher than those for other methods because of improper or incorrect usage.
- 3) Counselling must be given as early as possible in the post-emergency phase to ensure correct usage and to motivate both men and women to start and continue to use the method.
- 4) Continuous supply must be ensured
- 5) Emergency contraceptive pills must be given as a backup method

INJECTABLES:

- 1) The advantage of this method is that women are not required to make frequent contacts with the health care provider, which may be difficult during a crisis.
- 2) Pregnancy rates are approximately 3% in the first year of use.
- 3) Irregular or prolonged bleeding often appears during the first three to six months of use. For the progestin- only injectable, bleeding becomes infrequent or disappears after the first few injections. This advantage may prove appealing for women because of the less-than-ideal sanitary set-up and inaccessibility to hygienic products and water in evacuation areas or camps.
- 4) These methods can safely be provided by medical, paramedical, or any personnel trained in administering injections using the MEC checklist to determine client eligibility.
- 5) Regular supply of the contraceptives and proper disposal of needles must be ensured.

COMBINED ORAL CONTRACEPTIVE (COC) PILLS:

- 1) Pregnancy rate during the first year of use is approximately eight percent and declines thereafter
- 2) The pills can be dispensed by paramedical personnel or any trained provider using the MEC checklist to determine client eligibility.
- 3) A regular supply and easy access to pills **MUST** be ensured in the camps or centres, as well as in the community.

PROGESTOGEN-ONLY PILLS (POPS):

1. Approximately 1 in 100 breastfeeding women becomes pregnant within the first year of use.
2. This method is ideal for women in evacuation centres or camps who are breastfeeding and need additional protection because POPs do not affect the quality or quantity of breast milk.
3. Additional advantage is that this method may prolong lactation amenorrhea.
4. The pills can be dispensed by paramedical personnel or any trained provider using the MEC checklist to determine client eligibility.

5. Similar to COCs, a steady regular supply of POPs must be established for easy access by clients.

EMERGENCY CONTRACEPTION

This is extremely important in context of crisis as women may have poor access to regular contraception e.g. OCPs etc. Likewise, the rates of unintended pregnancy are high in crisis situations and EC is also indicated in cases of rape

INTRAUTERINE DEVICES (IUCDS)

- 1) The advantage of IUCDs is that they are among the most effective methods of contraception with pregnancy rates of only 6 to 8 per 1000 women during the first year of use.
- 2) The use of such devices in disaster areas depends on the availability of devices and skilled medical or paramedical providers for insertion.
- 3) IUCDs are suitable for clients coming from areas where the method is already known and where the IUCD is likely to be available once the client has returned.
- 4) Clients must also have access for post-insertion follow-up if the need for removal arises or if any complications occur (uncommon).

IMPLANTS

1. Approximately 1 in 100 women becomes pregnant over the first year of implant placement.
2. Prolonged protection is experienced for three, five, or seven years depending on the implant.
3. This method requires a minor surgical procedure; thus, trained physicians are the sole providers.
4. Clients must have access to follow-up and removal upon demand in the area of origin or in the new destination.

LACTATION AMENORRHEA METHOD (LAM)

1. For this method to be successful, the client must be fully or nearly fully breastfeeding, menses have not yet resumed, and the infant is less than six months old. Otherwise, an additional method, such as the POP, is needed.
2. Pregnancy rates are approximately 2 per 100 women in the first six months.

MALE AND FEMALE STERILIZATION

1. These permanent methods of contraception are suitable for couples who no longer desire any children.
2. Pregnancy rate for vasectomy is approximately 2 per 1000 over the first year after the male partners have had vasectomies, whereas that for tubal ligation is 5 pregnancies per 1000 over the first year.

3. Access to these methods may not be as easy in the early phase of the crisis compared with other contraceptive options because of the need for a facility to perform the procedure. Such facility and the physicians who are trained to perform the procedure may not be available initially. Nevertheless, every effort must be exerted to make these services accessible to clients at the soonest possible time.
4. Referral pathways must be in place, for those seeking these methods. An interim method should be provided.

FERTILITY AWARENESS-BASED METHODS:

1. Pregnancy rate is approximately 15 for 100 women over the first year of use.
2. Clients should be well counselled and motivated to follow the instructions closely when determining the time of the month during which fertilization is possible. This step is especially critical because couples may be burdened by more pressing concerns, such as finding food and water sources, as well as dealing with the loss of relatives, homes, and livelihood

CONSIDERATIONS FOR IMPROVING FAMILY PLANNING SERVICE DELIVERY IN CRISIS

In the context of humanitarian crisis, several promising, evidence-based interventions for family planning service delivery can help improve the uptake of these services.

These interventions are summarized as follows:

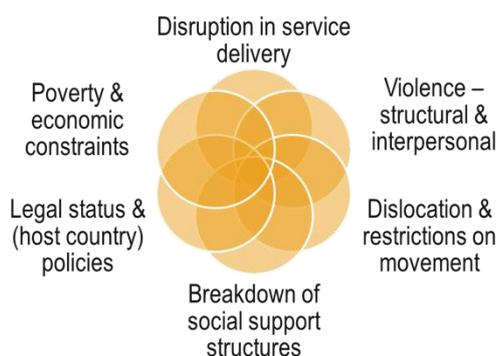
- 1) Provide comprehensive SRH services in line with global norms, such as the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations.
- 2) Provide a full range of family planning methods via mobile clinics and strengthen health centers' provision of short- and long-acting methods.
- 3) Train mobile health workers to provide short-acting methods.
- 4) Second refugee providers to health facilities to provide family planning in humanitarian settings, and train female community health workers (CHWs) to promote FP use.
- 5) Train CHWs to conduct FP education and provide short-acting methods.
- 6) Collaborate with the Ministry of Health on competency-based training, supply chain management, systematic supervision, and community mobilization to raise awareness and alter family planning norms.
- 7) Engage adolescents through Family planning counselling and referrals, coupled with recreational activities and group discussions.
- 8) Delivery of youth friendly SRH care and education via clinics, mobile health brigades, and community education.
- 9) Provision of SRH information and services through a comprehensive prevention approach, combining 'Talk,' 'Services,' and 'Livelihoods.'

CONTRACEPTIVES IN MISP KITS

Ensure availability of a range of long-acting reversible & short-acting contraceptive methods at primary health care facilities to meet demand.

- Oral contraceptives (Kit 4)
- Hormonal injectables & implants (Kit 4 & complementary)
- IUDs (complementary)
- Male & female condoms (Kits 1A & 1B)

FACTORS INFLUENCING UNINTENDED PREGNANCIES IN CRISIS SITUATIONS



WHY IS IT IMPORTANT TO ENSURE THE NEEDS OF ADOLESCENTS ARE ADDRESSED?

In the immediate aftermath of a crisis, the disruption of families and communities, and often the loss of educational opportunities, jobs and other meaningful activities, are common challenges for adolescents affected by crises. Adolescents are often idle, and their needs and capacities go unrecognized at a time when they face new risks.

They may have lost access to family, social supports, and health services as a result of displacement. Adolescents, particularly girls, are especially vulnerable to sexual violence with the breakdown of law and order, which further increases the risks of unwanted pregnancy, unsafe abortions and STIs including HIV.

Yet, although adolescents face numerous challenges to their sexual and reproductive health, they are typically a healthy cohort with strength that can be garnered to cope with their circumstances and help their communities. Adolescents should therefore be provided with opportunities to participate in designing and implementing accessible, acceptable, and appropriate MISP services.

Access to information and services is particularly difficult for adolescents

Adolescents report difficulty accessing services, including First Time Parents (FTPs). Adolescents are hesitant to seek contraceptives from the health facility and often face difficulty in their families too.

Unintended pregnancies and STIs in disaster situations:

Women are at higher risks for unwanted or unplanned pregnancies and sexually transmitted infections (STIs) for several reasons. Some of these reasons include the following:

1. Routine behaviour, that is, taking the daily pill or using condoms, may be disrupted, and forgotten while attending to emergent needs.
2. Access to contraceptives becomes difficult. [1]
[SEP]
3. Comfort-seeking behaviour, such as intimacy and sex, may increase.
4. The risk of women and children for domestic violence and sexual assault is also increased, resulting in higher predisposition to STIs, possible spread of human immunodeficiency virus (HIV), unwanted pregnancies, unsafe abortions, and other adverse outcomes, such as trauma, as well as maternal and neonatal deaths.
5. Notably, women have more miscarriages, premature deliveries, intrauterine growth restriction, and low birth weight infants after disasters.
6. Adolescents, aside from vulnerability to exploitation, violence, and transactional sex, may also be prone to risk-taking behaviour.

Four key aspects of reproductive healthcare in disaster and crisis situations must be addressed:

1. Safe motherhood (antenatal care, delivery care, and postpartum care)
2. Family planning
3. Prevention and care of STIs and HIV/AIDS
4. Protection from and response to sexual and gender-based violence

The following measures should be immediately undertaken:

1. Determine contraceptive availability.
2. Document the type, quantity, and expiration dates of contraceptives.
3. Distribute condoms to men and women.
4. Provide emergency contraception, as needed.
5. Promote use of injectable hormonal contraceptives, as they are relatively long acting and a private method.
6. Plan protective measures against violence and exploitation for women and children e.g. ensuring lighted paths to bathrooms

The following long-term measures must be employed to ensure access to FP services:

1. Institute obstetrics and gynaecology healthcare services with trained staff in evacuation centres or camps.
2. Provide education sessions on sexual health and reproductive health rights in these centres.
3. Provide educational materials on the above topics.
4. Establish a family planning program (as part of a comprehensive reproductive health program) that covers effective counselling, contraceptive choices, follow-up, education, and general information dissemination.

SESSION 3 A AND B
TITLE: CARING FOR IDPS AND ABUSED WOMEN
(30 AND 45 MINUTES)

OUTLINE & OBJECTIVES:

- 1) To address the specific needs of girls and women in crisis situation
- 2) Understand that contraceptive use is generally lower in refugee camps than in surrounding settlements.
- 3) To encourage the availability of EC as Emergency contraception
- 4) Reinforce and discuss in detail the place of FP in MISF
- 5) Role play to highlight the difficulties and barriers a girl or woman in an abusive relationship faces and what is the role of health care provider in helping her
- 6) This session highlights the importance of tailor-made services with emphasis on empathy and respect for confidentiality and privacy.
- 7) To understand that the woman undergoing abuse is vulnerable to all RH problems including poor access to FP services.
- 8) Having an opportunity to interact with her calls for a holistic and empathetic approach

METHODOLOGY:

- 1) Break participants into two groups and ask them to enlist the possible problems and solutions in provision of FP services in a crisis situation
- 2) Brain storming,
- 3) Group discussion

Handout: (H26.3A), (H26.3B), (H26.3B-1), (H26.3B-2), (H26.3B-3)

Activity: (A26.3)

CARING FOR GIRLS AND WOMEN UNDERGOING VIOLENCE & ABUSE
HANDOUT (H-26.3A)

VIOLENCE AND ABUSE



Activity (A26.3)

Activity to sensitize participants about violence against women

The facilitator asks the participants about what violence against women is and writes down all the responses on a flip chart. Then summarize the responses of the participants and define violence against women. Then ask participants to give examples of violence against women from their personal experiences and from their observation in their communities

And write their responses on a sticky note and paste it on the Flip Chart

Once everyone has given a response, start categorization of the responses based on the type of violence that is physical, sexual, mental, cultural and state violence. Categorize sticky notes which have similar responses e.g. slapping, pulling hair, kicking will go together, shouting, using abusive language will go together, rape, touching without her permission will go together. Facilitator can also ask why violence happens and can facilitate a discussion on it

Through years, violence has been increasingly found to have negative health outcomes. Sexual assault and violence against women have been estimated to account for 20% of the health burden among women aged 15 to 44 years. The general impact of violence on the health of women has been attributed to various reproductive health risks and problems that are consequences of gender-based victimization. These health risks and problems include emotional and psychological disturbances, physical injuries, and unwanted pregnancies, sexually transmitted infections (STIs) such as human immunodeficiency virus (HIV), decreased sexual desire, pain during sex, and chronic pelvic pain.

Health providers should discuss and assess the possibility of pregnancy in all women who have been sexually assaulted. The possibility of pregnancy is the usual concern of most women victims (particularly if sex was unprotected). The chance of pregnancy after an assault is reported to be at 2% to 5% among victims not protected by some form of contraception at the time of the attack.

Moreover, the risk for acquiring complications such as sepsis, spontaneous abortion, and premature birth is high when the pregnancy is complicated with STI.

The management of victims should be therefore comprehensive to appropriately address violence-related problems. Healthcare providers are expected to provide counselling and social support to promote quick recovery.

Follow-up consultations should also be offered to adequately cover current and long-term consequences of the victimization. All clients should have access to follow-up services,

including a medical review at two weeks, three months, and six months' post-assault, with referrals for counselling and other support services

VIOLENCE AGAINST WOMEN:

Every family planning provider probably sees many women who have experienced violence. Physical violence includes acts such as hitting, slapping, kicking, punching, beating, and using a weapon. Sexual violence includes unwanted sexual contact or attention, coercive sex, and forced sex (rape). Violence against women can be psychological, too, such as insults, intimidation, threats to hurt someone she loves, humiliation, isolating a woman from family and friends, and restricting her access to resources.

Women experiencing violence have special general health, sexual and reproductive health needs. Providers of reproductive health care are in a good position to identify women who experience violence and to attend to their physical health needs as well as provide psychosocial support.

Women who experience violence often seek health services, although many will not mention the violence. Violence can lead to a range of health problems, including injuries, unwanted pregnancy, sexually transmitted infections (STIs) including HIV, decreased sexual desire, pain during sex, and chronic pelvic pain. Violence may start or become worse during a pregnancy, placing the foetus at risk as well. A man's violence or the threat of violence can deprive a woman of her right to make her own choice about whether to use family planning or what method to use.

WHAT CAN FAMILY PLANNING PROVIDERS DO?

- 1- Help women feel welcome, safe, and free to talk. Help women feel comfortable speaking freely about any personal issue, including violence. Assure every woman that her visit will be confidential.**

Give the woman opportunities to discuss issues that concern her, for example, her husband's attitudes toward her use of family planning or any possible problems with using family planning. It is useful to ask if there is anything she would like to discuss. Most women will not bring up that they are being abused, but some may disclose it if asked. Be alert to symptoms, injuries, or signs that suggest violence. Violence at home may lead a woman to refuse or to insist on a specific family planning method, to resist family planning counselling, or to insist on reversal of female sterilization. Many pregnancies close together or requests for pregnancy termination also may reflect violence at home.

2- If violence suspected, ask about it.

Some tips for bringing up the topic of violence:

1. To increase trust, explain why provider is asking, because he/she wants to help.
2. Use open ended questions and language that is comfortable and best fits his/her own style.
3. Provider should not ask such questions when a woman's husband or anyone else is present or when privacy cannot be ensured.
4. To explore whether a client is experiencing partner violence and to support her disclosure of violence, first approach the topic indirectly. For example: "Many women experience problems with their husband or partner or someone else they live with". "I have seen women with problems like yours who have been having trouble at home."

More direct questions can be asked, such as these:

1. Are you afraid of your husband (or partner)?
2. Has your husband (or partner) or someone else at home ever threatened to hurt you or physically harm you in some way?
3. If so, when has this happened?
4. Does your husband (or partner) or someone at home bully you or insult you or try to control you?
5. Has your husband (or partner) forced you into sex or forced you to have any sexual contact you did not want?"

To explore further how violence affects a woman's reproductive and sexual life, ask these 4 questions:

1. Has your husband ever told you not to use contraception, blocked you from getting a method, or hidden or taken away your contraception?
2. Has your husband ever tried to force you or pressure you to become pregnant?
3. Has your husband ever refused to use a condom?
4. Has your husband ever made you have sex without using contraception so that you would become pregnant?

3- Offer first-line support.

In response to a disclosure of violence, you should offer first line support. First-line support provides practical care and responds to a woman's emotional, physical, safety, and support needs, without intruding on her privacy.

First-line support is the most important care that you can provide. Even if this is all you can do, you will have greatly helped your client. First-line support involves 5 simple tasks.

4- Provide appropriate care.

Tailor your care and counselling to a woman’s circumstances. Treat any injuries or see that she gets treatment. Discuss with her how she can make the best choices for family planning in her circumstances. If your client wants a method that would be hard for her partner to detect or to interfere with, an injectable may be her best choice.

You might also discuss IUCDs and implants. Be sure to point out that even these methods can sometimes be detected.

Make clear that these methods do not protect her against sexually transmitted infections (STIs), including HIV. Condoms are the only family planning method that protects against STIs as well as pregnancy. Give information and offer referral to support services, if available, for women’s empowerment and skills building on condom use negotiation and safer sexual practices.

Provide emergency contraceptive pills if appropriate and wanted.

5-Document the abuse experienced by the woman.

Carefully and confidentially document the woman’s history of abuse along with symptoms or injuries and the cause of the injuries if relevant. Record the relationship of the perpetrator to the woman.

HANDOUT (H26.3B–1)

The letters in the word “LIVES” are a reminder of the 5 tasks that protect women’s lives—Listen, inquire about needs and concerns, Validate, Enhance safety, Support.

Listen	Listen to the woman closely, with empathy, and without judging. Give her a chance to say what she wants to say in a safe, confidential, and private place to a caring person who wants to help. Listening is the most important part of good communication and the basis of first-line support. If she does not want to talk about violence, assure her that you are available whenever she needs you.
Inquire about needs and concerns	Assess and respond to her various needs and concerns. As you listen to the woman’s story, pay particular attention to what she says about her needs and concerns and what she does not say but implies with words or body language. She may let you know about physical needs, emotional needs, or economic needs, her safety concerns, or social support that she needs. Respect her ability and her right to make her own choices about her life.

Validate	<p>Show her that you understand and believe her. Validating another person's experience means letting the person know that you are listening closely, that you understand what she is saying, and that you believe what she says without judgment or conditions.</p> <p>Some important things that you can say:</p> <ol style="list-style-type: none"> 1. "It's not your fault. You are not to blame." 2. "This happens to many women." 3. "You are not alone, and help is available."
Enhance Safety	<p>Discuss a plan to protect herself from further harm if violence occurs again. Explain that partner violence is not likely to stop on its own. It tends to continue and may become worse and happen more often. You can ask:</p> <ol style="list-style-type: none"> 1. "Are you or your children in danger now?" 2. "Do you feel safe to go home?" 3. "Is there a friend or relative who can help you with the situation at home?" <p>If the woman faces immediate danger, help her consider various courses of action. If not in immediate danger, help her make a longer-term plan.</p>
Support	<p>Support her by helping her connect to information, services, and social support. Women's needs generally go beyond what you can provide in the clinic. You can help by discussing the woman's needs with her, telling her about other sources of help, such as shelter, social services, child protection, police, legal aid, financial aid, peer support, and assisting her to get help if she wants it.</p>

RECOMMENDED METHODS:

1) LEVONORGESTREL (LNG) AND YUZPE METHODS

These can prevent pregnancy in instances of unprotected sex. Yuzpe method consists of higher doses of regular COC pills containing Levonorgestrel and Ethinyl estradiol. Enlisted below are the criteria for administering the LNG and Yuzpe methods among women who have been victims of sexual assault

- 1) Presence of risk for pregnancy
- 2) Consult for treatment sought within five days from the time of the assault with the expressed desire to prevent pregnancy
- 3) Pregnancy tests or other definitive tests have established that the client is not currently pregnant
- 4) If pregnancy cannot be ruled out, can the fore mentioned methods still be prescribed?
 - a) Yes, as long as the following will be fulfilled:
 - b) Full disclosure to the client that the pills will not be effective if she is already pregnant but will not affect the pregnancy nor harm the foetus
- 5) Advise the client coming to the health facility more than five days after the assault to return for pregnancy testing if she misses her next menstrual period.

REPRODUCTIVE COERCION

HANDOUT (H26.3B-2)

Reproductive coercion (also called **coerced reproduction**) is threats or acts of violence against a partner's reproductive health or reproductive decision-making and is a collection of behaviours intended to pressure or coerce a partner into initiating or terminating a pregnancy. Reproductive coercion is a form of domestic violence, also known as intimate partner violence, where behaviour concerning reproductive health is used to maintain power, control, and domination within a relationship and over a partner through an unwanted pregnancy. It is considered a serious public health issue. This reproductive control is highly correlated to unintended pregnancy.

The three forms of reproductive coercion are pregnancy pressure, pregnancy coercion, and birth control sabotage; they can exist independently or occur simultaneously. Not complying with the husband's wishes may result in the partner acting out violently.

Pregnancy pressure:

Pregnancy pressure, or pregnancy coercion, is enacted by a woman's sexual partner when he pressures her into having unprotected sex to become pregnant, or into continuing or terminating the pregnancy. It might involve threats or acts of violence if the woman does not comply with the perpetrator's demands or wishes.

Reproductive pressure behaviours may result in unintended pregnancies that are then followed by coerced abortions. Women who seek abortions are nearly three times as likely to have experienced reproductive pressure by a partner in the past year, compared to women continuing their pregnancies. Forcing a woman to terminate a pregnancy she wants or to continue a pregnancy she does not want violates the basic human right of her reproductive health.

Birth control sabotage:

Reproductive coercion can take the form of birth control sabotage, either as verbal sabotage, behavioural sabotage, and/or acts as an active interference with contraceptive methods. Direct actions are taken to ensure the failure of birth control (such as poking holes in or breaking condoms) or complete removal of contraception (such as flushing birth control pills down the toilet or removing contraceptive rings or patches from the body). Husbands can also forbid women from using family planning or force them to have sex without protection.

Birth control sabotage is frequently associated with physical or sexual violence, and is a contributor to high pregnancy rates, especially teenage pregnancy rates among abused, disadvantaged women and teenagers.

A strong correlation exists between domestic violence and birth control sabotage. These studies have identified two main classes of the phenomenon:

1. Verbal sabotage—verbal or emotional pressure not to use birth control or to become pregnant.

2. Behavioural sabotage—the use of force to have unprotected sexual intercourse or not to use birth control.

Gender and sexual power dynamics and coercion associated with sexual power dynamics are both linked to condom non-use. In presence of high level of fear for abuse, even women with knowledge about STIs are likely to use condoms inconsistently.

Assessment and intervention

A typical assessment of women's reproductive health includes the following questions:

1. Has a current or former husband not let you use birth control, destroyed your birth control, or refused to wear a condom?
2. Has your husband ever tried to get you pregnant when you didn't want to be?
3. Has your husband ever forced you to have an abortion or caused you to have a miscarriage?
4. Has your husband ever purposely given you an STD?
5. Are you worried you might be pregnant?

Clinical implications discovered through case studies are the following: to assess for reproductive coercion as a part of a routine family planning care; to assess reproductive coercion before discussing contraceptive options; to offer discreet birth control methods; and to assess safety. Some believe that all reproductive health care settings should have a written protocol for identifying and responding to domestic violence that includes reproductive coercion, and agencies that already have a protocol should be reviewed and expanded to address reproductive coercion.

SEXUAL VIOLENCE

HANDOUT (H26.3B-3)

Sexual violence is any non-consented action of a sexual nature, including rape, attempted rape, sexual exploitation, and sexual abuse. Sexual violence is a subset of the broader category of gender-based violence (GBV). GBV is an umbrella term for any harm that is perpetrated against a person's will that results from power inequities that are based on gender roles.

Violence may be physical, sexual, psychological, economic, or socio-cultural.

The reason for addressing sexual violence in the MISP is to prevent rape and sexual exploitation and abuse, provide medical care for rape survivors and to ensure the availability of essential psychosocial services.

Once the situation stabilizes and all components of the MISP have been implemented, attention can be given to preventing the wider array of violence issues, including domestic violence; early and/or forced marriage; female genital mutilation/cutting; forced sterilization or forced

pregnancy; forced or coerced prostitution; trafficking of women, girls and boys; and additional forms of GBV.

WHY IS PREVENTING SEXUAL VIOLENCE A PRIORITY?

Although sexual violence is common even during peacetime, natural disasters and conflict increase the risk of rape and other forms of sexual violence. Women and adolescents are especially vulnerable to sexual abuse committed by combatants. The use of rape as a strategy of war has been documented in several conflicts as an effective means of controlling, degrading, and humiliating a community.

It is important to recognize that sexual violence may increase after natural disasters as well; it is therefore imperative to ensure that prevention and response mechanisms are also in place in these settings. It is critical to prevent sexual violence because it is a human rights violation.

Survivors may suffer from depression and anxiety, attempt/complete suicide, contract HIV or other STIs, become pregnant, or may be shunned by their families or communities. Moreover, the impact of sexual violence is manifold: it impacts the survivor's physical and mental health and social well-being, while also having possible consequences for the survivor's family and wider community.

WHO IS IMPACTED MOST BY SEXUAL VIOLENCE?

Sexual violence in crisis-affected settings does not happen in a vacuum. Most reported cases of sexual violence among crisis-affected communities and in most settings around the world involve male perpetrators committing violent acts against females. While all women in crisis-affected settings are susceptible to sexual violence, adolescent girls are exceptionally vulnerable as they are often targeted for sexual exploitation and rape.

In addition, sexual violence, even if exclusively perpetrated against women and girls, often affects and undermines the entire community including fathers, brothers, husbands and sons of the survivor. It is important to recognize that anyone can be a survivor of sexual violence (women, girls, boys, and men of all ages) and to ensure that services are available and accessible to all.

WHO ARE THE PERPETRATORS OF SEXUAL VIOLENCE?

Perpetrators may be others who have been displaced by the conflict or disaster; members of other clans, villages, religious groups or ethnic groups; military personnel; rebel forces; humanitarian workers from UN agencies or NGOs; members of the host population; the community; or family members. Perpetrators may also be male or female.

In short, anyone can perpetrate sexual violence. Rape may be used as a strategy of warfare to intimidate and traumatize a population, in which case the perpetrators are enemy combatants, but perpetrators of opportunistic rape can be anyone acting with impunity in the climate of

lawlessness that accompanies armed conflict and after natural disasters.

WHEN DOES SEXUAL VIOLENCE OCCUR?

Sexual violence can happen anytime during displacement, including prior to fleeing one's home area, during flight, while in the country of asylum and during repatriation and reintegration. It can occur in crisis-affected communities after a natural disaster, even among those not displaced from their homes. In addition, sexual violence frequently escalates in displaced settings as normal social structures are disrupted. Immediate prevention and response measures must be adapted to suit these different circumstances.

WHAT ARE THE KEY ACTIONS THAT SHOULD BE TAKEN TO REDUCE THE RISK OF SEXUAL VIOLENCE?

As part of the work of the overall health sector/cluster mechanism, the RH Officer and RH program staff must:

- 1) Ensure women, men, adolescents, and children have access to basic health services, including sexual and RH services.
- 2) Design and locate health facilities to enhance physical security, in consultation with the population and in particular with women and adolescents.
- 3) Consult with service providers and patients about security in the health facilities

Prevent and manage the consequences of sexual violence

Historically, sexual violence has consistently been a result of situations of conflict and forced migration, including natural disasters, and it continues to be so today. It is therefore urgent that all actors responding in an emergency are aware of this issue and put protective measures in place immediately proper layout of facilities such as latrines, for example, can reduce women's exposure to risk. Women and girls who have experienced sexual violence should receive health care as soon as possible after the incident in order to avert preventable consequences, such as unwanted pregnancies and life-threatening infections.

If left unaddressed, sexual violence may have serious negative personal and social consequences for women and girls, as well as for their families and the larger community. Psychosocial services that help to heal and empower/rehabilitate women are necessary.

Protection and community services staff should also be involved in offering legal support to survivors of sexual violence.

Steps to reduce these incidents

- 1) Locate separate male and female bathrooms and washing areas in the health facility in a secure location with adequate lighting at night, and ensure doors lock from the inside
- 2) Ensure all ethnic subgroup languages are represented among service providers or interpreters are available
- 3) Hire female service providers, community health workers, program staff and

interpreters

- 4) Inform service providers of the importance of maintaining confidentiality and have them sign and abide by a code of conduct against sexual exploitation and abuse
- 5) Ensure that codes of conduct and reporting mechanisms on sexual exploitation and abuse by health staff are in place, as well as relevant punitive measures to enforce them.

Urban Settings:

- 1) With all stakeholders to the humanitarian response, identify the specific risks for sexual violence in the setting and develop targeted protection measures.
- 2) Displaced populations, particularly women and girls, may be at additional risk of rape and sexual exploitation and abuse in an unfamiliar urban setting as they struggle to obtain their basic and survival needs.
- 3) As it may be difficult to identify and access displaced women in urban settings, it is important to discover creative ways to reach out to inform them of where and why to receive services after rape.
- 4) Working with a local women's organization to establish a hotline where displaced women can speak to someone (in their own language) about sexual violence, for example, may be helpful.

Adolescents:

Provide adolescent-friendly care for survivors of sexual violence at health facilities and encourage adolescent participation in any multi-sectoral GBV prevention task force.

What are the key actions that should be taken to respond appropriately to survivors?

RH Officers and program staff must:

- 1) Establish a private consultation area with a lockable filing cabinet;
- 2) Put in place clear protocols and sufficient supplies and equipment;
- 3) Hire male and female service providers fluent in local languages, or, where this is not possible, hire trained male and female chaperones and translators;
- 4) Involve women and male and female adolescents in decisions on accessibility to services and on an appropriate name for the services;
- 5) Ensure that services and a referral mechanism to a hospital for life-threatening complications are available 24 hours a day/seven day a week;
- 6) Once services are established, inform the community why, where and when (as soon as possible after a rape) these services should be accessed.
- 7) Use communication channels appropriate to the setting (e.g., through midwives, community health workers, community leaders, radio messages or information leaflets in women's toilets).

What are some situations that put women and girls at risk of sexual violence?

It has been shown that women without their own personal documentation for collecting food rations or shelter materials are vulnerable because they may be dependent on males for their daily survival. It also has been demonstrated that when men (fellow displaced persons or humanitarian actors) alone are responsible for distributing food and other essential goods,

women and children may be forced to perform sexual favours in order to obtain their survival needs.

Women and girls may have to travel to remote distribution points for food, firewood for cooking fuel and water. Their living quarters may be far from bathrooms and washing facilities. Their sleeping quarters may be unlocked and unprotected. Lighting may be poor. Male and female bathrooms and washing facilities may not be separate or these facilities may be in insecure areas of a camp. Given the stressful circumstances of displacement, women and girls may also be at increased risk of intimate partner violence. All these circumstances leave women and girls vulnerable to abuse and sexual assault.

Lack of police protection and lawlessness also contribute to an increase in sexual violence. Police officers, military personnel, humanitarian workers, camp administrators or other government officers may themselves be involved in forcing women and girls to engage in sexual activity for security, services, or other support. If there are no independent organizations, such as UNHCR or NGOs, to help ensure personal security within a camp, the number of incidents often increases. It is important that female protection officers are available since women and girls are often more comfortable reporting protection concerns and incidents of violence to another woman.

Why are incidents of sexual violence often not reported?

Even in non-crisis settings, sexual violence often goes unreported due to a range of factors, including fear of retribution, shame, stigma, powerlessness, lack of support, the unreliability of public health and other services, lack of trust in the services and the lack of confidentiality and unfamiliarity with the services. All these circumstances are exacerbated in humanitarian settings, increasing the likelihood that incidents of sexual violence within the population will go unreported. While ensuring that clinical management and other services is an essential part of the response, addressing sexual violence goes beyond this and must also include an environment where women are protected, supported and able to access this service.

Multisector coordinated mechanisms to prevent sexual violence must be in place to provide confidential health services to manage survivors of rape are in place, including:

- | |
|-------------------------------------------------------------------------------------|
| 1) Emergency contraception |
| 2) PEP |
| 3) Antibiotics to presumptively treat STIs |
| 4) Care of wounds and prevention of tetanus (Tetanus toxoid/tetanus immunoglobulin) |
| 5) Hepatitis B vaccine |
| 6) Wound care |
| 7) Referrals to health, psychological and social support services |

Inter-agency RH Kit(s)

Kit 3: Rape Treatment Kit (pink)

Kit 9: Suture of Tears (cervical & vaginal) and Vaginal Examination Kit (purple)

SESSION 4
WRAP UP AND SUMMARIZE
(10 MINUTES)

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

FURTHER READING:

CRISIS

- http://www.who.int/reproductivehealth/publications/gender_rights/eliminating-forced-sterilization/en/
- <https://www.who.int/reproductivehealth/displaced-refugee-women-violence-risk/en/>
- <https://www.who.int/reproductivehealth/publications/humanitarian-settings-contraception/en/>

CONTRACEPTION AND SEXUALLY TRANSMITTED INFECTIONS



TIME 2 HOURS

The main objective of this session is to highlight the interaction between STIs and provision and effectiveness of various contraceptive choices. The women with STIs and those at a high risk of contracting them, form a high risk, vulnerable group. It is of utmost importance that they are served appropriately and with due consideration of their specific problems.

Interactions between the contraceptives and medicines for STI treatment and prevention will also be highlighted.



TRAINING OBJECTIVES

- 1) Discuss the interaction between STIs and contraceptive choices.
- 2) Discuss provision of effective contraceptive choices for people with or at high risk of STIs.
- 3) Describe specific care of people with STIs in context of contraception.
- 4) Highlight Interactions between the contraceptives and medicines for STI treatment and prevention.



LEARNING OUTCOMES

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

- 1) Decide specific contraceptive methods best suited for client with or at a high risk of STI
- 2) Describe interactions between various medications and contraceptives
- 3) Highlight the concept of Dual protection
- 4) Understand the importance of integration of services



TRAINING/LEARNING METHODS

- 1) Interactive Power Point Presentation
- 2) Group discussions
- 3) Individual and group exercises
- 4) Experience sharing



TRAINING MATERIAL

Trainer' Material	Trainee's Material
Hand Outs: H27.1, H27.2, H27.3, H27.4	Hand Outs: H27.1, H27.2, H27.3, H27.4
Activity: A27.1, A27.3, A27.4a, A27.4b	Job aid: J27.1, J27.2a, J27.2b
Job aid: J27.1, J27.2a, J27.2b	
FAQs:	
PPT: (27)	



CONSTITUTION OF THE SESSION

Five mini sessions will be held:

1) STI s and contraceptive choices	Lecture/interactive discussion	30 Mins
2) Effects of contraceptive choices on STIs /AIDS	Brainstorming / Activity	30 Mins
3) The need for dual protection	Group work/Teach back	20 Mins
4) Integration of STI, RH and contraceptive choices	Brainstorming /Discussion	20 Mins
5) Wrap up		10 Mins

SESSION 1

TITLE: SEXUALLY TRANSMITTED INFECTIONS

(20 MINUTES)

OUTLINE & OBJECTIVES:

This session highlights various kinds of STIs, their transmission and common presentation

METHODOLOGY:

1. Brain storming session
2. Group work
3. Interactive power point presentation and discussion

Handout: (H27.1)

Activity: (A27.1)

Job Aid: (J27.1)

WHAT ARE SEXUALLY TRANSMITTED INFECTIONS (STIS)?

HANDOUT (H-27.1)



Activity (A27.1)

Divide the participants into two groups and ask the groups to enlist the common STIs and modes of transmission. Give each group 10 minutes to prepare and ask their chosen representative to present in 5 minutes each. The trainer then discusses any missing points

Women bear most of the worldwide burden of sexually transmitted infections (STIs) and their resultant morbidity and mortality. Sexually transmitted infections are caused by bacteria, viruses, and parasites spread through sexual contact. Infections can be found in body fluids such as semen, vaginal discharge, on the skin of the genitals and areas around them, and some also in the mouth, throat, and rectum. STIs can be contracted through vaginal, anal, or oral sex acts, as well as through the sharing of sex toys and digital penetration. Infections can be acquired from body fluids (e.g. semen, vaginal discharge) in and around the genital area. STIs

can also be transmitted from mother to child during pregnancy and childbirth, as well as through blood transfusion or tissue transfer. Other sources of STI include the mouth, throat, and rectum. Occasionally, the infection can also be contracted through some non- sexual means.

Some STIs cause no symptoms. Others can cause discomfort or pain. If not treated, some can cause pelvic inflammatory disease, infertility, chronic pelvic pain, and cervical cancer and can be transmitted to baby (congenital syphilis). Some STIs can also greatly increase the chance of becoming infected with HIV because of open skin surface area. STIs spread in a community because an infected person has sex with an uninfected person without protection. The more sexual partners a person has, the greater his or her risk of either becoming infected with STIs or transmitting STIs.

KEY POINTS

1. STIs are caused by bacteria, viruses, and parasites. If not managed accordingly and appropriately, complications and adverse sequelae will set in. Healthcare providers must be aware of the causes, risk factors, signs, and symptoms of STIs.
2. Early detection of STIs is important in instituting the appropriate management approach that aims to control and prevent further spread of infection.
3. Healthcare providers should adequately educate and counsel their women regarding STIs. This practice is essential in the management of STIs because the women play an active role in controlling and preventing transmission.
4. The family planning health provider and women should be aware of the possible effects of contraception on STIs and the effects of STI treatment on contraceptives, particularly the hormonal types. This awareness and knowledge will assist healthcare providers in providing the appropriate advice and counselling on contraceptive use.
5. The primary concerns for STI management include the institution of specific treatment and the prevention of transmission. The most effective method in terms of pregnancy and STI transmission prevention is the consistent and correct use of condoms as part of the dual protection strategy.
6. The women should be encouraged to familiarize themselves with the signs and symptoms of STIs for early detection. Client should also be encouraged to adhere to the recommended treatment. Referral to a specialist, whenever needed, for existing complications or sequelae should be provided.
7. Women should be tested for syphilis during antenatal checkup to ensure early treatment and avoid transmission to the infant.

WHO IS AT RISK OF STIS?

Many people seeking family planning services are in stable, mutually faithful, long-term relationships and so face little risk of getting an STI. Some women may be at high risk for STIs, however, or have an STI now. Women who might benefit most from discussion of STI risk include those who do not have steady partners, unmarried women, and anyone, married or unmarried, who asks or expresses concern about STIs or HIV or that her or his partner may have other partners.

The risk of acquiring an STI, including HIV, depends on a person's behaviour, the behaviour of that person's sexual partner or partners, and how common those diseases are in the community. Thus, the healthcare provider should be aware of the type of STIs and the sexual behaviour common in a certain locality. With this knowledge, the providers can improve the provision of risk assessment for STIs among their women and provide the appropriate treatment. Recognition of the risk for STIs by the women will serve as their guide in selecting the appropriate steps to protect themselves and others

By knowing what STIs are common locally, a health care provider can better help client assess her or his own risk. Understanding their own risk for HIV and other STIs helps people decide how to protect themselves and others. People are often the best judges of their own STI risk, especially when they are told what behaviours and situations can increase risk.

SEXUAL BEHAVIOUR THAT CAN INCREASE EXPOSURE TO STIS INCLUDES:

1. Persons with more than one partner, the more partners, the more the risk.
2. Unprotected sex with a partner who has STI symptoms.
3. Sex with a partner who has sex with others and does not always use condoms.
4. Persons with partners who have multiple sexual partners.
5. Persons with partners having symptoms and/or recently diagnosed with STI.
6. Those with sexual partners who do not always use condoms when having sex with others
7. Sex without a condom with almost any new partner in a community where many people have STIs.
8. Those who are sexually active but have no long-term relationships unless there is some contact.
9. Married or unmarried persons who are concerned about STIs or HIV.
10. Immunodeficiency virus (HIV) in his or her partner who has sexual relationships with other partners.

In certain situations, people tend to change sexual partners often, to have many partners, or to have a partner who has other partners. All these behaviours increase the risk of STI transmission. This includes people who:

1. Have sex in exchange for money, food, gifts, shelter, or favours.
2. Move to another area for work, or travel often for work, such as truck drivers.

3. Have no established long-term sexual relationship, as is common among sexually active adolescents and young adults.
4. Are the sexual partners of these people.

KEY POINTS	
People with sexually transmitted infections (STIs), including HIV, can use most family planning methods safely and effectively.	
Male and female condoms can prevent STIs	When used consistently and correctly
STI risk can be reduced in other ways, too	Limiting number of partners, abstaining from sex, and having a mutually faithful relationship with an uninfected partner.
STIs often have no signs or symptoms, particularly in women	People should seek care if they think that they or their partners might have an STI.
Some STIs can be treated.	The sooner treated, the less likely to cause long-term health problems, such as infertility or chronic pain, or to infect a sexual partner or a foetus
In most cases vaginal discharge comes from infections that are not sexually transmitted	

WHAT ARE THE CAUSES OF STIS?

STIs are caused by more than 30 microorganisms, including bacteria, viruses, protozoan parasites, and ectoparasites. The different types of STIs are tabulated below according to the manner of transmission, symptoms, associated diseases, and curability

WHAT ARE THE CAUSES OF STIS?

JOB AID (J27.1)

Bacterial STIs				
STI	Organism	Transmission	Associated diseases	Curable?
Lympho-granuloma venereum	Chlamydia trachomatis	Vaginal and anal sex	Both sexes: ulcer, bubo, proctitis	Yes
Non-gonococcal	Mycoplasma genitalium Ureaplasma urealyticum	Vaginal sex	Men: urethral discharge (nongonococcal urethritis) Women: bacterial vaginosis; probably pelvic inflammatory disease	Yes

Syphilis	Treponema pallidum	Genital or oral contact with an ulcer, including vaginal and anal sex Mother to child during delivery	Both sexes: primary ulcer (chancre) with local adenopathy, skin rashes, condylomata lata; bone, cardiovascular, and neurological damage Women: pregnancy wastage (abortion, stillbirth), premature delivery Neonates: stillbirth, congenital syphilis	Yes
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Viral STIs				
STI	Organism	Transmission	Associated diseases	Curable?
Acquired immunodeficiency syndrome (AIDS)	HIV	Unprotected vaginal and anal sex; very rarely, oral sex. Use of infected unscreened blood and blood products. From mother to child during pregnancy or delivery or in breast milk	Both sexes: HIV-related disease, AIDS	No
Cytomegalovirus infection	Cytomegalovirus	Vaginal sex	Both sexes: subclinical or nonspecific fever, diffuse lymph node swelling, liver disease, etc.	No
Genital herpes	Herpes simplex type 2	Genital or oral contact with an ulcer, including vaginal and anal sex; also, genital contact in area without ulcer	Both sexes: anogenital vesicular lesions and ulcerations Neonates: neonatal herpes (often fatal)	No
Genital warts	Human papilloma virus	Skin-to-skin and genital contact or contact between mouth	Men: penile and anal warts, carcinoma of the penis	No

		and genitals From mother to child during pregnancy or delivery	Women: vulval, anal and cervical warts, cervical carcinoma, vulval carcinoma, anal carcinoma Neonates: laryngeal papilloma	
Molluscum contagiosum	Molluscum contagiosum	Vaginal sex Intimate contact	Both sexes: genital or generalized umbilicated, firm skin nodules	No
Viral hepatitis	Hepatitis B	Vaginal and anal sex, or from penis to mouth In blood, from mother to child during delivery or in breast milk	Both sexes: acute hepatitis, liver cirrhosis, liver cancer	No

STI	Organism	Transmission	Associated diseases
Trichomoniasis	Trichomonas vaginalis	Vaginal, anal, and oral sex From mother to child during delivery	Men: urethral discharge (nongonococcal urethritis); often asymptomatic Women: vaginosis with profuse, frothy vaginal discharge; preterm birth, low birth weight babies Neonates: low birth weight
Pubic lice	Phthirus pubis	Genital contact Direct skin-to-skin contact	Both sexes: itching, excoriations, papules
Scabies	Sarcoptes scabiei	Genital contact Fomite transmission	Both sexes: nocturnal pruritus, symmetrically distributed burrows, papules, pustules, nodules, and excoriations

HOW ARE STIS DETECTED?

STIs are not commonly detected early because the majority do not immediately present with symptoms, as in cases of chlamydia and gonorrhoea infection. However, early detection is important in preventing the transmission and occurrence of long-term health consequences.

Early identification of STIs is not always possible. For example, chlamydia and gonorrhoea often have no noticeable signs or symptoms in women. However, early identification, if possible, is important both to avoid passing on the infection and to avoid serious long-term health consequences, such as stillbirth, cervical cancer, and congenital syphilis. To help detect STIs early, a provider can:

- 1) Ask the client's sexual history and assess the risk of having an STI
- 2) Ask whether the client or the client's partner has genital sores or unusual discharge
- 3) Look for signs of STIs when doing a pelvic or genital examination for another reason
- 4) Know how to advise a client who may have an STI
- 5) Promptly diagnose and treat, or else refer for appropriate care, the client who has signs or symptoms
- 6) Advise women to notice genital sores, warts, or unusual discharge in themselves or in their sexual partners
- 7) For women without STI signs or symptoms but who are at high risk for STIs, encourage syphilis screening and, when feasible, screening for gonorrhoea and chlamydial infection

In addition to developing awareness of the risk factors, the provider should look for signs and symptoms of an STI in a client. A particular type of STI may present with a specific manifestation. With the recognition of the specific signs and symptoms, diagnosis of the corresponding STI can be achieved.

Common signs and symptoms according to possible causative STI	
Signs and symptoms	Causative STI
Discharge from the penis or vagina: pus, clear or yellow-green	Common: Chlamydia, gonorrhoea Uncommon: Trichomoniasis
Abnormal vaginal bleeding or bleeding after sex	Chlamydia, gonorrhoea, pelvic inflammatory disease
Burning sensation or pain during urination	Chlamydia, gonorrhoea, herpes
Lower abdominal pain or pain during sex	Chlamydia, gonorrhoea, pelvic inflammatory disease
Swollen and/or painful testicles	Chlamydia, gonorrhoea

Itching or tingling in the genital area	Common: Trichomoniasis Uncommon: Herpes
Blisters or sores on the genitals, anus, surrounding areas, or mouth	Herpes, syphilis, chancroid
Warts on the genitals, anus, or surrounding areas	Human papillomavirus.
Unusual vaginal discharge—changes from normal vaginal discharge in terms of colour, consistency, amount, and/or odour	Most commonly: Bacterial vaginosis, candidiasis Common: Trichomoniasis Uncommon: Chlamydia, gonorrhoea

WHO STI TREATMENT GUIDELINES 2016

The World Health Organization has released new guidelines for treating gonorrhoea, syphilis, and chlamydia given their increasing resistance to treatment.

For gonorrhoea, which has been most affected by antibiotic resistance, the guidelines include the following changes:

1. Quinolones are no longer recommended given the high prevalence of resistance.
2. Dual therapy is preferred over single therapy.
3. Health authorities should advise doctors to prescribe the antibiotic that would be most effective, taking into account current local patterns of resistance.
4. Oropharyngeal treatment recommendations and guidance on retreatment after treatment failure are included.

For syphilis, the new guidelines strongly recommend 3 doses of benzathine penicillin, which has been in short supply, over procaine penicillin. At least one dose of benzathine penicillin for pregnant women before 36 weeks gestation to prevent congenital syphilis.

For chlamydia, the WHO developed recommendations for treating pregnant women. They also made recommendations for preventing and treating chlamydia ophthalmia neonatorum

SESSION 2

TITLE: INTERACTION OF STIS AND THEIR TREATMENT WITH CONTRACEPTIVE CHOICE, EFFICACY AND PROVISION

(20 MINUTES)

OUTLINE & OBJECTIVES:

This session highlights interaction of STIs and their treatment with contraceptive choice, efficacy and provision

METHODOLOGY:

Interactive power point presentation and discussion to highlight the interactions of various treatment options for STI s and contraceptives on each other

Handout (H27.2)

Job Aid (J27.2a J27.2b)

EFFECTS OF CONTRACEPTIVE CHOICES ON STIS /AIDS

HANDOUT (H27.2)

With contraceptive use, family planning health providers should routinely ask their women about current and previous medication use. Women using hormonal contraception should also be informed about the potential interaction that may alter contraceptive efficacy. Particularly in cases of STIs, antimicrobial therapy is the main mode of treatment and may potentially alter hormonal contraceptive blood levels. Hence, couples or women should be encouraged to seek advice before taking new medications. They should be aware of the duration of simultaneous drug intake as well as the nature of the condition for which the drug must be taken.

EFFECT OF ANTIBIOTICS ON CONTRACEPTIVE EFFICACY

Job Aid (J27.2a)

Doxycycline	No change
Fluoroquinolones (Ciprofloxacin and Ofloxacin)	No change
Macrolides (Azithromycin)	Erythromycin – less potent in increasing plasma concentration of estrogen and

	dienogest Azithromycin – No change
Nucleoside Reverse Transcriptase Inhibitors (NRTIs)	No change
Non-NRTIs	Increased effect of Ethinyl estradiol (EE) Decreased effect of Levonorgestrel
Protease Inhibitors and Ritonavir-boosted Protease Inhibitor	
Atazanavir/Ritonavir	Increased effect of EE and Norethindrone (NET)
Darunavir/Ritonar	Decreased effect of EE, no change in NET
Fos-amprenavir/ Ritonavir	Decreased effect of EE and NET
Indinavir	No change
Lopinavir/Ritonavir	Decreased effect of EE, no change in NET
Nelfinavir	Decreased effect of EE, no change in NET
Saquinavir	No data available
Tipranavir/ritonavir	Decreased effect of EE

EFFECTS OF CONTRACEPTIVE CHOICES ON STIS

Job Aid (J27.2b)

Effect on Developing STI	Recommendations
The risk of acquiring STI is not increased for both uninfected and HIV-infected women.	No restriction should be imposed on the use of any of the hormonal contraceptives for women who are at high risk for STIs (WHO Category 1).
The risk of HIV transmission to uninfected partners is not observed to increase.	If a risk for STIs or HIV exists, the correct and consistent use of condoms is recommended, either alone or with another contraceptive method.
Does not offer protection against STIs or HIV.	
Risk of infection is higher only during the first 20 days after insertion. Such infection is most strongly related to the insertion process	Strict infection prevention practices must be followed to minimize the risk of infection and serious disease. Removal of the IUD with the occurrence of PID is

<p>The risk of pelvic inflammatory disease (PID) associated with gonococcal and chlamydial infection does not increase with IUD insertion</p>	<p>unnecessary if continued use is desired.</p> <p>However, continued use should be based on the client's informed choice and her current risk factors for STIs and PID</p> <p>Insertion should be avoided in women at high risk for or currently infected with gonorrhoea, chlamydia, purulent cervicitis, or PID</p>
<p>The absolute risk of subsequent PID is found to be lower among women who have no STI at the time of IUD insertion than among women with STI during insertion</p>	<p>If STI or PID develops with or without IUD, the condition should be treated by using appropriate antibiotics to permit continued safe use of IUD.</p> <p>A client with HIV can have an IUD inserted. However, the same is not recommended for a client with AIDS unless she is clinically well and on antiretroviral (ARV) therapy</p>
<p>The association of the risk for HIV acquisition with IUD use is not increased. Its use among HIV-infected women is not known to increase the risk of transmission to sexual partners</p>	<p>If STI or PID develops with or without IUD, the condition should be treated by using appropriate antibiotics to permit continued safe use of IUD.</p> <p>A client with HIV can have an IUD inserted. However, the same is not recommended for a client with AIDS unless she is clinically well and on antiretroviral (ARV) therapy</p>

DOES HORMONAL CONTRACEPTION MODIFY THE RISK OF STI ACQUISITION?

Sexually transmitted infections, or STIs, are infections that are passed from one person to another through vaginal, anal and sometimes oral sex. Although condom use can decrease or prevent transmission of many of these diseases, STIs remain an important and common condition, affecting 340 million people worldwide each year.

There are many factors that increase the chance of developing an STI. The most common ones are: having multiple sexual partners, having sexual intercourse with partners who have more than one sexual partner, not using condoms during intercourse, the presence of genital ulcer disease, young age, and previously having had an STI.

Numerous studies have investigated this subject; however, the answers are not clear. What is clear is that none of these methods protects a woman from acquiring an STI; therefore, providers should counsel women at risk of infection to use condoms during each act of intercourse, even if they are already using another contraceptive method.

WHO Expert Working Group reviewed these studies and their findings to determine whether women at risk for STIs should use hormonal contraceptive methods. After extensive review, the Working Group determined that there should be no restriction of use for any of the

hormonal contraceptives for any woman based on her estimated risk of acquiring an STI.

These recommendations are included in the Medical Eligibility Criteria for Contraceptive Use. The guidelines also emphasize that hormonal contraception does not protect against STI infection (including HIV) and that the correct and consistent use of condoms is recommended, either alone or in combination with a family planning method, to prevent against STI and HIV.

IUDS AND STIS.

By itself, the IUD does not cause pelvic inflammatory disease (PID). IUD insertion when a woman has gonorrhoea or chlamydia may occasionally lead to PID, therefore this should be avoided. If a client's situation places her at high individual risk of infection, she generally should not have an IUD inserted.

When laboratory screening for gonorrhoea and chlamydia is unavailable service providers should ask the client to consider her own risk and to think about whether she might have an STI. If she considers herself at high risk of acquiring an STI, she should be counselled on alternative FP methods. In special circumstances, if other, more appropriate methods are not available or not acceptable, service providers should consider presumptively treating her with a full curative dose of antibiotics effective against both gonorrhoea and chlamydia and inserting the IUD after her finishes treatment.

If a woman develops a new STI after her IUD has been inserted, she is not especially at risk of developing PID because of the IUD. She can continue to use the IUD while she is being treated for the STI. Removing the IUD has no benefit and may leave her at risk of unwanted pregnancy. She should be counselled on condom use and other strategies to avoid STIs in the future. This may be a good option for a woman who wants to use an IUD for continuing contraception. It is more effective in preventing pregnancy than ECPs.

Ensure that the client is eligible for IUD insertion. If an IUD is inserted as EC after a rape, ensure that full presumptive STI treatment and PEP is provided, and thorough counselling has been done and a follow up visit is arranged.

AIDS AND HORMONAL CONTRACEPTIVES

There is no cure for HIV infection, but antiretroviral (ARV) therapy can slow the progress of HIV disease, improve health, prolong life, and reduce the risk of transmission to others. ARVs also can reduce mother-to-child transmission during pregnancy, at the time of delivery and during breastfeeding. Opportunistic infections can be treated. People at high risk of exposure to HIV can take pre-exposure prophylaxis (PrEP), to prevent HIV infection. PrEP consists of some of the same ARV drugs also used to treat infection. Hormonal contraceptives and PrEP can be taken at the same time. The effectiveness of the contraception and of PrEP are not

affected. Condom use while taking PrEP will help prevent both HIV and other STIs.

Family planning providers can help with prevention and treatment efforts for HIV,

1. Counselling about ways to reduce risk of infection
2. Counselling a couple that wants to have a child, and one partner has HIV, about how to conceive while trying to prevent HIV transmission to the uninfected partner.
3. Referring women for HIV counselling and testing and for HIV care and treatment if the clinic does not offer such services.

The use of hormonal contraceptives among women infected with HIV using ritonavir-boosted protease inhibitors is categorized as MEC 3.

Women on ARV treatment should be advised to use condoms consistently and correctly if they decide to initiate or continue the use of a hormonal contraceptive. This strategy will not only prevent HIV transmission but also compensate for the possible reduction in the effectiveness of the hormonal contraceptive.

When a combined oral contraceptive is chosen, a preparation that contains at least 30 µg EE should be selected. This practice will offset the blood-level lowering effects of ARV agents on estradiol.

CONTRACEPTIVES FOR WOMEN WITH STIS, INCLUDING HIV

People with STIs and people with HIV, whether they are taking antiretroviral (ARV) therapy, can start and continue to use most contraceptive methods safely. There are a few limitations, as listed below.

A summary on the recommendations on contraceptive use among women with STIs

Method	Has STIs	Has HIV
Intrauterine device (copper-bearing IUD or LNG-IUD)	Do not insert an IUD in a woman who is at very high individual risk for gonorrhoea and chlamydia, or who currently has gonorrhoea, chlamydia, purulent cervicitis, or PID. (A current IUD user who becomes infected with gonorrhoea or chlamydia or develops PID can safely continue using an IUD during and after treatment.)	A woman with HIV clinical disease that is mild or with no symptoms, including a woman on ARV therapy, can have an IUD inserted. Generally, a woman should not have an IUD inserted if she has HIV clinical disease that is severe or advanced (WHO Stages 3 or 4). A woman using an IUD who becomes infected with HIV or whose HIV clinical disease becomes severe or

Female sterilization	If client has gonorrhoea, chlamydia, purulent cervicitis, or PID, delay sterilization until the condition is treated and cured.	Women with HIV, including women on ARV therapy, can safely undergo female sterilization. The procedure may need to be delayed
Vasectomy	If client has scrotal skin infection, active STI, or swollen, tender tip of penis, sperm ducts, or testicles, delay sterilization until the condition is treated and cured.	Men who are living with HIV, including men on ARV therapy, can safely undergo vasectomy. The procedure may need to be delayed If he currently has an HIV-related illness.
Spermicides (including when used)	Can safely use spermicides.	Should not use spermicides if at high risk of HIV. Generally, should not use spermicides
Combined oral contraceptives, monthly injectables,	Can safely use combined hormonal methods.	Can safely use combined hormonal methods.
Progestin-only pills, injectables, and implants	Can safely use Progestin-only methods.	Can safely use progestin-only methods. There is some concern that using a progestin-only injectable could make a woman more likely to develop HIV infection if exposed to the virus.

SESSION 3

TITLE: THE NEED FOR DUAL PROTECTION AND STRATEGIES FOR STI PREVENTION

(20 MINUTES)

OUTLINE & OBJECTIVES:

To bring home the importance and need for dual protection for high risk population

METHODOLOGY:

- 1) Small group work to improve the efficiency of women centred services by integration of various service
- 2) Followed by presentation of strategies by the respective groups about the concept of dual protection
- 3) Large group discussion interactive power point presentation and discussion

Handout (H27.3)

Activity (A27.3)

THE NEED FOR DUAL PROTECTION AND STRATEGIES FOR STI PREVENTION

HANDOUT (H-27.3)



Activity (A27.3)

A flip chart with the title of dual protection is used and the participants' comments and opinion are noted down. Use another Flip chart with a line in the middle to write names of FP methods that do and do not protect against STIs. Get the participants to contribute till the list is complete

Women bear most of the worldwide burden of sexually transmitted infections (STIs) and their resultant morbidity and mortality. However, STIs are only one adverse health threat borne disproportionately by women, who also face important risks related to reproductive health, unplanned pregnancies, obstetric complications, violence, trauma, economic instability, and gender inequity.

Effective contraception used by more than 150 million women worldwide, and worldwide

implementation of safe and effective contraception has had substantial public health effect on prevention of unintended pregnancy and maternal morbidity. Apart from unwanted pregnancies, condoms may also be used to prevent sexually transmitted diseases (STDs).

CAN ALL TYPES OF CONTRACEPTION REDUCE STIS?

There are several varieties of birth control contraceptives available for people who are sexually active, which can lower the risk of unwanted pregnancies. While most birth control contraceptives are targeted for protection against pregnancies, very few can be used to prevent STIs.

MALE CONDOMS

Male condoms have proven to be effective for both preventing unwanted pregnancies and STIs. Male condoms are typically made from latex or polyurethane and are one of the only birth control options that offers protection from STIs. In fact, the male latex condom offers the best protection from STIs, including the HIV virus. Latex is the best material, but polyurethane is effective in the case of latex allergy.

The latex condoms offer barriers to some STI pathogens – presently, they offer the best protection from STIs. But people who are sexually active must realize that they cannot entirely prevent these diseases either. Some experts advocate the consideration of abstinence or monogamy as the most reliable way to prevent the transmission of STIs from one person to the next. It is important to know that natural condoms, or ones made of lambskin, are not effective as the tiny pores in the leather allow viruses to pass through. A condom is not 100 percent protective as transmission may occur through the areas not covered by the condom. Moreover, to be effective, it has to be used for each encounter of sexual intercourse.

The condom has become more popular since the beginning of the modern epidemic of HIV infection but has been around for thousands of years prior to this. The use of a condom with every sexual act reduces the risk of several STIs, including gonorrhoea, chlamydia, and herpes and other ulcerating viruses, bacterial vaginosis, and pelvic inflammatory disease.

FEMALE CONDOMS

Female condoms are also available over the counter and offer some protection from STIs, but they are not as effective as male condoms. The female condom is similar in its composition to the male condom, but its effectiveness in blocking the spread of viruses has not been equally studied. It is designed to allow the female partner to control contraception during intercourse.

DAMS

The dental dam is a thin piece of latex which is spread over the perineum and vulva, to prevent direct skin-skin or mucosal contact between the partners during oral sex. It is used along with male or female condoms.

DIAPHRAGMS

Diaphragms are another barrier type of contraception method where the device is inserted inside the vagina to prevent sperm from entering the uterus. Even though the diaphragm is a barrier contraception method, a diaphragm doesn't protect against STIs.

CERVICAL CAPS

Cervical caps are thimble-shaped cups made from latex and are smaller versions of diaphragms. Cervical caps must remain in the vagina for several hours after sex, but it must be removed within the prescribed time. These contraceptives serve as useful alternatives for women who get bladder infections from diaphragms. These caps offer only partial protection against STDs.

WHAT IS DUAL PROTECTION?

For the prevention of STIs, a couple can use condoms consistently and correctly during every sexual act in addition to another family planning method of their choice, such as an oral contraceptive. This practice is good for those who are at risk of acquiring STIs because it protects against pregnancy and STIs.

Because of the importance of preventing both unintended pregnancy and STI transmission, the use of a barrier method with another effective method of contraception is recommended. This is because the efficacy of a condom is not as high as that of other methods in preventing pregnancy. However, the technique of proper condom use should be mastered, as condom breakage is just as disastrous when it comes to STIs as it is in allowing pregnancy to occur. The second method may be a long-acting form of contraception. Even sterilized women need to use dual contraception if they have sex with infected partners or with multiple partners.

The general need to protect oneself against STIs is emphasized by considering the vulnerability, otherwise, to the acquisition of chronic and serious STIs such as HIV. The use of hormonal contraception should be supplemented by sexual fidelity, or using condoms for every sexual act if repeated with multiple partners.

CHOOSING A DUAL PROTECTION STRATEGY:

Every family planning client needs to think about preventing STIs, including HIV, even people who assume they face no risk. A provider can discuss what situations place a person at increased risk of STIs, including, and women can think about whether these risky situations come up in their own lives. If so, they can consider 5 dual protection strategies.

One person might use different strategies in different situations; one couple might use different strategies at different times. The best strategy is the one that a person is able to practice effectively in the situation that she or he is facing. (Dual protection does not necessarily mean just using condoms along with another family planning method.)

Strategy 1: Use a male or female condom correctly with every act of sex.

One method helps protect against pregnancy and STIs, including HIV.

Strategy 2: Use condoms consistently and correctly plus another family planning method.

- 1) Adds extra protection from pregnancy in case a condom is not used or is used incorrectly.
- 2) May be a good choice for women who want to be sure to avoid pregnancy but cannot always count on their partners to use condoms.

Strategy 3: If both partners know they are not infected, use any family planning method to prevent pregnancy and stay in a mutually faithful relationship

- 1) Many family planning women are in this group and thus are protected from STIs, including HIV.
- 2) Depends on communication and trust between partners.

Other strategies, which do not involve using contraceptives, include:

Strategy 4: Engage only in safer sexual intimacy that avoids intercourse or otherwise prevents semen and vaginal fluids from coming in contact with each other's genitals.

- 1) This strategy will not prevent syphilis, genital herpes, or infection with human papillomavirus. These spread through skin-to-skin contact.
- 2) Depends on communication, trust, and self-control.
- 3) If this is a person's first-choice strategy, it is best to have condoms on hand in case the couple does have sex.

Strategy 5: Delay or avoid sexual activity (either avoiding sex any time that it might be risky or abstaining for a longer time).

- 1) If this is a person's first-choice strategy, it is best to have condoms on hand in case the couple does have sex.
- 2) This strategy is always available in case a condom is not at hand.

People at high risk of HIV infection can take (pre-exposure prophylaxis) PrEP. This daily treatment with oral antiretroviral drugs greatly reduces the chances of infection if exposed to HIV. PrEP can be a part of any dual protection strategy. PrEP can be used along with condoms and any other family planning method. Taking PrEP and a hormonal contraceptive at the same time does not reduce the effectiveness of either one.

Many women will need help, support, and guidance to make their dual protection strategy succeed. For example, they may need help preparing to talk with their partners about STI protection, learning how to use condoms and other methods, and handling practical matters such as where to get supplies and where to keep them. If you can help with such matters, offer to help. If not, refer the client to someone who can provide more counselling or skills-building, such as role-playing to practice negotiating condom use.

MALE AND FEMALE CONDOMS

Male condoms have proven to be effective for both preventing unwanted pregnancies and STDs. Male condoms are typically made from latex or polyurethane and are one of the only birth control options that offers protection from STDs. In fact, according to the US Department of Health and Human Services, the male latex condom offers the best protection from STDs, including the HIV virus. Female condoms are also available over the counter and offer some protection from STDs, but they are not as effective as male condoms.

WHAT STRATEGIES ARE ESSENTIAL IN THE TREATMENT, PREVENTION, AND CONTROL OF STIS?

Whenever an infection is diagnosed or suspected, effective treatment should be provided promptly to avoid complications and to break the chain of transmission. Prevention of transmission is the most effective strategy in the management of STIs. It avoids exposure to the long-term consequences and complications of STI.

Family planning services must include schemes such as those below that will emphasize the prevention of transmission for client protection.

1- Promotion of safer sexual behaviour

Education and counselling of persons at risk on how to avoid STIs through changes in sexual behaviour and use of recommended preventive services.

2- Introduction of prevention and care activities

Promotion of early healthcare-seeking behaviour, which will facilitate the identification of asymptomatic and symptomatic persons unlikely to seek diagnostic and treatment services.

3- Institution of a comprehensive approach to case management

- a. Identification of the STI syndrome
- b. Appropriate antimicrobial (antibiotic, anti-parasitic, or antiviral treatment for the syndrome)
- c. Education and counselling on method by which to avoid or reduce risk of infection with sexually transmitted pathogens, including HIV

Promotion of the correct and consistent use of condoms, which may be used in addition to the chosen contraceptive (dual protection)

- a. Notification, evaluation, treatment, and counselling of sex partners of persons who are infected with an STI
- b. Pre-exposure vaccination of persons at risk for vaccine preventable STIs

SESSION 4

TITLE: INTEGRATION OF STI, RH AND CONTRACEPTIVE SERVICES

(20 MINUTES)

OUTLINE & OBJECTIVES:

The objective is to highlight the integration of STI, Reproductive health and contraceptive services

METHODOLOGY

- 1) Brainstorming by the participants
- 2) Experience sharing from their workplace
- 3) Discussion to improve the efficacy of services by integration

Handout: (H27.4)

Activity: (A27.4a, A27.4b)

INTEGRATION OF STI, RH AND CONTRACEPTIVE SERVICES

(H-27.4)



Activity (A27.4a)

The trainer moderates a brainstorming session to discuss the options and benefits of integrated RH, FP and other women health services

RATIONALE FOR INTEGRATED SERVICES

Any client who is visiting an FP clinic could have a need for services other than FP. Service providers should take advantage of the opportunity to discuss matters related to sex and sexuality while counselling women about FP methods.

Women and men should be assessed for risks of STIs, HIV, and reproductive cancers (e.g., cervical, breast, and prostate). They should be offered screening for these conditions, and counselled on dual protection (e.g., against pregnancy, STIs, and HIV).

FP service providers should play a leading role in risk assessment, screening, diagnosis, treatment, and referrals related to STIs (including HIV) and cancer. They should be able to provide women with the necessary information and skills to assess and reduce their risk of acquiring these conditions.

In addition, women who are living with HIV and attending ART centres should be counselled and offered FP methods (or referred for such services).

Specific reasons for integrating FP services with other RH services, including STIs, HIV, and reproductive cancers services, include the following:

- 1) Both cater to a similar clientele, women and men of reproductive age who are sexually active.
- 2) The same providers can be oriented with minimal inputs to serve in both areas.
- 3) FP programs are effective entry points for most of the STI, HIV, and reproductive cancer services, and vice versa. Providers in both areas should be able to assess the relevant needs of women and to direct them accordingly.
- 4) Integrated services are a good approach to access hard-to-reach women, including men and youth.
- 5) Integrated services can overcome the challenge posed by the stigma that is often associated with stand-alone services (whether HIV/AIDS or FP) and encourage more male participation.

PREVENTION OF STIS, INCLUDING HIV/AIDS, IN FP SETTINGS

Visits to FP clinics offer women an opportunity for detection and management of STIs, and provide a mechanism for early detection and referral for management of cancers of the reproductive organs. FP service providers are expected to integrate these services into their FP counselling. When a client is at risk of contracting or transmitting an STI or HIV, it is important that service providers strongly recommend and make accessible to the client dual protection methods—either the simultaneous use of condoms with other methods, or the consistent and correct use of condoms alone—for both pregnancy prevention and disease prevention.

Service providers at FP clinics can help prevent the transmission of STIs and the occurrence of cancer of the reproductive organs by adopting the following practices:

- 1) Provide women with information on modes of transmission, especially the risk of contracting STIs and HIV/AIDS through high-risk sexual behaviour.
- 2) Educate women on common reproductive cancers and the importance of early detection and treatment of premalignant lesions
- 3) Service providers should use specific job aids to help them with through counselling and risk assessment for STIs (including HIV) and reproductive cancers among women visiting FP clinics.
- 4) Screen women for cervical cancer using VIA/VILI.
- 5) Promote the use of condoms (male and female) for women who are at risk of acquiring

STIs, even if they are using other methods of FP.

- 6) All service providers offering treatment should follow contact- tracing guidelines.
- 7) Educate all women about:
 - a. High-risk sexual behaviours
 - b. The protective benefits of male and female condoms
 - c. The need to have the sex partner(s) evaluated and treated if a client is found to have an STI
 - d. The importance of knowing one's HIV status and information on where HTC services may be obtained

INTEGRATION OF FP WITH HIV COUNSELLING AND TESTING SERVICES

Health professionals should enable women living with HIV to plan their pregnancies or limit the size of their families by counselling them and providing them with the appropriate contraception at the time of HIV diagnosis (and during follow-up). Women who test positive for HIV should be referred appropriately

Additional recommendations include the following:

1. The basic FP information should be incorporated into all HIV-counselling sessions, for both women living with HIV and HIV- negative women.
2. FP services, including referrals, should be provided at the HIV testing and counselling sites, whenever possible.
3. HIV/AIDS services, especially HIV testing, counselling, and referrals, should be provided at all FP service delivery points whenever possible; otherwise, FP women with HIV/AIDS needs should be referred accordingly.
4. Counsellors should emphasize dual protection as a strategy to prevent both STI/HIV transmission and unintended pregnancy using condoms alone, the use of condoms combined with other methods (dual method use), or by practicing abstinence.
5. Counsellors need to explain to women living with HIV the risk of Mother to child transmission (MTCT), as well as the benefits of FP.
6. Both men and women should be encouraged to use FP services to make informed decisions about pregnancy and contraceptive measures appropriate to their HIV status. Family practice service providers should be able to discuss safer ways to get pregnant bearing in mind the client's reproductive rights regardless of HIV status (i.e., minimizing the risk of transmitting infection to both child and partner).
7. FP service providers should maintain confidentiality of HIV test results and treat all FP and HIV women with respect.

Persons living with HIV and AIDS have just as much need for FP services as the non-infected persons, and there is evidence that they have an unmet need for FP.

FP service providers must ensure that safe and effective contraception is accessible to women living with HIV in order to help them plan their future childbearing patterns.

FP is among the core interventions for PMTCT. The service provider should refer to the particular sections in these FP guidelines for eligibility criteria for use of different methods by persons living with HIV and AIDS. Most of the currently available methods can be used safely by such women.

FREQUENTLY ASKED QUESTIONS

HANDOUT (H-27.4)



Activity (27.4b)

The trainer runs a pass the basket session with a basket full of different questions on a different coloured piece of paper. Alternatively, the papers can be shaped into a cabbage, and the participants peel off a layer each. The music plays and the participants pass the parcel.

When 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 having another STI place a person at greater risk of infection if they are exposed to HIV?

Yes. Infections that cause sores on the genitals such as chancroid and syphilis increase a person's risk of becoming infected if exposed to HIV. Other STIs, too, can increase the risk of HIV infection.

2. Does using a condom only some of the time offer any protection from STIs, including HIV?

For best protection, a condom should be used with every act of sex. In some cases, however, occasional use can be protective. For example, if a person has a regular, faithful partner and has one act of sex outside of the relationship, using a condom for that one act can be very protective. For people who are frequently exposed to STIs, including HIV, however, using a condom only some of the time will offer only limited protection.

3. Who is more at risk of becoming infected with an STI, men or women?

If exposed to STIs, women are more likely to become infected than men due to biological factors. Women have a greater area of exposure than men (the cervix and the vagina), and small tears may occur in the vaginal tissue during sex, making an easy pathway or entry point for infection.

4. Can STIs be transmitted through oral sex (mouth on penis or vagina)?

Yes. Herpes, syphilis, hepatitis B, chlamydia, and gonorrhoea can be transmitted through oral sex.

5. Can STIs be transmitted through anal sex (penis in anus)?

Yes. STIs, including HIV, are commonly transmitted through anal sex. Unprotected anal sex carries the highest sexual risk of HIV transmission.

6. Can HIV be transmitted through hugging? Shaking hands? Mosquito bites?

HIV cannot be transmitted through casual contact. This includes closed mouth kissing, hugging, shaking hands, and sharing food, clothing, or toilet seats. The virus cannot survive long outside of the human body. Mosquitoes cannot transmit HIV, either.

7. Is there any truth to rumours that condoms are coated with HIV?

No, these rumours are false. Some condoms are covered with a wet or a powder-like material such as spermicide or corn starch, but these are materials used for lubrication, to have sex smoother.

8. Will having sex with a virgin cure someone with an STI, including HIV?

No. Instead, this practice only risks infecting the person who has not yet had sex.

9. Will washing the penis or vagina after sex lower the risk of becoming infected with an STI?

Genital hygiene is important and a good practice. There is no evidence, however, that washing the genitals prevents STI infection. In fact, vaginal douching increases a woman's risk of acquiring STIs, including HIV, and pelvic inflammatory disease. If exposure to HIV is certain, treatment with antiretroviral medications (post-exposure prophylaxis), where available, can help reduce HIV transmission. If exposure to other STIs is certain, a provider can treat presumptively for those STIs that is, treat the client as if he or she were infected.

10. Why is it especially important to prevent HIV infection during pregnancy?

If a woman becomes infected with HIV during pregnancy, the chances that HIV will be transmitted to her baby during pregnancy, delivery, and childbirth may be at their highest because she will have a high level of virus in her blood. If a pregnant woman thinks that she may have HIV, she should seek HIV testing. Resources may be available to help her prevent transmitting HIV to her baby during pregnancy, delivery, and childbirth. It is not clear whether a woman who is exposed to HIV is more likely to become infected if she is pregnant.

11. Is pregnancy especially risky for women with HIV and their infants?

Pregnancy will not make the woman's condition worse. HIV infection may increase some health risks of pregnancy, however, and may also affect the health of the infant. Women living with HIV are at greater risk of developing anaemia and infection after vaginal delivery or caesarean section. The level of risk depends on such factors as a woman's health during pregnancy, her nutrition, and the medical care she receives. Also, the risk of these health problems increases if HIV infection progresses. Further, women living with HIV are at greater risk of having preterm births, stillbirths, and low birthweight babies.

12. How well do condoms help protect against HIV infection?

On average, condoms are 80% to 95% effective in protecting people from HIV infection when used correctly with every act of sex. This means that condom use prevents 80% to 95% of HIV transmissions that would have occurred without condoms. (It does *not* mean that 5% to 20% of condom users will become infected with HIV.) For example, among 10,000 uninfected women whose partners have HIV, if each couple has vaginal sex just once and has no additional risk factors for infection, on average:

- 1) If all 10,000 did not use condoms, about 10 women would likely become infected with HIV
- 2) If all 10,000 used condoms correctly, 1 or 2 women would likely become infected with HIV.

The chances that a person who is exposed to HIV will become infected can vary greatly. These chances depend on the partner's stage of HIV infection (early and late stages are more infectious), whether the person exposed has other STIs (increases susceptibility), and male circumcision status (uncircumcised men are more likely to become infected with HIV), among other factors. On average, women face twice the risk of infection, if exposed, that men do.

SESSION 5
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:

- <https://www.fphandbook.org/contraceptives-women-stis-hiv>
- Robinson N, Stoffel C, Haider Global women's health is more than maternal health: a review of gynaecology care needs in low-resource settings. *Obstet Gynecol Surv.* 2015; 70: 211-222
- Cates W, Evidence for Contraceptive Options and HIV Outcomes (ECHO) Consortium Research on hormonal contraception and HIV. *Lancet.* 2014; 383: 303-304

Ruling out pregnancy is recommended before starting a hormonal contraceptive and before IUCD insertion. Family planning providers have 3 tools available for this routine task:

1. Medical history
2. Pregnancy tests
3. Delaying the start of the method until the client's next monthly bleeding.

IMPORTANT POINTS TO NOTE:

1. Unless the client has missed her monthly bleeding, ruling out pregnancy starts with the Pregnancy Checklist. This checklist can provide reasonable certainty that a woman is not pregnant.
2. Pregnancy tests are not likely to work before the first day of missed monthly bleeding. Using a test earlier is pointless and wasteful.
3. The only contraceptive method known to pose a health risk if started during pregnancy is the IUCD (either copper or hormonal). If the Pregnancy Checklist cannot rule out pregnancy, a provider should use another tool to rule out pregnancy before inserting an IUCD.
4. All hormonal methods except the LNG-IUCD can be provided without delay even when uncertainty about pregnancy exists. Follow-up is required in some cases
5. Delaying the start of the method is the worst choice among the 3 tools for assessing pregnancy. She may become pregnant before her next monthly bleeding. The other tools should be used first whenever possible.
6. Both the Pregnancy Checklist and a pregnancy test are highly accurate for ruling out pregnancy when used appropriately. When the checklist can be used, there is no reason to prefer a test.

PREGNANCY CHECKLIST

Ask these questions to be reasonably sure that the client is not pregnant. As soon as the client answers **YES** to any questions, stop and follow the instructions after last question.

Yes	Did your last menstrual period start within the past 7 days*?	No
Yes	Have you abstained from sexual intercourse since your last menstrual period, delivery, abortion or miscarriage?	No
Yes	Have you been using a reliable contraceptive method consistently and correctly since your last period, delivery, abortion or miscarriage?	No
Yes	Have you had a baby in the last 4 weeks?	No
Yes	Did you have a baby less than 6 months ago, are you fully or nearly- fully breastfeeding, and have you had no menstrual period since then.	No
Yes	Have you had a miscarriage or abortion in the last 7 days*?	No

*If the woman is planning to use the Copper bearing IUD, the 7 day windows expanded to 12 days

<p>If the client answered YES to at least one of questions and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant.</p>	<p>If the client answered NO to all of questions, pregnancy cannot be ruled out using the checklist Rule out pregnancy by other means</p>
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The following job aids will help the health care provider to guide the woman to choose the appropriate method of her choice.

For women with amenorrhea

Job Aid 1

Woman with amenorrhea (Postpartum or secondary amenorrhea)	
Implants, pills, ring, patch or injectables 	IUCDs Copper or LNG 
Use Pregnancy Checklist Pregnancy ruled out: Provide method.  	
Pregnancy not ruled out: Use a pregnancy test.  	
Pregnancy test is negative (or test is not immediately available) Provide the method now Schedule a follow-up pregnancy test in 3–4 weeks.	Pregnancy test is negative (or test is not immediately available): Advise woman to use COCs, DMPA, or condoms or abstain for 3–4 weeks, then repeat the pregnancy test. Second pregnancy test is negative: Provide the IUCD.

In cases where pregnancy cannot be ruled out, offer emergency contraception if the woman had unprotected sex within the last 5 days. Counsel all women to come back any time they have a reason to suspect pregnancy (for example, she misses a period).

* 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.

For women with regular menstrual cycle

Job Aid 2

Client between two regular menses (monthly bleeding)	
Implants, pills, ring, patch or injectables	IUCDs Copper or LNG
<p>Use Pregnancy Checklist Pregnancy ruled out: Provide method. Do not use a pregnancy test (In most cases it is too early for the test to be effective).</p>	
Pregnancy not ruled out: Provide the method now. Return for a pregnancy test, if next menses are delayed.	Pregnancy not ruled out: Do not provide method. Advise woman to return for LNG-IUCD insertion within 7 days of onset of her next menses, or within 12 days for a copper IUCD; but in the meantime, use COCs, DMPA, or condoms or abstain. Return for a pregnancy test if next menses are delayed.

IF THE CLIENT PRESENTS WITH A LATE/MISSED MENSES, USE A PREGNANCY TEST TO RULE OUT PREGNANCY:

If using a sensitive pregnancy test (for example, 25 mIU/ml) and it is negative, provide her desired method.

If using a test with lower sensitivity (for example, 50 mIU/ml) and it is negative during the time of her missed period, wait until at least 10 days after expected date of menses and repeat the test. Advise the woman to use condoms or abstain in the meantime. If the test is still negative, provide her desired method.

If test sensitivity is not specified, assume lower sensitivity.

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