MARIE STOPES SOCIETY
ماری اسٹوپس سوسائٹی

POPULATION WELFARE DEPARTMENT
Government of The Punjab

POST ABORTION FAMILY PLANNING TRAINER'S MANUAL

Foreword

Assalam Alaikum

MSS is pleased to present the **Post Abortion Family Planning Manual** to assist healthcare professionals who are providing reproductive health and family planning services to clients.

We are thankful to the Population Welfare Department Government of The Punjab, for entrusting MSS with the development of the afore-mentioned manual. We welcome this opportunity to reiterate our commitment to provision of high- quality reproductive health services across the country.

The training materials in the manual are based on international best practices for delivering safe medical care. We hope that this manual will be equally useful for frontline health care workers in both the public and the private sectors.

MSS master trainers have conducted a detailed review of the existing guidelines of the Government of Pakistan as well as the international literature in the compilation of this manual. Comprehensive information about all clinical practices and protocols for Post Abortion Care and Family Planning have been included.

Marie Stopes Society recognizes the critical role of the health care workers and makes this contribution towards enhancing their skills and competency for safe, effective and efficient service delivery.

Sincerely,

Asma Balal

Country Director

Marie Stopes Society

Acknowledgement

I would like to acknowledge the following team members for their great contributions.

Manual Writing Team
Dr Huma Mohsin, Dr Reshman Naz, Dr. Kanwal Ahsan, Ms. Shaista Rehman, Ms. Amina Majeed, Ms. Nousheen Farhan

Formatting and Editing
Mr. Muhammad Ayaz

Cover Design
Mr. Zuhair Mehdi

Advisor & Reviewers

We would like to extend special thanks and appreciation to Dr Syed Shershah, President Pakistan National Forum on Women's Health (PNFWH) and Dr Mumtaz Esker for their expert review, valuable technical input and publishing suggestions.

This spirit of maintaining partnerships and complementarities is invaluable, enabling us to grow and develop together. This will also prevent duplication and enhance the efficiencies of the resources.

Dr Tasneem Fatima

Director Health Services Department

Endorsement

From the desk of the Advisor:

I had the privilege of reviewing the Clinical Standards Manual for Service Providers developed by Marie Stopes Society. The subject is of topical interest in the field of study of Reproductive Health / Family Planning. It is also the need of the hour as it will help to focus and bring into clinical practice the minimum accepted international standards.

Current efforts to define and implement health standards are driven by issues related to the quality, cost and continuity of care, patient safety concerns, and safety of the staff executing the job. It endeavors to bring clinical research and evidence based practices & findings in a methodical and logical manner. This manual underscores the requirements for standardized clinical practices and the current state of standards development for filling the gaps and overlaps in relevant areas of Family Planning / Reproductive Health. Through this manual the sensitive unresolved issues and informatics challenges have been appropriately addressed, keeping terminology standards according to cultural norms.

I would specifically like to mention that the manual strives to highlight the basic requirement for maintaining a safe workplace environment with a client centered approach and most appropriate procedures to optimize client's safety and comfort. Besides, the quality assurance procedures are being laid down for equipment and instruments, required to determine that they operate at an acceptable performance level. The manual ensures and addresses equipment maintenance & operational standards besides environmental safety.

Its adaptation will be of tremendous help to all stakeholders in Public, Private and NGO Sector to provide quality of care by following the parameters laid down in the manual. I hope that the manual being user friendly will be widely adopted by medics & paramedics working in the RH field and prove to be a useful asset in their clinical practice. Keeping its utility in view; I recommend that the manual should be widely disseminated so that it is utilized by the largest number of service providers and its trickledown effect finally benefits the end users with the much needed quality services.

Dr Mumtaz Esker,

Advisor, MSS

27th March 2013

Validation Certificate

PAKISTAN NATIONAL FORUM ON WOMEN'S HEALTH
PNFWH
PMA HOUSE, AGA KHAN III ROAD, KARACHI TEL: 021-32231534

20th February 2013

The Head of Health Services
Marie Stopes Society
21-C, Commercial Area
Old Sunset Boulevard
DHA, Phase 2
Karachi.

Subject: **Validation of Curriculum for Social Franchise Training**

Dear Madam

We received the curriculum for training the Social Franchise Private Providers in Family Planning / Reproductive Health and Maternal Health related topics, submitted by MSS for review and validation.

After detailed review of all the topics and presentations we have no hesitation in validating the usefulness of this curriculum for training the Social Franchise Private Providers as per the recognized international standards.

We shall be glad to answer any queries in this regards.

Dr. Syed Shershah
President, PNFWH

Acronyms List

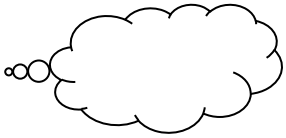
AIDS	Acquired Immune Deficiency Syndrome
BHU	Basic Health Unit
BTP	Birth to Pregnancy
CCFPS	Client-Centered Family Planning Services
COCs	Combined Oral Contraceptives
CU-T-	Copper T
DMPA	Depot- Medroxyprogesterone Acetate
DPT	Diphtheria Pertussis Tetanus
EC	Emergency Contraception
ECPs	Emergency Contraceptive Pills
EE	Ethinyl estradiol
FAM	Fertility Awareness Methods
FP	Family Planning
GATHER	Greet, Ask, Tell, Help, Explain, Reassure / Follow up
HLD	High Level of Disinfection
HTSP	Healthy Timing and Spacing of Pregnancy
IP	Infection Prevention
IUCD	Intra Uterine Contraceptive Device
LAM	Lactational Amenorrhea Method
LHW	Lady Health Worker
LNG	Levonorgestrel
MEC	Medical Eligibility Criteria
ML	Multi Load
MM	Male Mobilizer
MO	Medical Officer
MSU	Mobile Service Unit
MT	Medical Technician
NBS	Natural Birth Spacing Methods
Net-En	Norethisterone Enanthate
NGO	Non-governmental Organization
NSAIDS	Non-Steroidal Anti-Inflammatory Drugs
OC	Oral Contraceptives
OPD	Outdoor Patient Department
ORS	Oral Rehydration Salt
PAC	Post Abortion Care
RH	Reproductive Health
RHC	Rural Health Center
SAHR	Salutation, Ask, Help, Reassure
SDM	Standards Days Method
STD	Sexually Transmitted Disease
STIs	Sexually Transmitted Infections

Table of Contents

Foreword 2
Acknowledgement 3
Endorsement 4
Validation Certificate 5
Acronyms List 6
Table of Contents 7
Symbols 9
Introduction of Trainer's Manual 10
Methodology 11
Continuous Supportive Supervision CSS 15
Overview and Introduction 19
Expectations 20
Objectives of the Training 21
Pre Test 22
Module 1 23
Reproductive Health and its Components 24
Module 2 25
Family Planning and Islam 26
Healthy Timing and Spacing of Pregnancy (HTSP) 28
Module 3 31
Communication, Counseling and Informed Consent 31
Components of Communication 37
Tools of Communication 39
Module 4 59
High-Quality Safe Uterine Evacuation / Post-Abortion Care 59
Karachi Declaration 94
Components of PAC Services 97
Learning Log Sheet 100
Competency Assessment Checklist: MVA 101
Competency Assessment Checklist: PACM 104
Competency Assessment Checklist: Para-Cervical Block 107
Module 5 109

Post Abortion Family Planning 109
Family Planning Methods 113
Hormonal Methods 118
Combined Oral Contraceptive Pills (COC's) 119
Progestin-Only Injections 125
Implants 130
Non-Hormonal Methods 147
Barrier and Protective Methods (condoms) 147
Intrauterine Contraceptive Device (IUCD) 150
Emergency Contraceptive (EC) 161
Voluntary Surgical Contraception 166
Module 6 179
Reproductive Tract Infection 179
Module 7 208
The Pain Management 208
Module 8 212
Infection Prevention 212
Annexure 265
Competency Assessment Checklist: Counselling 265
Competency Assessment Checklist: Oral Contraceptive Pills 269
Competency Assessment Checklist: Progestin-Only Injectable 271
Competency Assessment Checklist: Contraceptive Implant Insertion 273
Competency Assessment Checklist: Contraceptive Implant Removal 276
Competency Assessment Checklist: Condom 278
Competency Assessment Checklist: IUD/IUS Insertion 280
Competency Assessment Checklist: IUD/IUS Removal 284
Competency Assessment Checklist: Emergency Contraceptive Pills 286
Competency Assessment Checklist: Mini-Laparotomy Tubal Ligation 288
References 293

Symbols



Brain storming

Case study

Demonstration

Presentation & Discussion

Role Play

Small Group

Gallery Walk

Video

Introduction of Trainer's Manual

Purpose

This training manual is developed to help and guide the trainer for better training skills. This will also facilitate trainer in the process of training. It has been developed with set of activities and material to assist trainer to execute training as per set policies of MSS.

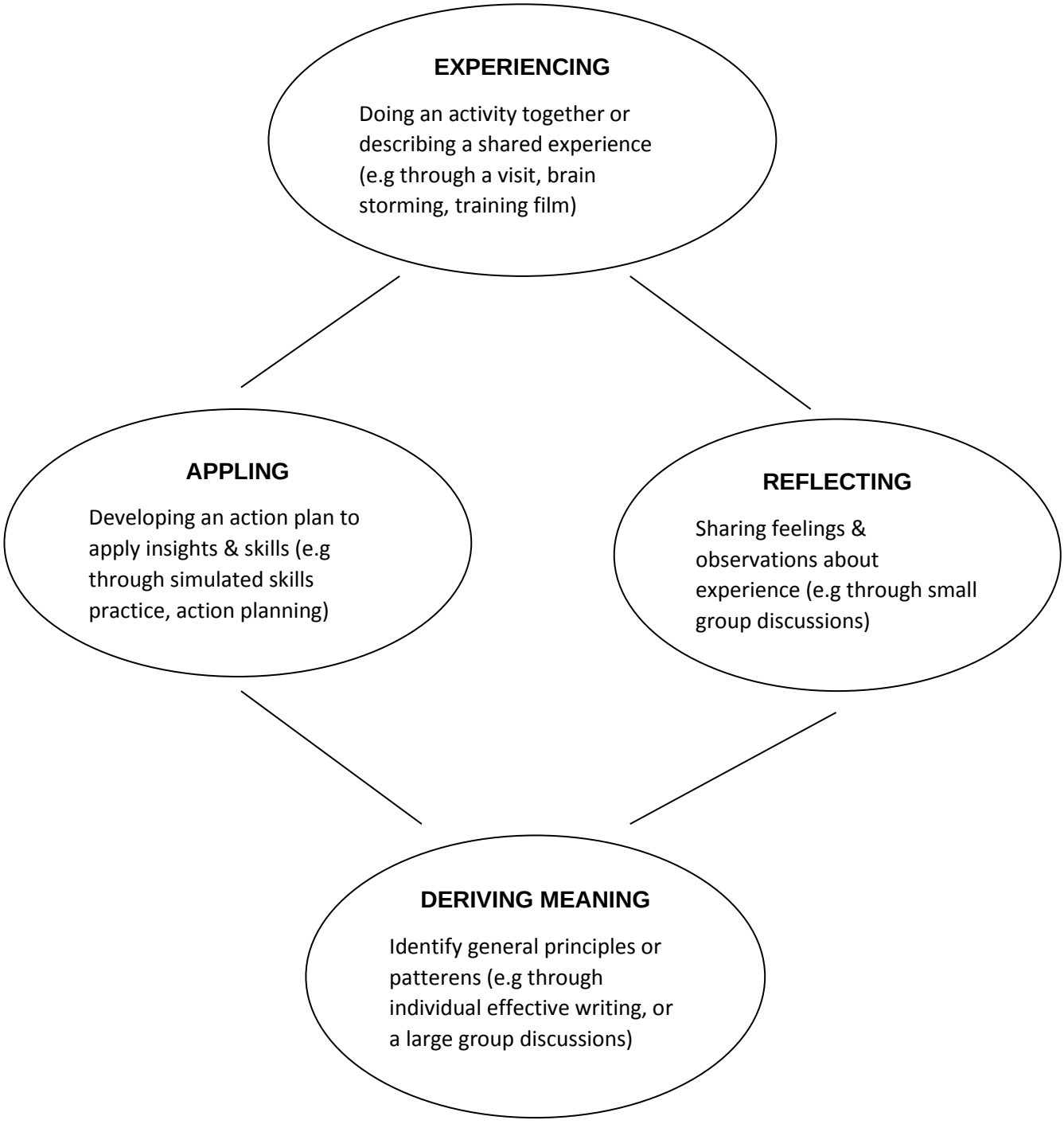
Design

The training Manual covers all the main thematic areas required for training on Reproductive Health and Family Planning. These are further sub divided into different Modules. The details are shared below.

1. Overview and Introduction
2. Module 1: Reproductive Health and It's Components
3. Module 2: Family planning in Islam
4. Module 3: Communication, Counseling and Informed Consent
5. Module 4: High Quality Safe Uterine Evacuation / Post Abortion Care
6. Module 5: Post Abortion Family Planning
7. Module 6: Reproductive Tract Infection
8. Module 7: The Pain Management
9. Module 8: Infection Prevention

Methodology

ADULT LEARNING CYCLE



Six Key Characteristics of adult Learners

1. Adults need to know why they should learn something

Therefore, an effective trainer:

- Provides real or simulated experience through which learner experiences the benefits of knowing and the costs of not knowing
- Creates a atmosphere of mutual trust and discusses expectations with the learner.

2. Adults need to be self-directing

Therefore, an effective trainer:

- Allows for as much choice as possible in making decisions during the learning experience
- Helps adults define their learning needs and set objectives and design activities suitable for these needs

3. Adults have a lot of experience to draw on

Therefore, an effective trainer

- Encourages participants to share their experiences
- Links new learning activities to the participants' experiences.

4. Adults become ready to learn when they feel they need to know something or need to perform a particular task

Therefore, an effective trainer:

- Recognises that a course will be more effective if the content meets participants' needs. Explains why particular topics have been included and their relevance to participants' work.

5. Adults have a task centred orientation to learning

- Therefore, an effective trainer
- Uses case studies and role-plays to help trainees feel they are working with real problems and achieving real tasks
- Helps participants plan how to use the learning back at work.

6. Adults are motivated to learn by both extrinsic motivators (job promotion, added responsibility, power) and intrinsic motivators (interest, curiosity)

Therefore, an effective trainer:

- Creates an environment which promotes learning and uses positive reinforcement to enhance learning.

The outline is flexible, and you should feel free to change the programme to suit your own resources and your participants' needs. Experienced trainers will develop their own preferred exercises and they should insert those alternatives in the in the appropriate section of this *guide* for future reference.

Competencies of Trainer

- Demonstrate, through their behaviour, a commitment to the work of MSS principles
- Demonstrate an appropriate level of clinical knowledge for the subject of the course exude enthusiasm and commitment for continuing professional development organize the course along sound educational lines:
- Keep to time
- Defining learning goals and objectives and express these clearly
- Selecting and using appropriate training approaches to meet objectives selecting or adapting training materials
- Organizing course logistics and materials
- Facilitating the transfer of learning and action planning sessions
- Administering, marking and reporting back on tests in a non-intimidating manner evaluating training events
- Demonstrate skills in different educational and communication methods:
- accurately explaining and demonstrating a given MSS procedure using, where relevant, an anatomical model
- managing role play and other simulations to develop participants' skills before they work with clients
- presenting information using clear language
- reviewing and summarizing what has been covered
- assessing individual progress and giving help where necessary
- using a range of presentation media and techniques
- writing quickly and legibly on the flip chart
- organizing group learning exercises and managing the training room appropriately
- work within the principles of learning:
- treating all participants with warmth and respect, encouraging participants to draw upon their own experience and creating opportunities for them to contribute
- making links between participants' work and the course content to show that the training is relevant and practical
- creating a positive learning atmosphere to generate energy and enthusiasm in the learning group giving constructive (supportive and challenging) feedback
- working effectively with a co-trainer or as part of a training team.

Tips For Trainers: Helping Participants to Remember Information

Participants may retain information for a short period of time but be unable to recall it after longer periods of time. These are some of the thing's trainers can do to help participants to remember information in the longer term:

- Summarise important information at the beginning and end of a session
- Review important concepts with participants, rather than presenting them only once
- Make connections and associations between different concepts
- Use learning exercises that draw on several senses: touch, sight, smell, taste, hearing
- Include movement in learning exercises so that physical gestures are associated with concepts or ideas use humour to help trainees remember, as well as to add variety
- Use key words and phrases. Emphasise main points. Avoid confusing detail

- Use drawings to help learners remember
- Number or colour code core concepts on posters and charts
- Provide breaks. Most people can't concentrate for more than 20-50 minutes.

Practice new skills and knowledge:

1. In each session, the trainer should begin by **finding out what participants already know and do** in regard to the topic. Discussion questions and short activities are included in the session plans to help trainers with this step.
2. Next, the trainer **builds on participants' current knowledge** by presenting new information or assigning them practical activities.
3. The trainer gives participants an opportunity to **practice the new knowledge or skills**, through a hands-on activity or discussion.
4. The trainer concludes the session by **evaluating** what participants have learned about the topic. The session plans include suggested questions or activities to help trainers and participants assess learning. There is also time set aside for a short evaluation activity at the end of each day.

After participants leave the training, they should be ready to **apply** their new skills in the real world.

The training should prepare them to make this transition by practicing skills in a realistic way.

Continuous Supportive Supervision CSS

Objectives:
By completing all the sessions participants will be able to:

- Employ the principles of adult learning to create a supportive and participative learning environment
- Demonstrate the ability to plan and manage classroom, and clinical-based learning using teaching methodology
- Provide timely assessment of competencies using competency framework.
- Define competency-based training.
- Monitor and evaluate the training.

Offering supervision in an enabling, confidential and non-judgmental environment motivates personnel to maintain standards and improve the quality of services being delivered.

This openness, encouraged by the fact that supportive supervision meetings are held in confidence, encourages the participants to identify and address issues as they arise, and before they can become problems. This kind of continuous support also identifies opportunities for staff development. By using adult-to-adult, two-way communication, both parties will recognize that they have something to contribute to the improvement process. MSS Provides Continuous Supportive Supervision (CSS) to their providers.

The benefits of CSS to the supervisee include:

- Achieving performance improvement on a regular basis
- A sense of empowerment
- Feeling valued by the organization

The benefits of CSS to the supervisor include:

- Observing improvements on a regular basis
- Being seen as an enabler, rather than an inspector
- Receiving a more welcoming response from supervisees

The benefits of CSS for the Country include:

- Effective allocation of resources based on skills gaps / training needs analysis
- Increased staff retention and provider satisfaction
- Sustained performance improvement: reduced incidents and increased client satisfaction

To achieve these benefits MSS have trained and competent Clinical trainers. They worked in development of their competencies which mean the knowledge, skills and attitudes required to complete a task by using the competency checklist for Clinical Trainer.

By fulfilling the above objectives, the Clinical Trainers will work towards achieving the competencies outlined in the competency framework. The framework below outlines the competencies that a Clinical Trainer requires to deliver during training and post training supervision effectively.

Competency Assessment Checklist: **Clinical Training**	
Creating a supportive and participative learning environment	met / partly met / not met / not appropriate
1. Appropriate number of trainees selected according to stated eligibility requirements	
2. Chosen training venues (classroom & clinical) are fit for purpose	
3. Trainee participation is actively encouraged	
4. Ground rules for behaviour in the training setting are set and agreed to	
Designing, planning and managing knowledge-based and practical skills training	
5. Verbal and visual communication is clear and audible/visible	
6. SMART course objectives are set and communicated	
7. Training follows a coherent structure based on course objectives	
8. A range of training techniques (hand-outs, small and large group work, training aids, A/V resources) are successfully employed	
9. Timings are communicated and kept to, allowing for well-judged flexibility	
10. Adequate client caseload is available for supervised skills practice if required	
11. Adequate time is made for review sessions and action planning	
Use of effective demonstration and coaching skills	
12. Four-stage method used when demonstrating clinical procedure in the classroom	
13. Trainees encouraged to identify own solutions / answer own questions rather than told answers	
14. Appropriate and previously agreed body language / gestures used to enhance demonstration and coaching in the clinical setting (if done)	
Provision of timely, supportive and challenging feedback	
15. SBI model employed when giving feedback by describing: a. A specific situation b. The trainee's behaviour in that situation c. The impact that behaviour had	

16. Positive points recognized as a foundation on which to build before areas for improvement highlighted (NB does not refer to weaknesses)	
Objective use of structured and explicit assessment processes	
17. Objective assessment carried out correctly using clearly referenced competency assessment checklist where available	
18. Final coaching offered and questions answered before commencing assessment procedure	
19. Timely, supportive and challenging feedback offered to trainees following assessment procedure	
Linking training to on-going supervision	
20. Importance of regular re-assessment of competencies by workplace supervisors communicated and mechanisms for doing so identified for/by each trainee	
Meaningful training evaluation	
21. Mechanisms for collecting and acting on information about effectiveness of training immediately post training, and over time, identified	

Competency level achieved:	Tick as appropriate
Level 1: All 'met' = Competent to train subject to regular re-assessment	
Level 2: One or more 'partly met' = Must train with an experienced trainer	
Level 3: One or more 'not met' = Not yet competent to offer training	
Actions to be taken to achieve / maintain competency	
Date of next assessment:	

Overview and Introduction

The opening and welcome of a training course are critical. Establishing a safe and comfortable environment will help foster a positive training atmosphere and facilitate the exchange of knowledge and experiences amongst participants. At the start of the training the facilitators should introduce themselves and talk about their own expectations for the course. The overall training objectives and goals should be reviewed and discussed by the group.

After opening remarks, exercises provide participants with the opportunity to introduce them and to talk about their expectations. Participants should get acquainted with each other and with the facilitators in order to work well together during the course.

1.1 Opening

- Welcome
- Introductions
- Participant's Expectations
- Setting Ground rules
- Course Objectives
- Training/ Logistics and Administrative issues
- Pre-test Questionnaire

1.2 Objectives

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

- Get acquainted with each other
- Set up common ground rules for the training
- List training purpose and objectives
- Access their knowledge and skills related to the topic
- Describe knowledge, attitude and skills required for good training

This is designed to let participants know each other's name, backgrounds and "break the ice".

- Write in a paper
- Drop in the basket
- One person draws and read the information WITHOUT NAME
- Other guess who it is
- This person then draws the next name

Expectations

Encourage participants to share their expectations or what they want to learn from PAFP Training?

Objectives of the Training

By the end of this session participant will be able to understand,

- Family planning in Islam
- Importance of healthy timing and spacing of pregnancy.
- Reproductive health and its component.
- Policy of government of Pakistan for family planning.
- How to use MEC wheel and its importance
- What is interpersonal communication and counseling? Barrier of counseling. How to overcome barriers and elements of effective counseling.
- Classification of family planning.
- Natural methods of family planning
- Modern method of family planning.
- Non-hormonal or barrier method
- Permanent method.
- Emergency contraception use and effectiveness.

Pre Test

Name: _____Designation: _____ Center: _____ Date _____

State whether the following statements are true or false:

S #	Statements	T/F
1.	Grade 1 in medical eligibility criteria means that the contraceptive method Cannot be used in any circumstances.	
2.	To rule out pregnancy asking 7 questions (SPR) is equal to PT or urine test for pregnancy	
3.	PV examination should be done before administering Depo-Provera injection	
4.	Depo provera and Norigest can be given 2 weeks after and 2 weeks before the scheduled date	
5.	A client who has forgotten to take oral contraceptive pills for 2 days should discard the remaining pill pack	
6.	The client average waiting time is one hour	
7.	COC can be given any day when you are sure that your client is not pregnant	
8.	Dual protection means contraceptive methods that not only prevent unwanted pregnancies but also protect against STIs	
9.	IUCD can be inserted to a nulliparous woman	
10.	Follow up of every client after IUCD is not mandatory	
11.	It is necessary that client and his or her partner both should be treated for STI at the same time	
12.	Limited to one sexual partner and using continuously using condom can minimize transmission of STIs	
13.	In REDI “R” means Return.	
14.	No consent is required for counseling	
15.	REDI is approach of Counseling	
16.	Breast tenderness, light headache, nausea and vomiting are the warning signs of COCs	
17.	ECP can be used 3 times in a month	
18.	The hormonal injection site should not be rubbed after administration	
19.	Acronym PAINS is used for assessing IUCD warning signs	
20.	For heavy or prolonged bleeding client should be given 500 mg mefenamic acid three times daily after meals for 5 days at beginning when irregular bleeding starts	

Module 1

PowerPoint Presentation with Discussion

Reproductive Health and its Components

Definition:

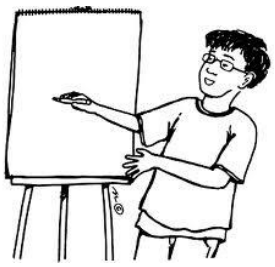
Reproductive health is a state of complete physical, mental, and social wellbeing and not merely the absence of disease and infirmity in all matters relating to the reproductive system and to its functioning and processes.

Men and women have the right to be informed and to have access to safe, effective, affordable methods of family planning as well as access to health care for safe pregnancy and childbirth.

Components

1. Reproductive rights –to meet the RH needs. (Safe motherhood)
2. Family planning-couples to meet reproductive goals
3. RTIs /STD/HIV AIDS-prevent reduce & treat.
4. Primary health care- to improve the quality of life.
5. Child survival and health- to reduce child morbidity and mortality.
6. Human sexuality and gender relations-to promote responsible sexuality and equity between genders.
7. Adolescents-to address adolescent sexual and RH issues.
8. Early screening of reproductive tract and breast cancer.
9. Promotion of breast feeding.
10. Treatment of infertility.
1. 11. Hormone replacement therapy

Module 2



PowerPoint Presentation with Discussion

Family Planning and Islam

These are certain dialogues, providing an Islamic perspective to questions agitating the minds of people today.

Can a couple limit their children?

Question: Is it appropriate for a married couple not to have more than 2 children because of their limited economic resources? Is it acceptable that they take measures to prevent pregnancy after having had 2 children?

Answer: During the time of the Holy Prophet (PBUH), some of His companions tried to reduce the chances of conception and pregnancy, because they did not want any more children. The Holy Prophet (PBUH) was aware of that. Some referred to Him while some relied on the fact that no edict was given concerning the question of preventing pregnancy. The general rule is that "everything is permissible unless pronounced otherwise." Thus, we have statements by some of the Holy Prophet (PBUH)'s companions such as: "We resorted to contraception at the time when the Qur'an was being revealed", and "We resorted to contraception and the Holy Prophet (PBUH) was aware of that but He did not stop us." These statements are clear in their import. If the Holy Prophet (PBUH)'s companions had been doing something unacceptable to Islam, God would have either revealed a prohibition in the Qur'an or the Holy Prophet (PBUH) would have given an order in a Hadith.

The fact is that the Holy Prophet (PBUH) did not give such an order. Instead, when He learned from one of His companions that he resorted to contraception, the Prophet said clearly that no method of contraception would stop the creation of a child, God will that the child be born. As such, no method of contraception can stop God's will from being fulfilled.

Coitus Interruptus:

Question: You advised a young man to get married and delay having children until he has finished his studies. This obviously means that he has to resort to methods of birth control. In our community, most scholars say that birth control is not acceptable from the Islamic point of view.

Answer: In ancient times, before the new methods of birth control were invented, people resorted to coitus interruptus to restrict their number of children. This is a safe method, because it does not involve the use of any substance or chemical compound. It is a simple method, which involves withdrawal before discharge. It is not highly effective, because some of the sperm may be released before the actual discharge. These could easily fertilize the female egg. This method was practiced in Arabia, as well in many other places. The companions of the Holy Prophet (PBUH) mentioned it to Him and asked Him whether it was wrong. The Holy Prophet (PBUH) did not forbid them that, but He told them that it could not stop Allah's work. If
He wants us to create something, or in this case, if He wants a child to be born, the resort to contraception would not prevent the mother from getting pregnant.

We have reports from companions of the Holy Prophet (PBUH) mentioning that He was aware of their resort to contraception, but He did not forbid them that.
In the light of the foregoing, we can say that using a safe and effective method of birth control is permissible, if it does not involve the use of a harmful substance. The couple must check with their doctor if a particular method is safe for them to use. If so, then they can decide whether to use it or not.

Why is birth spacing important?

Question: Is it necessary to keep an interval of 24 months after live birth?

Answer: The demands on a woman's body during pregnancy, childbirth, and breastfeeding are great. She needs adequate rest and nutrition during these challenging times. Taking care of the children that the mother already has is also physically taxing on her. Properly spacing the births of children can help give the woman time to recover and become strong again and will enable her to properly care for an infant before she faces the demands of another pregnancy. Health care professionals recommend spacing pregnancies at least 2 years apart.

In order to space pregnancies properly, a woman and her husband will need to use appropriate contraceptive methods. In your role as a religious leader, you can encourage them to seek advice on birth spacing from a health care professional.

"The carrying of the (child) to his weaning is (a period of) 30 months." (Quran 46:15)

"And We have enjoined on man (to be dutiful and good) to his parents. His mother bore him in weakness and hardship upon weakness and hardship, and his weaning is in two years, gives thanks to Me and to your parents, unto Me is the final destination." (Quran 31:14)

"For Muslim men and women for believing men and women for devout men and women for true men and women for men and women who are patient and constant for men and women who humble themselves for men and women who give in charity for men and women who fast (and deny themselves) for men and women who guard their chastity and for men and women who engage much in Allah's praise for them has Allah prepared forgiveness and great reward." (Quran 33:35

Healthy Timing and Spacing of Pregnancy (HTSP)

HTSP is an intervention to help women and families delay or space their pregnancies to achieve the healthiest outcomes for women, newborns, infants, and children, within the context of free and informed choice.

Introduction:

Recent research from developing countries shows that unhealthy timing or spacing of pregnancies is linked to increased risk of multiple adverse health outcomes. Following a pregnancy that occurred quickly after a previous birth, the risk of a child dying is at least twice as high as that for longer intervals.

An infant born after a short interval has increased chances of:

- Being born pre-term
- Having below normal weight at birth
- Being small for gestational age

A woman, who becomes pregnant too quickly following a previous birth, or miscarriage, faces higher risks of:

- Anaemia
- Premature rupture of membranes
- Miscarriage
- Death

In Pakistan:

Pakistan is the fifth most populous country in the world, with an estimated population growth rate is 2 percent per annum representing an annual addition of almost three million people. The country is facing great challenges to attain socio-economic development and break the cycle of poverty. This annual addition to the population, in the context of low socio-economic indicators, not only dilutes the results of development efforts but also creates overwhelming demand on limited resources. According to the Population Reference Bureau, Pakistan's population is 220 million, and it ranked 5th in the world. The 2050 projections are alarming; with Pakistan's population projected at 344 million. Based on these growth patterns and trends, the economy will be unable to sustain the growing population with hardly any scope for improvement in the quality of life, even under the most favorable circumstances. This situation is, therefore, a matter of deep concern and becomes a central issue in the overall planning perspective as well as the strategy for alleviating poverty in the country.

- Among married women of reproductive age (MWRA) approximately 1 out of 3 of births are space 18 months. The desire to space pregnancies is low (<20% among married women) but increasing.
- Need for birth spacing remains. Pakistan’s high maternal mortality ratio—currently estimated at 533/100,000 (2000-0 1 PRHFPS), with unsafe miscarriage being a significant contributing factor—is an issue of great concern for the government of Pakistan. At the root of this problem is one of the highest levels of unmet need for family planning services in the world. About 60% of Pakistani couples want contraception, but less than half of them have access to services.

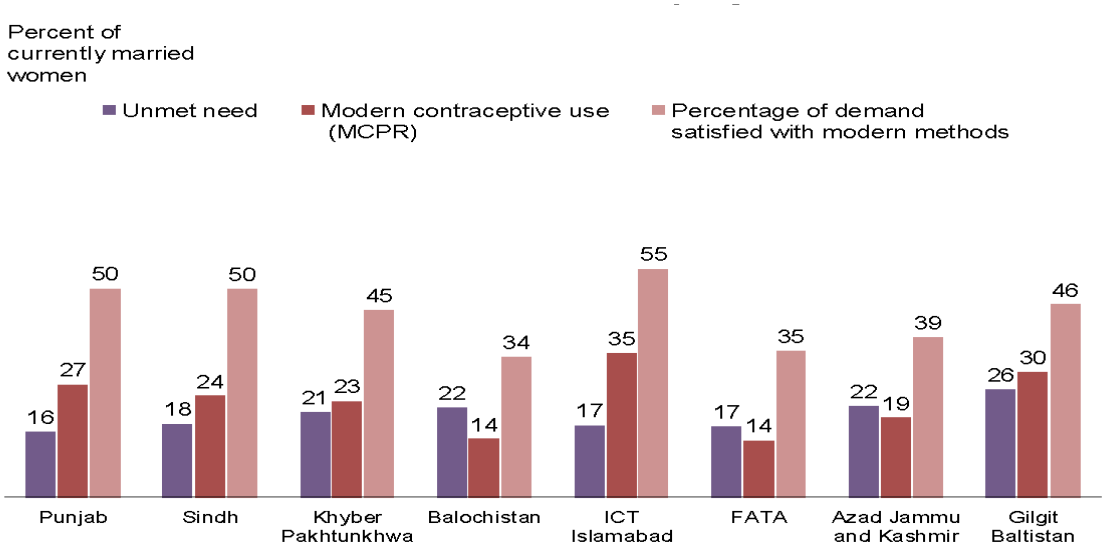
According to the 2017-18 Pakistan Demographic and Health Survey, Use of Family Planning More than one-quarter of MWRA currently use a modern method of family planning. Another 9% are using a traditional method.

The 2012-13 PDHS reveals that one in five married women have an unmet need for family planning 9% of women have a need for spacing births and 11% for limiting births.

Consider these findings in relation to the overall risks to mothers and newborns in Pakistan, outlined in Table 1

Table 1: Current Status on FP2020 Commitments				
	Current Status – 2017-18			FP2020 Commitment
	CPR (%)	Unmet Need (%)	Total Demand (%)	CPR (%)
Pakistan	34	17	52	52
Sindh	30.9	17.7	48.6	45
Punjab	38.3	15.8	54	52
KPK	30.9	20.5	51.4	42
Baluchistan	19.8	21.6	41.5	35

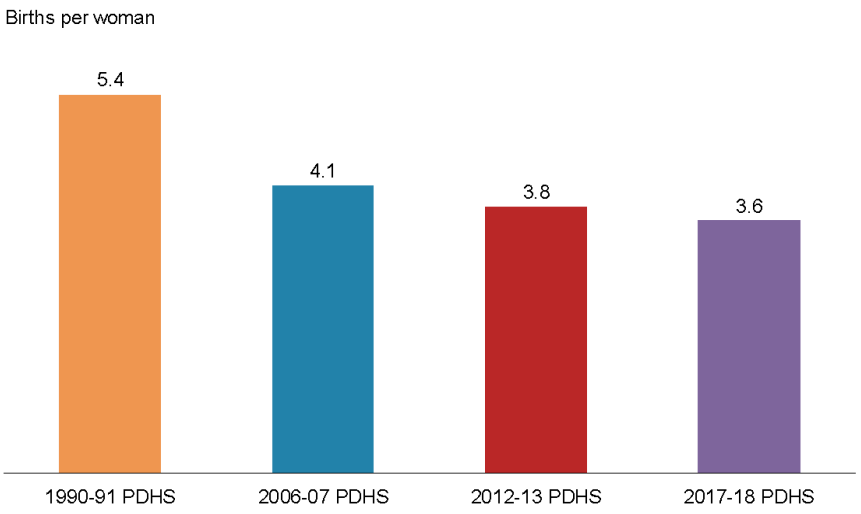
Source: NIPS; Pakistan Demographic and Health Survey 2017-18, Islamabad



Punjab

Punjab is the largest province with estimated population. The present growth rate indicates alarming situation in future when population will be doubled after 36 years. In 2015, there were approximately 26 million women of reproductive age and estimated to reach 30 million by 2020. The CPR has increased considerably and the unmet needs and total fertility rate (TFR) has shown a declining trend in figure: 1

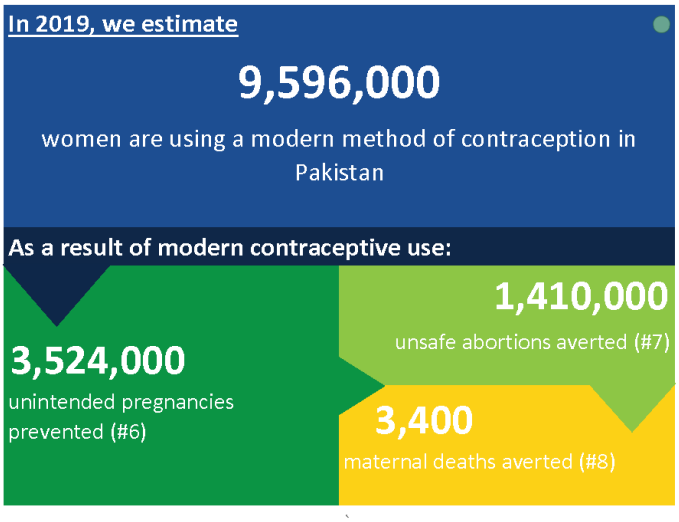
Figure 1 **Trends in total fertility rate**

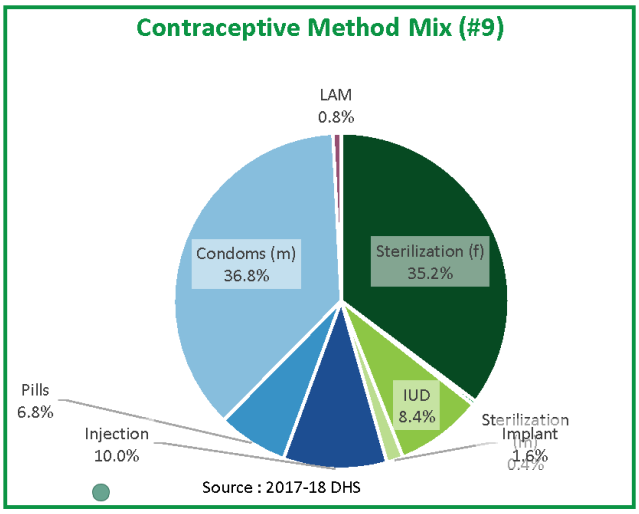


Note: Excludes Azad Jammu and Kashmir and Gilgit Baltistan

Other important factors affecting level of fertility are miscarriage and stillbirth. In Pakistan, induced abortion is illegal except in instances in which the life of the mother is at risk. Hence, it is extremely difficult to gather accurate information about the level of PAC.

Percent distribution of pregnancies ending in the five years preceding the survey by type of outcome, according to background characteristics





Module 3

Communication, Counseling and Informed Consent

Section A: Instructions to Trainers

Introduction

This Trainer's Guide for Communication, Counselling and Informed Consent. This training is designed to help experienced clinical trainers run a training course to teach the Guidelines for Communication, Counselling and Informed Consent which includes family planning and abortion counselling.

Objectives

By completing all the sessions in this guide trainees will be able to:

- Use a client-centered approach when speaking with clients about their SRH care needs.
- Use communication tools while communicating SRH issues.
- Take into consideration client's lifestyle preferences and tailor family planning counselling to client's needs
- Provide comprehensive information about family planning and safe abortion services in a way that can be easily understood by all clients to make an informed decision on availing SRH services for themselves
- Assess a client's capacity to understand, retain and use information provided to make informed decisions about their SRH needs.

Trainer Requirements

To teach this module the clinical trainer must possess the following competencies:

- Sound and current experience of delivering family planning and abortion counselling.
- Ability to use a range of training techniques
- Able to plan and manage classroom-based learning sessions according to available resources
- Effective demonstration and coaching skills in the clinical setting
- Ability to provide timely, supportive and challenging feedback as part of an objective competency assessment process

Throughout the training trainers should consider energizers and plan for breaks as required; approximately 1 hour for lunch 30 mins for tea breaks. For more information on best practice on training techniques.

Training Format and Logistics:

The Guidelines for Client Communication, Counselling and Informed Consent and Family Planning Flipchart form the main reference material for this training and should be distributed to all participants before the training commences so they can read them prior to the training. Trainers must also read the guidelines and this training package before planning their own training course

The course should be run with a ratio of 1 trainer to 4 trainees, where trainees are selected and grouped according to previous experience and ability.

This modular training package is made up of suggested exercises that support both knowledge and skills -based learning to give trainees the skills they need to carry out effective counselling services. In total this represents approximately theory and humanistic practice prior to supervised skills practice. The amount of time required for the supervised skills practice will depend on number of trainees and clients available.

This guide has been designed to allow trainers to adapt timings and select appropriate sessions according to the trainees needs, particular context and available resources. While ideally run in the order they appear in this guide, the sessions are presented so that the trainer can choose how and when to run them. If all of the sessions are delivered as follows:

Training Materials
This training package consists of the following resources:
- Client Communication, Counselling and Informed Consent guidelines.
- Family Planning Flipchart
- PowerPoint Slides for sessions

List of Training Resources (handouts linked to relevant sessions):
- Training Resource 1: Excluding Pregnancy Scenarios – 4 copies
- Training Resource 2: Family Planning Role Plays – 4 copies
- Training Resource 3: Fill in the Blanks – 1 per trainee
- Training Resource 4: PAFP Job Aide - 1 per trainee
- Training Resource 5: Written Consent Forms – 1 per trainee
- Training Resource 6 Final Role Plays – 4 copies
- Training Resource 7: Counselling Observation Checklist – 1 per trainee
- Training Resource 8: Post Knowledge Test – 1 per trainee
- Training Resource 9: Behaviour in the Clinical Setting – 1 per trainee
- Training Resource 10: Trainee Evaluation Feedback Form – 1 per trainee

Training Equipment and Supplies:
- 4 samples of all Family Planning Methods
- 4 flipchart paper pads and various flipchart pens
- Mounted flipchart for facilitator
- Projector for displaying PowerPoint slides

Assessment: (Pre/ Post Test)
This is an assessed, competency-based training course. Trainees will be assessed on their:

- Theoretical knowledge on key counselling messages for family planning methods
- Theoretical knowledge on key counselling messages for SAC/PAC options (as applicable)
- Ability to deliver client-centred counselling
- Ability to take informed consent for all clients

Theoretical knowledge will be assessed by a written test during the classroom-based sessions. This test has a pass mark of 80%.

Section B: Classroom Sessions
Introduction
By the end of this session trainees will be able to:

- State the workshop objectives and agenda

Timings: This session should take approximately 30 mins

Pre-training preparation: Trainer to develop this session and slides. Ensure trainees have a copy of Presentations with them.

Discuss: Welcome the group. Then READ OUT THE SESSION OBJECTIVES.

Present:

- Overall training objectives, agenda and training structure (theory; classroom demonstration followed by clinic visits) and the assessment process
- Guidelines for Client Communications, Counselling and Informed Consent are the main reference material for this training
- Describe the structure of the guidelines
- Counselling competency assessment checklists (5m)

Exercise 1: Introduction
Split into pairs and over the next 5 minutes ask them to find out the following information about each other: their name, their experiences with counselling and one thing they would like to learn. Then ask each pair to briefly introduce each other to the wider group. Write any additional learning objectives on a sheet of flipchart paper. Then explain to group that they have demonstrated one of the key skills

for counselling; active listening. (15m)

Exercise 2: Ground Rules
Ask volunteers to suggest some rules for how people should behave in the training room e.g. no mobile phones; listening to and respecting others; actively taking part in all sessions; keeping to time.
Make sure everyone agrees to them before writing them up on the flip chart. (10m)

Session 1: Communication Skills

Objectives: By the end of this session participants will be able to:
- Define Communication
- Define Components of Communication
- Define barriers of communication
- Demonstrate active listening skills
- Identify the impact of body language and behavior on interpersonal communication

Timings: This session should last approximately 30 minutes

Pre-training preparation: Session 2 slides. Ensure trainees have a copy of Power point Presentations.

Discuss: Read out the session objectives. Ask the group to call out some of the key communication skills required for client centered counselling and list these on a sheet of flipchart paper. (5m)

Present: Communication skills
- Verbal and nonverbal communication
- Barriers of communication.
- Active listening skills: reflecting, body language, eye contact
- Use of simple language
- Use of open-ended questions
- Validate emotions
- Encourage questions from client
- Use of if/then statements (5m)

Exercise 1: verbal and Non-Verbal Communication
The activity will highlight the importance of tone of voice in communication. And effectiveness of communicating the massage to group of people.

Exercise 2: Active Listening
You are going to give trainees the opportunity to experience what it feels like not to be listened to properly without telling them in advance that this is what you are doing. Ask trainees to shout out some "benefits of active listening". **Do not listen** to their responses. Turn their suggestions into your own misconstrued list and write it down on the flipchart. Then ask the trainees:
- What has just happened?
- How did it make them feel when you changed what you were saying into your own ideas?

Then facilitate a discussion about how clients may have similar feelings if they aren't listened to properly. Highlight that active listening skills are key to building rapport and trust with clients; to

understand the client's needs; and to avoid mistakes in client care. (10m)

Exercise 3: Identifying Open-Ended Questions
Project slide 12 and show some examples of open and closed questions. Ask the group to call out which questions are open-ended, and which are closed. (5m)

Discuss: Refer trainees to the counselling competency checklist to steps 2 and 3 as they relate to communication skills. Then individually ask them to carry out a self-assessment of these steps.

Action planning: Encourage trainees to note down:
a) Anything they particularly need to remember about their own communication skills
b) Areas of the counselling checklist they need to focus on to develop their communication skills (5ml)

Session 1: Communication and Components of Communication:

Exercise 1: verbal and Non-Verbal Communication

Activity

Verbal and nonverbal communication: tone of voice

Participatory Exercise: "mujhay pyaaz de do"

1. Ask participants to form a circle.
2. Distribute a card to each participant. Cards should have one of the following words written on it:
   - Ghussa
   - Gham
   - Khushi
   - Indifference
   - Jazba
   - Boriyat
   - Shauq/Interest
   - Dostana
   - Karobari
   - Thakawat
3. Each participant says "mujhay pyaaz de do" in the manner described on their card. The rest of the group has to decide what tone of voice they are using.

The activity will highlight the importance of tone of voice in communication

Definition

Communication has many definitions and can mean different things to different people. Some people may define it as an exchange of ideas, information, thoughts, feelings or images between two or more individuals or groups. Others may go for a more academic definition, such as: the use of various theories and techniques for helping people gain full awareness of their situation, exploring the options available to them and empowering them to make free and informed choices as per their needs.

In the context of public health and family planning, communication is a tool through which the provider can help the client understand his/her health situation and enable the client to make the most suitable choices. The most important element of communication is the ability to convey to the receiver the same meaning of a message as intended by the sender. Therefore, any communication that does not lead to a shared meaning of the message is not effective communication.

Components of Communication

Sender

Also referred to as the source. The sender is the person, or group of people, who want to communicate or send a message/direction/information to another person or group. The sender could be anyone - health provider, teacher, client, etc.

Message

The information, direction or feeling that the sender wants to convey to the receiver is called the message. Messages can be verbal as well as nonverbal. A typical message might be to wash hands before eating or brush teeth at least twice a day.

Channel

The channel is the medium through which the message is communicated. The selection of the channel depends on the nature of the message and the intended receiver of the message. Depending on the situation, the channel could be face-to-face interaction, telephone, letter, email, TV, radio, etc.

Receiver

The receiver is the actual target audience of the sender, the person or group for whom the message was designed and sent. In a two-way conversation, the individuals or groups involved can become senders and receivers simultaneously. For example, if a health provider chooses to deliver a talk on basic health and hygiene to students of a local school, the provider would be the sender during the talk and the students would be the receivers of the health education messages. However, if in the same setting, a student asks the provider a question, then the student will become the sender and the provider will become the receiver.

Feedback

The communication process is not complete without the feedback from the receiver that gives the receiver's reaction to the message that s/he has received. Feedback helps the sender understand if the message has been received properly, that is, that it has been understood by the receiver or that there is a need to refine or reinforce the message.

Communication can be as complex as any other process having many elements and components and involving behavior patterns and individual characteristics. There are many barriers and difficulties that can hamper the communication between sender and receiver. Some of these barriers are discussed below:

Barriers of Communication:

Barrier 1: Difference between *saying* and *hearing*

As the goal of communication is shared meaning and ultimately to bring about a change in behavior, the most important element in this process is delivering the message in a way and through a channel that allows it to reach the receiver. Message delivery alone is not enough. Ensuring that the message has been delivered to the intended audience is important. It is not enough to say something; it is equally important that it be received.

Barrier 2: Difference between *hearing* and *understanding*

Sometimes the sender is able to send a message to the receiver and the message is received well. However, this does not automatically mean that the message has also been understood. The reasons for not understanding could be that the message is in a language or spoken in a way that that the receiver does not understand. Another problem could be that the sender has sent a message in a written form but the receiver is not literate. Therefore, it is very important to understand the receiver well enough to make sure that the message is in a form that the receiver can understand or decode.

Barrier 3: Difference between *understanding* and *believing*

All of the messages that are understood are not always believed. We get so much information every day and sometimes we do not necessarily believe it all. Therefore, it is important for the sender to ensure that his/her message is believed as well as understood. One way to do this is to quote a credible source or give data that support the message. For example, one might say: spacing of 3-5 years between births enhances the chances of survival and better health for mother and child [message] according to the latest research published by Johns Hopkins University [credible source].

Barrier 4: Difference between *believing* and *practicing*

It is also important for a communicator to make sure that his/her message is not only credible but also that it helps achieve the goal of initiating the required action from the receiver. This may require creating an enabling environment for the receiver to act in a certain way. For example: convincing a woman to start using contraceptives is important; however, it is also important that she is able to access the contraceptives easily and also use them free of any fear or pressure. This means ensuring the supply as well as empowering the woman to convince her husband or family members if they object to the use of contraceptives that she should be able to use them.

Barrier 5: Difference between *practicing* and continuing to practice

There are so many practices that people may start, such as daily exercises to shed extra pounds or avoiding junk food, etc., and do for some time, but later they relapse into old habits once the initial euphoria is over and they discover that it is too taxing on their time or involves other costs. The important transition across the barriers between practicing and continuing to practice needs to be understood and strategies need to be utilized that will help remove barriers. The receiver needs constant appreciation and help in continuing to utilize new/better practices. For example: a woman may abandon the use of a contraceptive after experiencing some side effects. Using prior information, reassurance and follow up, a provider can help the woman continue using the method or switch to another method without risking an unplanned pregnancy.

Tools of Communication

Reflective Listening

The underlying theme of reflective listening is to understand the fact that when people talk they communicate more than words, they communicate their feelings also. A reflective response communicates to the speaker that the speaker has been heard and his or her feelings have also been understood. For example, a very worried looking woman brings her sick child in and says that her child is very ill. The provider should not only reflect back the woman's core message but also reflect back her core feelings (i.e., "I feel you are very upset because your child is very sick"). In another example, a woman comes to you crying that her child is suffering from severe diarrhea and vomiting and requests that you do something quickly otherwise her child may die. By using reflective listening, this woman might be calmed if she is reassured that not only her words have been understood but the provider also fully understands her feelings.

Stroking

A 'stroke' is any action that makes the receiver feels good and appreciated. This is different from flattery because in stroking the appreciation is genuine and honest. This can be done by words (e.g., good or excellent) and gestures (e.g., pat on the shoulder). For example, if a mother has completed her child's vaccination schedule, the provider should congratulate or commend her. The same is true if, during a client-provider interaction, a woman tells you that she has been having regular antenatal check-ups in the hospital or you go to a house and find that all of the edible items are properly covered.

Exercise 2: Active Listening

Q1. What is listening?

Paying attention to sounds, perceiving with the ears.

Q2. What is active listening?

It is more than just hearing. It involves:

- Observing (making use of other senses).
- Empathizing (putting oneself in the speaker's place)
- Communicating (understanding and showing interest).

Q3. Why do health providers listen?

- To obtain information to assess the needs of the client.
- To encourage the speaker to speak more frankly about their problems
- To understand people's problems in order to better help them.

Q4. What do we listen to?

- Facts
- Feelings or opinions.
- A person's way of talking.
- A person's mood (sighing, hissing).
- The sound of silence (shyness, sorrow).
- The hidden agenda (the unexpressed problem deep in the heart of the speaker).

Q5. How do we listen actively?
We actively listen by being:

- Attentive: giving undivided attention to what the speaker is saying with eye contact and no distraction.
- Accepting: respecting what the speaker is saying without arguing or censoring even though their ideas may differ from ours.
- Alert: trying to listen not only to the words and facts but to the feelings and emotions as well.
- Respectful: treating the speaker as an equal and giving respect to his/her feelings and attitudes.
- Encouraging: helping to bridge the gaps between the thoughts and feeling of the speaker in a supportive way. This is done to ensure that communication takes place smoothly (e.g., saying "yes," or "ok," or nodding, etc.).

Behavior

Q1: What is behavior?
Behavior is how we act, react and perform in response to different stimuli under different situations, circumstances and conditions. Different people can behave differently under the same conditions. Our behavior depends on different factors that influence and modify our behavior.

- In general, behavior stems from the following three things:
- Beliefs: Beliefs are ideas that are thought to be true by an individual, but which may or may not be supported by facts. For example: some women think that allopathic medicines, especially tablets, are very hot for the body. Some people think it is not good for a pregnant woman to go to a graveyard.
- Values: An opinion or standard that is important to an individual. Values are formed or influenced by religious, educational and cultural factors; they grow from our personal experiences. We display values, for example, in the way we greet each other, respect elders, obey parents, etc.
- Attitude: Our beliefs and values shape our points of view and attitudes that in turn shape our behavior. Attitude is what we think or intend to do. In other words, it is our point of view about an issue or act. Our attitudes determine our behavior, what we actually do. So, the attitude might be looked at as 'potential behavior.' Usually our attitude (our pre-existing point of view regarding a

particular issue) is in accordance with our behavior. This is not always true and sometimes our behaviors are different

from our attitude. This is called a gap between attitude and behavior. One example of this is in people's attitudes and behavior regarding cable/satellite TV, etc.

- Therefore, there are different factors and reasons why people behave in particular ways.

For example, a person from an urban society whose parents are well educated and economically sound will probably have received a quality education. His behavior will be different to that of a person with no education from a rural area.

Upbringing, education, social circumstances, family situations, religion, etc., are important factors in the formation of our behavior.

Listening

Activity

Verbal and nonverbal communication: active listening

Participatory exercise "interest and noninterest"

1. Divide participants in pairs and designate one person in the pair as A and the other as B. The person A will talk with B for 3 minutes. The B people cannot talk and will receive a card with instructions that they will have to follow. The instructions will either be: Don't demonstrate ANY interest in what this person is telling you! OR

   Demonstrate a LOT of interest in what this person is telling you!

2. After the 3 minutes, discuss the exercise with the As and Bs asking each of them how they felt about the exercise, whether the As felt comfortable taking to the Bs, why so, etc.
3. Discuss body language and emphasize the role it plays in communication.

Brainstorming: Active listening

Conduct a brainstorming exercise guided by the following.

- What is active listening?
- Give me some examples of active listening.
- Why is active listening important for the decision-making process?

Exercise 3: Identifying Open-Ended Questions

Types and Examples of Questions

Open-ended Questions

- Used in early part of the interview.
- Has many answers. Example: "What is your husband's opinion on family planning?"
- Used for learning about thoughts, feelings, knowledge and beliefs. Example: "How do you feel about family planning?"
- Helps clients to open up and say whatever they want to share. Example: "What are you thinking?" or "Is there anything else you want to tell me?"

Closed-ended Questions

- Most useful in taking medical history.
- Answer is usually given in one or two words. Example: "How old are you?" or "How long have you had this fever?"

Indirect Questions

Used when asking about sensitive issues (e.g., domestic violence, death of a child, etc.).

Example: When you suspect an injury is due to domestic violence, you would not ask the client if someone had beaten them. Instead, you would ask: "How did you get this bruise?" In the case of a child's death, you might ask: "You had another child?" The parent is free to answer as he/she chooses.

Suggestive Questions

Used when the question itself suggests an answer.

Suggestive questions should be avoided because they place the patient under pressure to agree to something that might not in fact be what they will do or would say if you asked an open-ended question. Example: “will you buy the medicines from the store?" [Urdu: *Aap bazaar say dawaikareedlaingina?].* It would be better to ask like this: "Where will you buy the medicines?"

Activity

Practice open-ended questions:

Tell participants:

- We will now play a short game to practice asking open-ended questions.

Distribute 5 to 10 cards with closed questions written on them to different participants.

Note to trainer: Cards are provided at the end of this session.

Ask one of the participants with a card to **read** out the question.

Then **ask** for a different participant to **re-word** the question so that it is open-ended. **Repeat** until all the cards have been discussed.

Closed Question Card:

1	Do you know what birth control pills are?
2	Does your husband like the contraceptive method you are using?
3	Did you choose the IUD because you wanted a secure method?
4	Is this method easy to use for you?
5	You want to continue with low-dose pills, right?

Possible answers:

1. "What do you know about birth control pills?"
2. "What is your husband's attitude toward your contraceptive method?"
3. "Why did you choose the IUD?"
4. "What has it been like to use this method? What were the difficulties of using this method?"
5. ing out for you?"

Tell participants:

- Closed, open-ended and probing questions all have their place in a counseling session, and a good counselor will use a mix of them.

Session 3: Communication Framework and Counselling:

Counselling:

Counseling is a two-way communication that provides information and helps clients to apply this information in making informed and voluntary decision by considering their own feelings and needs, weigh the benefits & risks of the available FP methods.

Counseling is a two-way communication between a clients and a health care staff member for the purpose of confirming or facilitating a decision by the client or of helping the client address problems or concerns.

Good FP counseling has two major elements and occurs when:

1. Mutual trust is established between client and service provider
2. The Client and service provider give and receive relevant, accurate and complete information that enable client to make decision about FP

Types of counseling

1. **General / Initial Counseling:** Usually take place at first FP visit**.** Needs of client discussed and concerns addressed. Give general information about FP choices, and questions answered. Myths discussed. Decision making and method choice begins
2. **Method specific counseling:** Method choice made. More information on method choice given. Screening process explained and instruction about how and when to use method. What to do in case of problems. When to return for follow up
3. **Return/follow up counseling:** problems and side effects discussed and managed, encouraged continue to use the method

Counseling is the interpersonal communication which is the face to face process of transmitting information and understanding between two or more people. Face to face communication takes place in two forms i-e verbal and nonverbal.

Verbal communication refers to words and their meaning. It is conscious and controlled by individual speaking.

Use **CLEAR** acronym for keys to verbal communication

C... Use clear & simple language

L... . Listen what client is saying

E... . Encourage the client that they will be able to use the method with good results

A... Ask for feedback from client

R.... Ask client repeat

Non-verbal communication refers to action, gesture, expressions, behaviors which express without speaking.

Principles of Good Counseling

1. **Treat each client well:** All clients deserve respect, regardless of their age, marital status, ethnic group, sex or sexual & reproductive age.
2. **Interact:** Each client is a different person. Ask questions, listen and respond to each client's own

needs, concerns and situation**.**

3. **Give the right amount of information:** Provide enough information for the client to make informed choices but not so much that the client is overloaded.
4. **Tailor and personalize information:** Give the clients specific information that they need and want and help clients see what the information means to them.
5. **Provide FP method** that the client wants: Provide the method unless a valid medical contraindication
6. **Help** clients remember instructions
7. **Ask** the client to return for follow up

Family Planning Counseling:

Providing clients with client-centered Sexual and Reproductive Health (SRH) choices are essential elements of MSS's commitment to delivering high-quality services globally. All clients have a fundamental, ethical right to make informed choices and determine what happens with their SRH. Therefore, all MSS clients are entitled to client-centered counseling, enabling information to be given to them to allow them to make an informed decision and for them to give informed consent.

Purpose:

The purpose of these guidelines is to:

Assist service providers, managers and senior management teams in implementing MSS Policy on Client Counseling and Informed Consent.

Outline Best Practice and Evidence-Based Standards for providing Counseling and Informed Consent.

Act as a reference for providing Counseling and Informed Consent. Guidelines can be adapted to the local context and to suit local Regulatory Frameworks.

Scope of Guidelines:

These guidelines refer to integrated SRH services offered by MSS through all service-delivery models and channels (Centers, Social Franchises, Outreach and Community level). This includes the following services:

- Family-Planning Methods ranging from Short Acting to Long Acting Reversible Contraception (LARC) and permanent methods (tubal ligation/vasectomy), as well as dual protection and emergency contraception.
- Planned maternal health procedures (safe delivery, Cesarean sections/induced deliveries).
- Emergency treatment for complications relating to reproductive and maternal health.
- RTI (STI) screening & treatment.

These guidelines should be used to offered counseling opportunities from their initial consultation to discharge to necessary follow-up appointments.

Family Planning Counseling- Benefits

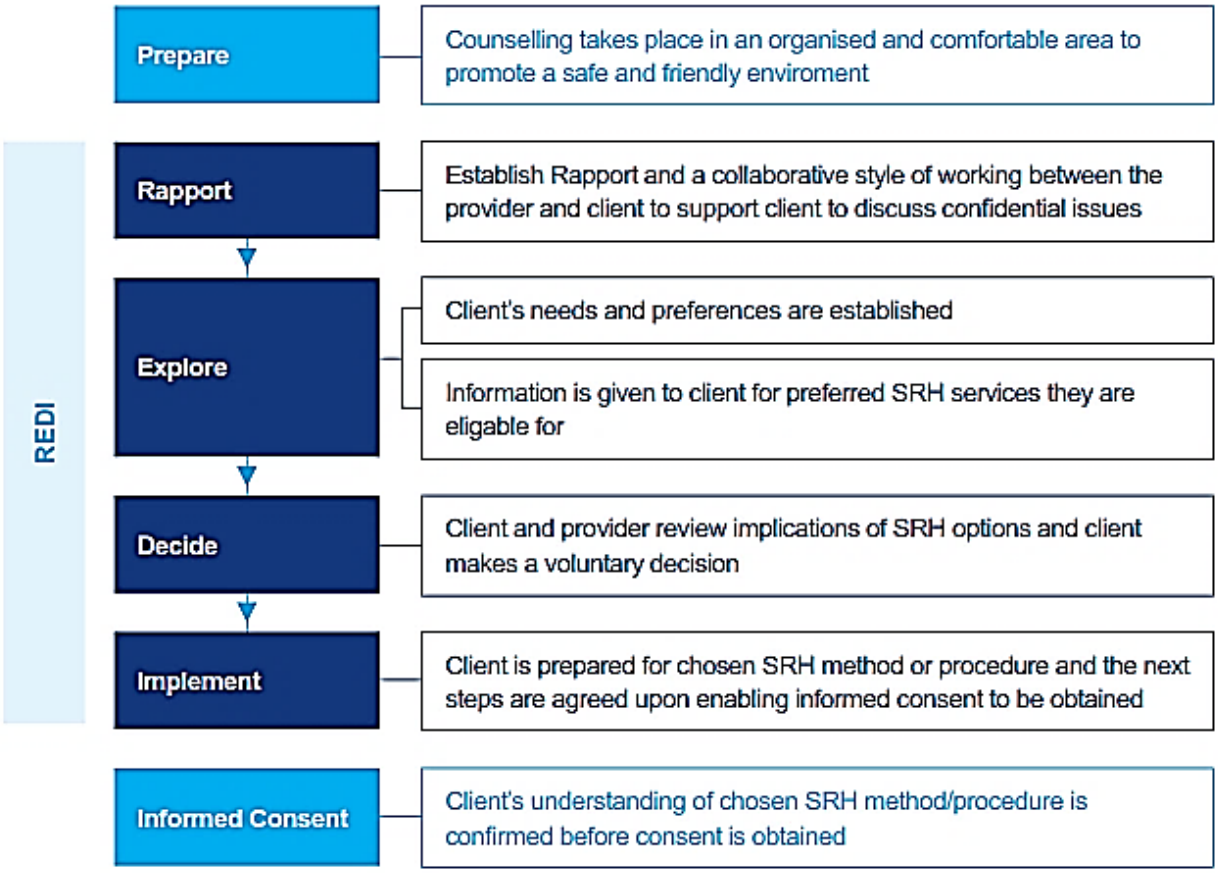
- Increases acceptance
- Promotes effective use
- Improves continuation
- Increases client satisfaction

- Dispels rumors and misconceptions

Key Principles for Couple Counseling

- In addition to the above, following counseling skills will help maintain balanced couples' interactions:
- Demonstrate neutrality and nonbiased concern for both members of the couple.
- Convey respect for the couple's relationship.
- Facilitate balanced participation of both partners during the session.
- Model appropriate listening and communication skills.
- Facilitate dialogue between members of the couple.
- Raise difficult issues that couple may need to address.
- Ease tension and diffuse blame where necessary

Figure 1 Counselling Framework



The six steps are described in more depth below. These do not represent all the tasks required for counseling and the sequence of steps may vary.

Refer to Annexure for Job Aid for Key Steps in Counseling

Prepare

- Ensure the area where counseling occurs maintains auditory and visual privacy.

- Ensure the area is clean and comfortable with adequate seating.
- Ensure appropriate visual aids are available (refer to Annexure).
- Ensure the necessary documentation is available, including written consent forms.
- Review client records, if available, to establish the reason for client's visit and what type of counseling is required.

Rapport

- Greet client and explain what will happen in the consultation and the need to discuss sensitive issues, assure confidentiality.
- Encourage client to talk about themselves and ask them the reason for their visit.
- Determine client's educational or language level that will be best understood by client, adapt
- communication skills to client's needs and use translators if necessary.

Explore

Explore Client's Reproductive Health Needs and Lifestyle Preferences

- Ask about previous experience of reproductive health services, including her/his satisfaction with them, and their interest in continuing or changing a service.
- Ask client about current family size, pregnancy status, previous miscarriages and abortions, and
- their desire to have children.
- Ask about sexual activity and symptoms/history of Sexually Transmitted Infections (STI) and HIV
- to assess client's risk.
- Ask about how side effects and methods of use fit into their lifestyle, relationships (partners,
- family members,) and whether their needs are / should be taken into account.
- Ask about general health and any medications.
- Discuss client's service preference(s).

Information Giving

- Keeping client preference(s) in mind, inform client of all available options highlighting the advantages and disadvantages.
- Promote dual protection and give client information about STI and HIV testing.
- Assist client to eliminate methods/procedures that either do not meet their lifestyle needs or they are not medically eligible for.
- Use visual aids to help explain SRH options e.g. MSS Family Planning Flip Chart, penile models and examples of contraceptive methods.
- Ask clients if they need any further explanation or if they have any questions.

Decide

- Encourage client to make comparisons between method/procedures to assist them with weighing up the advantages, disadvantages and consequence of each option.
- Support client to make their own decisions by asking them what their preferred method/
- procedure would be and whether it is necessary to be referred for STI/HIV testing.
- Establish whether client's decisions are voluntary and that they are not being influenced by a
- person, concern or belief that would stop them from choosing the service they want.

Implement

- Give client any further information about their chosen service e.g. obtaining the method, correct
- use and any procedural information.
- Make necessary referrals for other SRH services e.g. STI or HIV testing, cervical screening.
- Explain it is necessary to obtain informed consent before the service can be carried out, and clearly explain and agree the next steps
- Give client the opportunity to ask any more questions

As per National Standards of Pakistan 2017 one of the approach is **GATHER** Approach which has six elements.

- **G** = GREET the client in a friendly and polite manner.
- **A**= ASK and assess the client's knowledge, needs, and feelings. Remove any doubts/concerns the client has and listen actively following MEC Wheel.
- **T**= TELL the client about all available FP methods with the help of samples, flip charts, leaflets, and brochures.
- **H**= HELP the client choose a method. A particular method may not be suitable for a particular client. Explain this clearly and help the client choose another method. If this method is not available, help by referring the person to a relevant facility.
- **E**= EXPLAIN the use of the chosen method. This would include how it should be used, its effectiveness, advantages and limitations, possible side effects, warning signs, and follow-up regime. To ensure that the client has understood, ask the client to repeat the information given. The client must also be informed of the warning signs for which return to the facility is important.
- **R**= RETURN/ REASSURANCE for follow-up. At the follow-up visit, inquire if the client is still using the method. If the answer is “yes”, ask if there are any problems or side effects; also confirm that the method is being correctly used. Give appropriate advice about any minor side effects and refer for treatment if side effects are severe.

SAHR

SAHR model of client empowerment through information exchange is another approach for counseling, develop and tested by Population Council in Pakistan.
The Acronym SAHR stands for:
S..... Salutation (treat the client with dignity)
A ..... Assess the client’s RH needs holistically
H ..... Help negotiate a solution to the client’s RH needs
R ..... Reassure the client, provide on when to return and information on referral

Explore client future RH related plan, current situation and past experiences:

Assessing the reproductive intentions is the key step in counseling. Try to understand the current situation. Learn how the clients feel/respond. Find out what clients already knows about FP. If client is already using some method than ask about his or her experiences about method. Try to identify the areas of misunderstanding

Focus your discussion on methods of interest to the client
Assess the FP needs of clients and it allow the counselor to tailor the session according to specific needs of the clients and Help the client to reach a decision. This can save time both for counselor and the client.

During the step of ask try to ask open ended questions with probing questions. Open ended questions help to learn about client's feelings, thoughts, knowledge and beliefs. Counselor should actively listen to the client. Counselor should be attentive, alert and encouraging with the clients.
Talking about sensitive FP/RH issues is not possible without practice combined with knowledge. When the counselor is able to talk sensibly on sensitive issues, then the clients are likely to share required information.

Examples of Tasks Conducted Under Ask Step
Ask
- Ask client about her/his needs.
- Write down the client's: age, marital status, number of previous pregnancies and births, number of living children, basic medical history and previous use of family planning methods, history and risk for STDs.
- Assess what the client knows about family planning methods.
- Ask the client if there is a particular method s/he is interested in.
- Discuss any client concerns about risks vs. benefits of modern methods (dispel rumors and misconceptions).

Tell the client
The counselor responds to the client's needs, concerns and situation. The counselor gives the information that helps the client to reach a decision and make an informed choice. To tell about FP methods, it is essential for counselor to have basic information about female and male reproductive system's anatomy and physiology. In order to respond the client's need, concerns, the counselor tells the clients the information that helps them to reach a decision and make an informed choice. Counselor should make information tailored and personalized.

Tailored information helps the client to make a specific decision. During ask step counselor assess the client needs than in tell step give specific information that are according to the client's need and helps her/him in decision making.
Personalized information is to put information in term of client's own situation. This information helps to understand what the information means to them personally. Counselor should skip irrelevant information because irrelevant information will confuse the client New FP clients usually have a method in mind. The tell step in effective counseling about method choice starts with that method.
- Do you have a method in mind?
- What is it about this method that you like?
- Counselor tries to remove the client's misconceptions about FP.

IEC materials greatly help in telling clients about FP methods. Show different IEC materials to the trainees such as brochures, flip charts, and posters. Videos, and contraceptive samples.

- During this step tell the client about the available methods.
- Focus on methods that most interest the client, but briefly mention other available methods.
- Describe how each method works, the advantages and benefits and possible side effects and disadvantages.
- Answer client concerns and questions

Help the client / Decision making

During help step counselor and client discuss different choices, their results and how the client would feel about these results. In this way counselor will help the client to finalize one most appropriate method according to her/him needs. When client consider all options and decide for a method then ask few more questions. Theses question will help to confirm the client as well as counselor about the decision. The question makes clear that the decision is made by the client

By answering, client makes commitment to carry out the decision or else recognizes that client is not ready to decide. The client answers tell the health care provider what the clients wants, so there is no need to guess or assume. If client answer is not clear more questions should be asked to be sure the counselor should reflect back the client's decision. Then the client can agree or disagree.

Explain the client about chosen method:
In this step explain the client about the chosen method of FP. This includes?

- What are the advantages and limitations?
- How to use the method?
- Possible side effects and warning signs?
- What to do in case of side effects or warning signs?
- Ensure that the client understand instructions?
- Give IEC material?

Return visits

Client should be asked to return to their counselor for follow up. At the same time client should not be made to come back when not necessary. Healthcare provider should give client plenty of supplies and should not schedule un-needed follow up.

All follow up clients need attention as much as the new clients. Return visit is the best time to ask if the client is satisfied with her/his choice of method. Key words for return visits are

Please come back any time, for any reason, or I hope to see you again

- At the follow-up or return visit ask the client if s/he is still using the method.
- If the answer is yes, ask her/him if s/he is experiencing any problems or side effects and answer her/his questions, solve any problems, if possible.
- If the answer is no, ask why s/he stopped using the method and counsel her/him to see if s/he would like to try another method or re-try the same method again.
- Make sure s/he is using the method correctly (ask her/him how s/he is using it).

Counselor's Kit

- Diagrams of Male and Female Reproductive Systems
- Samples of all available contraceptive methods
- A Checklist of the minimum information that all clients should receive - A Leaflet on common questions and answers about Islam & FP.
- A List of referral outlets
- A List of contra-indications for all methods

Activity: Role Play to demonstrate principle of effective counseling in family planning

Role Play 1

A woman aged 26 years has 3 children; a boy aged 4 years and two girl's age 2 years and 4 months. She has come for contraception for the first time. She has come with her husband who has some reservations about the use of contraceptives.

Role Play 2

A woman age 24 years whose father and elder sister aged 30 years are known hypertensives. She has two school going children. She doesn't want another child for three years.

Role Play 3

A young woman of 19 years has come at six weeks postpartum. She is not breast feeding her baby girl. She wants to wait two years for her next pregnancy. She is accompanied by her mother-in-law who feels contraception will make her daughter-in law infertile.

1. Discuss demonstration role play on "good counseling" (10 min)

Ask:

- What was different this time?
- How do you think the client felt?
- What were the characteristics of the counseling you saw demonstrated here?
- In your experience counseling clients, what makes work well?

Listen to responses from many participants.
Then **summarize** the responses.

Then **show** the possible responses on these **slides, pointing out** how they are similar to or different from the responses given by participants.

Tips for good counseling

- Use a mix of closed, open-ended and probing questions as appropriate.
- Ask follow-up questions and rephrase what the client says to make sure you have understood.
- Use language and terminology that is familiar to the client.
- Use a friendly, welcoming tone of vice
- Maintain eye contact.

Tell participants:

- We will discuss closed, open-ended and probing questions later in this session.
- Nonverbal communication and body language is very important. Nonverbal actions on the part of the client as well as the provider often give stronger messages than words. The provider should be aware of his/her nonverbal communication and be watchful for the same in clients.
- Using good questioning techniques, being an active listener, and observing nonverbal behavior are essential to effective counseling.

2. Discuss demonstration role play on "poor counseling" (5 min)

Ask:

- What did you think about this counseling scene?
- How would you feel if you were this client?
- What could be improved in the counseling in this scene? Be specific.

Listen to responses from many participants.
If participants do not mention provider's body language, tone of voice, and the type of questions she/he asked, **asks** them about these aspects of the role play.

3. Conduct demonstration role play on "good counseling" (5 min)

Then trainers **perform** a **role play** on the same situation, but this time demonstrating **good counseling skills**.

Note to trainer: This role play does go through a full counseling session with all the steps of "GATHER."

Trainer guidelines for "good counseling" role play: Situation: The same as above.
Points to demonstrate: The provider exhibits good counseling skills by:

i. Introducing him/herself
ii. Greet client in a polite way.
iii. Asking open-ended and probing questions.
iv. Checking understanding by asking follow-up questions
v. Nodding and encouraging the woman when she speaks.
vi. Letting the woman choose the method, not telling her what to use
vii. Using positive body language
viii. The provider maintains eye contact; sits down with the woman and gives her full attention; leans toward her and faces her; appears at ease

Session 4: Informed Consent:

- Define informed consent in the context of SRH service provision
- Take informed consent appropriately with consideration for youth and other vulnerable groups
- Obtain and document informed consent

Timings: This session should last approximately 30 min

Pre-training preparation: Session 11 slides. Ensure trainees have a *Guidelines for*

Discuss: READ OUT THE SESSION OBJECTIVES. Ask volunteers to define what we mean by

"informed consent" (5m)

Present:

- Define informed consent
- Informed Consent Process Diagram
- Eligibility of informed consent
- Documenting verbal consent
- Key points for written consent
- Documenting informed consent

Activity 1: Is she able to give informed consent?

Inform trainees that they will see a set of 4 images and scenarios of young women. Highlight that in this activity each of the young women live in countries where there are no third- party involvement laws so, the provider can determine whether the young woman has capacity to make a decision about their SRH needs. Then ask trainees to pair up with the person next to them to discuss the following questions:

- Which of the women were considered to have capacity? How did you come to that conclusion?
- How did it feel to decide if each young woman had capacity or not? Did anything surprise you about the process of assessing her capacity? Was anything difficult?
- How do we determine whether a young woman has capacity to consent for an abortion/FP method?
- How do we evaluate her ability to understand the procedure, risks and alternatives?
- How might our evaluation impact her sexual and reproductive rights?

Give them 10 minutes to discuss their responses. Then ask the pairs to share their answers and views with the wider group (10ml)

Activity 2: Assessing young people for capacity to consent

Divide trainees into 4 groups and refer them to Appendix 4 of the guidelines: job aid for assessing a

young person for informed consent. Allocate each group one of the key questions from the job aid for assessing young people: Then within their groups ask them to consider their questions and discuss

whether it is necessary to use different words or phrases that young people would relate to when exploring these issues with them.

- Does the young person understand the advice and information you have given and the reason for the service/product?
- Have you done all you can to encourage the young person to inform parents or guardians?
- Is the young person likely to begin or continue having sex without SRH treatment or remain in a risky environment?
- Is it in the young person's best interests to give SRH advice or treatment without consent of parent/adult?

After 10 minutes, ask each group to share their thoughts and ideas for how to better communicate these issues to young people. Finally, highlight the value of using the client's own words to help them understand and make them feel comfortable when discussing personal issues. (20m)

Activity 3: Written Consent Forms

Divide the participants into small groups and give them a copy of the relevant consent forms, which can be found in *Training Resource 7: Sample Consent Forms*. Ask them to review the written consent forms to check that:

- The nature of the procedure/treatment, benefits, associate risks and complications and alternative options are clearly outlined
- There is a space for the client, provider and witness to sign if applicable
- They are client friendly and avoid complicated terminology.

Decision Making and Informed Consent.

Clients have a fundamental legal and ethical right to determine what treatment they taken from healthcare. Once the client has received effective counseling, they should be able to make a informed decision, enabling them to give their informed consent. Informed consent means that clients:

Have received sufficient information: about the nature of condition, procedure, associated risks, side effects (for FP methods), benefits and alternative options available.

Have ability to make decisions: through weighing up the information in light of the discussions she/he has had with the provider on each option. At the time of making decisions and giving informed consent, client must not be under the influence of drugs or alcohol.

Are not acting under threat: consent cannot be obtained by means of special inducement, force, fraud, deceit, pressure, bias or other forms of coercion. The client must provide consent him/herself (NB: In contexts where partners or family members are legally able to consent for another, the client must also provide consent).

Verbal Versus Written Consent

For all types of examinations, procedures and treatments, it is essential that verbal consent is obtained prior to interventions being carried out. It is also a good practice to document any relevant information from counselling sessions.

Written Consent:
Written consent must be obtained for All surgical and LARC procedures as follows:
- Tubal Ligation.
- Vasectomies.
- Cesarean Section. require written consent
- Intrauterine Device.
- Implant.

Informed consent is a process of counseling in which signing of the form is the final step before the procedure. Having a client sign a written consent form without counseling is unacceptable.

Written consent forms should:
- Clearly document the nature of procedure/treatment, benefits, associated risks and complications, and alternative options available.
- Indicate client's agreement to treatment by providing a space for client, provider and witness to sign.

Key points to remember for written informed consent:
Be client friendly and avoid complicated terminology while taking informed consent
Written consent can be obtained on a same or different day of the procedure.
Any changes to a form made after it has been signed by the client should be initialed and dated by both client and service provider.
Clients can change their mind at any time without any consequences, and they can still receive other FP services or have procedure/treatment later.

Retention of informed consent:
Written consent forms provide evidence that the informed-consent process has occurred, therefore, they should be filed in the client's records and stored securely for three years.

Factors Influencing Client's Decision Making and Informed consent:
It is important to consider the context in which SRH services are provided and different types of clients, as different population groups will have different needs. Consideration for vulnerable groups is required as there could be barriers for obtaining consent, such as difficulties understanding the information provided. Examples of vulnerable groups include:
People with disabilities, inclusive of clients with long-term physical, mental, intellectual or sensory impairments and clients with mental-health illnesses.
Members of oppressed minority groups, refugees, victims of gender-based violence, people living with HIV and sex workers (this list is not exhaustive).

Key Points for Young People and Informed Consent:
- Young people, including adolescents and young unmarried women, should be able to make their own SRH Choices.
- Support clients in expressing their views and concerns, rather than simply guiding them to a procedure or treatment with which the parent/caretaker or the provider feels most comfortable with.
- Young clients should be encouraged to involve a parent/adult in their SRH decisions and, where necessary, service providers should advocate on behalf of the young person.

- In some situations, it may be in the best interest of the young person to obtain SRH services without parental consent. Consider whether the young person will be putting themselves at risk of pregnancy, acquiring an STI/HIV or being subject to abuse or violence without providing the SRH service.

Assess client's understanding of what is being provided or suggested and the reason for this, ask them to explain this to you.

Young clients are more vulnerable to abuse; therefore, service providers should be aware of any signs of abuse and report in accordance to local procedures.

Module 4

High-Quality Safe Uterine Evacuation / Post-Abortion Care

Introduction to the Guide

Welcome to the Post Abortion Care (PAC) Trainers Guide. This guide offers a format for training that includes theoretical knowledge and mock drill on model/ client learning. This course should ideally be run with a Trainer to Participant ratio of 1 trainer to 4 participants.

The course covers

Surgical Post Abortion Care (S-PAC 6 -14 weeks)
Medical Post Abortion Care (M-PAC 5-9 weeks)
Karachi declaration
Components of PAC

Assessment

This is an assessed, competency-based training course. Participants will be assessed on their:
Theoretical knowledge of PAC
Ability to administer S-PAC AND M-PAC through mock drill on pelvic model/ client

Theoretical knowledge will be assessed by a written test during the classroom-based sessions. This test has a pass mark of 75%.

Trainee ability to administer S-PAC and M-PAC safely and effectively will be checked during classroom-based demonstration and then formally assessed by a trainer or supervisor during site-based practical sessions. Formal assessment should be carried out through observation using the appropriate competency assessment checklist to ensure objectivity.

Trainees undergoing formal assessment of their clinical skills will achieve one of three outcomes relating to their competency as a PAC provider:
Level 1: Competent to offer service subject to regular re-assessment

Level 2: Competent to offer service only under direct supervision

Level 3: Not safe to offer service

On completion of this training all course trainees will be given a certificate of attendance and a completed assessment checklist to discuss with their clinical supervisor.

Competency framework for providers of PAC under 14 weeks

The framework below outlines the competencies that a provider must have to carry out PAC services up to 14 weeks gestation safely and effectively. It also indicates whether each competency is covered (C), not covered (N) or revised (R) by this training module.

Assessment and initial management	
Ability to take a complete medical history and to estimate gestational age	C
Ability to carry out bimanual pelvic and speculum examinations	C
Ability to carry out a pregnancy test if indicated	N
Ability to assess for sexually transmitted diseases and treat syndromically as indicated	N
Knowledge of all contraindications to medical and surgical abortion	C
Knowledge of local referral mechanisms for testing and/or treatment where required	C
Knowledge of local regulatory restrictions and requirements for SAC	N
Client counselling and information provision	
Comprehensive knowledge of all SAC management options available, including post abortion family planning, and ability to present them in a language the client understands	C
Informed consent	
Ability to assess client's capacity to understand, retain, and use information provided to make informed decisions	N
Medical abortion	
Ability to select correct regimen for chosen/available method of medical abortion	C
Ability to administer appropriate analgesia, prophylactic antibiotics and Rhesus Anti-D if indicated	N
Ability to monitor and manage clients for pain, bleeding and vital signs	C
Ability to assess completeness of abortion	C
Cervical preparation	
Competent cervical preparation using accepted medical or physical preparation methods	C
Ability to assess condition/state of cervix (ripeness)	C
Paracervical block	
Competent technique for anaesthetisation of cervix with lignocaine	C
Manual Vacuum Aspiration	
Ability to administer appropriate analgesia and prophylactic antibiotics	N
Ability to monitor and manage clients for pain, bleeding and vital signs	C
Ability to accurately assess uterine depth	C
Competent technique for evacuation of uterus using Manual Vacuum Aspiration	C
Ability to assess completeness of abortion	C
Post procedure care	
Ability to recognise and manage complications and side effects arising from the above	C
Ability to administer appropriate family planning methods	N
Client discharge	
Ability to make discharge decision based on assessment of pain, bleeding and vital signs	C
Ability to provide accurate discharge instructions including contact numbers for follow up	C

Linking to Continuous Supportive Supervision

Regular re-assessment of competencies is required to ensure that lessons learnt persist outside the training room. This is particularly important for trainees classed as either 'Competent to offer service only under direct supervision' or 'Not safe to offer service'. It is vital that clear links are made between this training course and the clinical supervision offered to the trainee in their workplace to ensure on-going professional development.

Trainers should use their discretion to provide participants with opportunities to succeed to the best of their ability, including scheduling extra sessions and repeat tests/skills assessments as time allows.

Objectives of session

By the end of this assessed course, all participants should be able to:

- Assess their level of confidence and competence in providing a comprehensive Post Abortion Care (PAC) service
- Develop an action plan for continually improving levels of confidence and competence in their places of work
- Everyone participating should also be able to:
- Demonstrate sound knowledge of standard PAC protocols, including management of complications. Assess client eligibility for PAC management options
- Demonstrate effective client counselling skills for decision making and informed consent about different PAC options, PAFP and PAC follow-up advice
- Provide M-PAC in line with local regimens
- Provide S-PAC (up to 14 weeks gestation)
- Define Karachi declaration
- Enlist components of PAC

Day	Topics	Methodology	Time required	Material require
Day 1st	• Introduction of PAC • Definition of PAC • Causes of PAC • Types of PAC • Who can provide PAC service • Procedure of PAC • Complication and management • Karachi declaration • Components of PAC	Brain storming, Question answers, PPTs, Flip chart, Activities, Video, Exercises, discussions, role play. Four stage demonstration, Scenarios,	6 hours	Flip charts, Multimedia, Markers, Pelvic model and instrument set, MVA syringe, Cannulas for mock drill. Pens, sticky notes, checklists, Hand out

Introductory Session

Overview

This session start to build trusting relationships on the course, beginning by ensuring that everyone is clear about the range of tasks to be undertaken and the resources available.

Objectives

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

- Name at least two other people
- Describe the objectives and plan for the course and how they will be assessed
- Identify specific expectations they have for the course
- Agree to a set of ground rules to encourage inclusivity, honesty and respect
- Pre-course knowledge test

Overview

This session focuses on finding out, and helping participants to find out for themselves, what they know about PAC and what knowledge gaps they have at the start of the course.

Objectives

By the end of this session participants will:

- Identify knowledge gaps and therefore their training needs
- Be familiar with the style of questions that will be used to test their knowledge on the end of the day.
- Test completion (30 min)
- Distribute the Pre-course Knowledge Test hand out (pages 15 and 15) and invite participants to complete this on their own. Remind them that, at this stage, they are testing their own knowledge as a way of identifying gaps and so guide their learning over the rest of the course.
- Emphasize that this test result will not affect their overall mark. After a 15 min break …

Marking papers (10 min)

- Ask participants to swap papers and go through the correct answers. Try to avoid discussing any queries at this stage, emphasizing the purpose of the pre-course test as a self-assessment tool.
- Identifying specific needs (10 min)
- In pairs (or tutor groups) ask participants to discuss and make a note of any specific questions or knowledge gaps / needs which they have identified.

Group discussion (15 min)

Introduction:

WHO defines unsafe abortion as a procedure for termination of a pregnancy done by an individual who does not have the necessary skills or in an environment not conforming to minimal medical standards or both? According to a recent study by WHO and the Guttmacher Institute, 25.1 million unsafe abortions (45.1% of all abortions) occurred every year between 2010 and 2014 worldwide and majority of the unsafe abortions (97%) occurred in developing countries in Africa, Asia and Latin America. The proportion of unsafe abortions was significantly higher in developing countries than developed countries (49·5% vs 12·5%). When grouped by the legal status of abortion, the proportion of unsafe abortions was significantly higher in countries with highly restrictive abortion laws than in those with less restrictive laws.

The deaths and disabilities due to unsafe abortion are almost entirely avoidable: contraception can greatly reduce the need for abortion, and when properly performed, abortion is extremely safe. As such, these preventable deaths represent enormous shortcomings in the delivery of essential health and contraceptive services and the failure of laws, policies, healthcare system and societies to respond to women's needs. Vulnerable women are most affected by unsafe abortion – poor rural women, women in refugee and displaced settings, women who have experienced violence, and women with low levels of education. Unsafe abortion constitutes a global public health crisis, a social injustice and a violation of women's human rights and dignity.

Effectively addressing the provision of high-quality, safe, accessible uterine evacuation care is essential to ensuring fewer maternal deaths and better reproductive health outcomes for women and girls in Pakistan. High levels of unmet need for contraception and low levels of contraceptive use put women and girls at particular risk for unintended pregnancies. Given high levels of stigma, service cost barriers and the lack of clarity in interpreting law by both women/girls and healthcare providers, many women and girls experiencing an unintended pregnancy in Pakistan resort to clandestine and unsafe abortion procedures. A national study released by the Population Council in 2013 found that an estimated 696,000 women were treated for post abortion complications in healthcare facilities across the country. The primary reason for abortion is poor socio-economic status.

Following a 1989 decision of the Pakistan Supreme Court, which held that part of the Penal Code of 1860 dealing with offences against the human body was invalid because it was repugnant to the injunctions of Islam Pakistan, the abortion law was revised. The revised law, now in conjunction with Islamic principles came into effect provisionally in 1990 and became permanent law in 1997. Abortion is legal in Pakistan for expanded indications in early pregnancy, generally accepted by Islamic legal scholars as up

to 120 days of pregnancy, when the abortion is caused in good faith to save the woman's life and to provide "necessary treatment". After 120 days of pregnancy, abortion is legal only to save a woman's life.

Clearly, serious complications and morbidity from unsafe abortion have a substantial impact on women's health, on their families, on the communities to which they belong, and on the healthcare system. Government at every level must strive to prevent unintended pregnancies and to mainstream and institutionalize safe uterine evacuation care in the health system within a supportive policy environment, so that women and girls can safely exercise their sexual and reproductive rights.

Ask question to participants what they mean by intended and unintended pregnancy

Provide flip charts to participants and facilitate them to write down their answers.

An intended pregnancy is when a child is by choice not by chance, when couple is mentally, physically and socially ready to have a baby.

An unintended pregnancy is a pregnancy that is either unwanted, such as the pregnancy occurred when no children or no more children were desired. Or the pregnancy is mistimed, such as the pregnancy occurred earlier than desired.

After brainstorming ask participants what are the causes of unintended pregnancy.

Provide flip charts to participants and facilitate them to write down their answers.

- Not being care full or unaware of family planning methods
- Unprotected intercourse
- Irregular use of family planning methods
- Intolerance to family planning methods
- Failure of family planning methods
- Not wanting any more children
- Sexual abuse
- Economic prosperity
- Family and social values

Every year approximately 210 million females get pregnant in world. 70 million 36% of them are unintended pregnancies. These unintended pregnant female want to get rid of that pregnancy. For this purpose, most of female come in contact with unsafe services. Approximately 40 million 22% of pregnancies come into end with abortion. If unintended pregnancies can be stopped, up to 33% of population rate can be controlled.

The need for PAC:

Overview

This session focuses on the political, social and medical context of providing PAC services.

Objectives
By the end of this session participants will be able to:
Advocate for a comprehensive PAC service
Describe the scale of need in their own country context
Identify cultural and personal values which may be barriers to effective PAC services.
Ask participants what are the methods for providing post abortion care and who can provide PAC service and which factors into consideration in deciding which uterine evacuation method to use.
Provide flip charts to participants and facilitate them to write down their answers
Values Clarification (15 min)
Manage a Values Clarification exercise.

Cross the Line
This activity is often used as an icebreaker to bring participants' different views on abortion to the surface and address the connection between abortion and stigma. It helps participants understand how stigma affects people's diverse views and experience with abortion, as well as broader public dialogue on abortion.

Objectives
By the end of this activity, participants will be able to:
- Articulate their feelings and views on abortion.
- Identify diverse views among participants.
- Describe how stigma affects individual and societal views and reactions to abortion.

Materials
Masking tape or string, approximately 2-3 meters long, to mark a line on the floor. If neither tape nor string is available, ask participants to pretend that there is an imaginary line across the floor.

Timeline
15 minutes

Activity
Instructions Read some of the following statements, beginning each time with, "Cross the line if … " After participants have moved, follow up each statement with, "observe who crossed the line and who did not … notice how it feels to be wherever you are … now please all move back to the same side of the line."

- Cross the line if:
- You were raised to believe that abortion should not be openly discussed
- At some point in your life, you believed abortion is wrong
- You were raised to believe that abortion is a woman's right
- You have been asked to keep someone's abortion a secret
- You have ever felt uncomfortable talking about abortion
- You have ever felt embarrassed talking about abortion

- You have ever heard a politician talking in a derogatory manner about women who have had abortions
- You have ever heard a friend or family member talk in a derogatory manner about women who have had abortions
- You or someone you are close to has had an abortion
- You have ever stiffed your feelings about an abortion experience
- You have ever avoided the topic of abortion to avoid conflict
- You have heard the term “baby killers” applied to women who have abortions or health workers who perform abortions
- At some point in your life, you believed that relief is a common reaction after abortion
- You believe there is a need for a supportive social environment for abortion
- You believe all women deserve access to safe, high-quality abortion services.

Eligibility Case Studies

Case Study 1

Bea is 30 years old, married, with two children. Her LMP was eight weeks ago and for two days she has been bleeding vaginally. She describes the bleeding as clots. She lives within ten minutes walking distance from the Centre and doesn’t want to be away from her children much longer – she has left them with her sister and her younger child is due for his next feed.

Case Study 2

Jay, dressed in school uniform, arrives anxious, and sweating, having walked for 4 hours from her village. She was sexually assaulted by a relative about two months ago but she doesn’t want anyone in the village to know. She has missed two periods but has been bleeding heavily since last week after attempting to terminate the pregnancy with the help of someone in the neighborhood. She also noticed a smelly discharge a few weeks ago.

Trainer Resource: Eligibility Case Studies Notes

Case Study 1 – Bea

- What else would you do to diagnose threatened or incomplete abortion?
- Misoprostol is an option – can be taken at home if no signs of infection
- Rule out allergy to Miso
- Rule out significant infection or treat minor infection before M-PAC / S-PAC
- Advise about not breast feeding for a few hours after administering misoprostol (discarding milk) to avoid diarrhea

Case Study 2 – Jay

- Ask if there is anyone you can contact to accompany / support her
- Treat infection symptomatically
- Advice S-PAC taking into consideration confidentiality, follow up, but also the invasive nature of the procedure
- Refer for confidential counselling and advice to child protection agency or police
- Counsel about PAFP
- Counsel about and test for HIV and other STIs and refer if appropriate

Supporting client decision making in PAC

Overview

This session focuses on the principle of enabling PAC clients to make their own decisions from the range of options available to them.

Objectives

By the end of these three linked sessions participants will be able to:

- Describe key principles in assisting clients to make informed decisions and give consent
- Demonstrate appropriate use of the REDI framework in helping clients make decisions about PAC
- Demonstrate appropriate language and contextual knowledge in supporting clients in their decision-making
- Identify, through observation and reflection, further training needs in this area.

Role Play Scenarios (20 min)

Divide participants into groups of three and allocate the roles of “Counsellor”, “PAC Client” and “observer”. Explain the REDI framework and how to use it

Divide participants into groups of three and allocate the roles of “Counsellor”, “PAC Client” and “observer”. Explain the REDI framework and how to use it (Ask the group to choose and play out one of the Role Play Scenarios on the handout with the ‘Counsellor’ using everything they have learned so far to give client-centered information to support the client’s decision making.

Keep time – 5 min for the role play, followed by another 5 min for feedback, starting with:

Reflections from the “Counsellor” first

Followed by feedback from the "PAC Client"
And, finally, feedback from "Observer" based upon their notes on the Observation Sheet.

After each counselling and feedback session, ask participants to switch roles so that everyone has the opportunity to provide client counselling.
Summing up and Log sheet notes (5 min)
Summarize the main points emerging from the session.

Trainer Resource: REDI framework

The **REDI framework** uses four key words to remind providers / counsellors of best practice in client counselling:

Rapport – It is important to develop an easy rapport with the client so that they are relaxed and confident in you as a provider/counsellor. There are different ways to develop rapport, for example to ask them how far they have come, or what would they be doing if they weren't here.

Explore – A provider/counsellor should explore with the client their personal circumstances and their preferences for any potential healthcare intervention. This involves finding out what the client already knows (if anything) and tailoring the comprehensive information you provide to suit the client's experience, understanding and particular needs.

Decide – The provider/counsellor should guide the client to make their own decision about a healthcare intervention. This will involve ensuring that the client fully understands the options open to them, the differences between them and the consequences of each to them and their family. Clients should be encouraged to ask as many questions as needed.

Implement – The provider/counsellor should only go ahead with a healthcare intervention once they have checked that the client has fully understood the information provided, made an informed decision and given consent. This can be done by asking the client to describe back to you what they think is going to happen during the chosen service.

Role Play Scenario
Maria is 35 years old who is accompanied by her husband to the MS Centre with a history of vaginal bleeding after amenorrhoea for nearly 3 months. When she got a positive pregnancy test result about a month ago, she was hopeful about having a second child – she has been pregnant 3 times before but was "forced" to have a termination the first time she got pregnant and believes that the other two miscarriages she has had since her daughter was born are punishment for this decision years before. On examination, there is slight bleeding from the cervical os but this is not open.

When her husband leaves the room for a moment, she confides in you that he knows nothing about her earlier termination which happened before she was married.

When her husband comes back, he says he wants something "active" to be done.

Trainer Resource: Role Play Scenario

- A wait-and-see expectant management approach might be possible.
- How can her anxiety be acknowledged and lowered?
- At what point might an active PAC option be required / suggested?
- How does the counsellor acknowledge her beliefs whilst challenging any link between her past choices and her chances of having another child?
- How does the counsellor maintain confidentiality for the client without alienating the husband?

Characteristics of effective learning groups

- Participants are an important resource for each other's learning. Forming small groups helps participants to share experience through focussed discussion. Learning groups work if:
- Members of the group share a common purpose
- They think of themselves as a group and share a common experience in taking part in the course
- They enjoy the process and feel engaged and stimulated by what they are asked to do and consider
- Each participant's contributions are valued and respected
- An open and trusting atmosphere develops
- Group members pay attention to how they work together.

Ideas for Quick Review: Hand-out

We learn best by being active and applying learning to our own experience and by applying it practically so try to plan the review session in a way that engages your peers actively in doing something – physically, through words or images or combinations of these.

Remember that you will have just 5 to 10 min for the Quick Review so don't try to cover everything, just a memorable selection of key points, and keep it active and energetic!

Revisiting learning at the end of the day and again at the beginning of the next day is a good way of reinforcing learning points. At the end of the day, ask trainees simply to share one thing that stuck out for them to help them review the day's content and embed new knowledge. Then ask an individual, or small group of individuals, to invent a short game for their colleagues to play before the start of the next day's training that will revise what was learned the day before. Suggest doing something that will engage the other trainees actively to increase the blood flow and wake them up, for example throwing a ball and asking whoever catches it to ask a question about yesterday's sessions.

4 stage method:

(Timing: dependent on skill being demonstrated. Purpose: To teach clinical skills through demonstration and commentary)

1. Real time demonstration of skill by trainer **–**
   Trainer demonstrates procedure in real time with no commentary or questions to allow trainees see what they are expected to learn. Trainees observe with reference to clinical guidelines

2. Real time demonstration of skill by trainer with trainer commentary –

Trainer demonstrates procedure in real time with commentary to break it down into individual components. Trainee questions to be answered after this stage.

3. **R**eal time demonstration of skill with trainee commentary –
   Trainer demonstrates procedure in real time with commentary from volunteer trainee to allow trainees to reflect on what they would be doing. Any errors made by the trainee in providing the commentary should be corrected immediately. Stage may be repeated with other volunteers if time allows.

4. Real time demonstration of skill by trainee with trainee commentary –
   Volunteer trainee demonstrates procedure with own commentary. Trainer observes and listens, making immediate corrections when necessary. All trainees to perform this stage during on-going skills practice.

Surgical PAC (PAC-S):

Overview
This session focuses on the standard protocol for using Manual Vacuum Aspiration (MVA) within the context of a comprehensive PAC service.

Objectives
By the end of this session participants will be able to:
- Describe the MVA
- Describe the key steps of MVA
- And demonstrate how to put together the MVA syringe.

Trainer Notes:

Presentation with reference to relevant section of PAC (20 min)
Use PowerPoint slides to highlight the key points of PAC
Equipment handling (10 min)
Demonstrate assembly and disassembly of the MVA sets and name each part. Then, in small groups (possibly Tutor Groups) have participants handle the MVA equipment and become familiar with how to properly assemble the MVA syringe. Make sure that everyone can do this as well as name the function of each piece of equipment on the tray.
- Summing up and Log sheet notes (5 min)
- Summarize the main points emerging from the session.
- Uterine Evacuation Care Methods

WHO-recommended methods to be used for uterine evacuation care are vacuum aspiration (electric or manual) and medical methods (mifepristone followed by misoprostol or misoprostol only where mifepristone is not available).

1. Healthcare providers need to take the following factors into consideration in deciding which uterine evacuation method to use:

a. Women and girls' personal preferences
b. clinical condition
c. uterine size/gestational age
d. availability of equipment, supplies and skilled staff, and
e. currently available scientific and medical evidence.
2. Sharp curettage is not recommended because it is less safe than other methods.
3. The use of medical methods of uterine evacuation requires the back-up of vacuum aspiration either on-site or through referral to another healthcare facility in case of failed or incomplete abortion.
4. Providers should explain the difference between all available options and help the woman/girl explore which option is best for her.
5. Providers should discuss the possible benefits, risks and what to expect with each method.

Healthcare Providers

Uterine evacuation care can be safely provided by any properly trained health care provider, including doctors and a range of non-physician and midlevel providers such as Midwives, Nurse-Midwives, Lady Health Visitors and Community Midwives, who are trained to provide basic clinical procedures related to reproductive health, including bimanual pelvic examination to determine the age of pregnancy and positioning of the uterus, uterine sounding and other trans- cervical procedures.

Provider Skills and Performance

Healthcare workers must be trained, technically competent and use appropriate clinical technologies in order to provide high-quality medical and MVA uterine evacuation care.
Uterine evacuation care training programs (both pre-and in-service) must be competency based which may require a wide range of number of cases for different trainees and conducted in facilities that have sufficient patient flow to provide all trainees with the requisite supervised practice, including practice in managing abortion complications. Sites with low case flow may avail other facilities for clinical practice to ensure adequate practice for trainees.

1. Training programs should use a variety of teaching methodologies and should address both technical and clinical skills. All staff should receive periodic updating in these skills.

2. Training should address healthcare provider's attitudes and beliefs about sexual and reproductive health, including abortion, safeguarding privacy and confidentiality, treating all women and girls with dignity and respect, and attending the special needs of the rape survivors and those who may be vulnerable for other health or socioeconomic reasons.

3. In addition to skills training, participating in values clarification exercises can help providers differentiate their own personal beliefs and attitudes from the needs of women and girls seeking uterine evacuation care.

4. Training curricula may vary in content, as well as length of training depending on the skills the healthcare provider has on entry into the training program.

5. Trained providers need support following training to put skills into practice and need to work in an environment that ensures adequate drugs, equipment, infrastructure, remuneration and professional development to support the provision of safe uterine evacuation care services.

The service system must ensure that trained providers receive supportive and facilitative supervision and oversight along with commodities and supplies to ensure that service delivery meets norms and standards, satisfies clients' needs and respects their rights. An important tool for supervision can be a checklist of items that supervisors are to monitor regularly.

Where certification of uterine evacuation care providers (such as CMWs) is required, the purpose must be to ensure that providers are clinically competent for safe provision of care.

Certification and licensing requirements must not be used to exclude categories of health professionals, or impose excessive requirements for sophisticated equipment, infrastructure or staff that are not essential to the provision of safe uterine evacuation care and would unnecessarily restrict access.

Healthcare Levels

Properly trained community-based healthcare providers (including skilled birth attendants and all midlevel cadres) play an important role in helping women and girls avoid unintended pregnancy by providing contraceptive information, counselling and methods, and informing, women, girls and men about the risks of unsafe abortion. They can also provide women and girls with misoprostol for uterine evacuation care and inform them about how to use the medications, what to expect and when to seek additional care. They also inform them about how and where to obtain safe vacuum aspiration; and can refer women and girls with complications from unsafe abortion to emergency care.

Community level support by Lady Health Workers (LHWs) is very important. LHWs have a key role in providing counselling in safe uterine evacuation/post abortion care and family planning services, and making referrals to the health facilities when required.

Both vacuum aspiration and medical methods may be considered at the primary-care level, but where capacity to provide high-quality uterine evacuation care services does not exist, referral to services at higher levels is essential.

District hospitals should offer all primary-care level uterine evacuation care services on an outpatient basis and be equipped and prepared to manage the complications of abortion; they should therefore be prepared to accept abortion-related referrals from healthcare facilities throughout the catchment area.

Secondary and tertiary-care level hospitals should have staff and facility capacity to perform uterine evacuation care in all circumstances permitted by law and to manage all complications of unsafe abortion.

The provision of uterine evacuation care at teaching hospitals is particularly important to ensure that relevant cadres of health professionals develop competence in safe uterine evacuation service delivery, including provision of medical methods and MVA during clinical training rotations.

Most of the supplies, equipment and infrastructure needed for uterine evacuation care are same as those needed for gynaecological care and for clinical contraception. These instruments and medications

must be routinely included in the planning, budget procurement, and distribution and management systems.

Health facility budgets must include sufficient funds for the following types of costs (equipment, medications and supplies required to provide safe uterine evacuation care; staff time;

Training programs and supervisions; infrastructure upgrades; record-keeping; monitoring and evaluation).

A well-functioning referral system must be in place for the provision of safe uterine evacuation care services. All health centres, clinics or hospital staff must be able to direct women and girls to appropriate services if they are not available on site.

1. Referral and transport arrangements among various levels of the healthcare system are necessary to ensure that:

a. women and girls who need services can obtain them in a timely manner and;

b. women and girls who need care for complications of unsafe abortion receive treatment promptly and properly.

Brainstorm the participants what are important measures to take for PAC service.

Write down answers on board.

Infection Prevention

Overview
This session focuses on the standard protocol for Infection Prevention, particularly as this applies to MVA.

Objectives
By the end of this session participants will be able to:
- Describe the key IP features of the standard PAC protocol
- And demonstrate how to decontaminate MVA equipment safely.

Trainer notes
Presentation with reference to relevant section of PAC (20 min)
Use the PowerPoint slides to highlight the key points of PAC

Decontaminating equipment (35 min)
With participants in small groups, demonstrate how to decontaminate different pieces of the MVA equipment.

All clinical and support staff that provide uterine evacuation care services must understand and apply standard precautions (also known as universal precautions) for infection prevention, for both their own protection and that of their clients. Training of the support staff in infection prevention should be made

mandatory as part of their basic training, and accordingly revision of their job description would help in ensuring the implementation.

1. Standard precautions should be applied in all situations where healthcare workers anticipate contact with blood, secretions, excretions and other body fluids, non-intact skin, and mucous membranes.
2. The support staff should also be trained in infection prevention.
3. IEC material regarding infection prevention should be displayed in the facility.
4. The essential elements of infection prevention are hand washing, use of personal protective barriers, proper handling and processing of sharp instruments and items, proper handling and processing of instruments and materials, use of aseptic technique, environmental cleanliness and proper disposal of infectious waste.
5. During surgical procedures and when handling sterile instruments, it is essential to use a no-touch technique.
6. All infectious waste should be incinerated, or at the least, secured, contained and disposed of properly.
7. Protocols must be available, displayed and implemented at all places.
8. If a healthcare worker is exposed to blood or other body fluids, follow appropriate procedures for the management of occupational exposures as indicated in hospital waste management and infection prevention guidelines being locally implemented.

Summing up and Log sheet notes (5 min)
Summarize the main points emerging from the session.

Community Linkages
Health systems will make safe uterine evacuation care available in communities where women and girls live and work.

Healthcare providers should be aware of their role in the community as role models and leaders, while working in partnership with community members to advance women and girls' health. LHWs in areas where they are appointed or working, or where the services of LHWs are utilized, should play an important role for building linkages between communities and providers. LHWs should be updated about the Referral Hospitals in the vicinity. Partnerships between health facility staff and communities play a key role in reducing maternal mortality and morbidity from unsafe abortion.

Health systems should partner closely with communities to help ensure that all women and girls with abortion-related emergencies can recognize signs and symptoms and access care in a timely manner.

Respect for Women and Girls' Informed and Voluntary Decision-Making, Autonomy, Confidentiality and Privacy

All women and girls have the right to high-quality, safe, comprehensive uterine evacuation care. Healthcare providers must provide high-quality care while protecting the human rights of their clients, including clients' rights to privacy and confidentiality, information, dignity and autonomy. High quality woman/girl-friendly care must be provided without discrimination, with special attention to equal treatment for marginalized groups such as young girls, poor women, and women with disabilities. Healthcare providers must be prepared to offer effective and compassionate interaction, communication, emotional support and, if desired, counseling that focuses on the women and girls' needs.

Healthcare providers must explain the woman/girl's condition and options to her in non-technical language and obtain her voluntary, informed consent prior to initiating care. She needs to be treated with respect and understanding and to be provided with information in a way that she can understand so that she can decide free of inducement, coercion or discrimination. In cases of shock or other life-threatening conditions, a complete clinical assessment and voluntary, informed consent may be deferred until after the woman/girl is stabilized. If a woman/girl is in extreme pain or emotional distress, counseling should be offered when she is stable and able to comprehend and communicate.
Healthcare providers must be trained to inform, counsel and treat all women and girls regarding the treatment and care options being offered.

Healthcare workers must support minors to identify what is in their best interest, including consulting parents or other trusted adults about their pregnancy, without bias, discrimination or coercion.
Confidentiality is a key principle of medical ethics and the right to privacy and must be guaranteed.

1. Healthcare providers have a duty to protect medical information against unauthorized disclosures.
2. Health service managers should ensure that facilities provide auditory and visual privacy for conversation between women/girls and providers, as well as for actual services. The woman/girl seeking treatment is entitled to counselling alone, if she desires.

Informed consent should be taken and documented.
Women and girls who are pregnant as a result of rape are in need of particularly sensitive treatment, and all levels of the health system should be able to offer appropriate care and support without requiring involvement of administrative or judicial procedures.

Conscientious Objection
Healthcare providers have a right to conscientious refusal to providing abortion, but that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women and girls, putting their health and life at risk. Where a healthcare provider refuses to provide uterine evacuation, they must refer the woman/girl to a willing and trained provider in their facility, or another

easily accessible healthcare facility. Where referral is not possible, the healthcare provider who objects must provide safe abortion to save the woman/girl's life and to prevent serious injury to her health.
All women and girls who experience complications from an unsafe abortion must be treated urgently and respectfully, as any other emergency patient, without punitive, prejudiced or biased behaviors.

Contraceptive Services
All women and girls irrespective of their age or status receiving uterine evacuation care, must be offered comprehensive contraceptive information and counseling, and if they desire, a contraceptive method, including emergency contraception must be provided before leaving the healthcare facility.

1. It is important for healthcare providers to discuss contraceptive and uterine evacuation options together because the uterine evacuation method selected has implications for whether and how certain contraceptive methods can be provided, for example: at the time of service versus at a return visit. For example, for a woman/girl who want an IUD, a vacuum aspiration procedure would allow her to have the IUD inserted immediately, ensuring that she can leave the facility with her method of choice. However, a woman/girl who choose medical abortion and desire an IUD must return to a provider to have it inserted. Those who choose an implant can have it inserted immediately, whether they have a vacuum aspiration procedure or medical abortion.

Contraceptive services support the basic human right to decide whether and when to have children. Women and girls receiving contraceptive services have the right to privacy, confidentiality and informed choice.

Healthcare providers must establish trust, strive to understand a woman/girl's contraceptive preferences and needs, and tailor the counseling session to meet those needs.
Healthcare providers must ensure women and girls know they may ovulate within 10 days after uterine evacuation care and can become pregnant if they resume sexual intercourse without a modern contraceptive method.

Providers must be knowledgeable about the range of contraceptive methods and consider each woman/girl's medical eligibility for various methods, including emergency contraception.

Clinical Assessment
Clinical assessment for uterine evacuation care must include.

Taking a client history including LMP, history of IUD usage, previous history of ectopic pregnancy, estimate the duration of pregnancy, identify contraindications to vacuum aspiration or medical methods and risk factors for complications; a general physical exam, pelvic exam, speculum and bimanual exam; and if needed collection of specimens and ordering of any lab tests.
Laboratory testing and ultrasound are not required for routine uterine evacuation care services but may be helpful if a woman/girl's pregnancy status and dating are unclear.
An assessment of the uterine size and position and gestational age must be completed before performing a uterine evacuation care procedure. In addition to estimating the duration of pregnancy,

clinical history taking should serve to identify contraindications to vacuum aspiration or medical methods and to identify risk factors for complications.

A woman/girl presenting for post abortion care should be stabilized and then clinical assessment can focus on determining abortion-related complications and eligibility for vacuum aspiration or misoprostol. It may be necessary to refer to another facility if life-threatening complications or pre-existing conditions require additional resources.

Prophylactic antibiotics are not needed for medical methods. Lack of access to prophylactic antibiotics should not be a barrier to uterine evacuation care.

Determining Gestational Age (GA)

Determine the GA of the pregnancy by using any of the methods outlined below:

- LMP – by the number of weeks from the first day of LMP to the present time if periods are regular
- Size of uterus – the size of the uterus palpated on the physical examination. This method is particularly useful for confirming the calculation of GA using the LMP method above. The table below displays the approximate dimensions for estimating gestational age
- Ultrasound Scan – can be used if gestational age cannot be accurately assessed by the above two methods and resources and trained Provider are available

Gestational age approximate size of uterus

After 4 weeks Uterus increases in size by approximately 1 centimetre Per week
6 to 8 weeks 6 to 7 centimetres diameter (“Lemon sized”)
8 to 10 weeks 7 to 9 centimetre diameter (“Orange sized”)
11 to 12 weeks 9 to 11 centimetre diameter
12 weeks Uterus at level of symphysis pubis
15 to 16 weeks Uterus at mid-way between umbilicus and symphysis Pubis
20 weeks uterine fundus at level of umbilicus
After 20 weeks Fundal height in centimeters measured from the symphysis pubis approximates the weeks of gestation

Exclude an ectopic pregnancy

Ectopic pregnancy is where the embryo develops outside the womb and occurs in approximately 1% of pregnancies. This will typically be in a fallopian tube or, less commonly, in the abdominal cavity, ovary or cervix.

Key Considerations

- Complications from an ectopic pregnancy can be life-threatening and include severe blood loss, anemia, and loss of a fallopian tube, infertility and death
- Ectopic pregnancies can be difficult to diagnose. A client with a positive pregnancy test and abdominal or pelvic tenderness should be considered to have an ectopic pregnancy until proven otherwise. Suspected ectopic pregnancies should be referred to a higher-level facility for diagnoses using an Ultrasound Scan and treatment as necessary

- The role of the Provider is to educate client about signs of ectopic pregnancy and to minimize the potential impact of an ectopic through early diagnosis and appropriate referral/treatment

Post Abortion Family Planning (PAFP)

Key Points for PAFP include:

- Immediate initiation of family planning methods following an abortion has been shown to both improve adherence and reduce risk of unintended pregnancy
- Client should be provided with comprehensive PAFP counselling and access to chosen method on the same day wherever possible
- Providing written consent is obtained prior to abortion, IUD and implant can be initiated safely at the end of successful surgical abortion
- MSL can also be performed after a successful procedure with client's consent
- In a medical abortion all hormonal Family Planning (FP) methods except the LNG-IUS can be started immediately after administration of mifepristone
- For medical abortions the IUCD can only be inserted and MSL done after confirmation of expulsion of products of conception

Ask whether trainees feel comfortable and able to offer post abortion family planning services to clients. Then facilitate a discussion on how post abortion family planning uptake can be improved at their place of work.

(10 m)

Notes for trainers: Barriers and Strategies to Increase PAFP include:

- Strong leadership from Clinical Leads are required to drive PAFP
- Ensuring PAFP supplies are available
- Time constraints to deliver effective counselling for abortion and family planning, therefore, skills required to present concise PAFP information. Focus primarily on FP methods that fit into client's lifestyle and that are the most effective. Ensure clients have access to family planning information in waiting rooms e.g. posters, leaflets and group information sessions
- Client only focused on abortion, and does not want to talk about family planning, therefore, it is important to emphasize the importance of PAFP to reduce risk of another unwanted pregnancy

PAC – S MVA practical

Overview

This session focuses on handling MVA equipment and practicing MVA using a pelvic model. It also introduces the S-PAC competency assessment checklist.

Objectives

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

Describe key steps of the MVA

- Demonstrate the early development of MVA equipment handling skills using a pelvic model
- Understand how they will be assessed in these skills later on in the course

Trainer Notes

Review of steps (10 min)

Direct participants to the section covering the step by step guide to MVA Talk through each step, clarifying words and terms.

Observed 4 Stage demonstration of MVA (using model) (10 min)

Demonstrate the MVA, using only the first three stages of the four-stage technique (the fourth stage involves the participants practicing the procedure). Inform them of the 3 stages you will follow:

1. Demonstrate in real time without commentary
2. Demonstrate again with commentary
3. demonstrate again, this time inviting a participant to provide the
4. Practical MVA skills in small groups

Give every participant the opportunity to practice MVA with commentary from another participant Split into tutor groups to save time. Ensure that each participant has the opportunity to practice and encourage fellow participants to offer constructive feedback.

Whole group discussion & introducing the competency assessment checklist (10 min)

Manage a discussion about any outstanding questions.

Repeat the assessment process and tell participants that they will be assessed demonstrating MVA on a model using the competency assessment checklists before being allowed to practice on clients in a clinical setting.

Summing up and Log sheet notes (5 min)

Summaries the main points emerging from the session. Log sheets and ask participants to make notes

Uterine Evacuation Care with Manual Vacuum Aspirator (MVA)

All women and girls who present for uterine evacuation care must be offered pain medications (e.g. non-steroidal anti-inflammatory drugs) and non-pharmacologic approaches to treat pain and provided these services without delay.

1. Providers should offer gentle, respectful care and provide appropriate information which can help women/girls stay calm and reduce anxiety.
2. Pain and discomfort during an MVA procedure can be reduced using a combination of verbal support, oral medications, Paracervical block, gentle clinical technique and calming environment.
3. Prophylactic antibiotics should be administered prior to vacuum aspiration to help reduce the risk of post-procedure infection.
4. General anesthesia is not routinely recommended for MVA.

5. Evacuated tissue must be inspected for quantity and the presence of products of conception and signs of complete evacuation or molar pregnancy.
6. If visual inspection is not conclusive, the material should be strained, immersed in water or vinegar, and viewed with light from beneath. If indicated, tissue specimen may also be sent to a pathology laboratory.

Post-procedure monitoring for at least 2 hours is conducted to ensure that the woman/girl is recovering well, to detect and manage any complications, to offer counseling and referrals and to provide the woman/girl with discharge instructions and information along with post-abortion family planning counseling.

Instrument Sets

- Quantity per set
- Sponge holding forceps. Cuscus vaginal speculum – all sizes (small, medium and large) 1
- Stopes forceps
- Stopes probe / plastic dilator (back-up)
- MVA sets: IPAS MVA plus Aspirator or Stopes syringe (Single Valve for all early first trimester
- and double valve as back-up)
- Gauze 1 pack of 5pcc
- Kidney dish for tissue/RPOCs 1
- Bowl for antiseptic solution 1
- Glass bowl, light box, and sieve for tissue inspection 1 each
- Supplies Quantity, in the procedure room
- Infection Prevention Equipment
- Clean disposable gloves 1 Pack
- Needles and syringes 1 Pack of 10ml and 5ml
- Liquid soap and chlorine solution in usual container
- Povidone Iodine solution 1 bottle of 1 liter
- Sanitary napkins/pads
- Lubricant for MVA syringe
- Drugs Quantity
- Lidocaine, 1% without adrenaline for para-cervical blocks 1 bottle of 50ml
- Misoprostol for cervical preparation 1 box
- Osmotic dilators/Luminaire tents 1 box
- Oral +/- parental analgesia 1 pack
- Antibiotics: Metronidazole caps and doxycycline tabs,
- Ceftriaxone IV
- Packs/vials
- Sedation drugs refer to pain management guidelines NA
- Emergency box as per the MEM checklist 1
- Equipment / Facility Quantity
- Minor gynecological procedure setup with proper bed and fittings suitable to put the client in dorsal lithotomy position
- Blood pressure equipment 1
- Lab set-up as per MSI Protocols +/- Ultrasound 1 Stethoscope 1

Cervical Preparation

Key Considerations

- Cervical preparation softens the cervix to enable the surgical instruments to be passed easily to reduce the risk of cervical trauma
- Cervical preparation before surgical abortions is recommended for gestation ages from 12 – 20 weeks

- Cervical preparation is not routinely recommended for pregnancies less than 12 weeks. If a client is considered to be at higher risk for abortion complications some Providers may consider cervical preparation in earlier gestations
- If client starts to bleed heavily during cervical preparation, evacuation should commence immediately

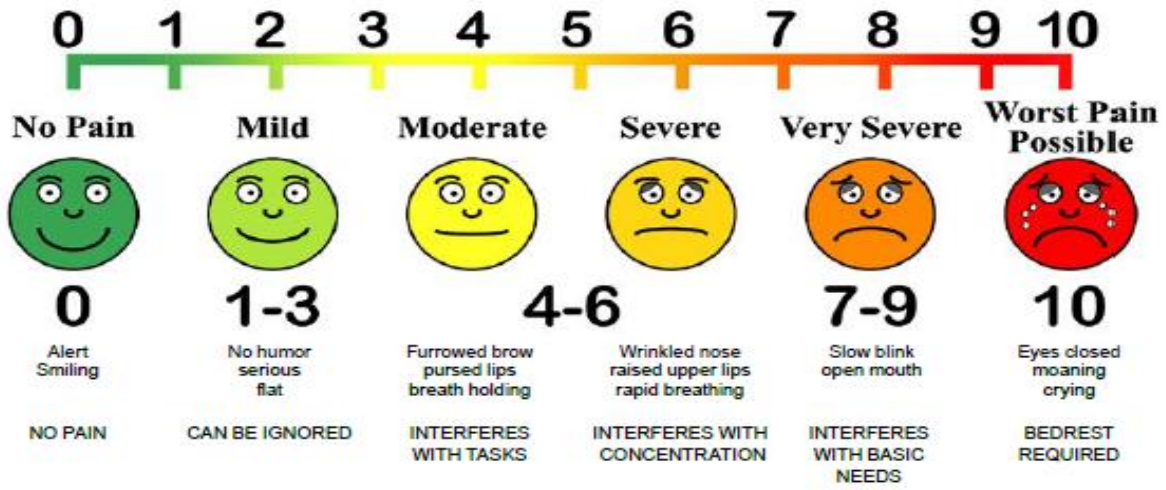
Pain Management

The foundation of all pain management is Vocal Local. All clinical and non-clinical team members need to be trained to provide this (MSI Vocal Local Source Book)

- In addition, oral analgesia should be offered to all women pre- and post-procedure, preferably an anti-inflammatory +/- paracetamol
- There are two further pain management options depending on client's gestational age, medical history, anxiety levels and available resources Local Anesthesia, Vocal Local, +/- a combination of systemic analgesia, +/- para-cervical block can be used

Key Considerations

- The level of pain experienced varies between clients, therefore it is necessary to assess individual client pain pre, during and post procedure by Wong Bakers Facial grimaces pain assessment scale and management needs
- Where possible administer local anesthesia



Paracervical Block

- Inject 1 - 2ml of local anesthetic at the cervical site where the tenaculum will be placed (either at 12 o'clock or 6 o'clock, depending on the preference of the Provider or the presentation of the cervix)
- Stabilize the cervix with the tenaculum at the anaesthetized site
- Use slight traction to move the cervix and define the transition of smooth cervical epithelium to vaginal tissue, which delineates the placements for additional injections
- Slowly inject 2 – 5ml lidocaine into a depth of 1.5 – 3cm at 2 – 4 points at the cervical/vaginal junction (2 and 10 o'clock, and/or 4 and 8 o'clock)
- Move the needle while injecting OR aspirate before injecting to avoid intravascular injection
- The maximum dose of lidocaine in a Paracervical block is 4.5mg/kg/dose or generally 200 – 300mg (approximately 20ml of 1% or 40ml of 0.5%)

Mock drill on pelvic model, divide participants into two groups, Manage 4 stage demonstration

Steps to perform MVA

- Check procedure room is clean and adequately equipped
- Check client's identification and notes (medical history, consent, and family planning options). A pre-procedure and procedure checklist can be used to ensure essential checks are carried out prior to procedure.
- Ask client to empty bladder
- Perform a bimanual examination to confirm or update findings
- Insert the vaginal speculum, visualize the cervix, and lock the speculum
- Clean the cervix with antiseptic solution twice from os to the edge of the cervix and perform Paracervical block if required

Uterine Evacuation

- Ensure that Vocal Local is established and can be maintained throughout procedure
- While holding the speculum with one hand, gently grasp the cervix with the Stopes forceps at the 12 o'clock position
- While gently pulling on the cervix, pass a size 5 cannula through the cervical os and progressively increase the cannula size until you reach the appropriate size for the gestational age

Gestation Age (weeks)	< 7	7+1- 8	8+ 9+6	12+1 – 14	
Cannula size for the corresponding GA	5	5, 6	6, 7	8, 9	10, 12

- When there is initial difficulty passing size 5 cannula, you may attempt dilating the cervical canal with an os finder
- Once you have the appropriate cannula in place, attach the charged syringe to the cannula
- Note: do not push the syringe to the cannula, but fix the syringe and pull the cannula to the syringe to avoid risk of perforation
- Reach uterine fundus with cannula and release the valve, hold the barrel and start aspiration of uterine content, withdraw slightly by rotating the MVA set 180 degrees to cover all surface of the

uterine cavity When the syringe is ¾ full, pull the cannula tip down to the internal os, close the valve, detach the syringe, open the valve and empty the contents into a strainer/kidney dish

- Repeat the three steps above until you find signs of completeness, which include: appea ance of red foam with air bubble in the syringe/cannula, a 'gritty' sound or feel and sense of gripping of the cannula by the uterus
- When you are confident the evacuation is complete, remove the cannula, clean the vaginal canal and make sure there is no major on-going bleeding Checking evacuation is complete and bleeding is controlled
- Leaving the speculum in place, undertake tissue inspection as follows:
- Empty the aspirated content into a sieve
- Wash off the blood and clots under running water
- Empty the contents onto a glass bowl with some water in it for the tissue to float
- Observe the tissue with the light bulb from beneath
- If you fail to identify gestational sac and villi, repeat the evacuation process. If there is no tissue again, suspect ectopic pregnancy or question the pregnancy
- If client has consented to IUD, insert it before removing Stopes forceps otherwise give a hormonal method or MSL at end of procedure, depending on what she wants
- Gently remove the Stopes forceps, make sure there is no on-going bleeding and place in a decontamination solution
- Gently remove the speculum; pull it out while gently closing the blades and rotating it counterclockwise to the vertical position
- Reassure the woman that the procedure is finished, help her into a comfortable position and ensure she is escorted to the recovery area
- Dispose of fetal parts, clean room and sterilize instruments
- Wash your hands with soap and water and dry with clean towel or air dry
- Document surgical notes in client records.

Post Procedure Care

By the end of this session trainees will be able to:

- Outline the stages of post procedure care and the key risks of not carrying it out
- Describe post procedure monitoring
- Provide clear discharge instructions to a PAC client and PAFP advise
- Describe common complications of PAC and what to do about them

Timings**:** This session should take approximately 1/2 hour

Pre-training preparation**:** Ensure adequate copies of relevant resources to hand out. Plan for breaks as required. Consider energizers as required.

Discuss – READ OUT THE SESSION OBJECTIVES. Then ask the group if anyone has experienced a client returning after a PAC service with signs of complication. Get them to describe what happened and how they managed the situation. (10m)

1. Outline the stages of post procedure care and highlight the key risks of not providing post procedure care
2. Describe post procedure monitoring requirements

3. Describe discharge assessment process
4. Go over the common complications of abortion and what to do about them

Discuss – Answer any questions that arise. (5m)

Exercise: Complications case studies – Divide trainees into small groups for PAC complications case studies. Assign one case to each group and ask them to agree a management plan for each case. Ask them to note how they reached their decisions on a flipchart, highlighting any important information about the client's situation or the available facilities and referral options. Then, as a group, go through each Case Study to ensure agreement and understanding. (15 m)

Discuss – Ask the group what process they should follow for reporting incidents relating to PAC service provision

Exercise: Referral protocol - A referral protocol is a set of instructions on where to refer a client for follow-up care in the case of complications. As individuals, or smaller groups of people from the same facility, if possible, get trainees to draft a referral protocol for their local situation. Once completed, ask for volunteers to share theirs with the group.

Action planning – Encourage trainees to note down:

a) what they are going to do differently as a result of what they have learned in this session
b) a plan for reviewing their referral protocol with supervisor when they get back to their place of work
c) Any aspect of post procedure care they particularly want to explore, discuss or practice further

Complications case studies – notes for trainer

Case Study 1 – Salma

- Either retention of blood in the uterus (haematomata) OR pelvic abscess.
- Conduct physical examination (abdomen, vital signs, U/S if available) to determine diagnosis
- Administer pain killers
- Administer prophylactic antibiotics
- MVA to confirm expulsion
- Administer uterotonics (oxytocin or misoprostol) to ensure uterine contraction
- Document in notes

Case Study 4 – Shazia

Incomplete abortion

- Conduct physical examination (abdomen, vital signs, U/S if available) to determine diagnosis
- Check HB
- Administer another dose of misoprostol if she is confident about managing this herself OR
- MVA to confirm expulsion
- Document in notes

Post-Procedure Monitoring

- Monitor client whilst resting in recliner for pain, bleeding and deterioration in condition
- For PAC < 14 weeks monitor and record vital signs every 30 minutes for
- One to two hours
- Provide analgesia as required

Discharge Assessment and Preparation

- Assess client's vital signs, pain, bleeding and whether client has passed urine
- Refer to other appropriate services as determined by assessment such as STI/HIV counselling, gender-based violence support services
- Provide clear oral and written instructions to the client for both medical and surgical abortions on the following:
- Sexual intercourse should only occur after bleeding stops

PAFP is advisable as soon as possible as fertility can return within two weeks. Provide or advise the client on the appropriate use of the chosen FP method and advice on dual protection to reduce STI/HIV transmission

Vaginal bleeding is normal for two weeks after medical and surgical abortions. Client may experience light bleeding or spotting following surgical abortion, heavier bleeding occurs with medical abortions and lasts for approximately nine days, advise client to use sanitary pads

Signs of complications which require client to return to centre immediately include: excessive bleeding (e.g. soaking more than two pads in an hour for two hours in a row), continuous bleeding beyond seven days, any fever beyond the first day or fever greater than 38ºC at any time, offensive vaginal discharge, significant abdominal distension, and severe pain

Routine follow up appointment is not necessary; client should be advised to contact centre with any concerns

Give client the discharge information sheet, which must include the contact details of centre (Refer to Appendix 2 for examples of client information sheet for medical abortion and surgical abortions)

- Document care given. A discharge checklist can be used to ensure that essential discharge checks are performed.

Complication of PAC: Signs and Symptoms Treatment
Main complication includes

- Uterine Atony
- RPOCs
- Uterine Perforation
- Cervical trauma
- Infection

Uterine Atony
Sign & Symptoms: Heavy vaginal bleeding. Hemodynamically unstable with rapid pulse first, then hypotension

Management: Uterine Bimanual Massage.10 IU of oxytocin or an ampoule of ergometrine IM, 5 Tablets Misoprostol /rectum (dose 1000mcg)

RPOCs
Sign & Symptoms: Uterine bleeding, pelvic pain, fever, and/or uterine tenderness.

Conservative Management: If there is no continuing pregnancy, infection, pain or severe cramping, the client can be advised to go home and return for a review in 2 – 7 days. Symptoms often resolve with the next menses
Antibiotics for 7-14 days if there are signs of pelvic inflammatory disease. MSI recommends a regime of Doxycycline 100 mg and Metronidazole 400 mg twice a day.

Surgical Evacuation of RPOCs: Re evacuation can be undertaken if it is the client's preference, or if conservative management has failed

Management of Unstable Client: If a client is unstable IV fluids should be commenced, and the client should be transferred to a higher-level facility

- Uterine Perforation (Signs & Symptoms)
- Heavy vaginal bleeding
- Abdominal pain / Shoulder pain
- Lack of fundal resistance
- Vacuum decreases suddenly

Management If Perforation Observed at the End of Procedure:
- Check vital signs hourly
- Assess abdomen every four hours
- Discharge after eight hours with oral antibiotics if the client remains stable
- Consider referral if client deteriorates, vital signs are unstable or if the abdomen becomes tender

Management If Perforation Observed During the Procedure:
- Stop further evacuation
- Treat for haemorrhage shock if necessary
- Arrange for immediate transfer to hospital for further management if client deteriorates.

Cervical trauma
Signs: Fresh Bleeding
Management: Expose laceration site using speculum repair apply pressure & haemostatic interrupted suture Fever, foul smelling purulent vaginal discharge, lower abdominal tenderness and cervical motion tenderness.

Infection
Fever, foul smelling purulent vaginal discharge, lower abdominal tenderness and cervical motion tenderness.
Management: Start broad spectrum antibiotics, followed by evacuation of the uterine content if RPOC

Post course knowledge test
By the end of this session trainees will be able to:
- Score their SAC knowledge out of 100%
- Identify any particular knowledge gaps they need to revise.

Uterine Evacuation Care with Misoprostol (5-9 weeks)

Overview
This session focuses on the use of medication regimens for PAC.

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

- Assess eligibility for M-PAC
- Describe standard M-PAC regimens
- And explain what to expect if a client chooses MA.
- Session 6: trainer notes
- Presentation with reference to relevant section of PAC (25 min)
- Use the PowerPoint slides where possible to highlight the key points of PAC
- Agree what regimens should be assumed for the Role Play scenarios.

Role Play scenarios (FAQs) (20 min)
Invite volunteers to role-play the part of a PAC provider and answer Frequently Asked Questions with a Trainer playing the part of the PAC client contemplating misoprostol as her preferred option.
After each role-play, encourage the rest of the group to give feedback and ensure that the salient points of each case have been understood, as shown in the Role

Play Scenarios (FAQs):
PAC- M Role Play Scnario :
Hand out : FAQs

- I am bleeding heavily and feel feverish – why can't I take the pills at home?
- I know my IUCD didn't work this time, but I don't want it taken out in case it happens again … Can't you leave it in?
- Thinking about allergies, I get a rash with some antibiotics, does this mean I can't have Misoprostol?
- Will it all be over before tonight?
- know I've been bleeding already, but can I wait until I get home to take the pills? The bus takes 3 hours and I don't want anything major to happen on the way …
- How much bleeding is too much?

- I'm going in for an implant next week, once this is all over - what should I do in the meantime?
- How long is it safe, when I can't become pregnant again?
- If I want to go on the pill again, can I get it today?
- Will it just be like my period?
- Do you want me to come back for a check-up?
- Will taking Misoprostol this time mean that I probably won't be able to have a baby again?

Trainer resource: Answers

- It is advised to administer in the facility because of the risks of bleeding and infection
- An IUCD should be removed before Misoprostol administration
    - Once the procedure has been confirmed as complete, another IUCD can be inserted
- An allergy to prostaglandins is the only allergy relevant
- Under normal circumstances, the bleeding may continue for two days
- Slight bleeding for up to seven days is normal with MA
- The distance from the Service Site might suggest it is better to consider MVA for incomplete abortion in case of complications
- Soaking more than 2 maxi pads for two consecutive hours
- Offer to insert implant now
- If client declines give condoms
    - Advise about "pelvic rest" and safe sex options
    - Check her implant appointment
- Depends what client's experience of periods has been
    - Bleeding may be heavy for two days
    - May be accompanied by cramping
    - Depends on the GA – tissues may be more substantial
- Depends on local protocols
    - Not necessarily unless:
    - Excessive bleeding (quality or quantity)
    - If no bleeding
    - If abdominal pain with distension or discharge (possible infection)
- Medical abortion consultation role play – notes for trainer

Case Study – Samina (eligible)

- 6 weeks GA
- Either regimen appropriate
- Admit and administer 800µg vaginal or sublingual every 3 hours for a maximum of 3 doses. Monitor for signs of expulsion (vital signs, bleeding, pain), give pain killers, advise and give PAFP as appropriate
- Ensure clear instructions for how and when to take the drugs are given along with clear instructions on what to look out for and reasons to return

Counseling includes the discussion of basic information about uterine evacuation care with misoprostol, risks and benefits, expected effects and possible side effects, the warning signs for potential complications, and when and where to seek medical help.

Preparation prior to administering misoprostol includes: counseling and obtaining informed consent; performing a client assessment, including physical, speculum and bimanual exam; ruling out ectopic pregnancy through clinical assessment; confirming that the woman/girl knows what to do, if there is an emergency; and discussing her contraceptive needs.

1. Whenever possible, women/girls should be offered a choice of taking the misoprostol at home or in the healthcare facility, as different women/girls have different needs and desires.

For some women/girls, home may be a more private place but for others, the healthcare facility may afford a greater degree of privacy.

2. It is of great importance that only those women/girls are given the medicine to use at home, who can and will return at the time of emergency e.g., heavy bleeding. The distance from the health facility, support at home, transport and support, all should be carefully evaluated.

3. Healthcare providers should provide the following things to all women and girls taking misoprostol at home:

- Misoprostol pills or a prescription for them.
- Detailed information on number of tablets to be taken.
- Details on the route of taking misoprostol.
- Give 800 µg misoprostol vaginally or sublingually ideally
- every three hours (or up to 12 hours between doses) until expulsion
- Up to three doses can be given
- Give NSAIDs for pain management as required
- If expulsion fails to happen after three doses, refer for surgical abortion
- Pain medicine, such as ibuprofen and/or mild narcotics with instructions about how to take it
- Written and pictorial information on the uterine evacuation with misoprostol process, side
- effects and the warning signs, what signs indicate that the evacuation is complete, and information for follow-up contact, if desired.

- Information on whom to contact, including a telephone number where possible, in case of questions, problems or complications, or the possibility of an unsuccessful evacuation, and where to go in the case of an emergency.
- Other optional items: sanitary pads, cotton wool, contraceptive information and supplies.
- The woman/girl should be counseled that the process may take as long as 10 days.

Thoroughly and accurately confirming the uterine size and gestational age and ruling out ectopic pregnancy is the key to safe, effective uterine evacuation care with misoprostol.

Both non-narcotic and narcotic analgesics can be used to treat pain associated with uterine evacuation with misoprostol.

Since different misoprostol products have varying quality and can degrade over time, healthcare providers should track medical abortion success rates to ensure that they are using an effective product. Misoprostol should be stored in a cool, dry place.

To ensure the adequate drug efficacy, quality of purchased misoprostol should be in line with the recommended protocols.

Discharge and Follow-up
Healthcare providers must provide clear oral and written discharge instructions.

Healthcare providers must provide emotional support, if needed and refer to other services as determined by assessment of each woman/girl's individual needs, such as STI/HIV counseling. At discharge, the family planning method being practiced by the client should be documented. If no contraceptive method is being practiced, post abortion family planning (PAFP) counseling should be provided.

Routine follow-up is not necessary but may be offered following an uncomplicated vacuum aspiration procedure, especially if no contraceptive was given. A routine follow-up visit within 7-10 days is recommended in the case of medical methods with misoprostol to assess uterine evacuation success and serve as an additional opportunity to follow-up regarding contraceptive options e.g., IUD may be inserted then.

Summarize the main points emerging from the session.

Complications
Healthcare staff must recognize and be able to treat or make the appropriate referral for complications that might occur during post abortion care, during a uterine evacuation procedure, in the recovery period or later. Complications may be presenting, procedural or pregnancy related.
Women/girls with abortion complications must be closely monitored, informed about necessary follow-up care and counseled on any medical and emotional consequences.
Adverse events should be documented, reported and analyzed so that information learned can be used to improve care and client safe

Key Risks:

- Incorrect regime of medical abortion given could increase risk of failed abortion
- • Poor post expulsion monitoring of client could lead to early signs of complication not being detected resulting in severe complication
- Risks associated with medical abortion include failure to expel products of conception, continued pregnancy (fetal abnormalities if pregnancy kept), infection, and severe bleeding

Post course knowledge test

By the end of this session trainees will be able to:

- Score their PAC knowledge out of 100%
- Identify any particular knowledge gaps they need to revise
- Collect the papers in for marking and indicate when you will return the results.

Discuss – Go through the paper as a group and ensure everyone understands the answers, shown below of this document. (10 m)

- Site-based practical sessions
- Preparing for site-based practical

By the end of this session's trainees will be able to:

- Describe ways of behaving and acting in a clinical setting that show respect to staff and clients alike
- Refer to an individual plan for completing the site-based practice they require before an initial competency assessment

Timings: This session should take approximately 1/2 hour

Present – Behaviour in a clinical training venue…

1. Highlight how MSS expects trainees to behave when completing a site-based practical
2. Outline the various rights of a client and how to protect them during a clinical training session (5ml)

Discuss – Ask the group for reasons why a client may not want to have a service done by a trainee. Write them up on a flip chart. Then do the same for reasons why a client might agree to help out by allowing a trainee to deliver their service. Facilitate a discussion to ensure that everyone understand the issues and will be sensitive to them during the site-based practice. (10 m)

Present – Clearly describe to the group where and when the site-based practicals are going to be carried out and what they need to do in preparation (e.g. plan their own transport if necessary). Ensure everyone understands and writes it down. (5m)

Then highlight how the practicals will run, i.e.:

- Clinical training will cover all client-related aspects of carrying out SAC including counselling, taking informed consent, prescribing medical abortion drugs and carrying out surgical procedures
- Clinical training starts with repeated demonstrations of the above by a trainer or supervisor until everyone is happy to proceed
- When the lead trainer judges it appropriate, trainees will be given opportunities to practice under direct supervision.
- For surgical procedures, trainees will be given opportunities to practice by increasing gestational age so as to build their confidence steadily
- When the lead trainer judges it appropriate, and trainees agree, then formal competency assessments can be carried out. (5 m)

Action planning – Encourage trainees to note down:

a) What they need to know and remember for the site-based practical session
b) Anything they particularly need to practice before being assessed. (5m)

Site-based practical

By the end of this session's trainees will be able to:

- Demonstrate ability to build rapport with SAC clients whilst enabling them to make informed choices about their SAC management plan and PAFP method
- Assess client eligibility for abortion inclusive of medical conditions and estimating Gestational Age (GA) accurately
- Provide medical abortion in line with local regimens and monitor client
- Perform surgical abortion under supervision and monitor client
- Give clear follow-up advice to PAC clients and PAFP advise
- Make accurate PAC client notes and, where necessary, complete an incident form accurately
- Complete an initial competency assessment using the appropriate checklist

Timings**:** This session should take as long as required

Read Out the Session Objectives.

Exercise: SAC skills practice followed by competency assessments –

During the site-based practice, trainers / supervisors should use the relevant competency assessment checklists and their own experience as a PAC provider to make un-biased judgements on whether a trainee demonstrates the required competencies. Additional coaching should be then provided until the trainee is confident to undergo formal assessment of their skills.

For surgical procedures, wherever possible trainees should be given opportunities to practise by increasing gestational age so as to build their confidence steadily.

In all supervised procedures, however, the trainer/supervisor must double check that:

- informed consent has been taken
- the gestational age has been correctly assessed (medical and surgical procedures)

- the uterus has been fully evacuated (surgical procedures only)
- the correct regimen has been administered (medical processes only)

Practical skills training and assessment may occur in a variety of settings. An ideal situation would be for the training team to organize a clinical skills session to follow straight after the classroom teaching. However, time constraints and the availability of clients or experienced supervisors may mean this is not always possible. In these cases, it may be necessary to extend the period of skills practice to ensure all trainees can achieve competency or assign trainees to an experienced provider that can offer 'on-the-job' training at a host facility.

During supervised practice, ask trainees to keep notes about their experiences in the relevant section of their continuous supervision record to aid learning. Towards the end of the site-based practice and formal skills assessment, make appointments with each trainee in order to provide feedback and to give them the result of their formal skills assessments using the checklist
Remember that trainees will be signed off one of the following:

Level 1: Competent to offer service subject to regular re-assessment
Level 2: Competent to offer service only under direct supervision
Level 3: Not safe to offer service

Action planning – With each individual…
a) Discuss what they are going to do differently as a result of what they have learned in this session
b) Discuss what they still need to do (if anything) to improve their knowledge, attitudes and skills in PAC provision and achieve level 1 competency.
c) Outline a detailed action plan that they can share with a named clinical supervisor when they return to their place of work.

Pre-training preparation: ensure that everyone has a blank competency assessment checklist for providers of PAC under 14 weeks, and certificate of training, to take home

Before the end of the training ensure that everyone knows:
- Their post course knowledge test score
- The results of their competency assessment
- The name of the supportive clinical supervisor who will assist them to develop and maintain PAC competencies back in their place of work

Karachi Declaration

KARACHI DECLARATION

"Commitment to improving maternal, newborn, child health and family planning in Pakistan"

October 1-2, 2009

Karachi

Karachi Declaration on Scaling Up MNCH –FP Best Practices in Pakistan

Pakistan has steadily improved maternal, newborn and child health (MNCH) and family planning (FP) services over time, with a wide infrastructure of primary, secondary and tertiary health services, induction of Lady Health Workers to provided preventive, promotive health and family planning services and addressing the gaps through National Maternal, Newborn and Child Health Program. However the progress has been limited due to absence of a holistic approach or community participation and poor use of evidence for policy.

To catalyze the national commitment and make progress towards achievement of the Millennium Development Goals (MDG) 4 & 5, a two day meeting on scaling up MNCH-FP best practices in Pakistan was held in Karachi, on October 1-2, 2009 in Karachi. This declaration stems from the said meeting.

Alarmed that:

1. 1 in 89 women will die during child birth with 60% of these details are due to preventable causes such as obstetric bleeding;
2. Out of every 1000 children born in Pakistan, 95 will not live to see their 5th birthday mainly due to pneumonia, diarrhea and malnutrition;
3. Almost 70% of infant deaths occur in first month of life largely resulting from asphxia sepsis and pre-maturity; and
4. High fertility rates continue to contribute significantly to the lives of mothers and children.

Noting that most of the deaths and diseases occur among the poor and the disadvantaged segments of population as a result of inadequate access to quality maternal, newborn and child health care and family planning services, low skilled birth attendance ,inadequate emergency obstetric and newborn care, low female literacy, poverty, malnutrition and heavy burden of communicable diseases.

Recognizing that most of the causes are preventable and manageable/treatable and effective implementation of best practices can help in saving lives of mother, newborns and children.

Realizing that inter-sectoral collaboration, participation of civil society and private sector and building partnerships are essential to meet these challenges.

Reaffirming commitment of the Government of Pakistan towards its Poverty Reduction Strategy and MDG's.

Encouraged at the efforts of the Government to own and provide effective leadership for the MNCH-PP response.

Acknowledges that access to essential maternal, newborn, child health care and family planning services is a basic human right and is the shared responsibility of the state and civil society.

Convinced that effective implementation of MNCH-FP best practices can help Pakistan to make progress towards achieving the goals.

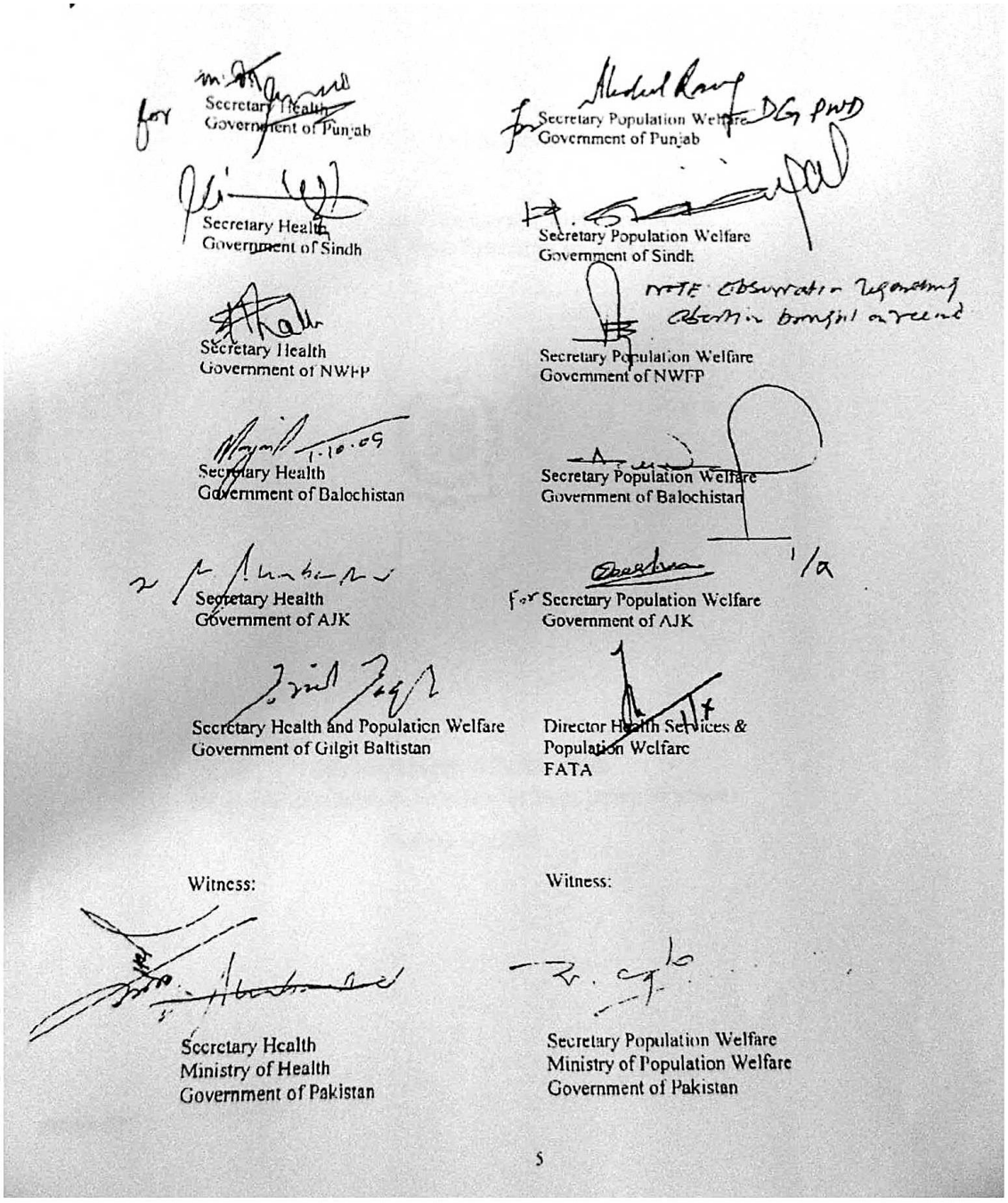
Endorses the country action plan for scaling up MNCH-FP best practices.

PLEDGES the scale up of MNCH-FP best practices in Pakistan through:

- Inclusion of the practice of Active Management of Third Stage Labor (AMTSL) in policies, guidelines, protocols and standards for health facilities at national level.
- Expanding the use of Low osmolarity ORS and Zinc supplements across the health sector for the treatment of childhood diarrhea.
- Promoting and enhancing skills of facility and community based health care providers in essential newborn care including neonatal resuscitation and management of other newborn complications.
- Building upon the progress made in the antenatal (ANC) and postnatal care (PNC), expand early PNC visits and management protocols through community and facility based health care providers.
- Expanding community case management of childhood severe pneumonia nationally, through early detection and appropriate use of oral amoxicillin.
- Ensuring availability of quality family planning services and products including emergency contraception in all public sector health facilities.
- Inclusion of the practice of Post Abortion Care in policies, guidelines, protocols and standards for health facilities at national level.

CALLS UPON

- The Ministry of Health and Ministry of Population Welfare to own, ensure resources availability for MNCH FP services and operate a robust monitoring and evaluation system for effective implementation of MNCH-FP best practices.
- The national and international partners to prioritize and support the government in the scale up of MNCH-FP best practices in Pakistan.



for Secretary Health
Government of Punjab

for Secretary Population Welfare
Government of Punjab

Secretary Health
Government of Sindh

Secretary Population Welfare
Government of Sindh

Secretary Health
Government of NWFP

Secretary Population Welfare
Government of NWFP

Secretary Health
Government of Balochistan

Secretary Population Welfare
Government of Balochistan

Secretary Health
Government of AJK

For Secretary Population Welfare
Government of AJK

Secretary Health and Population Welfare
Government of Gilgit Baltistan

Director Health Services &
Population Welfare
FATA

Witness:

Secretary Health
Ministry of Health
Government of Pakistan

Witness:

Secretary Population Welfare
Ministry of Population Welfare
Government of Pakistan

5

Components of PAC Services

Treatment of Incomplete Abortion
Use surgical methods (MVA as first-line) or medication (misoprostol as first-line) for treatment of incomplete abortion

Counselling
Identify and respond to women's emotional and physical health needs

Contraceptive services
Help women prevent an unwanted pregnancy or practice birth spacing

Reproductive and other health services
Preferably provided on-site or via referrals to other accessible facilities

Community and service provider partnerships
To prevent unwanted pregnancy and unsafe abortion, mobilize women to help receive care for complications from unsafe abortion, and ensure health services meet needs

Pre/Post -Course Knowledge Test

Name: **Date:**

True or false?

1- De-medicalization' includes making the service site as relaxing and 'client focussed' as possible

2- Routine tissue inspection to identify gestational sac and parts of the foetus is one of the key steps in MVA

3- Globally, unsafe abortion is one of the five leading causes of maternal mortality

4- Waste should be sorted as medical, general and sharps at point of origin and disposed into respectively labelled and colour coded waste-buckets

5- The Vocal Localist should put on a gown and face mask before the MVA procedure begins

6- The client's experience and quality of the PAC service can be impacted by the providers' attitude towards abortion and women who seek PAC services

7- Active listening is not part of successful counselling

8- A threatened abortion always leads to miscarriage of a pregnancy

9- The main purpose of client counselling is an opportunity for the provider to demonstrate everything they know about PAC and PAFP, in order to gain client's trust

10- A comprehensive PAC service includes services on family planning and addressing other reproductive health need.

11- An intrauterine device can be inserted after PAC using MVA, as long as there is no established uterine/pelvic infection or other contraindications

12- Clients should be advised to start a family planning method at about 4 weeks after PAC using MVA as fertility return is usually expected with the second month's menstrual cycle.

13- The correct order of processing a MVA cannula is: decontamination; cleaning; drying; HLD; rinsing, drying and storage.

14- If wrapped sterile instruments are stored for longer than 7 days, they should undergo all steps of instrument processing and re-sterilization before use.

15- Chronic PID and infertility are a potential long-term complications of septic incomplete

16- Cervical laceration can be avoided by using Stopes forceps, gentle tissue handling and use of appropriate size cannula.

17- Although it is a woman's decision to choose which PAC option is suitable for her, the provider should screen the client for her eligibility before they provide the chosen method.

18- It is important that vocal local starts at the beginning of the MVA procedure

19- Taking in-depth client history and performing a physical examination is not necessary before proceeding with the MVA procedure as most cases are straightforward

20- Counselling to assist client decision making should be carried out thoroughly and done in an empathetic and non-judgmental manner

21- Management of incomplete abortion using misoprostol is most suited for clients whose condition is unstable

22- If the client has spotting that lasts for three days following administration of misoprostol, she should contact the health facility

23- It is possible to use any method of family planning in all circumstances after PAC.

24- Vocal local is a sufficient pain control approach in most cases of PAC using MVA

25- In resource poor or inaccessible areas, expectant management is not a preferred primary option for MSI clients experiencing incomplete abortion

1 T	6 T	11 T	16 T	21 F
2 T	7 F	12 F	17 T	22 F
3 T	8 F	13 T	18 F	23 F
4 T	9 F	14 T	19 F	24 T
5 F	10 T	15 T	20 T	25 T

Learning Log Sheet

Name: ……..

Date: ……

Topics covered: ……
……..
……

Important ideas I want to remember:
……
……
……

Skills I would like to develop or feedback I have been given:
……
……
……

Specific points I would like to discuss further:
……
……
……

Specific relevance of these issues to my own work and workplace:
……
……..
……

Competency Assessment Checklist: MVA

Clinical Staff Name: _____ Designation: _____

Pre-Procedure	Yes/No/NA	Notes
1. * Reviews client information; and confirms client has been counselled on PAC and PAFP and informed consent has been documented for chosen options as per local protocols		
2. * Takes relevant detailed history		
3. **Completes clinical examination (including vital signs, general, abdominal, speculum and bimanual examinations)**		
4. * Assesses for sexually transmitted infections and treats if indicated as per WHO/national guidelines		
5. Carries out pregnancy test if required		
6. * Confirms that client is eligible for MVA (and PAFP service(s) if chosen)		
7. * Ensures necessary equipment, processed instruments and supplies are ready (including back-up instruments, MEM equipment and supplies)		
8. * Administers prophylactic antibiotics		
Procedure: MVA/ PAC S	**Yes/No/NA**	**Notes**
9. * Checks vacuum in aspirator		
10. Administers cervical preparation using recommended protocols where indicated: • Monitors client for pain, bleeding and cervical readiness • Repeats priming if necessary		
11. * Ensures client has an empty bladder		
12. Inserts and locks speculum after visualising the cervix		
13. * Cleans cervix with antiseptic solution at least twice		
14. * Grasps cervical lip with Stopes forceps and applies gentle traction to straighten the cervical canal		
15. * Dilates cervix using cannulas (dilators if needed) of increasing size to level required		

16. **Uses MVA equipment correctly - checks for vacuum, aligns valves, holds syringe by barrel, releases and closes valves at appropriate times, pushes cannula on to syringe instead of syringe on to the cannula, rotates cannula 180 degrees in each direction, empties aspirator when 3/4 full**		
17. * Uses a gentle no-touch technique at all times		
18. * Stops aspiration as soon as signs of empty uterus observed		
19. * Inspects aspirated tissue for presence and quantity of POC		
20. * Re-evacuates if tissue inspection indicates retained POC		
21. * Rules out ectopic pregnancy if indicated		
22. Inserts an IUD if requested and eligible, before removing speculum		
23. * Removes forceps and speculum, cleans local area, provides a sanitary pad		
24. Provides other PAFP (or provides referral) based on client's choice and eligibility		
25. * Identifies major bleeding, pain and trauma and manages complications promptly and appropriately (if applicable)		
Post Procedure	**Yes/No/NA**	**Notes**
26. Ensures client is helped to recovery area		
27. * Ensures vital signs and bleeding are monitored and recorded at least twice post - procedure		
28. * Assesses the need and provides pain management according to Guidelines before, during and after the procedure		
29. * Follows Infection Prevention Principles at all times		
30. Completes documentation of client records including: • History, examination findings and investigation results • Procedure details and time indicating cervical preparation, pain management, cannula/dilator sizes used, details of tissue inspection, adverse event management if any and PAFP provided • Batch number and expiry date of cervical preparation and FP medicines used with their dose, route of administration and timings		
31. Assesses if client is ready for discharge		

32. * Confirms client understands instructions, especially after care, what to expect, warning signs, and has contact details for any emergency related to the service.		

Result of Competency Assessment * Attach Competency Assessment Checklist if clinical staff is assessed as level 2/3	
Service Assessed: MVA/ PACS	**Tick as appropriate**
Level 1 • Individual completed all steps correctly. • Competent to provide this service independently subject to regular re-assessment.	
Level 2 * • Individual completed all bold steps correctly but missed one or more of the others. • Cannot provide this service independently. Must offer this service only under direct supervision of a competent clinical staff till endorsed as fully competent by the competent clinical staff.	
Level 3 * • Individual missed one or more bold steps. • Cannot provide this service. To undergo training by competent trainer on or off site.	
Other observations:	
Specify action(s) to be taken to achieve/maintain competency:	

Clinical Staff Name:	Clinical Staff Signature:
Competency Assessor Name:	Competency Assessor Signature:
Date of Assessment:	Location:

Competency Assessment Checklist: PACM

Clinical Staff Name: _____ Designation: _____

Pre-Procedure	Yes/No/NA	Notes
1. * Reviews client information; and confirms client has been counselled on PAC and PAFP and informed consent has been documented for chosen options as per local protocols		
2. * Takes relevant detailed history		
3. **Completes clinical examination (including vital signs, general, abdominal, speculum and bimanual examinations)**		
4. * Assesses for sexually transmitted infections and treats if indicated as per WHO/national guidelines		
5. Carries out pregnancy test if required		
6. * Confirms that client is eligible for chosen PACM and PAFP service(s)		
7. Administers antibiotics if indicated		
8. * Ensures back-up surgical evacuation is available		
9. * Ensures necessary equipment and supplies are ready (including for MEM)		
Procedure: PACM under 9 weeks	**Yes/No/NA**	**Notes**
10. * If gestation of client requesting PACM is < 9 weeks: • Administers first dose of mifepristone or misoprostol • Gives clear instructions on how to use subsequent doses (if applicable), what to expect, warning signs and who to contact if problems arise • If misoprostol only protocol is used for PAC, advises follow up after two weeks		

Post-Procedure	Yes/No/NA	Notes
11. * Assesses the need and provides pain management according to guidelines at all times		
12. * Follows infection prevention principles at all times		
13. Completes documentation of client records including: • History, examination and investigation results • PAC M process details with adverse event if any and details of PAFP provided • Batch number and expiry date of drugs along with their dose, route of administration and timings		
14. * Confirms client understands discharge instructions, especially after care, what to expect, warning signs, and has contact details for any emergency related to the service		

Result of Competency Assessment * Attach Competency Assessment Checklist if clinical staff is assessed as level 2/3	
Service Assessed: PAC M	**Tick as appropriate**
Level 1 • Individual completed all steps correctly. • Competent to provide this service independently subject to regular re-assessment.	
Level 2 * • Individual completed all bold steps correctly but missed one or more of the others. • Cannot provide this service independently. Must offer this service only under direct supervision of a competent clinical staff till endorsed as fully competent by the competent clinical staff.	
Level 3 * • Individual missed one or more bold steps. • Cannot provide this service. To undergo training by competent trainer on or off site.	
Other observations:	
Specify action(s) to be taken to achieve/maintain competency:	
Clinical Staff Name:	Clinical Staff Signature:
Competency Assessor Name:	Competency Assessor Signature:
Date of Assessment:	Location:

Competency Assessment Checklist: Para-Cervical Block

Clinical Staff Name: _____ Designation: _____

Procedure – Para-Cervical Block	Yes/No/NA	Notes
1. Superficially injects 1–2mls of 1% lidocaine anesthetic at the cervical site where the non-traumatic forceps will be placed		
2. Stabilizes the cervix with the non-traumatic forceps at the anaesthetized site		
3. * Aspirates and then slowly injects 2–5mls lidocaine into a depth of 1.5–3cm at 2–4 points at the cervical/vaginal junction (2 and 10 o'clock, and/or 4 and 8 o'clock)		
4. Uses correct dose of lidocaine 3 mg/kg/dose. Maximum dose 200–300mg (approximately 20ml of 1%)		
5. Inspects the injection sites for bleeding and maintains pressure with a cotton swab if needed		
6. Monitors client and waits about 2-3 minutes before starting the procedure		
7. * Follows MSI infection prevention principles at all times		

Result of Competency Assessment * Attach Competency Assessment Checklist if clinical staff is assessed as level 2	
Service Assessed: Para-Cervical Block	**Tick as appropriate**
Level 1 • Individual completed all steps correctly. • Competent to provide this service independently subject to regular re-assessment.	
Level 2 * • Individual missed one or more of the steps. • Cannot provide this service independently. Must offer this service only under direct supervision of a competent clinical staff till endorsed as fully competent by the competent clinical staff.	
Other observations:	
Specify action(s) to be taken to achieve/maintain competency:	
Clinical Staff Name:	Clinical Staff Signature:
Competency Assessor Name:	Competency Assessor Signature:
Date of Assessment:	Location:

Module 5

Post Abortion Family Planning

Family planning allows individuals and couples to anticipate and attain their desired no of children and spacing and timing of their births. It is achieved through use of contraceptive methods after post abortion care and the treatment of involuntary infertility.

This session focuses on enabling clients to choose Post Abortion Family Planning method appropriate to their needs and what to look out for after they leave the service site.

Objectives:

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

- Describe the range of PAFP methods available to PAC clients
- Discuss special issues that relate to PAFP
- Discuss common concerns about PAFP methods
- Give appropriate discharge information to PAC clients.

Post abortion family planning - PAFP is the initiation and use of contraceptive methods as soon as possible after PAC. The objective is to prevent an unintended pregnancy in women who do not want to get pregnant again.
PAFP should be started before fertility returns, which can be as early as two weeks after PAC.
Women should be advised of the greater effectiveness and duration of Long Acting Reversible Contraceptive methods (implants and IUDs) and of their safety. Healthcare staff should dispel any myths they may have about these methods.

Immediately after surgical PAC is an optimal time for insertion of an IUD, if there are no contra-indications such as infection. Contraceptive implants can be provided on the day of PAC-S or immediately after first dose day of PAC-M.

Sterilization can be safely performed at the time of PAC-S if client is otherwise eligible (e.g. no infection, severe trauma or bleeding) although it is more likely to be associated with regret compared to interval sterilisation

If a contraceptive method is chosen by the client, and this cannot be provided immediately (e.g. IUD with PAC-M) this should be documented and provided as soon as the client is eligible for it.

When to take PAFP

Family Planning Methods	PAC-M (5-9 weeks)	PAC-S (6-14 weeks)
Hormonal: **Pills, Implants, Injection**	Immediately with **first dose** of misoprostol	Immediately at the end of complete uterine evacuation
Intra-Uterine Devices: **Copper IUCD, LNG-IUCD**	After confirming completion of PAC M	Immediately at the end of complete uterine evacuation
Barrier Methods	As soon as sexual contact resumed	As soon as sexual contact resumed
Permanent Methods: **Tubal Ligation**	After confirming completion of Service.	Immediately at the end of complete uterine evacuation

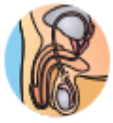
Key Points for PAFP include:

- Immediate initiation of family planning methods following PAC has been shown to both improve adherence and reduce risk of unintended pregnancy.
- Client should be provided with comprehensive PAFP counselling and access to chosen method on the same day wherever possible.
- Providing written consent is obtained prior to PAC, IUCD and implant can be initiated safely at the end of successful surgical PAC.
- MSL can also be performed after a successful procedure with client's consent
- In a medical PAC all hormonal Family Planning (FP) methods except the LNG-IUS can be started immediately after administration of misoprostol.
- For medical PAC the IUCD can only be inserted and MSL done after confirmation of expulsion of products of conception

Trainer's Note:

Ask whether trainees feel comfortable and able to offer post abortion family planning services to clients. Then facilitate a discussion on how post abortion family planning uptake can be improved at their place of work.

Post abortion contraception

	Method	Duration of protection: 1 time	1 month	3 months	1 year	5 years	10 years	Permanent	Effectiveness
Reversible short acting									85%
									92%
									97%
Reversible long acting									99.9%
									99.2%
Permanent									99.5%
									99.8%

Attitude Towards Natural Family Planning

Activity:

Explore attitudes toward natural family planning methods: "Gallery walk" (25 min)

Note to trainer: Before the session, write each of the statements given below on a separate flip chart. Post the two flip charts on two different walls of the training room.

Ask a participant to read out the statements written on **flip charts** and posted on the wall:

Give each participant a small **piece of paper**

Flip chart #1:
"Natural family planning methods are as effective as modern methods."

Flip chart #:
"Health care providers should encourage their clients to choose a different method rather than a natural family planning method."

Ask participants to count off from 1 to 2. Instruct the "1" s to refer to the first flip chart, and the "2s" to refer to the second flip chart. Participants should remain seated where they are.

Show slide with these instructions:

Natural family planning exercise:

1. Read the statement about natural family planning methods on your assigned flip chart. Write down what you think about the statement. Do you agree? Disagree? Why or why not?

When you have finished, tape your piece of paper to the wall where the statement is posted.

Tell participants:

- You have 5 minutes to finish this activity.
- If you have extra time, you can write a response to the other statement too.

Note to trainer:

- When participants post their responses on the wall, encourage them to spread them around so that the papers are not all clustered together. This way it is easier for the group to read the cards.
- If participants do not completely agree or disagree with a statement, tell them they can write down an explanation of their opinion.

PowerPoint Presentation with Discussion

Family Planning Methods

It is the provider's responsibility to help the couple choose and continue to use correctly the best method for them and provide the method or refer them to a family planning centre. The best method is the most effective one (has best chance of always preventing pregnancy) that is safe for them and that they want to use.
Following are the types of family planning methods given after a client having abortion.

Types of Contraceptive Methods

<table>
<tr><td>Natural Methods
• Lactational Amenorrhea Method (LAM)
• Standard Days Method (SDM)
• Withdrawal</td><td>Hormonal Methods
• Combined Oral Contraceptives pills
• Progestin-only contraceptives– Implants (Implanon, femplant, Jaddle)
• Progestin-only Injectable Contraceptives</td></tr>
<tr><td rowspan="2">Non-Hormonal Methods

Barrier and protective Methods
• Male condoms

Intrauterine Devices
• Copper-T
• Mirena
• Multi-load</td><td>Emergency Contraceptives
• Pills
• IUCD</td></tr>
<tr><td>Voluntary Surgical Contraception (permanent methods)

• Female: Tubal ligation
• Male: Vasectomy</td></tr>
</table>

Natural Methods:

Lactational Amenorrhea Method (LAM):
Many women do not have menstruation due to increased level of prolactin hormones during breastfeeding (lactation). Absence of menstruation is called amenorrhea.

Therefore, exclusive breastfeeding can delay the next pregnancy for a while, if all of the following are present:

- Baby is less than 6 months old and mother is giving only breast milk (exclusive breastfeeding during day and night)
- The baby does not take pacifiers or dummies
- The mother breastfeeds the baby frequently, a minimum 8–12 times during day and night

Under the effect of prolactin, ovaries do not release an egg, so ovulation does not take place. The provider should explain to the woman that in exclusive breastfeeding ovulation starts after 6 months, as other foods are also introduced into the baby's diet, and baby feeds less frequently at the breast. At this time, another birth spacing method is needed.

If a woman starts having menstruation during the exclusive breastfeeding a baby younger than 6 months, then the provider should tell the woman that it means that ovulation has returned, maybe because the mother was not feeding her baby frequently enough during day and night. Therefore, she should use another birth spacing method.

Advantages of LAM:
When practiced correctly, LAM is very effective. It is reliable to use immediately after childbirth without having to seek medical attention. It gives time to the mother to decide on another method for birth spacing after 6 months of exclusive breastfeeding (as long as she has not begun to menstruate).

Standard Days Method (SDM):
A woman can use the Standard Days Method if most of her menstrual cycles are 26–32 days long. If she has more than two longer or shorter cycles within a year, the Standard Days Method will be less effective and she may want to choose another method. Risk of pregnancy is greater when couples have sex on fertile days without using another method with consistent and correct use 5 pregnancies occurs per 100 women over the first year of use.

How to use?

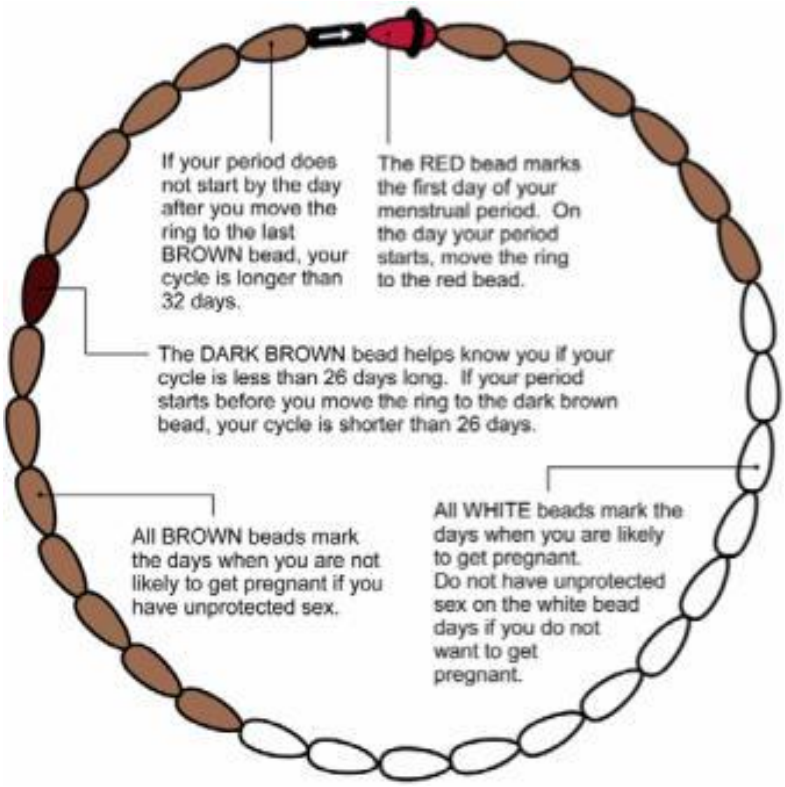
- A woman keeps track of the days of her menstrual cycle, counting the first day of monthly bleeding as Day 1.
- Days 8 through 19 of every cycle are considered fertile days for all users of the Standard Days Method.
- The couple avoids vaginal sex or uses condoms during days 8 through 19. They can also use withdrawal, but this is less effective.
- The couple can have unprotected sex on all the other days of the cycle-days 1–7 at the beginning of the cycle and from day 20 until her next monthly bleeding begins.
- Developed by the Institute for Reproductive Health, the SDM is based on the “fertile window” during a woman’s menstrual cycle, and involves a simple set of color-differentiated counting beads (Cycle Beads TM) that couples can use to help them avoid intercourse during that period.[5] If a couple wishes to prevent a pregnancy, the woman and her partner avoid unprotected intercourse on days 8 through 19 of every menstrual cycle (see **Figure 1** below).

Figure 1 The Fertile Window

Fertile Window																																
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	32-Day Cycle
Fertile Window																																
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	26-Day Cycle						

The SDM can be taught by a trained provider or community health/outreach worker to women, men, or couples in either individual or group sessions

Figure 2. ***Cycle Beads***



The Standard Days Method® and Cycle Beads TM are trademarks of the Institute for Reproductive Health at Georgetown University. Cycle Beads are a U.S. patent-pending technology.

Although the SDM does not protect against HIV/AIDS, counseling for the method can afford the counselor an opportunity to provide information about HIV/AIDS and the importance of dual protection.

Activity 3: Safe Days Method Activity

Read the following example:

If a woman with a 30-day cycle starts her menses on 10 July, what are the dates of her next fertile period according to the Standard Days Method?

Ask for a volunteer to answer the question.

Note to trainer: The correct answer is: 17 July through 28 July. During these dates, the woman should use a barrier method like condoms or abstain from intercourse.

Withdrawal (Coitus Interruptus):

In this method the man withdraws his penis from inside the woman before ejaculation. The provider should tell the couple that this is a natural method that can be practiced without any medical checkup or visit to a medical clinic. This method is well-accepted by clients. However, it has a higher failure rate, and a woman can get pregnant. Sometimes a man is not able to pull out before he ejaculates and even a very little amount of fluid containing sperm leaked into the vagina can cause pregnancy.

Hormonal Methods

Activity 4: Combined Oral Contraceptive Activity

Ask:

- What has been your experience with clients who choose COCs?
- Why do they choose them?
- If a client does not want to use COCs, what reasons does she usually give?

Listen to several responses.

Summarize the main points you heard.

Tell participants the information while **showing** the presentation **slides.**

Combined Oral Contraceptive Pills (COC's)

Key Points for providers and clients:
All range of contraceptives should be offered to the client. In case she selects pills then following key points should be kept in mind:

- Explain how to use the pill pack (with the help of IEC material and sample of pill).
- Instructions about suitable timings for taking pills.
- Counsel about side effects and possible complications.
- What should be done in case pills are missed?

Mode of Action:

- Inhibit ovulation

Effectiveness of Combined Oral Contraceptive Pills (COCs):
When no pill-taking mistakes are made, less than 1 pregnancy per 100 women using over the first year (3 per 1,000 women). There is no delay in return of fertility
Pills do not provide protection against sexually transmitted infections (STIs)

Health benefits, health risks and side effects:
In order for a client to make an informed choice about COCs, the information giver, or counselor, **must ensure** that the client **understands** the health benefits and health risks and side effects.

Known health benefits:

- Very effective when used correctly
- Monthly periods are regular, lighter and shorter
- Can be used as long as women wants to prevent pregnancy
- No rest period needed
- Can be used at any age from adolescence to menopause
- Fertility returns soon after stopping
- Can prevent or decrease iron deficiency anaemia

Help prevent:

- Ectopic pregnancies
- Endometrial cancer
- Ovarian cysts
- Pelvic inflammatory disease (PID)
- Benign breast disease

Reduce:

- Menstrual cramps
- Menstrual bleeding problems
- Ovulation pain
- Symptoms of polycystic ovarian syndrome (irregular bleeding, acne and excess hair of face or body)
- Symptoms of endometriosis (pelvic pain and irregular bleeding)

Known health risks:

Very rare:

- Blood clot in deep veins of legs or lungs (deep vein thrombosis or pulmonary embolism) –
- pharmacologic oestrogens used in COCs increase the production of clotting factors.

Extremely rare:

- Stroke and heart attack
- Gallstones – COCs use increases the secretion of cholic acid in bile, potentially leading to a higher incidence of gallstone formation
- Cervical cancer - use of COCs for five years or more appears to speed up the development of persistent HPV infection into cervical cancer. The number of cervical cancers associated with COCs use is thought to be very small.
- Liver tumours – increases the relative risk of benign adenoma or hematoma, either of which can cause pain or rarely a haemo-peritoneum. However, these cases are already extremely
- rare and therefore the COCs-attributable risk is minimal.

Contraindications to COCs according to medical eligibility criteria (MEC wheel):

- Postpartum breastfeeding up to 6 months
- Client is 35 years of age or older and smokes
- Active liver disease which includes jaundice, active hepatitis, severe cirrhosis and liver tumor
- Diabetes for more than 20 years or with complications
- Migraine with aura
- Hypertension with systolic blood pressure is 140 mm Hg or higher or diastolic blood pressure is 90 or higher
- Having gall bladder disease or taking medicines for it
- Stroke
- Risk factors for cardiovascular disease or Ischemic heart disease
- Drug interaction with Rifampicin and anti convulsants
- Deep venous thrombosis
- Breast Cancer

Note: Breast cancer – research surrounding a small increased risk in breast cancer for COCS users is contradictory and inconclusive. Women should be shown how to check their breasts for abnormalities if they feel they are at risk of developing the disease

When to start?
A woman can start using COCs at any time if it is reasonably certain she is not pregnant. If more than five days have passed after the start of her monthly bleeding, she will need a backup method for seven days.

Following instruction must be given to the client:
- Give blister packet of 28 pills to the client. Explain that 21 white hormonal pills provide contraception and 7 additional brown pills do not contain hormones.
- Instruct her how to start the pills and follow the directions or arrow on the packet
- The woman should always take one pill each day until the pill blister packet gets empty.
- When she finishes one pack, she should take the first pill from the next pack on the very next day.
- Taking the pill at the same time each day may help them to remember the dose. (Preferably after dinner, before going to bed).

Guidance for Missed Pills

Managing Missed Pills
It is easy to forget a pill or to be late in taking it. COC users should know what to do if they forget to take pills. If a woman misses one or more pills, she should follow the instructions below

Making up Missed Pills with 30–35 µg Oestrogen ≠
Key message - Take a missed hormonal pill as soon as possible

Keep taking pills as usual, one each day (she may take 2 pills at the same time or on the same day)

Missed 1 or 2 pills? Started new pack? 1 or 2 days late?
Take a hormonal pill as soon as possible

Little or no risk of pregnancy

Missed pills 3 or more days in a row in the first or second week? Started new pack 3 or more days late?
Take a hormonal pill as soon as possible
Use a backup method for the next 7 days
Also, if she had sex in the past 5 days, can consider ECPs (see Emergency Contraceptive Pills)

Missed 3 or more pills in the third week? Take a hormonal pill as soon as possible

Finish all hormonal pills in the pack. Throw away the 7 non-hormonal pills in a 28-pill pack. Start a new pack the next day
Use a backup method for the next 7 days
Also, if she had sex in the past 5 days, can consider ECPs (see Emergency Contraceptive Pills)

Missed any non-hormonal pills? (Last 7 pills in 28-pill pack)
Discard the missed non-hormonal pill(s)
Keep taking COCs, one each day. Start the new pack as usual

Side Effect and Management:
Important: Thorough counseling about bleeding changes and other side effects is an important part of providing the method. Counseling about bleeding changes may be the most important help a woman needs to keep using the method

Side Effects	Management
Bleeding	• Reassure her about irregular or lighter bleeding pattern. • To reduce irregular bleeding:
	• Ask her to take the pill each day and at the same time. • Instruct her to make up for missed pills properly, including after vomiting/diarrhea • For short-term relief, Ibuprofen 800 mg three times daily for five days can be given or other NSAID can be given. • If irregular bleeding continues or starts after several months of normal or no monthly bleeding, consider underlying conditions unrelated to use of method.
Amenorrhea	• Do a pregnancy test to ensure she is not pregnant. • If there is just small stain reassure her that some women using COCs stop having monthly bleeding, and this is not harmful.
Ordinary headaches (non migrainous)	• Try the following (one at a time): • Suggest Ibuprofen (200–400 mg), Paracetamol (500–1000 mg), or other pain relievers.
Dizziness Nausea	• For nausea, suggest taking COCs at bedtime or with food • Check for pregnancy if no cause is found, reassure the client
Vomiting & diarrhea	• If she vomits within 2 hours after taking a pill, she should take another pill from her pack as soon as possible, and then keep taking pills as usual. • Is she vomits more than twice a day pills should be stopped inform her that withdrawal bleeding will occur and change over to another method of her choice
Breast tenderness	• Recommend that she wears a supportive bra • Try hot or cold compresses. Suggest pain reliever
Weight change	• If she gains weight more than 3 kg in 2 months stop COCs.

Mood changes	• Clients who have serious mood changes such as major depression should be referred for care
Acne	• Acne usually improves with COCs use. It may worsen for a few women. • Suggest local remedies.

Describe the most common side effects:

- In the first few months, bleeding at unexpected times (irregular bleeding) Then lighter, shorter, and more regular monthly bleeding.
- Headaches, breast tenderness, weight change, and possibly other side effects

Explain about these side effects:

Side effects are not signs of illness. Most side effects usually become less or stop within the first few months of using COCs common, but some women do not have them occur

Explain what to do in case of side effects:

- Keep taking COCs, skipping pills risks pregnancy and can make some side effects worse
- Take each pill at the same time every day to help reduce irregular bleeding and also help with remembering, take pills with food or at bedtime to help avoid nausea
- The client can come back for help if side effects bother her

Following are the warning signs which require switching or stopping the use of COCs:

- Severe headache
- Blurring of vision
- Severe chest pain
- Severe lower abdominal pain
- Severe calf pain

Problems that may need method change:

Unexplained vaginal bleeding or heavy and prolonged bleeding

Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate. She can continue using COCs while her condition is being evaluated

If bleeding is caused by sexually transmitted infection or pelvic inflammatory disease, she can continue using COCs during treatment.

Any client with unexplained vaginal bleeding – either during the cycle, or after sexual intercourse, must have this investigated prior to commencing the COCs.

Other possible physical changes:

Blood pressure may increase a few points (mm Hg). When increase is due to COCs, blood pressure declines quickly after use of COCs stops.

Correcting Misunderstandings (Combined oral contraceptives):

- Do not build up in a woman's body. Women do not need a "rest" from taking COCs
- Must be taken every day whether or not a woman has sex that day
- Do not make women infertile
- Do not cause birth defects or multiple births
- Do not change women's sexual behavior
- Do not collect in the stomach instead, the pill dissolves each day
- Do not disrupt an existing pregnancy

Progestin-Only Injections

Scenario: Injectables

Hasina is 36 years old and has three children. She is using Famila, a low-dose COC, and has been since her last delivery 2 years ago. Hasina is having headaches and is concerned that they may be related to her use of Famila. She wants to shift to an injectable (progestin-only injectable contraception [PIC]). Hasina has come to the family planning clinic today to get an injection. She tells you she is not presently having her menses, and that she has been taking medications for epilepsy.

The Injectable contraceptives Depo-Medroxy-Progesterone-Acetate (DMPA), Sayana Press, Subcutaneous single dose injection given just below the skin, for every 13 weeks and Norethisterone Enanthate (NET-EN) each contain a progestin like the natural hormone progesterone in a woman's body.

Key points for provider and clients: All range of contraceptives should be offered to the client. In case she selects injections then following key points should be kept in mind:

- **Bleeding changes are common but not harmful:** Typically, irregular bleeding for the first several months and then no monthly bleeding.
- **Return visit for injections regularly:** Coming back every 13 weeks for DMPA or every
- 8weeks for NET-EN is important for greatest effectiveness.
- **Gradual weight gain is common.** (1-2 kg in first year of use)
- **Return of fertility is often delayed:** It takes several months longer on average to become pregnant after stopping progestin only injections than after other methods.

Mode of action:

The progestin in the Injectables acts as a contraceptive by:

- Inhibiting ovulation

Effectiveness of Progestin only injections:

Effectiveness depends on getting injection regularly: When a woman misses an injection it can lead to pregnancy, about 3 pregnancies per 100 women using progestin-only injectables over the first year (97 of every 100 women using injectables will not become pregnant)

Injections do not provide protection against sexually transmitted infections (STIs)

Health benefits, health risks and side effects:

In order for a client to make an informed choice about progestin-only injectable, the information giver, or counselor, **must ensure** that the client **understands** the health benefits, health risks and side effects.

DMPA:

Help protect against:

- Pregnancy – through preventing conception the woman will not have an unwanted pregnancy with the associated risk of morbidity and mortality
- Cancer of the lining of the uterus (endometrial cancer)
- Uterine fibroids

May help protect against:

- Symptomatic pelvic inflammatory disease – thickening of the cervical mucus acts as a barrier to ascending infection from vagina
- Iron-deficiency anemia–reduction in heavy bleeding in menstrual cycles may benefit a client suffering from anemia

Reduces:

- Sickle cell crises among women with sickle cell anemia – through inhibition of in vivo sickling with hematologic improvement during treatment
- Symptoms of endometriosis (pelvic pain, irregular bleeding).

NET-EN:

Same as DMPA in addition it also helps protect against:

- Iron-deficiency anemia.

Known health risks:

- Anaphylactic shock - due to inert substances present in injections.

Other possible physical changes: decrease bone density, it is reversible, give some other FP method for one year after every two years of use

Contraindications to Progestin only injections according to medical eligibility criteria (MEC Wheel):

- Hypertension with systolic blood pressure 160 mmHg or higher and diastolic blood pressure
- 100 mmHg or higher.
- Stroke.
- Ischemic heart disease.
- Multiple risk factors for cardiovascular disease.
- Active liver disease which includes jaundice, active hepatitis, severe cirrhosis and liver tumor
- Diabetes for more than 20 years or with complications.
- Breastfeeding up to 6 weeks of post-partum.
- Breast cancer.
- Migraine with aura.
- Unexplained vaginal bleeding.
- Acute deep vein thrombosis.

Important: Thorough counseling about bleeding changes and other side effects must come before giving the injection. Counseling about bleeding changes may be the most important help a woman needs to keep using the method.

Side effect and management:

Side effect	Management
Irregular Bleeding	• For modest short-term relief take Tab. Mefanemic acid (Ponstan) • 500 mg 3 times daily for 5 days
Amenorrhea	• Reassure
Heavy or Prolong Bleeding (twice as much as usual or longer than eight days)	• Reassure - 500 mg of Mefanemic acid twice daily after meals for five days. • One COC daily for 21 days.
Ordinary Headaches	Try the following (one at a time): • Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), Paracetamol (500–1000 mg) or other pain reliever.
Weight Change	• Review diet and counsel as needed.
Dizziness	• Tab Serc 8mg two to three times daily for a week
Mood changes	• Consider extended use
Abscess/ Infection at site of injection	• Follow IP protocols • Cap Amoxicillin 500 mg thrice daily for 5 days • If abscess is formed requires incision and drainage under antibiotic coverage

Describe the most common side effects:

- For the first several months, irregular bleeding, prolonged bleeding, frequent bleeding. Later no monthly bleeding.
- Weight gain (about 1–2 kg per year), headaches, dizziness, and possibly other side effects.

Explain about these side effects:

- Side effects are not signs of illness.
- Common, but some women do not have them.
- The client can come back for help if side effects bother her.

When to start:

Important: A woman can start injectables any time she wants if it is reasonably certain she is not pregnant. To be reasonably certain she is not pregnant, use the Pregnancy Checklist

While injecting the dose:

- Wipe injection site with antiseptic. (Use a circular motion from injection site outward.)
- DPMA: gently shake the vial, NET-EN: shaking the vial is not necessary. Fill up the syringe with entire content.
- Insert sterile needle deep into upper arm or buttock and inject the entire content gently.
- Dispose off the needles with syringes safely according to MSS procedure.
- Provider should not rub the injection site.
- Give the date for next dose of injectable contraceptive.
- On follow up visit provide proper counseling if there are any signs of side effects.

Give specific instructions:

- Tell her not to massage the injection site.
- Tell the client the name of the injection and agree on a date for her next injection

Following are the warning signs which require switching or stopping the use of injections:

- Severe headache
- Blurring of vision
- Severe chest pain
- Severe lower abdominal pain
- Severe calf pain

Reasons to return before the next Injection:

Assure ever client that she is welcome to come back any time—for example, if she has problems, questions, or wants another method; she has a major change in health status; or she thinks she might be pregnant.

Planning the Next Injection:

Agree on a date for her next injection in 13 weeks for DMPA, or in 8 weeks for NET-EN. Discuss how to remember the date, perhaps tying it to a holiday or other event. Ask her to try to come on time. With DMPA she may come up to one weeks late and still get an injection. With NET-EN she may come up to 2 weeks late and still get an injection. With either DMPA or NET-EN, she can come up to 3 weeks early. She should come back no matter how late she is for her next injection. If more than 4 weeks late for DMPA or 2 weeks late for NET-EN, she should abstain from sex or use condoms, spermicides, or withdrawal until she can get an injection. Also, if she has had sex in the past 5 days without using another contraceptive method, she can consider emergency contraceptive pills.

Implants

There can be different types of implants:

- Jadelle & Sinoplant (Femplant): two rods, effective for five years although the Sinoplant is currently only registered for four years
- Implanon: 1 rod, effective for 3 years

Key points for providers and client:

- Implants are small flexible rods or capsules that are placed just under the skin of the upper arm.
- Provide long-term pregnancy protection.
- All clients should be counseled that they can expect unpredictable vaginal bleeding in terms of timing, amount and duration.
- Require a specifically trained provider to insert and remove the Implant; woman cannot start or stop Implant on her own.

Mode of action:

Implant contain progestin hormone that works by:

- Disrupting the menstrual cycle, including preventing the release of eggs from the ovaries (ovulation).

Client screening and assessment:

Following factors must be considered:

- Age (20 to 45 years)
- Blood pressure (140/90) cautionary
- Last menstrual period (LMP)
- Possible pregnancy
- Menstrual history (regularity, flow description (normal or abnormal)
- Previous contraceptive use (correct or incorrect)
- Breastfeeding
- Gravity and parity:
- No. of live births
- Any previous abortions
- Any history of ectopic pregnancies
- Any caesarean sections
- Any obstetric complications
- STIs or pelvic inflammatory disease (PID).

Medical History:

Any major medical problem including

- Any current medication being taken
- Any drug allergies
- Any history of cardiac disease and hypertension
- Any personal (or family history) of blood clots
- Any red blood cell disorders (sickle-cell anaemia) or blood fat (lipid) disorders
- Any current or history of breast or uterus cancers
- Any abnormal bleeding from the vagina of an unknown cause
- Diabetes
- Any liver disease
- Any history of hospitalization
- Any history of surgery
- Other (epilepsy/tuberculosis)

When to insert implant:

S #	Time of Implant insertion	Use of Backup method
1.	If woman is starting within 7 days of her menstrual cycle	No need for backup method
2.	If she is starting after 7 days of her menstrual cycle	She will need backup method for first 7 days after Implant insertion
3.	If woman is switching from IUCD she can have Implant inserted immediately	If using within 7 days of menstrual cycle, no need for backup method. If using after 7 days of her menstrual cycle, she will need backup method
4.	If woman is switching from a hormonal method she can have Implant inserted immediately	No need for backup method
5.	Breastfeeding **less than 6 months after giving birth** • Menstrual cycle has not returned She can have Implant inserted any time between 6 weeks and 6 months. • Menstrual cycle has returned She can have Implant inserted if reasonably certain that she is not pregnant. **More than 6 months after giving birth** • Menstrual cycle has not returned She can have Implant inserted any time if reasonably certain she is not pregnant. • Menstrual cycle has returned She can have Implant inserted if reasonably certain that she is not pregnant.	• No need for backup method • She will need backup method for first 7 days after Implant insertion • She will need backup method for first 7 days after Implant insertion • If using within 7 days of menstrual cycle, no need for backup method • If using after 7 days of her menstrual cycle, she will need backup method
6.	**Not breastfeeding:** **Less than 4 weeks after giving birth** She can have Implant inserted any time **More than 4 weeks after giving birth** • Menstrual cycle has not returned She can have Implant inserted any time if reasonably certain she is not pregnant.	• No need for backup method • She will need backup method for first 7 days after Implant insertion

	• Menstrual cycle has returned She can have Implant inserted if reasonably certain that she is not pregnant.	• If using within 7 days of menstrual cycle, no need for backup method • If using after 7 days of her menstrual cycle, she will need backup method
7.	**No monthly bleeding** (not related to childbirth or breastfeeding) She can have Implant inserted any time if reasonably certain she is not pregnant	• She will need backup method for first 7 days after Implant insertion
8.	**After taking emergency contraception**, She can have Implant inserted within 7 days of her menstrual cycle, or any other time if she is reasonably certain she is not pregnant	• No need for backup method • Need backup method to use until Implant is inserted
9.	**After miscarriage or abortion,** She can have Implant inserted immediately. If Implant is inserted after 7 days of miscarriage	• No need for backup method • She will need backup method for first 7 days after Implant insertion.

Contraindications of Implant:

Absolute contraindications

- Liver Cirrhosis.
- Blood clot in her legs or lungs.
- Unexplained vaginal bleeding
- Breast cancer.

Relative contraindications

- Breastfeeding less than 6 weeks since giving birth
- Unexplained vaginal bleeding
- Breast cancer
- Severe liver disease, infection, or tumor.

Counseling of Implant:

- A full family planning consultation must be provided covering all available family Planning methods
- Client should always be counseled on dual protection
- Client should be counseled on the benefits, risks and side effects of the Implant

Health benefits, health risks and side effects:
In order to make an informed client choice about implant, the information giver, or counselor, **must ensure** that the client **understands** the health benefits and health risks and side effects.

Known health benefits:
Help protect against:
- Pregnancy – through preventing conception the woman will not have an unwanted pregnancy with the associated risk of morbidity and mortality
- Pelvic inflammatory disease – thickening of the cervical mucus acts as a barrier to ascending infection from the vagina.

May help protect against:
- Iron-deficiency anaemia – reduction in heavy bleeding in menstrual cycles may benefit a client suffering from anaemia.

Known health risks:
- None.

Implant Insertion:
- **Instructions for service provider**

Explain to the client what will happen during insertion.

Implant Insertion technique:
Preparation:
1. Clean instrument tray prepared
2. Cover the procedure table and arm support with a clean cloth
3. Prefer less dominant hand for Implant insertion and ensure clients arm is clean. (ask client to wash arm if needed)
4. Explain what is going to be done and encourage client to ask questions
5. Ask client to lie on her back on the table so that arm in which Implant will be placed is turned outwards, and is well supported
6. Open the sterile instrument pack without touching the instruments or other items
7. Carefully open sterile pouch containing Implant rods by pulling apart sheets of pouch and without touching the rods allow them to fall into sterile receiver cup or bowl
8. Prepare Lignocaine in syringe – at least 2-3 ml of 1%

Before Insertion:
1. Identify insertion sites – about 6- 8 cm above the elbow on the medial aspect of the upper arm in the groove between the biceps and triceps muscles
2. Swab injection site with alcohol swab

3. Perform surgical hand washing and put on sterile gloves
4. Place “O” drape on arm exposing planned insertion sites
5. With forceps, clean arm with gauze and antiseptic

Insertion:

1. With the plunger inserted in the trochar, hold the trochar so that the beveled edge is upward and marks are visible and insert through the incision under the skin.
2. While inserting the trochar stretch out the skin, so that trochar is visible directly beneath the skin and can be felt by finger.
3. Take the plunger out of trochar and load first implants in the trochar, then put back the plunger inside the trochar and push lightly until you feel the resistance.
4. Hold plunger **stationary** and withdraw the trochar to the mark closest to trochar tip allowing the Implant to drop out under the skin at this point.
5. Do not remove trochar
6. Place second Implant by aligning trochar so that second Implant is positioned at 30° angle relative to first Implant placing rods in shape of a ‘V’ opening towards the shoulder
7. Insert second Implant using same technique
8. Remove trochar completely

After Insertion:

1. Presse down on insertion site with gauze for a minute or so to stop bleeding, then clean area around insertion site with antiseptic solution on a swab.
2. Bring edges of insertion site together and closes with Saniplast
3. Remove drape and wipe client’s skin with alcohol swab.
4. Encourage the client to feel the Implant securely inserted.
5. Dress with gauze bandage to absorb any excess fluid
6. Before removing gloves, dispose off sharps in the sharp box properly (syringe, trochar, blade etc) and place all instruments in 0.5% chlorine solution for 10 minutes.
7. Dispose of waste materials by placing in leak-proof container or plastic bag
8. Immerse gloved hands in 0.5% chlorine solution and remove gloves by turning inside out.
9. If disposing of gloves, place in leak-proof container, If reusing gloves place in 0.5%chlorine solution for 10 minutes for decontamination
10. Washes hands thoroughly and dry them on clean towel
11. Completes client record, including drawing position of capsules and noting batch number and expiry date

After Insertion Care:

1. Explain wound care – keep dry and remove after 3 days, do not scratch the wound site, try not to overuse this arm for 5 days
2. Counsel about anticipated side effects and management of side effects.
3. Discuss action in case of post-insertion problems or complications
4. Assures client she can have Implant removed at any time
5. Asks client to repeat instructions and answers any questions
6. When she is ready, client can leave the centre

Implant Removal:

Before removal:

1. Checks the precise location of Implant(s) on client's User Card
2. Locate the Implant(s) by palpating
3. Mark the distal end(s)
4. Follow steps 1-15 of insertion checklist.
5. Anaesthetize arm with 2-4ml lignocaine (1%) at site of incision, which is just below the distal end of Implant(s), applying anaesthetic under the tip of the Implant

Removal:

1. Make an incision 4mm long at the distal end of Implant if possible in the same location as the insertion site
2. Gently push Implant towards incision until tip is visible
3. Gently insert closed tip of curved mosquito forceps under tip of Implant without opening - going beyond the tip of the Implant into an un-anaesthetized area will hurt the client
4. Open forceps and grasp tip of Implant – reveal the tip of the Implant by moving forceps handle towards the client
5. Apply straight mosquito forceps to remove Implant fully
6. If Implant has fibrotic tissue, gently wipe away this tissue to expose the tip and remove the Implant with straight forceps
7. Show the client the removed Implant(s)
8. Close incision with Saniplast
9. Apply sterile gauze with pressure bandage to prevent bruising
10. Client leaves centre/clinic she is ready

Problems Reported as Side Effects or Complications

- Problems with side effects and complications affect women's satisfaction and use of
- Implants.
- They deserve the provider's attention.
- If the client reports any side effects or complications, listen to her concerns, give her advice and if appropriate provide treatment
- Help the client to choose another method now if she wishes or if problems cannot be overcome.

Common side effects:
Explain to the client that:

- Side effects are not signs of illness.
- Most side effects usually become less or stop within the first year.
- Client can come back for help if side effects bother her.

Changes in her bleeding pattern:

- Irregular bleeding that lasts more than 8 days at a time over the first year.
- Regular, infrequent, or no bleeding at all later.
- Headaches, abdominal pain, breast tenderness and possibly other side effects.

Irregular bleeding (bleeding at unexpected times that bothers the client)

- Reassure her that many women using Implants experience irregular bleeding but it is not harmful and usually becomes less or stops after the first year of use.
- She can take 800 mg ibuprofen or 500 mg Mefanemic acid three times daily after meals for
- 5 days at beginning when irregular bleeding starts.
- If these drugs do not help her, she can try one of the following (following beginning when irregular bleeding starts)
- Combined oral contraceptives. Ask her to take one pill daily
- 50 µg ethinyl estradiol daily for 21 days.
- If irregular bleeding continues or starts after several months of normal or no monthly
- bleeding or you suspect that something may be wrong for other reasons, consider underlying conditions which is not related to the use of method

No monthly bleeding:

- Reassure her that some women stop having monthly bleeding when using Implants and this is not harmful.
- There is no need to lose blood every month.
- It is similar to not having monthly bleeding during pregnancy.
- She is not infertile, and Blood is not building up inside her. (Some women are happy to be free from monthly bleeding.)

Heavy or Prolonged Bleeding (twice as much as usual or longer than 8 days)

- Reassure her that some women using Implants experience heavy or prolonged bleeding. It is generally not harmful and usually becomes less or stops after a few months.
- She can take 800 mg ibuprofen or 500 mg Mefanemic acid three times daily after meals for
- 5 days at beginning when irregular bleeding starts
- Combined oral contraceptives with 50 µg of ethinyl estradiol may work better than lower dose pills.
- To help prevent anemia, suggest her iron tablets and tell her it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver) fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).

- If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something maybe wrong for other reasons, consider underlying conditions which is not related to the use of method.

Ordinary headaches (non Migrainous):
- Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), Paarcetamol (325–1000 mg), or other pain reliever.
- Any headaches that get worse or occur more often during use of Implants should be evaluated.

Mild abdominal pain:
- Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), Paarcetamol (325–1000 mg), or other pain reliever
- Consider locally available remedies.

Acne:
- If client wants to stop using Implants because of acne, she can consider switching to COCSs
- because many women's acne improves with COCs use.
- Consider locally available remedies.

Weight changes:
- Review diet and counsel as needed.

Breast tenderness:
- Recommend that she wear a supportive bra (including during strenuous activity and sleep).
- Try hot or cold compresses.
- Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), Paracetamol (325–1000 mg), or other pain reliever.
- Consider locally available remedies.

Mood changes or change in sex drive:
- Ask about changes in her life that could affect her mood or sex drive, including changes in her relationship with her partner. Give her support as appropriate.
- Clients who have serious mood changes such as major depression should be referred for care.
- Consider locally available remedies.

Nausea or dizziness:
- Consider locally available remedies.

Pain after insertion or removal:
- For pain after insertion, check that the bandage or gauze on her arm is not too tight.
- Put a new bandage on the arm and advise her to avoid pressing on the site for a few days.

- Give her aspirin (325–650 mg), ibuprofen (200–400 mg), Parcetamol (325–1000 mg), or other pain reliever.

Infection at the insertion site (redness, heat, pain, pus):
- Do not remove the Implants.
- Clean the infected area with soap and water or antiseptic.
- Give oral antibiotics for 7 to 10 days.
- Ask the client to return after taking all antibiotics if the infection does not clear. If infection has not cleared, remove the Implants or refer for removal.
- Expulsion or partial expulsion often follows infection. Ask the client to return if she notices an Implant coming out.

Abscess (pocket of pus under the skin due to infection):
- Clean the area with antiseptic.
- Cut open (incise) and drain the abscess.
- Treat the wound.
- Give oral antibiotics for 7 to 10 days.
- Ask the client to return after taking all antibiotics if she has heat, redness, pain, or drainage of the wound. If infection is present when she returns, remove the Implants or refer for
- removal.

Expulsion (when one or more Implants begin to come out of the arm):
- Rare. Usually occurs within a few months of insertion or with infection.
- If no infection is present, replace the expelled rod or capsule through a new incision near the other rods or capsules, or refer for replacement.

Severe pain in lower abdomen (suspected ectopic pregnancy or Enlarged ovarian follicles or cysts)
- Many conditions can cause severe abdominal pain. Be particularly alert for additional signs or symptoms of ectopic pregnancy, which is rare but can be life-threatening
- In the early stages of ectopic pregnancy, symptoms may be absent or mild, but eventually they will become severe. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy:
  - Unusual abdominal pain or tenderness
  - Abnormal vaginal bleeding or no monthly bleeding—especially if this is a change from her usual bleeding pattern
  - Light-headedness or dizziness
  - Fainting
- If ectopic pregnancy or other serious health condition is suspected, refer at once for immediate diagnosis and care.
- Abdominal pain may be due to other problems, such as enlarged ovarian follicles or cysts.
  - A woman can continue to use Implants during evaluation.

- There is no need to treat enlarged ovarian follicles or cysts unless they grow abnormally large, twist, or burst. Reassure the client that they usually disappear on their own. To be sure the problem is resolving, see the client again in 6 weeks, if possible.

New Problems That May Require Switching Methods (May or may not be due to method.)

Unexplained vaginal bleeding (that suggests medical condition not related to method)
- Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate.
- If no cause of bleeding can be found, consider stopping Implants to make diagnosis easier, provide another method of her choice to use until the condition is evaluated and treated (not progestin-only injectables, or a copper-bearing or hormonal IUCD).
- If bleeding is caused by sexually transmitted infection or pelvic inflammatory disease, she can continue using Implants during treatment.

Starting treatment with anticonvulsants or rifampicin:
- Barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, and rifampicin may make Implants less effective.
- If using these medications long-term, she may want a different method, such as progestin only injectables or copper IUCD.
- If using these medications short-term, she can use a backup method along with Implants.

Migraine headaches:
- If she has migraine headaches without aura, she can continue to use Implants if she wishes.
- If she has migraine with aura, remove the Implants. Help her choose a method without hormones.

Certain serious health conditions (suspected blood clots in deep veins of legs or lungs, liver disease, or breast cancer) and Symptoms of Serious Health Conditions)
- Remove the Implants or refer for removal
- Give her a backup method to use until her condition is evaluated.
- Refer for diagnosis and care if not already under care.

Heart disease due to blocked or narrowed arteries (ischemic heart disease) or stroke
- A woman who has one of these conditions can safely start Implants. If however, the condition develops while she is using Implants:
  - Remove the Implants or refer for removal.
  - Help her choose a method without hormones.
  - Refer for diagnosis and care if not already under care.

Suspected pregnancy:
- Assess for pregnancy, including ectopic pregnancy.
- Remove the Implants or refer for removal if she will carry the pregnancy to term.
- There are no known risks to a fetus conceived while a woman has Implants in place

Follow up visit:

No routine return visit is required until it is time to remove the Implants. The client should be clearly invited to return any time she wishes, however.

- Ask how the client is doing with the method and whether she is satisfied, ask if she has any questions or anything to discuss.
- Ask especially if she is concerned about bleeding changes. Give her any information or help that she needs
- Ask a long-term client if she has had any new health problems since her last visit. Address problems as appropriate. For new health problems that may require switching method
- Ask a long-term client about major life changes that may affect her needs—particularly plans for having children and STI/HIV risk. Follow up as needed.
- If possible check the weight of the client who is using Implants. If her weight has changed
- enough to affect the duration of her Implants' effectiveness, update her reminder card, if
- she has one, or give her a new reminder card with the proper date

If she wants to keep using Implants and no new medical condition prevents it, remind her how much longer her Implants will protect her from pregnancy.

Standard instruments and supplies:

- Sterile gauze (3 or 4)
- Surgical gloves of various sizes (may need two pairs per procedure)
- Sterile trochar and plunger
- Antiseptic
- Two drapes – one on which the client rests her arm and one "O" arm drape to expose
- insertion site (e.g. about 50 cm square with 12 cm diameter hole (centralised in one direction - 19 cm from each side – and about 10 cm and 28 cm from top and bottom)
- Galipot 2
- 60-90% alcohol/Pyodine
- Tray / trolley
- "Sharps" box / puncture-resistant container
- Gauze for pressure bandage.
- Sponge holding forceps
- Butterfly tape
- Sterile tape or Saniplast.

Implant removal set: As above plus:

- Lignocaine (note any locally-specific name) – 1% or 2% with sterile water for dilution
- 5 ml syringe and needle (21 gauge / green)
- Curved mosquito forceps
- Straight mosquito forceps
- Scalpel blade (Size 11)

Side Effects and their Management:

Side Effects	Management
Pain in the arm for 1-2 days	• Reassure client • Give her Tab Paracetamol
Pain continuous after 2-3 days with swelling of the insertion site	• Give her appropriate antibiotic and analgesic and follow her.
Menstrual changes Spotting/slight bleeding between periods.	• Reassure the client that it will be resolved on its own. • Advise ibuprofen up to 800mg (max) or ponstan 500mg three times daily after meal for 5 days • Give iron tab 1×3 for 1 month, or • Give COC pills 1 daily for 21 days • If this does not help, provide: • 50mcg of ethinyl estradiol daily for 21 days • If bleeding continuous to be heavy and the client is worried, • remove the Implanon.
Amenorrhea after scanty menses	• Reassure the client that it will not harm her (as it does not harm her when she is pregnant)
Amenorrhea after regular cycles	• Do a pregnancy test • If not pregnant, reassure the client • If pregnant, remove the Implanon.

Rare Side Effects	Management
Weight gain Less than 2 kg in 3 months	• Reassure the clients • Ask her to reduce food intake, especially fats and sweets.
More than 2kg in 3 months	Watch her weight for another 2-3months on a reduced diet.
If client continues to gain weight	Remove the Implanon.
Depression or other mood	Refer client to a doctor

changes	
Infection at insertion site (pain, heat, and redness) but no abscess	• Do not remove Implanon • Clean the infected area with soap and water or antiseptic. • Give an oral antibiotic for 7 days and ask the client to return in 1 week. If still not better, remove the Implanon or refer
Infection with abscess	• If significant skin infection is involved, give oral antibiotic for • 7 days. • Prepare the infected area with antiseptic, make an incision, and drain the pus. • Remove the Implanon or refer for removal.

Explain Warning signs:
Tell the client to come to the clinic as soon as possible if any of the following problems occur:

D= Delay in monthly periods
I= Infection at insertion site
S= Severe abdominal pain
C= Capsule of the Implanon comes out of the skin
U= Unusually heavy vaginal bleeding
S= Soreness of the arm
S= Severe headache or blurred vision

Activity as a group discussion

When to insert implant

S #	Time of Implant insertion	Use of Backup method
1	If woman is starting within 7 days of her menstrual cycle	No need for backup method
2	If she is starting after 7 days of her menstrual cycle	She will need backup method for first 7 days after Implant insertion
3	If woman is switching from IUCD she can have Implant inserted immediately	If using within 7 days of menstrual cycle, no need for backup method. If using after 7 days of her menstrual cycle, she will need backup method
4	If woman is switching from a hormonal method, she can have Implant inserted immediately	No need for backup method
5	Breastfeeding **less than 6 months after giving birth** • Menstrual cycle has not returned	

	She can have Implant inserted any time between 6weeks and 6 months. • Menstrual cycle has returned She can have Implant inserted if reasonably certain that she is not pregnant. **More than 6 months after giving birth** • Menstrual cycle has not returned She can have Implant inserted any time if reasonably certain she is not pregnant. • Menstrual cycle has returned She can have Implant inserted if reasonably certain that she is not pregnant.	• No need for backup method • She will need backup method for first 7 days after Implant insertion • She will need backup method for first 7 days after Implant insertion • If using within 7 days of menstrual cycle, no need for backup method • If using after 7 days of her menstrual cycle, she will need backup method
6	**Not breastfeeding:** **Less than 4 weeks after giving birth** She can have Implant inserted any time **More than 4 weeks after giving birth** • Menstrual cycle has not returned She can have Implant inserted any time if reasonably certain she is not pregnant. • Menstrual cycle has returned She can have Implant inserted if reasonably certain that she is not pregnant.	• No need for backup method • She will need backup method for first 7 days after Implant insertion • If using within 7 days of menstrual cycle, no need for backup method • If using after 7 days of her menstrual cycle, she will need backup method
7	**No monthly bleeding** (not related to childbirth or breastfeeding) She can have Implant inserted any time if reasonably certain she is not pregnant	She will need backup method for first 7 days after Implant insertion
8	**After taking emergency contraception**, She can have Implant inserted within 7 days of her menstrual cycle, or any other time if she is reasonably certain she is not pregnant	No need for backup method Need backup method to use until Implant is inserted

	After miscarriage or abortion, She can have Implant inserted immediately. If Implant is inserted after 7 days of miscarriage	No need for backup method She will need backup method for first 7 days after Implant insertion.

Non-Hormonal Methods

Barrier and Protective Methods (condoms)

Barrier and protective method include vaginal method are male and female condoms. These are available over the counter and are inexpensive.

Key Points for Providers and clients:

- Male condoms help protect against sexually transmitted infections, including HIV.
- Condoms are the only contraceptive method that can protect against both pregnancy and sexually transmitted infections
- Require correct use with every act of sex for greatest effectiveness
- Require both male and female partner's cooperation.
- Talking about condom use before sex can improve the chances one will be used
- May dull the sensation of sex for some men. Discussion between partners sometimes can help overcome the objection

Introduction of Male condoms:

Sheaths, or coverings, that fit over a man's erect penis. Also called rubbers, "raincoats," "umbrellas," skins, and prophylactics; known by many different brand names. Most are made of thin latex rubber.

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 partner.

Return of fertility after use of condoms is stopped: No delay

Health benefits, health risks and side effects:

In order for a client to make an informed choice about the male condom, the information giver, or counselor, **must ensure** that the client **understands** the health benefits and health risks and side effects.

Known health benefits:
Help protect against:
- Pregnancy – through preventing conception the woman will not have an unwanted pregnancy with the associated risks of morbidity and mortality
- STIs, including HIV by preventing skin to skin contact and exchange of bodily fluids
- No hormonal side effect.

May help protect against:
- Conditions caused by STIs;
- Recurring pelvic inflammatory disease and chronic pelvic pain
- Cervical cancer
- Infertility (male and female).

Known health risks:
Very rare*:*
- Severe allergic reaction (among people with latex allergy).

When to start:
Any time the client wants

Contraindications to the male condom:
Do not suggest the use of the male condom if:
The client or their partner has had or is at risk of a severe allergic reaction to latex (there are latex free condoms – Avantii & Ez-on - which can be used)

Important: Whenever possible, show clients how to put on a condom. Use a model of a penis, if available, or other item, like a banana, to demonstrate

Instruction for use:
- Give the client an adequate supply.
- Also give the client supply of Emergency Contraceptive Pill (ECP) Show the client the condom and explain how to use the condom using pictures.
- Explain to the client that for it to be effective it must be used each and every time the client has sexual intercourse, and at the start of the penis being erect.
- Explain the importance of lubrication for latex condoms.

Don’ts:
- Do not unroll the condom and try to put it on the penis.
- Do not use lubricants with an oil base because they damage latex.
- Do not use if it is past the expiry date.
- Do not store in a hot environment.
- Do not use a condom if the color is uneven or changed.

- Do not use a condom that feels brittle, dried out, or very sticky.
- Do not reuse condoms.

Five basic steps of using condoms:

1. Use a new condom for each act of sex
2. Before any physical contact, place the condom on the tip of the erect penis with the rolled side out
3. Unroll the condoms all the way to the base of the erect penis
4. Immediately after ejaculation, hold the rim of the condom in place and withdraw the penis while it is still erect
5. Dispose off the used condom safely

Intrauterine Contraceptive Device (IUCD)

IUCD Eligibility Scenarios

Trainer will divide group into 5 small groups. Each group will be given a scenario to solve. Afterwards groups will present the scenario. Trainer will add points which are missed by group.

Scenario 1 Sonia is 30 years old, married and monogamous with 3 children. She knows she is HIV positive but has no symptoms and feels healthy. She has been using a reliable contraceptive method consistently and correctly.

- Is Sonia a good candidate for receiving IUCD during today's visit?
- Why or why not?
- What action would you take?

Scenario 2 Muneeza is 30 years old and has five children. She had a miscarriage four days ago. She is married and faithful to her husband but thinks he may see other women when he is away from home.

- Is this client a good candidate for receiving IUCD during today's visit?
- Why or why not?
- What action would you take?

Scenario 3 Tauseef is 26 and gave birth to her first child three weeks ago. She and her husband want to wait two or three years before having another baby.

- Is Tauseef a good candidate for receiving IUCD during today's visit?
- Why or why not?
- What action would you take?

Scenario 4 Sumaira is 26 and has been diagnosed with AIDS. She does not want to have any children and pass on the disease. She is not on antiretroviral treatments. She has been using contraceptive pills consistently and correctly but is afraid she may forget to take a pill. She wants to switch to another method that is easier to use.

- Is Sumaira a good candidate for receiving IUCD during today's visit?
- Why or why not?
- What other advice would you give?

Scenario 5 Lubna is a 21 years old married woman with no children. Neither she nor her husband wants children at this time, but Lulu is nervous because they do not use contraception. She is menstruating at the time of her visit.

- Is Lubna a good candidate for receiving IUCD during today's visit?
- Why or why not?

What other action might you take?

IUCD Eligibility Scenarios – discussion issues

Scenario 1

- Yes

Why or why not?

- HIV is not a contraindication for IUD insertion or continuing use. She has not gone on to develop AIDS.

What other action would you take?

- Get her to return for you check the IUCD a month later and make sure there is not infection and find out how well she has adapted to the method.

Scenario 2

- No

Why or why not?

- Muneeza may be 'very high individual risk' of an STI if her partner has other partners. Unless it is possible to be sure she is not infected, IUD is not a good choice for her.
- If you cannot test for STIs and other methods are unavailable or unacceptable to Muneeza, you could insert IUCD, get her to return so you can check she is not infected and explain the warning signs of infection so she knows the action to take.

What other action would you take?

- Ideally both she and her partner should be treated for STIs and persuaded to use condoms during treatment. Her partner should always use condoms outside the relationship.

Scenario 3

- No

Why or why not?

- Although it is very unlikely that Tasneen is pregnant, women who are between 48 hours and 4 weeks postpartum high a higher risk of uterine perforation during IUCD insertion. The IUD is also more likely to be expelled if it is inserted at this time.

What action would you take?

- Ask Tasneen to come back for IUCD insertion once the baby is four weeks old. Explain she is not at risk of becoming pregnant until then because there is no risk of pregnancy during the first four weeks postpartum.

Scenario 4

- No

Why or why not?

- If Sumaira is not on ARVs she is at increased risk of STIs and PID because her immune system is suppressed. An IUCD could increase that risk

What other action would you give?

- Tell her about other methods that could suit her, implants, injectables and sterilisation. Give her condoms to use until she makes her decision. Help her to get counselling about ARVs if possible

Scenario 5

- Yes

Why or why not?

- IUCD is not contraindicated because the client is young and has no children. The fact that she is menstruating means she is not pregnant.

What other action might you take?

- Get her to return to the clinic in a month to check the IUCD is in place and she is satisfied with the method

Types:
- Multi load (5 years)
- Copper T (10-12 years)

Introduction:
Intrauterine contraceptive device is suitable and convenient for birth spacing/limiting. Once inserted, it is effective for 5-10 years.

The types now most widely used are copper bearing IUCDs made of plastic with copper sleeves/copper wire on the plastic, for example, the CuT-380 A and Multiload Cu-375; and hormone containing IUCDs such as the levonorgestrel intrauterine system (LNG-IUS)

Key Points for Providers and clients: In case the client chooses IUCD then following points should be kept in mind:
- Long-term pregnancy protection, very effective, immediately reversible.
- Inserted into the uterus by a specifically trained provider.
- Bleeding changes are common especially in the first 3 to 6 months.

Mode of Action:
- Causes endometrial changes that inhibit implantation

Effectiveness of intrauterine contraceptive device (IUCD):
One of the most effective and long-lasting methods:
- Less than 1 pregnancy per 100 women using an IUCD over the first year
- A small risk of pregnancy remains beyond the first year of use and continues as long as the woman is using the IUCD.
  - Over 10 years of IUCD use: About 2 pregnancies per 100 women

No delay in return of fertility after removal
Does not protect against Sexually Transmitted Infections

Advantages:
- Very effective
- No interference with sex
- Immediately reversible. After removal, pregnancy can occur as quickly as in women who have not used IUCDs
- Has no effect on lactation
- No interaction with any medicines
- Reduces the risk of ectopic pregnancy (less risk of ectopic pregnancy than in women not using any FP method)

Counseling: Offer all range of contraceptives and let her make the decision. After client chooses particular method then do the method specific counseling. If she chooses IUCD then counsel her about method, duration of effectiveness, side effects, warning symptoms and thread checking.

Health benefits, health risks and side effects:
In order for a client to make an informed choice about the IUCD, the information giver, or counselor, **must ensure** that the client **understands** the health benefits and health risks and side effects.

Known health benefits:
Help protect against:
- Pregnancy – through preventing conception the woman will not have an unwanted pregnancy with the associated risk of morbidity and mortality
- May help protect against:
- Cancer of the lining of the uterus (endometrial cancer) – the protective effect of IUCDs may be prompted by "inflammatory actions" that eliminate abnormal and precancerous
- endometrial cells.

Known health risks:
Uncommon
- May contribute to anaemia if a woman already has low iron blood stores before insertion and the IUCD causes heavier monthly bleeding.
- Rare:
- Pelvic inflammatory disease (PID) may occur if the woman has Chlamydia or gonorrhea at the time of IUCD insertion – the presence of the IUCD in the uterus may provide a vehicle for the ascent of these infections from the vagina to the uterus and fallopian tubes
- Vaso-vagal reaction or seizure during insertion of IUCD. Must have access to emergency equipment and must be trained in its use.
- Puncturing (perforation) of the wall of the uterus by the IUCD or an instrument used for insertion. Usually heals without treatment
- Miscarriage, preterm birth, or infection in the rare case that the woman becomes pregnant with the IUCD in place.

Screening of client: This will include history taking, general examination (e.g. anemia) and pelvic examination.

Contraindications to intrauterine contraceptive devices according to medical eligibility criteria (MEC Wheel):
- 48 hours to 4 weeks after delivery
- Puerperal and post abortion sepsis
- Unexplained vaginal bleeding
- Cervical, endometrial or ovarian cancer
- Pelvic tuberculosis

- Sexually transmitted infections: Chlamydia and Gonorrhea
- Acute pelvic inflammatory disease

When to start?

Important: In many cases a woman can start the IUCD any time it is reasonably certain she is not pregnant.

1. Having menstrual cycle.
2. Switching from another method.
3. Any time within 48 hrs. of child birth.
4. Fully or nearly fully breastfeeding.
5. Partially or not breastfeeding.
6. No monthly bleeding.
7. After abortion.
8. After taking emergency contraceptive pills.

Preventing infection at IUCD insertion:

- Proper insertion technique can help prevent many problems, such as infection, expulsion, and perforation.
- Follow proper infection-prevention procedures.
- Use high-level disinfected or sterile instruments. High-level disinfect by boiling, steaming, or soaking them in disinfectant chemicals.
- Use a new, pre sterilized IUCD that is packaged
- Loading the IUCD into the inserter while the IUCD is still in the sterile package, to avoid touching the IUCD directly

Procedure:

Perform procedure according to the protocols under aseptic measures.

- Use gentle, non-touch (aseptic) technique throughout the procedure.
- Do routine hand washing and air-dry hands or dry with a personal towel.
- Put on disposable and clinically clean gloves.
- Wipe the vulva with cotton swab dipped in antiseptic solution.
- Do a gentle bimanual pelvic examination to rule out pregnancy, infection or any other pathology.
- Insert speculum and apply antiseptic solution to the cervix and cervical canal in a clockwise motion once.
- Gently grasp the upper lip of the cervix with Stopes forceps in the vertical position and close it till one mark.
- Gently pass the tip of the HLD/sterile Plastic cannulae into the cervical OS while maintaining gentle traction with the Stopes forceps. (Be careful not to touch walls of vagina with tip of
- cannuale.)
- On the basis of the bimanual assessments of the position of the uterus, insert the plastic cannuale carefully and gently into the uterine cavity while pulling steadily downwards and outwards on the Stopes forceps.

- Gently exerting traction on the Stopes forceps may enable the cannulae to pass more easily.
- If client begins to show symptoms of fainting, or pallor with slow heart rate, stop the procedure and manage vaso vagal shock.
- When a slight resistance is felt it indicates that the tip of the plastic cannulae has reached the fundus of the uterus, note the direction of the uterine cavity and the cannulae.
- Determine the length of the uterus by noting the level of mucus and/or blood on the cannulae. The average uteri will allow cannuale to a depth of 6 to 9 cm. Do not attempt to
- insert an IUCD into a uterus that is less than 6 cm or more than 9cm in depth.
- Load arms of copper-T into the inserter tube without opening the upper part of sterile pack while loading the arms and adjust the Depth gauge according to the size of the uterus. Then load the inserter in the inserter tube.
- Do not use force at any stage of the procedure.

Instructions for Inserting the Loaded Copper T 380 A IUCD:

- Grasp the Stopes forceps (which is still in place on the cervix after measuring the uterus)
- and pull gently to align the uterine cavity and cervical canal.
- Carefully introduce the loaded inserter assembly through the cervical Os, keeping the blue depth-gauge in a horizontal position.
- According to the position and direction of the uterine cavity, advance the loaded inserter assembly until the blue depth gauge comes in contact with the cervix or resistance of the uterus fundus is felt. Be sure that the blue depth-gauge is in the horizontal plane.
- Hold the sponge forceps and the white rod stationary in one hand. With your free hand, withdraw (pull towards you) the inserter tube until it touches the thumb grip of the white
- rod. This will release the arms of the Copper T 380A high in the uterine fundus.
- Hold the inserter tube stationary while removing the white rod. Once the rod has been removed, again very gently and carefully push the inserter tube upward, towards the top of the uterus, until you feel a slight resistance.
- This step ensures that the arms of the T are as high as possible in the uterus.
- Partially withdraw the inserter tube from the cervical canal. When the strings extend approximately 2-3cm from the cervical Os, use sharp scissors to cut the strings. This ensures that the pieces of the string cut off will stay in the inserter tube for easy disposal.
- • Alternatively, fully withdraw the inserter tube from the cervical canal. Place uterine tube from the cervical canal. Place uterine dressing forceps across the IUCD strings
- approximately 3-4 cm from the cervical os. Use the forceps to push towards the uterus and cut the strings in front of the forceps so that the strings protrude only 2-3cm into the vagina. The method for cutting the strings minimizes the risk of inadvertently removing the IUCD (if the scissors are dull and not cut well, the strings may be trapped in the closed blades of the scissors).
- Remove the sponge forceps. If there is excessive bleeding from the Stopes forceps site, use
- HLD or sterile forceps to press a swab to the site until the bleeding stops.
- Assist the client from the table slowly (be alert to possible dizziness) and instruct her how and when to check the strings. Have the client wait in the clinic for 15-30 minutes after insertion.

Steps in Removing IUCD:

- Tell the client what you are going to do and encourage her to ask questions.
- Insert the speculum to visualize the cervix and IUCD strings.
- Thoroughly apply antiseptic solution to the cervix and vagina two or more times.

Normal Removal:

- Tell the client you are now going to remove the IUCD. Ask her to take slow, deep breaths and relax. Inform her that there may be some cramping which is normal.
- Grasp the strings close to cervix with HLD or sterilize forceps and pull slowly and firmly.
- Apply steady but gentle traction and remove IUCD slowly.
- The device can usually be removed without difficulty and you should not apply excessive force to avoid breaking the strings.
- If the strings break off but the IUCD is still visible, grasp the device with the forceps and remove it.

Difficult Removal:

- If the strings are not seen, after ruling out pregnancy, probe gently for them in the cervical canal with sterilize artery forceps.
- If the strings cannot be located in the cervical canal, the uterine cavity may be probed with sterilize hook, which can be used to grasp the strings or the IUCD itself.
- If the IUCD is partially removed and there is difficulty in drawing it through the cervical canal, attempt gentle, slow twisting motion while applying outwards traction, as long as client remains comfortable.
- If, from your bimanual examination, you believe a sharp angle between the uterus and cervix exists, place sterile Stopes forceps on the cervix and apply gentle traction downwards and outwards, while repeating the gentle traction on the IUCD. Do not use force.
- Insert a new IUCD if client wishes and conditions are appropriate.

IUCD Replacement:

- There is no need for a "rest period" before replacing another IUCD.
- If the client does not want to become pregnant and wants to continue the same method then IUCD can be inserted immediately once the effective period is over.

Side effects and management:

Side effect	Management
Heavy or prolonged Bleeding (twice as much as usual or longer then 8 days)	• Reassure her that many women using IUCDs experience heavy or prolonged bleeding. It is generally not harmful and usually becomes less or stops after the first several months of use. • Give COC's for 21 days. • For modest short-term relief (one at a time): – Tab. Mefenamic /Ponstan (500 mg) 3 times daily for 5 days, to be taken when heavy bleeding starts. – Ibuprofen 800 mg (max) 3 times daily after meals for 5 days. • Provide iron tablets if possible and tell her it is important to eat foods containing iron. • If heavy or prolonged bleeding continues consider underlying conditions unrelated to method use
Cramping and pain	• She can expect some cramping and pain for the first day or two after IUCD insertion. This is common in the first 3 to 6 months, decreases over time, suggest pain killer if it doesn't settle then evaluate and treat underlying condition.
Possible anemia	• The copper-bearing IUCD may contribute to anemia if a woman already has low iron blood stores before insertion and the IUCD causes heavier monthly bleeding provide iron tablets if possible.
Partner can feel IUCD strings during sex	• Explain that this happens sometimes when strings are cut too short and also that with the time it softens.

Complications and their management:

Complications	Si	Management
Pelvic inflammatory disease(PID)/ Suspected Pelvic inflammatory disease- due to noncompliance with aseptic techniques	• Unusual vaginal discharge • Fever or chills • Pain during sex or urination • Bleeding after sex or between monthly bleeding • Nausea and vomiting • A tender pelvic mass • Lower abdominal pain	Treat with: • Capsule Doxycycline (Vibramycin) 100mg twice daily for 7 days With • Tab Metronidazole (Flagyl) 400mg twice daily for 7 days
Ectopic Pregnancy	• Unusual abdominal pain or tenderness • Abnormal vaginal bleeding or no monthly bleeding—especially if this is a change from her usual bleeding pattern • Light-headedness or dizziness • Fainting	Refer to health care facility for further management
Uterine Perforation	• Abdominal distension • Constipation / Failure to pass flatus • Nausea and vomiting • Lower abdominal pain • Fever	Manage with: • Inj Clafron I/V and Inj Flagyl • I/V fluids Refer to designated hospital
Partial Expulsion		Remove the IUCD and place if its sure that she is not pregnant
Complete Expulsion	If client reports that IUCD has been expelled	Insert another IUCD if she wants making sure that she is not pregnant
	If client is not sure that IUCD is	Refer for X-ray or ultrasound
Missing strings	Suspect pregnancy or	Manage accordingly

New updates on IUCD insertion:

	New advice
STIs and PID	Risk lower than previously thought. Relates to gonorrhea or Chlamydia in the cervix when IUCD inserted. No effect on fertility.
STI risk and IUCD eligibility	STIs only disqualify women with 'a very high individual risk of exposure to gonorrhea or Chlamydia.' Woman is the best judge of her level of risk, once she has had risk explained.
Vaginal discharge	A simple vaginal discharge is not at all a good indicator of STI risk.
HIV positive	OK for HIV positive women until advanced stages reached and then OK if on ARVs and clinically well.

When to insert	Through first 12 days of menstrual period and at any other time reasonably sure she is not pregnant.
Blood loss and Anemia	With copper IUCDs vaginal blood loss typically only slightly increased. So, WHO categorizes Anemia as Category 2
Ectopic pregnancy	Because pregnancy is so unlikely with IUCD, IUCD is highly protective against ectopic.
Women need a rest period	This is a bad practice; a woman is exposed to the risks of pregnancy during the 'rest' and she is at risk of PID at second insertion.

The IUCD as emergency contraception:

The copper bearing IUCD (not the Levonorgestral IUCD) can also be inserted post-coitally and prevents pregnancy in 99% of women who choose this method. This can work either through the toxicity of copper ions to sperm or by blocking implantation.

To be effective the insertion must be made within five days after first sexual exposure or when the time of ovulation can be estimated, she can have an IUCD inserted up to five days after ovulation.

The eligibility criteria and contraindications for the copper bearing IUCD remain the same

Discharge Instructions for clients:

- Give post procedure instructions to the client for thread checking.
- Thread is to be checked after each menstrual period
- Instruct client to wash her hands and sit in a squatting position.
- Tell client to feel the thread of IUCD with her left Index & middle finger while sitting in squatting position.

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, questions, or wants another method; or she has a major change in health status. Also, if:

- She thinks the IUCD might be out of place. For example, she: – Feels the strings are missing.
- Feels the hard plastic of an IUCD that has partially come out.
- She has symptoms of pelvic inflammatory disease (increasing or severe pain in the lower abdomen,

pain during sex, unusual vaginal discharge, fever, chills, nausea, and/or vomiting),
- especially in the first 20 days after insertion.
- She thinks she might be pregnant.

Follow-up visits:

There is need for routine follow up through phone call to check if client has any of the warning symptoms. Provider should ask for development of any sign of complications and counsel for side effects.

(Note: Sometimes the color of copper bearing IUCD's darkness this does not mean that the IUCD has become contaminated. Unless the IUCD package is torn or opened or the shelf like has expired an IUCD with dark colored copper is still sterile and safe to use.)

Emergency Contraceptive (EC)

Role Play on EC

Two students will take part in the role play. One will act as a provider and the other will act as a woman who complains that the condom leaked inside her and she does not want to become pregnant. She wants to know what could be done to prevent pregnancy. The provider will tell her about ECP and counsel her. After the role play, the class will discuss the points missed by the provider and her communication skills. Ten minutes will be given to prepare the role play.

Emergency contraception (EC) is a method used by woman to prevent an unwanted pregnancy after unprotected sexual intercourse.
There are currently two methods of EC:

- Oral emergency contraceptive pills (ECPs)
- ECP contains either a progestin alone or a progestin and an estrogen together. ECPs are
- also known as the "morning after pill" or post coital contraceptives.
- Copper-bearing intrauterine contraceptive device IUCD

They should all understand that the Copper IUCD is more effective than the Emergency Contraceptive Pill and can be used as the future method of contraception.

Pills:

Key points for Service providers and clients:

- Emergency contraceptive pills help to prevent pregnancy when taken up to 5 days after unprotected sex. The sooner they are taken, the better.
- Do not interrupt an existing pregnancy.
- Safe for all women—even women who cannot use ongoing hormonal contraceptive methods.
- Provide an opportunity for women to start using an ongoing family planning method.
- Many options can be used as emergency contraceptive pills. Dedicated products, progestin- only pills, and combined oral contraceptives all can act as emergency contraceptives.

Mode of Action:

- Emergency contraceptive pills have been shown to prevent ovulation, and do not have any detectable effect on the endometrium or progesterone levels when given after ovulation. ECPs are not effective once the process of implantation has begun and will not cause abortion.

Effectiveness:

- If 100 women each had sex once during the second or third week of the menstrual cycle without using contraception, 8 would likely become pregnant.
- If all 100 women used progestin only ECPs, one would likely become pregnant.

- If all 100 women used estrogen and progestin ECPs, 2 would likely become pregnant.

Health benefits, health risks and side effects:
In order for a client to make an informed choice about ECP, the information giver, or counselor, must ensure that the client understands the health benefits, health risks and side effects.

Known health benefits:
Help protect against:
- Pregnancy – through preventing conception the woman will not have an unwanted pregnancy with the associated risk of morbidity and mortality
- Client should be aware that ECPs are not 100% effective and that their efficacy decreases with the increase in time lapsed since unprotected sex taking place.

Known health risks:
- None.

Advantages:
- Safe and effective
- Easy to use
- Few or temporarily side effects
- Can also be used by breast feeding women
- Not associated with birth defects in case of method failure
- Do not cause delay in fertility return

Counseling:
- The client must be counseled that there are 2 options – the IUCD or the ECP. She should be advised that the IUCD is the most effective and can be kept in-situ for continuous contraception
- A short review of current use of contraception options available should be offered
- The consultation should take place in a private, demedicalised environment
- Clients should be treated with dignity and respect
- Client should always be counseled on dual protection
- Clients should be aware that the ECP will not protect from any future unprotected sex
- Client should be counseled on the efficacy of ECP and where to contact if she thinks she maybe pregnant
- There should be an opportunity for clients to ask questions.

Side effects:
Counseling is essential in ensuring that the client can make an informed decision about taking ECP. It is therefore important to make the client aware of any side effects she may experience as a result of taking ECPs.

Possible side effects are:

- Slight irregular bleeding 1-2 days after taking ECPs
- Monthly bleeding that starts earlier or later than expected. In the week after taking ECP
- Nausea
- Abdominal pain
- Fatigue
- Headaches
- Breast tenderness
- Dizziness
- Vomiting

All clients taking condom must be advised to take emergency pack as a backup in case of condom rupture or leakage.

- Help to prevent pregnancy up to 5 days after unprotected intercourse. The sooner they are taken the better.
- Emergency contraception (EC) is **not an abortifacient** (it delays ovulation and prevents
- Implantation: it does not work if pregnancy is already established).
- It does not disrupt an already existing pregnancy
- Can only be used twice in a month; not to be used as an alternative to a regular contraception method
- Safe for all women

Hormonal Method (Oral contraceptive pills)

- Can be given up to 120 hours after unprotected intercourse (but efficacy starts to decrease significantly after 24 hours, no contra-indications exist (usual hormonal contra-indications
- do not apply since EC doses are given over short period of time).
- Always counsel women on regular contraceptive methods.

How to take the tablets or (when to take them)

- Give client pills; these can be taken immediately. If she is using a two-dose regimen, tell her to take the second dose in 12 hours
- Take tablets after eating meal (less nausea).
- If vomiting occurs within two hours of taking tablets, repeat the dose; (anti emetic medicine can be taken an hour before EC pills in order to avoid vomiting)
- Explain common side effects
- Explain to client that not use ECP's more than two times in month.
- Provide ECPs for future emergency use only
- Provide additional contraceptive method

Client Instructions:

Assure every client that she is welcome to come back any time, however, and also if:
She thinks she might be pregnant, especially if she has no monthly bleeding or her next monthly bleeding is delayed by more than one week

- Irregular bleeding due to ECPs will stop without treatment
- Assure the women that this is not a sign of illness or pregnancy

- These tablets will not protect against an already established pregnancy or from further unprotected intercourse.
- These tablets should not be used as a substitute for regular contraception (higher failure rates and side-effects than regular contraception).
- Encourage use of regular contraceptive method.
- Expect next menstrual period early or on time; advise to return if next menstrual period is delayed by more than one week.
- If method fails, no evidence of teratogenic (harmful effect on the fetus) effect from hormones, but a slightly higher risk of ectopic pregnancy.
- Advise women to come as early as possible after unprotected intercourse, if this occurs again in the future.

Copper Intrauterine Device (IUCD) Method:

Copper IUCD can be inserted up to five days after unprotected intercourse.

- Highly effective.
- Sexually transmitted Infection (STI) risk must be assessed.
- IUCD method chosen if:
  1) Greater efficacy required.
  2) Client wants IUCD as future contraception.

Implant can be inserted after taking Emergency Contraceptive Pills (ECPs)

Implants can be inserted within seven days after the start of her next monthly bleeding (within five days for IMPLANON) or any other time it is reasonably certain she is not pregnant. Give her a backup method, or oral contraceptives to start the day after she finishes taking the ECPs, to use until the implants are inserted.

Activity: Properties of an ideal contraceptive:

Properties of an ideal contraceptive	Oral pills	Injections	Femplant	IUCD	Tubal ligation	Vasectomy	Condoms	Natural methods
6755t3100 % Effective No failure rate								
Easy to use								
Easily available								
Doesn't interfere with intercourse								
Cheap								
Protects against STIs								

No side effects								
No complications								
Immediately effective								
Immediately ineffective								
Easily reversible								
No contraindication								
Under clients control								

Voluntary Surgical Contraception

Introduction

Voluntary Surgical Contraception (VSC) is one of the most effective methods of contraception when the desired family size has been achieved. It is also desirable for women or couples for whom another pregnancy might be detrimental to their health.

VSC is one of the most effective forms of contraception and is a one-time procedure intended to be permanent for both men and women. It includes tubal ligation (TL) in the female and vasectomy in the male.

Both Tubal Ligation (TL) and vasectomy are usually performed under local anaesthesia. The client is sent home after a few hours, and hospital admission is not required. TL can be performed within one week of delivery or within 48 hours of an abortion or as an interval procedure. Vasectomy is easier, safer, simpler, and less expensive than TL.

Policy:

- Surgical contraception will be purely voluntary.
- There will be no element of coercion while offering contraceptive surgery to clients.
- Informed consent of the couple and written consent of both husband and wife will be obtained in every case.
- Clients having two living children are eligible for contraceptive surgery, provided the age of the younger child is more than 1 year.
- VSC should not be denied to any client, regardless of age, who wants to undergo the procedure.
- Contraceptive surgical procedures will be performed only by trained and certified medical personnel.
- The staff assisting the surgeon during the surgical procedure must also be trained.
- VSC will be performed by a medical doctor in a properly equipped facility that has acceptable standards of asepsis and infection control.
- Mini laparotomy will be the preferred surgical technique for TL, as compared to laparoscopy.
- No-scalpel vasectomy (NSV) will be the preferred technique for vasectomy.
- To promote vasectomy, more stress should be placed on information, education, and counseling for men.

Standards:

The following standards must be maintained:

- Adequate facilities for carrying out the procedure must be available. This includes equipment and drugs to handle life-threatening situations and other emergencies.
- The surgeon and staff must be trained and skilled in the techniques they are using and in the use of appropriate and safe anaesthesia.

- All instruments and equipment must be in optimum working order.
- Strict asepsis must be maintained.
- A back-up or a referral system must be ensured.
- Proper counseling, informed choice, and accurate information regarding the irreversible nature of VSC should be provided to all potential clients.

For Female Sterilization (tubal ligation/mini laparotomy)

- The surgeon must be skilled in the management of emergencies related to the mini laparotomy procedure.
- A backup facility for the management of any complications that may arise must be available.
- Follow-up after 7 days must be ensured for all acceptors.

For Male Sterilization (vasectomy):

- No-scalpel vasectomy (NSV) would be the standard technique for vasectomy. However, where surgeons trained in NSV are not available, the conventional technique would be
- acceptable.
- All vasectomy clients must be advised to use condoms, or their wives can use a temporary method like pills or injection or abstain from sexual contact, for 3 months after having the vasectomy.
- All vasectomy clients must be advised to get their semen analysis done 3 months after the procedure to make sure that the operation was successful.

Female Sterilization / Mari Stopes Ligation (MSL):

- Female sterilization provides permanent contraception for women when the desired family size has been achieved.
- It is a safe and simple surgical procedure. It can usually be done with just local anaesthesia and light sedation. Proper infection prevention procedures are required.
- The two most common approaches are mini laparotomy and laparoscopy.

Mode of Action:

The doctor makes a small incision in the woman's abdomen and blocks off or cuts the two fallopian tubes. These tubes carry eggs/ovum from the ovaries to the uterus. When the tubes are blocked, the woman's ovum cannot be fertilized by the sperm, but she continues to have menstrual periods.

Effectiveness:

Female sterilization is very effective and permanent. In the first year after the procedure, 0.5 pregnancies occur per 100 women (1 in every 200 women).

Within 10 years after the procedure, 1.8 pregnancies occur per 100 women (1 in every 55 women). Effectiveness depends partly on how the tubes are blocked, but all pregnancy rates are low.

Advantages:

- Very effective.
- Permanent: A single procedure leads to life-long, safe, effective family planning.
- Nothing to remember, no supplies needed, and no repeated clinic visits required.
- No interference with sex; does not affect a woman's ability to have sex.
- Increased sexual enjoyment because no need to worry about pregnancy.
- No effect on breast milk.
- No known long-term side effects or health risks.
- Can be performed just after a woman gives birth.
- May help protect against ovarian cancer.

Limitations:

- Requires minor surgery by a specially trained provider.
- Compared with vasectomy, female sterilization is:
  - Slightly more risky
- Reversal surgery is difficult, expensive, and not available in most areas.
- Successful reversal is not guaranteed.
- No protection against sexually transmitted infections (STI's), including HIV/AIDS.

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

The questions on the following pages check whether the client has any known medical conditions that limit when, where, or how female sterilization should be performed.

The checklist should be used after the client has decided not to have more children and has chosen female sterilization. It is not meant to replace counseling.

The questions on the checklist refer to known conditions. Generally, the healthcare provider can learn about these conditions by asking the client. The health care provider does not usually have to perform special laboratory tests to rule out these conditions.

No medical condition prevents a client from having sterilization. Some conditions and circumstances call for delay, referral, or caution, however. These conditions are noted in the checklist.

Delay means delay female sterilization. These conditions must be treated and resolved before female sterilization can be done. Temporary methods should be provided in the meantime.

Refer means refer client to a centre where an experienced surgeon and staff can perform the procedure in a setting equipped with general anaesthesia and other medical support. Temporary methods should be provided.

Caution means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition.
If no conditions require delay or referral, female sterilization can be performed in these routine settings:

Mini laparotomy can be done in RHS-A and RHS-B Centres where surgery can be performed. These include both static and mobile camp facilities that can refer clients for special care if needed.

Laparoscopy requires a well-equipped centre, with highly trained staff, one where laparoscopy is performed regularly and an anaesthetist is available.

Ask the client the questions below. If the client answers "no" to all of 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 (female conditions), such as pregnancy, infection, or cancer?
2. DELAY female sterilization and treat if appropriate or refer in case of:
3. Pregnancy
4. Postpartum or after second-trimester abortion (7–42 days)
5. Serious postpartum or post abortion complications (such as infection or haemorrhage)
6. except uterine rupture or perforation (see below)
7. Unexplained vaginal bleeding that suggests a serious condition
8. Pre-eclampsia/eclampsia
9. Pelvic inflammatory disease (PID) within the past 3 months
10. Current STIs
11. Pelvic cancers
12. 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:
- Acute heart disease. Deep vein thrombosis or pulmonary embolism.

Refer to a centre with experienced staff and equipment that can handle potential problems:
- Moderate or severe high blood pressure (160/100 mm Hg or higher)
- Vascular disease
- 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:
- Gall bladder disease with symptoms
- Active viral hepatitis
- Severe iron deficiency anaemia (haemoglobin less than 7 g/dl)
- Acute lung disease (bronchitis or pneumonia)
- Systemic infection or significant gastroenteritis
- Abdominal skin infection
- Abdominal surgery due to acute abdomen
- Immobilization due to major surgery
- Post-surgical wound infection
- Current AIDS-related acute illness

Refer her to a centre with experienced staff and equipment that can handle potential problems:
- Severe cirrhosis of the liver
- Diabetes for more than 20 years
- Hyperthyroidism
- Bleeding disorders
- Chronic lung disease
- Pelvic tuberculosis

Caution:
- Epilepsy or taking medicine for seizures (phenytoin, carbamezapine, barbiturates, primidone)
- Taking the antibiotics rifampicin or griseofulvin

- Diabetes without vascular disease
- Hypothyroidism
- Mild cirrhosis of the liver, liver tumours, or schistosomiasis with liver fibrosis
- Moderate iron deficiency anaemia (haemoglobin 7–10 g/dl)
- Sickle cell disease
- Inherited anaemia (thalassaemia)
- Kidney disease
- Diaphragmatic hernia
- Severe malnutrition
- Obesity
- Elective abdominal surgery at time sterilization is desired
- Young age
- 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 counseling and informed consent, sterilization can be used in any circumstances by female clients who:

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

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

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

Before the procedure, the client should:

- Not eat or drink anything for 8 hours before surgery, except for clear liquids, which the client can take until 3 hours before surgery.
- Not take any medication for 24 hours before surgery. The morning dose of medicine for hypertensive or diabetes can be taken with doctor's advice.
- Bathe thoroughly, especially belly, genital area, and upper legs.
- Wear clean, loose-fitting clothing.

- Not wear nail polish or jewellery.
- Bring a friend or relative to accompany her home afterwards.

Method of Use:

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

- If it is certain that she is not pregnant.
- Immediately after childbirth, ideally within 48 hours postpartum but allowable within 7 days after delivery (minilaparotomy procedure only).
- At any time 6 weeks or more after childbirth if it is reasonably certain she is not pregnant.
- 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.
- Any other time, but not between 7 days and 6 weeks postpartum.

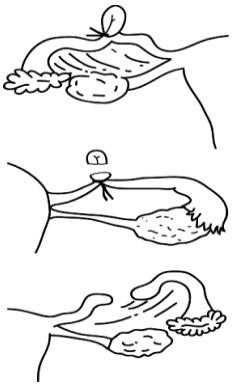
Techniques of Female Sterilization:

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:

Below is a description of the interval procedure, used more than 6 weeks after childbirth. The postpartum procedure used less than 7 days after childbirth, is slightly different.

1. Use proper infection prevention procedures.
2. Ask questions about the client's past and current health, and perform a physical examination and a pelvic examination.
3. Give light sedation to relax the client.
4. Infiltrate local anaesthetic into the incision site just above the pubic hair line.
5. Make a small incision (2–5 cm) in the anaesthetized area and expose the abdominal cavity.
6. Raise and turn the uterus with the uterine elevator to bring each of the two fallopian tubes under the incision.
7. Tie and cut each tube.



8. Close the incision with stitches and cover with adhesive bandages.

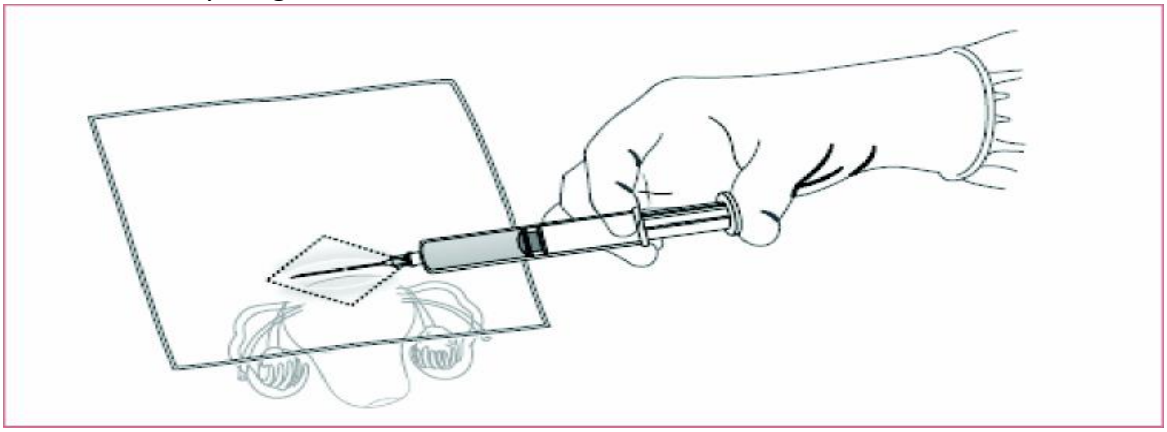
The Laparoscopy Procedure:

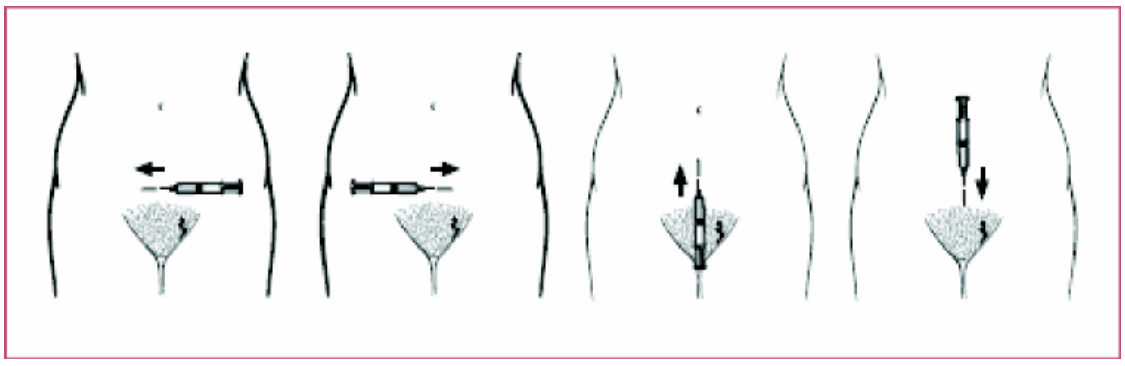
1. Use proper infection prevention procedures.
2. Ask questions about the client's past and current health, and perform a physical
3. examination and a pelvic examination.
4. Give the client light sedation.
5. Infiltrate the local anaesthetic into the incision site just under the navel.
6. Insert a special needle into the abdomen and, through the needle, introduced gas to inflate the abdomen. This raises the wall of the abdomen away from the organs inside.
7. Make a small incision (about 2 cm) under the navel and insert the trocar.
8. Insert the laparoscope or laprocator through the trocar.
9. Apply the fallope ring or clip using the laprocator to close off the tubes. Each tube is closed with a clip or a ring
10. After the tubes are closed, remove the trocar and laparoscope. Let the gas come out of the abdomen.
11. Close the incision with stitches and cover it with adhesive bandages.

Anaesthesia:

Local anaesthesia, used with or without mild sedation:

- Is safer than general, spinal, or epidural anaesthesia.
- Minimizes the length of the client's stay at the hospital.
- May involve use of many different anaesthetics and sedatives.
- May need to use additional sedation and/or analgesia; this should be adjusted according to the client's body weight.





For situations in which clients need general anaesthesia, see the section on Medical Eligibility Criteria for medical conditions requiring referral to a centre that can provide general anaesthesia.

After the Procedure:

The client should:

- Rest for 2 or 3 days and avoid lifting heavy objects for 7 days.
- Keep the incision clean and dry for 2 or 3 days.
- Not rub or irritate the incision for 1 week.
- Take paracetamol or another safe, locally available pain relief medicine, if needed.
- Not have sex for at least 1 week.

Side Effects and Management:

- Some discomfort is common after the operative procedure. This discomfort can be relieved with analgesics.
- 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.
- Some women complain of heavy or irregular periods after TL. These are not related to the procedure. If the complaint is troublesome, the client should be referred to a gynaecologist.

Complications of Minilaparotomy:

TL using minilaparotomy is a safe procedure, and complications are few. There may, however, be short-term (immediate) or long-term (delayed) complications as listed below.

- Possible short-term (immediate) complications are:
  - Drug reaction
  - Bleeding from the wound
  - Uterine perforation with the uterine elevator
  - Injury to mesosalpinx and broad ligament
  - Bladder or intestinal injury
  - Anaesthesia problems
  - Tears/transaction of the tubes

- Possible long-term (delayed) complications are:
  - Wound infection
  - Haematoma or abscess formation
  - Menstrual disorders
  - Ectopic pregnancy
  - Failure of sterilization (which is rare)

Complications of Laparoscopic Ligation:

- Bleeding
- Visceral injuries
- Infection
- Gas insufflation such as gas embolism, subcutaneous emphysema, and respiratory or cardiac arrest
- Lacerations of large blood vessels or abdominal organs by trocar

Resuscitation and Emergency Management:

Anaesthesia Problems

There is a small but definite risk of problems with the use of parenteral sedation and/or analgesia. Emergency drugs should be ready in case a reaction occurs. Adequate monitoring will lead to early recognition and prompt management of:

- Allergy to the local anaesthetic agent
- Reaction to pre-medication

Haemorrhage during Surgery and Early Post-Operative Period:

Haemorrhage may occur with both minilaparotomy and laparoscopic ligation, and may be detected by closely monitoring the vital signs of the client during the pre- and post-operative periods. If haemorrhage occurs, do the following:

- Establish an intravenous line, preferably with a large-bore needle or cannula.
- Introduce intravenous fluids or plasma expanders, if necessary.
- Send blood for grouping and cross-matching and transfuse blood, if necessary, after you receive the laboratory clearance for hepatitis and HIV.

- Take the client into the theatre for emergency surgery. Ensure that a sterile emergency laparotomy kit is available at all times (to meet such emergencies).
- In case of bladder and bowel injury, call a surgeon.

Uterine Perforation:
If perforation occurs during minilaparotomy:
- Change the position of the elevator and observe the client.
- If bleeding occurs, apply pressure with a hot-water sponge and use spongostan. Apply mattress stitches and, if bleeding does not stop, call a surgeon.

Post-Operative Complications and Management: Infection:
Tubal Ligation may be followed by pelvic infection. The chances of infection increase if there is a history of previous sepsis after surgery, or if undiagnosed infection was present before surgery. Immediately refer to the doctor (preferably to the operating surgeon) any client complaining of fever, severe lower abdominal pain, or vaginal discharge. Wound infection may occur but is usually not serious. The wound should be dressed daily, and if the discharge persists for more than 2 days, refer the client to a doctor.

Menstrual Changes:
In some cases, menstrual changes have been reported. Studies have shown that these changes could be due to a decline in the level of serum progesterone.

Other Problems
- Subsequent regret
- Psychological problems

Failure of Tubal Ligation:
All tubal occlusion methods have a failure rate, however slight, and the pregnancy that results carries a higher risk of being ectopic. Pregnancy after TL may occur when:
- The woman may have become pregnant in the same menstrual cycle in which the operation was carried out, i.e., she was already pregnant at the time of surgery.
- Structures other than the tubes were ligated.
- The fallopian ring was not applied properly.
- The cut ends of the tubes reconnected spontaneously.
- The uterine end of the tube developed a fistula with the peritoneal cavity, which may permit the sperms to pass.

If the client complains of amenorrhoea, send her for a pregnancy test. Be alert to the possibility of an ectopic pregnancy if the client complains of amenorrhoea, irregular vaginal bleeding, or lower abdominal pain, and refer her immediately to an appropriate medical facility for diagnosis and treatment.

Post-Operative Danger Signs:

- Fever (greater than 100.4o F or 39°C)
- Dizziness with fainting
- Abdominal pain that is persistent or increasing
- Bleeding or fluid oozing from the incision
- Signs of tetanus: Twitching of facial muscles, lockjaw, etc.
- Abdominal distension associated with vomiting and failure to pass gas

Patients with these danger signs should be referred to the doctor immediately.

Counseling:

Greet the client, ask her to sit down and make sure that she is comfortable. Now ask her some questions to confirm whether she needs permanent contraception.

Ask the client following questions:

- Do you want to have any more children in the future?
- If not, do you think you could change your mind later? What might change your mind?
- Suppose, God forbid, one of your children dies?
- Suppose you lose your spouse, and you marry again?
- Have you discussed sterilization with your spouse?
- Does your spouse want more children in the future?
- Do you think your spouse might change his or her mind later?
- Clients who cannot answer these questions may need encouragement to think further about their decisions regarding sterilization.

Special Care:

In general, people most likely to regret sterilization have these characteristics:

- Young
- Few or no children
- Have not talked with their spouse about sterilization
- Spouse opposes sterilization
- Not married
- Have problems in their marriage

Also, for a woman, just after delivery or abortion is a convenient and safe time for voluntary sterilization, but women sterilized at this time are more likely to regret it later. Thorough counseling during pregnancy and ensuring that the woman made her decision well before labour and delivery began, helps avoid regrets.

A client should return to the clinic for any of these reasons:

- For a follow-up visit, within 7 days to have stitches removed.
- The client has questions or problems of any kind.

- Return at once if:
  - High fever (greater than 38°C) in the first week
  - Pus or bleeding from the wound
  - Pain, swelling, or redness of the wound
  - Abdominal pain, cramping, or tenderness
  - Fainting or dizziness
- The client suspects pregnancy.
- The client should come to the clinic at once if she has any of the following signs:
  - Lower abdominal pain or tenderness on one side
  - Abnormal or unusual vaginal bleeding
  - Faintness (indicating shock)

Note: Pregnancies among users of voluntary sterilization are rare. But when pregnancy occurs, it is more likely to be ectopic than the normal pregnancy. Ectopic pregnancy is life-threatening. It requires immediate treatment.

Module 6

Reproductive Tract Infection

Session Hour: 04 Hour

Introduction

This guide is intended for people responsible for in-service training at any first-level health facility, such as a health center or clinic dedicated to the care of clients with sexually transmitted infections (STIs) and their management.

It is made up of suggested exercises that support both knowledge and skills-based learning to give trainees the skills they need to carry out safety measures to ruled out Reproductive tract infection (RTI) and their syndrome tic management and treatment.

The structure and content of the Guide

This module contains section. Each of the section is interactive, providing learners with questions, activities and projects to make their learning as relevant, stimulating and effective as possible. By taking the time to answer all the questions and complete any activities, learners have the opportunity to draw on their own experience, reflect on current practice, digest new concepts and apply them to their workplace.

List of section:

Section 1: Introduction to STI and RTI.

Section 2: Introducing STI Syndromic Management

Section 3: History-taking with STI Clients

Section 4: Examination the STI client

Section 5: Counselling to STI Client

Section 6: Syndromic Management Plan

Objectives

By completing all the sessions in this guide trainees will be able to:

- Understand the Overview of Reproductive Tract Infection (RTIs and STIs).
- Describe how STIs Transmitted.
- Identify the Prevention of STI.
- Demonstration of CMT and CFT.
- Describe the Syndromic management of STI.

Resources used in Training Session for trainee

1. Pre-Posttest for Evaluate Keen knowledge.
2. PPTS for group presentation.
3. Pelvic models and Instrument for demonstration of CFT and CMT.
4. Case studies/Activities photocopies
5. Checklist for Evaluation
6. Feedback /Evaluation Form

Section 1: An Introduction to STI and RTI

Not all sexually transmitted infections are reproductive tract infections; and not all reproductive tract infections are sexually transmitted; STI refers to the way of transmission whereas RTI refers to the site where the infections develop. Reproductive tract infection is a broad term that includes sexually transmitted infections as well as other infections of the reproductive tract that are not transmitted through sexual intercourse.

Reproductive tract infections are being increasingly recognized as a serious global health problem with impact on individual women and men, their families and communities. They can have severe consequences, including infertility, ectopic pregnancy, chronic pelvic pain, miscarriage, and increased risk of HIV transmission

Facts about STIs by WHO.

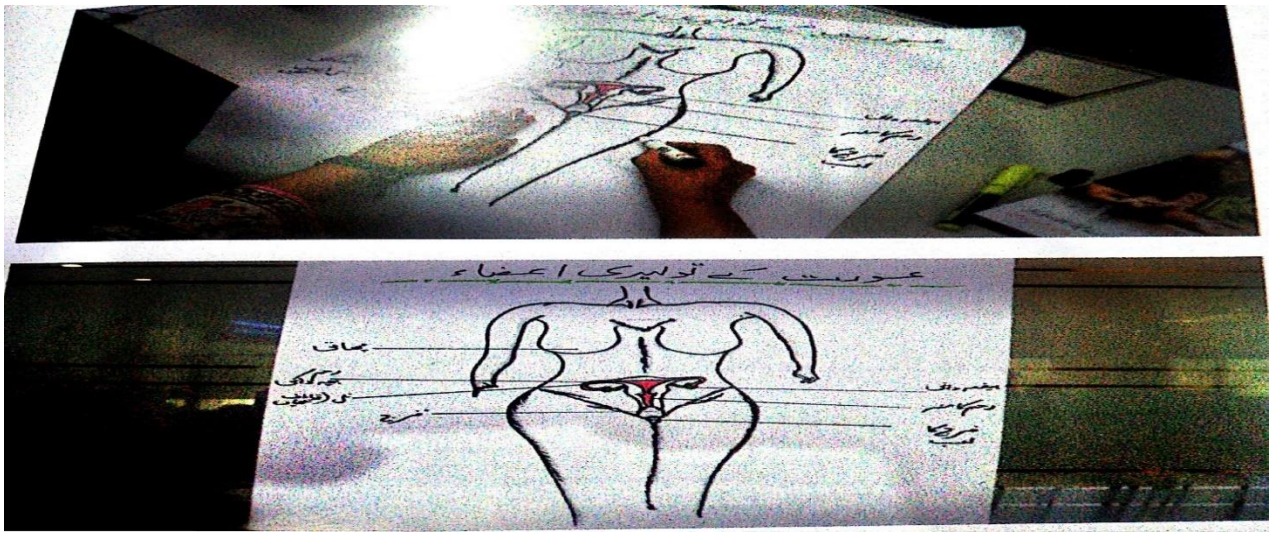
More than 30 different bacteria, viruses and parasites are known to be transmitted through vaginal, anal and oral sex, while some can also be spread through blood or blood products. Many STIs, including chlamydia, gonorrhoea, hepatitis B, herpes, HIV and syphilis, can also be transmitted from mother-to-child during pregnancy and childbirth

Globally in 2016, the four infections (chlamydia, gonorrhoea, syphilis and trichomoniasis) accounted for 376.4 million new infections in 15–49-year old men and women for that year

6 June 2019 – The prevalence and incidence of four curable sexually transmitted infections (STIs)—chlamydia, gonorrhoea, trichomoniasis, and syphilis—remain high according to global estimates, with over one million new infections each day on average in 2016.

Activity Body Mapping

The purpose of this Boding Mapping activity is to get men and women in the community to draw body organs on chart in each group in order to assess their knowledge and understanding of their body parts and reproductive health , by Referring WHO Health Definition , it is used to assess the level of knowledge that participants have regarding Their body organs and what the level of comfort they can draw these organs on chart and discuss in front of class.



What are RTIs?
Reproductive tract infections are infections of the genital tract. They affect both women and men.

RTIs are widespread. The World Health Organization estimates that each year, there are over 333 million new cases of curable STIs

RTIs result in numerous serious consequences, particularly in women. Pregnancy-related complications, as well as congenital infections, can result from RTIs. Pelvic inflammatory disease (PID) can develop, and can cause infertility, ectopic pregnancy, and chronic pain.

RTIs affect more than health. The morbidity associated with RTIs also affects the economic productivity and quality of life of many individual women and men, and consequently, of whole communities.

What are STIs?
Sexually transmitted Infections (STIs) are infections that have significant probability of transmission between humans by means of sexual behavior, including vaginal intercourse, oral and anal sex or by vertical transmission (from mother to newborn). Sexually transmitted infections (STIs) are a major global cause of acute illness, infertility, long-term disability and death with serious medical and psychological consequences of millions of men, women and infants. According to WHO the total number of new cases in adults of STIs in 2008 was estimated to be 498.9 million. The number of new infections highlights the global health problem posed by STIs in general. The direct clinical manifestations of STIs are uncomfortable for those affected, and if they are left untreated, can result in serious complications and sequel.

The purpose of this manual is to assist Service Providers in early identification and provision of appropriate care to clients with RTIs/STIs by using Syndromic management and timely referral if needed.

Types of Infection

Endogenous infections: are probably the most common RTIs worldwide. They result from an overgrowth of organisms normally present in the vagina. Endogenous infections include bacterial vaginosis and candidiasis. These infections can be easily treated and cured.

Iatrogenic infections:

occur when the cause of infection (a bacterium or other micro-organism) is introduced into the reproductive tract through a medical procedure such as menstrual regulation, induced abortion, and the insertion of an IUD or during childbirth. This could happen if surgical instruments used during the procedure have not been properly sterilized, or if an infection that was already present in the lower reproductive tract is pushed through the cervix into the upper reproductive tract.

Sexually transmitted infections (STIs): are caused by viruses, bacteria, or parasitic microorganisms that are transmitted through sexual activity with an infected partner

Responsibility: Doctor, paramedic and counselor

How are STIs transmitted?

By far the most common mode of transmission of STIs is through unprotected penetrative sexual intercourse (vaginal or anal). Other, more rare modes of transmission include:

- From mother to child:
  - during pregnancy (e.g. HIV and syphilis)
  - at delivery (e.g. gonorrhea, chlamydia and HIV)
  - after birth (e.g. HIV)
  - through breast milk (e.g. HIV)
- Through unsafe (unsterile) use of needles or injections or other contact with blood or blood products (e.g. syphilis, HIV and hepatitis).

It is important to remember that HIV is transmitted in the same ways as any other STI.

Role of Health Care Provider:

All health care providers have a responsibility to do what they can to prevent and treat STIs. The provider should recognize signs of STIs and either promptly treat or refer for treatment.

Women who currently have an STIs indicative of gonococcal or chlamydia origin are likely to be at higher risk for these infections and should not use IUCDs. Provider should diagnose and treat STIs before inserting an IUCD. During the treatment period, the couple should be provided with an option to use alternative contraceptive methods.

Men and who have several sex partners have more chances of getting STIs. Sex workers and the clients of sex workers are most likely to get STIS, Female Sex workers also usually want to avoid pregnancy, so they may come to health care provider for contraceptive.

Section 2: STI Syndromic Management

This section will enable you to list a number of problems associated with classic approaches to treating patients with STIs. Health-care providers generally use one of two approaches to STI diagnosis:

1. Etiological diagnosis: using laboratory tests to identify the causative agent.
2. Clinical diagnosis: using clinical experience to identify the symptoms typical for a specific STI.

In this section we introduce you to a third approach to STI treatment known as syndromic case management.

Syndromic management Approach:

Syndromic Management of STI's

Many STIs/RTIs can be identified and treated based on characteristic symptoms and signs. Symptoms and signs can be grouped together into syndromes. It is often difficult to know exactly what organism is causing the syndrome, however, and treatment may need to cover several possible infections.

Advantages of the Syndromic Approach

- Reduces probability of incorrect clinical diagnosis
- Specialized equipment unnecessary
- Clinical protocols are standardized
- Uniformity in collecting data
- Can be used by any level of health care providers
- Diagnosis and treatment can be provided at first visit
- In many cases, referral is not needed

Disadvantages of the Syndromic Approach

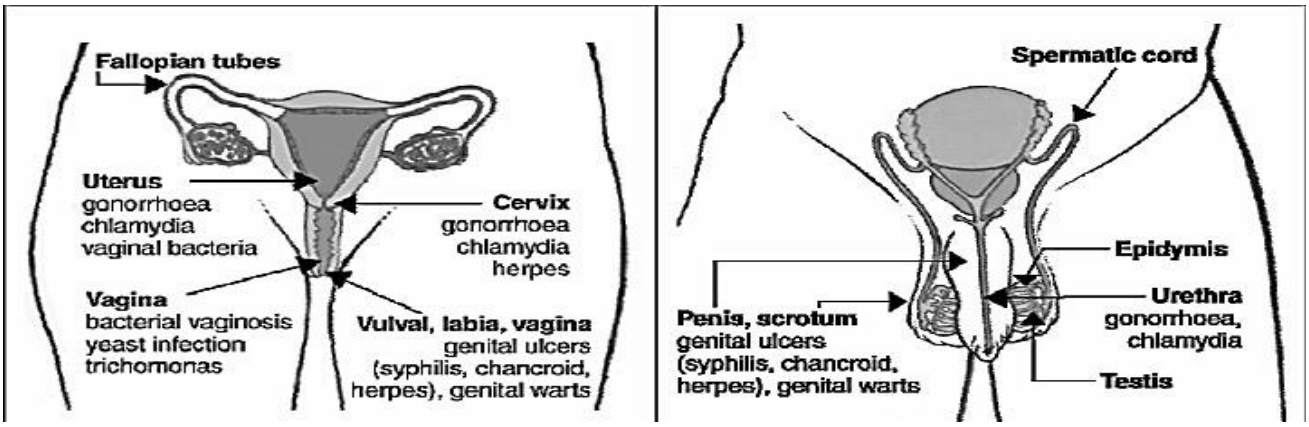
- Undue exposure to potential side effects of drugs due to over treatment
- Health care providers feel uncomforted not to use his/her clinical experience

There are 7 syndromes

1. Vaginal discharge
2. Urethral discharge
3. Lower abdominal pain
4. Genital Ulcers
5. Scrotal swelling
6. Inguinal Bubo
7. Neonatal conjunctivitis

Syndrome	Symptoms	Signs	Most common causes
Vaginal discharge	Unusual vaginal discharge Vaginal itching Dysuria (pain on urination) Dyspareunia (pain during sexual	Abnormal vaginal discharge	VAGINITIS: – Trichomoniasis – Candidiasis CERVICITIS: – Gonorrhoea
Urethral discharge	Urethral discharge Dysuria	Urethral discharge (if necessary ask patient to	Gonorrhoea Chlamydia
Genital ulcer	Genital sore	Genital ulcer	Syphilis Chancroid Genital herpes
Lower abdominal pain	Lower abdominal pain Dyspareunia	Vaginal discharge Lower abdominal tenderness on palpation Temperature >38°	Gonorrhoea Chlamydia Mixed anaerobes
Scrotal swelling	Scrotal pain and swelling	Scrotal swelling	Gonorrhoea
Inguinal bubo	Painful enlarged inguinal lymph nodes	Enlarged inguinal lymph nodes Fluctuation	LGV Chancroid
Neonatal conjunctivitis	Swollen eyelids Discharge	Oedema of the eyelids Purulent discharge	Gonorrhoea Chlamydia

Sites of Infection



Female anatomy	Male anatomy

Main symptoms of sexually transmitted infections in males:

- Sores, ulcers, blisters, small hard lumps, rashes on and around the sex organs.
- Burning sensation while passing urine; frequent urination
- Discharge (or "leak") from penis.
- Swelling in the scrotum (bag with balls or testicles) and in the groin area.

Main symptoms of sexually transmitted infections in females:

- Discharge (or "leak") from vagina.
- Sores, ulcers, blisters, small hard lumps, rashes around and in the sexual organs.
- Pain, itching, burning, swelling in and around vaginal area.
- Lower Abdominal/belly pain.
- Frequent urination
- PID
- Organism may come from outside or inside the body
- Spread by any medical procedure, examination, childbirth

Basic clinical anatomy and Basic Facts about Sexually Transmitted infections

STD	Main Clinical Features	Causative Agent	Incubation Period
Gonorrhoea	Pus discharge from the urethra or the cervix, dysuria, frequency.	Neisseria gonorrhea	2 - 6 days
Genital candidiasis	White curd like discharge coating the walls of the vagina that is itchy. Soreness, excoriation and cuts.	Candida albicans	May be endogenous and recurrent
Trichomoniasis	Greenish itchy discharge from the vagina with offensive smell	Trichomonas vaginalis	Variable
Chancroid	Dirty painful ulcer, usually one that is undermining	Haemophilus ducreyi	1 - 3 weeks
Herpes genitalis	Recurrent small multiple painful ulcers which begin as vesicles	Herpes simplex virus	2-7 days (initial infection)
Syphilis	Primary chancre is a painless, well demarcated ulcer. Other features depend on the clinical stage.	Treponema pallidum	2 - 4 weeks
Non gonococcal urethritis/ cervicitis	Thin non itchy discharge from the cervix or urethra	Chlamydia, Mycoplasma hominis and others	7 - 14 days
Bacterial vaginosis	Thin discharge with a fishy smell from the vagina	Overgrowths of Gerdenerella vaginalis	May be endogenous
HIV / AIDS	According to WHO clinical criteria for the case definition for AIDS	Human Immuno-deficiency Virus	Months – 10 years or more

Section 3: History-taking with STI Clients:

History Taking

This is the most critical part of the management of STIs science syndromic diagnosis is exclusively based on a good history & examination.

1. General history
2. Medical history
3. Sexual history
4. Present illness

1. General history

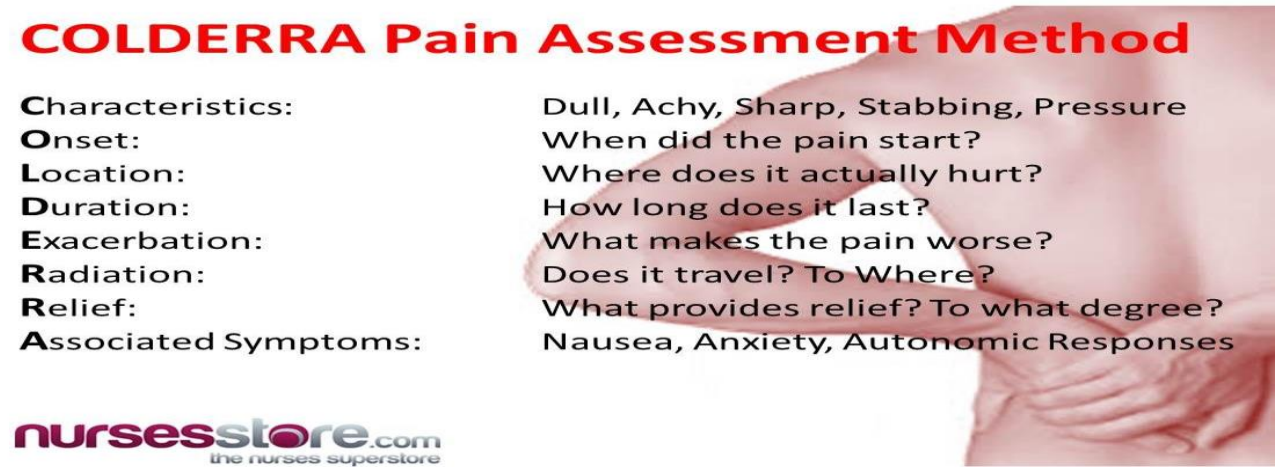
- Age
- Marital status
- Number of children
- Employment
- Address

2. Medical History

- Any past STIs history
- Other illness
- Medication being taken currently
- Drugs allergies

3. Present illness—COLDERRA

C : Character of complaint (VD- color, consistency)
O : Onset of complaint (day, months, acute, sudden, gradual
L : Location (area of the body)
D : Duration (Intermittent, continuous, chronic
E : Exacerbating factors (during or after sexual intercourse)
R: Radiation
R : Relieving
A : Associated factors



Common complains in men	Common complains in women
Urethral discharge	Vaginal discharge
Scrotal swelling	Lower abdominal pain
Genital ulcer	Genital ulcer
Itching & discomfort	Itching & discomfort
	Difficult pregnancy
	Painful or difficult menstruation
	Missed or overdue periods

4. Sexual History

Some patients may not be comfortable talking about their sexual history, sex partners, or sexual practices. Try to put patients at ease and let them know that taking a sexual history is an important part of a regular medical exam or physical history.

The 5 'P's OF Sexual health: -

- Partners
- Practices
- Protection from STIs
- Past History of STDs
- Prevention of pregnancy

Partners

To assess the risk of contracting an STD, it is important to determine the number and gender of your patient's sex partners.

Remember: Never make assumptions about the patient's sexual orientation.

Dialogue with patient

- Are you currently sexually active?
  - (Are you having sex?)
  - If no, have you ever been sexually active?
- In recent months, how many sex partners have you had?
- Are your sex partner's men, women, or both?

Practices

If the client has had more than one partner in the past year, the health care provider may want to further explore the client's sexual practices and condom usage. Asking about other sex practices will guide risk reduction strategies and help in identifying anatomical sites from which to collect Specimens for STI's testing.

Dialogue with patient

- What kind of sexual contact do you have or have you had?
- Genital (penis in the vagina)?
- Anal (penis in the anus)?
- Oral (mouth on penis, vagina, or anus)?

Protection from STIs

Through discussion, the health care provider should explore different issues such as condom use, monogamy/polygamy, client self-perception of risk, and perception of spouse's risk.

Dialogue with patient

- Do you and your partner(s) use any protection against STDs?
- If not, could you tell me the reason?
- If so, what kind of protection do you use?
- How often do you use this protection?
- If "sometimes," in what situations or with whom do you use protection?

Past History

A history of gonorrhea or chlamydia increases a person's risk of repeated infection. STI's in the recent past indicate higher risk behavior.

Dialogue with patient

- Have you ever been diagnosed with an STD? When? How were you treated?
- Has your current partner or any former partners ever been diagnosed or treated for an STD? Were you tested for the same STD(s)?
- If yes, when were you tested? What was the diagnosis? How was it treated?

Prevention of Pregnancy

Based on partner information from the prior section, you may determine that the patient is at risk of becoming pregnant or of fathering a child. If so, first determine if a pregnancy is desired.

Dialogue with patient

- Are you currently trying to conceive or father a child?
- Are you concerned about getting pregnant or getting your partner pregnant?
- Are you using contraception or practicing any form of birth control? Do you need
- Any information on birth control?

Section 4: Examination of STI Clients

Basic gynecological examinations are important for assessing client eligibility for many of Core services i.e. (Cervical Cancer, Safe Abortion Care, Tubal Ligation, IUD/S) and to help prevent complications

developing. They detect abnormalities in the lower abdomen, external genitalia, vagina, cervix, uterus, fallopian tubes and adnexa that may need medical interventions prior to the provision of SRH services or to determine whether the client is pregnant.

A basic gynecological examination has four parts:

- **Abdominal examination** checks for any distension (guarding & rigidity), swelling, lesions, scars, tenderness
- **Examination of the external genitalia** to rule out abnormalities that may be seen in sexually transmitted infections
- **Bimanual examination** to determine the size, shape, position, consistency, mobility and tenderness of the uterus. It also assesses cervical motion tenderness and the adnexa for adnexal masses and tenderness
- **Speculum examination** to assess the vaginal walls and ectocervix

All examinations should begin with a general assessment, including vital signs and inspection of the skin, to detect signs of systemic disease. It is beyond the scope of these guidelines to cover all aspects of the physical examination.

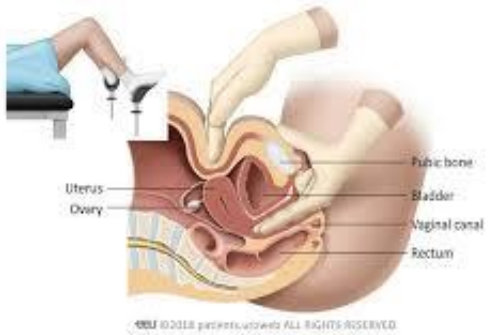
Ensure that the examination can be conducted in privacy.

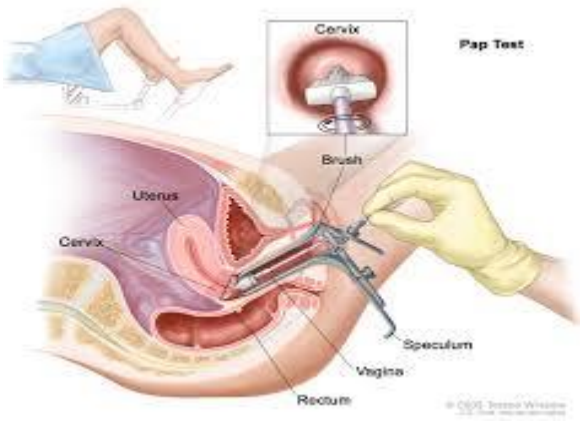
Supplies and equipment

- The following equipment and supplies are required to do a pelvic examination:
- Non-sterile gloves
- Sterile/HLD bivalve speculums of various sizes (small should be used for clients who have not had vaginal deliveries, medium/large – can be used for clients depending on their size and how many vaginal deliveries they have had)
- Normal saline/cotton wool/small kidney dish

The External Genital Examination for Women

Signs to look for when doing an external examination
Discharge and redness of the vulva are common signs of vaginitis. When the discharge is white and curd- like, yeast infection is likely.
Ulcers, sores or blisters
Swelling or lumps in the groin (inguinal lymph adenopathy).





Bimanual Examination

Signs to look for when doing a speculum examination
Vaginal discharge and redness of the vaginal walls are common signs of vaginitis. When the discharge is white and curd-like, yeast infection is likely.
Ulcers, sores or blisters.
If the cervix bleeds easily when touched or the discharge appears mucopurulent with discoloration, cervical infection is likely.
If you are examining the woman after birth, induced abortion or miscarriage, look for bleeding from the vagina or tissue fragments and checks whether the cervix is normal.
Tumors or other abnormal-looking tissue on the cervix.
Cervical Friability Test (CFT) Cervical Friability Test is another sign to diagnose cervicitis. To elicit this, during STI screening and after the insertion of speculum, cervix is swabbed with dry cotton ball, then inspect the cervix to see the appurtenance of bleeding spot on the cervix which will indicate the presence of cervicitis. Hold the cotton ball for few seconds and look for bleeding again to ensure that the blood is not coming from inside the uterus

Signs to look for when doing a bimanual examination
Lower abdominal tenderness when pressing down over the uterus with the outside hand.
Cervical motion tenderness (often evident from facial expression) when the cervix is moved from side to side with the fingers of the gloved hand in the vagina.
Uterine or adnexal tenderness when pressing the outside and inside hands together over the uterus (center) and adnexa (each side of uterus).

Any abnormal growth or hardness to the touch.
Cervical Motion Tenderness (CMT) Cervical motion tenderness is one of the sign to diagnose PID (Pelvic Inflammatory Disease) which is the consequence of untreated cervicitis, though there are many other causes of PID. PID is a grave consequence of untreated STI leading to infertility. To elicit this, cervix is moved from side to side during bi manual examination during STI screening process and Client will feel pain if she is suffering from PID.

Examination of a Male Patient

- Wash your hands before the examination and put on clean gloves.
- Tell the patient what you are going to do as you do each step of the examination
- Ask the patient to stand up and lower his underpants to his knees. Some providers prefer the man to lie down during the examination.
- Palpate the inguinal region (groin) looking for enlarged lymph nodes and buboes.
- Palpate the scrotum, feeling for the testis, epididymis, and spermatic cord on each side.
- Examine the penis, noting any rashes or sores.
- Ask the patient to pull back the foreskin if present and look at the glans penis and urethral meatus.
- If you do not see any obvious discharge, ask the patient to milk the urethra.
- Ask the patient to turn his back to you and bend over, spreading his buttocks slightly. This can also be done with the patient lying on his side with the top leg flexed up towards his chest.
- Examine the anus for ulcers, warts, rashes, or discharge.
- Wash your hands following the examination.
- Record findings, including the presence or absence of ulcers, buboes, genital warts, and urethral discharge, noting color and amount.
- Follow up: Within one week of completing treatment.
- Refer if: Failure of response to treatment at follow up.

Signs to look in Men during Examination
Urethral Discharge
Ulcers, sores and blisters
Swelling or lumps in the groin (inguinal lymph adenopathy) and swelling of testicles

Activity

Rationale for Pelvic Examination - 'Match It'

Steps	Rationale
1. Examine lower abdomen	A. Check for inflammation, sores, swelling and urethral discharge
2. Examine external genitalia	B. Check for vaginal/cervical discharge and lesions
3. Perform bimanual examination	C. Check for distention, swellings, tenderness, lesions/scars and lymph nodes
4. Perform speculum examination	D. Check size and position of uterus; cervical motion tenderness, and the adnexa tenderness and masses

Section 5: Counseling to STI Clients

Counselling helps clients to understand themselves better as individuals. It explores feelings, attitudes, values and beliefs. Equipped with the correct information and knowledge, the client should seek to change behavior as a result of counseling.

Well Approach

W:	**Welcome the Clients**	Greet the clients warmly and offer them a seat. Sit close enough to them so that they can talk comfortably and privately. Have a welcoming tone in the voice.
E:	**Encourage the Clients to Talk**	Encourage clients to talk by looking at them as they speak, by asking questions, by nodding as they speak, by saying "Mmm, hmmm" or "Tell me more about that", etc.
L:	**Look at the Clients**	Looking at the clients as they speak helps them to talk comfortably. Make sure the provider has a warm and friendly facial expression.
L:	**Listen to the Clients**	Listen carefully to what the clients have to say

4 C's for Counseling:

In syndromic management of RTIs/STIs, the following messages are a must in counseling the patients and/or their partner(s):

- Comply with treatment.
- Counseling
- Use condoms for prevention of both pregnancy and STIs. (Refer to barrier method in chapter of FP)
- Contact partner.

There is no standard order in which these messages should be delivered

Counseling role plays

Instructions:

Divide the participants into groups of two. one play her role as service provider & second participant as client each group must cover the 5Ps, WELL approach, 4Cs, COLDERRA

1. A 30-year-old woman complains of a white discharge, itching and burning in her private parts. She is married and her husband lives with her.

2. A 25-year-old married woman has had lower abdominal pain for 2 weeks which is getting worse. Her husband was recently home to visit from the city where he works. She uses COC for contraception. She just finished a normal menstrual period but did note more than the usual cramping. On examination you note a normal vagina, and the cervix is red and bleeds easily. She has a non-pregnant uterus and positive cervical motion tenderness. The uterus and adnexae are very tender to palpation. She has a low grade fever.

3. A 20-year-old woman complains of a watery discharge "down below." It has been there for two weeks and getting worse. It smells bad. She does not know if her partner has a discharge or not because she has not seen him for two weeks.

5. A 35-year-old widowed woman works in a roadside bar and occasionally has casual partners. She complains of burning and discharge for two days. She had a new partner one week ago.

6. A 40-year-old married woman was treated for vaginal discharge 8 days ago at your clinic. She still has a discharge and her husband complain of burning micturation with itching

.

7. A 50-year-old businessman has a thick yellow discharge from his penis for 3 days and urination is very painful. He wants to go home to the village to see his wife, whom he has not seen for 3 months, and would like to be rid of this problem.

Activity

Put in the appropriate column:-

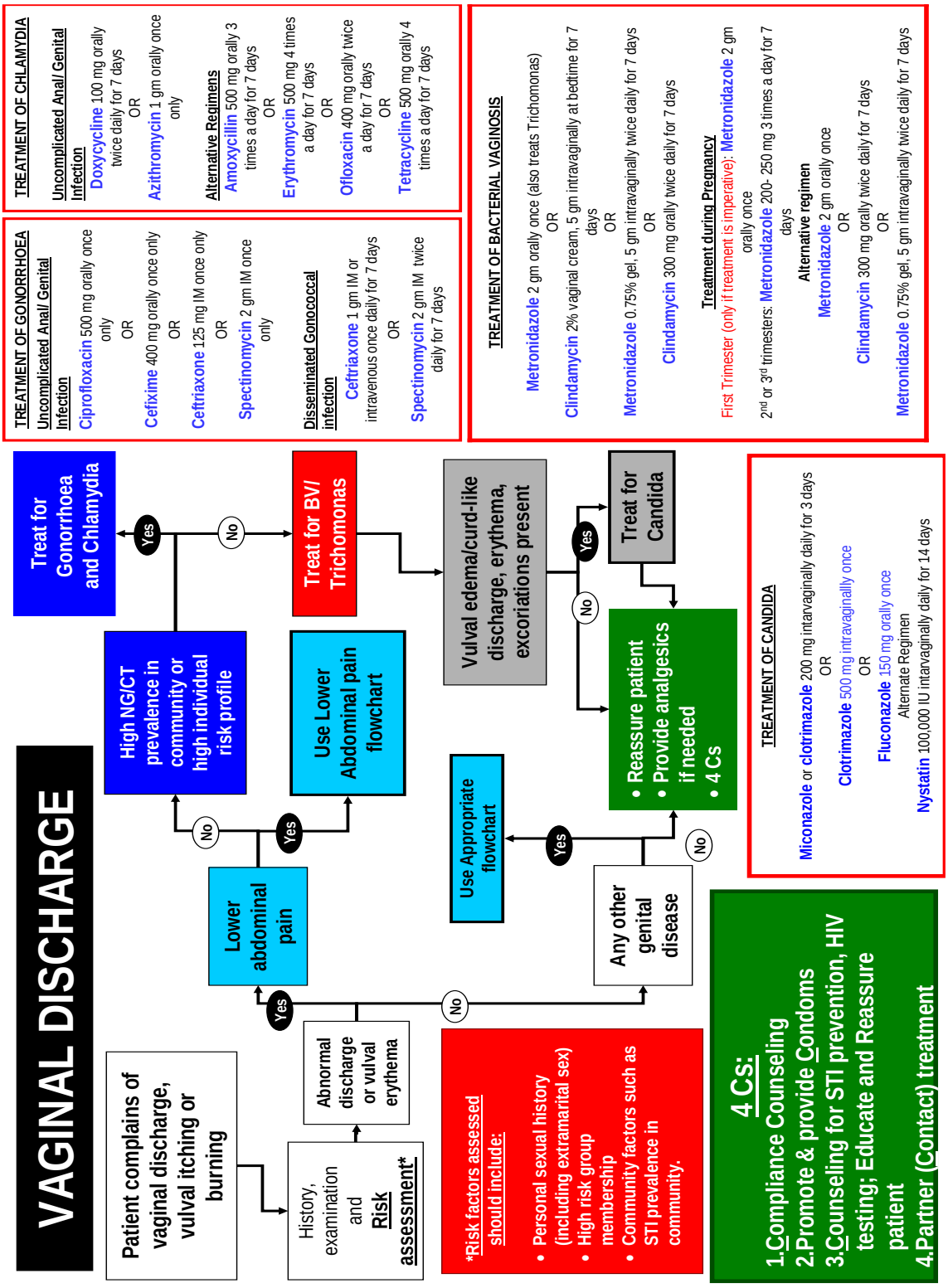
Ulceration, Itching, redness of vulva, cervix bleed easily when touch, sore, blisters, Scrotal swelling, lower abdominal pain, discomfort, missed periods, painful micturation, adnexal tenderness, discharge,

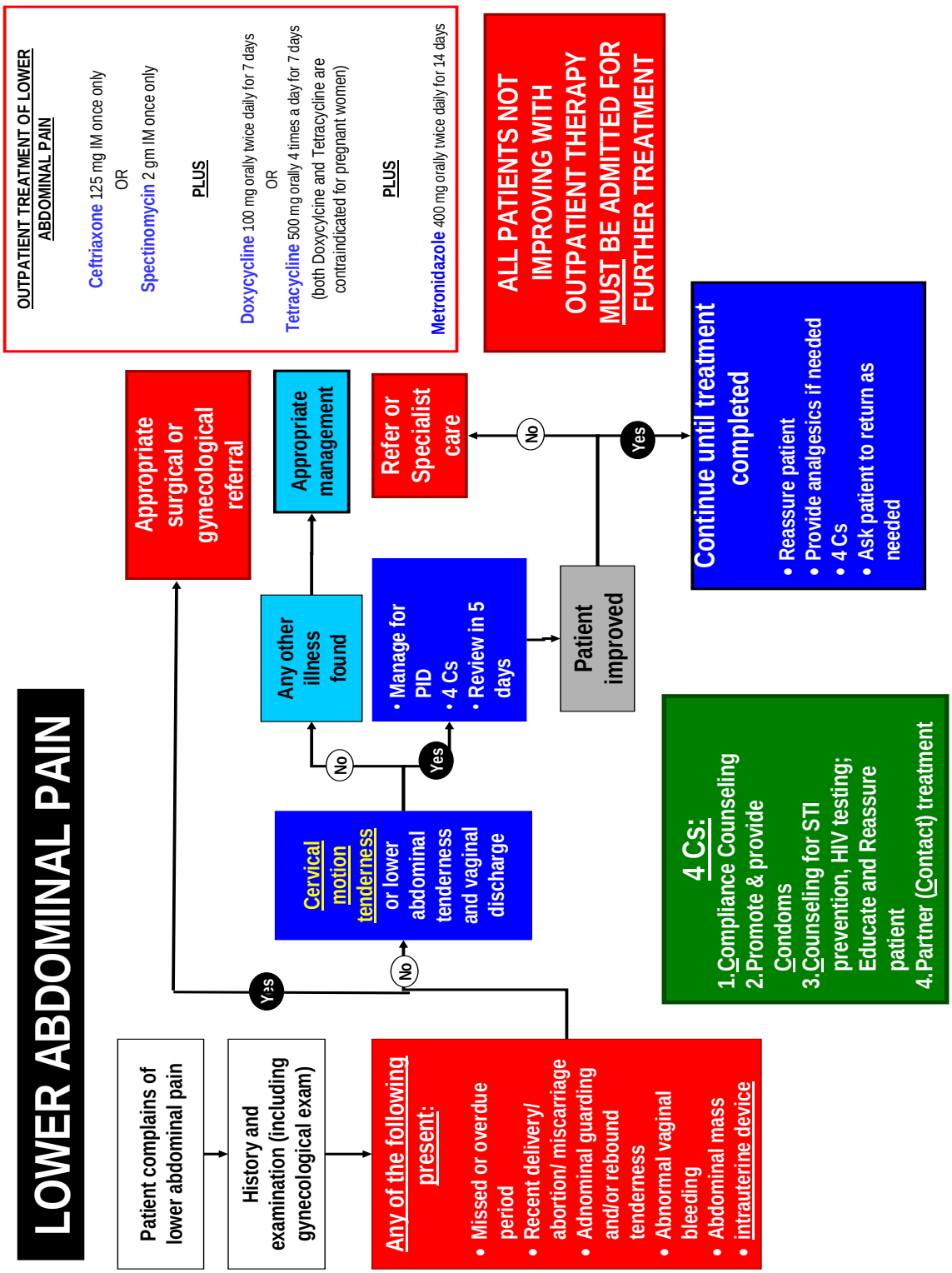
MALE SIGNS	FEMALE SIGNS

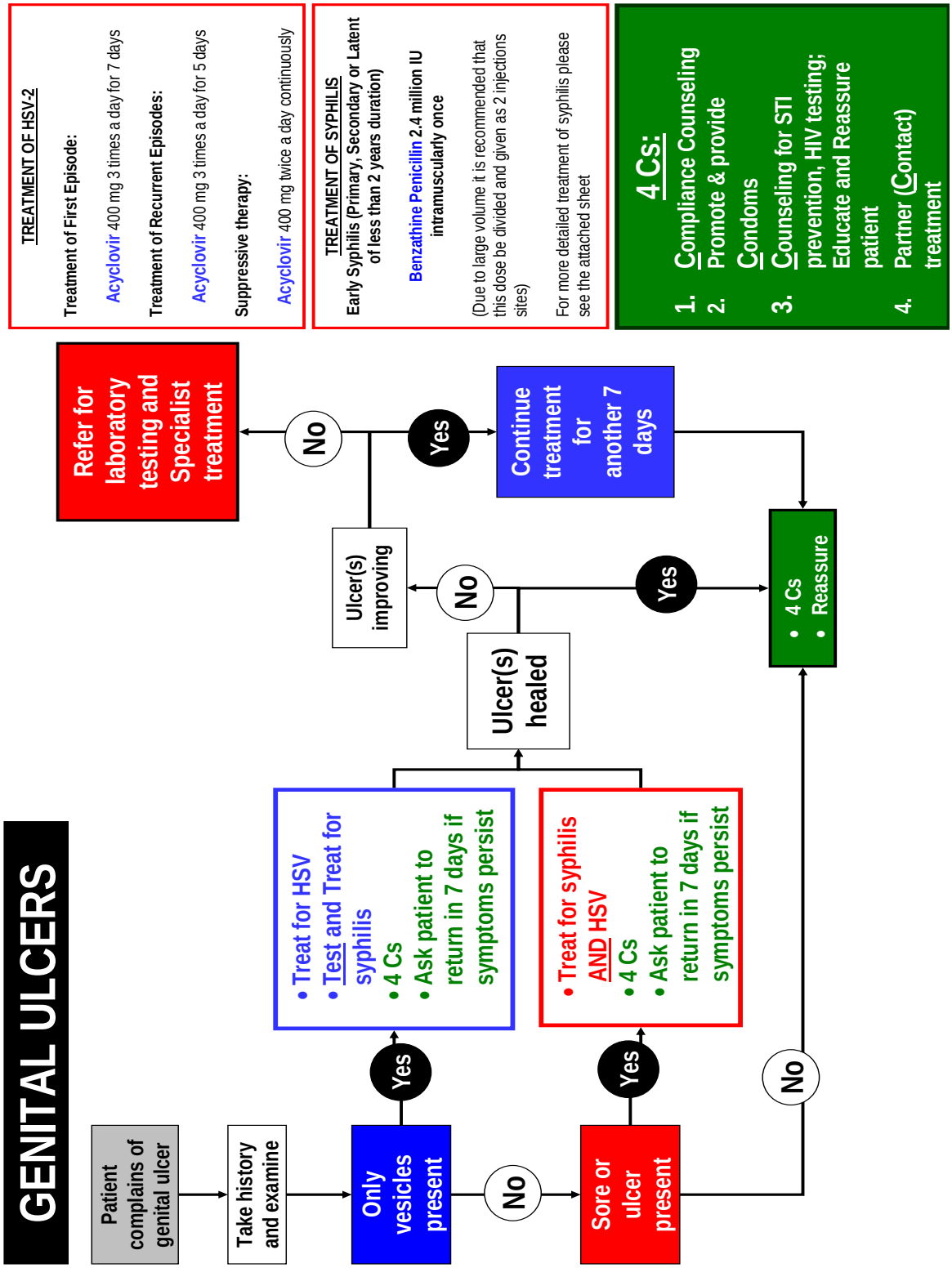
Observer's Role Play Checklist for History taking & Counseling Skills

TASK	YES	NO
WELL Approach		
Ask about her presenting illness • Character of complaint (VD- color, consistency) • Onset of complaint (day, months, acute, sudden, gradual • Location (area of the body) • Duration (Intermittent, continuous, chronic • Excercabating factors (during or after sexual intercourse) • Radiation • Relieving • Associated factors		
Ask about the sexual relation completely • Partners • Practices • Protection from STDs • Past history of STDs • Prevention of pregnancy		
Counseling done about the condom		
Instructions to client are complete and clear?		
Asks client to repeat back instructions?		
Does "Service Provider" treat client/family with respect?		
Is the counseling • Service Provider -controlled? • Client-controlled? • Balanced		
Return visit planned		

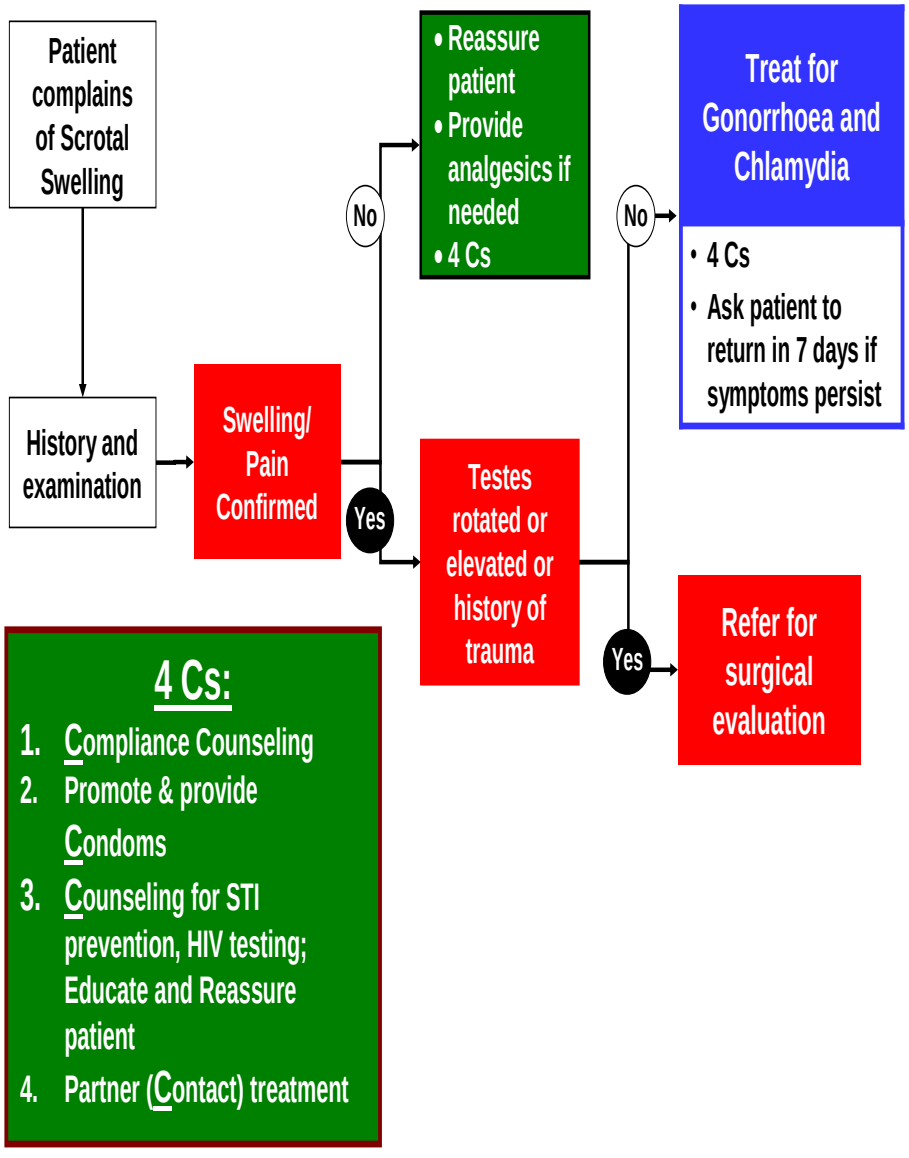
Section 6: Syndromic Management Plan




LOWER ABDOMINAL PAIN
Patient complains of lower abdominal pain
History and examination (including gynecological exam)
Any of the following present:
• Missed or overdue period
• Recent delivery/ abortion/ miscarriage
• Adnominal guarding and/or rebound tenderness
• Abnormal vaginal bleeding
• Abdominal mass
• intrauterine device
Yes
No
Cervical motion tenderness or lower abdominal tenderness and vaginal discharge
Yes
No
• Manage for PID
• 4 Cs
• Review in 5 days
Any other illness found
Appropriate management
Appropriate surgical or gynecological referral
Patient improved
Yes
No
Refer or Specialist care
Continue until treatment completed
• Reassure patient
• Provide analgesics if needed
• 4 Cs
• Ask patient to return as needed
4 Cs:
1.Compliance Counseling
2.Promote & provide Condoms
3.Counseling for STI prevention, HIV testing; Educate and Reassure patient
4.Partner (Contact) treatment
ALL PATIENTS NOT IMPROVING WITH OUTPATIENT THERAPY MUST BE ADMITTED FOR FURTHER TREATMENT
OUTPATIENT TREATMENT OF LOWER ABDOMINAL PAIN
Ceftriaxone 125 mg IM once only
OR
Spectinomycin 2 gm IM once only
PLUS
Doxycycline 100 mg orally twice daily for 7 days
OR
Tetracycline 500 mg orally 4 times a day for 7 days
(both Doxycycline and Tetracycline are contraindicated for pregnant women)
PLUS
Metronidazole 400 mg orally twice daily for 14 days


GENITAL ULCERS
Patient complains of genital ulcer
Take history and examine
Only vesicles present
Yes
No
Sore or ulcer present
Yes
No
• Treat for HSV
• Test and Treat for syphilis
• 4 Cs
• Ask patient to return in 7 days if symptoms persist
• Treat for syphilis AND HSV
• 4 Cs
• Ask patient to return in 7 days if symptoms persist
Ulcer(s) healed
Yes
• 4 Cs
• Reassure
Ulcer(s) improving
No
Yes
Continue treatment for another 7 days
No
Refer for laboratory testing and Specialist treatment
TREATMENT OF HSV-2
Treatment of First Episode:
Acyclovir 400 mg 3 times a day for 7 days
Treatment of Recurrent Episodes:
Acyclovir 400 mg 3 times a day for 5 days
Suppressive therapy:
Acyclovir 400 mg twice a day continuously
TREATMENT OF SYPHILIS
Early Syphilis (Primary, Secondary or Latent of less than 2 years duration)
Benzathine Penicillin 2.4 million IU intramuscularly once
(Due to large volume it is recommended that this dose be divided and given as 2 injections sites)
For more detailed treatment of syphilis please see the attached sheet
4 Cs:
1. Compliance Counseling
2. Promote & provide Condoms
3. Counseling for STI prevention, HIV testing; Educate and Reassure patient
4. Partner (Contact) treatment

SCROTAL SWELLING



4 Cs:

1. Compliance Counseling
2. Promote & provide Condoms
3. Counseling for STI prevention, HIV testing; Educate and Reassure patient
4. Partner (Contact) treatment

TREATMENT OF GONORRHOEA

Uncomplicated Anal/ Genital Infection

Ciprofloxacin 500 mg orally once only (Ciprofloxacin is contraindicated in pregnancy and for children or adolescents)

OR

Cefixime 400 mg orally once only

OR

Ceftriaxone 125 mg IM once only

OR

Spectinomycin 2 gm IM once only

Disseminated Gonococcal infection

Ceftriaxone 1 gm IM or intravenous once daily for 7 days

OR

Spectinomycin 2 gm IM twice daily for 7 days

TREATMENT OF CHLAMYDIA

Uncomplicated Anal/ Genital Infection

Doxycycline 100 mg orally twice daily for 7 days (Not to be used for pregnant women, children or adolescents)

OR

Azithromycin 1 gm orally once only

Alternative Regimens

Amoxycillin 500 mg orally 3 times a day for 7 days

OR

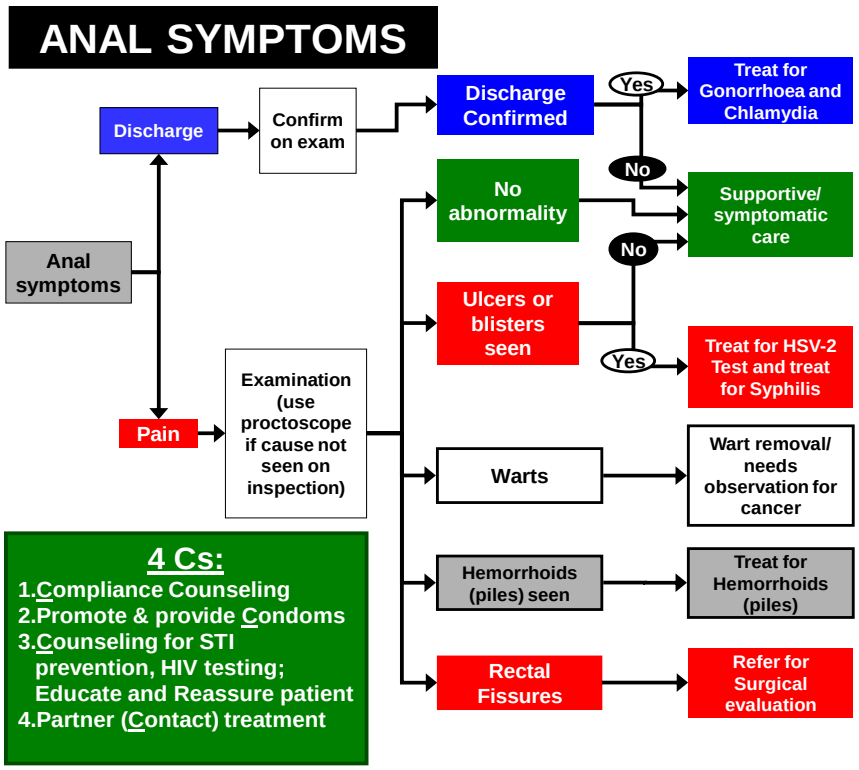
Erythromycin 500 mg 4 times a day for 7 days

OR

Ofloxacin 400 mg orally twice a day for 7 days

OR

Tetracycline 500 mg orally 4 times a day for 7 days



TREATMENT OF GONORRHOEA

Uncomplicated Anal/ Genital Infection

Ciprofloxacin 500 mg orally once only
OR
Cefixime 400 mg orally once only
OR
Ceftriaxone 125 mg IM once only
OR
Spectinomycin 2 gm IM once only

Disseminated Gonococcal infection

Ceftriaxone 1 gm IM or intravenous once daily for 7 days
OR
Spectinomycin 2 gm IM twice daily for 7 days

TREATMENT OF CHLAMYDIA

Uncomplicated Anal/ Genital Infection

Doxycycline 100 mg orally twice daily for 7 days
OR
Azithromycin 1 gm orally once only

Alternative Regimens

Amoxycillin 500 mg orally 3 times a day for 7 days
OR
Erythromycin 500 mg 4 times a day for 7 days
OR
Ofloxacin 400 mg orally twice a day for 7 days
OR
Tetracycline 500 mg orally 4 times a day for 7 days

TREATMENT OF HSV-2

Treatment of First Episode:
Acyclovir 400 mg 3 times a day for 7 days

Treatment of Recurrent Episodes:
Acyclovir 400 mg 3 times a day for 5 days

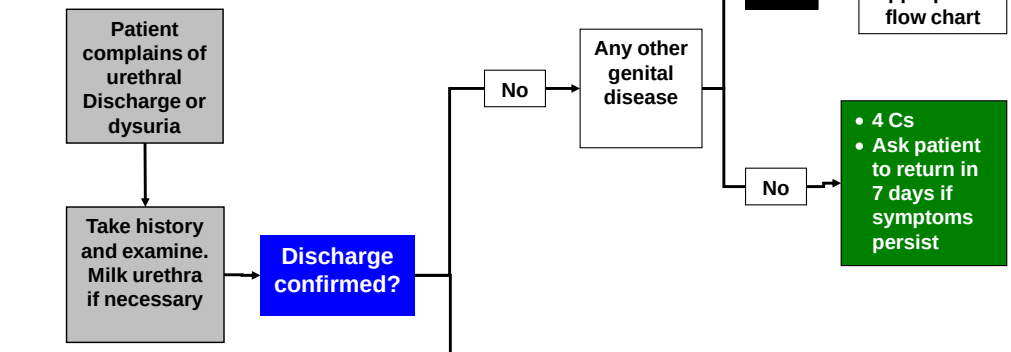
Suppressive therapy:
Acyclovir 400 mg twice a day continuously

TREATMENT FOR WARTS

Treatment is meant for external genitalia and vaginal. Please refer to gynaecologic specialist for cervical warts

Provider administered: Podophyllin 10-25% in compound of tincture or benzoin. Apply carefully avoiding normal tissue. External genital genitalia should be washed thoroughly in 1-4 hours. Allow the applied medicine to dry before removing speculum. Repeat application weekly as needed.
OR
Cryotherapy (when available). Repeat after 1-2 weeks as needed

URETHRAL DISCHARGE



4 Cs:

1. Compliance Counseling
2. Promote & provide Condoms
3. Counseling for STI prevention, HIV testing; Educate and Reassure patient
4. Partner (Contact) treatment

TREATMENT OF GONORRHOEA

Uncomplicated Anal/ Genital Infection

Ciprofloxacin 500 mg orally once only
(Ciprofloxacin is contraindicated in pregnancy and for children or adolescents)
OR
Cefixime 400 mg orally once only
OR
Ceftriaxone 125 mg IM once only
OR
Spectinomycin 2 gm IM once only

Disseminated Gonococcal infection

Ceftriaxone 1 gm IM or intravenous once daily for 7 days
OR
Spectinomycin 2 gm IM twice daily for 7 days

TREATMENT OF CHLAMYDIA

Uncomplicated Anal/ Genital Infection

Doxycycline 100 mg orally twice daily for 7 days
(Not to be used for pregnant women, children or adolescents)
OR
Azithromycin 1 gm orally once only

Alternative Regimens

Amoxycillin 500 mg orally 3 times a day for 7 days
OR
Erythromycin 500 mg 4 times a day for 7 days
OR
Ofloxacin 400 mg orally twice a day for 7 days
OR
Tetracycline 500 mg orally 4 times a day for 7 days

Treatment Options for Neonatal Conjunctivitis: -
Recommended Syndromic Treatment
Ceftriaxone, 50 mg/kg by intramuscular injection, as a single dose, to a maximum of 125 mg

Alternative Regimen where Ceftriaxone Is Not Available
Kanamycin, 25 mg/kg by intramuscular injection, as a single dose, to a maximum of 75 mg
Spectinomycin, 25 mg/kg by intramuscular injection, as a single dose, to a maximum of 75 mg

Syndromic Treatment of STI

S. no	Name of drug	Prescribed quantity	Dosage	Duration
1	Tablet. Ciproxin	500mg	One stat	Only once
2	Capsule Vibramycin	100 mg	One cap. Twice a day	7 days
3	Tablet Flagyl	400 mg	One tab. Twice a day	7 days
4	Condoms	25 unit	As per requirement	During treatment period

NB: Partner treatment is necessary, and the treatment will be the same as above for 7 days. If signs and symptoms persist treatment can be repeated for 7 days after assessment.

How much do you know?

Read the following statement carefully, if your answer is YES than write the statement in HAPPY if your answer is wrong the write the statement in danger zone.

1. Could a person get STIs by sharing a needle and syringe with someone when injecting drugs?
2. Could a woman get HIV (the AIDS virus) through having sex with a man?
3. If someone with HIV coughs or sneezes near other people, could they get the virus?
4. Could a man get STIs through having sex with a man?
5. Could a person get HIV from mosquitoes?
6. If a woman with Syphilis is pregnant, could her baby become infected with Syphilis?
7. Could a person get STI/HIV by hugging someone who has it?
8. Does the pill (birth control) protect a woman from STIs infection?
9. Could a man get STIs through having sex with a woman who is a bar girl?
10. If condoms are used during sex does this help to protect people from STIs?
11. Could someone who looks healthy pass on STIs infection?

4)11 year old shazia come to you with her mother, who told you that shazia is not feeling well since 8 days she has complained of sever burning & pain in perineal area with fever of 100°- 101°F. during history taking you find that she is miss used by her driver. On examination you find Ulceration & blisters on vulva & labia.

- What is your diagnosis?
- Describe the related flow chart.
- Treatment would you suggest?

5)28 years old Sara married since 5 years having 3 children her last baby is 5 months old on breast feed, now she has complained of thick white vaginal discharge with itching & burning. During history taking she told that she found yellowish spots in his cloths.

- What is your diagnosis?
- Describe the related flowchart
- Treatment would you suggest?

6) Mrs. Noshaad told that her son who is 19 years old complained of swelling in scrotal area with pain which increased gradually she further told you about his friends gathering is not good he spend most of the nights outside.

- Describe the related flowchart?
- Treatment would you suggest?

CASE SENAROS FOR PRESENTATION

Give one case in a group or individual participant as per your training. each scenario have three linked question .every presentation must covered these topics. Presentation is either on flipcharts or on multimedia.

1)30 year old Shazia married since 3 years having one child of 2 years old. now she came to you with the complain of itching in vulva vagina since 15 days relief when she washed her perineum with detol, but now she complaining of sever burning while passing urine. Her husband is army officer. give the following answers

- What is your diagnosis?
- Describe the related flow chart.
- Treatment you suggest.

2)22 years old Fatima married since 8 months complaining of irregular bleeding with the pain in anal area while sitting. During history taking she told that her husband forces her for anal sex. she also complain of purulent discharge from anus & vagina. give the answer of the following questions.

- What is your diagnosis?
- How you counsel her partner?
- Treatment would you suggest?

3)30 years old Sara having 4 children all females, last delivered 1 year back. Now she has complained of 100°F fever since 3 days with vomiting. On examination she has milky white vaginal discharge her cervical motion tenderness positive, she also given history of painful intercourse.

1) What is your diagnosis?
2) Describe the related flow chart.
3) Treatment would u suggest?

Module 7

The Pain Management

Objectives:

1. Introduction of pain and responsibilities of health care practitioners in pain management.
2. How to Assess the pain.
3. What are the approach for pain Management?
4. how these approach helps clients to manage the discomfort and pain that can be associated with critical procedures
5. what attitudes and skills are needed to provide effective Vocal Local techniques during a procedure itself?

Introduction:

Pain is an inevitable consequence of most clinical procedures. The level of pain experienced is influenced by a number of factors including the type of procedure as well as the pain threshold and attitude of the individual client. Health care workers are committed to helping all clients who undergo an procedure, experience minimal pain and /or discomfort.

Responsibilities of Health care practitioners:

- **Recognizing and assessing the pain level** of all clients, ensuring that an appropriate form of pain relief is provided in a timely manner.
- **Identifying any known allergies** that clients have, prior to administering any analgesia
- **keeping themselves up to date** on analgesia available in Health care center, including usage, recommended dosage, frequency of administration, side effects and contraindications
- **Documenting pain relief administered** in the client records, and if the client remains in the Healthcare centre post-administration of analgesia, for assessing and recording the impact of the pain relief

Assessment of Pain:

Learning to recognize pain in adults and adolescents is key to good client care, and for the comfort of the client through the Surgical / medical procedure and recovery periods. Indicators of pain vary with each individual client and assessments should be carried out throughout these periods.
It is known that most women undergoing medical abortion reported abdominal pain and factors associated with pain during surgical abortion. The degree of pain has been found to vary depending upon on a number of factors such as:

- Their age
- The length of the pregnancy (gestation time)
- The amount of cervical dilatation
- Their past experiences with pain

Factors to be considered include:

- size/weight of the client
- history of any drug-related addictions i.e. analgesic dependency
- current medication (where applicable)

Those with a known drug dependency may report a higher prevalence of pain and this should be considered by the healthcare practitioner when deciding how to manage their expectations about pain relief.

Method of assessing pain:
The most effective method of assessing pain is by using client self-reporting tools. With this technique, clients are asked questions about their pain and asked to describe it. Typically used words: none/just noticeable, mild/weak, moderate, strong/severe, excruciating. A specific ten point scale is then used by the clients to help them assess their pain based on their descriptions, where a score of 0=no pain and a score of 10=pain as bad as can be imagined, team members will ensure that clients understand the differences between the two end points. Visual analogue scales4 may be used where language may prove to be a barrier to expressing in words or when dealing with younger clients.

Pain Scale:
Clinical Symptoms and Signs:
- high blood pressure,
- high pulse rate,
- sweating,
- Shallow breathing,
- restlessness,
- facial grimacing,
- guarding,
- pallor

Management of Pain:
By using counselling techniques and taking a sympathetic attitude the client's fear and perception of pain will decrease. This method should be encouraged in along with the recognition that each type of procedure may require a differing approach to pain relief.

There are range of techniques to manage pain effectively including:
- Non-pharmacological, i.e. distraction techniques **(Vocal Local)** and use of heat pads
- Analgesia; oral and intravenous
- Local anesthesia i.e. prior to insertion of implants or cervical blocks

Distraction Technique (Known as 'Vocal Local' technique)
Vocal Local refers to the range of ways to manage the discomfort and pain of simple sexual and reproductive health (SRH) procedures with the minimum of drug treatment. As such, it is often referred to as a non-pharmacological approach to pain management. Health care providers provides Vocal local for all procedures, whether or not local anaesthesia is also used. Ideally, every team member should contribute to the Vocal local approach of the healthcare centre. It is an important aspect of client focused approach and a unique feature of healthcare service provision.
The Vocal Local approach is based upon the following concepts:

Manage anxiety and build confidence
Pain is directly related to anxiety. By decreasing anxiety at all times during the client's time in an Healthcare centre (through excellent communication and a welcoming non hospital-like environment) pain can be decreased.

Prevent pain occurring
Using gentle and minimally invasive clinical techniques avoids causing pain (or minimises it) and so can be more effective than using drugs to stop pain caused by the technique itself.

Manage the experience of pain
Non-pharmacological pain management techniques such as distraction and relaxation have been researched in hospital settings and found to be very effective.

Avoid Risks Associated with Drugs
Pharmacological approaches to pain relief have limitations and risks. Clients may experience more side effects and complications from the effects of narcotic or sedative pharmaceuticals during procedures. Vocal Local alone, or in combination with local anaesthesia, allows Health facility to perform procedures without complications from pharmaceuticals.

Pharmacological Approach (Analgesia):
Medical abortion:
Healthcare facility actively promotes clients undergoing a medical abortion to take prophylactic non-steroidal anti-inflammatory analgesia (NSAID), one hour prior to their 2nd tablets (misoprostol) (precaution when advising clients with history of asthma, allergic reactions or history of gastric bleeding, or those using selective serotonin reuptake inhibitors (SSRI's), as these clients will need codeine based drugs [paracetamol is only appropriate for very mild pain])

Surgical abortion
Appropriate analgesia will be administered at key stages of the client pathway to ensure discomfort is kept to the minimum pre, during and following her surgical procedure. The anaesthesia will be skill fully titrated to allow for a safe surgical procedure to be carried out and be in accordance to the signed consent option: either General anaesthetic, Sedation Anaesthetic, or Local Anaesthetic.

Post-Operative Recovery
Healthcare facility recommends specific prescribing guidelines for analgesia. Analgesia to be given in line with the client's pain score, using oral and/or intravenous routes appropriate to the level of pain and procedure performed. If the pain persists over a period longer than 30 minutes after analgesia has been administered and the level remains intense, the senior clinician should be alerted to the client's status, a full assessment which may include ultrasound scan to precludes underlying physiology should be considered, before prescription for alternative/stronger oral or intravenous analgesia. Effectiveness of analgesia given, is to be documented.

Discharge advice:
Prior to discharge all clients are given advises to how to manage their pain and at what point they should seek more advice.
Clients who remain in persistent discomfort and/or pain and have taken the recommended regular analgesia with little relief are advised.
Immediately see the doctor if persistent pain warrants an evaluation, to rule out underlying pathology, such as infection or an ectopic pregnancy and clients may be counselled to have a post-operative consultation at the Centre.

Module 8

Infection Prevention

Introduction to the Guide

Welcome to the Infection Prevention Trainers Guide. This guide is designed to help experienced clinical trainers run a training course on infection prevention for Health care service delivery.
It is made up of suggested exercises that support both knowledge and skills-based learning to give trainees the skills they need to carry out safe and effective infection prevention procedures.

While ideally run in the order they appear in this guide, the sessions are presented so that the trainer can choose how and when to run them. In addition, not all sessions are required recognizing that the trainer may only need to teach part of the module, for example if trainees already have certain knowledge or skills, or if the content is not relevant to their particular job role. For example teaching cleaning staff about aseptic techniques would not be appropriate. Similarly certain sessions may need to be given more time, or be repeated. This way the module can be adapted to suit the people being trained, as well as the time and resources available to carry it out.

Section A: Instructions to Trainers

Objectives of the Training

By the end session trainees will be able to:

- Understand the importance of Infection Prevention (IP) when delivering services
- Carry out safe and effective IP procedures according to Guidelines on Infection Prevention

Training format and logistics

This training module is designed to teach the Guidelines on Infection Prevention and Waste Management. Together, these two documents form the main reference material and should be distributed to all participants before training commences.
Ideally the course should be run with a ratio of 1 trainer to 4 trainees. The ideal number of trainees is 12 where trainees are selected and grouped according to previous experience and ability.

This training guide is consist of three sections:

Section A contains instructions for trainers
Section B contains detailed instructions for suggested classroom-based sessions.
Section C contains basic guidance on how to run the optional site assessment visit for trainees

Trainers are encouraged to read all three sections in full before using it to plan their own Infection Prevention (IP) training course.

Assessment

This is an assessed training course. Participants will be assessed on their knowledge and skills of infection prevention

Trainee knowledge will be assessed by a written test during the classroom-based sessions. This test has a pass mark of 75%.

Trainee ability to carry out certain IP measures should be observed during classroom-based demonstration. Formal assessment should be carried out through observation using the appropriate competency assessment checklist to ensure objectivity.

Level 1: Competent to offer service subject to regular re-assessment

Level 2: Competent to offer service only under direct supervision

On completion of this training all trainees will be given a certificate of training and filled checklist according to the level trainee has been endorsed.

Linking to Supportive Clinical Supervision

Trainees should be allocated a named Clinical Supervisor for regular support in their work place to ensure that lessons learnt persist outside the training room. It is vital that clear links are made between this training and the clinical supervision offered to the trainee in their workplace to ensure on-going professional development.

Infection Prevention training equipment and supplies

To run the practical aspects of this module you will need the following: **Hand hygiene**	**No. per 3 trainees**
Alcohol hand rub	3 bottles
Fresh water	Access to supply
Water bowl (if wash basin with tap not available)	1
Water pourer (if wash basin with tap not available)	1
Liquid soap	1 bottle
(or individual bars of soap with draining soap dish)	3
Clean personal towels	3 (or access to supply)
Gloving	**No. per 3 trainees**
Disposable examinations gloves	Multiple
Sterile gloves	Multiple
Sterile towels	Multiple
Utility gloves	3
Other items of PPE for show	Various
Handling sharps	**No. per 3 trainees**
Puncture proof bin	1
Needles and syringes	3
Antiseptics and disinfectants	**No. per 3 trainees**
Plastic buckets with lids	1
Locally used chlorine bleach	1
Measuring jug or cup	1
Labels	1
Marker pen	1
Fresh water	Access to supply
Instrument processing	**No. per 3 trainees**
Instrument sets for MSL and/or PAC and/or forceps and scissors for IUD	1
Decontamination	

Locally used chlorine bleach	Access to supply
Plastic buckets with lids for decontamination	1
Measuring jug or cup	1
Timer	1
Cleaning	
Fresh water	Access to supply
Locally used detergent	Access to supply
Plastic buckets for cleaning	1
Toothbrushes and sponges	1 of each
Drying racks	1
Sterilization	
Autoclave (or mock up) with manual	1
Lifting or Cheatle forceps and container	
Square cloths for wrapping instruments	Several
Autoclave tape	1
Non-autoclave tape	1
HLD	
Bleach or locally used equivalent	Access to supply
Lifting or Cheatle forceps and container	1

Aseptic Technique

Syringe and needle	1
Multi dose vial	1
Sterile instruments tray with various sterile instruments	1 of each

Suggested warm-ups and other useful training techniques
Trainers are required to set up appropriate conditions for training according to best practice in clinical training.

Overview and expectations (timing: approximately 5 minutes. Purpose: To clarify expectations, and involve trainees in learner-led training)
Give an overview of the course objectives and the proposed agenda. Then ask participants if they have any individual objectives.
Ground rules (timing: approximately 5 minutes. Purpose: To build trust within the group and establish a supportive learning environment)

Pre-course knowledge test (timing: approximately 10 minutes.

End of day / start of day reviews (timing: approximately 10 minutes.

4 stage method (timing: dependent on skill being demonstrated. Purpose: To teach clinical skills through demonstration and commentary).

1. **Demonstration of skill by trainer / video -** Trainer demonstrates procedure in real time with no commentary or questions to allow trainees see what they are expected to learn. Trainees observe with reference to clinical guidelines

2. **Demonstration of skill by trainer / video with trainer commentary** - Trainer demonstrates procedure in real time with commentary to break it down into individual components. Trainee questions to be answered after this stage.

3. **Demonstration of skill by trainer / video with trainee commentary** – Trainer demonstrates procedure in real time with commentary from volunteer trainee to allow trainees to reflect on what they would be doing. Any errors made by the trainee in providing the commentary should be corrected immediately. Stage may be repeated with other volunteers if time allows.

4. **Real time demonstration of skill by trainee with trainee commentary** – Volunteer trainee demonstrates procedure with own commentary. Trainer observes and listens, making immediate corrections when necessary. All trainees to perform this stage during on-going skills practice.

Energizers (timing: approximately 2 minutes. Purpose: To re-focus attention on the trainer and to stimulate blood flow to the brain)

Course end
Course monitoring and evaluation (timing: approximately 10 minutes. Purpose: To collect information on training outcomes and how the course may be improved in future)

Post course knowledge test
By the end of this session trainees will be able to:
- Score their infection prevention knowledge out of 100%
- Identify any particular knowledge gaps they need to revise

Ensure that everyone has a filled infection prevention monitoring checklist and a certificate of training, to take

Section B: Classroom Content

Agenda (Annexure)
Pre-course knowledge test (timing: approximately 20 minutes. Purpose: To lay a foundation of knowledge for participants to build on; to identify particular issues for individuals to concentrate on during the course)
Opening Quiz/ Key (Annexure)
Session 1: Importance of Infection Prevention

By the end of this session trainees will be able to:
- Describe the importance of infection prevention
- Describe the ways in which infections can be spread
- List eight standard precautions required for infection prevention

Timings: This session should take approximately 1/2 h

Discuss – Ask trainees what we mean by infection prevention and who they think is responsible for infection prevention. Facilitate a discussion to ensure agreement and understanding. (10m)
Present –
1. Give an overview of the importance of IP and the guiding principles
2. Give an overview of disease transmission cycle
3. Give an overview of the modes of transmission and examples of diseases spread for each mode (contact, vehicle, air, and vector)

Exercise -:
'If the cycle is interrupted at any point, the spread of infection is prevented'.
Then split trainees into groups of 2 or 3 and ask them to spend some time reading the hand out before listing as many ways as they can think of to interrupt the cycle. After 10 minutes ask volunteers to shout out their answers. Note these down on a flip chart. (20m)

Present – MODES OF TRANSMISSION OF INFECTION ACTIVITY:
(15 Minutes)
Participants will be divided into 2 groups, 1 group will write key points on HOW HIV, HEP B & CAN BE TRANSMITTED, and 2nd group will write on HIV, HEP B & C TRANSMISSION DOESN'T OCCUR THROUGH. 5 minutes will be given to write, and 5 minutes will be given to present.

Activity Objective:
To brainstorm and remember key learning points regarding HIV, HEP B & C transmission

Key Answer:
HIV, Hepatitis B and Hepatitis c can be transmitted:
- By blood and other body fluids through
- Improper instrument processing contact with broken skin
- Sharps injuries through infected needles, sharp instruments
- Transfusion of infected blood shared needles and syringes contaminated razors
- Tattooing
- Splashes of contaminated body fluid into mucous membranes of healthcare worker
- Through sexual contact (heterosexual and homosexual) through unprotected vaginal or anal intercourse
- From mother-to-child through pregnancy, delivery and breastfeeding.

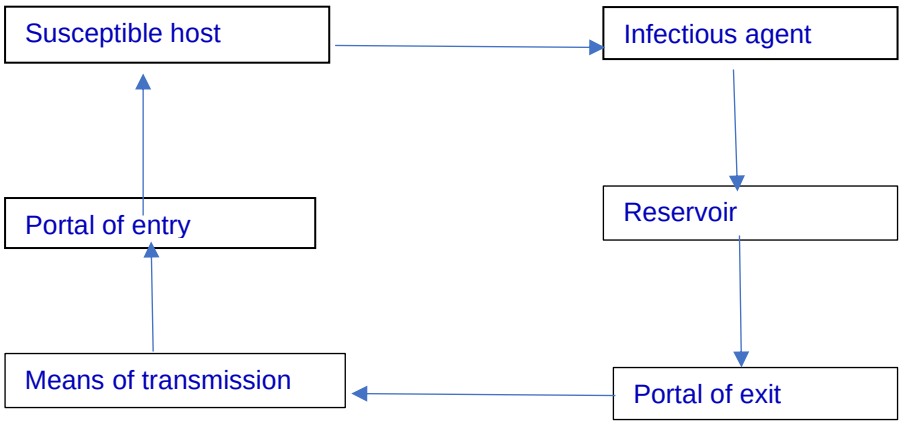
Remember that HIV, HEPATITIS B and Hepatitis C Transmission Does not Occur Through:
- Casual social contact
- Shared eating utensils
- Insect bites
- From donating blood
- By eating shared food or drink

Read the following case study then answer the questions below
Nurse shazia is working in a busy centre, and is taking blood from a client. shazia has performed this task many times before. The client has Hepatitis B but neither she nor shazia knows this. shazia completes the blood taking and puts the needle and syringe down on the table – so she can take the tourniquet off the client's arm. When she goes to pick it up again she accidentally pricks her finger on the needle.

Referring back to the *Disease transmission* cycle:
1. Who or what is the 'reservoir' in this case study?
2. What is the Hepatitis B microorganism's 'place of exit'?
3. What is the mode of transmission
4. Who or what is the suscipteble host
5. What action could shazia taken to protect herself from the risk of infection

Answer Key of Case Study
1. Blood
2. Client
3. Blood in needle
4. Nurse shazia
5. Worn gloves, proper sharp handling, proper waste disposal

Chain of infection.



Session 2: Standard precautions

Standard precautions are the minimum practices that apply to all health care providers to prevent the spread of infection

They are:

1. Environmental cleaning
2. Hand hygiene
3. Use of personal protective equipment
4. Processing of instruments
5. Prevention of sharps injuries
6. Respiratory hygiene
7. Processing of linen
8. Waste management

Meeting Infection Prevention Standards

(15 minutes)

Participants will be divided into 2 groups; each group will write key points on how they can meet infection prevention standards at MSS centers. 5 minutes will be given to write, and 5 minutes will be given to present.

Objective of The Activity:

To brainstorm the participants and to remember key learning points how or what they can they do to achieve infection prevention standards in order to get client satisfaction and team members satisfaction.

Key Answer:

- Ensure a clean and well-maintained centre
- Be knowledgeable, confident and competent in regard to MSIP have formal infection prevention training
- Have regular supervision and monitoring for proper infection prevention standards
- Be vaccinated for Hepatitis B
- Have a post exposure prophylaxis (PEP) protocol and policy frequently wash hands
- Wear appropriate gloves
- Have clean linen and uniforms

- Undertake proper waste management
- Ensure clean toilets with hand washing facilities
- Do proper screening for possible post-operative wound infection ensure proper sharps handling
- Use appropriate protective barriers – gloves, aprons etc. ensure proper instrument processing. Follow strict aseptic technique

Action planning – Encourage trainees to note down:

a) Anything they particularly want to learn about during this training course
b) What they can do to promote high standards of infection prevention in their work place (5m)

Environmental cleaning (Effective cleaning and housekeeping)

By the end of this session trainees will be able to:

- Identify low and high-risk areas for cleaning and carry out effective cleaning according to the risk of infection
- Describe how to clean spillages
- List equipment required for cleaning high and low risk areas

Timings: This session should take approximately 1h

Discuss – start with the following statement: 'cleanliness of MSS centres is the most important aspect mentioned by clients in satisfaction questionnaires' Ask the group whether this statement is true or false (answer is true)
Then ask the group whether they think the cleaning in their workplace is to a high standard? If not ask them to come up with suggestions how it could be improved? How is cleaning currently carried out in their workplace?
(10m)

Present –

1. Describe the general principles of effective cleaning
2. Describe low and high-risk areas and how to clean them effectively
3. Describe how to clean spills
4. List the equipment and materials required (10m)

Exercise: Suggested cleaning schedule for high risk areas

Split the group into pairs Cleaning Schedule for High Risk Areas
Exercise. Ask each pair them to complete the information in the table by looking it up in the guidelines. After 10 minutes go over the correct answers with the wider group ensuring agreement and understanding. (15m)

Suggested cleaning schedule for high risk areas

Schedule	Area	Equipment
Every morning	• Tables, counters • Floor	• Damp cloth to remove dust • Damp mop to remove dust
Daily and if dirty	• Toilets • Sinks • Floors • Walls • Waste containers	• Toilet brush disinfectant cleaning solution; scrub brushes • Cloth dampened with disinfectant cleaning solution • Mop dampened with soapy water • Cloth dampened with soapy water • Cloth dampened with disinfectant solution
At end of each day	• Wipe all surfaces top to bottom, sinks and walls • Clean floors • Dispose of sharps containers • Dispose of clinical waste • Wash waste containers	• Cloth dampened with disinfectant cleaning solution • Mop soaked in soapy water solution • Dispose of sharps boxes when ¾ full • Disinfectant cleaning solution and rinse with water
Between clients	• Procedure tables • Equipment and surfaces used for prior client	• Cloth dampened with disinfectant solution • Cloth dampened with disinfectant solution
Weekly	• Ceilings • Procedure room cupboards	• Mop dampened with soapy water solution

Case Studies.
Assign a different case study to each group and ask them to come up with a cleaning management plan. After 10 minutes ask each group to feedback to the wider group (20m)

Action planning – Encourage trainees to note down:
6. anything they will do differently as a result of what they have learnt in this session
7. any aspect of cleaning they particularly want to explore, discuss or practice further
8. How they can promote best practice for cleaning in their workplace (5m)

Trainers Guide –
Environmental cleaning Case Study 1

- This is a low risk area however, blood spillage needs cleaning immediately
- Keep calm and ask clients in waiting room to be careful not to come into contact with blood spill
- Wash your skin gently with soap and water and put on utility gloves
- Prepare use 0.5% chlorine solution with general housekeeping bucket and low risk mop
- Remove all signs of blood from all surfaces
- After using mop, decontaminate it with disinfectant, clean with soap and water, rinse with water and allow to dry
- Remove gloves and wash hands

Environmental cleaning Study 2

- High risk area
- Thank the client, acknowledging that this has been missed in the general cleaning and you will resolve the issues as soon as possible
- Make a note for this to be cleaned after all the procedures today – discuss not disturbing this reservoir
- At end of day clean area with damp mop/cloth
- Check cleaning rota and schedule is easily visible
- Inform centre manager about cleaning issue

Environmental cleaning Case Study 3

- High risk area
- As a minimum: wipe down procedure table and other surfaces with cloth dampened with disinfectant solution between every client
- Ensure the chlorine solution is made up daily
- Rinses cloths in chlorine solution
- Ensure any spills that occur are cleaned immediately with cloth/mop saturated in 0.5% chlorine solution and disinfectant used mops
- Removal of waste or sharps bins when ¾ full

Environmental cleaning Case Study 4

- Low risk area requiring immediate cleaning to prevent the spread of infections
- Put on utility gloves and apron
- Use low risk mop or cloth soaked in chlorine solution to clean area
- After using mop/cloth decontaminate it with disinfectant, clean with soap and water, rinse with water and allow to dry
- Disinfect mop/cloth after cleaning
- Remove gloves and wash hands

Environmental cleaning Case Study 5

- Wear utility gloves
- Wipe all surfaces top to bottom, sinks and wall with cloth dampened with disinfectant solution
- Clean floor with mop soaked in disinfectant
- Dispose of sharps containers, clinical waste and wash waste containers using disinfectant cleaning solution and rinse with water
- Remove gloves and wash hands

Hand Hygiene

By the end of this session trainees will be able to:

- describe why hand hygiene is important
- describe the use of different methods of hand hygiene (alcohol rub, soap & water) and when to use them
- Describe how to prepare hands for surgical procedures using alcohol rub, or soap and water
- Describe respiratory hygiene practices

Timings: This session should take approximately 1h

Pre-training preparation: Ensure adequate copies of relevant resources to hand out. Plan for breaks and consider energisers as required. Set up skills stations equipped with equipment and supplies required for alcohol rub, hand-washing, surgical rub and surgical scrub – one for every three or four trainees.

Discuss – Ask the group why we clean our hands at work. Do they think we clean them often enough? (5m)

Present -

1. Highlight that hand hygiene is the most important step in infection prevention
2. Explain the different methods for hand hygiene and why alcohol based hand rubs are preferred over washing with soap and running water
3. Describe all the instances when staff should clean their hands
4. Give an overview of surgical hand preparation and how it differs from normal hand hygiene
5. Briefly describe the need for, and main techniques of, respiratory hygiene (15m)

Discuss – Answer any questions that arise. Then briefly discuss where respiratory hygiene and hand hygiene would feature in terms of breaking the Disease Transmission Cycle.
Hint: Both are associated with places of exit (respiratory system, skin) and both are associated with modes of transmission (air borne and contact) (10m)

Exercise: Obstacles and enablers to hand washing

- Divide participants into groups of three or four. Give them a flipchart sheet and ask them to make a list under each of the following headings:
- Why people don't clean their hands at work
- What can be done to improve hand cleaning at work

After 5 minutes ask each group to present their list to the whole group, facilitating a discussion to ensure agreement and understanding

Exercise: Hand Hygiene Demonstration

- At a hand hygiene skills station, refer the 4 stage method to demonstrate the following:
- Alcohol Hand Rub Job Aid (Annexure)
- Hand Washing Job Aid (Annexure)
- Surgical Rub Job Aid (Annexure)
- Water Based Surgical Scrub Job Aid (Annexure)

Then, at skills stations, allow trainees to practice these skills in pairs, encouraging them to use the 4-stage method with their colleagues. Allow ample time for repeated practice so that trainees become comfortable with these techniques **and ensure that each trainee is observed using each technique successfully at least once.** (30m)

Action planning – Encourage trainees to note down:

a) what they will do differently as a result of what they have learnt in this session
b) anything they need to remember about techniques for hand hygiene
c) positive actions they can take to promote hand and respiratory hygiene practices in their workplace (5m)

Hand Hygiene Method	When to use it
Handwashing – action of performing hand hygiene for the purpose of physically or mechanically removing dirt, organic material, and/or micro-organisms	Before and after touching client or client's surroundings, or before procedure and after body fluid exposure risk
Alcohol hand rub – applying an antiseptic hand rub to reduce or inhibit the growth of micro-organisms without the need for a water source and requiring no rinsing or drying with towels or other devices	As above
Surgical hand preparation – surgical scrub and surgical hand rub performed preoperatively by the surgical team to eliminate transient flora and reduce resident skin flora	Before commencing any invasive procedure where aseptic technique is needed such as MSL, MSV, delivery

Gloves and other barriers (Personal protective equipment) PPE
By the end of this session trainees will be able to:

- Describe the 3 types of gloves used in MSS facilities and when they should be used
- Recognize other items of Personal Protection Equipment (PPE) and when they should be used
- Demonstrate the key steps for putting on and removing sterile gloves

Timings: This session should take approximately 1h

Pre-training preparation: Ensure adequate copies of IP Training Resource – PPE Matching Exercise to hand out. Plan for breaks and consider energisers as required. Set up skills stations equipped with equipment and supplies required for sterile glove demonstration – one for every three or four trainees

Discuss – Ask the group what they think the term Personal Protection Equipment (PPE) means. When have they used PPE at work? (5m)

Present - Referring to appropriate items of PPE….

1. Describe the general measures for glove use
2. List the 3 types of gloves and when they should (and must) be used
3. Describe other Personal Protection Equipment (PPE) such as caps, masks, eye covers, aprons, gowns, footwear and when they should (or must) be used

4. Highlight how use of non-mandatory PPE items is discretionary based on assessment of the risk of coming into contact with blood and bodily fluids (10m)

Discuss –answer any questions. Then ask volunteers to compare best practice in gloving with what happens in their place of work. Is there much difference?

Exercise: Matching type of gloves/PPE to specific tasks exercise - Give out IP Training Resource – PPE Matching Exercise and ask trainees to use the guidelines to complete the exercise, either individually or in pairs. After 5-10 minutes, go through the correct answers to ensure agreement and understanding. (20m)

Exercise: Sterile glove demonstration – At a gloving skills station, refer to the 4-stage method to demonstrate putting on and removing sterile gloves.

Then, at skills stations, allow trainees to practise these skills in pairs, encouraging them to use the 4-stage method with their colleagues. Allow ample time for repeated practice so that trainees become comfortable with this technique **and ensure that each trainee is observed completing the procedure successfully at least once.** (20m)

Action planning – Encourage trainees to note down:
a) what they are going to do differently as a result of what they have learnt in this session
b) anything they particularly want to work on going forwards
c) how can they promote use of PPE in their workplace (5m)

Trainer's resource – PPE matching exercise answers Task

	Gloves (specify type)	**Sterile gowns**	**Eye covers**	**Waterproof aprons**
Taking blood pressure	*No*	*No*	*No*	*No*
Drawing blood	*Disposable examination*	*No*	*No*	*No*
Pelvic examination	*Disposable examination*	*No*	*No*	*No*
Giving oral medication	*No*	*No*	*No*	*No*
Handling medical waste	*Utility*	*No*	*No*	*Yes*
Performing a Vasectomy (MSV)	*Sterile*	*Yes*	*No*	*No*
Inserting implants	*Disposable examination*	*No*	*No*	*No*
Cleaning a blood spill	*Utility*	*No*	*No*	*Yes*

Safe abortion care under 14 weeks	*Disposable examination*	*No*	*No*	*No*
Inserting an IUD	*Disposable examination*	*No*	*No*	*No*
Cleaning used instruments	*Utility*	*No*	*No*	*Yes*
Taking a client's temperature	*No*	*No*	*No*	*No*
Carrying out Tubal Ligation	*Sterile*	*Yes*	*Yes*	*No*
Giving an injection	*Disposable examination*	*No*	*No*	*No*
Safe abortion care over 14 weeks	*Disposable examination*	*No*	*Yes*	*Yes*
Safe delivery	*Sterile*	*Yes*	*Yes*	*Yes*

Glove Type	Indication	Comment	Material
Non-medical utility gloves (heavy duty)	Housekeeping, cleaning, disinfection, handling contaminated waste, sharps, chemicals Not for use in patient care	General purpose Puncture and chemical resistant Clean and disinfect with 0.5% chlorine after use	Natural rubber latex (NRL) and nitrile or chloroprene blends Neoprene Nitrile Rubber
Patient examination gloves	Examinations and other non-surgical procedures involving contact with mucous membranes, laboratory procedures	Non sterile Single-use Disposable Use for one patient only	NRL Polyvinyl chloride Polythene (plastic)
Sterile surgical gloves and sterile gynaecological gloves	Surgical procedures	Sterile Single-use Disposable Use for one patient only	NRL combination of latex and synthetic

Gloves Exercise

What are the appropriate gloves to use, if any, for the tasks listed in the chart below:

Task	Are gloves needed?	Preferred type of glove
Taking blood pressure		
Drawing blood		
Pelvic examination		
Handling medical waste		

Performing a Vasectomy		
Removing implants		
Cleaning a blood spill		
Performing a PAC		
Inserting an IUD		
Cleaning used instruments		
Taking a client's temperature		
Carrying out a MSL		

Key Gloving Exercise:

Task	Are gloves needed?	Preferred type of glove
Taking blood pressure	No	
Drawing blood	Yes	Non-sterile examination
Pelvic examination	Yes	Non-sterile examination
Handling medical waste	Yes	Utility
Performing a Marie Stopes Vasectomy (MSV)	Yes	Sterile surgical
Removing Norplant implants	Yes	Sterile surgical
cleaning a blood spill	Yes	Utility
Performing a MSP	Yes	Non-sterile examination

Inserting an IUD	Yes	Non-sterile examination
cleaning used instruments	Yes	Utility
Taking a client's temperature	No	
carrying out a MSL	Yes	Sterile surgical

Instrument processing

By the end of this session trainees will be able to:

1. Describe the importance of effective instrument processing
2. Demonstrate the key steps of instrument processing (decontamination, cleaning, sterilisation/High Level Disinfection and storage)

Timings: This session should take 1h

Pre-training preparation:

Set up four skills stations equipped with equipment and supplies required for instrument processing (one for decontamination, cleaning, sterilisation (autoclave) inclusive of instrument wrapping and HLD. There should be one for every three or four trainees. Plan for breaks and consider energisers as required

Discus – Ask the group whether they know any babies who drink milk from a bottle. How is that bottle cleaned and why is so much care taken? Are there any similarities between a baby's bottle and the equipment MSI uses in its facilities? (5m)

Present –

1. Describe the five steps for processing instruments (Decontamination, Cleaning, Sterilisation, High Level Disinfectant and Storage)
2. Describe handling and cleaning dirty linen (15m)
1. Discuss – Answer any questions and discuss any differences identified between recommended practice and what happens in participants' workplace.
2. Exercise: Review of Instrument Processing - Lay the ten index cards created from IP Training Resource 4 – Instrument Processing Exercise to create face down on a table. Then ask 10 volunteers to pick one each and work with each other to find their partner by matching the term with its definition. Then ask each pair to line up in the correct order for effective instrument processing. Invite the rest of the group to comment on whether the line-up is accurate or not. Review and discuss the steps. (15m)

Answer:

Decontamination card starts with "Involves soaking in 0.5% chlorine solution for 10 minutes"
Cleaning card starts with "Use of detergent and water to remove blood, body fluids, organic material, dirt"
Sterilisation card starts with "Kills all bacteria, viruses and bacterial endospores"

HLD card starts with "Kills most microorganisms accept from some bacterial endospores"

Storage card starts with "Maintains the status of sterilised or HLD instruments"

* Exercise: Instrument processing demonstrations – At the correct instrument processing skills station refer to sections 8 and appendix I of the guidelines whilst using the 4 stage method to demonstrate each stage of instrument processing (decontamination, cleaning, steam sterilisation and wrapping of instruments and HLD). In order show both sterilisation and HLD methods, demonstrate with different pieces of equipment appropriate

for core services offered by trainees– for example, an instrument tray, forceps, scissors, gown and MVA syringe. Remember to 're-set' the equipment at each station so it can be re-used by trainees

Then allow trainees to practise these skills by splitting them into five groups and rotating them around each of the skills stations. Ensure ample time for every participant to practice each stage of instrument processing and encourage trainees to give commentary to/for their colleagues while demonstrating. Ensure that each trainee is observed demonstrating each stage of instrument processing successfully at least once. (80m)

Action planning – Encourage trainees to note down:

a) anything they will do differently as a result of what they have learnt in this session
b) any aspect of instrument processing they particularly want to explore, discuss or practice further how they can promote best practice for instrument processing in their workplace. (5m)

Activity

Divide participants in group and ask them to match the description according to the stage of instrument processing allocated time: 15 minutes

DECONTAMINATION	▸ Soak in 0.5% chlorine solution for 10 minutes kills viruses (Hepatitis B and other Hepatitis, HIV and many other microorganisms ▸ Makes items safer to handle ▸ Prevents blood and tissues from drying – so easier to clean instruments.
CLEANING	▸ Scrubbing with a sponge or brush, ▸ Detergent and water to remove blood, body fluids, organic material, dirt ▸ Greatly reduces numbers of microorganisms including bacterial endospores ▸ Without proper cleaning, sterilization and HLD may be ineffective – microorganisms can be trapped and survive; organic ▸ Material can make chemicals for sterilizing and HLD less effective.
STERLIZATION	▸ Eliminates all microorganisms ▸ Recommended for all instruments that contact bloodstream or tissues under the skin ▸ Can be done by autoclaving, dry heat or chemicals.

Activity CONTINUE

HIGH LEVEL DISINFECTION	▸ Eliminates all microorganisms but does not reliably kill bacterial endospores – tetanus, gas gangrene ▸ Suitable for instruments that come in contact with broken skin or intact mucous membranes ▸ Can be done by boiling, chemicals or steaming.
STORAGE	▸ Maintains the status of sterilized or HLD instruments ▸ Efficient grouping of procedure-specific instruments ▸ Must be stored in a proper location instruments must be dated with ▸ Sterile expiry.

Do	Don't
Ensure detergent water is prepared according to manufacturer's instructions, at the correct concentration and temperature and used for the recommended contact time	Use metal brushes or abrasive items when cleaning instruments
Keep instrument moist and clean as soon as possible after a procedure	Clean instruments under running water as this can produce splashes
Disassemble instruments prior to cleaning	Use a detergent that is not intended for medical devices
Open hinged/jointed instruments to ensure access to all surfaces	
Flush with soapy water or detergent to clean cannulas and devices with lumens	
Use soft bristle brushes to clean serrations	
Inspect instruments after cleaning	
Clean instruments under the surface of water to reduce risk of splashes	
Follow manufacturer's instructions	

Correct Handling of Sharps
By the end of this session trainees will be able to:
- Describe the correct handling of sharps
- Demonstrate how to dispose of sharps safely
- Describe what to do if a sharps injury occurs in the workplace

Timings: This session should take approximately 1h
Pre-training preparation: Ensure adequate copies of IP Training Resource – PEP Case Studies to hand out. Plan for breaks and consider energisers as required

Discuss – Ask the group to give some examples of clinical sharps (e.g. injection and suture needles, scalpel, glass vials) and whether they have had any experiences with sharps injury (to providers or clients)? Ask group to come up with a list of ways to prevent sharps injuries. (10m)

Present - Referring to demonstration equipment you have (e.g. sharps bin, needles and syringes) …
1. Describe types of diseases spread through sharps injuries (HIV, Hepatitis B and C)
2. Describe how to prevent sharps injuries
3. Describe/Demonstrate the safe disposal of sharps
4. Describe what to do in the event of a sharps injury (10m)

Exercise: PEP Case Studies – split the trainees into three groups. Assign each group a different case study and ask them to spend 5 minutes discussing how to safely manage that situation before presenting back to the group. Encourage them to consult the guidelines for clues.
NB You may wish to write alternative case studies of your own that are more relevant to the work of the trainees

After each group has presented, facilitate a discussion to ensure agreement and understanding of the correct management process as outlined in the Trainers Guide on page 14.
(50m)

Action planning – Encourage trainees to note down:
a) anything they will do differently as a result of what they have learnt in this session
b) anything they particularly want to work on going forwards
c) positive actions they can take when they return to their own facility to ensure that sharps injuries are minimised. (5m)

Trainers Guide - PEP Case Studies Exercise

Case Study 1
While suturing a tubal ligation incision site, Dr Marjorie punctures her finger with a suture needle. She drops the needle holder with the suture needle on the sterile drape covering the client and removes her gloves. The wound is not bleeding much so she squeezes the punctured finger. The assistant removes the needle from the drape, pours antiseptic over the wound and helps Dr Marjorie re-glove. Dr Marjorie completes the procedure.
- Dr Marjorie should have immediately washed skin puncture with soap and water
- Incident should have immediately been reported to Centre Manager or Team Leader
- Incident should have been documented
- Risk of possible HIV transmission should have been assessed
- Dr and client should have been referred or counselled about having HIV test, and informed consent taken
- If test results are not available within 72 hours PEP should be administered

Case Study 2
Nurse Ann is working in a busy centre, and is taking blood from a client. Ann has done this process many times before. The client is HIV positive but neither she nor Ann know this. Ann completes the blood taking and puts the needle and syringe down on the table so she can take the tourniquet off the client's arm. When she goes to pick it up again she accidentally pricks her finger on the needle.
- Ann should wash skin puncture with soap and water as soon as possible
- Incident should be reported immediately to Centre Manager or Team Leader
- Incident should be documented
- HIV transmission risk should be assessed – there is a high risk of HIV transmission
- Client should be referred or counselled for HIV testing
- Immediate commencement of PEP should occur

Case Study 3
Whilst carrying out surgical abortion on a client with a gestation of 18 weeks a splash of blood from the client accidently goes into the Provider's eye. The Provider is not wearing eye protection, but, decided to carry on with the procedure and talk to the Centre Manager at the end of the day.
- The Provider should have irrigated their eye with saline or water as soon as possible
- Incident should have been reported immediately to Centre Manager or Team Leader
- Incident should have been documented
- Risk of possible HIV transmission should have been assessed

- Provider and client are referred or counselled about having HIV test, and informed consent is taken
- If test results are not available within 72 hours PEP should be administered

Reviewing Sharp Injuries
Suggested time allocated: 15 minutes
Aim: to demonstrate the likelihood of infection, post sharps injury.

Always consider that there may be participants in your group who are HIV, Hepatitis B or Hepatitis C positive. Ensure that this exercise is conducted with appropriate sensitivity.

Prior to the exercise – and without the trainees seeing this being done – stick Post-It notes (or papers with sticky tape) underneath the seats of participants' chairs ensuring that
- 30% of the notes read 'Sorry – you have Hepatitis B
- 3% should read 'Sorry – you have Hepatitis c'
- 1 or 1% should read 'Sorry – you have HIV'
- the remainder should read 'You have no infection'

Ask for a volunteer to pretend to be a client. One trainer should role play withdrawing blood from this 'client' and pricking their finger while recapping

The trainer explains to the participants that they have just sustained a needle stick injury.

Ask the participants to move to a different seat from the one they are currently sitting in, then look under this seat and read what is on the post-it/paper.

Ask those with post-its reading 'HIV' to stand up, then those with hepatitis c and then those with hepatitis b.

Explain to everyone that this is the relative risk of getting one of these infections as a result of a sharps injury – and how important sharps handling is.

Virus	Post-exposure prophylaxis
Hepatitis B virus	PEP with HBIG and/or Hepatitis B vaccine series after evaluation of the HBsAG status of the source and the vaccine-response of the exposed person Perform follow-up anti –HBs testing in persons who receive Hep B vaccine Test for anti HBs 1-4 months after last dose of vaccine
Hepatitis C virus	PEP not recommended Perform baseline and follow-up testing for anti HCV if possible 4-6 months after exposure Perform HCV RNA at 4-6 weeks if earlier diagnosis of HCV desired or if source known to be HCV positive
HIV	Start PEP as soon as possible if indicated Offer pregnancy testing to all women of childbearing age not known to be pregnant Administer PEP for 4 weeks Perform follow-up testing and provide counselling Advise exposed persons to seek medical evaluation for any acute illness occurring during follow-up Perform HIV antibody testing testing for at least 6 months post-exposure (baseline, 6 weeks, 3 months, 6 months) Perform HIV antibody testing if illness compatible with an acute anti-retroviral syndrome occurs Advise exposed persons to use precautions to prevent secondary transmission during the follow-up period Evaluate exposed persons taking PEP within 72h after exposure and monitor for drug toxicity for at least 2 weeks

Type of exposure	Source unknown HIV status	Source HIV-positive status
Any needle stick injury	Give PEP	Give PEP
Any cut from a scalpel contaminated with blood	Give PEP	Give PEP
Deep wound with a material contaminated with blood	Give PEP	Give PEP
Mucous membrane or damaged skin in contact with a significant amount of blood, splashes	Give PEP	Give PEP

Rape	Give PEP	Give PEP
Type of exposure	**Source unknown HIV status**	**Source HIV-positive status**
Scratch	No PEP	No PEP
Contact with blood on undamaged skin	No PEP	No PEP
Contact with other body fluids not containing blood	No PEP	No PEP

Waste Management

By the end of this session trainees will be able to:

- Describe the different types of waste
- Describe the key principles behind sorting, handling, interim storage and final disposal of waste generated in clinical settings
- Assess waste disposal needs in case study situations.

Timings: This session should take 1h

Pre-training preparation: Ensure that everyone has access to a copy of the MSS Guidelines for Waste Management. Ensure adequate copies of IP Training Resource 7: Waste Management Case Studies. Plan for breaks and consider energisers as required

Discus – Read out the following statement:
'Most of health care waste is non-hazardous waste'
Ask the group whether they think this statement is true or false (answer true).
Ask how clinical and non-clinical waste is disposed of at their workplace, are different bins used? Can they make any suggestions for improvement? (10m)

Present – Referring to the MSS Guideline on Waste Management…

1. Define non-hazardous and hazardous waste (sharps, infectious, pathological, pharmaceutical and chemical)
2. Describe the importance of separating the disposal of different types of waste: non-hazardous (black bag), sharps (yellow container) infectious (yellow bag)
3. Describe the principles of Waste Management Planning – (segregating waste, handling, interim storage and Transport or treatment or disposal) (10m)

Discuss –answer any questions and discuss any differences identified between recommended practice and what happens in participants' workplace(s).
Exercise: Split trainees into groups of three or four and give out IP Training Resource 7: Waste Management Case Studies. Assign a different case study to each group and ask them to come up with a waste management plan. After 10 minutes ask each group to feedback to the wider group. Referring to trainers notes on page 20 of this guide facilitate a discussion to ensure agreement and understanding of the correct procedures for each case study. (50m)

Action planning – Encourage trainees to note down:
a) anything they will do differently as a result of what they have learnt in this session
b) any aspect of waste management they particularly want to explore, discuss or practice further
c) How they can promote best practice for waste management in their workplace. (5m)

Trainers Guide - Waste management Case studies

Waste disposal Case Study 1

- DO NOT ATTEMPT TO UNBLOCK THE CONTAINER – discuss the risk and consequences of a needle-stick injury
- Replace this container with a new one – discuss the cost-benefit of using a new one
- Dispose of this container as you would a full one – review recommended and local practices

Waste disposal Case Study 2

- Check that your agreed local policy is clear and bring this to the attention of all Providers
- Keep labelled clinical and non-clinical waste containers accessible in all rooms
- Review emptying practice and location of bins if this continues to be problematic to Providers

Waste disposal Case Study 3

- Discuss risk of contamination (including through direct transmission via gravity and through reservoirs such as doorknobs used when storing contaminated waste)
- If space is limited, review possibility of reallocating separately accessed and locked storage below higher sterile storage
- Ideally, keep in clearly separate areas

Waste disposal Case Study 4

- Check that your agreed local policy is clear and bring this to the attention of the Provider
- Keep labelled clinical and non-clinical waste containers accessible in all rooms
- If issues persist speak to senior team member

WHO-recommended segregation scheme

Type of waste	Colour of container and markings	Type of container
Highly infectious waste	Yellow, marked "HIGHLY INFECTIOUS", with biohazard symbol	Strong, leak-proof plastic bag or container
Other infectious waste, pathological and anatomical waste	Yellow with biohazard symbol	Leak-proof plastic bag or container
Sharps	Yellow, marked "SHARPS", with biohazard symbol	Puncture-proof container
Chemical and pharmaceutical waste	Brown, labelled with appropriate hazard symbol	Plastic bag or rigid container
Radioactive waste	Labelled with radiation symbol	Lead box
General health-care waste	Black	Plastic bag

Antiseptics and disinfectants

By the end of this session trainees will be able to:

- Describe the correct use of common antiseptics
- Describe the coorrect use of common disinfectants
- Demonstrate how to make up chlorine solution as an effective disinfectant

Timings: This session should take approximately 1h

Pre-training preparation: Set up skills stations with equipment and supplies for making up chlorine solution with water and liquid bleach. Plan for breaks and consider energisers as required

Discus – Ask the group to give examples of when they have used antiseptics or disinfectants either at home in or in the workplace. Why did they use those particular products? (5m)

Present Referring to section 7 and Appendix H of the guidelines….

1. Describe common antiseptics including how and when to use them effectively
2. Describe the two types of disinfectants (low and high level) including how and when to use them effectively
3. Go through the instructions for making 0.5% chlorine solution from
4. Liquid bleach
5. Bleaching powder (15m)

Discuss – Answer any questions. Then ask volunteers to compare best practice in the use of antiseptics and disinfectants with what happens in their place of work. Is there much difference? Why is that? (5m)

Exercise: Demonstrate making up a chlorine solution using liquid bleach – Referring to section 7.5 of the guidelines, demonstrate how to make up a 1 litre bucket of 0.5% chlorine solution from the bleach you have available to you.

Show how you are working this out by writing it up on a flipchart or whiteboard so everyone can see it.

Then ask participants to work out how they would make a 1 litre bucket of 0.5% chlorine solution using a 5% liquid chlorine bleach. They can do this individually or in pairs. Encourage the first person to finish to call out the answer.
Answer: the formula for making a 0.5% chlorine solution using 5% active chlorine bleach is:
(5 x 2) – 1 = 9 parts of water for 1 part of bleach So you need 100ml of bleach plus 900ml of water (20m)
Discuss – Facilitate a discussion to ensure agreement and understanding. Then ask the group what they think the risks are if chlorine solution is mixed incorrectly?

Answer: if too weak the solution will not kill microorganisms and if too strong it can damage instruments (10m)
Action planning – Encourage trainees to note down:
a) anything they will do differently as a result of what they have learnt in this session
b) any aspect of using antiseptics and disinfectants they particularly want to explore, discuss or practice further
c) how they can take promote effective us of antiseptics and disinfectants in their workplace (5m)

Aseptic Technique
By the end of this session trainees will be able to:
- describe the extent and features of “sterile field”
- describe how to maintain the sterile field through good practice.

Timings: This session should take approximately 1h

Pre-training preparation: Ensure adequate copies of IP Training Resource 8: Sterile Field. Set up skills stations for aseptic technique Plan for breaks and consider energisers as required

Discus – Ask the group what their experience has been with using aseptic technique? When have they seen it be used? How has it been done? (5m)

Present - Referring to section 10 and Appendix J of the guidelines:
1. Define aseptic technique
2. Describe preparing a client for incision site and principles of maintaining a sterile field
3. Describe ‘No Touch’ Technique and correct use of IVs and multi dose vials (15m)

Discuss –answer any questions and any differences identified between recommended practice and what happens in participants’ workplace.

Exercise: Picture quiz - Give out IP Training Resource 8: Sterile Field and ask participants, to shade in the area / surfaces that are included within the sterile field. After 5 minutes ask them to refer to Appendix J to see if they shaded the correct areas. (10m)

Discuss – Check that everyone for the answer right or understands why they didn’t. Then, discuss what a sterile field means in practice and what to do if the field becomes “contaminated” (answer: re-process all equipment/staff and re-set the sterile field)
Finally ask what type of MSS procedure requires a sterile field? (answer: Tubal Ligation)
(10m)

Exercise: demonstration of aseptic techniques - At an aseptic technique skills station, use clear commentary when demonstrating how to set up a sterile instrument tray for, and then giving, an injection from a multi dose injection vial (note this requires both sterile and non-sterile equipment).Be sure to demonstrate no touch technique when drawing up an injection from the vial Then, at skills stations, allow trainees to practise this procedure in small groups, encouraging trainees to give commentary to/for their colleagues while demonstrating. Allow ample time for repeated practice so that trainees become comfortable with these techniques and ensure that each trainee is observed completing the procedure successfully at least once.
(60m)

Action planning – Encourage trainees to note down:
a) anything they will do differently as a result of what they have learnt in this session
b) any aspect of aseptic technique they particularly want to explore, discuss or practice further
c) how they can promote aseptic technique when they return to their own facility to ensure the effective aseptic techniques are used for the correct MSS procedures (5m)

RespiratoryHygiene

Airborne infectious agents, or those present in saliva or mucus, can be spread by coughing or sneezing

Both team members and clients should take care to prevent this as follows:

- When coughing or sneezing, cover mouth and nose with a tissue or the crook of the arm
- Discard tissue in wastebasket
- Clean hands immediately with alcohol rub or soap/running water
- Providers and clients with symptoms of influenza should be encouraged to wear face masks

Clear instructions on correct etiquette when coughing or sneezing should be prominently displayed for the intended audience

ProcessingLinen

- Handle soiled linen as little as possible and place in a leak-proof container at place of use
- Wear utility gloves and other protective attire when handling, transporting and processing used linens
- Washing linens
- Sort to ensure no sharps, instruments or waste
- Use detergent and warm water, if available, rinsing with clean water
- Machine wash if possible to reduce risk of exposure to infectious materials
- If hand washing, wear utility gloves – with long cuffs, apron and eye/face shield
- Sterilization of linens
- When wrapping linens for sterilization, the pack size should not be more than 30 x 30 x 50cm
- Place packs of linens on their sides so steam can penetrate
- When folding gowns for sterilization, fold with the inside of gown facing out so when putting gown on, the outside will not be touched
- Disposable gowns
- Sterile disposable gowns can be used for outreach situations where it is not possible for surgeons to sterilize gowns due to the high volume of clients and surgeries
- Disposable gowns are intended for single use only, these should not be processed

Post course knowledge test
By the end of this session trainees will be able to:
- score their infection prevention knowledge out of 100%
- identify any particular knowledge gaps they need to revise

Timings: This session should take approximately 1 hour

Pre-training preparation: Ensure adequate copies of IP Training Resource 9: IP Knowledge Test. Ensure you have time to mark and return test papers prior to advancing to the site-based practical sessions of this module

Exercise – Highlight that their knowledge is being tested as a requirement of the module and that they must achieve 80% on this test to proceed to the optional site-based practical's. Indicate that any knowledge gaps they identify can be picked up during the site-based practical sessions, and anyone not passing the test this time round will be given the opportunity to re-take it. Then give out IP Training Resource 9: IP Knowledge Test and instruct trainees to complete this on their own.

After 30 minutes collect the papers in for marking and indicate when you will return the results. (40m)

Discuss – Go through the paper as a group and ensure everyone understands the answers, shown below. (15m)

NB: If you are not running the optional site assessment visit as part of your IP training course then you should end the course now with Session 13 on page 26.
Action planning – Encourage trainees to note down:
a) Any aspect of infection prevention they particularly want to explore, discuss or practice further during the practical session
b) A plan for re-taking the knowledge test if required (5m)

Infection Prevention Posttest (Annexure)

Section C: Optional site assessment visit

Preparing for the site-based practical
By the end of this sessions trainees will be able to:
- Describe ways of behaving and acting in a clinical setting that show respect to staff and clients
- Refer to an individual plan for completing the site-based practice

Timings: This session should take approximately 45m

Pre-training preparation: Ensure that you can communicate clear details of where and when the site-based practice is going to happen. Ensure adequate copies of Training Resource 10: Behavior in a clinical setting

Discus – Ask the group for reasons why a client or college may not want another person observing them? Write these up on a flip chart and facilitate a discussion to ensure that everyone understands such issues and will be sensitive to them during the site-based practice. Give out IP Training Resource 10: Behaviour in a clinical setting for reference. (20m)

Present – Referring to Appendix K of the guidelines: MSI Infection Prevention Monitoring Checklist 1. Describe the MSS Infection Prevention Monitoring Checklist, highlighting how each section corresponds to a different part of the training they have just completed

Discuss – Answer any questions. Then ask the group whether they have had any experience carrying out audit or monitoring checklists in their workplace? What things did they have to consider when carrying this out? (10m)

***Present** – Explain that the purpose of the optional site visit is to give them, as IP experts, the opportunity to observe IP practices firsthand in an MSI facility. **Highlight that the aim is not for them to find and point out fault in the host facility, but instead to help trainees to spot good and bad practice in a facility.** Encourage trainees to keep notes of their observation for discussion as a group after the visit.

Finally, clearly describe to the group where and when the optional site assessment visit is going to take place and what they need to do in preparation (e.g. plan their own transport if necessary). Ensure everyone understands and writes it down. (10m)

Action planning – Encourage trainees to note down:
a) What they need to know and remember for the site-based practical session
b) Anything they particularly need to practice or revise before they assess IP measures in the facility (5m)

Assessing IP in an MSS facility
By the end of this sessions trainees will be able to:
- Use the MSI Infection Prevention Monitoring checklist to assess IP measures taken in a clinical facility
- Share observations and thoughts on possible ways of improving IP measures in a clinical facility

Timings: This session should take as long as required

Pre-training preparation: Ensure adequate copies of IP Training Resource 11: IP Checklist with notes. Ensure adequate access to MSS clinical facilities for all trainees – **NB this may require splitting the**

Group up and arranging supervision of different trainee groups at different facilities. Ensure that the facility or facilities hosting this practical session are ready to receive visitors. Ensure time for a de-brief session after the visit for trainees to share their observations and ideas for improved IP at the host facility (if any)

Exercise – Ensuring that each trainee has a copy of IP Training Resource 11: IP monitoring checklist with notes, encourage trainees to quietly observe staff at an MSI clinical facility as they go about their work while referring to their knowledge of IP and the IP monitoring checklist to form an

opinion of the IP measures taken at that facility. Encourage them to make notes of their observations as they go, for discussion at a later time.
To save time, you may wish to split the monitoring checklist out and assign a section to each individual or pair of individuals. (Timing as required)

Discuss – After adequate time for observation, bring the group back together in a room or area where they can debrief on the visit in private, away from staff or clients from the facility. Ask them the following questions:

- Did anyone observe particularly good IP measures being carried out? What were they?
- Did anyone observe particularly bad IP measures being carried out? What were they?
- What would be the single most important recommendation they could make to their host facility in terms of IP? (Timing as required)

Action planning – Encourage trainees to note down:
a) anything they will do differently as a result of what they have learnt in this session
b) how they can promote best practice for IP in their work place.

Course end
Pre-training preparation: ensure that everyone has a blank infection prevention monitoring checklist and a certificate of training, to take home

By the end of the training ensure that everyone knows:

- Their post course knowledge test score
- How and where they will re-take the test, if required
- The name of the supportive clinical supervisor who will assist them to exhibit excellent Infection Prevention technique back in their place of work

Annexure:

Training Resources:
Provider Competency Framework for InfectionPrevention

Infection prevention
Knowledge of standard precautions for infection prevention
Awareness of requirements for HIV, Hepatitis B & C prevention and PEP
Competent technique for hand hygiene
Demonstrate use of personal protective equipment
Awareness of requirements for safe handling and disposal of sharps
Ability to use antiseptics and disinfectants appropriately
Competent in maintaining aseptic technique
Knowledge of instrument processing
Demonstrates effective cleaning and housekeeping duties
Knowledge of safe disposal of clinical and non-clinical waste

Provider competency assessment checklist for infection prevention

General knowledge	Mark Y/N or N/A as applies
1. Can describe the 8 standard precautions for infection prevention, in particular measures for hand hygiene	
2. Describes the post-exposure prophylaxis (PEP) policy and how to access Hepatitis B vaccine and testing, and HIV testing and treatment	
Environmental cleaning	
3. Maintains a rota of cleaning with evidence of daily and weekly cleaning, and cleaning between clients	
4. Sprays and cleans procedure table with disinfectant (0.5% chlorine) between procedures	
5. Cleans and disinfects all surfaces coming into contact with blood or other body fluids daily and/or when soiled	
6. Wears utility gloves and aprons when cleaning	
Hand hygiene	
7. Carries out appropriate hand hygiene (washing or alcohol rub) BEFORE and AFTER examining or providing a service for EVERY client	
8. Carries out surgical scrub or surgical hand rub between clients during invasive procedures	
Use of PPE	
9. Uses examination gloves and appropriate PPE when delivering client care or handling of items involves blood, body fluids, or laboratory specimens	
10. Uses sterile gowns as single-use per client for invasive procedures (MSL, MSV)	
Instrument processing: cleaning	
11. Wears apron and utility gloves when cleaning instruments	
12. Uses detergent water to soak instruments prior to cleaning	
13. Cleans instruments in a cleaning area with a sink and a source of running water	
14. Opens all instruments and disassembles them prior to cleaning to allow the complete removal of blood and foreign matter	
15. Rinses instruments in water to remove residue	
16. Air dries instruments and/or uses clean cloth or towel	
17. Inspects instruments and cannulas for damage and discards damaged items	
Instrument processing: steam sterilization (autoclave)	
18. Double wraps items and labels with processing date, initials of team member, content of wrap and date of sterile expiration	
19. Uses autoclave indicator tape and indicator strips with each pack	

20. Arranges items in the autoclave so that steam is able to reach all surfaces
21. Follows guidelines for sterilizing instruments in the autoclave
22. Documents monitoring of autoclave cycle in the autoclave register
Instrument processing: dry heat sterilization if applicable
23. Only uses dry heat sterilization for metal or glass instruments that have been decontaminated, cleaned and double wrapped
24. Performs dry heat sterilization according to oven manufacturer's instructions
25. Removes items using sterile pickups
26. Records in register to evidence monitoring of sterilization cycle
Instrument processing: chemical HLD
27. Completes chemical HLD using chemical disinfectants prepared to manufacturer's instructions and stored in a clearly labelled, lidded container indicating an expiry date
28. Cleans items, and ensures they are fully dry before being immersed in solution for 20 minutes
29. Removes items using sterile pickups, rinsed with sterile water (3 rinses of 1 minute each) and dried with a sterile towel
30. Monitors chemical HLD validity using chemical indicator strips

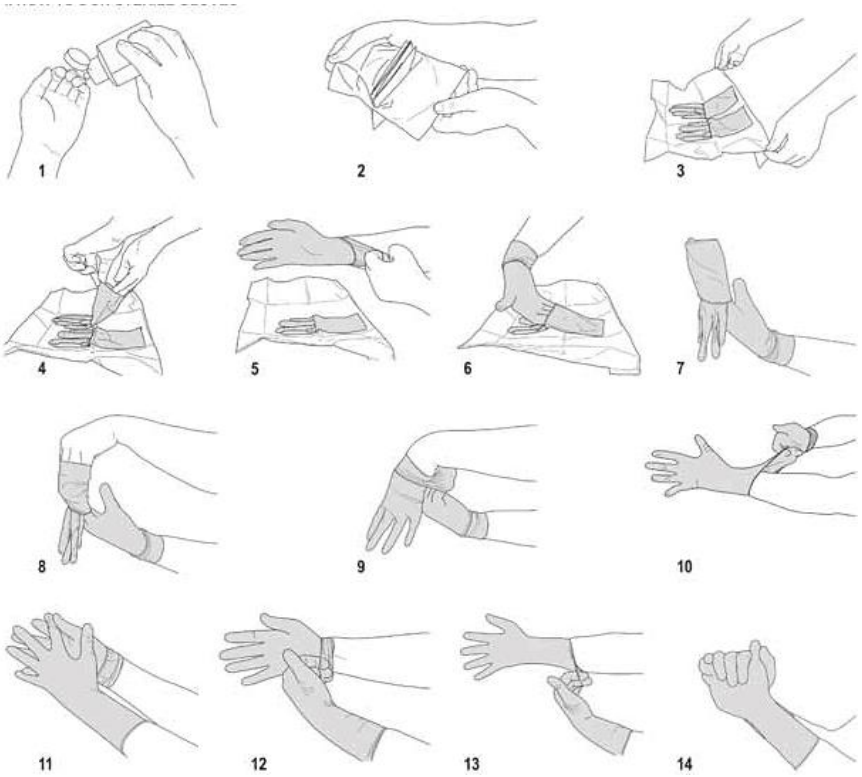
Instrument processing: storage	
31. Describes how processed items are either used immediately or stored in a sterile container for a maximum of seven days	
32. Describes how packs once opened must be used within 24 hours or re-processed	
Correct handling of sharps	
33. Uses clearly marked, puncture-resistant containers to dispose of contaminated sharps immediately after use	
34. Needles are not recapped, bent after use	
35. Sharps containers are disposed of when ¾ full	
Respiratory hygiene	
36. When coughing or sneezing covers mouth and nose with a tissue or the crook of the arm, discards of tissue in wastebasket and cleans hands immediately with alcohol rub or soap/running water	
Processing linen	
37. Wears utility gloves and other protective attire when handling, transporting and processing used linens	

Aseptic technique	
38. Holds hands above the level of the elbow after surgical scrub	
39. Uses sterile towel to dry hands and forearms after surgical scrub	
40. Uses sterile drapes to ensure sterile field is achieved	
41. Uses 'no touch' technique throughout relevant procedures	
42. Dons and removes sterile gloves using a 'no touch' technique	
43. Uses double gloving for surgical procedures longer than 30 minutes and/or large amounts of blood and body fluids e.g. vaginal deliveries	
44. Follows correct procedure for using multi-dose vials, checks quality of content, uses new needle and syringe to withdraw solution, swabs with antiseptic before use, discards vial within 28 days	
45. Uses 0.5% chlorine that is labelled with date of preparation to clean surfaces	
46. Can describe how to prepare 0.5% chlorine	
47. Can describe how to clean up blood spills	
Waste disposal	
48. Segregates clinical waste and general waste and stores them in different areas prior to disposal	
49. Disposes of fetal waste according to clinical waste management guidelines, sensitively and according to local laws (which may include burial)	

Providers completing each function should have achieved all of the competencies included

Job Aid- Putting on Sterile Gloves

The purpose of this technique is to ensure maximum asepsis for the patient and to protect the health care worker from the patient's body fluids – the skin of the health care worker remains exclusively in contact with the inner surface of the glove and has no contact with the outer surface



1. Perform hand hygiene before an "aseptic procedure" by hand rubbing or handwashing
2. Check the package for integrity. Open the first non-sterile packaging by peeling it completely off the heat seal to expose the second sterile wrapper, but without touching it
3. Place the second sterile package on a clean, dry surface without touching the surface. Open the package and fold it towards the bottom so as to unfold the paper and keep it open
4. Using the thumb and index finger of one hand, carefully grasp the folded cuff edge of the glove
5. Slip the other hand into the glove in a single movement, keeping the folded cuff at the wrist level

6-7. Pick up the second glove by sliding the fingers of the gloved hand underneath the cuff of the glove

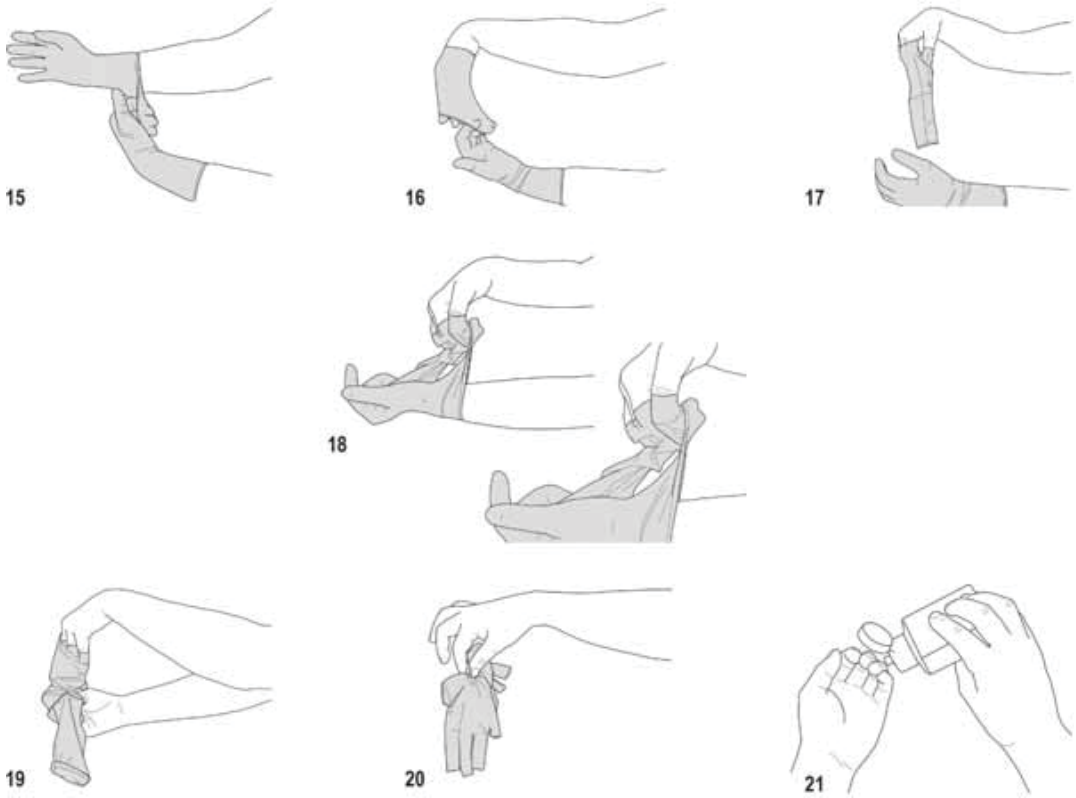
8-10. In a single movement, slip the second glove on to the ungloved hand while avoiding any contact/resting of the gloved hand on surfaces other than the glove to be donned (contact/resting constitutes a lack of asepsis and requires a change of glove)

11. If necessary, after donning both gloves, adjust the fingers and interdigital spaces until the gloves fit comfortably

12-13. Unfold the cuff of the first gloved hand by gently slipping the fingers of the other hand inside the fold, making sure to avoid any contact with a surface other than the outer surface of the glove (lack of asepsis requiring a change of gloves)

14. The hands are gloved and much touch exclusively sterile devices of the previously disinfected patient's body area

Job Aid- Removal of Sterile Gloves



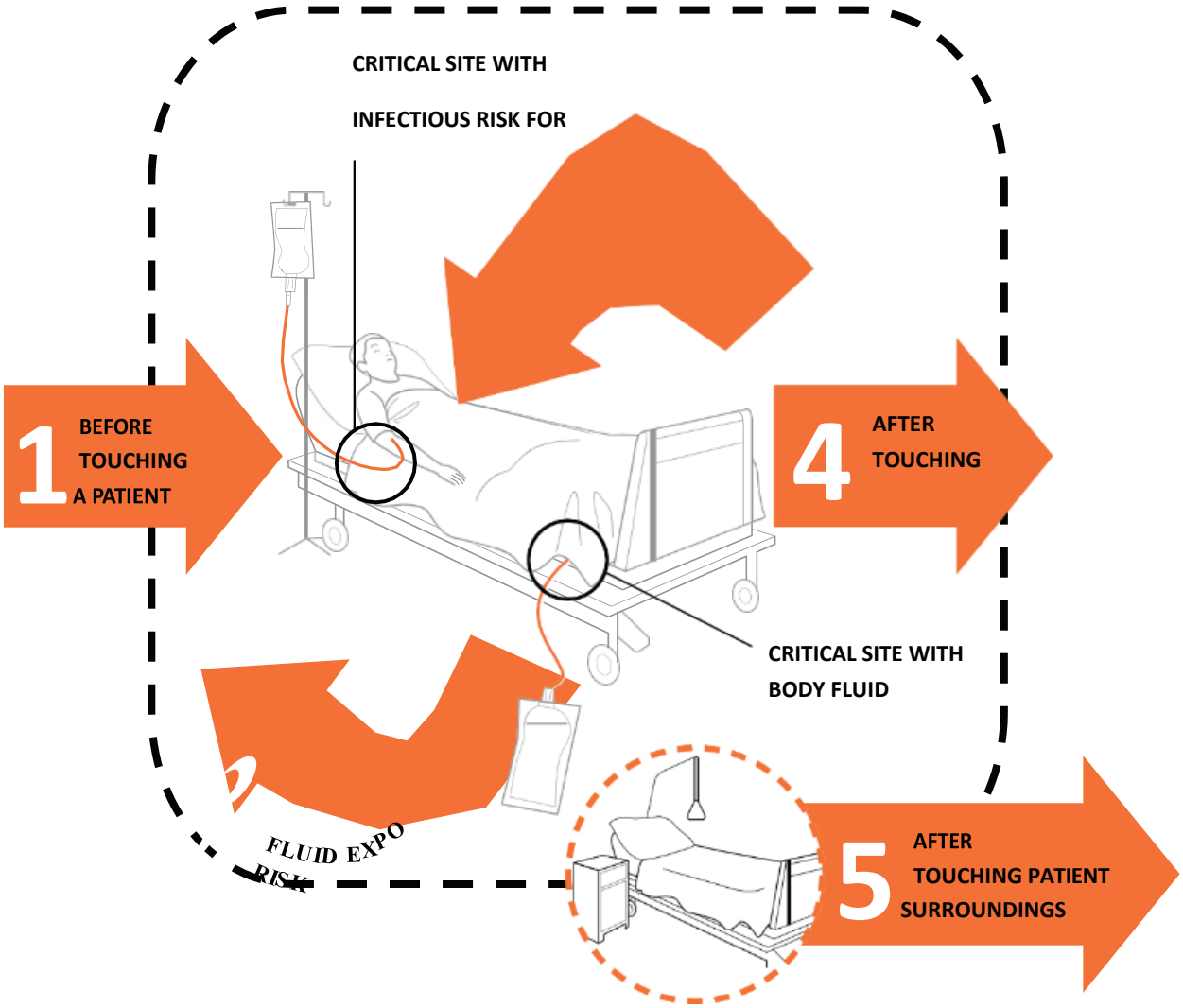
15-17. Remove the first glove by peeling it back with the fingers of the opposite hand. Remove the glove by rolling it inside out to the second finger joints (do not remove completely)

18. Remove the other glove by turning its outer edge on the fingers of the partially ungloved hand
19. Remove the glove by turning it inside out entirely to ensure that the skin of the health care worker is always and exclusively in contact with the inner surface of the glove
20. Discard gloves
21. Perform hand hygiene after glove removal according to the recommended indication

NB: Donning surgical sterile gloves at the time of a surgical intervention follows the same sequences except that:

i. It is preceded by a surgical hand preparation.
ii. Donning gloves is performed after putting on the sterile surgical gown.
iii. The opening of the first packaging (non-sterile) is done by an assistant.
iv. The second packaging (sterile) is placed on a sterile surface other than that used for the intervention.
v. Gloves should cover the wrists of the sterile gown

JobAid–My5Moments for Hand Hygiene



Post-ExposureProphylaxis (PEP)

The primary aim of good infection control practices is to prevent sharps injuries occurring. However, when they do occur, it is critical to ensure that the injuries are managed appropriately and in a timely fashion, to minimize the risk of harm to HCWs or others directly or indirectly affected by sharps injuries. All staff who have contact with client blood or body fluids should be vaccinated against Hepatitis B. In the event of a sharp's injury the HCW must be counselled, and following this counselling and evaluation of the risk the HCW may decide to start HIV PEP

Virus	Post-exposure prophylaxis
Hepatitis B virus	PEP with HBIG and/or Hepatitis B vaccine series after evaluation of the HBsAG status of the source and the vaccine-response of the exposed person Perform follow-up anti –HBs testing in persons who receive Hep B vaccine Test for anti HBs 1-4 months after last dose of vaccine
Hepatitis C virus	PEP not recommended Perform baseline and follow-up testing for anti HCV if possible 4-6 months after exposure Perform HCV RNA at 4-6 weeks if earlier diagnosis of HCV desired or if source known to be HCV positive
HIV	Start PEP as soon as possible if indicated Offer pregnancy testing to all women of childbearing age not known to be pregnant Administer PEP for 4 weeks Perform follow-up testing and provide counselling Advise exposed persons to seek medical evaluation for any acute illness occurring during follow-up Perform HIV antibody testing for at least 6 months post-exposure (baseline, 6 weeks, 3 months, 6 months) Perform HIV antibody testing if illness compatible with an acute anti-retroviral syndrome occurs Advise exposed persons to use precautions to prevent secondary transmission during the follow-up period Evaluate exposed persons taking PEP within 72h after exposure and monitor for drug toxicity for at least 2 weeks

Eligibility for HIV PEP

Type of exposure	Source unknown HIV status	Source HIV-positive status
Any needle stick injury	Give PEP	Give PEP
Any cut from a scalpel contaminated with blood	Give PEP	Give PEP
Deep wound with a material contaminated with blood	Give PEP	Give PEP
Mucous membrane or damaged skin in contact with a significant amount of blood, splashes	Give PEP	Give PEP
Rape	Give PEP	Give PEP
Type of exposure	**Source unknown HIV status**	**Source HIV-positive status**
Scratch	No PEP	No PEP
Contact with blood on undamaged skin	No PEP	No PEP
Contact with other body fluids not containing blood	No PEP	No PEP

Immediate care

1. Wash skin puncture or wounds with soap and water
2. Rinse exposure of nose, mouth or skin with water
3. If eyes exposed, irrigate with saline (use water if no saline available)

Report and assess risk

1. Report incident immediately to Centre Manager or team leader, who will notify the Clinical Services Manager and document incident
2. Assess the risk of possible HIV or HBV/HCV or other blood borne infection transmission, which depends on type of exposure and the infection status of source person
3. Consider if there was parenteral, needle stick, scalpel blade cut or mucous membrane exposure (sexual exposure and splashes to the eye, nose or oral cavity)
4. Consider the nature of the exposure – exposures that do not require HIV post-exposure prophylaxis include:
5. When the exposed individual is already HIV-positive;
6. When the source is established to be HIV-negative, and;
7. Exposure to some body fluids do not pose a significant risk: e.g. tears, non-blood-stained saliva, urine and sweat.

8. Counsel both source person and receiving person
9. Either refer persons to appropriate facility or obtain informed consent for HIV testing

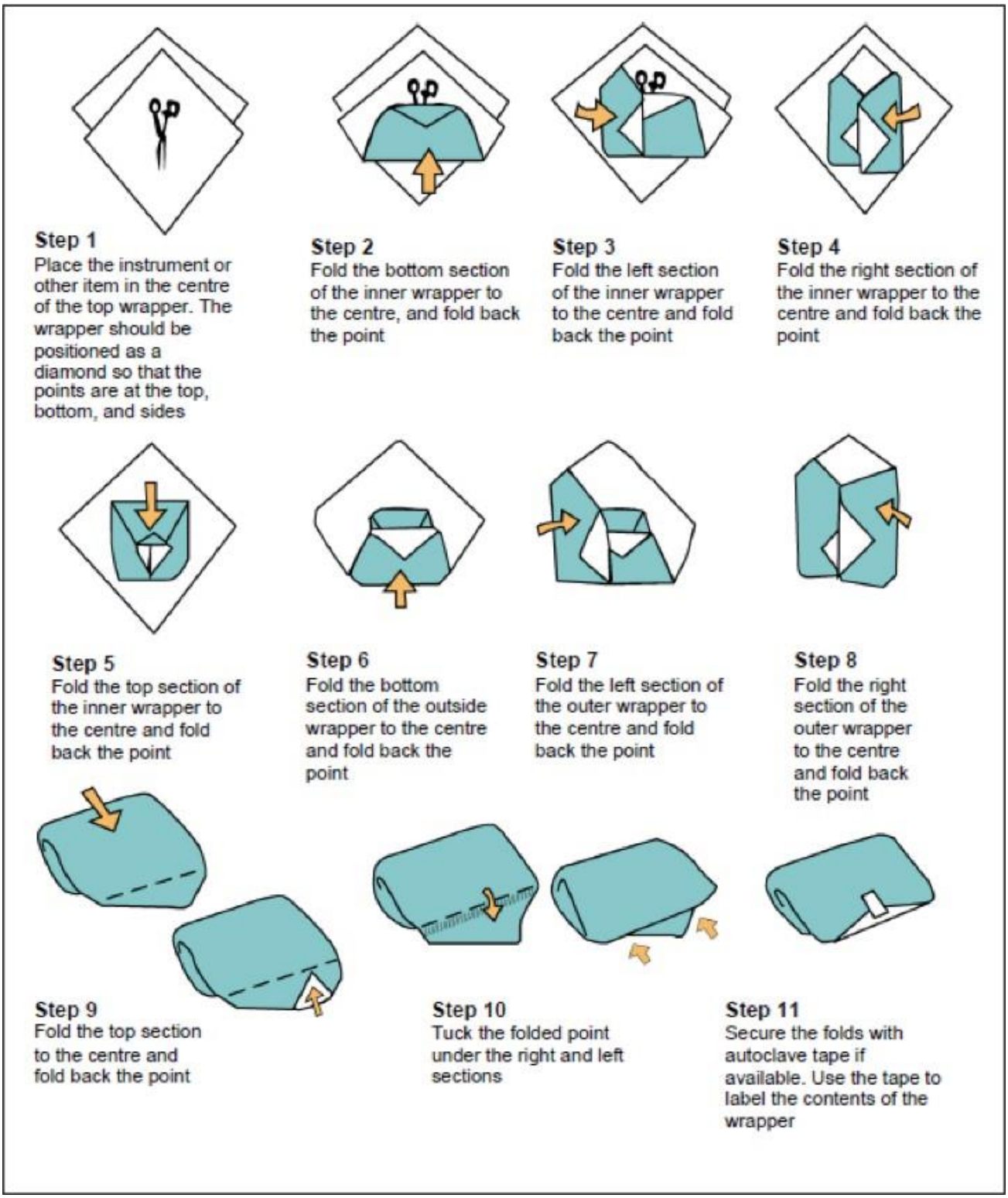
HIV PEP is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure

- If indicated, start regime of anti-retroviral drugs as soon as possible, preferably within one hour of exposure, and not later than 72 hours after possible exposure. Decisions on initiation of PEP more than 72 hours after exposure should be left to the discretion of the local clinicians in discussion with the exposure recipient, in full knowledge of the lack of evidence of efficacy after this time point
- If started soon after exposure, PEP can reduce the risk of HIV infection by over 80%. Adherence to a full 28-day course of ARVs is critical to the effectiveness of the intervention
- Do not wait on HIV tests if results delayed, and do not wait if only 2 ARV drugs are available. Give first dose as soon as possible. PEP can be cancelled if test results are negative. Baseline HIV testing should be done
- If PEP is not available, the exposed person should be immediately referred to an HIV care and treatment center for assessment and treatment

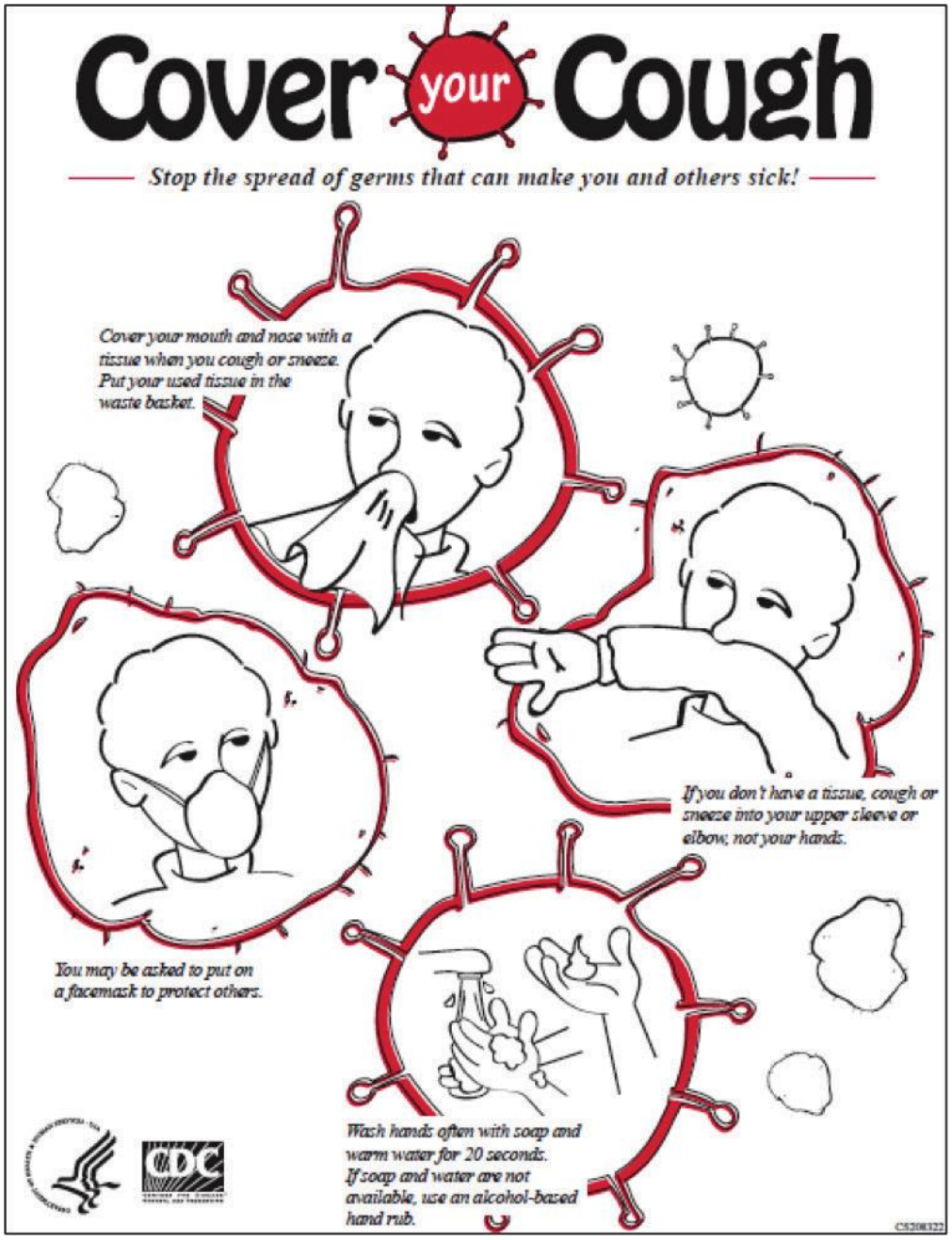
Eligibility for PEP treatment:

- Exposure within past 72 hours
- Exposed person not infected or known to be infected with HIV
- Significant exposure via mucous membranes or non-intact skin
- Source is HIV-positive, or HIV status is unknown (in some settings with high background HIV prevalence or where the source is known to be at high risk for HIV infection, all exposure may be considered for post-exposure prophylaxis without risk assessment)
- Post-exposure prophylaxis is not indicated if the exposed person is already HIV- positive
- If an individual considered eligible for PEP is found to alredy be HIV-positive, they should be referred to appropriate services for assessment for eligibility for ART according to national guidelines

Job Aid–InstrumentWrapping



RespiratoryHygienePoster for Health CareSettings



Standard Precautions forHealthCareFacilities

Hand Hygiene

Summary technique

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

Summary Indications

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

Gloves

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

1. Facial protection (eyes, nose and mouth)

- Wear (1) a surgical or procedure mask and eye protection (eye visor, goggles) or (2) a face shield to protect mucous membranes of the eyes, nose, and mouth during activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions.

2. Gown

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

3. Prevention of needle stick and injuries from other sharp instruments

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

1. Respiratory hygiene and cough etiquette

Persons with respiratory symptoms should apply source control measures:

- Cover their nose and mouth when coughing/sneezing with tissue or mask, dispose of used tissues and masks, and perform hand hygiene after contact with respiratory secretions.

Health care facilities should:

- Place acute febrile respiratory symptomatic patients at least 1 meter (3 feet) away from others in common waiting areas, if possible.
- Post visual alerts at the entrance to health care facilities instructing persons with respiratory symptoms to practice respiratory hygiene/cough etiquette.
- Consider making hand hygiene resources, tissues and masks available in common areas and areas used

for the evaluation of patients with respiratory illnesses.

1. **Environmental Cleaning**

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

2. Linens

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

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

3. **Waste disposal**

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

Common Antiseptics and their Uses

Type	Use on mucous membranes	Use as surgical scrub	Use for client skin prep	Comments
Iodophors; povidone-iodine **(Betadine)**	Yes – best antiseptic for genital area, vagina, cervix	Yes – can be used for surgical scrub	Yes – can be used for client preparation Effective 1-2 minutes after application	Use full strength Iodophors are less irritating than iodine Effectiveness reduced by blood or other organic material
Chlorhexidine gluconate (Hibiclens, Hibiscrub); chlorhexidine gluconate with cetrimide (Savlon)	Yes – but can cause irritation in genital area – better to use an iodophor Products with an alcohol base should not be used on mucous membranes	Yes – can be used for surgical scrub	Yes – can be used for skin preparation	Concentration of chlorhexidine in Savlon varies, always read the label
Iodine; tincture of iodine **(iodine and alcohol)**	No	No	Yes – but should be allowed to dry before starting procedure	When used for skin prep, allow to dry and then remove with alcohol It is too irritating to use for routine surgical scrub or use on mucous membranes
Alcohol (60% – 90% ethyl or isopropyl)	No	Yes	Yes	Cannot be used when skin is dirty. Wash area before applying. Must dry completely to be effective Strength of 60-70% is most effective because alcohol must be diluted for optimal effectiveness and is also less drying to skin

Infection Prevention Pre/ Post-Test

Write either True (T) or False (F) for each of the following 10 statements in the box.

1. It is not necessary to protect yourself from infections with every client because it is easy to tell which clients are infected with HIV and other blood borne infections.
2. Housekeeping staff are not at risk of infections as long as they are not directly involved in client care.
3. Hands should always be washed after removing gloves following a procedure.
4. Injuries from sharps are the number one cause of infections among MSS team members.
5. As long as instruments will be sterilized or HLD, it is not necessary to clean them first. If the person who processes the instruments is very busy, it is acceptable to leave equipment soaking in the decontamination bucket for the day.
6. If you run out of disinfectant, it is acceptable to wipe down the procedure table with antiseptic after each client.
7. Items such as lifters, Cheatle forceps and suture needles should not be left soaking in antiseptic or disinfectant solutions.
8. For steam sterilization to be effective, steam must reach all surfaces of the instruments and other items.
9. Boiling is a method of sterilization
10. Cleaning is not always necessary if decontamination in a 0.5% chlorine solution is performed immediately after a procedure.
11. Hand soap is preferable to detergent for cleaning instruments and other items.
12. Hard brushes should never be used on plastic instruments because they cause scratching.
13. It is important to dry instruments and other items to be chemically sterilized or HLD because water can dilute the chemicals used.
14. Decontamination kills all microorganisms on soiled instruments and other items.
15. Instruments and other items should be decontaminated immediately after the procedure is completed.
16. When preparing a 0.5% chlorine solution, it is important to know the amount of active chlorine in the product being used.
17. Although soaking items in a 0.5% chlorine solution for 10 minutes is adequate, it is acceptable to leave them in all day if the centre is busy.
18. A chlorine solution prepared for decontamination on Monday can be used throughout the week.
19. Chlorine solutions are cheap and effective disinfectants.
20. Antiseptics are suitable for use when processing instruments and other items.
21. Microorganisms can multiply in both antiseptic and disinfectant solutions.
22. Alcohol or antiseptic solutions containing alcohol are ideal for use on mucous membranes such as the vagina and cervix.

23. Storing scalpel blades, needles and pickups (lifters, Cheatle forceps) in a container of antiseptic solution is a good way to reduce the risk of infection.
24. Storing cotton wool buds and gauze in antiseptics is a good way of keeping them sterile.
25. It is not necessary to clean the procedure room at the beginning of the day if it has been carefully cleaned with a disinfectant cleaning solution at the end of the previous day.
26. Clean surfaces in client care areas with a cloth saturated in disinfectant solution between clients.
27. You do not need to wear gloves for housekeeping if you are using a solution which contains both disinfectant and detergent.
28. If a small spill of blood or other body fluid occurs in the centre, wipe it up immediately with a cloth saturated in disinfectant solution.
29. There are 5 standard precautions.
30. Infection prevention is the foundation for any high-quality service.
31. Multiple choice questions – there may be more than one correct answer for each question. Circle the correct response(s) for each question.
32. Following appropriate infection prevention practices is important in order to:
    a) Prevent infections in service providers and other team members.
    b) Prevent post procedure infections in clients.
    c) Protect the community from infections that originate in the msi centre.
33. Decontaminating instruments and other items immediately after use in a 0.5% chlorine solution for 10 minutes:
34. Reduces the risk of infections in centre team members by killing HIV and the hepatitis viruses.
35. Removes blood and tissue, making it unnecessary to clean the instruments and other items.
36. Allows instruments to be reused immediately.

Hand washing:

1. Decreases client and provider sickness and death.
2. Is usually performed appropriately in most centers.
3. Protects both the client and service provider from infection.
4. Antiseptics and disinfectant solutions:
5. Should be stored in a cool, dark place.
6. Can be easily contaminated.
7. Can be used in place of each other
8. To reduce the risk of injuries from sharps:
9. All needles should be recapped.Sharps should be disposed of in a clearly marked, puncture-proof container.
10. Which of the following are ‘low risk’ areas?
11. Waiting area
12. Procedure room
13. Toilet/latrine
14. Centre manager’s office.

15. Which cleaning solution would you use to clean client care areas?
16. Disinfectant cleaning solution
17. Detergent and water.
18. For PAC instruments, which of the following are correct:
19. Do not use detergent during cleaning
20. Do not use a brush or other small object to clean inside the Cannula
21. Do not use a brush on the syringe during cleaning
22. Cleaning is not necessary if the instruments will be sterilized or high level disinfected.
23. Antiseptics are used for:
24. Processing instruments and other items
25. Surgical hand scrub
26. Skin and vaginal preparation before clinical procedures.
27. Disinfectants are used for:
28. Processing Instruments and Other Items
29. Skin and Vaginal Preparations Before Surgical Procedures
30. Cleaning Foors And Countertops
31. Hand Washing Before Invasive Procedures.

Key:

1. F
2. F
3. T
4. T
5. F
6. F
7. T
8. T
9. F
10. F
11. F
12. T
13. T
14. F
15. T
16. T
17. F
18. F
19. T
20. F
21. T
22. F
23. F
24. F
25. F
26. T
27. F
28. T
29. F
30. T

Multiple Choice Questions:

1. ALL TRUE
2. A
3. ALL TRUE
4. A & B TRUE
5. B TRUE

6. A & D
7. A
8. B
9. C
10. A

Annexure

Competency Assessment Checklist: Counselling

Clinical Staff Name: _____ Designation: _____

	General Counselling Pre-Procedure	Yes/No/NA	Notes
1.	* Maintains privacy and confidentiality		
2.	Greets and employs a client-centred style of communication when speaking to clients		
3.	Uses language the client is comfortable with		
4.	* Follows a structured counselling approach like REDI (Rapport, Explore, Decide and Implement) or according to local protocols		
5.	* Asks client about the service(s) they are seeking and if they have something specific in mind		
6.	* Provides comprehensive and correct information on service options that fits with client's reproductive health needs and lifestyle preferences		
7.	* Explains dual protection to clients		
8.	Uses flipchart or other job aids appropriately to explain service options		
9.	* Supports clients to make own decisions after weighing up all information including advantages, disadvantages and consequences of each option		
10.	* Explains how the chosen service would be provided; its side effects; and possible complications which may require referral to higher level facility in rare cases		
11.	Checks that client fully understands the chosen option by asking them to repeat key points		
12.	* Checks that client's decision for chosen service is voluntary		
13.	* Takes informed consent appropriately with consideration for vulnerable groups such as young people; illiterate; clients with history of sexual abuse or violence, long term physical, mental, intellectual or sensory impairments and mental health illness		

14. * Documents written informed consent appropriately as per protocols		
15. Indicates how and where to access the chosen service. If appropriate, discusses scheduling; and interim or partner contraception		
Method-Specific Counselling	**Yes/No/NA**	**Notes**
TUBAL LIGATION		
16. * Emphasises that although tubal ligation is a permanent method there is a very small chance of failure		
17. If postpartum, discusses if her decision will change if the baby were to die or suffer from health problems		
VASECTOMY		
18. * Emphasises that although vasectomy is a permanent method there is a very small chance of failure		
19. * Explains that the method will become effective only after 3 months so an additional contraceptive method will be required during this time		
IUD/IUS		
20. * Emphasises that IUD/IUS are long acting reversible contraceptives that are very effective		
21. Explains that IUD/IUS can be removed at any time without any delay in return to fertility		
IMPLANTS		
22. * Emphasises that implants are long acting reversible contraceptives that are very effective		
23. Explains that it can be removed at any time without any delay in return to fertility		
PROGESTIN-ONLY INJECTABLE		
24. * Emphasises that progestin-only injectable is a reversible contraceptive with a very small chance of failure if the injection is repeated at the right time		

25. Explains that after stopping the injection there may be a delay in return to fertility of up to one year		
ORAL CONTRACEPTIVE PILL		
26. * Emphasises that oral contraceptive pills are short acting contraceptives with a small chance of failure if the pill is taken correctly		
27. Explains that after stopping the pill there is no delay in return to fertility		
CONDOM		
28. Emphasises that condoms are effective, but a new condom must be used correctly before every sexual act		
29. * Emphasises that condoms are the only method that protects against STI/HIV		
EMERGENCY CONTRACEPTION		
30. * Explains that emergency contraception (EC pill and copper IUD) helps to prevent pregnancy when taken up to 5 days after unprotected sex but the sooner they are taken, the more effective they will be		
31. * Explains that EC pills do not disrupt an existing pregnancy nor do they protect a woman against pregnancy from acts of sex that occur 24 hours after she has taken the ECPs		
General Counselling: Post-Procedure	**Yes/No/NA**	**Notes**
32. * Provides post procedure instructions orally and in writing if possible, for the following: • Follow-up care • Follow-up visits where required or as per local protocols • To return or call any time for advice or medical attention • Warning signs and what to do in such cases • Contact number (preferably 24/7) for any emergency related to the service		
33. Discusses arrangement for discharge (e.g. person accompanying client to home)		

Result of Competency Assessment * Attach Competency Assessment Checklist if clinical staff is assessed as level 2	
Service Assessed: Counselling	**Tick as appropriate**
Level 1 • Individual completed all steps correctly. • Competent to provide this service independently subject to regular re-assessment.	
Level 2 * • Individual missed one or more of the steps. • Cannot provide this service independently. Must offer this service only under direct supervision of a competent clinical staff till endorsed as fully competent by the competent clinical staff.	
Other observations:	
Specify actions to be taken to achieve/maintain competency:	

Clinical Staff Name:	Clinical Staff Signature:
Competency Assessor Name:	Competency Assessor Signature:
Date of Assessment:	Location:

Competency Assessment Checklist: Oral Contraceptive Pills

Clinical Staff Name: _____ Designation: _____

Progestin Only Pill (POP) and Combined Oral Pill (COC)	Yes/No/NA	Notes
1. Reviews client information and confirms client has been counselled and informed consent provided		
2. * Completes a relevant history and clinical examination as per guidelines		
3. * Confirms that client is eligible for the chosen type of OCP by checking that the client: • Is not currently pregnant or at risk of being pregnant using the Pregnancy Checklist • Does not have history of any vaginal bleeding that is unusual for them • Does not have liver disease • Does not have/has not had breast cancer • Does not have/has not had a blood clot in the legs or lung • Enquires about use of other medicines and correctly identifies those reducing effectiveness of the OCP		
4. * Ensures that COC client meets additional eligibility requirements below: • Has not just given birth or is not breastfeeding a baby less than 6 months • Does not get bad migraine headaches affecting vision or hearing • Does not have or is not being treated for high blood pressure and/or understands risk of taking COC without knowing blood pressure • Des not have complicated or long-standing diabetes • Does not have heart disease or history of stroke • Is not a smoker aged over 35 years		
5. * Correctly advises start time of OCP depending on client's state (last menstrual period, post-partum with or without breastfeeding)		
6. * Explains how to take OCPs and what to do if pills are missed		
7. Completes documentation of client records including: • History and examination findings • Type of OCP provided, batch number, expiry date, duration of supply		

8. Confirms client understands what to expect, the need for daily use preferably at the same time for the pills to be effective and the importance of telling another prescriber about OCP use		

Result of Competency Assessment * Attach Competency Assessment Checklist if clinical staff is assessed as level 2	
Service Assessed: Oral Contraceptive Pills	**Tick as appropriate**
Level 1 • Individual completed all steps correctly. • Competent to provide this service independently subject to regular re-assessment.	
Level 2 * • Individual missed one or more of the steps. • Cannot provide this service independently. Must offer this service only under direct supervision of a competent clinical staff till endorsed as fully competent by the competent clinical staff.	
Other observations:	
Specify action(s) to be taken to achieve/maintain competency:	

Clinical Staff Name:	Clinical Staff Signature:
Competency Assessor Name:	Competency Assessor Signature:
Date of Assessment:	Location:

Competency Assessment Checklist: Progestin-Only Injectable

Clinical Staff Name: _____ Designation: _____

Pre-Procedure	Yes/No/NA	Notes
1. Reviews client information: and confirms client has been counselled and informed consent has been documented as per MSS/local protocols		
2. * Takes relevant detailed history as per MSS guidelines and confirms that client is eligible for POI by checking that the client: • Is not currently pregnant or at risk of being pregnant using the Pregnancy Checklist • Does not have any history of vaginal bleeding that is unusual • Is not breast feeding a baby less than 6 weeks • Does not currently have deep vein thrombosis (blood clot in leg) or Pulmonary embolism (blood clot in lung) • Does not have high blood pressure (systolic ≥160 or diastolic ≥100 mm Hg) • Does not have multiple risk factors for cardiovascular disease (such as smoking, diabetes, high blood pressure or cerebrovascular disease (stroke). • Does not have vascular disease • Does not have systemic lupus erythematosus (SLE) and positive (or unknown) antiphospholipid antibodies or severe thrombocytopenia • Does not have diabetes of > 20 years duration or diabetes with nephropathy/ retinopathy/ neuropathy • Does not have/ has not had severe decompensated cirrhosis or liver cancer (hepatocellular adenoma or malignant hepatoma) • Does not have/ has not had breast cancer		
Administering Injection	**Yes/No/NA**	**Notes**
3. * Checks expiry date and integrity of injection		
4. * Shakes injection just before use		
5. * Correctly identifies correct physical location for the injection type: • Intramuscular: upper outer quadrant of buttocks / three fingers down from the top of the shoulder • Subcutaneous: thigh/abdomen/upper arm		
6. IM: Cleans area with antiseptic SC: Washes injection site with soap and water, if it is dirty		
7. *Administers injection correctly as per guidelines/ guides the client to self-inject SC correctly.		

8. *IM: Gently shakes the vial before loading the syringe, aspirates and injects the medicine slowly with needle at 90° to the skin taking 5 – 7 seconds before withdrawing		
* SC: Holds the port of injector and shakes the injector vigorously for 30 sec, activates the injector correctly by pushing the needle shield and port together, closing the gap, gently grasps and squeezes a large area of skin, pushes the needle straight into the skin with the needle pointing down and empties the reservoir by squeezing firmly but slowly for 5-7 seconds.		
9. * Does not massage site after injection		
10. * Follows infection prevention principles at all times		
11. Completes documentation of client records including: • History and examination findings • Date, site, route and type of injection, batch number, and expiry date • Gives completed POI card to client		
12. * Confirms client understands duration of use, what to expect, need for regular injections and date of next injection		

Result of Competency Assessment * Attach Competency Assessment Checklist if clinical staff is assessed as level 2	
Service Assessed: Progestin-Only Injectable	**Tick as appropriate**
Level 1 • Individual completed all steps correctly. • Competent to provide this service independently subject to regular re-assessment.	
Level 2 * • Individual missed one or more of the steps. • Cannot provide this service independently. Must offer this service only under direct supervision of a competent clinical staff till endorsed as fully competent by the competent clinical staff.	
Other observations:	
Specify action(s) to be taken to achieve/maintain competency:	
Clinical Staff Name:	Clinical Staff Signature:

Competency Assessor Name:	Competency Assessor Signature:
Date of Assessment:	Location:

Competency Assessment Checklist: Contraceptive Implant Insertion

Clinical Staff Name: _____ Designation: _____

Pre-Procedure	Yes/No/NA	Notes
1. Reviews client information: and confirms client has been counselled and informed consent has been documented as per protocols		
2. * Takes relevant detailed history as per guidelines and confirms that client is eligible for implant by checking that the client: • Is not currently pregnant or at risk of being pregnant using the Pregnancy Checklist • Does not have any history of vaginal bleeding that is unusual for them • Does not have a serious liver disease (yellow eyes and skin) needing treatment • Does not have/has not had breast cancer • Does not have problems with a blood clot in the legs or lung • Does not have a rheumatic disease such as lupus		
3. Ensures necessary equipment, processed instruments and supplies are ready		
Procedure: Implant Insertion	**Yes/No/NA**	**Notes**
4. * Ensures implant packs are undamaged and not beyond expiry date		
5. Marks insertion points appropriately		
6. * Cleans area with antiseptic and waits for it to dry		
7. * Covers area with sterile drape		
8. * Aspirates and slowly injects local anaesthetic appropriately and waits for 2 minutes before checking that anaesthetic is working		

9. **Using aseptic technique handles and inserts implant correctly (trocar inserted at 20 – 30 degree angle, tents skin, smooth insertion and withdrawal of trocar)**		
10. Palpates the implant to confirm correct insertion and invites the woman to palpate the implant		
11. * Applies a sterile dressing to insertion site		
Post-Procedure	**Yes/No/NA**	**Notes**
12. * Assesses the need and provides pain management according to guidelines at all times		
13. * Follows infection prevention principles at all times		
14. Completes documentation of client records including: • History and examination findings, investigations if any • Procedure notes including date and site of insertion, type of implant and duration of effectiveness, batch number, and expiry date		
15. Ensures completed Implant card is given to client		
16. * Confirms client understands post procedure instructions, especially what to expect (including common side-effects), warning signs and duration of use; and ensures client has contact details for any emergency related to the service.		

Result of Competency Assessment * Attach Competency Assessment Checklist if clinical staff is assessed as level 2/3	
Service Assessed: Contraceptive Implant Insertion	**Tick as appropriate**
Level 1 • Individual completed all steps correctly. • Competent to provide this service independently subject to regular re-assessment.	
Level 2 * • Individual completed all bold steps correctly but missed one or more of the others. • Cannot provide this service independently. Must offer this service only under direct supervision of a competent clinical staff till endorsed as fully competent by the competent clinical staff.	
Level 3 * • Individual missed one or more bold steps. • Cannot provide this service. To undergo training by competent trainer on or off site.	
Other observations:	
Specify action(s) to be taken to achieve/maintain competency:	
Clinical Staff Name:	Clinical Staff Signature:
Competency Assessor Name:	Competency Assessor Signature:
Date of Assessment:	Location:

Competency Assessment Checklist: Contraceptive Implant Removal

Clinical Staff Name: _____ Designation: _____

Pre-Procedure	Yes/No/NA	Notes
1. Reviews client information and asks for client's reason for removal; and confirms client has been counselled and informed consent has been documented as per protocols		
2. Completes a relevant history and clinical examination as per guidelines		
3. Ensures necessary equipment, processed instruments and supplies are ready		
Procedure: Removal of Implant	**Yes/No/NA**	**Notes**
4. Locates implant		
5. * Follows Algorithm for Missing Implant if cannot locate implant		
6. Marks the distal end of the implant(s) closest to the elbow with a pen		
7. * Cleans area with antiseptic and waits for it to dry		
8. * Covers area with sterile drape		
9. * Aspirates and injects local anaesthetic appropriately and waits for 2 mins before checking for anaesthetic effect		
10. **Removes implant correctly (small and shallow incision, gentle and correct technique, correct instruments)**		
11. Applies a sterile dressing		
12. Provides other contraception if requested and eligible or refers appropriately		
13. * Assesses the need and provides pain management according to guidelines at all times		
14. * Follows infection prevention principles at all times		
15. Completes documentation of client records including: • History and examination findings • Procedure notes with adverse event if any		
16. * Confirms client understands post procedure instructions, especially warning signs and ensures client has contact details for any emergency related to the service		

Result of Competency Assessment * Attach Competency Assessment Checklist if clinical staff is assessed as level 2/3	
Service Assessed: Contraceptive Implant Removal	**Tick as appropriate**
Level 1 • Individual completed all steps correctly. • Competent to provide this service independently subject to regular re-assessment.	
Level 2 * • Individual completed all bold steps correctly but missed one or more of the others. • Cannot provide this service independently. Must offer this service only under direct supervision of a competent clinical staff till endorsed as fully competent by the competent clinical staff.	
Level 3 * • Individual missed one or more bold steps. • Cannot provide this service. To undergo training by competent trainer on or off site.	
Other observations:	
Specify action(s) to be taken to achieve/maintain competency:	
Clinical Staff Name:	Clinical Staff Signature:
Competency Assessor Name:	Competency Assessor Signature:
Date of Assessment:	Location:

Competency Assessment Checklist: Condom

Clinical Staff Name: _____ Designation: _____

Male Condom	Yes/No/NA	Notes
1. Reviews client information and confirms client has been counselled		
2. * Affirms that condoms are the only contraceptive method that can protect against both pregnancy and sexually transmitted infections		
3. * Emphasises that a new condom needs to be used correctly with every act of sex for maximum effectiveness		
4. * Demonstrates the steps (4-9) of using a condom on a penis model: Checks package for tear, damage, expiry and then opens package carefully at one end without damaging/tearing condom.		
5. * Places condom on tip of erect penis model holding collapsed tip with one finger and the rolled side out with other hand, highlighting that the condom must be used as demonstrated before the penis makes any genital, oral, or anal contact.		
6. * Unrolls the condom all the way to the base of the erect penis while holding tip with a finger, highlighting that if the condom does not unroll easily, it should be thrown away and a new condom used		
7. * Demonstrates how to hold the rim of the condom in place after ejaculation while withdrawing the erect penis		
8. * Shows how to slide the condom off erect penis without spilling semen		
9. * Shows how to dispose used condom safely by wrapping it in own package and putting it in the rubbish but not in a flush toilet		
10. Asks client to demonstrate how they will use the condom using a model if she/he is willing and corrects any errors		
11. * Explains use of ECP to prevent pregnancy in case condom tears or slips during sex, is used incorrectly or not at all		
12. Completes documentation of client records including number of condoms provided, their Batch number and expiry date		

Result of Competency Assessment * Attach competency assessment checklist if clinical staff is assessed as level 2	
Service Assessed: Condom	**Tick as appropriate**
Level 1 • Individual completed all steps correctly. • Competent to provide this service independently subject to regular re-assessment.	
Level 2 * • Individual missed one or more of the steps. • Cannot provide this service independently. Must offer this service only under direct supervision of a competent clinical staff till endorsed as fully competent by the competent clinical staff.	
Other observations:	
Specify action(s) to be taken to achieve/maintain competency:	
Clinical Staff Name:	Clinical Staff Signature:
Competency Assessor Name:	Competency Assessor Signature:
Date of Assessment:	Location:

Competency Assessment Checklist: IUD/IUS Insertion

Clinical Staff Name: _____ Designation: _____

Pre-Procedure: IUD/IUS Insertion	Yes/No/NA	Notes
1. Reviews client information: and confirms client has been counselled and informed consent has been documented as per protocols		
2. * Takes relevant detailed history as per guidelines and confirms that client is eligible for IUD/IUS by checking that the client: • Is not currently pregnant or at risk of being pregnant using the Pregnancy Checklist • Does not have any history of vaginal bleeding that is unusual for them • Has not had a baby over 48 hours ago and in the last 4 weeks • Does not have or is unlikely to have a genital or pelvic infection • Does not have/has not had genital cancer • Does not have/has not had breast cancer (IUS only) • Does not have/has not had blood clots (IUS only) • Does not have/has not had liver disease (IUS only)		
3. * Ensures necessary equipment, processed instruments and supplies are ready, IUD/IUS packs are undamaged and not beyond expiry date		
Procedure: IUD/IUS Insertion	**Yes/No/NA**	**Notes**
4. * Confirms client has an empty bladder		
5. **Inspects external genitalia and conducts bimanual examination and then speculum examination to confirm eligibility for IUD/ IUS**		
6. * Assesses for sexually transmitted infections and treats if indicated as per WHO/national guidelines		
7. * Cleans cervical os with an antiseptic		

Procedure: IUD/IUS Insertion	Yes/No/NA	Notes
8. * Grasps cervix with Stopes forceps and applies gentle traction to straighten cervical canal		
9. **Accurately assesses depth and position of uterine cavity with sound or cannula using no-touch technique**		
10. * Loads IUD/IUS in sterile package using aseptic technique		
11. **IUD insertion** • **Sets blue gauge of loaded IUD insertor to assessed uterine depth** • **Gently inserts and releases loaded IUD in the uterus using withdrawal technique** • **Discards plunger and pushes insertion tube gently upwards for fundal placement**		
12. **IUS insertion** • **Makes sure the arms of the IUS are horizontal.** • **Releases the threads and pulls them to retract arms of the IUS into the insertion tube.** • **Secures threads and sets flange to assessed uterine depth** • **Gently inserts IUS using no touch technique till 1-2 cm short of assessed uterine depth** • **Retracts slider to the mark and waits 10 seconds for the IUS arms to fully open** • **Advances flange all the way to the cervix** • **Holds insertion device steady and pulls slider all the way down** • **Removes insertion device**		
13. Cuts strings with scissors 3 – 4 cm from cervical os		
14. Examines cervix for bleeding before removing speculum		
15. Explains and demonstrates self-checking of IUD/IUS threads		

Post-Procedure	Yes/No/NA	Notes
16. * Assesses the need and provides pain management according to Guidelines at all times		
17. * Follows Infection Prevention Principles at all times		
18. Completes documentation of client records including: • History and examination findings, investigations if any • Procedure notes including date of insertion and duration of effectiveness, type of IUD/IUS, batch number, expiry date, and details of adverse events if any		
19. Ensures completed IUD/IUS card is given to client		
20. * Confirms client understands post procedure instructions, especially what to expect (including common side effects), warning signs and duration of use and ensures client has contact details for any emergency related to the service		

Result of Competency Assessment * Attach Competency Assessment Checklist if clinical staff is assessed as level 2/3	
Service Assessed: IUD/IUS Insertion	**Tick as appropriate**
Level 1 • Individual completed all steps correctly. • Competent to provide this service independently subject to regular re-assessment.	
Level 2 * • Individual completed all bold steps correctly but missed one or more of the others. • Cannot provide this service independently. Must offer this service only under direct supervision of a competent clinical staff till endorsed as fully competent by the competent clinical staff.	
Level 3 * • Individual missed one or more bold steps. • Cannot provide this service. To undergo training by competent trainer on or off site.	
Other observations:	
Specify action(s) to be taken to achieve/maintain competency:	
Clinical Staff Name:	Clinical Staff Signature:
Competency Assessor Name:	Competency Assessor Signature:
Date of Assessment:	Location:

Competency Assessment Checklist: IUD/IUS Removal

Clinical Staff Name: _____ Designation: _____

Pre-Procedure: IUD/IUS Removal	Yes/No/NA	Notes
1. Reviews client information and asks client their reason for removal; confirms they have been counselled and informed consent has been documented as per protocols		
2. Completes a relevant history		
3. Ensures necessary equipment, processed instruments and supplies are ready		
Procedure: IUD/IUS Removal	**Yes/No/NA**	**Notes**
4. * Confirms client has emptied bladder recently		
5. * Performs a bimanual examination and inserts speculum gently to look at length and position of strings		
6. Use Stopes forceps to stabilize cervix if required after cleaning cervix with an antiseptic		
7. * Grasps IUD/IUS strings close to the os with forceps and applies steady gentle traction to remove the IUD/IUS		
8. * Shows client the removed IUD/IUS		
9. * Uses Missing IUD Threads algorithm if unable to remove IUD/IUS or threads are missing		
10. Provides other contraception if requested and eligible or refers appropriately		
Post-Procedure	**Yes/No/NA**	**Notes**
11. * Assesses the need and provides pain management according to guidelines at all times		
12. * Follows infection prevention principles at all times		
13. Completes documentation of client records including: • History and examination findings, investigations if any • Procedure notes including date of removal and details of adverse events if any		
14. * Confirms client understands post procedure instructions		

Result of Competency Assessment * Attach Competency Assessment Checklist if clinical staff is assessed as level 2	
Service Assessed: IUD/IUS Removal	**Tick as appropriate**
Level 1 • Individual completed all steps correctly. • Competent to provide this service independently subject to regular re-assessment.	
Level 2 * • Individual missed one or more of the steps. • Cannot provide this service independently. Must offer this service only under direct supervision of a competent clinical staff till endorsed as fully competent by the competent clinical staff.	
Other observations:	
Specify action(s) to be taken to achieve/maintain competency:	
Clinical Staff Name:	Clinical Staff Signature:
Competency Assessor Name:	Competency Assessor Signature:
Date of Assessment:	Location:

Competency Assessment Checklist: Emergency Contraceptive Pills

Name of team member: ..... Name of supervisor:.....

Job Title: ..... Job Title: .....

Date of assessment: .....

The following supporting guidelines to this document must be read prior to undertaking this competency assessment

MSI Guidelines for Emergency Contraception

Having the right facilities	Tick as appropriate
Has adequate space and privacy for provision of service	
Has the right facilities for IUD insertion (refer to MSI Guidance on IUD)	
Checks expiry date and integrity of packaging of supplied ECs	
Identifying a suitable client	**Tick as appropriate**
Ensures informed consent by ensuring client understands:	
ECPs work by preventing or delaying the release of eggs from the ovaries (ovulation)	
ECPs help to prevent pregnancy when taken up to 5 days after unprotected sex. The sooner they are taken, the better	
ECPs do not disrupt an existing pregnancy	
They do not cause birth defects in the fetus if pregnancy cannot be prevented and client wants to continue with the pregnancy	
ECPs will not protect a woman from pregnancy from acts of sex after she takes the ECP – not even if sex happens on the next day	
There is no delay in return to fertility after stopping	
ECP and IUD can cause a range of side-effects related to changes in bleeding patterns and nausea	
ECP and IUD do not protect against sexually transmitted infections. She needs to use a condom if she has concerns **Confirms it is safe for the woman to use an EC by** **confirming client:** Is not pregnant	
Understands ECPs are safe for all women- even women who cannot use hormonal contraceptive methods	
Is eligible to use the Copper IUD if she chooses that for emergency contraception	
Completing the consultation	**Tick as appropriate**
Reminds woman of key points about the EC and its use:	
All women can use ECPs safely, irrespective of age and with HIV, AIDS or on ART	
Correctly identifies start time of EC depending on when the client last had unprotected sex	

Competency level achieved*:	Tick as appropriate
Emphasises need for correct use	
Emphasises about use of regular contraception if she has sex frequently	
Emphasises importance of client telling another prescriber that she takes ECP or is using the Copper IUD **Completes documentation:** Type of EC used, its batch number, expiry date, duration of protection/supply provided	
No routine return visit is required	
She should definitely come back if she thinks she might be pregnant, especially if she has no monthly bleeding or her next monthly bleeding is delayed by more than one week	
She must think about whether she should start a regular contraceptive method. This will be offered depending on her needs and wishes	
Level 1: Competent to offer service subject to regular re-assessment	
Level 2: Competent to offer service only under direct supervision	
Level 3: Not safe to offer service	
Actions to be taken to achieve / maintain competency	
Date of next assessment:	

*Level 1 – Individual completes all steps correctly

Follow up	Tick as appropriate
Level 2 – Individual completes all **bold** steps correctly but misses one or more	
Discusses key points about follow-up:	
others Level 3 – Individual misses one or more **bold** steps	

Competency Assessment Checklist: Mini-Laparotomy Tubal Ligation

Clinical Staff Name: _____ Designation: _____

Pre-Procedure	Yes/No/NA	Notes
1. * Reviews client information; and confirms client has been counseled and informed consent has been documented for chosen method as per local protocols		
2. * Takes/reviews relevant detailed history as per guidelines		
3. **Completes/reviews clinical examination (including vital signs, general, abdominal, speculum and bimanual examinations)**		
4. * Reviews/assesses for sexually transmitted infections and treats if indicated as per WHO/national guidelines		
5. * Confirms that client is eligible for tubal ligation		
6. * Ensures necessary equipment, processed instruments and supplies are ready (including MEM equipment and supplies)		
Procedure: Mini-Laparotomy Tubal Ligation	**Yes/No/NA**	**Notes**
7. * Confirms client has emptied bladder recently and has been nil by mouth appropriately		
8. Ensures that client is helped into appropriate position on procedure table		
9. * Performs bimanual examination (if not done by surgical provider earlier)		
10. * Performs steps 10 – 14 if uterine elevator is used: Inserts vaginal speculum gently to expose cervix		
11. * Applies antiseptic solution twice to cervix and vagina inside out		
12. * Grasps cervix with Stopes forces (or tenaculum)		
13. **Gently retracts Stopes forceps/tenaculum and inserts uterine elevator gently up to cervical guard using no-touch technique**		
14. **Removes speculum and Stopes forceps/tenaculum without dislodging uterine elevator**		
15. Places client's legs flat on table with handle of elevator between thighs		

Local Anesthesia	Yes/No/NA	Notes
16. * Prepares skin at identified site of incision appropriately with antiseptic solution		
17. Covers prepared area with fenestrated drape (with uterine elevator under drape if used)		
18. **Aspirates and infiltrates skin, subcutaneous tissue, fascia, and peritoneum with local anesthetic appropriately**		
19. * Massages site for 2 - 3 minutes and tests for anesthetic effect with tissue forceps. Gives more LA if needed taking care not to exceed maximum dose and aspirating every time before injecting to avoid injecting into blood vessel		
Entering the Abdomen	**Yes/No/NA**	**Notes**
20. **Makes a transverse skin incision at appropriate site**		
21. **Dissects subcutaneous tissue gently with haemostatic forceps or blunt scissor tips to reach fascia**		
22. Ensures that table is placed in slight Trendelenburg position (no more than 20^{o})		
23. **Exposes fascia with retractors and makes a transverse nick in the centre (in postpartum clients, lifts up fascia with two Allis tissue forceps and nicked gently)**		
24. **Grasps nicked fascia with Allis forceps and extends opening on both sides**		
25. **Separates rectus muscles longitudinally in the midline (if needed) to expose pre-peritoneal fat**		
26. **Bluntly dissects pre-peritoneal fat to expose the peritoneum**		
27. **Lifts peritoneum with two artery forceps and checks for translucency and thinness to confirm abdominal viscera are not sticking to it**		
28. **Makes a small opening in elevated peritoneum with scissors or scalpel**		
29. * Extends opening by placing retractors inside peritoneum and pulling apart slightly		

Retrieving Fallopian Tubes	Yes/No/NA	Notes
30. **Sub-umbilical (postpartum): Pushes uterus towards opposite side of the tube being retrieved to make tubes appear below incision (or uses retractors to gently move incision above the tube being retrieved)**		
31. **Supra-pubic:** • **If uterine elevator is used, gently pushes down its handle to bring uterine fundus up towards incision, then rotates elevator around its long axis to bring uterine cornu and corresponding Fallopian tube under incision** • **If uterine elevator is not used, repositions incision with retractors above uterine fundus and gently sweeps tubal hook around uterine fundus to one side and then pulls it out horizontally to retrieve the corresponding fallopian tube**		
32. Drops 1 – 2ml of 1% lidocaine on Fallopian tube before grasping with Babcock forceps		
33. **Gently grasps the tube with Babcock forceps and confirms by walking forceps to the fimbrial end**		
Occluding Tubes	**Yes/No/NA**	**Notes**
34. **Instructs assistant to hold up middle third of tube with Babcock forceps**		
35. **Passes suture on atraumatic needle through avascular part of meso-salpinx**		
36. **Places square knot on one side of tube about 2cm below tip of tubal loop and then on the other side**		
37. **Cuts tubal loop above ligature, leaving 0.5cm stump on both sides**		
38. * Loosens pull of suture on stump to rule out bleeding before cutting suture		
39. Delivers and occludes second tube in the same way		
40. * Ensures that table is returned to horizontal position		
Closing Abdomen	**Yes/No/NA**	**Notes**
41. **Closes fascia with continuous 0 or 1 – 0 chromic catgut**		
42. **Closes skin with same absorbable (subcutaneous stitches) or non-absorbable suture**		

43. Applies sterile dressing to incision site		
44. * Removes uterine elevator (if used)		
45. * Identifies and manages complications appropriately (if applicable)		
Post-Procedure	**Yes/No/NA**	**Notes**
46. Ensures client is helped to recovery area		
47. * Ensures vital signs and client condition are monitored and recorded every half hour for at least two hours and a sleepy client is not left unattended		
48. * Assesses the need and provides pain management according to guidelines at all times		
49. * Follows infection prevention principles at all times		
50. Completes documentation of client records including: • History, examination findings and test reports • Procedure notes, pain management details with adverse event if any		
51. Assesses client is ready for discharge		
52. * Confirms client understands post procedure instructions, especially after care, what to expect and warning signs, and ensures client has contact details for any emergency related to the service		

Result of Competency Assessment * Attach Competency Assessment Checklist if clinical staff is assessed as level 2/3	
Service Assessed: Mini-Laparotomy Tubal Ligation	**Tick as appropriate**
Level 1 • Individual completed all steps correctly. • Competent to provide this service independently subject to regular re-assessment.	
Level 2 * • Individual completed all bold steps correctly but missed one or more of the others. • Cannot provide this service independently. Must offer this service only under direct supervision of a competent clinical staff till endorsed as fully competent by the competent clinical staff.	
Level 3 * • Individual missed one or more bold steps. • Cannot provide this service. To undergo training by competent trainer on or off site.	
Other observations:	
Specify action(s) to be taken to achieve/maintain competency:	
Clinical Staff Name:	Clinical Staff Signature:
Competency Assessor Name:	Competency Assessor Signature:
Date of Assessment:	Location:

References

Manual of National Standards for Family Planning Services 2017

Family Planning- A Global Handbook for Providers, USAID, WHO, John Hopkins

Training Manual- Mustahab Social Development Advisors.

WHO guidelines

Population Council, John Hopkins University, FALAH project for Ministry of Population Welfare (PWD), Government of Pakistan. 2017. *National Standard of Family Planning 2017.* Pakistan,

National Service Delivery Standards and Guideline for high-quality safe Uterine Evacuation/post-Abortion Care.

National Institute of Population Studies (NIPS) [Pakistan] and ICF International. 2013. *Pakistan Demographic and Health Survey 2012-13*. Islamabad, Pakistan, and Calverton, Maryland, USA: NIPS and ICF International.

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

https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion

Pakistan_2019_CI_Handout.pdf

Population Council, John Hopkins University, FALAH project for Ministry of Population Welfare (PWD), Government of Pakistan. 2017. *National Standard of Family Planning 2017.* Pakistan,
WHO + MSS MSS Infection Prevention Policy

MSS Guidelines for Infection Prevention

Safe management of wastes from health-care activities / edited by Y. Chartier et al. – 2nd ed. WHO, 2014

Guidelines for the storage of essential medicines and other health commodities.2003. John Snow Inc./DELIVER in collaboration with the World Health Organization for the U.S. Agency for International Development.

Safe Disposal and Management of Unused, Unwanted Contraceptives, United Nations Population Fund (UNFPA), 2013.

Guidance on the disposal of pregnancy remains following pregnancy loss or termination, Human Tissue Authority, 2015

Sensitive disposal of all foetal remains: Guidance for nurses and midwives, Royal College of Nursing 2

National guideline of Pakistan for RTI

CDC Guideline for RTI

https://www.cdc.gov/reproductivehealth/productspubs/pdfs/Epi_Module_03A_Tag508.pdf

Sexually transmitted infections: implementing the Global STI Strategy
Evidence-to-action brief