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Jhpiego

an affiliate of Johns Hopkins University

Post Partum Family Planning Contraceptive Technology Update

TRAINER'S MANUAL

2012

Strengthening Post Partum Family Planning in Punjab

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Trainer's Manual

Post Partum Family Planning Contraceptive Technology Update

2012

for

Strengthening Post Partum Family Planning in Punjab

Department of Health & Family Welfare

Government of Punjab.

Jhpiego is an international, non-profit health organization affiliated with The Johns Hopkins University. For more than 36 years, Jhpiego has empowered front-line health workers by designing and implementing effective, low-cost, hands-on solutions to strengthen the delivery of health care services for women and their families. By putting evidence-based health innovations into everyday practice, Jhpiego works to break down barriers to high-quality health care for the world's most vulnerable populations.

This product was made by Jhpiego for FALAH project and it is adapted by incorporating updates on Postpartum Family Planning under the project of Strengthening Postpartum Family Planning Services in Punjab.

TECHNICAL UPDATES ON CONTRACEPTIVE TECHNOLOGY

NOTEBOOK FOR TRAINERS

SECTION ONE: GUIDE FOR TRAINERS

SECTION TWO: WORKSHOP POWERPOINT HANDOUTS

ABBREVIATIONS AND ACRONYMS

CIC	Combined injectable contraceptive
COC	Combined oral contraceptive
DMPA	Depot-medroxyprogesterone acetate
EC	Emergency contraception
ECP	Emergency contraception pill
EE	Ethinyl estradiol
FP	Family planning
PPFP	Postpartum Family Planning
IP	Infection prevention
IUCD	Intrauterine contraceptive device
LAM	Lactational amenorrhea method
LMP	Last menstrual period
LNG	Levonorgestrel
Mcg	Microgram
ML	Multiload
ml	milliliter
Net-en	Norethisterone enanthate
NSV	No-scalpel vasectomy
PIC	Progestin-only injectable contraceptive
PID	Pelvic inflammatory disease
POP	Progestin-only pill
PPT	PowerPoint
RHC	Rural health center
STI	Sexually transmitted infection
VSC	Voluntary surgical contraception

OVERVIEW

The purpose of this document is to help guide the trainer through the Overview Workshop on Contraceptive Technology, as conducted through the "Strengthening Postpartum Family Planning Services in Punjab" project. This model workshop training package is intended for use by trainers conducting the Technical Update Workshop on Contraceptive Technology throughout Pakistan. This update includes information on the following topics:

- Quality and access in Post Partum family planning
- Birth spacing and healthy timing and spacing of pregnancy
- Available methods of contraception, including combined oral contraceptives (COCs), emergency contraception (EC), injectable contraceptives, intrauterine contraceptive devices (IUCDs), barrier methods such as the male condom, LAM and permanent/surgical contraception
- New contraceptive technologies
- Contraception for special situations (post-pregnancy and post-miscarriage, women over 35)
- Essential infection prevention practices

The technical component of the training package incorporates the following elements:

- *Notebook for Participants*
- *Notebook for Trainers*
- *PowerPoint Presentations*

MODEL COURSE OUTLINE

The course outline presented here is a model plan for the technical component of the training to be delivered. It presents topics for presentations and supporting activities needed to accomplish the participant learning objectives described in the course syllabus (*Notebook for Participants*). For each topic or activity, there are suggestions regarding appropriate learning activities, as well as resources and materials needed. The trainer may develop additional practice activities and prepare case studies, role plays or other learning experiences that are specific to a particular group of participants.

The course outline is divided into four columns, the content of which is described below:

Time: The first column of the outline indicates the approximate amount of time to be devoted to each learning activity.

Topics/Activities: The second column lists the presentation topics and learning activities. The combination of presentation topics and activities (introductory activities, small-group exercises, clinical practice, breaks, etc.) outlines the **flow** of the training.

Learning Methods: The third column describes the various methods, activities and strategies to be used to deliver the content and skills related to each topic.

Resources/Materials: The fourth column in the course outline lists the resources and materials needed to support the learning activities.

Note that the course schedule (*Notebook for Participants*) is based on the course outline and that change or modifications to one should be reflected in the other.

Technical Update Workshop on Contraceptive Technology (Standard Course: 2 days, 10 sessions)			
TIME	**TOPICS**	**ACTIVITIES AND TRAINING/LEARNING METHODS**	**RESOURCES/MATERIALS[2,3]**
DAY 1			
SECTION 1: OVERVIEW OF THE WORKSHOP			**TOTAL TIME ALLOTTED: 1 HR, 45 MIN**
Session 1.1: Overview—60 Minutes (09:00-10:00)			
10 minutes	Welcome and Introduction	' Welcome the participants in the workshop **Activity** Divide the participants into group by using either colored chits or using letters for each pair ' Then share with them the instructions on introduction prewritten by the facilitator ' Give them some time & ask each member to introduce their partner. '	Pre written Flip Charts Small colored chits for activity as per number of participants
15 minutes	Overview/objectives of the workshop	**Discussion:** ' Provide overview of the workshop. Discuss objectives of the workshop ' Explain that 2 days of workshop will focus on technical information regarding various methods of Post partum contraception. ' Brief participants about the use of the Notebook for Participants and the Reference Manual. ' Share the day's schedule. (Ask participants to open their Notebook to the schedule; inform them of the page number.) '	Flip charts indicating objectives of of workshop Flip chart on Agenda 1 sample of participant's folder
15 minutes	Setting Norms and Expectations	**Facilitation/Brainstorming** Set ground rules and assess expectations and note down on flip chart Attach it to the wall for reference throughout the course	Flip charts Flip Charts Easel Markers Sticking Tape
20 minutes	Pre course Knowledge Assessment	**Facilitation** Distribute copies of pre test and allocate time for completion. Assess questionnaires and share the result on matrix with the group	Printed copies of Pre test as per number of participants

Technical Update Workshop on Contraceptive Technology (Standard Course: 2 days, 10 sessions)			
TIME	**TOPICS**	**ACTIVITIES AND TRAINING/LEARNING METHODS**	**RESOURCES/MATERIALS[2,3]**
DAY 1			
Session 1.2: Importance of Post Partum Family Planning—30 Minutes (10:00-10:30)			
30 minutes	What is postpartum Family Planning?	**Discussion/Brainstorming:** ' Brainstorm about the magnitude of existing problems related to unmet need for PPFP. Share importance of the role of health care provider in fighting against these problems. ' Brainstorm about the important factors that are considered when going out to buy anything. Try to reach overall agreement that access and quality are the most important factors. Discuss examples. ' Ask participants what they feel when they go to a health facility as a client. Tell them to try to adopt the role of a client for the time being. What would be the expectations of an FP client before and after going to the facility? How important are the rights of the client? How do they relate to clients' adoption of FP methods? ' Use slides if/as needed.	Prepared transparencies/PPT if/as needed
TEA BREAK(10:30-10:45)			
SECTION 2: BIRTH SPACING AS A HEALTH INTERVENTION			**TOTAL TIME ALLOTTED: 50 MIN**
Session 2.1: Why Birth Spacing Is Important—20 Minutes (10:45-11:05)			
20 minutes	Benefits of birth spacing	**Discussion/Brainstorming:** ' Brainstorm and discuss what participants understand about the concept of "birth spacing" and why it is important—specifically how birth spacing can help the: – Mother – Child – Family – Community and country ' Write the responses on the flip chart for all the four categories and paste the pages on the wall. ' Tell participants that the group will now discuss what should be the "healthy timing of pregnancy."	

Technical Update Workshop on Contraceptive Technology (Standard Course: 2 days, 10 sessions)			
TIME	**TOPICS**	**ACTIVITIES AND TRAINING/LEARNING METHODS**	**RESOURCES/MATERIALS[2,3]**
DAY 1			
Session 2.2: Healthy Timing and Spacing of Pregnancy—30 Minutes (11:05–11:35)			
10 minutes	"My Children's Birth Intervals"	**Discussion/Brainstorming:** Ask participants to raise their hands if they have more than one child. Those who do not have a child or have only one will be paired with individuals with more than one. ' Ask each person/group to take a piece of paper and pen and map out the birth interval of their children in months (start counting from delivery to next pregnancy for each child). (Time to complete is 5 minutes.) ' After 5 minutes, start asking "How many of you have children with…" – 1–6 months interval – 12–18 months interval – 18–24 months interval – >24 months interval – >60 months interval ' Write their responses on the flip chart according to the above format. ' Ask: – "Why" the interval? – What is the ideal interval for spacing pregnancies? – Why is spacing important? ' Introduce the slide presentation.	
15 minutes	Healthy timing and spacing of pregnancies	**Lecture:** ' Walk participants through the slide presentation to share information about HTSP (be sure to have prepared slides to share information about newer concepts). ' Ask a variety of questions to encourage participation.	Prepared transparencies/PPT
5 minutes	Healthy timing and spacing of pregnancies (cont.)	**Summary/Question and Answer:** Encourage participants to ask questions about HTSP.	

Technical Update Workshop on Contraceptive Technology (Standard Course: 2 days, 10 sessions)			
TIME	**TOPICS**	**ACTIVITIES AND TRAINING/LEARNING METHODS**	**RESOURCES/MATERIALS[2,3]**
DAY 1			
SECTION 3: HOW TO COUNSEL A CLIENT (11:35-12:15)			**TOTAL TIME ALLOTTED: 40 MIN**
5 minutes	Introduction to counseling—what it is	**Brainstorming:** ' Brainstorm on the question "What is effective FP counseling?" ' After listing all responses, review the list and identify items that are relevant/ appropriate to the topic. ' Introduce the next activity.	Prepared transparencies/PPT if/as needed
15 minutes	Counseling—how to do it	**Discussion/Brainstorming/Role Play:** The trainer will demonstrate a counseling session using a role play activity: ' Organize the group so that everyone can see and hear the role play demonstration. ' Share with the group the objective and the situation of the role play. ' Ask for volunteers to conduct the role play. ' Brief the participants about their roles. ' One of the participants will play the role of a counselor and another will play the role of a client who wants contraception. ' Instruct the remaining participants to quietly observe the role play and to focus on the following: – Conduct of the counselor – Information the counselor is providing ' Role play should not last more than 10 minutes. ' Process the role play by first asking for feedback from the volunteers and then getting feedback from the observers. Write the feedback on flipchart paper. ' Thank the volunteer and the observers; and introduce the next activity.	Two prepared name labels (with adhesive)—one for Counselor, another for Client Job aides as needed (FP counseling flip chart if available) Stethoscope, table, chair, white coat, BP apparatus **From the Notebook(s):** Role Play on Counseling
15 minutes	Counseling (cont.)	**Discussion/Illustrated Presentation:** ' Walk participants through the slide presentation to share information about counseling (be sure to have prepared slides to share information about newer concepts); ' Ask a variety of questions to encourage participation.	Prepared transparencies/PPT if/as needed

Technical Update Workshop on Contraceptive Technology (Standard Course: 2 days, 10 sessions)			
TIME	**TOPICS**	**ACTIVITIES AND TRAINING/LEARNING METHODS**	**RESOURCES/MATERIALS[2,3]**
DAY 1			
5 minutes	Counseling (cont.)	**Discussion/Brainstorming/Summary:** ' Ask each participant to reflect for a minute about an important aspect of counseling that they learned in the session and write it down on a piece of paper. ' Collect the papers and go through each one, aloud. ' Provide comments or clarify as needed.	
SECTION 4: METHODS FOR BIRTH SPACING **TIME ALLOTTED:**			**TOTAL**
Session 4.1: Natural Birth Spacing Methods (NBS) and LAM— (12:15-12:55) 40 minutes			
10 minutes	Common NBS methods	**Game/Discussion:** ' Divide the participants into two groups. ' Provide a flipchart and a marker to each group. ' Instruct the groups as follows: – This is a competitive game and the winner gets a prize. – The task is to list as many NBS methods as they can. The winning team should have the highest number of correct NBS methods. – Time to complete is 1 minute ' After 1 minute, the facilitator will review each list indicating the correct ones. A prize is given to the group with the most number of correct NBS methods	Flip charts and markers for each group Watch Candies or fruits for the winning group (plus extra to share with the rest of the class)
30 minutes	Lactational amenorrhea method (LAM)	**Discussion/Lecture/Illustrated Presentation:** ' Walk participants through the slide presentation to share information about LAM; ' Ask a variety of questions to encourage participation	Prepared transparencies/PPT
LUNCH (12:55-14:00)			
WARM UP (14:00-14:10)			
Session 4.2: Barrier Methods (Male Condoms)—30 Minutes (14:10-14:40)			

Technical Update Workshop on Contraceptive Technology (Standard Course: 2 days, 10 sessions)			
TIME	**TOPICS**	**ACTIVITIES AND TRAINING/LEARNING METHODS**	**RESOURCES/MATERIALS[2,3]**
DAY 1			
15 minutes	Male condoms	**Facilitation/Questionnaire/Game:** ' Write each question on a separate piece of paper. Fold the papers and place them in a bowl. Ask participants to pick one paper from the bowl. Each paper will have a question written on it. ' The total number of questions will be 10; if there are more than 10 participants, the same question can be given to more than one of them. (For example, Question 7 [client instructions] has a long answer and can be given to more than one participant [2–3 participants] to cover all the points or as per required. ' Give 10 minutes to the participants to write their responses on the paper. Encourage participants to use the National Standards as a reference.	Prepared questions written on pieces of paper (one for each question), folded and kept in bowl National Standards Reference Guide **From the Notebook(s):** Barrier Methods (Condoms) Questionnaire and Answer Key
25 minutes	Male condoms (cont.)	**Discussion/Group Discussion/Presentation:** ' Read out the questions one by one from the questionnaire. After each question, ask who answered this question; have this participant(s) share the answer. ' Discuss each response with the participants. Try to reach agreement. ' Inform the participants that the next session will be about hormonal methods of contraception.	Sample condoms Prepared transparencies/PPT if/as needed
Session 4.3: Medical Barriers and Access to Contraception—45 Minutes (14:40-15:20)			
20 minutes	Medical barriers that affect and limit access to quality FP services	**Small Group Activity:** ' Explain concept of medical barriers. ' Divide participants into pairs to brainstorm on examples of medical barriers. ' Ask each pair to share one or two of their examples.	
15 minutes	WHO classification for use of contraceptive methods (medical eligibility criteria [MEC])	**Lecture/Illustrated Presentation:** Walk participants through the slide presentation to share information about increasing contraceptive access/WHO MEC guidelines.	Prepared transparencies/PPT Prepared instructions on flip chart

Technical Update Workshop on Contraceptive Technology (Standard Course: 2 days, 10 sessions)			
TIME	**TOPICS**	**ACTIVITIES AND TRAINING/LEARNING METHODS**	**RESOURCES/MATERIALS[2,3]**
DAY 1			
10 minutes	Use of MEC to improve FP provision	**Small Group Activity/Summary:** ' Divide participants into pairs. Provide one or two conditions for each pair. ' Have them identify the medical eligibility category for use of hormonal contraceptive for their particular condition(s). ' Advise them to open their reference manual to find information. Ask each pair to share one or two of their examples.	One or two medical conditions (per pair of participants), each written on 4×5 in. piece of paper **From the Notebook(s):** Paper Chits for MEC Exercise

Technical Update Workshop on Contraceptive Technology (Standard Course: 2 days, 10 sessions)			
TIME	**TOPICS**	**ACTIVITIES AND TRAINING/LEARNING METHODS**	**RESOURCES/MATERIALS[2,3]**
DAY 1			
Session 4.4: Hormonal Contraceptives—			
Session 4.4.1: Hormonal Contraceptives (Back To Basics)—1 Hour, 30 Minutes (15:20-16:55)			
20 minutes	COCs and PIC	**Exercise:** ' Form four groups of not more than five participants each. Two groups will be assigned to the COC, the remaining two to the PIC. ' Assign each group two of the four question groups in their assigned case study. ' Give them 12 minutes to answer their questions. ' Advise them to open their reference manual to find information.	**From the Notebook(s):** Case Studies on Pills (COCs) and Injectables (PICs), Facilitator/ Trainer Notes, Answer Keys
30 minutes	Key information and practices regarding COCs	**Discussion:** ' Start the session by asking the first COC group to read the case aloud. ' Ask them to share answers to questions assigned to their group. ' Ask follow-up questions directed at the larger group. ' Encourage the group to ask questions about the method. ' Use the slide presentation to cover any topic not discussed in the case study, including ECP. ' Use the FP Handbook for Service Providers as a reference.	Prepared transparencies/PPT if/as needed
30 minutes	Key information and practices regarding PICs	**Discussion:** ' Continue the session by asking the first PIC group to read the case aloud. ' Ask them to share answers to questions assigned to their group. ' Ask follow-up questions directed at the larger group. ' Encourage the group to ask questions about the method. ' Use the slide presentation to cover any topic not discussed in the case study. ' Use the National Standards as a reference.	Prepared transparencies/PPT if/as needed National Standards Reference Guide

Technical Update Workshop on Contraceptive Technology (Standard Course: 2 days, 10 sessions)			
TIME	**TOPICS**	**ACTIVITIES AND TRAINING/LEARNING METHODS**	**RESOURCES/MATERIALS[2,3]**
DAY 1			
10 minutes	Technique for providing injectables safely	**Demonstration:** ' Demonstrate the appropriate technique for providing injections safely. ' Have participants follow along with the safe injections checklist.	Disposable syringes, cushion/prepared arm, spirit swab, injection, Destruclip **From the Notebook(s):** Checklist for Safe Injection Technique
05 minutes	Wrap up of the day	**Facilitation** The facilitator will summarize the important messages on different technical topics discussed during the day	
10 minutes	Opening of the day	**Facilitation** Ask the volunteer to present agenda of the day	Pre written Agenda of Day 2
20 minutes	Reflections	**Activity** The facilitator will do an activity to review the contents learned by the participants on day 1.	Flip Charts, Easel ,Markers,
Session 4.4: Progestin Only Pills(POPs)-30 minutes (9:30-10:00)			
20 minutes	Key information and practices regarding POPs	**Lecture/Discussion:** ' Provide key information regarding POPs (e.g., benefits, limitations, client's instructions, when to start, who can use, warning signs). ' Highlight similarities (e.g., mode of action) and differences (e.g., use in breastfeeding women) between COCs and POPs. ' Use the slide presentation to cover any topic not discussed. ' Encourage the participants to ask questions.	Prepared transparencies/PPT if/as needed
10 minutes	POPs (cont.)	**Exercise/Questionnaire/Summary:** ' Ask the participants to solve the POPs questionnaire in 5 minutes. ' Summarize the session by answering the answers.	**From the Notebook(s):** Exercise on Progestin-Only Pills, Answer Key

Technical Update Workshop on Contraceptive Technology (Standard Course: 2 days, 10 sessions)			
TIME	**TOPICS**	**ACTIVITIES AND TRAINING/LEARNING METHODS**	**RESOURCES/MATERIALS[2,3]**
DAY 1			
Session 4.5: Emergency Contraception—45 Minutes (10:00-10:45)			
5 minutes	Emergency contraception (EC)	**Brainstorming/Discussion:** ' Start the session by asking the participants, "What are ECPs and how do they work?" "What types of different methods are available for emergency contraception?" ' Write the responses on the flip chart.	
30 minutes	EC (cont.)	**Group Activity/Group Discussion/Case Study:** Divide the group into four smaller groups of three to four participants each, and provide instructions for each group: ' Discuss the case of Warda. ' Assign each group a specific set of questions to complete. ' Have each group identify a reporter to share their response. ' The time to complete the task is 15 minutes. ' Have each group state their questions and their responses in 3 minutes. ' Ask the other groups to respond or ask questions. ' Summarize the key learning point of the discussion after all groups have presented.	**From the Notebook(s):** Case Study on Emergency Contraception, Answer Key
10 minutes	Key information and practices regarding EC	**Discussion/Lecture/Summary/Illustrated Presentation:** Walk participants through the slide presentation to share information about EC; ' Ask a variety of questions to encourage participation	Prepared transparencies/PPT
TEA BREAK (10:45-11:00)			
Session 4.6: Intrauterine Contraceptive Devices (IUCD)—40 Minutes (11:00-11:45)			
15 minutes	Types of IUCDs available in Pakistan	**Discussion/Lecture:** ' Start the session by asking the participants to list types of IUCDs. ' Walk participants through the slide presentation to share information about IUCDs. ' Discuss attributes of IUCDs (e.g., mode of action, characteristics, safety).	Prepared transparencies/PPT (except part about myths)

Technical Update Workshop on Contraceptive Technology (Standard Course: 2 days, 10 sessions)			
TIME	**TOPICS**	**ACTIVITIES AND TRAINING/LEARNING METHODS**	**RESOURCES/MATERIALS[2,3]**
DAY 1			
15 minutes	More information about IUCDs (who can use, who can't)	**Group Activity:** ' Divide the group into two. Have each group pick a leader who will present after the activity. ' Give each group flip charts with markers. ' Ask the first group to write about who can use the IUCD, and the other to write about who cannot use it. ' Give them 5 minutes to think and write. ' Ask each of the group leaders to present their flip charts. ' Correct them where required, reinforcing correct information with presentation slides.	Flip charts and markers for each group Prepared transparencies/PPT if/as needed
10 minutes	Dispelling myths by providing correct messages	**Brainstorming/Discussion:** ' Walk participants through the slide presentation on the different myths and rumors about the IUCD. ' Brainstorm with the participants on ways to correct rumors and myths. ' Discuss those ideas that are relevant/appropriate. '	Prepared transparencies/PPT
SECTION 5: VOLUNTARY SURGICAL CONTRACEPTION (VSC)			**TOTAL TIME ALLOTTED: 30 MINUTES (11:45-12:15)**
10 Minutes	Introduction to VSC	**Brainstorming/Lecture:** ' Ask the participants what they know about the VSC. ' Ask participants to list the types of VSC.	
10 minutes	VSC mode of action	**Presentation/Discussion:** ' Explain the mode of action of minilap and vasectomy, with the help of presentation slides. ' Ask the participants to open the counseling desk reference (Annexes 7 & 8) to gain a clear understanding of the procedure.	Prepared transparencies/PPT
10 minutes	Key information and practices regarding VSC	**Brainstorming/Lecture:** ' Brainstorm with the participants about the benefits and limitation of VSC. Reinforce the message with the help of presentation slides. ' Present the characteristics of TL and VS. ' Brainstorm with the participants about the selection criteria used for TL and VS clients. '	Prepared transparencies/PPT if/as needed

Technical Update Workshop on Contraceptive Technology (Standard Course: 2 days, 10 sessions)			
TIME	**TOPICS**	**ACTIVITIES AND TRAINING/LEARNING METHODS**	**RESOURCES/MATERIALS[2,3]**
DAY 1			
SECTION 7: INFECTION PREVENTION (IP)			**TOTAL TIME ALLOTTED: 30 MIN (12:15-12:45)**
10 minutes	Introduction to IP	**Warm-Up:** Do not tell participants what the session is about. Instead have them "Guess the session." ' Write a few words on the flip chart, such as: – Client – Viruses – HIV/AIDS – 0.5% chlorine ' Let participants try to recognize the topic. ' Direct them toward the topic as needed.	
15 minutes	Key information and practices regarding IP	**Brainstorming/Presentation/Discussion:** ' Ask the participants about the importance of infection prevention practices. ' Reinforce correct comments with the help of presentation slides as/if needed. ' Share key information regarding IP (e.g., standard precautions) and generate discussion as you walk then through the remaining presentation slides.	Prepared transparencies/PPT
5 minutes	Technique for providing injectables safely (reinforcement of earlier session)	**Demonstration:** ' Demonstrate the appropriate technique for providing DMPA injections safely. ' Have participants follow along with the DMPA injection checklist.	Syringes, ampoules of injections (DMPA), spirit swabs, Destruclips **From the Notebook(s):** Checklist for DMPA Injection
SECTION 8: CONTRACEPTIVE NEEDS FOR POSTPARTUM WOMEN			**TOTAL TIME ALLOTTED: 40 MIN (12:45-13:30)**
30 minutes	Special situations	**Discussion/Small Group Work/Group Activity:** Divide the participants into four smaller groups of three to four each. Give each group a flip chart, marker and adhesive tape. Provide the following instructions: ' Select a team reporter. ' The reporter will pick one of the following topics (special situations) from the bowl/box: – Postpartum – Post-miscarriage/abortion	Flip charts, markers and adhesive tape for each group Prepared topics written on pieces of paper (one for each group), folded and kept in bowl/box Zopp cards

Technical Update Workshop on Contraceptive Technology (Standard Course: 2 days, 10 sessions)			
TIME	**TOPICS**	**ACTIVITIES AND TRAINING/LEARNING METHODS**	**RESOURCES/MATERIALS[2,3]**
DAY 1			
		– Young and teenage women – Peri-menopausal women ' The reporter will write the topic on a flip chart, and mount it on the wall. ' Each group member will be given Zopp cards on which to write the appropriate contraceptive method that can be used in their particular situation. ' They will paste their Zopp cards on the flip chart. ' Time to complete the task is 10 minutes. ' Ask each reporter to share the findings of his/her group. ' Provide appropriate feedback. ' Walk participants through the slide presentation to reinforce information about special situations and cover any issues not covered.	Prepared transparencies/PPT if/as needed
		' Ask a variety of questions to encourage participation and summarize the activity. ' Introduce the next activity while instructing the participants to remain in their small groups.	
SECTION 9: SOLVING THE POST-WORKSHOP QUESTIONNAIRE			**TOTAL TIME ALLOTTED: 40 MIN (13:30-14:00)**
30 minutes	Solving the post-workshop questionnaire	**Questionnaire/Discussion:** ' Divide the questionnaire among the participants; ask them to fill in the answers. ' Collect the papers and let the co-trainer check the papers during the next session of role play. ' The answers will be discussed with the group after the role play session.	**From the Notebook(s):** Post-Workshop Questionnaire
SECTION 10: WORKSHOP EVALUATION/CLOSING			**TOTAL TIME ALLOTTED: 30 MIN (14:00-14:30)**
30 minutes	Wrap-up	**Closing Activities:** Vote of thanks, Evaluation forms, Photograph, Certificates	Camera, Evaluation forms, Certificates
LUNCH			

For all activities: Trainers will be expected to provide clear oral and written instructions. These should be prepared beforehand.
Additional materials needed for all of the sessions: flip chart, thumb pins/scotch tape, markers, easel stand, pens, pencils, overhead projector with prepared transparencies of each of the sessions (or a multi-media system) and screen, Notebook for Participants and Reference Manual;

Technical Update Workshop on Contraceptive Technology
Pre Course Knowledge Needs Assessment Questionnaire
(Answer Key)

Name: _____ **Date:** _____

Instructions:

Attempt all questions. Identify each of the statement either as True (by encircling **"T"**) **OR** as False (by encircling **"F"**), whichever is the appropriate response.

Example:
Mumbai is the capital of Kenya

T	(F)

COUNSELING			
1	The best way to correct a Family Planning rumour is to ignore it.	T	**F**
2	The doctor should prescribe Family Planning as per his/her best judgment.	T	**F**
3	It is important to discuss misconceptions and rumors about Family Planning methods with the client	**T**	F
HEALTHY TIMING AND SPACING OF PRAGNANCY			
4	Pregnancy before the age of 18 years has no adverse effects on the clients health	T	**F**
5	Recommended interval before attempting the next pregnancy is at least 24 months in order to reduce the health risk to mother and the child	**T**	F
COCs			
6	Oral contraceptive method is the best method of contraception for a woman who is breast-feeding her infant age 3 months.	T	**F**
7	Oral contraceptive Pills are also used as emergency contraception	**T**	F
8	Combined oral contraceptive Pills regularize the menstrual period	**T**	F
9	Combined Oral contraceptive Pills have protective effect on ovarian cancer.	**T**	F
10	COCs decreases menstrual cramps	**T**	F
11	COCs is the combination of estrogen and progesterone.	**T**	F
12	The mechanism of action of COCs is to prevent the release of the ovum (or egg).	**T**	F
13	COC pills can be started only during the menstrual period	T	**F**
14	COCs benefit the breast feeding mothers by increasing the quantity of milk	T	**F**
15	Excessive bleeding is the most common side effect experienced by the pill users	T	**F**
MEDICAL ELIGIBILITY CRITERIA			
16	When a contraceptive method is safe to use for client, it will be in the category number 1	**T**	F
17	When the use of a particular contraceptive is absolutely contraindicated, it will fall in	T	**F**

	the category number 2		
18	Nulliparous woman can use the IUCD as a method of contraception	**T**	F
EMERGENCY CONTRACEPTIVES			
19	Emergency contraceptive pills (ECPs) are effective if taken within 120 hours of unprotected intercourse	**T**	F
20	Emergency Contraceptive Pills should be used if the client forgot to take the Oral contraceptive (brown Pills) on the 24th day of menstrual cycle	T	**F**
21	After the use of ECP, menstrual cycle gets 1 week late	T	**F**
INJECTABLE CONTRACEPTIVES			
22	If the client is on injectable contraceptive (3 months), she comes one week later than the schedule time, she should be given second injection	**T**	F
23	Since the women are familiar with injections, they do **not** need to have counseling.	T	**F**
24	If the patient develops bleeding P/V following Contraceptive injection, next injection should not be given.	T	**F**
25	Changes in bleeding pattern is the major reason of the discontinuation of injectables	**T**	F
CONDOMS			
26	It is preferable to lubricate condoms before use	T	**F**
27	Condoms protects from sexually transmitted infections	**T**	F
INFECTION PREVENTION			
28	Standard precautions are the guidelines designed to create the barriers between A healthy person and microorganisms	**T**	F
29	Decontamination of needle and syringe must be done before destroying it in destruclip	**T**	F
IUCDs			
30	Copper T 380 IUCD is not recommended for nulliparous women	T	**F**
31	As long as a woman is not pregnant, Multiload Copper 375 IUCD can be inserted anytime in her cycle	**T**	F
VOLUNTARY SURGICAL CONTRACEPTION			
32	Vasectomy is effective immediately after the surgery	T	**F**
33	Minilap tubal ligation is performed 7 days after delivery of the baby	T	**F**
LACTATIONAL AMMENNORHOEA METHOD(LAM)			
34	One of the three criteria for effective lactational amenorrhea (LAM) is that the baby is exclusively breast fed	**T**	F
35	LAM can be effective for up to 6 months after childbirth	**T**	F

PRE-WORKSHOP KNOWLEDGE NEEDS ASSESSMENT: Individual and Group Assessment Matrix

COURSE:_____ **DATES:**_____ **CLINICAL TRAINER(S):**_____

Question Number	CORRECT ANSWERS (Participants)																							
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
1																								
2																								
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16																								
17																								
18																								

COUNSELING	rows 1–3
HTSP	rows 4–5
COCs	rows 6–15
MEC	rows 16–18

Question Number	CORRECT ANSWERS (Participants)																								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
19																									**EC**
20																									
21																									
22																									**Injectable Contraceptives**
23																									
24																									
25																									
26																									**Condoms**
27																									
28																									**Infection Prevention**
29																									
30																									**IUCDs**
31																									
32																									**VSC**
33																									
34																									**LAM**
35																									

POST-WORKSHOP QUESTIONAIRRE

USING THE POST-WORKSHOP KNOWLEDGE ASSESSMENT QUESTIONNAIRE

The main purpose of the post-workshop questionnaire, which is administered as soon as all of the scheduled subject areas have been covered, is to help each participant and the clinical trainer assess the participants' progress in mastering the course objectives.

A score of 85% or more correct indicates knowledge-based mastery of the material presented during the course. For those scoring less than 85% in their first attempt, the clinical trainer should review the results with the participant individually and guide her/him on using the Reference Manual to learn the information.

Technical Update Workshop on Contraceptive Technology

Post Course Knowledge Needs Assessment Questionnaire

Name: _____ **Date:** _____

Instructions:

Attempt all questions. Identify each of the statement either as True (by encircling **"T"**) **OR** as False (by encircling **"F"**), whichever is the appropriate response.

Example:
Mumbai is the capital of Kenya

T	(F)

COUNSELING			
1	The best way to correct a Family Planning rumour is to ignore it.	T	F
2	The doctor should prescribe Family Planning as per his/her best judgment.	T	F
3	It is important to discuss misconceptions and rumors about Family Planning methods with the client	T	F
HEALTHY TIMING AND SPACING OF PRAGNANCY			
4	Pregnancy before the age of 18 years has no adverse effects on the clients health	T	F
5	Recommended interval before attempting the next pregnancy is at least 24 months in order to reduce the health risk to mother and the child	T	F
COCs			
6	Oral contraceptive method is the best method of contraception for a woman who is breast-feeding her infant age 3 months.	T	F
7	Oral contraceptive Pills are also used as emergency contraception	T	F
8	Combined oral contraceptive Pills regularize the menstrual period	T	F
9	Combined Oral contraceptive Pills have protective effect on ovarian cancer.	T	F
10	COCs decreases menstrual cramps	T	F
11	COCs is the combination of estrogen and progesterone.	T	F
12	The mechanism of action of COCs is to prevent the release of the ovum (or egg).	T	F
13	COC pills can be started only during the menstrual period	T	F
14	COCs benefit the breast feeding mothers by increasing the quantity of milk	T	F
15	Excessive bleeding is the most common side effect experienced by the pill users	T	F
MEDICAL ELIGIBILITY CRITERIA			
16	When a contraceptive method is safe to use for the client, it will be in the category number 1	T	F
17	When the use of a particular contraceptive is absolutely contraindicated, it will fall in the	T	F

	category number 2		
18	Nulliparous woman can use the IUCD as a method of contraception	T	F
	EMERGENCY CONTRACEPTIVES		
19	Emergency contraceptive pills (ECPs) are effective if taken within 120 hours of unprotected intercourse	T	F
20	Emergency Contraceptive Pills should be used if the client forgot to take the Oral contraceptive (brown Pills) on the 24th day of menstrual cycle	T	F
21	After the use of ECP, menstrual cycle gets 1 week late	T	F
	INJECTABLE CONTRACEPTIVES		
22	If the client is on injectable contraceptive (3 months), she comes one week later than the schedule time, she should be given second injection	T	F
23	Since the women are familiar with injections, they do **not** need to have counseling.	T	F
24	If the patient develops bleeding P/V following Contraceptive injection, next injection should not be given.	T	F
25	Changes in bleeding pattern is the major reason of the discontinuation of injectables	T	F
	CONDOMS		
26	It is preferable to lubricate condoms before use	T	F
27	Condoms protects from sexually transmitted infections	T	F
	INFECTION PREVENTION		
28	Standard precautions are the guidelines designed to create the barriers between A healthy person and microorganisms		
29	Decontamination of the needle and syringe must be done before destroying it in destruclip		
	IUCDs		
30	Copper T 380 IUCD is not recommended for nulliparous women	T	F
31	As long as a woman is not pregnant, Multiload Copper 375 IUCD can be inserted anytime in her cycle	T	F
	VOLUNTARY SURGICAL CONTRACEPTION		
32	Vasectomy is effective immediately after the surgery	T	F
33	Minilap tubal ligation is performed 7 days after delivery of the baby	T	F
	LACTATIONAL AMMENNORHOEA METHOD(LAM)		
34	One of the three criteria for effective lactational amenorrhea (LAM) is that the baby is exclusively breast fed	**T**	F
35	LAM can be effective for up to 6 months after childbirth	**T**	F

WORKSHOP ACTIVITIES AND FACILITATION NOTES

ROLE PLAY ON COUNSELING

Directions for the Participants

The trainer and one volunteer from the group will conduct this activity. One will be a clinician, the other a client. Each participant who has a part in the role play should take a few minutes to read the background information and prepare. The observers in the group also should read the background information so that they can participate in the small group discussion following the role play.

Time Allotted: 10 minutes

Participant's Role

Clinician: The physician is a health care provider providing services at a rural health center (RHC).

Client: The client is 25 years of age and has four children, the youngest being 8 months old. She comes to RHC for contraception. She has heard from someone that pills are very effective but she is, at the same time, afraid of the side effects.

Focus of the Role Play

The focus of the role play is on the interaction between the physician and the client. The physician must counsel and reassure the client. The client should continue to be nervous until the physician chooses the appropriate words and expressions that will inform and calm the client.

Discussion Questions

1. Did the provider approach the client in a positive, reassuring manner?
2. Did the physician's approach have the planned effect on the client? What other approaches would have been effective?
3. Were the client's fears realistic?
4. How could this problem have been avoided?

PPFP OPTIONS THAT CAN BE PROVIDED AT DIFFERENT STAGES AFTER DELIVERY

1. FAMILY PLANNING METHOD OPTIONS	2. FULLY OR NEARLY FULLY BREASTFEEDING*	3. PARTIALY BREASTFEEDING OR NOT BREASTFEEDING
Lactational Amenorrhea Method(LAM)	This option can be exercised immediately after delivery	Not applicable
IUCD	Options are: • Post placental insertion within 10 minutes of delivery • Immediate Postpartum insertion within 48 hours of delivery • Postpartum insertion at or after 6 weeks of delivery	
Female Sterilization	Options are: • Abdominal Tubectomy (Minilap) within 7 days of delivery • Laproscopic and Abdominal (Minilap)Tubectomy after 6 weeks	
Progestin-Only Pills, Progestin only Injectables, Implants	This option can be exercised 6 months after childbirth	This option can be exercised immediately if not breastfeeding or 6 weeks after childbirth if partially breastfeeding
Combined Oral Contraceptives and Combined Injectables	This option can be exercised 6 months	This option can be exercised 21 days after childbirth if the mother is not breastfeeding
Male Condom	This option can be exercised whenever sex is resumed	
Vasectomy	This option can be exercised at anytime.	

*at least 75% of the feeds

FIVE QUESTIONS ABOUT LACTATIONAL AMMENORRHOAEA METHOD (LAM):

1. Can LAM be an effective method for birth spacing?

2. Can only well-educated couples use fertility awareness methods?

3. List the hormonal contraceptive methods which are compatible with breastfeeding?

4. What are the 4 messages that a health provider should include during postnatal care that will support the successful use of LAM?

5. List 3 ways that a service provider can promote LAM during antenatal period?

FIVE QUESTIONS ABOUT LACTATIONAL AMMENORRHOAEA METHOD (LAM):

ANSWER KEY

1. Can LAM be an effective method for birth spacing?

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

2. Can only well-educated couples use fertility awareness methods?

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

3. List the hormonal contraceptive methods which are compatible with breastfeeding?

Answer: a) Progestin Only Pills
b) Progestin Only Injectable
c) Implants

4. What are the 4 messages that a health provider should include during postnatal care that will support the successful use of LAM?

Answer:

a) Assist the mother to breastfeed shortly after delivery or at least within the first half hour
b) Encourage the mother to breastfeed her baby on demand
c) If the mother has accepted LAM, provide instructions for the method, verify that she understands how it works and when she will need to begin using complementary contraception
d) Give the mother a follow up appointment to monitor maternal recuperation, infant growth, breastfeeding practices and LAM

5. List 3 ways that a service provider can promote LAM during antenatal period?

Answer:

a) Begin giving clients health messages during antenatal care:
    - Promote breastfeeding as the optimal choice for infant feeding
    - Support optimal breastfeeding practices
    - Assist her with learning how to achieve these behaviors
b) Begin giving clients health messages that promote child spacing of at least 2 years and information about contraceptive methods
c) Towards the latter part of the second trimester of pregnancy, begin counseling clients in preparation for selecting a postpartum contraceptive method, including LAM

BARRIER METHODS (CONDOMS) QUESTIONNAIRE

1. What are the different types of barrier methods in use?

2. There are different types of male condoms (made of the different materials), such as:
   a. _____
   b. _____
   c. _____

3. How do condoms protect against pregnancy? Do all types protect against STIs?

4. What are other benefits associated with the use of condoms?

5. Allergic reaction to condoms is uncommon. In case of local irritation, what advice will you give to the client?

6. What are the limitations of condom use?

7. What instructions will you give to the client when advising about how to use condoms?

8. What are the lubricants that should be avoided with condoms use?

9. How can you avoid condom rupture during use?

10. What will you advise the client to do if a condom breaks or slips off during intercourse?

BARRIER METHODS (CONDOMS) QUESTIONNAIRE:

ANSWER KEY

1. What are the different types of barrier methods in use?
   There are different types of barrier methods in use all over the world, for example: male condoms, female condoms, diaphragm and cervical caps. But male condoms are the most commonly used FP method among all of the barrier methods in Pakistan.

2. There are different types of male condoms (made of different materials), such as:

   a. Thin sheaths of rubber (latex)

   b. Vinyl

   c. Natural products

   Note: Condoms differ in such qualities as shape, color, lubrication, thickness, texture and whether a spermicidal has been added.

3. How do condoms protect against pregnancy? Do all types protect against STIs?
   The condoms prevent sperm from gaining access to the female reproductive tract. They also prevent microorganisms (STIs) passing from one partner to another (latex and vinyl condoms only).

4. What are the other benefits associated with the use of condoms?
   - **Condoms are used for the prevention of pregnancy and also for the prevention of STIs (only FP method that provides protection against STIs [latex rubber and vinyl condoms only]).**
   - **Condoms can also be used as backup to other methods, do not have method-related health risks or systemic side effects, and are widely available (at pharmacies and community shops).**
   - **No prescription or medical assessment is required for use of condoms; they are inexpensive (short-term), promote male involvement in family planning and may also help prevent cervical cancer.**

5. Allergic reaction to condoms is uncommon. In case of local irritation, what advice will you give to the client?
   Allergic reactions—although uncommon—can be uncomfortable. In case of any such event, ensure that the condom is not medicated. If the reaction persists with unmedicated condoms, consider natural condoms (lambskin or gut) or choose another method (help the client do this).

6. What are the limitations of condom use?
   The use of condoms does have some limitations, such as:
   - **They are moderately effective (two pregnancies per 100 women during the first year when correctly used), as their effectiveness as contraceptives depends on the couple's willingness to follow instructions.**
   - **They are user-dependent (require continued motivation and consistent use with each act of intercourse).**
   - **They can reduce sensitivity of the penis, making maintenance of erection more difficult.**

7. What instructions will you give to the client when advising about how to use condoms?
   The following instruction's should be given to the condom user:
   - **Use a new condom every time.**
   - **Do not use teeth, knife, scissors or other sharp utensils to open the condom package.**
   - **The condom should be unrolled onto an erect penis before the penis enters the vagina, because pre-ejaculatory semen contains active sperm.**
   - **If the condom does not have an enlarged end (reservoir tip), about 1 to 2 cm should be left at the tip for the ejaculate.**
   - **Check the date on the condom package to ensure that it has not expired.**
   - **Do not use a condom if the package is broken or the condom appears damaged or brittle.**
   - **Do not use mineral oil, cooking oils, baby oil or petroleum jelly as lubricants for a condom. They damage condoms in seconds. If lubrication is required, use saliva or vaginal secretions.**
   - **While holding on to the base (ring) of the condom, withdraw the penis before losing the erection. This prevents the condom from slipping off and spilling semen.**
   - **Each condom should be used only once.**
   - **Dispose of used condoms by placing in a waste container.**
   - **Keep an extra supply of condoms available. Do not store them in a warm place or they will deteriorate and may break or leak during use.**

8. What are the lubricants that should be avoided with condoms use?
   Lubricants like mineral oil, cooking oils, baby oil or petroleum jelly should not be used with condoms. They damage condoms in seconds. If lubrication is required, use saliva or vaginal secretions.

9. How can you avoid condom rupture during use?
   Condom rupture can be avoided by adhering to the following guidelines:
   - **Do not use teeth, knife, scissors or other sharp utensils to open the condom package.**
   - **If the condom does not have an enlarged end (reservoir tip), about 1 to 2 cm should be left at the tip for the ejaculate.**
   - **Check the date on the condom package to ensure that it has not expired.**
   - **Do not use mineral oil, cooking oils, baby oil or petroleum jelly as lubricants for a condom. They damage condoms in seconds. If lubrication is required, use saliva or vaginal secretions.**

10. What will you advise the client to do if the condom breaks or slips off during intercourse?
    Consider using a method of emergency contraception.

PAPER CHITS FOR MEC EXERCISE

ENDOMETRIOSIS	**HIV/AIDS**
PREGNANCY	**CURRENT PELVIC INFLAMMATORY DISEASE (PID)**
TUBERCLULOSIS	**UTERINE FIBROIDS**
ISCHEMIC HEART DISEASE	**EPILEPSY**
HYPERTENSION (HIGH BLOOD PRESSURE)	**VIRAL HEPATITIS**
HYPOTHROIDISM	**POST-ABORTION**

NULLIPARITY	**SEVERE DYSMENORRHEA**
VAGINITIS	**IRON-DEFICIENCY ANEMIA**
NONVASCULAR DIABETES	**UNEXPLAINED VAGINAL BLEEDING**
VARICOSE VEINS	**ENDOMETRIAL CANCER**

CASE STUDY ON PILLS

Rashida is a 30-year-old mother of three children. Her youngest child was delivered about 6 months earlier. Today, she has come to your clinic to get some family planning pills (specifically, combined oral contraceptives [COCs]). Rashida's menses have not yet returned because she has been exclusively breastfeeding her infant. Three days ago, she was at another health center for some medical problems. She is taking antibiotics for a urinary tract infection and ferrous sulfate for anemia.

- During the counseling, Rashida wants to learn more about the pill and ask the following questions:
  1. What is the difference between low-dose and high-dose pills? Are high-dose pills better than the low-dose?
  2. What are some of the advantages of taking the pill?
  3. How about disadvantages—are there any?

- During the screening, there are several considerations:
  4. Given her condition, how does breastfeeding affect her eligibility to use COCs?
  5. How about her medical problems? What antibiotics will affect the effectiveness of the COCs? How about anemia and her intake of ferrous sulfate?
  6. What other pieces of information should you ask Rashida to help her make a decision about whether to use COCs? How would this additional information help?

- Toward the end of the counseling, she also asks about how to use the pill.
  7. Given her situation, 6 months postpartum and no menses, when can she start taking the pill?
  8. Aside from doing a pregnancy test, what can you do to be reasonably sure she is not pregnant? What questions should you ask?
  9. What should you tell her about what to do if she misses pills?
  10. How about if she forgets to start her new pack on time?

After all of Rashida's questions have been answered, you instruct her to return to the clinic for resupply or if there are problems related to using the pill. Three months later, Rashida returns to the clinic to get more pills. During her consult, she says that in the first 2 months of using the pills, she had 1–2 days of spotting in the middle of her cycle. She was not too concerned but would like to know if this is going to happen every time she is on pills. Rashida also mentions that she experienced nausea and some vomiting in the first month but presently gets nausea very infrequently.

11. Are her symptoms normal with pills? What other conditions may cause spotting?
12. What would you advise Naseeb bi about the spotting?
13. Will this spotting continue while she is on pills?
14. What should you advise Rashida about the nausea and vomiting? When should this information have been provided and what advice would have been appropriate at that time?

CASE STUDY ON PILLS—FACILITATOR/TRAINER NOTES

Learning Objectives

- Practice using the reference manual
- Practice using the WHO medical eligibility criteria for FP
- Review key information about using combined oral contraceptives (COCs)

Instructions for the Facilitator/Trainer

- Use this case study as a classroom activity. The trainer/facilitator will decide whether it will be an individual or group-based effort. In all cases, the national standards will be used as a reference source and both participants and facilitators/trainers must evaluate their answers based on it.

- When the case study is used in the classroom alone, the trainer/facilitator needs to include the following information as part of the instructions:
  - Individual or group activity
  - Learning objectives
  - Time for completing the task
  - How the case study results will be discussed

- The trainer/facilitator must prepare for the case study. This will include:
  - Deciding on the instructions to be given to participants
  - Reviewing the case study and the answers beforehand

- Check the location (page numbers) of relevant information in the reference manual. This is critical to help participants find the answers quickly. Also, when participants have questions, this will help the trainer/facilitator model looking for answers in the reference manual.

CASE STUDY ON PILLS: ANSWER KEY

1. **Components of COCs:** COCs contain estrogen and progesterone hormones. Low-dose COCs contain 30–35 mcg ethinyl estradiol (EE); while high-dose contain 50 or more mcg EE. In Pakistan, most of the available COCs are the low-dose types. Both are very effective in preventing pregnancy; however, the high-dose COCs often have the side effects associated with this method.

Examples of Low-Dose COCs

BRAND NAME	LOW-DOSE
NOVA	EE 30 mcg /Levonorgestrel 150
FAMILA 28	EE 30 mcg /Levonorgestrel 150
NORDETTE 28	EE 30 mcg /Levonorgestrel 150

2. Advantages of using pills include:
   - Very effective in preventing pregnancies
   - Fertility returns right after stopping use of pills
   - Monthly periods are regular

3. **Disadvantages** of using pills include:
   - Common side effects such as nausea and vomiting
   - Breast tenderness and weight gain
   - Spotting or bleeding between periods

4. **Breastfeeding:** There is some theoretical concern that the newborn may be at risk due to exposure to steroid hormones during the first 6 weeks postpartum. There is also some theoretical concern regarding the association between COC use up to 3 weeks postpartum and risk of thrombosis in the mother. In the first 6 months postpartum, use of COCs during breastfeeding diminishes the quantity of breast milk, decreases the duration of lactation and may affect the growth of the infant. Thus, the following is recommended by the World Health Organization:

CONDITION	CATEGORY	CATEGORY EXPLANATION
<6 weeks postpartum (PP)	4	Do not use the method
>6 weeks to <6 months PP	3	Do not use method unless no other method available
>6 months PP	2	Generally use the method

5. **Medical Problem:** Griseofulvin (antifungal) and Rifampicin (anti-TB) are two antibiotics that affect the effectiveness of COCs, especially the low-dose formulation of COC. In this case, it is important to ask the client which antibiotic she is taking. Presence of anemia or the use of ferrous sulfate remains Category 1 in the WHO eligibility criteria. In fact, the use of COCs may even help the client conserve her iron stores because the monthly bleeding will be lessened by COC use. This is one of the non-contraceptive benefits of COCs. The one piece of advice that this client may find useful will be to separate the time of intake for COC and iron. Some clients are sensitive to the smell of iron. Iron also causes some gastric discomfort when taken on empty stomach.

6. **Other information that might affect Rshida's decision:** Before it can be determined whether COCs are a suitable choice for Rashida, more discussion of her medical history is needed—such as whether she currently has or has a history of cardiovascular problems or hypertension. For women who are **hypertensive presently,** COCs are Category 3 or 4. For those who are not hypertensive presently but have a history of hypertension, COCs are Category 2.

7. **Starting COCs:** Although Naseeb bi is amenorrheic, she can start COCs at any time as long as it is reasonably certain that she is not pregnant. If she starts COCs immediately, she will need to abstain from sex or use additional contraceptive protection for the next 7 days. If a woman is not amenorrheic, she can start COCs within 5 days after the start of her next menses. In that case, no additional contraceptive protection is needed.

8. **Determining Pregnancy:** You can be reasonably sure a client is not pregnant if she has no signs or symptoms of pregnancy and:
   - Has not had intercourse since her last menses
   - Has been correctly and consistently using another reliable contraceptive method
   - Is within the first 7 days after the start of her menses
   - Is within 4 weeks postpartum (for non-breastfeeding women)
   - Is within the first 7 days post-abortion
   - Is fully breastfeeding, less than 6 months postpartum and has had no menstrual bleeding

Note: When a woman is more than 6 months postpartum, you can still be reasonably sure she is not pregnant if she: has kept her breastfeeding frequency high, still has no menstrual bleeding (amenorrheic), and has no clinical signs or symptoms of pregnancy.

A pregnancy test is needed only when it is difficult to confirm pregnancy and the results of the pelvic examination are not clear.

9. Missing Pill Intake: The client needs to know that the pills must be taken on time each day. The provider can help her find strategies, such as taking her pill as part of a daily routine (tied in with regular activities), to help her remember to take her pill. If compliance to the consistent, daily intake of the pill will be a problem, explore finding another, more appropriate method.

   If the woman misses one active (hormonal) pill, she must take the missed pill as soon as she remembers it, also take the other pill scheduled for that day (this means taking two pills in the same day) and complete the pack as usual. No backup method is necessary.

   When she misses two or more active pills (consecutively), she must take the missed pills as soon as she remembers, and continue with the remaining hormonal pills (as scheduled). The next day after the last hormonal pill has been taken, she should throw away the nonhormonal pills and begin a new pack. She needs to use a backup method for 7 days and should consider using EC if she has had sex within the last 5 days.

10. **Starting Next Pack Late:** Start the new pack that day (as soon as remembered), continue taking the pills as usual, one each day, and abstain from sex or use a backup method for the next 7 days.

11. **Breakthrough Bleeding or Spotting:** Check for other causes of spotting including gynecologic conditions (ectopic or intrauterine pregnancies, incomplete abortion and PID) and recent intake of new drugs. If neither is the case, advise the client that this is common during the first 3 months of COC use and decreases significantly in most women by the fourth month of use. If it persists and is bothersome, switch to another COC or help client choose another method.

12. **Nausea and Vomiting:** Check for other causes such as early pregnancy and time of intake (morning or on empty stomach). If the client is not pregnant, advise her to take the pill with her evening meal or before bedtime. Counsel that nausea and vomiting will probably decrease over the first 3 months.

CASE STUDY ON INJECTABLES

Naima is 36 years old and has three children. She is using Famila, a low-dose COC, and has been using it for the last 2 years. Naima 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]). Naima 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.

1. During the counseling, Naima wants to learn more about injectable contraceptives:
   - What are DMPA (Depot-Medroxyprogesterone Acetate, or Depo-Provera) and Net-en (Norethisterone enanthate)? What are their similarities and differences?
   - What are some of the advantages of using injectables?
   - How about disadvantages—are there any?
   - What other information should you share with Naima about PICs?

2. During screening, there are several considerations:
   - Do you think Naima's fears about her headaches being related to her use of Famila are valid? Why?
   - Given her age and headaches, do these factors affect her eligibility to use PICs?
   - How about the medical problem of headaches? How would you further evaluate her complaint of headaches? How about epilepsy? Do medications for epilepsy affect the effectiveness of DMPA?
   - What other conditions should you check out to see if she is eligible?

3. Toward the end of the counseling, Naima also asks about how she can get started on DMPA:
   - Given her condition (not presently having her menses), when can she start receiving Depo-Provera? If, for example, Naima just had a delivery, can she receive an injection before discharge?
   - Aside from doing a pregnancy test, what can you do to be reasonably sure she is not pregnant? What questions should you ask?
   - What should you tell her about returning for reinjection?
   - How about warning signs indicating that she should return to the clinic immediately?

Naima has come back to the clinic for a reinjection. You check her records and note that she is 2½ weeks late. Naima reports that she experienced two episodes of 1–2 days of spotting in the past 2 months.

Moreover, Naima is complaining that she has gained about 1.5 kilograms since she started the PIC.

- What should you Naima advise about spotting?
- Does her spotting need to be treated using other hormones? When is it appropriate to give additional hormones?
- How should you address the weight gain?
- What about the delay in returning for injection? Should you give her the injection? Will she need additional protection because of the delay?
- What will you advise her regarding the next follow-up visit?

CASE STUDY ON INJECTABLES—FACILITATOR/TRAINER NOTES

Learning Objectives

- Practice using the reference manual
- Practice using the WHO medical eligibility criteria for FP
- Review key information about using combined oral contraceptives (COCs)

Instructions for the Facilitator/Trainer

- Use this case study as a classroom activity. The trainer/facilitator will decide whether it will be an individual or group-based effort. In all cases, the national standards will be used as a reference source and both participants and facilitators/trainers must evaluate their answers based on it.
- When the case study is used in the classroom alone, the trainer/facilitator needs to include the following information as part of the instructions:
  - Individual or group activity
  - Learning objectives
  - Time for completing the task
  - How the case study results will be discussed
- The trainer/facilitator must prepare for the case study. This will include:
  - Deciding on the instructions to be given to participants
  - Reviewing the case study and the answers beforehand
- Check the location (page numbers) of relevant information in the reference manual. This is critical to help participants find the answers quickly. Also, when participants have questions, this will help the trainer/facilitator model looking for answers in the reference manual.

CASE STUDY ON INJECTABLES: ANSWER KEY

1. Both DMPA and Net-en are progestin derivatives, but they have different durations of effectiveness. Other similarities and differences are summarized in the table below:

	DMPA	NET-EN
Similarities	' Mechanism of action: prevention of ovulation ' Pregnancy rate: 0.3% (perfect use), 3% (typical use) ' Effective immediately if given within 7 days of menses ' Window period: 2 weeks ' Active component: progestin only ' Eligibility, complications, side effects: same as POPs	
Differences	' Type and amount of progestin: 150 mg of depot-medroxyprogesterone acetate ' Timing of injection: 3 months	' Type and amount of progestin: 200 mg of norethisterone enanthate ' Timing of injection: 2 months

2. Some of the advantages of PICs are:
   - They are a very effective and reversible method of family planning.
   - The client can use the method privately.
   - A breastfeeding woman can use the method after 6 weeks postpartum. A woman who is not breastfeeding can start PIC soon after delivery.
   - There are no estrogen-related side effects for PIC-users.
   - They protect against endometrial cancers (specifically DMPA) and ectopic pregnancies.
   - They may help decrease menstrual cramps and bleeding (endometriosis).

3. Some of the disadvantages of PICs are:
   - Trained provider is needed to provide the injection.
   - Resupply must be available.
   - Client must return for injections every 3 months (for DMPA) (every 2 months for Net-en).
   - There is delayed return of fertility after discontinuation.

4. **Other information** regarding injectables:
   - Naima can be reassured that injectables are highly effective (3 pregnancies per 100 women during first year of typical use) and are rapidly effective (<24 hours) if started by Day 7 of the menstrual cycle.
   - Naima can shift to the injection at any time, provided she has been using oral contraceptives correctly (i.e., you can be reasonably sure she is not pregnant).

- The postpartum woman can have the injection immediately if not breastfeeding, or anytime after 6 weeks postpartum if breastfeeding. Husnia has not had a baby for 2 years, so this is not an issue for her

5. **Considering the client's complaint of headaches:** Naima is on Famila tablets, which are low-dose COCs. Famila tablets usually do not cause headaches for such a prolonged period time. Most women on Famila will not experience any headaches. Some women may experience mild headaches, which eventually will disappear (usually after 3 months of starting pill intake). Since Naima has been using Famila for 2 years, it is unlikely that her headaches are due to COC use. However, clients having recurring severe headaches accompanied by neurological signs, as in migraine headaches, while on pills are advised to switch to another method. The provider needs to ask Naima about the nature of her headaches to be able to advise her on which methods might be best for her.

6. **Considering her age and headaches in terms of eligibility:** PICs can be used by women of any age, including adolescents and women who are over 40. To further evaluate Naima's headaches, the provider needs to ask whether her headaches are accompanied by neurological signs (e.g., aura).

7. Any woman with non-migrainous headaches or migraines with or without aura may start PIC, regardless of age. However, a woman who experiences new onset of migraines with aura while on PIC should stop using this method.

8. **Considering epilepsy:** PICs can be used in clients who have epilepsy, including those who are receiving medications for epilepsy. DMPA has been found to decrease the frequency of seizure episodes among those with epilepsy.

9. **Considering other eligibility issues:** Other eligibility issues that the provider needs to be aware of in the use of PICs include:
   - Breastfeeding: Breastfeeding women can start PICs 6 weeks after childbirth.
   - Smoking: PICs may be used by women who smoke.
   - Mild or controlled hypertension: PICs may be used by women with these conditions.
   - Multiple cardiac risk factors, including history of heart attacks, ischemic heart diseases, stroke, blood clots, or severe hypertension, or diabetes of more than 20 years: PICs are not advisable for women with these conditions.
   - Breast cancer, severe liver cirrhosis and liver tumor: PICs are not advisable in women with these conditions
   - Unusual vaginal bleeding: This should be investigated first before starting PICs.

10. **Starting PICs:** Naima can be shifted to injectables at any time. Although Naima is not presently having her menses, she can start PICs at any time as long as it is reasonably certain that she is not pregnant.

11. **Determining pregnancy:** You can be reasonably sure a client is not pregnant if she has no signs or symptoms of pregnancy and:
    - Has not had intercourse since her last menses
    - Has been correctly and consistently using another reliable contraceptive method
    - Is within the first 7 days after the start of her menses
    - Immediately (for non-breastfeeding women)
    - Is within the first 7 days post-abortion
    - Is fully breastfeeding, less than 6 months postpartum and has had no menstrual bleeding

12. **Returning for reinjection:**
    - Advise the DMPA client to visit for reinjection every 3 months. To help her remember, provide her with a client reminder card and specifically mention the date of reinjection.
    - The injection can be given on time (3 months after the last injection), or up to 4 weeks early or late.
    - If more than 4 weeks late for next injection, use a back-up method such as condoms or abstain from sex.
    - Return even if more than 4 weeks late for injection.

13. **Warning signs** indicating that she should return to the clinic immediately include:
    - Significant/heavy vaginal bleeding
    - New onset of migraine headaches with neurologic signs
    - Yellowing of skin and eyes

14. **Spotting on PICs:** Check that prolonged bleeding is not due to pregnancy. If not due to pregnancy, reassure client that light, intermenstrual bleeding/spotting occurs in many women using PICs (50–80%) during the first few cycles of use. It is not serious and usually does not require treatment. Most women can expect the altered bleeding pattern to become more regular after 6–12 months.

15. **Treatment for spotting:** If medical treatment is needed, prescribe:
    - A cycle of COCs (warn client that she will bleed after taking the pills and this is normal); OR
    - Ibuprofen (up to 800 mg 3 × daily for 5 days).

16. **Weight gain:** Counsel the client that fluctuations of 1–2 kg may occur especially with PICs. Review diet if weight change is excessive. If weight gain is unacceptable even after counseling, assist the client in choosing another method.

17. **Delay in returning for injection:** Current guidelines allow for up to 4 weeks delay in DMPA reinjection without checking for pregnancy or requiring use of a back-up method. For greater delays, pregnancy must be ruled out before giving the injection. In such cases, the WHO recommends also providing a backup method such as condoms to be used for a length of time equal to the delay past 14 weeks. For example, if it has 15 weeks since the last injection, the client should use the backup method for one week.

18. **Advice for next visit:** See #11 above.

EXERCISE ON PROGESTIN-ONLY PILLS (POPS)

1. Can a woman who is breastfeeding safely use POPs?

2. How long does it take to become pregnant after stopping POPs?

3. Is it important for a woman to take her POP at the same time each day?

4. Do POPs cause cancer?

5. Can POPs be used as emergency contraceptive pills (ECPs) after unprotected sex?

EXERCISE ON PROGESTIN-ONLY PILLS (POPS):

ANSWER KEY

1. Can a woman who is breastfeeding safely use POPs?

Answer: Yes. This is a good choice for a breastfeeding mother who wants to use pills. POPs are safe for both the mother and the baby, starting as early as 6 weeks after giving birth. They do not affect milk production.

2. How long does it take to become pregnant after stopping POPs?

Answer: A woman who stops using POPs can become pregnant as quickly as women who stop non-hormonal methods. POPs do not delay the return of a woman's fertility after she stops taking them. The bleeding pattern that a woman had before she used POPs generally returns after she stops the method.

3. Is it important for a woman to take her POP at the same time each day?

Answer: Yes, for two reasons. POP contain very little hormone, and taking a pill more than 3 hours late could reduce their effectiveness for women who are not breastfeeding. (Breastfeeding women have the additional protection from pregnancy that breastfeeding provides, so taking pills late is not as risky.) Also, taking a pill at the same time each day can help women remember to take their pills more consistently. Linking intake of pills with a daily activity also helps women remember to take them.

4. Do POPs cause cancer?

Answer: No. Few large studies exist on POPs and cancer, but smaller studies on the method are reassuring. Larger studies of implants have not shown any increased risk of cancer. Implants contain hormones similar to those used in POPs and at about twice the dosage during the first few years of implant use.

5. Can POPs be used as emergency contraceptive pills (ECPs) after unprotected sex?

Answer: Yes. As soon as possible, but no more than 5 days after unprotected sex, a woman can take POPs as ECPs. Depending on the type of POP, she will have to take 40 to 50 pills. Although this is a lot of pills, it is safe because there is very little hormone in each pill.

CASE STUDY ON EMERGENCY CONTRACEPTION

Situation

Warda is 24 years old. She is a student of medical science and was married about 6 months ago. She had unprotected sexual intercourse last night, and has come to you seeking advice about emergency contraception.

Activity

Working in small groups, participants will discuss and decide how they—as health care providers—would deal with this situation. For each small group, there are additional guidelines provided below. Participants may also look for information in the reference text, *The Family Planning Handbook for Service Providers.*

Small Group 1: Before you can advise Warda about EC pills, what do you need to tell her about EC in general? (Be sure to consider different types of methods available. Also describe how you will counsel the client [mention the steps].)

Small Group 2: Warda has chosen to use POPs, and wants to know more about the safety and success rate of the method. What information will you give to her?

Small Group 3: In case of COCs, how are they used as a method of emergency contraception? Can Warda take COCs as needed for emergency contraception in the future? What advice will you give regarding future use?

Small Group 4: How effective are the IUCDs as an EC method? How do they work?

CASE STUDY ON EMERGENCY CONTRACEPTION:

ANSWER KEY

Group 1

Throughout the interaction with the client, the provider should follow all of the steps of the GATHER approach.

As part of GATHER, the client should be provided technical information regarding the selected method, emergency contraception, such as:

- There are different methods of emergency contraception available, for example:
  - Combined oral contraceptives (COCs)—low-dose (30–35 μg ethinyl estradiol and 150 μg Levonorgestrel [LNG])
  - Progestin-only pills (POPs)—750 μg LNG (preferred)
  - IUCDs—Copper T 380A or Multiload 375
- These methods have enormous potential for use as safe and effective post-coital contraceptives.
- Emergency contraception does not cause abortion.
- The correct use of the emergency methods should be explained to the client; it should also be emphasized that these methods are not suitable for regular use. Side effects and limitations should also be discussed:
  - Nausea and vomiting are common with COCs and POPs and cramping is common with IUCDs.
  - EC pills do not provide future protection.
  - EC pills will not cause menses to come immediately.
  - Once the above information is given, the provider should counsel client to use regular contraceptive methods.

Group 2

The provider should give the client the following information:

- COCs and POPs are effective as EC only if used within 120 hours of unprotected intercourse.
- They may cause nausea and vomiting, which are short-term side effects. They have a success rate of 98% when used correctly.
- Instructions to use the POP method of EC:

  Step 1: Take 1 tablet (750 μg of LNG) orally within 120 hours of unprotected intercourse.

  Step 2: Take 1 more tablet in 12 hours. (Total = 2 tablets)

  Step 3: If no menses within 3 weeks, the client should consult the clinic or service provider to check for possible pregnancy.

Group 3

The provider should give the client the following information: As the name "emergency contraception" suggests, these methods are to be used only in an emergency situation. They are not suitable for regular use and should not be a person's routine method of contraception. The client should be counseled to use a regular method of contraception on an ongoing basis.

Group 4

The provider should give the client the following information:

- IUCDs are very effective, with a failure rate of less than 1%.
- They have no adverse fetal effects (although the IUCD should be removed if pregnancy is not prevented).
- They act by:
  - Preventing fertilization by interfering with sperm transport or function; or
  - Preventing implantation by altering the tubal or endometrial environment.

- Instructions to use the POP method of EC:

  Step 1: Insert IUCD within 5 days of unprotected intercourse.

  Step 2: If no menses within 3 weeks, the client should consult the clinic or service provider to check for possible pregnancy.

CHECKLIST FOR DMPA CLINICAL SKILLS

(To be completed by the Participants during demonstration by the Trainer)

Place a "✓" in the "YES" or "NO" observation box if the step is performed or not.

STEP/TASK	OBSERVATIONS	
	YES	NO
GETTING READY		
1. Check expiration date on DMPA single-dose vial.		
2. Ensure arm or buttocks are clean for giving IM injection.		
PREPARING THE INJECTION SITE		
1. Wash hands with soap and water and dry them with a clean, dry towel or air dry.		
2. Check that injection site is clean.		
3. If a single-use cotton swab is used to prepare the skin, allow skin to dry before giving the injection.		
PREPARING THE INJECTION		
1. Shake the vial of DMPA thoroughly before withdrawing the dose.		
2. Attach and tighten the needle to the syringe.		
3. Insert the needle through the rubber stopper.		
4. Draw up complete contents of the DMPA vial.		
5. Remove the needle from the vial.		
6. Expel any air bubbles by gently depressing the plunger.		
7. Carefully push the plunger to the dose mark 1.0 mL.		
GIVING THE INJECTION		
1. Insert the needle deep into the muscle (deltoid in arm or upper outer quadrant of gluteal area).		
2. Inject the full dose of DMPA slowly and remove the needle.		
POST-INJECTION TASK		
1. Apply pressure to injection site with cotton, but do not rub.		
2. Discard needle and syringe in a puncture-proof container without recapping or breaking or bending the needle.		
3. Wash hand with soap and water and dry them on a clean towel or air dry.		

Counseling Guide for PPFP Counseling

(To be completed by the Participants during Role Play)

Place a "✓" in the "YES" or "NO" observation box if the step is performed or not.

STEP/TASK	OBSERVATIONS	
	YES	NO
GREET—***Establish good rapport and initiate counseling on PPFP.***		
• Greets the woman, using her name and introducing self.		
• Shows respect for the woman and helps her feel at ease.		
Encourages the woman to explain her needs and concerns and ask questions.		
• Listens carefully and supports the woman's informed decisions.		
• Includes woman's partner or important family member in the discussion, as the woman desires and with her consent.		
ASK—***Determine reproductive intentions, knowledge of pregnancy risk and use of various contraceptives.***		
• Explores woman's knowledge about the return of fertility and the benefits of pregnancy spacing or limiting (as desired).		
• Asks whether she has had prior experience with family planning methods, any problems, reasons for discontinuing, etc.		
• Explores partner's/family's knowledge about the return of fertility and the benefits of pregnancy spacing/limiting.		
• Asks about desired number of children, desire to space or limit births, desire for long-term family planning, etc.		
• Explores woman's need for protection from STIs, including HIV.		
• Explains and supports condom use, as a method of dual protection.		
• Asks whether she has a preference for a specific method, based on prior knowledge or the information provided.		
TELL—***Provide the woman with information about PPFP methods***		
• Advises that to ensure her health and the health of her baby (and family), she should wait at least 2 years after this birth before trying to get pregnant again.		
• Advises about the return of fertility postpartum and the risk of pregnancy. **Advises how LAM and breastfeeding are different.**		
• Advises about the health, social and economic benefits of healthy pregnancy spacing (or limiting, if desired).		
– LAM – Condoms – POPs, COCs – Contraceptive Injectables – PPIUCD		

STEP/TASK	OBSERVATIONS	
	YES	NO
– Vasectomy – Postpartum tubal ligation		
• Shows the methods (using poster or wall chart) and allows the woman to touch or feel the items, including the IUCD, using a contraceptive tray.		
• Corrects any misconceptions about family planning methods.		
<u>HELP</u>—*Assist the woman in making a choice; give her additional information that she might need to make a decision.*		
• Gives woman additional information that she may need and answer any questions.		
• Assesses her knowledge about the selected method; provides additional information as needed.		
• Acknowledges the woman's choice and advises her on the steps involved in providing her with her chosen method.		
<u>EVALUATE and EXPLAIN</u>—*Determine whether she can safely use the method; provide key information about how to use the method*		
• Asks the woman about her medical and reproductive history.		
• Effectiveness: Prevents almost 100% of pregnancies		
• Mechanism for preventing pregnancy: Causes a chemical change that damages the sperm BEFORE the sperm and egg meet		
• Duration of IUCD efficacy: Can be used as long (or short) as woman desires, up to 12 years (for the Copper T 380A)		
• Removal: Can be removed at any time by a trained provider with immediate return to fertility		
• Simple and convenient IUCD placement, especially immediately after delivery of the placenta		
• No action required by the woman after IUCD placement (although one routine follow-up visit is recommended)		
• Immediate return of fertility upon removal		
• Does not affect breastfeeding or breast milk		
• Long-acting and reversible (as described above)		
• Heavier and more painful menses for some women, especially first few cycles after interval IUCD (less relevant or noticeable to postpartum women)		
• Does not protect against STIs, including HIV		
• Higher risk of expulsion when inserted postpartum (though less with immediate postpartum insertion)		
• Bleeding or foul-smelling vaginal discharge (different from the usual lochia)		
• Lower abdominal pain, especially if the first 20 days after		

STEP/TASK	OBSERVATIONS	
	YES	NO
insertion—accompanied by not feeling well, fever or chills		
● Concerns she might be pregnant		
● Concerns the IUCD has fallen out		
● Encourages the woman to ask questions.		
● Asks the woman to repeat key pieces of information.		
<u>RETURN</u>—*Plan for next steps and for when she will arrive to hospital for delivery.*		
● Makes notation in the woman's medical record about her PPFP choice or which methods interest her.		
● If the woman cannot arrive at a decision at this visit, asks her to plan for a follow-up discussion at her next visit; advises her to bring partner/family member with her.		
● Provides information about when the woman should come back, as appropriate.		

ROLE PLAYS: PRACTICING COUNSELING (GATHER) TECHNIQUES

Directions

Two participants in each group will assume (or be assigned) roles, as shown in "Participant Roles." One will be the clinician, the other the client. Participants taking part in the role play should spend a few minutes reading the background information ("Participant Roles" and "Situation") and preparing for the exercise. The observers in the group also should read the background information so that they can participate in the small group discussion following the role play. "Focus of the Role Play" and "Observer Discussion Questions" can be used to guide or generate this discussion.

Combined Oral Contraception (COCs)

Participant Roles

Provider: The clinician is an experienced family planning provider who is skilled in counseling.

Client: Client A is 31 years old and began taking COCs after the birth of her fifth child 2 years ago. At that time, she was screened for medical conditions that might be a precaution for COC use, but none were found. She has had no problems with COCs, once she got over the initial nausea and breast tenderness. She has had to take a job to contribute to the household income. Because of the job and work at home she has never gotten more than 4 hours of sleep on any night for the last 4 months.

Situation

Client A has now returned to the clinic complaining of headaches that she believes are caused by the COCs. She is very nervous. Her mother-in-law told her about someone who died after using COCs for years and suffering bad headaches, because the COCs caused something in her head to burst.

Focus of the Role Play

The focus of the role play is on the interaction between the clinician and the client. The clinician needs to assess the extent of the client's headaches and their possible relationship with COCs. She needs to counsel and reassure the client and recommend a plan of management. The client should remain adamant in her belief that the COCs are causing her headaches until the clinician provides her with the information and management plan that will calm her concerns.

Observer Discussion Questions

1. How did the clinician approach the client?
2. How did the client respond to the clinician? Did the clinician change her approach based on this response? If so, was it appropriate?
3. Did the clinician accurately assess the relationship between the headaches and the COCs? Did she outline an appropriate management plan?
4. How might the clinician improve her interaction with the client?

Voluntary Surgical Contraception

Participants Roles

Provider: A medical practitioner has basic knowledge about family planning and counseling.

Client: Client B is 34 years old and has five living children. She has also had two abortions and one baby that died in infancy. Her last pregnancy, 3 years ago, was extremely difficult and both she and the baby almost died during delivery. The doctors have told her that it would be very dangerous for her to get pregnant again.

Situation

The client and her husband agree that sterilization is a good option for them, but are unsure which of them should be sterilized. They have come to the clinic today to get more information so that they can make a decision as soon as possible. The client is worried that if she is sterilized she will become fat and lazy and unable to care for all of her children. Her husband has heard that vasectomy will make him weak and unable to work in the fields or support his family.

Focus of the Role Play

The focus of the role play is on the interaction between the medical practitioner and the clients. The provider needs to provide information on tubal occlusion and vasectomy that will address the clients' misconceptions and assist them in making a decision. The discussion should continue until a decision is reached.

Observer Discussion Questions

1. How did the provider approach the clients?
2. How did he access the current situation?
3. How did the provider help the couple in reaching a decision?

Young Married Female Seeking Family Planning

Participant Roles

Provider: The clinician is an experienced family planning service provider. She does not, however, fully believe that a teenaged married woman should use any family planning method other than condoms, even though national policies state that adolescents may also use COCs and Norplant.

Client: Client C is a 16-year-old girl. She was married at the age of 13 years and now has two sons. The youngest child is 6 months old. She and her husband have tried to use condoms, but the husband doesn't like them and they really don't know how to use them.

Situation

Client C now comes to the clinic looking for another family planning method because she is afraid of getting pregnant. Several of her friends are using oral contraceptives and they haven't gotten pregnant yet. She thinks pills would be good for her too, but she is nervous and ill at ease.

Focus of the Role Play

The focus of the role play is on the interaction between the clinician and the client. The clinician needs to assess the client's knowledge and understanding of family planning, specifically COCs and condom use. She needs to assess the appropriateness of these methods for the client. The clinician, because of her personal feelings, should focus more on condoms and their correct use. The interaction should continue until the client decides to try condoms again, now that she knows how to use them effectively.

Observer Discussion Questions

1. How did the service provider approach the client? How effectively did the service provider overcome her personal biases?
2. How did the client respond to the service provider?
3. Did the service provider help the client to make the best decision for her? Did she provide the client with all of the information she needed?
4. How might the service provider improve her interaction with the client?

Male Voluntary Sterilization

Participant Roles

Provider: The clinician is an experienced family planning service provider. He is calm and knowledgeable when counseling clients.

Client: Client D is a 38-year-old man with five children: three sons and two daughters. Because he and his wife have limited resources, he is certain that it would be very difficult for them to raise any more children. He plans to be sterilized.

Situation

Client D has now come to the clinic to get more information on sterilization. He says that he does not want to have any more children, and repeatedly asks about the permanent nature of sterilization.

Focus of the Role Play

The focus of the role play is on the interaction between the clinician and the client. The clinician needs to assess the client's understanding of vasectomy. The clinician needs to give the client the information he needs in an impartial manner. He needs to pay particular attention about the permanence of vasectomy and what this implies.

Observer Discussion Questions

1. How did the clinician approach the client?
2. How did the client respond to the clinician?
3. How might the clinician improve her interaction with the client?
4. Was the decision reached an appropriate one? If yes, why? If not, what would have been better?

Depo-Provera Counseling: Side Effects

Participant Roles

Provider: The clinician is an experienced family planning service provider. She/he is calm and knowledgeable when counseling clients.

Client: Client E is a 29-year-old woman with six children. She has been using Depo-Provera since 6 weeks after the birth of her youngest child, 2½ years ago. She says that she had trouble breastfeeding her child because of the Depo-Provera. She kept taking the Depo-Provera, however, because she was more concerned about another pregnancy than about her problems with breastfeeding.

Situation
Client E has come to the clinic complaining of feeling very tired and unable to do her work for the past several months. She is sure it is because she has been taking Depo-Provera for such a long time. She thinks it would be a good idea to take a rest period from Depo-Provera.

Focus of the Role Play
The focus of the role play is on the interaction between the clinician and the client. The clinician needs to assess the relationship between the client's problems and her use of Depo-Provera. She/he also needs to counsel and reassure the client regarding her misconceptions about Depo-Provera. The client should remain firm in her wish to take a rest from Depo-Provera until the clinician provides her with the information that will calm her fears and concerns.

Observer Discussion Questions

1. What were strengths and weakness of the interaction?
2. How might the service provider improve her interaction with the client?
3. Are the client's past or present problems related to her use of Depo-Provera? Did the service provider explain this in an appropriate and convincing manner?
4. What might be better or alternative contraceptive choices for her? Why?

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Post partum Family Planning Contraceptive Technology Update

Objectives

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

- The importance of postpartum family planning and HTSP
- Importance of LAM in Postpartum Period
- The benefits, limitations and counseling considerations for using:
  - Progestin-only pills
  - Progestin-only injectables
  - Combined oral contraceptives (COCs)
  - Emergency contraception (EC)

2

Objectives (*cont.*)

- The benefits, limitations, and counseling considerations for using
  - Intrauterine contraceptive devices (IUCDs)
  - Condoms
  - Female sterilization
  - Vasectomy
- Effective counseling

3

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Post partum Contraception

A
Better
Choice for mothers

What is Postpartum Family Planning?

PPFP is a subset of FP for the prevention of unintended pregnancies through the first year postpartum.

- **Post-Placental** within 10 minutes of placental delivery
- **Immediate Post Partum** within 48hrs after delivery (e.g. voluntary sterilization)
- **Early Post Partum** 48 hrs- 6weeks
- **Extended Post Partum** 6 weeks to 1 year

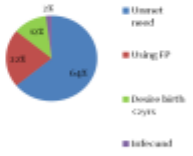
Rationale for including postpartum family planning in MNCH and FP Programs

- To achieve healthy maternal ,perinatal, newborn, infant and child health outcomes, including reduction of maternal and neonatal mortality
- To address the unmet need for FP among Postpartum women

Unmet need : Fertility Preferences of Post Partum Women

According to PDHS :

- 34% of births occur within short birth interval of less than 24 months
- 34% occur within 24-35 months
- Only 22% use any FP method
- 12% desire another birth within 2 years



Barriers to PPFP Services

Lack of Information

- Lack of awareness of health benefits of spacing
- Shifts in traditions that protected from pregnancy- Post partum abstinence
- Lack of knowledge about fertility return

Misconceptions

- Misconceptions about BF as a method of FP
- Misconceptions about FP for Breastfeeding women

Social Support

- Spousal Permission
- Co-wife competition
- Lack of support from Mother In Law

Barriers to PPFP Services

Access to Services

- Low mobility particularly for low parity women-40 days period after birth
- Non availability of support influence access
- Referrals

Supportive Environment

- Religious beliefs

Risk of Pregnancy May Return Soon after Birth

- For the non-breastfeeding mother:
  - The mean average for first ovulation is 45 days after delivery
  - Return to fertility occurs prior to the return of menses in two out of three women.
- Once menses return, a woman is at as high risk for pregnancy as before conception.

Key Content for PPFP messages

- Healthy spacing of pregnancies
- Mother's risk for unintended pregnancy after a birth and abortion
- LAM and the transition
- Methods for Breastfeeding mothers
- Discussing and choosing a family planning methods within the first month postpartum(couples communication)
- Importance of PPFP services-Referral

HEALTHY TIMING AND SPACING OF PREGNANCY (HTSP)

What Is HTSP?

Healthy
Timing
Spacing of
Pregnancy

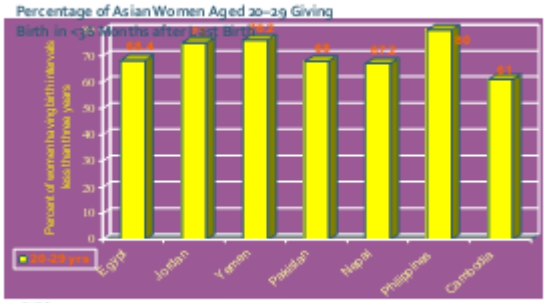
Delaying pregnancy until age 18
Healthy pregnancy spacing (after live birth/miscarriage/induced abortion)
Interventions to help women and families:
- Make informed decisions about delay/spacing
- Achieve healthiest maternal/newborn outcomes

DEMAND FOR HTSP

- Large generation of adolescents
- Main FP demand for <29 age group is for spacing methods
- High percentages of births occur after too-short intervals
- Even higher percentages of young women with short birth intervals also desire longer birth intervals
- Only 3–5% of postpartum women want another child within 2 years
- Significant service delivery gaps

Ross and Winfrey, 2001; Jansen, 2004; Rutstein, 2005

Birth Interval: Selected Asian Countries



Source: DHS Surveys

Perinatal Outcomes

Birth to pregnancy (BTP) interval of <18 months is associated with increased risk of:

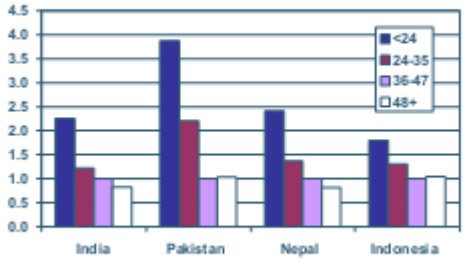
- Maternal mortality
- Induced abortion
- Miscarriage
- Pre-term birth
- Small size for gestational age
- Low birth weight

Perinatal Outcomes *(cont'd)*

- BTP interval of >59 months is associated with increased risk of:
  - Pre-eclampsia
  - Abortion/miscarriage
- Pregnancy interval of <6 months is associated with increased risk of:
  - Premature rupture of membranes, maternal anemia
  - Pre-term birth, low birth weight, small for gestational age

Source: Conde-Agudelo, A. et al. "Effect of the interpregnancy interval after an abortion on maternal and perinatal health in Latin America," *International Journal of Gynecology and Obstetrics*, Vol. 89, Supplement No. 1, April 2005.

Birth Intervals Associated with Lower Mortality Risk for Infants (Asian Countries)



Birth Interval Recommendations

- Recommendation for spacing after a live birth:
  - Recommended minimum interval before attempting the next pregnancy is at least 24 months in order to reduce the risk of adverse maternal, perinatal and infant outcomes.
- Recommendation for spacing after miscarriage or induced abortion:
  - Recommended minimum interval to next pregnancy should be at least 6 months in order to reduce risks of adverse maternal and perinatal outcomes
  - First Pregnancy should not be before the age of 18 years as it results in maternal and neonatal complications

Source: World Health Organization, 2006 *Report of a WHO Technical Consultation on Birth Spacing*

Postpartum Family Planning Counseling

IT IS IMPORTANT TO AID, NOT PERSUADE, THE CLIENT IN CHOOSING A CONTRACEPTIVE

Counseling: Pregnancy Risk

When a woman can become pregnant after delivery depends on:

- Breastfeeding practices
- Return of menses
- Return to sexual activity

Counseling: Return to Fertility for Breastfeeding Women

- Period of infertility longer with only/exclusive breastfeeding:
  - **Likelihood of menses and ovulation is low during first six months**
  - **After six months, even if her period has not returned, she is at risk of pregnancy**
  - **Women can ovulate before menses if she is on longer only breastfeeding or the baby is more than six months old**

Counseling: Return of Fertility

- Every pregnancy is different. A woman cannot predict fertility from previous pregnancies.
- No woman has a specific "set point" for return of fertility:
  - Return of fertility is unpredictable. If she doesn't want to get pregnant, she needs contraception.

Counseling: Return of Fertility (*cont.*)

- Counsel women using LAM about return of fertility and risk of pregnancy
- Counsel women about return of fertility and risk of pregnancy during antenatal, postpartum, newborn and child care visits—or at any contact
- Inform colleagues—many healthcare workers are unaware of risk of pregnancy during the postpartum

Counseling: Women Who Want to Limit Pregnancies

- Some couples do not want to become pregnant now or in the future.
- For them, there are long-term contraceptive options (male or female sterilization, IUDs and Implants)
- While they are deciding or in process of reaching long-term contraception services, she should use a short-term method to prevent pregnancy until she can get the long-term method.

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Role Play

Let's go through the counseling checklist and follow the guidelines

Best Practices in Family Planning

Medical Eligibility Criteria for Contraceptive Methods

Medical Eligibility Criteria

- Covers 17 contraceptive methods, 120 medical conditions
- Addresses *who* can use contraceptive method based on medical methods
- Gives guidance to providers for clients with medical problems or other special conditions

Purpose of the Medical Eligibility Criteria (MEC)

- To guide family planning practices based on the best available evidence
- To address and change misconceptions about who can and cannot safely use contraceptive methods
- To reduce medical policy and practice barriers (i.e., not supported by evidence)
- To improve quality, access, and use of family planning services

What Is Answered by MEC?

Identifies which contraceptive or FP method can be safely used in the presence of a given individual characteristic or medical condition

Identification of Conditions

- CONDITIONS represent either:
  - An individuales characteristics (e.g., age, parity)
  - Known pre-existing medical conditions (e.g., hypertension)
  - Use of medications

WHO Medical Eligibility Criteria Classification Categories

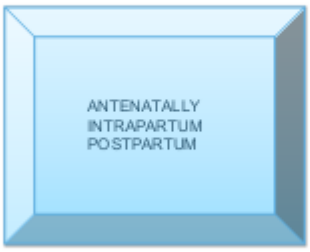
Classification	With clinical judgment	With limited clinical judgment
1	Use method in any circumstances	Yes Use the method
2	Generally use: advantages outweigh risks	Yes Use the method
3	Generally do not use: risks outweigh advantages	No Do not use the method
4	Method not to be used	No Do not use the method

Exercise – Let's Find Out !

- Case 1 – 26 years old, 2 children, smokes about 1 cigarette pack per day and wants to use combined oral contraceptives.
- Case 2 – 36 years old, 1 child and on Depo provera, found hypertensive at 150/90 mm Hg, and wants to continue to use Depo Provera.
- Case 3 – 30 years old, 7 days post elective early abortion and wants a copper T 380 A IUCD
- Case 4 – 20 years old, delivered a baby 3 weeks ago and wants to start POP

REVITALIZING THE LACTATIONAL AMENORRHOEA METHOD

When the LAM can be offered?

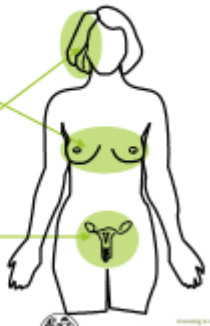


LAM requires 3 conditions

- Exclusive Breastfeeding on demand
- The mother's monthly bleeding has not returned
- The baby is less than 6 months old

LAM: Mechanisms of Action

- Frequent intense suckling disrupts secretion of gonadotrophin-releasing hormone (GnRH)
- Irregular secretion of GnRH interferes with release of follicle-stimulating hormone (FSH) and leutinizing hormone (LH)
- Decreased FSH and LH disrupts follicular development in the ovary to suppress ovulation



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Contraceptive Benefits of LAM

- Effective (1–2 pregnancies per 100 women during first 6 months of use)
- Effective immediately
- Does not interfere with sexual intercourse
- No systemic side effects
- No medical supervision necessary
- No supplies required
- No cost involved

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Non-Contraceptive Benefits of LAM

- For the child:
  - Passive immunization and protection from infections
  - Best source of nutrition
  - Decreased exposure to contaminants in water, in other milk or formulas, or on utensils
- For the mother:
  - Decreased postpartum bleeding

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Limitations of LAM

- User dependent
- May be difficult to practice because of social circumstances
- Highly effective only until menses return or up to 6 months
- Does not protect against STIs

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"Transition" in Relationship to LAM

- Move from the use of LAM to the use of another modern method of contraception
- Can occur at any time:
  - When any one of the three criteria is no longer met
  - When the woman/couple chooses to use another method

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Importance of Transition—Need Contraception for at Least Two years

- The maximum length of time that LAM may offer protection from pregnancy is six months.
- For best maternal and newborn health outcomes, a couple needs to wait at least two years after a birth before attempting to become pregnant again.

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Importance of Transition: Maternal Mortality—FP Saves Lives

"Promotion of family planning in countries with high birth rates has the potential to . . . avert 32% of maternal mortality."

- 90% of abortion-related mortality and morbidity
- 20% of obstetric-related mortality and morbidity

Source: Cleland et al. 2006.

Importance of Transition: Child Mortality—FP Saves Lives

Conservatively, "2 million of the 11 million deaths in children <5 could be averted by elimination of inter-birth intervals of less than 3 years. Effective use of postpartum family planning is the most obvious way in which progress should be achieved."

Source: Cleland et al. 2006.

Initiation of Post-LAM Contraception

- You do NOT need to wait for the woman to have her menses in order to initiate another modern method of contraception
- You can initiate a modern contraceptive method at ANY TIME you are reasonably sure that a woman is not pregnant
- If a woman has been using LAM, you can be reasonably sure she is NOT pregnant

When can various methods be introduced to the mother who is "transitioning" from LAM?

Time for an EXERCISE…

Postpartum Contraceptive Options

In your experience, what factors may be barriers to prevent a woman from transitioning to another method of contraception?

Time for a DISCUSSION…

What factors affect the choice of contraceptive methods?

Factors Affecting Method Choice

- Reproductive goals of woman or couple (spacing or limiting births)
- Personal factors including client preference, time, travel costs, discomfort associated with FP method
- Accessibility and availability of products that are necessary to use method
- Medical factors

What are progestin-only pills (POPs)?

Progestin-Only Pills (POPs): What Are They?

- Pills that contain a very low dose of a progestin like the natural hormone progesterone in a woman's body
- Does not contain estrogen
- Also called "mini-pills"
- Work primarily by:
  - Thickening the cervical mucus (this blocks sperm from meeting egg)
  - Disrupting the menstrual cycle, including preventing ovulation

Progestin-Only Pills: Key Benefits

- Safe for breastfeeding women—No effect on breastfeeding, milk production or infant growth and development after infant is six weeks old
- Adds to the contraceptive effect of breastfeeding—Together, if taken correctly, failure rate less than 1% during first year of use
- Does not interfere with sex

Progestin-Only Pills: Limitations

- Less effective for non-breastfeeding mother—If taken correctly, 3–10 women/100 will become pregnant first year
- Pill must be taken every day
- Bleeding changes (more frequent, irregular) are common but not harmful
- A few women may have headaches, dizziness or breast tenderness

Progestin-Only Pills: Key Counseling Considerations

- Discuss limitations (bleeding irregularities)
- Can be given to a woman at any time to start later
- Discuss tips to help woman remember to take pill every day—link to a daily activity, such as brushing teeth; take same time every day; etc.
- Provide back-up method (e.g., condoms) to use if/when pill is missed

Progestin-Only Injectables

- The injectable contraceptive DMPA (depot medroxyprogesterone acetate) contains a progestin similar to the progesterone naturally in a woman's body
- Does not contain estrogen
- Also known as "the shot" or the injection
- Given by injection into the muscle
- Works primarily by preventing the release of eggs from the ovary

What are some key benefits of injectables?

Progestin-Only Injectables: Key Benefits

- No effect on breastfeeding, milk production or infant growth and development; safe for use after infant is 6 weeks
- When women have injections on time, failure rate less than 1% during first year of use
- Does not require daily action
- Are private
- Do not interfere with sex

Progestin-Only Injectables: Key Benefits (*cont.*)

Helps protect against:

- Cancer of lining of uterus (endometrial cancer)
- Uterine fibroids
- Iron-deficiency anemia

Progestin-Only Injectables: Limitations

- Bleeding irregularities for first two to three months (usually no bleeding at one year)
- Some women may have weight gain, headaches, dizziness, mood changes
- Should wait until six weeks to give first injection to the breastfeeding woman (who is not using LAM)

Progestin-Only Injectables: Counseling Considerations

- Discuss limitations (side effects)
- If the client is less than 4 weeks late for repeat injection of DMPA or less than 2 weeks late for a repeat injection of NET-EN, she can receive her next injection.
- She should come back no matter how late she is for her next injection; if reasonably sure she is not pregnant, can give injection any time
- Assure her that she is welcome to return any time she has questions, concerns or problems

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What are combined oral contraceptives?

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COCs: What Are they?

- Pills that contain low doses of two hormones—a progestin and an estrogen
- Also called "the pill"
- Work primarily by:
  - Preventing the release of eggs from the ovary
  - Thickening cervical mucus so that sperm cannot penetrate

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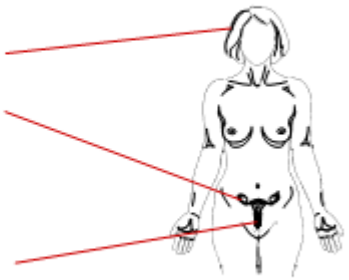
COCs: Mechanisms of Action



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You are counseling a woman who is transitioning from LAM to COCs. What will you tell her are the benefits of COCs?

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COCs: Key Benefits

- Highly effective when taken daily (failure rate 0.1–0.5 % during first year of use)
- Controlled, and can be stopped, by the woman
- Does not interfere with sex
- Pelvic examination or routine labs for hormonal levels not required to initiate use
- Helps protect against cancer of the uterine lining, cancer of the ovary, symptomatic pelvic inflammatory disease (PID) and anemia

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COCs: Limitations

- User-dependent (require continued motivation and daily use); forgetfulness increases method failure
- Some nausea, dizziness, breast tenderness, headaches, spotting or depression may occur (but usually stop after three to four months of use)
- Effectiveness may be lowered when certain drugs are taken
- Re-supply must be readily and easily available
- Do not protect against STIs (e.g., HBV, HIV/AIDS)

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COCs: Who Should Not Use (WHO Category 4)

COCs should not be used if a woman:

- Has migraine headaches with aura
- Has BP 160/100 (140–159/90–99 is Category 3)
- Is breastfeeding (less than six weeks postpartum)
- Is jaundiced (symptomatic viral hepatitis or cirrhosis)
- Has ischemic heart disease or stroke
- Has complicated valvular disease
- Has blood clotting disorders (deep vein thrombophlebitis or pulmonary embolus)

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COCs: Who Should Not Use (WHO Category 4) (*cont.*)

COCs should not be used if a woman:

- Has breast cancer
- Is 35 years old or older and smokes 15 cigarettes/day
- Has diabetes (>20 years duration)
- Has breast cancer
- Has liver tumors
- Has to undergo major surgery with prolonged bed rest

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COCs: Conditions Requiring Precautions (WHO Category 3)

COCs are not recommended unless other methods are not available or acceptable if a woman:

- Is more than six weeks but less than six months postpartum and is primarily breastfeeding
- Is less than three weeks postpartum if not breastfeeding
- Has high blood pressure (140–149/90–99)
- Has a history of breast cancer and no evidence of current disease in last five years

Source: WHO 2004.

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COCs: Conditions Requiring Precautions (WHO Category 3) (*cont.*)

COCs are not recommended unless other methods are not available or acceptable if a woman:

- Develops migraines without aura while on COCs
- Has current gall bladder disease
- Is taking drugs for epilepsy (phenytoin or barbiturates) or tuberculosis (rifampin)

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COCs: Conditions for Which There Are No Restrictions (Category 1)

- Age
- Diabetes (uncomplicated or less than 20 years duration)
- Endometriosis
- Genital tract cancers (cervical, endometrial or ovarian)
- Pregnancy-related benign jaundice (cholestasis)

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COCs: Counseling Considerations

- Discuss limitations (side effects)
- Can start three weeks after delivery if not breastfeeding; six months after delivery if breastfeeding
- Can start even if menses has not started, as long as you are reasonably sure she is not pregnant, but will need to use condoms or abstain for the first week of use

COCs: Counseling on What to Do for Missed Pills (*cont.*)

- Take a missed hormonal/active pill as soon as possible
- Keep taking pills as usual, even if this means she will take 2 pills on same day
- If missed 1 or 2 pills:
  - Take pill as soon as possible
- If missed 3 or more pills in Week 1 or 2:
  - Take pill as soon as possible and use back-up method for seven days
  - Use EC in case of unprotected contact

COCs: Counseling on What to Do for Missed Pills (*cont.*)

- If missed 3 or more pills in Week 3:
  - Take a hormonal pill as soon as possible
  - Finish all hormonal pills in pack and throw away all non-hormonal pills
  - Start a new pack the next day
  - Use a back-up method for seven days
  - If she had sex in the past 5 days, can consider ECPs
- If missed non-hormonal pills discard the missed non-hormonal pills and continue COCs, one a day

COCs: Counseling on Danger Signs

- Return immediately to healthcare provider or clinic if you develop any of the following problems:
  - Severe chest pain or shortness of breath
  - Severe headaches or blurred vision
  - Severe leg pain
  - Absence of any bleeding or spotting during pill-free week (21-day pack) or while taking seven inactive pills (28-day pack)—may be a sign of pregnancy

Emergency Contraception (EC)

Questions for Small Group Activity:

- What is "emergency contraception"?
- What EC's key benefits?
- What are EC's limitations?

Emergency Contraception (EC): What Is It?

- Methods that *prevent* pregnancy after unprotected sexual intercourse has occurred
- Regular contraceptive pills (COCs or POPs) used in a special way.
  - Used in higher dosages
  - Used as soon as possible after unprotected sex (within 120 hours or five days)

NOTE: Emergency contraception does not stop a pregnancy that has started!

Effectiveness

- Progestin-only OCs
  - →If all 100 women used Progestin only ECPs, one would likely become pregnant (1/100 will get pregnant)
- Combined OCs: ethinyl estradiol (EE) and levonorgestrel (LGN)
  - → If all 100 women used Progestin only ECPs, two would likely become pregnant (2/100 will get pregnant)

Types of EC Pills (ECPs)

ECP Type	Dosage
Levonorgestel dedicated product	Singe dose of 1.5 mg of LNG
Estrogen-progestin dedicated product	Ethinyl estradiol (EE) 0.1 mg + LNG 0.5 mg 1 dose and repeated after 12 hours
Progestin only	Single dose of 1.5 mg LNG or 3.0 mg of Norgestrel
COC	EE 0.1 mg+ LNG 0.5 mg (1 dose and repeat after 12 hours) EE 0.1 mg + Norgestrel 1.0 (1 dose and repeat after 12 hours) EE 0.1 mg + Norethindrone 2.0 (1 dose and repeat after 12 hours)

When to START regular contraception after using an emergency contraception?

- COCs – Provide a pack and instruct to start the next day*
- DMPA - Can be given on the same day as ECP is used*
- IUDs - can be used as emergency contraception * and kept up to 12 years as long as contraception is needed

*Family Planning A Global Handbook for Providers 2011

EC: Key Benefits

- Again, EC is the only method that prevents pregnancy after unprotected sex.
- EC could avert:
  - Millions of unintended pregnancies and abortions
  - At least 20 million unsafe abortions and the deaths of 80,000 women
- Woman can have EC on hand in case of emergency.

EC: Key Benefits (*cont.*)

- COCs and POPs are most effective if used as soon as possible after unprotected sex and up to 120 hours (five days)
- Progestin-only regimen safe for breastfeeding woman, but breastfeeding should be delayed (8–24 hours) after EC

(Source: Gainer et al. 2007)

EC: Limitations

A woman using EC may experience the following side effects, none of which indicate illness:

- Nausea and vomiting
  - Less common with POPs
  - May take anti-nausea medicine
- Changes in bleeding pattern
- Abdominal pain, fatigue, headaches, dizziness or nausea in the week after taking the EC pills

EC: Counseling Considerations

- Be sure that client does not want to be pregnant
- Take as soon as possible after unprotected intercourse
- Explain:
  - Correct use—more effective when taken sooner
  - EC is not suitable for regular use because not as effective as other routine methods
  - Nausea and vomiting are common with COCs; significantly less common with POPs
  - EC pills will not cause menses to come immediately
  - EC pills do not provide protection against STIs (e.g., HIV/AIDS, HPV)

EC can be used multiple times in the same month

- For women who have unprotected sex several times during the month
  - Taking emergency contraception several times is not dangerous
  - May cause break-through bleeding and irregular menses
  - Using emergency contraception is not as effective as using modern contraception continuously
    - For a woman who is sexually active, encourage her to initiate modern contraception.

What is an intrauterine contraceptive device (IUCD)?

The IUCD: What Is It?

- The IUCD is a small T-shaped plastic device with fine copper wire wrapped around it; it is inserted into the uterus through the vagina.
- Most IUCDs have one or two strings tied to them that hang through the cervix.
- IUCDs work primarily by causing a chemical change that damages the sperm and egg before they can meet.

Postpartum Insertion of IUCDs (PP-IUCD)

- IUCDs can be inserted:
  - Immediately after delivery of the placenta
  - During cesarean section
  - Within 48 hours of childbirth
- If not inserted within 48 hours of delivery, insertions should be delayed for at least four weeks

NOTE: An IUCD can be inserted immediately after first-trimester abortion.

Risk of Expulsion and Timing of Insertion Postpartum

IUD Expulsion Rates by Timing of Insertion

Time Of IUD Insertion	Definition	Expulsion Rate	Observations
Postplacental	Within 10 minutes after delivery of placenta	9.5–12.5%	Ideal; low expulsion rates
Immediate Postpartum	After 10 minutes to 48 hours post delivery	10-15%	Still safe
Late Postpartum	After 48 hours to 4 weeks post delivery	NOT RECOMMENDED	Increased risk of perforation and expulsion
Interval-Extended Postpartum	After 4 weeks post delivery	3–13%	Safe

Time for a debate…

Participants will be divided into two groups to hold a debate.

- One side will argue for benefits of using an IUCD
- Other side will argue for limitations and reasons not to use an IUCD

IUCDs: Key Benefits

- Highly effective (failure rate <1% in first year of use)
- Very safe (WHO Category 1) from 4th week postpartum
- Effective immediately
- Long-term method (up to 12 years with Copper T 380A)
- Immediate return to fertility upon removal

IUCDs: Key Benefits (*cont.*)

- Do not affect quantity or quality of breast milk; can be used by postpartum women whether or not they are breastfeeding
- Few side effects
- Do not interfere with intercourse

IUCDs: Limitations

- Requires a trained healthcare provider to insert
- Some users report:
  - Changes in bleeding patterns, especially during first three months of use
  - More cramping and pain during monthly menses

NOTE: None of these side effects indicate illness.

- Counseling clients and obtaining informed consent should be done during ANC

PP-IUCDs: Who Should Not Use (WHO Category 4)

Woman with the following should not use the IUD:

- Current puerperal sepsis/endometritis/pelvic inflammatory disease (PID)
- Membranes ruptured >18 hours before delivery (for immediate PP insertion)
- Unexplained vaginal bleeding, which may indicate serious condition
- Cervical or endometrial cancer

PP-IUCDs: Conditions Requiring Precautions (WHO Category 3)

- Insertion from 48 hrs to less than four weeks postpartum
- Woman with AIDS who are not clinically well

PP-IUCDs: Method May Not Be Best Choice if Other Methods Available (WHO Category 2)

- HIV infected but clinically well
- High risk of HIV or STIs
- Vaginitis (trichomoniasis or bacterial vaginosis)
- Anatomic abnormalities of uterus
- Endometriosis
- Complicated valvular heart disease (use prophylactic antibiotic if insertion)
- Less than 20 years of age

IUCDs: Counseling Considerations

- Discuss limitations (note that cramping occurs during involution even without IUD insertion)
- Explain procedure prior to insertion
- Talk with client during the procedure to tell her what is happening and reassure her
- Advise return after three to six weeks or any time she has questions or concerns

What are some benefits of male condoms?

Male Condoms: Benefits

- When used consistently and correctly, male condoms are highly effective against pregnancy (97%) and STIs/HIV
- Can be used soon after childbirth (as soon as intercourse is resumed)
- Protects against STIs/HIV AIDS

Male Condoms: Limitations

- Moderately effective (three to 14 pregnancies per 100 women during the first year) with typical use; with perfect use, 97% effective
- Effectiveness as contraceptives depends on willingness to follow instructions
- User-dependent (require continued motivation and consistent use with each act of intercourse)
- May reduce sensitivity of penis, making maintenance of erection more difficult

Male Condoms: Counseling Considerations

- Explain limitations and discuss need to use for every act of intercourse
- Ensure that client knows how to correctly use condoms, demonstrating on model, banana or cucumber as needed
- Ask client how many condoms are needed—provide plenty of condoms, as well as information on where more can be purchased
- Discuss skills and techniques for negotiating condom use with partner

What is postpartum female sterilization and when can it be done?

Postpartum (PP) Female Sterilization

- Permanent contraception for women who want no more children
- Performed by minilaparotomy, which involves small incision in abdomen
- Works because fallopian tubes are blocked or cut so egg cannot move down tube and reach sperm

PP Female Sterilization (*cont.*)

- Ideally done within 48 hours after delivery
- May be performed immediately following delivery or during cesarean section
- If not performed within one week of delivery, delay for six weeks
- Follow local protocols for counseling clients and obtaining informed consent in advance
  - Must be done during antenatal care for immediate PP sterilization

PP Female Sterilization: Key Benefits

- Highly effective (99.5%); comparable to vasectomy, implants, IUDs
- No long-term side effects
- No need to worry about contraception again
- Is easy to use; nothing to remember or do

PP Female Sterilization: Limitations

- Involves a physical examination and surgery
- Cannot be reversed or stopped if couple changes their mind about wanting another pregnancy
- Rare complications of surgery, such as wound infection or anesthesia complication

Female Sterilization: Who Should Not Use (WHO Category 4)

While contraindications are rare, surgery should be delayed for:

- Women with symptomatic systemic infection (AIDS*, malaria, etc.)
- Women who are more than one week and less than six weeks postpartum

*Minilap may be performed on women with AIDS if in a specialized facility

What is a "vasectomy"?

Vasectomy (Male Sterilization): What Is It?

- Permanent contraception for men who want no more children
- A safe, convenient, highly effective and simple contraceptive procedure for men that is provided under local anesthesia in an out-patient setting
- Surgery through a small incision in the scrotum that closes off the vas deferens, keeping sperm out of semen

Vasectomy: Key Benefits

- No serious side effects
- Vasectomy is safer, simpler, less expensive and equally effective as female sterilization (tubal ligation)
- Can be timed to coincide with the breastfeeding woman's postpartum period when fertility is reduced
- Does not affect male sexual performance

Vasectomy: Key Benefits (*cont.*)

- After first 3 months, highly effective in preventing pregnancy (99.6 to 99.8% effective)
- Is safe, permanent and convenient
- Allows man to take responsibility for contraception
- Increases enjoyment and frequency of sex

Vasectomy: Limitations

- Is not effective for three months after procedure
  - Need backup method—LAM may be appropriate
- Cannot be reversed if man changes his mind
- Rarely man may have
  - Severe scrotal or testicular pain
  - Infection at the incision site
  - Bleeding under the skin
  - Vans deferens grow back together after some time

Contraception during Special Periods

Teenagers
Post-Pregnancy and Miscarriage
Women over 35

Contraceptive Options for Teens and Young Women

METHOD	REMARKS
OCs	■ Precautions in young women are rare ■ Most popular among young women ■ Lifestyle may increase missed intake ■ Used for EC also
Implants	■ Side effects (spotting, acne and weight gain) are potential issues

Source: Pocketguide for FP Service Providers, 1996-1998;Global FP Handbook 2007

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Contraceptive Options for Teens and Young Women (cont'd)

METHOD	REMARKS
PICs	■ Side effects (spotting, acne and weight gain) are potential issues ■ Highly recommended for young woman requiring intermediate-duration contraception
IUDs	■ Not recommended for woman with increased risk of STIs
Condoms	■ Provide immediate protection ■ Protects against STIs

Source: Pocket guide for FP Service Providers, 1996-1998;Global FP Handbook 2007

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Additional Points to Tell Teens and Young Women

- Caution that OCs do not prevent STIs
- Discuss condom use: "How are you protecting yourself from AIDS?"
- Ask how he/she plans to discuss condom use with her partner
- Discuss EC

4

Contraception for Women 35 Years and Older

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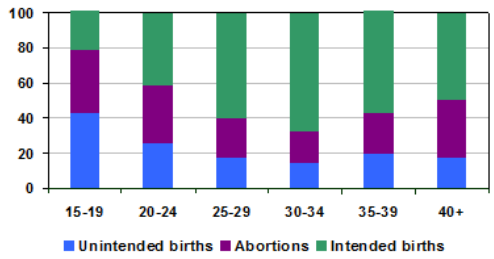
Do Women > 35 Still Need Contraception ?



*Does not include miscarriages.

Source: Lynch, C, Contraception for Women 35 and older, 2001

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Contraceptive Options for over 35 Women

METHOD	REMARKS
COCs and CICs	▪ Women over 35 who smoke > 15 cigarettes/day (Class 4) ▪ Low-dose COCs source of estrogen for perimenopause ▪ ECPs can be used
POCs (implants, PIC and POPs)	▪ POCs can be used in perimenopausal years (40s-50s) ▪ Safely used by older women who smokes (Class 1)
IUDs	▪ Safely used by older women if not at risk for STIs ▪ Possibly preferred method because it is long-term and effective
Condoms	▪ Best used by women with predictable intimacy acts ▪ Only method protecting against STIs
Surgical Contraception	▪ Appropriate for clients/couples who are certain about limiting pregnancies

Source: Pocket guide for FP Service Providers, 1996-1998;Global FP Handbook 2007

Post-Pregnancy Contraception

Postpartum and Postabortion Periods

Why Postpartum Contraception?

- Women in the first year postpartum have higher unmet need for FP than the general population of women.
- Demographic and Health Survey data show that very few women (3%-8%) want another child within two years after giving birth; 40% of women in the first year postpartum intend to use a FP method but are not doing so (MAQ*).

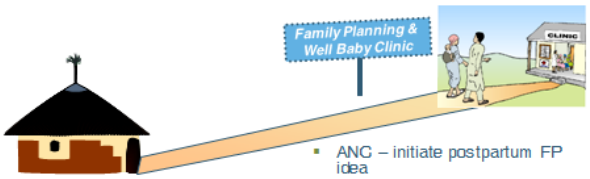
*Data from-Maximizing Access and Quality-Global Health Technical Briefs-USAID

Postpartum FP Goals

- Reduce unmet need for FP
- Improve contraceptive choice
- Promote optimum health through breastfeeding
- Counsel on return to fertility
- Promote health of mothers and their newborns through pregnancyspacing
- Integrate with maternal, newborn and infant services

Stephenson & MacDonald, "FP for Postpartum Women: Seizing a Missed Opportunity" 2005

FP Opportunities for Postpartum Woman



- ANC – initiate postpartum FP idea
- Discharge – counsel
  - Breastfeeding – LAM
  - Non-breastfeeding
    - 6-week postpartum visit
    - Immunization visits
    - Sick and well-child visits

Need for Postabortion FP Services

- Unsafe abortion is a prime indicator of unmet need for FP
- Failure to provide FP is a major contributor to the problem of unsafe abortion
- Emergency treatment is not linked to FP counseling or services

Risk Factors for Repeat Unsafe Abortion

- Lack of understanding of patients' reproductive health needs (provider)
- Lack of FP services for some groups of women (e.g., adolescents, single women)
- Separation of emergency services from FP services
- Misinformation about which FP methods are appropriate postabortion (provider and patient)
- Lack of recognition of problem of unsafe abortion and patient FP needs (provider)

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Why Start Postabortion FP Immediately?

- Increased risk of repeat pregnancy because:
  - Ovulation may occur by day 11 postabortion
  - 75% of women will have ovulated within 6 weeks postabortion

Source: Lähteenmäki 1993; Lähteenmäki et al 1980.

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Postabortion Contraception

METHOD	WHEN TO START	REMARKS
Hormonal Contraception (COCs, DMPA)	Immediate	Effective immediately Can be used even if infection present
IUCDs: First trimester Second trimester	Immediate or delayed 4 to 6 weeks postabortion	No infection present Similar to postpartum
Tubal Ligation/ Vasectomy	Immediate Delayed	Clean procedure Allow infection/injury to resolve

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