Post-Pregnancy Family Planning Services

Package for Service Providers

UNFPA

jhpiego
Johns Hopkins University Affiliate

Government of Canada

Jhpiego is an international, non-profit health organization affiliated with The Johns Hopkins University. For more than 40 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.

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PREFACE

Pakistan has committed at 2012 London Summit on Family Planning to address barriers faced by women when trying to access family planning. Under this coordinated commitment-referred broadly as FP 2020.under this commitment, to increase its CPR to 50 percent by 2020.But unfortunately, according to recent Pakistan Demographic and Health Survey (PDHS-20118) it dropped from 35 to 34 in the past five years with only 25% couples using modern contraceptive method of family planning. The unmet need is 17%. nearly half of all pregnancies are unintended and of 25 percent end as abortions while 15% results in unwanted births. According to an estimate 15 percent abortions take place in Pakistan annually. (PDHS 20017-18)

The goal of the Strengthening& Sustaining Post pregnancy Family Planning Services-Project, funded by UNFPA is to empower women and couples to fulfill their reproductive desires, contributing to a broad range of positive health and development outcomes. The project will strategically focus on addressing unmet need for family planning (FP) during the post pregnancy period by integrating PPFP into existing public and private maternal and neonatal health services. Additionally, the Strengthening Post pregnancy Family Planning Services Project, through Jhpiego, will support training and quality assurance of PPFP services in the public and private sectors.

The initiative to expand access to long-term, cost-effective contraceptive methods supports the development of this learning resource package for comprehensive post pregnancy contraceptive methods. The PPFP methods enable women to leave the birth facility with a safe and extremely effective, long-acting, reversible contraceptive method already in place.

ACKNOWLEDGMENTS

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Six Days Agenda of Training of Trainers on Post Pregnancy Family Planning

DAY 1	DAY 2	DAY 3	DAY 4	Day 5	Day 6
09:00am-04:00pm)	(09:00am-04:00pm)	(09:00am-04:00pm)	(09:00am-04pm)	(09:00am-4:00pm)	(9:00am-2:30pm)
Opening Activities: Welcome/Introduction -Workshop objectives & Goals -Norms and Expectations -Pre-Course Questionnaires	Reflection of the day Warm Up -Overview of Contraceptive Implants -Demonstration on the RITA Model for Implant Insertion -Practice/Simulation session by participants	Reflection of the day Warm Up -Visit clinical site for insertion of Implants and PPIUD on Clients -Role-play for FP Counseling by Participants	Reflection of the day Warm Up -Medical Eligibility Criteria (MEC Wheel) -Visit clinical site for insertion of Implants and PPIUD	Reflection of the day Warm Up -Side effect & management of IUCD -**Introduction to the Training Skills Course** Presentation /discussion	Reflection of the day -Facilitation skills presentations by Participants and facilitators sign out Checklist -Post Course Questionnaires -Course Evaluation
Tea Break (11:00 -11:15)					

- Principles of Family Planning services -Over view of Post-Partum Family Planning - Healthy Timing and Spacing of Pregnancy	- FP Counseling followed by Role Play - Introduction of PPIUCD (Presentations/discussions -Video on PPIUCD Insertion /removal - Demonstration on Mama U for Insertion and Removal of PPIUCD	-Infection Prevention Protocols - Demonstration on Decontamination & IP Protocols - Demonstration on Interval IUCD Insertion on Zoe Model -Divide into Groups and Practice simulations on Models using Skill Checklist	- Side effect & management of Implant **(Using PPFP Manual)** - Divide into groups for PPIUCD and Implant Skill Practice /Simulations using Checklists followed by IP Protocols	**-Facilitation Process** Presentation /discussion Review key concepts. Small group work (Demonstration, Coaching Skills) Small group rotate and practice presentations.	- Final Skill assessments on PPIUCD, Implant and Interval Insertions using Checklist -- Certificate Distribution Wind up followed by Lunch
Lunch Break 1:30 –2:15					
Warm Up Short Acting Contraceptives (PICs,COCs)	Warm Up --Videos on Implant Insertion and Removal -Divide into groups for PPIUCD,	Warm Up -Divide in groups for Practice of IUD Loading	Warm Up -Role-play for FP Counseling by	-Facilitator will assigned topics for Facilitation Skill presentations and Participants prepare Presentations for final	

Permanent Wrap Up with assigned tasks to Participants	Implant Skill Practice /Simulations using Checklists -Wrap Up with assigned tasks to Participants	Wrap Up with assigned tasks to Participants	Wrap Up with assigned tasks to Participants	assessments Wrap Up with assigned tasks to Participants	

INTRODUCTION

During the postpartum period, many women are not aware of their risk for pregnancy, which may occur as early as 4 to 6 weeks after birth. Although post pregnancy women may want to either space or limit subsequent births and would like to use contraception, most in developing countries are not. Mothers are often "too busy" taking care of their new babies and their families, and may mistakenly believe that they cannot get pregnant as long as they are breastfeeding. Some may be unsure of their contraceptive options or where they can access services, if available. And the next time they go to the health facility, it is often too late: they are pregnant again. It may also be too soon.

When pregnancies are spaced too closely together (<24 months, from birth to next pregnancy), mothers and babies are at increased risk from adverse health outcomes. Family planning, including post pregnancy family planning (PPFP), saves lives by enabling women to delay or limit their pregnancies. As such, family planning/PPFP has the potential to dramatically decrease maternal and child mortality and morbidity rates.

The most successful PPFP programs will focus on providing PPFP counseling to women at every opportunity. Ideally, counseling would be initiated during pregnancy, such as at an antenatal care (ANC) visit. Services should continue into the post pregnancy period, for routine follow-up and management of potential problems.

The **goal** of PPFP services is threefold: to

1. **Assist** women and couples in understanding their risk of unintended pregnancy and the benefits of healthy spacing of pregnancies (or limiting, if desired); clarifying their fertility intentions; and choosing a contraceptive method that is well-suited to them;
2. **Provide** the chosen method, in adherence with international global standards and local protocols;
3. **Support** the woman and couple throughout the process—with kindness and respect, up-to date information, quality care and, when needed, reassurance—to help ensure continued use of the method or smooth transition to another method of their choosing if appropriate.

Before Starting the Course

Welcome to the PPFP clinical skills training course! You may benefit from understanding a few things about the course before getting started.

First, it will be conducted in a way that is very different from traditional training courses—based on the assumption that you are here because you:

- Are **interested** in providing PPFP services;
- Wish to **improve** your knowledge and skills in PPFP service delivery, and thus your job performance; and
- Desire to be **actively involved** in course activities. Therefore, the course will be very participatory and interactive, helping to create an environment that is more conducive to learning.

Second, the development and assessment of your skills throughout the course will focus more on your performance than on what you know or have memorized. This is because clients deserve providers *who are able to provide* safe and effective services, *not just knowledgeable* about them. **Third**, a variety of educational technologies will be used to maximize the effectiveness and efficiency of course activities, enhancing your learning experience while conserving valuable resources. The training approach to be used is discussed in more detail on pages 1-9 to 1-12.

Course Design

This clinical skills course is designed to prepare qualified service providers (primarily maternal, newborn and child health [MNCH] providers [e.g., midwives, nurse-midwives, doctors] and other clinicians) who are capable of delivering high-quality PPFP services to women—beginning with counseling when they are pregnant (ideally) and continuing through their first PPFP method follow-up at 4 to 6 weeks. Throughout the course, the trainer will use a variety of approaches to develop the learners' skills and to assess their performance. Key skills development and performance assessment methods and processes are described briefly below.

Knowledge Update

- During the morning of the first day, learners are introduced to the key features of the course and are briefly assessed (using the **Precourse Knowledge Assessment**, a standardized written test) to determine their individual and group knowledge of the provision of PPFP services. Based on the results of this assessment.
- The trainer and learners identify their collective strengths and weaknesses, and decide what adjustments should be made to the course schedule/outline—in terms of time allotted to topics and activities.
- Each learner develops a **Personal Learning Plan** to articulate how she/he will use the course to achieve the **PPFP Performance Standards**.
- The knowledge component of the course includes interactive presentations, discussions and other activities designed to help learners develop a *working understanding* of the latest, evidence-based information about the PPFP methods.

Skills Development and Assessment

- Classroom and clinic sessions focus on **key aspects of PPFP service delivery** (e.g., counseling and screening of clients, performing the procedures in the context of routine obstetric services, managing side effects and other potential problems during follow-up).
- Learners will first practice skills "in simulation" (on anatomic models) using a detailed step by-step **Counseling Guide** and **Clinical Skills Checklists**, which list the key steps in counseling and screening clients and performing the procedures. In this way, they learn the skills needed to provide PPFP services more quickly and in a standardized manner, without placing clients at risk.
- Once the trainer determines that a learner has achieved an adequate level of skill with anatomic models, or in simulation, s/he will be able to practice the new skills in the clinical setting with actual clients. Progress in learning new skills is assessed (formally and informally) and documented throughout the course using the **Counseling Guide, Clinical Skills, Checklists and Skills Tracking Sheet.**

Qualification

Although qualification[2] is a statement by the trainer that the learner has met the requirements of the course, the responsibility for becoming qualified is shared by the learner and the trainer. Qualification is based on demonstrated mastery of, or competency in, the following areas:

- **Knowledge:** A score of at least 85% on the Midcourse Knowledge Assessment
- **Skills:** Satisfactory performance of PPFP methods counseling and clinical skills (as outlined in the checklists)
- **Provision of Services (Practice):** Demonstrated ability to provide safe and effective PPFP services in the clinical setting

A true determination of a learner's competency can be made only through observing how the learner applies all that s/he has learned with actual clients.

After the Course

It is recommended that within 1 to 2 months of qualification, the learners be observed and assessed at their workplace by a course trainer, using the same counseling and clinical skills checklists used in the course. (At the very least, learners should be observed by a skilled provider soon after completing training.) This post course assessment is important for several reasons.

First, it not only gives the newly trained providers direct feedback on their performance (so that they can work on further strengthening their skills, from competency to proficiency), but also

Qualification does not imply certification. Providers can be certified only by specifically designated organizations.

PPFP Course Notebook for Learners provides the opportunity for them to discuss any start-up problems or constraints to implementing the new skills in service delivery (e.g., due to lack of instruments, supplies or support staff). Second, and equally important, it provides the training center, via the clinical trainer, key information on the adequacy of the training and its appropriateness to local conditions. With this type of feedback, programs can be improved in a targeted manner to better meet the needs providers and communities. Without this type of feedback, training easily can become routine, stagnant and irrelevant to service delivery needs.

Course Syllabus

Course Description

This three day clinical training course is designed to prepare the learner to become competent in:

- Counseling women/couples about PPFP contraceptive method best accepted by the clients.
- Screening women to ensure that they do not have any characteristics or conditions that would make the method an unsuitable option for them;
- Providing wide range of options in postpartum period
- Managing side effects and other potential problems associated with the use different methods.

Course Goals

- To influence in a positive way the attitudes of the learner toward the benefits and appropriate use of PPFP methods during the post pregnancy period
- To provide the learner with the knowledge, skills and attitudes necessary to provide PPFP services

Learning Objectives

By the end of the course, the learner will be able to:

- Discuss the importance of healthy spacing (or limiting) of pregnancies and the benefits of post pregnancy family planning.
- Explain the steps of Active Management of Third Stage of labor (AMTSL)
- Explain basic information about the method mix approach, its effectiveness, safety, mechanism of action, advantages and limitations, and other general attributes; and the medical eligibility criteria and other client assessment criteria used to determine whether the chosen method is a good option for the woman.
- Demonstrate appropriate counseling and assessment of antenatal women for PPFP methods in general.

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Training/Learning Methods

- Illustrated lectures and group discussion
- Individual and group exercises
- Role plays
- Simulated practice with anatomic (pelvic) models
- Guided clinical activities (focusing on counseling, screening and PPIUCD insertion)
- Learner Selection Criteria

Learners for this course should be providers who are:

Working in a health care facility (clinic or hospital) that provides women's health services including antenatal care, labor and childbirth, and post pregnancy care, including family planning Familiar with providing different contraceptives insertion and removal services (if learners are not proficient in these services, the course may be lengthened to allow for sufficient clinical practice) willing to update their knowledge and acquire the skills and attitudes essential to provide PPFP services.

MODULE – 1

POSTP-REGNANCY FAMILY PLANNING (PPFP)

NEED FOR POST-PREGNANCY FAMILY PLANNING

Multiple studies performed around the world have shown that adverse maternal, perinatal and infant outcomes are related to pregnancies spaced too closely together. The risks are particularly high for women who become pregnant very soon after a previous pregnancy, miscarriage or abortion. Table 1 presents a summary of findings.

The good news is that family planning/PPFP enables women/couples to achieve healthy intervals between births—potentially averting 25% to 40% of maternal deaths[i] and reducing child mortality by an estimated 10%.

Table1. Risks of Adverse Health Outcomes after Very Short Interval Pregnancy

Increased Risks when Pregnancy Occurs 6 Months after a Live Birth		
Adverse Outcome	**Increased Risk**	
Induced abortion	650%	
Miscarriage	230%	
Newborn death (<9 months)	170%	
Maternal death	150%	
Preterm birth	70%	
Stillborn	60%	
Low birth weight	60%	
Increased Risks when Pregnancy Occurs Less than 6 Months after an Abortion or Miscarriage		
Increased Risk	**With 1–2 Month Interval**	**With 3–5 Month Interval**
Low birth weight	170%	140%
Maternal anemia	160%	120%
Preterm birth	80%	40%

Healthy Spacing of Pregnancies

In June 2005, the World Health Organization (WHO) brought together over 30 technical experts to review the available global scientific evidence regarding healthy intervals between pregnancies. The following recommendations are based on the results of this technical consultation:

After a live birth, a woman should **wait at least 24 months** (but not more than 5 years) before attempting the next pregnancy to reduce the risk of adverse maternal, perinatal and infant outcomes. Women should plan a healthy birth-to-birth interval of about 36 months, or 3 years, between children.

After a miscarriage or induced abortion, a woman should **wait at least 6 months** before attempting the next pregnancy to reduce the risk of adverse maternal, perinatal and infant outcomes.

Adolescents should delay first pregnancy until at least 18 years of age to reduce the risk of adverse maternal, perinatal and infant outcomes. Every woman and every maternal/newborn health or family planning worker should know and understand the key recommendations for healthy spacing of pregnancies. (Specific messages related to the healthy spacing of pregnancies are presented in Appendix A.)

Unmet Need for PPFP

Despite the adverse health outcomes associated with short birth intervals, a significant proportion of births are spaced too closely together. Family planning during the first year postpartum has the potential to reduce a significant proportion of these unintended pregnancies because, as research has demonstrated, women experience a large "unmet need" for family planning during this time. **Loosely defined, unmet need refers to the percentage of women who do not wish to become pregnant but are not currently using a contraceptive.**

Factors That Contribute to Short Birth Intervals

Given the unmet need for family planning and prevalence of shorter-than-recommended birth intervals, women and their health care providers should understand the factors that contribute to the high risk of unintended pregnancy among postpartum women.

Return to Fertility

Postpartum women are frequently fertile again before they realize it. A woman will ovulate before she begins regularly menstruating again. And the chance of a woman's fertility returning before menstruation resumes increases as the postpartum period extends.

An individual woman's return to fertility cannot be predicted. Most non-breastfeeding women experience menses return within 4 to 6 weeks. Breastfeeding delays the resumption of ovulation and the return of menses, but it cannot be relied upon for contraceptive protection unless the woman is practicing LAM (further discussed on the following page).

Women often initiate family planning after their menstruation resumes. Individual studies appear to draw a correlation between return of menses and initiation of contraceptive use and suggest that family planning—if used at all during the postpartum period—is most likely to be initiated in the month following the return of menses, which is often too late. And in one study, 8%–10% of women who were still experiencing postpartum amenorrhea conceived.

Resumption of Sexual Activity

Reported return to sexual activity after a birth varies greatly. A recent study of 17 developing countries looked at percentages of couples returning to sexual activity by 3 to 5.9 months. At one end of the range is Guinea, where about 10% of women have resumed sexual activity within that timeframe; at the other end are Bangladesh and Rwanda, where almost 90% of women are having sex again by 6 months.

Postpartum abstinence, in countries that practice it, is not always strictly observed. Qualitative research has indicated that even among those countries practicing postpartum abstinence, sexual activity may occur irregularly early on, gradually progressing to more regular activity.

Women may be unwilling to ask for contraception "too soon" after birth. If a woman resumes sexual activity sooner after the birth than is deemed appropriate in her culture, she may assume that the provider will judge her if she asks for contraception. As a result, the woman may forego contraception even though this will put her at risk for unintended pregnancy.

Breastfeeding versus LAM

Breastfeeding ≠ LAM. To prevent unintended pregnancy, breastfeeding women must use a method of contraception (breastfeeding is not a contraceptive). One option is LAM, which is 98.5% effective for up to 6 months post pregnancy —provided that the woman exclusively breastfeeds her baby on demand (whenever the baby wants, day or night; no other food or other fluids in between), and her menses have not returned. As effective and convenient as LAM is, it still is not widely practiced.

LAM is effective only for 6 months. For women using LAM, it is likely their fertility will return (often before menstruation resumes) after 6 months, even if they continue to breastfeed. This is why women practicing LAM must transition to another method as soon as any of the three LAM criteria is no longer being met.

Exclusive breastfeeding drops off after 3 months. Although many women exclusively breastfeed their babies in the first few months following delivery, the rate drops off significantly after 3 months—which leads to return of fertility.

Implications for Family Planning Programming

In addition to ensuring that high-quality PPFP services are available, the objective of PPFP programs is to help women and couples understand their risk of unintended pregnancy, as well as the maternal and newborn benefits of spacing pregnancies at healthy intervals (or limiting pregnancy, if desired). Linkage of MNCH and family planning services is critical to achieving pregnancy-spacing recommendations and to addressing unmet need for family planning.

Information on healthy spacing of pregnancies should be incorporated into health education, counseling and service delivery for women and their families wherever they receive medical care. Suggested service delivery approaches include:

- Giving clients complete information about the benefits of and recommendations for healthy spacing of pregnancies as a part of routine family planning services, during both general and method-specific education and counseling.
- Emphasizing the importance of timely initiation of a family planning method after childbirth, miscarriage or abortion (and a "transition" method after LAM) as a part of routine antenatal, post pregnancy and postabortion care.
- Providing family planning services to women while they are still in the health care facility, following a facility-based delivery.
- Integrating family planning services with other health services, such as immunization and newborn or child care services.
- Helping clients to exercise their right to make a free and informed choice regarding family size, fertility goals and contraceptive options.

Remember: The right contraceptive for a woman **is the one she chooses for herself**, provided there are no medical reasons why the method should be withheld. As providers, we can give the woman the information she needs to make a suitable choice, but the choice is hers to make.

Overview of Postpartum Family Planning

Objectives

- Define PPFP and its importance.
- Discuss methods of Postpartum Family Planning
- Describe the specific situation of postpartum women
- Discuss breastfeeding and LAM
- List opportunities and mechanisms for post partum FP integration

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Postpartum Family Planning?

- Postpartum family planning (PPFP) is the prevention of unintended and closely spaced pregnancies through the first 12 months following childbirth.
- Not only do pregnancies during this period hold the greatest risk for mother and baby, the first 12 months after childbirth also present the greatest opportunities in terms of number of contacts with health care services.

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PPFP Importance

- According to an analysis of Demographic and Health Survey data from 27 countries, 65% of women who are 0–12 months postpartum want to avoid a pregnancy in the next 12 months but are not using contraception. This is unmet need.
- 40% Unplanned Pregnancies World wide and 45% pregnancies ends with unsafe abortions
- Contraceptive Prevalence rate (CPR) of Pakistan 34.2%
- Fertility rate 3.6%

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Contd.

- . Closely spaced pregnancies within the first year postpartum are the riskiest for mother and baby, resulting in increased risks for adverse outcomes such as preterm, low birth weight and small for gestational age. Pregnancy occurring within six months of the last delivery holds a 7.5-fold increased risk for induced abortion and a 1.6-fold increased risk of stillbirth.

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Strategies to Address Unmet Need for PPFP

- Raise Awareness of FP Needs of Postpartum Women Providers, women, their families and communities, as well as policymakers and program managers, are often unaware of the need for PPFP
- Ensure No Missed Opportunities across the Continuum of Care I,e maternal, newborn and child health (MNCH) services including antenatal, birth, newborn, immunization, nutrition and community health care
- Organize Services
- Expand the Range of Options offered to the PP clients

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Considerations with Postpartum Family Planning

- Through the first year postpartum
  - Timing of return to fertility
  - Return to sexual activity
  - Breastfeeding and use of various methods
  - Timing of various methods
  - LAM, concurrent use and transition to other methods
- Underlying factors
  - Healthy spacing of the next pregnancy
  - Integration of FP into other service opportunities

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Return to Fertility

- Non breastfeeding:
  - As early as 3 weeks postpartum – 21 days postpartum
- Breastfeeding
  - Using LAM accurately:
    - some time after 6 months – variable
  - Breastfeeding without using LAM:
    - possibly even before 6 months, but again, variable.
    - average is 45 days
    - 5 – 10% of breastfeeding women get pregnant in first year PP
- : Fertility returns before menses returns!

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Return to sexual activity

- Physiologically women can resume intercourse when the perineum is fully healed
- But she should do so when she is ready
- Typically, sexual activity resumes before a woman is on a effective FP method
- Therefore, the woman is at risk of pregnancy

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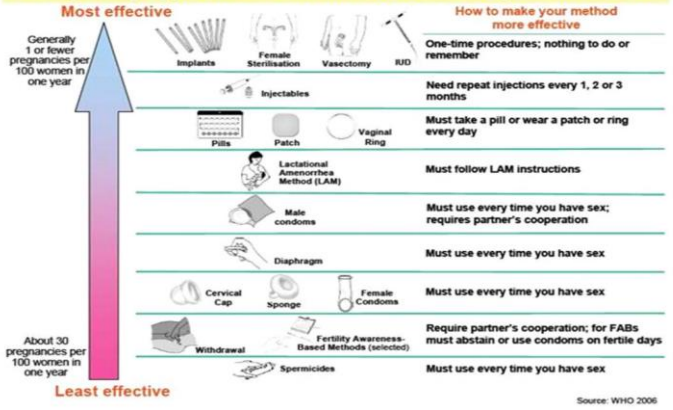
Comparing Typical Effectiveness of Contraceptive Methods



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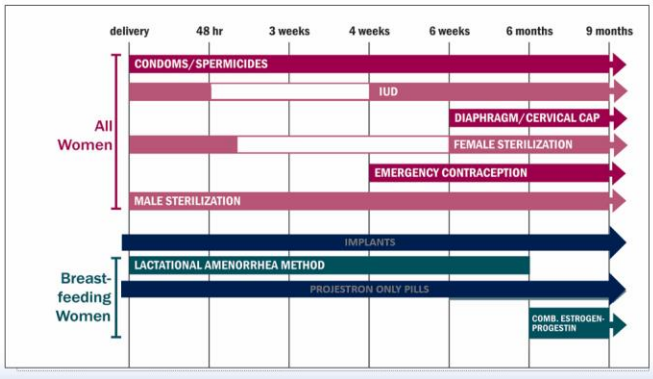
FP Methods for Breastfeeding Mothers



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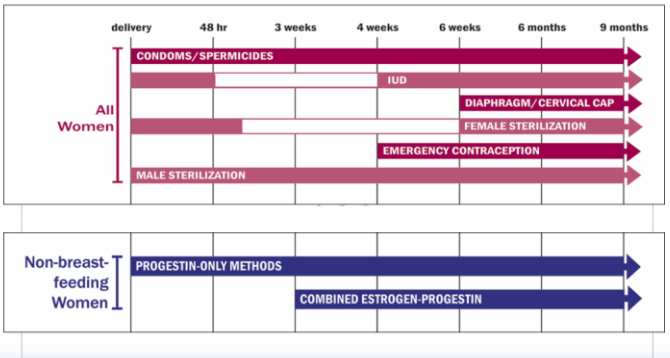
FP Methods for Non-Breastfeeding Mothers



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Timing of Initiating FP Methods Postpartum

- LAM – immediately
- Condoms – when intercourse resumes
- Progestin-only methods –
  - BF: when good milk supply and BF going well – 6 weeks
  - Non-BF – right away
- Combined Oral Pills (Estrogen + Progestin)
  - BF: when there is no risk if quantity of milk decreases – 6 months
  - Non-BF: when risk of thrombosis is reduced – 3 weeks
- IUCD – when risk of infection and perforation is low
  - First 48 hours or after 4-6 weeks
- Tubectomy – when tubal inflammation and risk of infection low:
  - First 7 days or after 6 weeks

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IMPORTANT!

- BREASTFEEDING IS NOT THE SAME AS LAM!

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LAM Mechanism of Action

- Stimulation of nipple causes release of prolactin
- Prolactin and oxytocin result in increased milk production (which encourages suckling)
- Prolactin reduces estrogen and suppresses ovulation

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LAM Criteria: I

- Baby is being only breastfed
  - The baby is not receiving any other solid food or liquids; only breast milk
- Breastfeeding on demand
- Breastfeeding at least every 4 hours
  - No more than 4 hours between feeds during day
  - No more than 6 hours between feeds at night

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Baby is being only breastfed

- Why is this condition important?
- When baby receives any food, water, or other liquid:
  - The baby becomes full and will not want the breast milk as often.
  - The mother will not produce as much milk.
  - Infrequent suckling will reduce prolactin and lead to ovulation make the mother's fertility return

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Effectiveness of LAM

- LAM is 99.5% effective with consistent and correct use and more than 98% effective as typically used
- Effectiveness rates comparable to those of other modern methods

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LAM Criteria: 2

- Amenorrhea – Menstruation has not returned since the birth of the child
  - Bleeding during the first 2 months post-partum does not count as menstruation
  - Bleeding after 2 months post-partum can be an indication of the return of ovulation and the return of fertility

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LAM Criteria: 3

- The baby is less than 6 months old
  - Biologically appropriate cut-off point.
  - WHO recommends supplementing after 6 months.
  - Supplemental food will decrease suckling.

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LAM: Use and Transition

- If a woman is using LAM, when should she transition to another FP method?
- If all components are met:
  - Help a woman transition to use another method by 6 months
- If any component of LAM is not met:
  - Help her transition as soon as component not met
- Help a woman add another method whenever she is ready
- LAM can be seen as a "gateway" to use of a modern method (OCPs, Progestin-only methods, IUCD)

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Timings and types of integration

- During ANC
  - Recommended within FANC
  - Counseling on reproductive intentions, LAM, return to fertility, timing for starting contraception
  - Counseling for PPIUCD or sterilization
  - Limited association with postpartum FP use
- Immediate post-delivery
  - Opportunities during mother/baby checks/discharge
  - Counseling on reproductive intentions, return to fertility, timing for starting contraception
  - PPIUD and sterilization
  - Progestin-only for non-breastfeeding women
  - LAM
  - Stronger association with starting FP use by offering methods

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Timings and types of integration: Extended postpartum period

- 1- 6 weeks postpartum consultation(s)
  - Opportunities during mother/baby checks
  - Counseling on reproductive intentions, return to fertility
  - Reinforce LAM, plan transition to other modern methods
  - If ending LAM, transition to IUD, pills, injectable, implant
  - Strong association with FP use
- Child health consultations
  - Opportunities during health / immunization visits
  - Referral or provision of method
  - Some evidence of association with FP use

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Advantages of post partum IUDs

1. Readily accessible for women who deliver at a health facility
2. No effect on breastfeeding
3. Safe in HIV positive women
4. Immediately reversible Long acting
5. Cost effective
6. Long acting

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Postpartum Family Planning Summary

- There are a variety of postpartum family planning methods:
  - LAM, hormonal methods, IUCD, condom, tubectomy
- Considerations of the postpartum woman:
  - Return to fertility, resumption of intercourse
  - Use of LAM and changes due to breastfeeding
- Starting FP postpartum
  - Counsel early and often – begin during ANC
  - Provide numerous opportunities
  - Make it part of routine care

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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 Post pregnancy insertion within 48 hours of delivery (PPIUCD) • Post pregnancy insertion at 4 - 6 weeks of delivery (interval) or any time after excluding Pregnancy	
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

MODULE – 2

LONG ACTING REVERSABLE CONTRACEPTIVES

INTRAUTERINE CONTRACEPTIVE DEVICE (IUCD)

Introduction

The IUCD is one of the most highly effective methods of long-acting, reversible contraception. Its effectiveness is essentially equivalent to the effectiveness of hormonal implants or male or female sterilization. For example, if 1,000 women use the Copper T 380A IUCD, only six to eight would become pregnant over the first year of use, meaning it is more than 99% effective. While the effectiveness of the Copper T with **correct use** is the same, whether it is used as a PPFP method or as an interval method, the **typical-use** effectiveness is influenced by a slightly higher expulsion rate of IUCDs inserted in the post pregnancy period. Several factors appear to influence the risk of expulsion post pregnancy. Proper insertion to achieve high fundal placement of the IUCD (more easily done immediately post pregnancy) is essential to ensuring IUCD retention.

Timings of IUCD Insertion

IUCD insertion refers to those IUCDs placed during the immediate or early postpartum period (within 10 minutes or up to 48 hours after birth) and after 4 weeks postpartum. **IUCDs inserted during the immediate post pregnancy period (i.e., post placental and intracesarean) have the highest rates of retention,** but the IUCD can be safely inserted at any time during the early postpartum period, that is, within the first 48 hours after the birth.

The types of IUCD insertion are:

- **Post placental:** *Immediately* following the delivery of the placenta (active management of the third stage of labor [AMTSL]) in a vaginal birth, the IUCD is inserted with an instrument or manually before the woman leaves the delivery room.
- **Intracesarean:** *Immediately* following the removal of the placenta during a cesarean section,the IUCD is inserted manually before closure of the uterine incision, before the woman leaves the operating theater.
- **Early post pregnancy:** Not immediately following the delivery/removal of the placenta but within 2 days/48 hours of the birth (preferably within 24 hours, such as on the morning of post pregnancy Day 1), the IUCD is inserted with an instrument during a separate procedure.

Interval IUCD: IUCD is placed after 4 weeks post pregnancy and onwards. The technique of interval IUCD is quite different from the PPIUCD insertion. **The IUCD should not be inserted between 48 hours and 4 weeks postpartum because of an overall increase in the risk of complications, especially infection and expulsion. IUCDs inserted at 4 weeks post pregnancy and beyond are considered interval IUCDs, rather than PPIUCDs.**

PPIUCD SERVICES – A New Intervention

As part of a comprehensive family planning/PPFP program, PPIUCD services should be fully integrated with MNCH services—from ANC, through intrapartum and postpartum/newborn care. Done correctly, insertion of an IUCD post pregnancy will not interfere with the conduct of routine care. And the PPIUCD must never take precedence over prompt, proper treatment of life-threatening conditions that may arise during labor, delivery and the post pregnancy /newborn period—because insertion can easily be deferred until an appropriate time when the mother and newborn are medically stable.

Basic Attributes of the IUCD and PPIUCD

Basic Attributes		Messages
General Information	**What it is**	The IUCD is a small plastic device that is inserted into the uterus.
	Effectiveness	The IUCD is more than 99% effective at preventing pregnancy, which makes it one of the most effective contraceptive methods currently available.
	Mechanism of action	The IUCD prevents pregnancy by preventing the sperm from fertilizing the egg.
	When it is inserted	For interval IUCD insertion, the device can be inserted any time it is reasonably certain the woman is not pregnant—including during menstruation. The PPIUCD can be inserted either immediately after the placenta comes out (after a vaginal birth or during a cesarean section) or in the early postpartum period (not immediate but up to 48 hours after delivery). Postplacental/immediate IUCD insertion is preferred because it has a lower rate of expulsion than early postpartum (not immediate but up to 48 hours) insertion, and it is easier/more convenient for both the woman and provider.
	Duration of protection	The IUCD begins to work immediately and the Copper T is effective for up to 12 years. It can be removed at any time, for any reason, with immediate return to fertility—which means it is a long-acting but reversible method of family planning. Women who have the IUCD inserted postpartum will have contraceptive protection in place even before they leave the birth facility.
Screening-Related Information	**Who can use it**	Most women can use the IUCD, including those who are young/ nulliparous, are **postpartum and breastfeeding**, or do hard work—as well as those who have certain medical conditions such as HIV or diabetes. It is especially well-suited to women who think they are finished having children, but want to delay sterilization until they are certain.
	Who cannot use it	Some women who should not use the IUCD include those who have a misshapen uterus (e.g., from fibroids), a high personal risk of STIs or current pelvic infection, PID, gonorrhea or chlamydia. Sometimes women develop an infection during the time of birth. These women should wait until after the infection has been treated to have the IUCD inserted. Key points are: Chorioamnionitis • Postpregnancy endometritis/metritis (Category 4) • Puerperal sepsis (Category 4) • More than 18 hours from rupture of membranes to delivery of the baby • Unresolved postpartum hemorrhage • Extensive genital trauma, the repair of which would be disrupted by postpartum placement of the IUCD
	Breastfeeding	Women who are breastfeeding can safely use the IUCD. Using the IUCD postpartum will not affect the amount or quality of breast milk.
	Protection against HIV and other STIs	The IUCD offers no protection against HIV or other STIs. Only barrier methods (e.g., the condom) help protect against exposure to HIV and other STIs. If a woman thinks she has a "very high personal risk" for certain STIs, she should not use the IUCD.

Basic Attributes		Messages
Other Considerations	**Limitations and risks**	The IUCD must be inserted and removed by a skilled provider. The PPIUCD is more convenient than interval IUCD because it will not require a separate visit or (if postplacental) a separate procedure. The IUCD has some associated risks/complications but they are rare and few, all of which can be virtually eliminated through proper screening and insertion technique: Uterine perforation is a rare occurrence and infection occurs in less than 1% of cases (**both risks may be even lower in PPIUCD**). Although it is not a problem for most women, expulsion of the IUCD is the main risk. Risk of expulsion is higher for PPIUCD insertion than for interval IUCD insertion. When the IUCD is inserted post pregnancy, about 5 to 10 women out of 100 will find that the IUCD has fallen out during the first 3 months. (Fewer IUCDs inserted during the immediate postpartum period [postplacental, intracesarean] are expelled than those inserted within 24 to 48 hours after birth.) If the IUCD is expelled, the woman should return to the clinic and have another IUCD inserted to continue protection against pregnancy. Strings may not be visible initially after postpartum insertion, which might require some additional follow-up or investigation to ensure that the IUCD has not fallen out.
	Advantages and benefits	**Safe and effective:** The IUCD is safe and effective, with a very low rate of complications. **Cost-effective and convenient:** Once it is inserted until it must be removed, it requires no additional actions, supplies or costs on the part of the woman. In most cases, only one follow-up visit to the clinic is required (at 4 to 6 weeks). **Getting a PPIUCD is especially cost-effective and convenient. The device will be placed before the woman leaves the health care facility (will not require a separate visit nor [if immediate post pregnancy] a separate procedure).** **Versatile and quick-acting:** It is both long-acting and reversible–can be used to prevent pregnancy for a short time or as long as 12 years, and fertility returns as soon as it is removed. It also begins preventing pregnancy immediately upon insertion. Reduces overall risk of ectopic pregnancy (IUCD users are much less likely to have an ectopic pregnancy than non-contraceptive users); however, if a woman becomes pregnant with an IUCD in place, she has an increased risk of ectopic pregnancy.

Basic Attributes		Messages
User Information/Instructions	**Side effects**	Copper-bearing IUCDs (e.g., the Copper T) have no "hormonal side effects" (such as those associated with DMPA injections, implants, the pill), but sometimes cause an increase in the amount, duration and painfulness of menstrual periods. These symptoms usually lessen or go away during the first few months after insertion. Often these symptoms are not noticed by postpartum women because they are still recovering from pregnancy and childbirth. And women who are breastfeeding may not yet have resumed their menstrual periods. If side effects become very bothersome to the woman, she should return to the facility for care.
	Warning signs	Warning signs for IUCD users, as follows, indicate that the woman should return to the facility as soon as possible for urgent attention and care: Foul-smelling vaginal discharge (different from the usual postpartum lochia) Lower abdominal pain, especially if accompanied by not feeling well, fever or chills Concerns that the IUCD has fallen out Signs of pregnancy
	Removal	The woman can have the IUCD removed at any time for any reason by a skilled provider. She should return to the facility to have it removed no later than 12 years after insertion. A new IUCD can be inserted at this time, if the woman desires.

Postplacental (Instrumental) Insertion of the IUCD (Copper T 380A)

(To Be Used by Learners and Trainers)

Learners: Study this tool together with the appropriate chapter in the Reference Manual to learn about and practice the correct steps needed to provide this clinical skill. Ask your colleagues to use this tool to follow along as you practice with anatomic models and gain experience with clients. Your colleagues should offer specific feedback using this tool to guide their observations.

Trainers: Use this tool when the learner is ready for assessment of competency in this clinical skill. Place a **"ü"** in case box if task/activity is performed **satisfactorily**, an **"û"** if it is **not** performed **satisfactorily**, or **N/O** if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

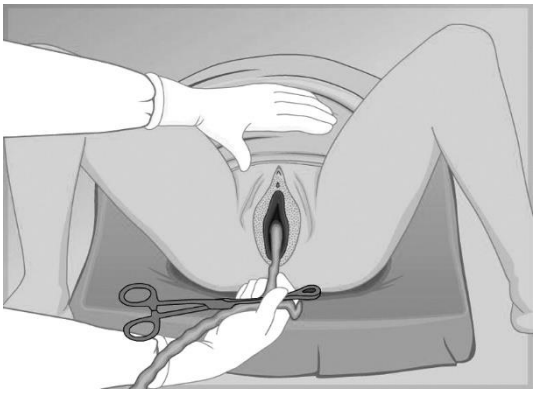
Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step, task or skill not performed by learner during evaluation by trainer

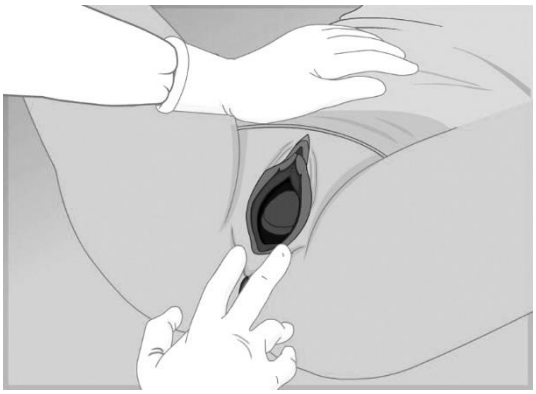
Learner _____ **Date Observed** _____

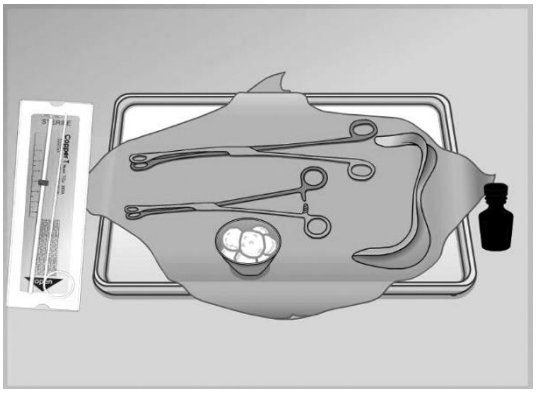
Postplacental Insertion of the IUCD Using Forceps

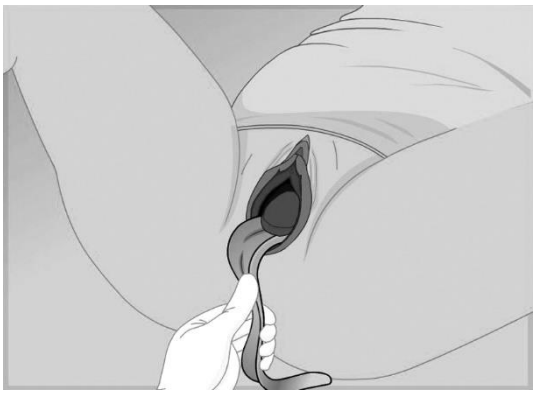
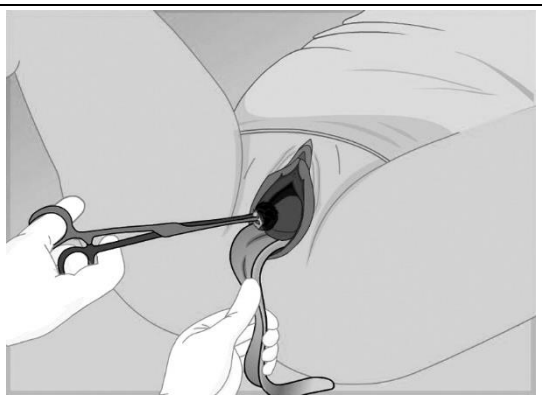
Tasks to Perform before Active Labor and Delivery		
No.	**Step**	**Explanation/Additional Guidance**
Steps 1–5	***Ensure that the woman has chosen to have an IUCD inserted immediately postpartum, and that it is an appropriate method for her.***	
1.	**Review the woman's medical record** to ensure that she has chosen the PPIUCD.	*Before approaching the woman's bedside, the provider reviews the woman's record. If she has **chosen the PPIUCD**, ensure that she has been:* Educated/counseled regarding PPFP and provided in-depth information about the PPIUCD. Screened for characteristics and conditions that would make the IUCD a poor contraceptive choice for her (i.e., according to the WHO MEC).
2.	**Ensure that she has been appropriately counseled** and screened for PPIUCD insertion.	
3.	**Greet the woman** with kindness and respect.	
4.	**Explain that you will insert the IUCD immediately following delivery** of the baby and placenta (if needed, remind her that this is the best time). Confirm with the woman that she still wants the PPIUCD.	

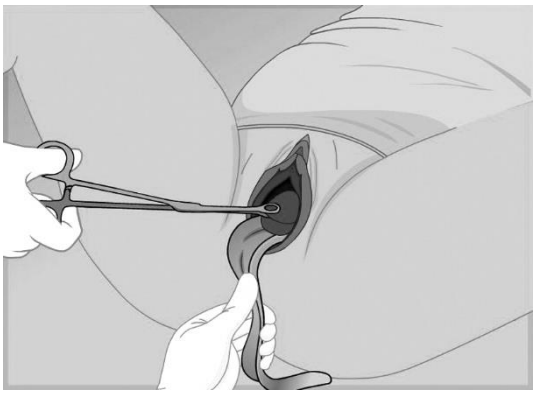
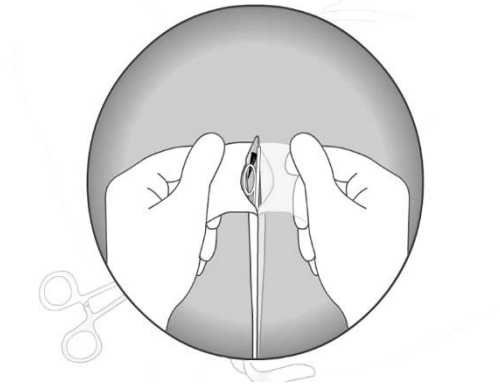
Tasks to Perform before Active Labor and Delivery		
No.	**Step**	**Explanation/Additional Guidance**
5.	**Answer any questions** the woman might have; provide reassurance, as needed. (Provide counseling, as needed.[1]) **Note:** Key messages that may be appropriate at this time are: Immediate insertion is best. She can change her mind at any time. The IUCD can be removed at any time with immediate return to fertility.	 *Talking to the woman about her choice allows her to ask questions. Women who feel supported in their decision are more likely to use the method correctly and for a longer time.*
Steps 6, 7	***Ensure that supplies/equipment and sealed IUCD are available and ready to use.***	
6.	Once the woman has confirmed that she wants the PPIUCD, **obtain a PPIUCD kit/tray** (or gather the correct sterile instruments, supplies, light source) for the procedure.	*The provider should ensure that all of the items needed are available and ready to use so that there is no unnecessary delay after the placenta is delivered. Keep the tray wrapped/covered until after the birth of the baby.*
7.	**Obtain a sterile IUCD**; keep the package sealed until immediately prior to insertion.	*The package should be kept sealed to maintain its sterility until it is absolutely certain the IUCD will be inserted (i.e., after the woman's second screening and final confirmation).*
Steps 8–11	***Perform AMTSL and the second screening.***	
8.	After labor and delivery (including performing AMTSL-Oxytocic is given within one minute of the delivery after excluding the second twin, cord is clamped, placenta delivered by controlled cord traction (CCT) with counter-traction on the fundus followed by fundal massage), **screen for delivery-related conditions that preclude insertion** of IUCD now: Prolonged rupture of membranes for more than 18 hours Chorioamnionitis Unresolved postpartum hemorrhage [Further discussed on pages 26, 27; see also Appendix G.]	 ***Remember:*** *AMTSL should be performed as usual to prevent postpartum hemorrhage.* ***The processes of AMTSL and postplacental IUCD insertion do not interfere with each other.***

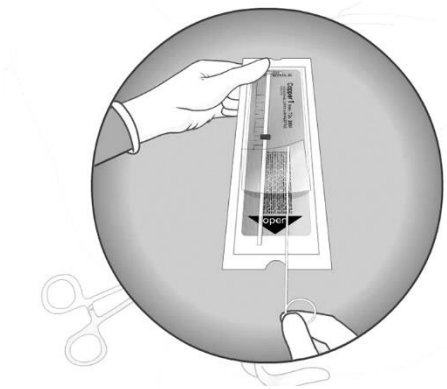
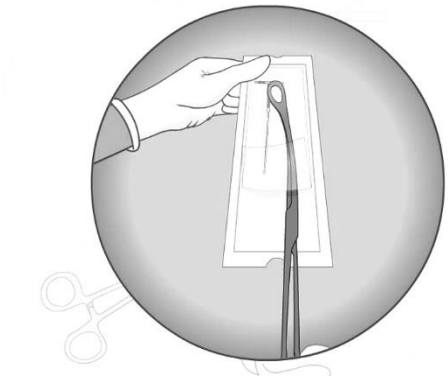
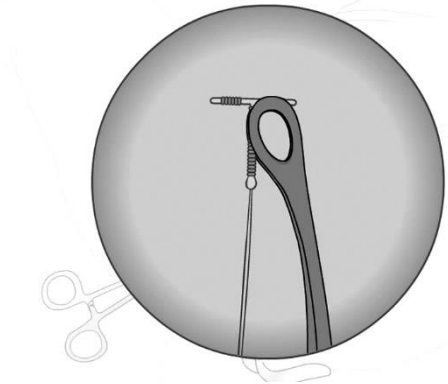
[1] If the woman has not received an initial screening, she can still have a PPIUCD. If the woman has an uneventful pregnancy and birth, it is unlikely that she has any of the conditions that would exclude the IUCD as an option. The second screening addresses the most critical concerns.

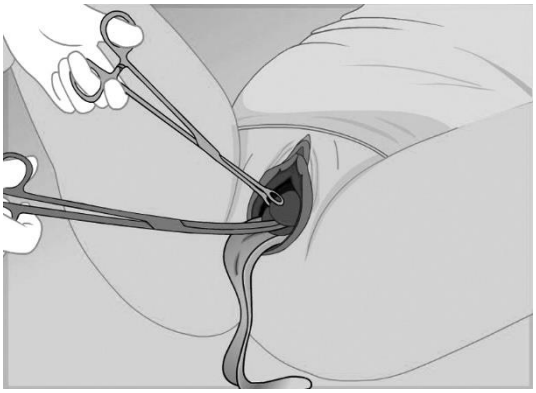
Tasks to Perform before Active Labor and Delivery		
No.	**Step**	**Explanation/Additional Guidance**
9.	Before continuing with the second screening, **perform infection prevention measures** as appropriate: The provider who manages the birth and inserts the IUCD does not need to change gloves. The provider who did not manage the birth but inserts the IUCD should ensure that AMTSL has been completed, then perform hand hygiene and put on sterile or HLD gloves.	*If the same provider does the delivery and the IUCD insertion, new gloves are not needed because the IUCD is grasped with the Kelly forceps inside the wrapper; therefore, the provider never touches the IUCD (i.e., the "no-touch" technique is used).* *However, if a different/new provider does the IUCD insertion, that provider should perform hand hygiene and put on a new pair of sterile or HLD gloves.*
10.	Inspect perineum, labia and vaginal walls for lacerations. If there are lacerations and they are bleeding, *apply a clamp to the bleeding areas to stop the bleeding and* proceed with the IUCD insertion procedure. Repair lacerations, if needed, after the procedure. [Further discussed on pages 26, 27.]	 *The provider does not need to delay insertion to repair minor lacerations.*
11.	**If any of the conditions exists**, speak with the woman and explain that now is not a safe time for insertion of the IUCD. Counsel her and offer her another PPFP method as appropriate.	*Women who cannot receive the IUCD now may be able to receive it on postpartum Day 1 or 2. Otherwise, advise the woman to return at 4 weeks postpartum for re-evaluation and possible IUCD insertion; and/or assist her in choosing another PPFP method.*
Steps 12, 13	***Let the woman know that you are about to insert the IUCD, if that is acceptable to her, and arrange instruments/supplies.***	

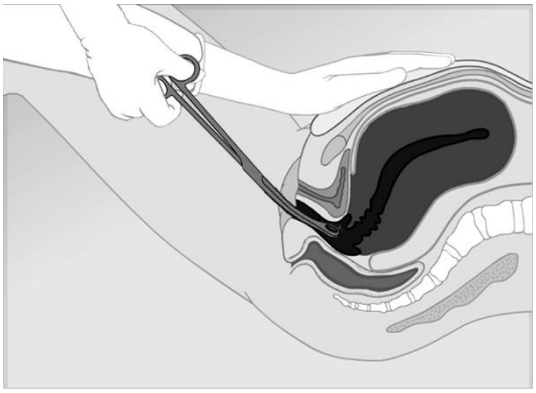
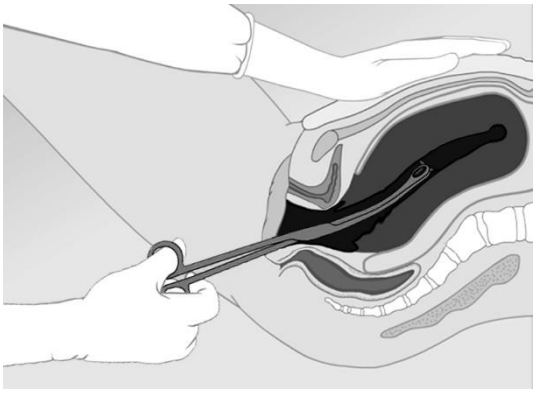
Tasks to Perform before Active Labor and Delivery		
No.	**Step**	**Explanation/Additional Guidance**
12.	If the second screening has revealed no conditions that contraindicate insertion of the IUCD at this time, **ensure that the woman is ready to have an IUCD inserted**. Answer any questions the woman might have; provide reassurance, as needed.	 *Just as the woman should be talked to and supported during labor and delivery, it is important continue these behaviors throughout the IUCD insertion procedure.*
13.	Open the PPIUCD kit/tray and **arrange insertion instruments and supplies** in a sterile field. Keep the IUCD in its sterile package to side of the sterile field. Place a dry, sterile cloth on the woman's abdomen.	 *To prevent infection, it is critical that all instruments and supplies have been properly processed and are protected in a sterile field. The IUCD should be to the side because it is in a package whose exterior is not sterile. The sterile towel on the woman's abdomen will protect the provider's hand from contamination while "elevating" the uterus.*
Steps 14–16	***Prepare the woman's vagina and cervix for insertion.***	

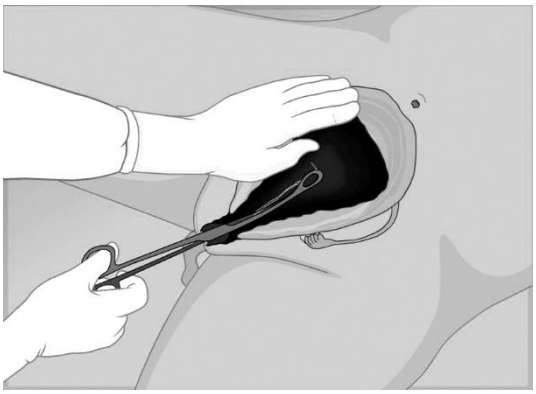
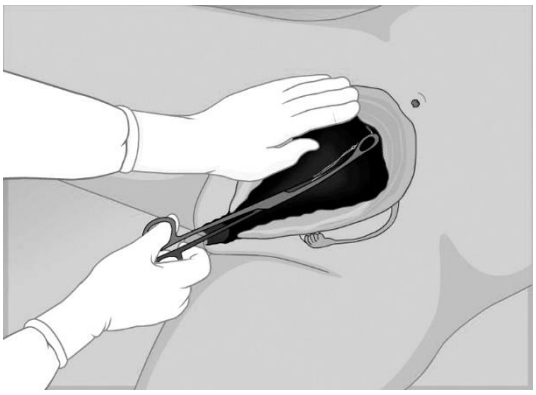
Tasks to Perform before Active Labor and Delivery		
No.	**Step**	**Explanation/Additional Guidance**
14.	Gently **insert the Simms speculum and visualize the cervix** by depressing the posterior wall of the vagina. (Note: If the cervix is not easily seen, gently apply fundal pressure so that the cervix descends and can be seen.)	 *The provider holds the Simms or other appropriate speculum in her/his left (or nondominant) hand and uses it to visualize the cervix.* *It is usually not necessary to have an assistant hold the speculum in place, but if the provider is having difficulty, an assistant may use the retractor to gently visualize the cervix.*
15.	**Clean the cervix and vagina** with antiseptic solution two times, using two gauzes (a separate gauze each time).	 *Using betadine or chlorhexadine to gently clean the cervix and edges of the vagina helps to prevent infection.*

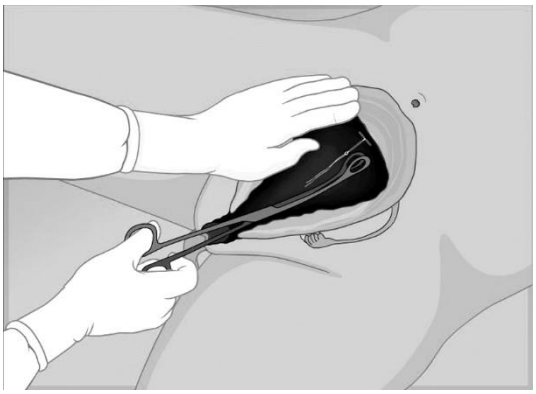
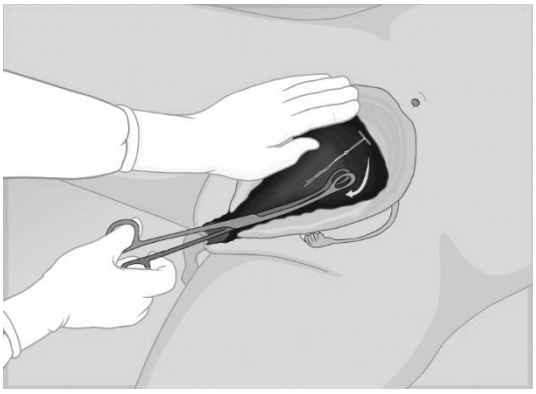
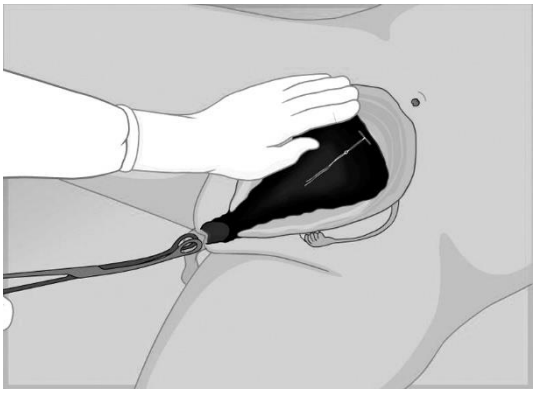
Tasks to Perform before Active Labor and Delivery		
No.	**Step**	**Explanation/Additional Guidance**
16.	**Gently grasp the anterior lip of the cervix** with the ring forceps. (The speculum may be removed at this time, if necessary.) Let the forceps out of your hand, keeping them attached to the cervix.	 *The same ring forceps that was used to clean the cervix and edges of vagina can be used to grasp the anterior lip of the cervix and apply gentle traction.*
Steps 17–19	***Open the IUCD package and remove IUCD.***	
17.	**Open the sterile package of the IUCD** from the bottom, by pulling back the plastic cover approximately one third of the way.	 *The "no-touch" technique for removing the IUCD from the package (Steps 17 to 19) helps to ensure that the IUCD remains perfectly sterile throughout the insertion procedure.*

Tasks to Perform before Active Labor and Delivery		
No.	**Step**	**Explanation/Additional Guidance**
18.	**Remove everything except the IUCD from the package:** Holding the IUCD package at the closed end with the nondominant hand, stabilize the IUCD in the package by pressing it between the fingers and thumb of the nondominant hand—through the package. With the other hand, remove the plunger rod, inserter tube and card from the package.	 *The plunger rod and inserter tube are not needed for the postpartum insertion of the IUCD. The card will not be needed until later.*
Steps 17–19	***Open the IUCD package and remove IUCD. (cont.)***	
19.	With your dominant hand, use the placental forceps to **grasp the IUCD inside the sterile package.**	 *As shown below, the IUCD should be held just at the edge of the placental forceps so that the IUCD will be easily released from the forceps when they are opened at the uterine fundus.* 
Steps 20, 21	***Insert the IUCD gently, using the "no-touch" technique.***	

Tasks to Perform before Active Labor and Delivery		
No.	**Step**	**Explanation/Additional Guidance**
20.	**Gently lift the anterior lip of the cervix** using the ring forceps, adjusted to one notch.	Lifting the anterior lip opens the cervical os to allow the IUCD to pass through.
21.	**While avoiding touching the walls of the vagina**, insert the placental forceps**—**which are holding the IUCD—through the cervix and into the lower uterine cavity. **Gently move the IUCD further into the uterus**, toward the point where slight resistance is felt against the back wall of the lower segment of the uterus. **Be sure to keep the placental forceps firmly closed**. Lower the ring forceps and gently remove them from the cervix; leave them in the sterile field.	 *Limiting the extent to which the IUCD comes in contact with the vaginal walls helps to prevent infection. Keeping the placental forceps firmly closed helps avoid dropping the IUCD midcavity during insertion. Forceps are placed in the sterile field in case they are needed again.*
Steps 22–24	***"Elevate" the uterus and advance the placental forceps toward the umbilicus—to negotiate the vagino-uterine angle—until the fundus is reached.***	

Tasks to Perform before Active Labor and Delivery		
No.	**Step**	**Explanation/Additional Guidance**
22.	**"Elevate" the uterus:** Place the base of your nondominant hand on the lower segment of the uterus (midline, just above the pubic bone with the fingers toward the fundus). Through the abdominal wall, push the entire uterus superiorly (in the direction of the woman's head). Maintain this position to stabilize the uterus during insertion.	*This maneuver, elevating the uterus, is done to smooth out the angle between the uterus and the vagina so that the instrument can easily move upward toward the uterine fundus.*  
Steps 22–24	***"Elevate" the uterus and advance the placental forceps toward the umbilicus—to negotiate the vagino-uterine angle—until the fundus is reached. (cont.)***	

Tasks to Perform before Active Labor and Delivery		
No.	**Step**	**Explanation/Additional Guidance**
23.	**Keeping the forceps closed, advance the IUCD by:** Gently moving the IUCD upward toward fundus, in an angle toward the umbilicus. Lowering the dominant hand (the IUCD/forceps-holding hand), so that the forceps can pass easily through the vagino-uterine angle. Following the contour of the uterine cavity. **If significant resistance is felt before the fundus is reached**, the provider should try repositioning the uterus (again, by gently pushing it upward) and re-attempt to advance the instrument.	 *The provider moves the instrument upward in the uterus, following an arc toward the umbilicus, to negotiate the angle between the vagina and uterus more easily. Even though the angle has been lessened by "elevation" of the uterus (Step 22), insertion still requires careful technique.* ***Note: Throughout this part of the procedure, the provider should (1) take care not to apply excessive force** (if not careful, the provider could perforate the back wall of the uterus); and **(2) always keep the instrument closed** so that the IUCD is not inadvertently dropped in the midportion of the uterine cavity.*
24.	**Continue gently advancing the forceps until the uterine fundus is reached**, when you will feel a resistance. Confirm that the end of the forceps has reached the fundus.	 *When the instrument reaches the uterine fundus, the provider will feel resistance. She/he may also be able to feel the instrument at the fundus with her/his nondominant hand through the abdominal wall.* ***Note:** An added advantage of the Kelly placental forceps is that the broad ring at the distal end makes it extremely unlikely that the forceps will perforate the uterine fundus.*
Steps 25–27	***Release the IUCD at the fundus and withdraw the forceps, being careful not to dislodge the IUCD.***	

Tasks to Perform before Active Labor and Delivery		
No.	**Step**	**Explanation/Additional Guidance**
25.	While continuing to stabilize the uterus, **open the forceps**, tilting them slightly toward midline, to release the IUCD at the fundus.	 *Keep the nondominant hand in position to maintain stabilization of the uterus. This aids in proper placement of the IUCD.*
26.	**Keeping the forceps slightly open, slowly remove them from the uterine cavity,** being careful not to dislodge the IUCD. Do this by: Sweeping the forceps to the side wall of the uterus, and Sliding the instrument against the side of the uterine wall.	 *If the forceps close and/or catch the strings of the IUCD**,** the forceps can inadvertently pull the IUCD down from its fundal position, and increase the risk of expulsion.*
27.	**Keep stabilizing the uterus until the forceps are completely withdrawn.** Place the forceps aside, in the sterile field.	 *Forceps are returned to the sterile field in case they are needed again.*
Steps 28, 29	***Examine the cervix and begin processing instruments.***	

Tasks to Perform before Active Labor and Delivery		
No.	**Step**	**Explanation/Additional Guidance**
28.	**Examine the cervix** to see whether any portion of the IUCD or the IUCD strings are protruding from the cervix. **If the IUCD or the IUCD strings are seen protruding from cervix**: Remove the IUCD using the same forceps used for the first insertion; Position the same IUCD in the forceps inside the sterile package (as in Steps 18 and 19); and Reinsert the device (repeating Steps 20–27).	*It is important to check that the IUCD is not visible at the cervical os. If it is visible, or if the strings appear to be very long, then the IUCD has not been adequately placed at the fundus and the chance of spontaneous expulsion is higher.* *The same IUCD can be reinserted if it has not been contaminated.*
29.	**Remove all instruments and place them in a 0.5% chlorine solution.**	*This is the first step in infection prevention processing. Forceps should be "open"; all instruments should be totally submerged.*
Steps 30–33	***While the woman rests, continue infection prevention measures.***	
30.	**Allow the woman to rest for a few minutes. Support the initiation of routine postpartum care**, including immediate breastfeeding as appropriate.	*The woman should rest on the table for several moments following the insertion procedure. Routine care for the mother and baby become the provider's focus now.*
31.	**Dispose of waste materials** in the appropriate container(s).	*Because this insertion has taken place immediately after a vaginal delivery, the provider should follow all routine delivery-related infection prevention practices, as well as those described earlier in this chapter.*
32.	**Process gloves prior to removal and disposal**. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out and properly dispose of them.	
33.	**Perform hand hygiene.**	
Steps 34–36	***Provide post-insertion counseling and update records.***	

Tasks to Perform before Active Labor and Delivery		
No.	**Step**	**Explanation/Additional Guidance**
34.	**Tell the woman that the IUCD has been successfully placed and provide her with post-insertion counseling**, including IUCD instructions. Tell her these instructions will be provided again prior to discharge. **Reassure her and answer any questions that she may have.**	 *IUCD instructions should be provided again by the staff of the postpartum unit to the woman, and perhaps to her family, to be certain that the instructions are understood. If possible, instructions should also be provided to the woman in writing, for her to take home.*
35.	**Record information in the woman's chart or record. Attach an IUCD card** to the chart/record, for the woman to take home with her upon discharge.	*Including essential information regarding the IUCD insertion in the woman's record (and on a card she can take with her) helps facilitate appropriate clinical follow-up, including proper timing for removing the IUCD and inserting a new one or switching to a different family planning method, as the woman desires.*
36.	**Record information in the procedure room register.**	*Basic information should also be recorded, along with contact information, in a PPIUCD register to ensure that the PPFP/PPIUCD program is being successfully implemented.*

Intracesarean Insertion

For intracesarean insertion, the woman has been counseled and prepared prior to the start of the operation, preferably during the antenatal period. She will still be in the operating theater, in the lithotomy position on the operating table. Typically, manual insertion is sufficient (as opposed to instrumental insertion) because the provider can easily reach the uterine fundus. After the placenta is removed, the provider:

Holds the IUCD between the index and middle fingers of the hand, passes it through the uterine incision and places it at the uterine fundus;

Slowly withdraws the hand, ensuring that the IUCD remains properly placed; and

Closes the uterine incision, taking special care not to incorporate the IUCD strings into the suture.

Note: The strings can be pointed toward the cervix but should NOT be pushed through the cervical canal. This helps prevent both uterine infection (caused by contamination of the uterine cavity with vaginal flora) and displacement of the IUCD from the fundus (caused by drawing the strings downward toward the cervical canal).

PPIUCD Insertion Register

Name of Health Facility: _____ **Period of (Month/Year):** _____

S. No.	Name	Client Address	Contact No.	Date of Insertion (dd)	Age	Parity	Choice for		Education Level*	Previously using FP Method**	Types of IUCD	Timing of IUCD			Gest. Age at Delivery				Membrane Ruptured		Time of Counseling			Service Provider***
							Limiting	Spacing			Copper – T	Post Placental	Post pregnancy	Trans CS	Less than 20 Weeks	21 – 32 Weeks	33 – 36 Weeks	37 – 41 Weeks	Yes	No	ANC	Early Labor	Post Pregnancy	

***** Service Provider**: A)_____ B)_____ C) _____

**** Previously using FP Method:** 1) Condom 2) Pills 3) Injectable 4) Implant 5) IUCD 6) None

*** Type of IUCD Insertion:** 1) Post Placental 2) Post Partum 3) Trans CS

PPIUCD Follow-Up Register

Name of Health Facility: _____ **Period of (Month/Year):** _____

S. No.	Reg. No.	Name, Address,	Phone No.	Counselled during			Type of IUCD Insertion				Date of Insertion (dd/mm/yy)	Follow-UP Type		Date of Follow-Up (dd/mm/yy)	Expulsion Y/N	Infection Y/N	If Pregnancy Occurs Y/N	Strings Seen(S) / Not Seen (NS)	If removed, Reason	Service Provider Sign/ Designation	Client Satisfaction (Y/N)
				Antenatal Care	Early Labor	Post Pregnancy	Post Abortion	Post Placental Within 10 min	Post Pregnancy	Tran C/S		4 – 6 Weeks	3 Months								

Service Provider: A) _____ B) _____ C) _____

PRACTICE CHECKLIST FOR IUCD COUNSELING AND CLINICAL SKILLS

(ADAPTED FOR THE **REGULAR** COPPER T 380A)

(To be used by **Participants** for practice)

Place a "✓" in case box of step/task is performed satisfactorily, an "✗" if it is not performed satisfactorily, or **N/O** if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step, task or skill not performed by participant during evaluation by trainer

STEP/TASK	
1. Greet client respectfully and with kindness.	
2. Ask woman about her reproductive goals and need for protection against sexually transmitted infections.	
3. If IUCD counseling not done, arrange for counseling prior to performing procedure.	
4. Determine that the woman's contraceptive choice is the IUCD.	
5. Review Client Assessment Checklist (see **Appendix A**) to determine if the IUCD is an appropriate choice for the client.	
6. Assess woman's knowledge about the IUCD's major side effects.	
7. Be responsive to client's needs and concerns about the IUCD.	
8. Describe insertion procedure and what to expect.	
1. Obtain or review brief medical and reproductive health history.	
2. Check that client has recently emptied her bladder and washed and rinsed her genital area, if necessary.	
3. Tell client what is going to be done and encourage her to ask questions.	
4. Palpate abdomen and check for lower abdominal, especially suprapubic, tenderness and masses or other abnormalities.	
5. Wash hands thoroughly and dry them.	
6. Put new examination or high-level disinfected surgical gloves on both hands.	
7. Arrange instruments and supplies on high-level disinfected or sterile tray.	

STEP/TASK	
8. Inspect external genitalia and palpate Skene's and Bartholin's glands.	
9. Perform bimanual exam (see **Note** above).	
9a. Perform rectovaginal exam only if indicated.	
9b. **If rectovaginal exam is performed**: immerse both gloved hands in 0.5% solution; remove gloves by turning inside out and dispose of properly; and put on new examination gloves.	
10. Perform speculum examination (see **Note** above).	
11. Collect vaginal and cervical (urethral) specimens if indicated.	
12. Perform microscopic examination if indicated.	
13. If microscopic exam done, wash hands thoroughly and dry them.	
14. If gloves need to be changed, dispose of contaminated gloves in 0.5% bleach solution and put new examination or high-level disinfected surgical gloves on both hands.	
15. Insert vaginal speculum to see cervix.	
16. Apply antiseptic solution two times to cervix, especially the os, and vagina.	
17. Gently grasp cervix with tenaculum (or vulsellum).	
18. Sound uterus without touching vaginal walls or speculum (no-touch technique).	
19. Load Copper T 380A in sterile package.	
20. Set gauge depth and insert the Copper T 380A IUCD using the **withdrawal** technique.	
21. Carefully push the inserter tube upward toward the fundus and insert the IUCD.	
22. Withdraw the white solid rod while holding the inserter tube stationary, and then remove the inserter tube.	
23. Cut IUCD strings to 3–4 cm in length.	
24. Gently remove tenaculum (or vulsellum) and speculum and place in 0.5% chlorine solution for 10 minutes for decontamination.	
25. Before removing gloves, place all instruments in 0.5% chlorine solution for 10 minutes for decontamination.	
26. Dispose of waste materials in leakproof container or plastic bag.	

STEP/TASK	
27. Immerse both gloved hands in 0.5% chlorine solution and removes gloves by turning inside out. • If disposing of gloves, place in leakproof container or plastic bag. • If reusing surgical gloves, submerge in 0.5% chlorine solution for 10 minutes for decontamination.	
28. Wash hands thoroughly and dry them.	
29. Complete client record.	
1. Discuss type of IUCD, years of effectiveness, and immediate effectiveness.	
2. Instruct client when to return for followup.	
3. Discuss possible side effects or cautions.	
4. Discuss use of condoms for dual protection against STIs.	
5. Explain to client when the IUCD should be removed.	
6. Observe client for at least 15 to 20 minutes before sending her home.	
1. Greet woman respectfully and with kindness.	
2. Ask client her reason for removal and answer any questions.	
3. Review client's reproductive goals and need for protection against GTIs and other STIs.	
4. Describe the removal procedure and what to expect.	
1. Check to be sure client has emptied her bladder and washed and rinsed her genital area, if necessary.	
2. Tell client what is going to be done and encourage her to ask questions.	
3. Wash hands thoroughly and dry them.	
4. Put new examination or high-level disinfected surgical gloves on both hands.	
5. Perform bimanual exam.	
6. Insert vaginal speculum to see cervix and IUCD strings.	
7. Apply antiseptic solution two times to the cervix, especially the os, and vagina.	
8. Grasp strings close to cervix and pull slowly but firmly to remove IUCD.	
9. Show IUCD to client.	

STEP/TASK	
10. Immerse IUCD in 0.5% chlorine solution and dispose of in leakproof container or plastic bag.	
11. Gently remove speculum and place in 0.5% chlorine solution for 10 minutes for decontamination.	
12. Before removing gloves, place all instruments in 0.5% chlorine solution for 10 minutes for decontamination.	
13. Dispose of waste materials in leakproof container or plastic bag.	
14. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning inside out. • If disposing of gloves, place in leakproof container or plastic bag. • If reusing surgical gloves, submerge in 0.5% chlorine solution for 10 minutes for decontamination.	
15. Wash hands thoroughly and dry them.	
16. Record IUCD removal in client record.	
17. Discuss what to do if client experiences any problems, and answer any questions.	
18. Counsel client regarding new contraceptive method, if desired.	
19. Help client obtain new contraceptive method or provide temporary (barrier) method until method of choice can be started.	

Post Partum Intrauterine Contraceptive Devices

Objectives

- By the end of this presentation, participants will be able to
- List the clinical criteria for provision of the IUCD in the postpartum setting
- Describe the key characteristics of the IUCD when provided postpartum
- Discuss the advantages and limitations
- Discuss the key elements of postpartum IUCD service provision

2

The Context for Postpartum IUCD

- We accept that pregnancy spacing of at least 24 months is recommended
- We recognize that there is large unmet need for postpartum FP
- We see that the new focus on Skilled Attendance at Birth gives us a unique and new opportunity to provide women with postpartum FP, then….

3

The Context for Postpartum IUCD

- The postpartum IUCD is a potential answer to issues of:
  - Variety of different methods
    - More choices increases satisfaction
  - Possibility of a long term reversible method
    - IUCD may be an alternative to tubectomy for some couples
  - Access
    - Immediate postpartum insertion is convenient for women

4

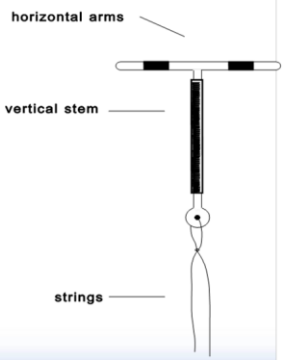
IUCDs – the Basics

- Mechanism of action
- Effectiveness and length of use
- Advantages and limitations

5

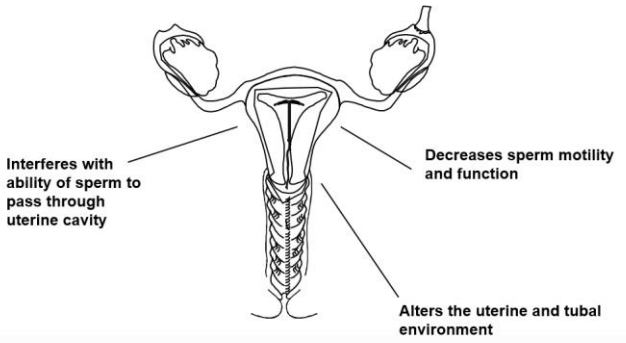
Copper T 380A

- Comes in a regular and Safe Load varieties
- Monofilament string
- Effective for up to 12 years; approved for 10 years of use



6

Mechanisms of Action



▪7

Effectiveness

- Effectiveness: > 99% effective
  - 6 – 8 pregnancies per 1 000 women in first year
- Effective immediately upon insertion
- Immediate return to fertility once removed
- Effective for 12 years
- Can be used as short-term method

▪8

Postpartum Insertion Advantages and Limitations

Advantages:

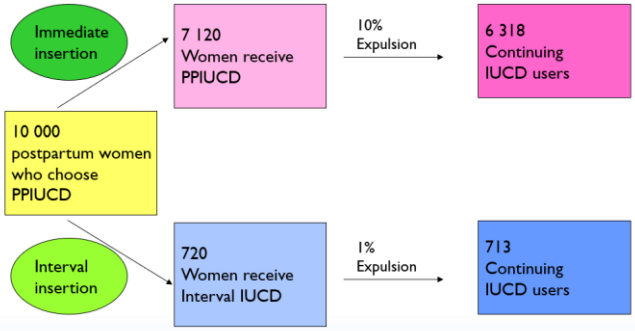
- Very effective, reversible, long-term method
- Safe, convenient and no increased risk perforation or infection
- Does not affect the quantity or quality of breast milk
- Greater coverage of population

Limitations:

- Changes in monthly bleeding pattern
- Slightly higher rate of expulsion
  - 8 – 14%
- Requires special training of providers

▪9

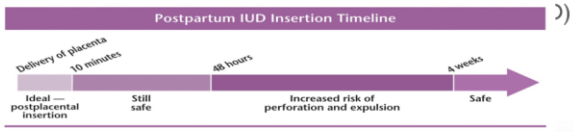
Expulsion Dilemma :Weigh Convenience and Expulsion for Public Health Impact



▪10 10

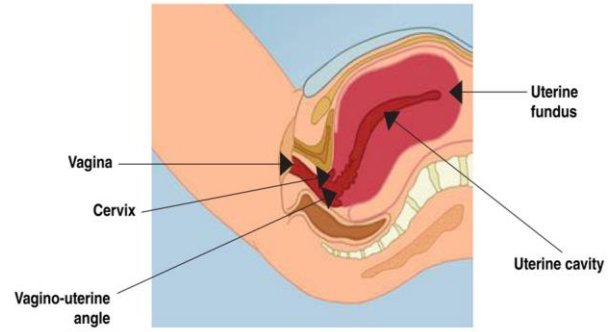
Timing of Postpartum IUCD Insertion

- IUCDs can be inserted postpartum
  - Right after birth = Postplacental (10 minutes after placenta)
  - Soon after birth = Immediate postpartum (< 48 hours after delivery)
  - During cesarean section = Transcesarean



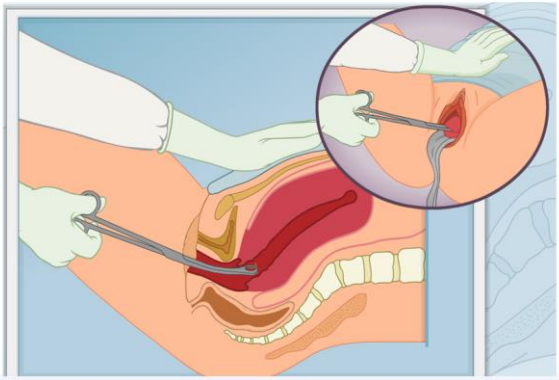
▪11

Anatomy of Postpartum Uterus



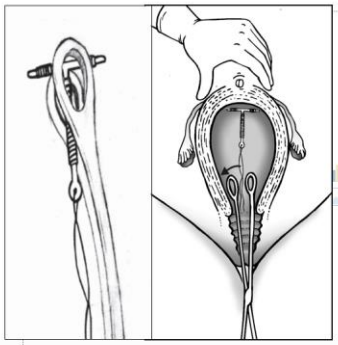
▪12

Postpartum IUD



13

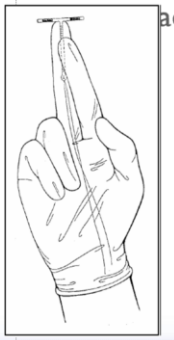
Post placental insertion



- Gently moves IUCD upward toward fundus
- Keep Kelly's placental forceps closed so IUCD does not become displaced.
- Confirm that end of placental forceps has reached the fundus.
- Open forceps and releases IUCD at fundus.
- Sweep Kelly's placental forceps to side wall of uterus.

14

Transcaesarean Insertion



- Insert IUCD through uterine incision and to fundus of uterus.
- Release IUCD at fundus of uterus.
- Slowly remove hand from uterus. Take particular care not to dislodge IUCD as hand is removed.

15

Management of Strings

- Do not cut strings while placing IUCD postpartum, postplacental or transcesarean
- During cesarean section, do NOT pass the strings through cervix; leave in lower uterine segment
- Strings will typically descend during involution and curl in posterior vaginal fornix
- Sometimes they may remain in the uterus, but this is not usually a problem
- Strings can be cut at follow-up visit
- Strings should be cut if the woman complains or they protrude from introitus

16

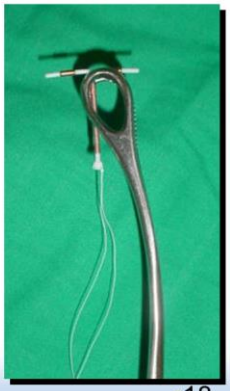
Risk of Expulsion and Timing of Insertion Postpartum

- Expulsion rates vary from 3 – 37%.
- In general, expulsion rates for PPIUCD range between 10 – 14%
- Postplacental expulsion rates are lower than postpartum expulsion rates

17

Expulsion Rates Are Related to Provider

- To reduce expulsion:
  - Use correct technique
    - place all the way at fundus
    - sweep instrument to the side
    - take care that IUCD does NOT come out during withdrawal
  - Use correct instrument
    - Kelly placental forceps (curved, longer) may be better than ring forceps
  - Insert at the correct time
    - postplacental is better



18

Myths and Misconceptions

- We must work to correct misunderstandings:
- IUCDs:
  - Rarely cause PID
  - Do not increase the risk of contracting STIs, including HIV
  - Do not make a woman infertile
  - Do not increase the risk of miscarriage when a woman becomes pregnant after the IUCD is removed
  - Do not cause birth defects
  - Do not cause cancer
  - Do not move to the heart or brain
  - Do not cause pain or discomfort for the woman during sex
  - Substantially reduce the risk of ectopic pregnancy

19

IUCDs are safe and effective

- Contraception option for postpartum women who wish to space or limit subsequent births.
- When combined with elements of high quality care:
  - appropriate screening
  - informative counseling
  - adequate infection prevention measures and careful insertion
  - proper follow-up care

20

Review of Safety of Postpartum IUCD Cochrane database review, 2010

- Main results
- No randomized controlled trials that directly compared immediate post-partum insertion with either delayed post-partum or interval insertion.
- Most studies showed no important differences between insertions done by hand or by instruments.
- Expulsion rates are highly variable.
- Lippes Loops and Progestasert devices did not perform as well as did copper devices (CuT380A).

Grimes D, Schulz K, van Vliet H, Stanwood N. Immediate post-partum insertion of intrauterine devices. The Cochrane Database of Systematic Reviews 2003, Issue 1

21

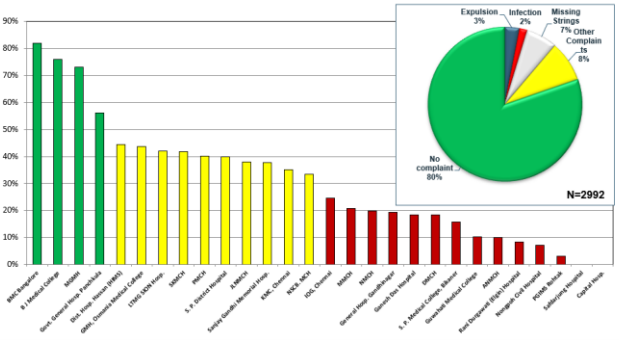
Review of Safety of Postpartum IUCD Cochrane database review, 2010

Authors' conclusions

- Immediate post-partum insertion of IUDs appeared safe and effective.
- Advantages: high motivation, assurance that the woman is not pregnant, and convenience.
- Few contraindications to method
- Expulsion rates appear to be higher than with interval insertion.
- The popularity of immediate post-partum IUD insertion in countries as diverse as China, Mexico, and Egypt support the feasibility of this approach in identifying spontaneous IUD expulsions

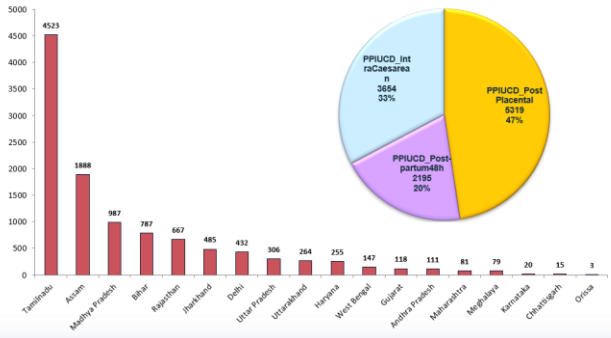
22

Follow-up of PPIUCD Acceptors-India



23

PPIUCD Experience in India Data from18 States (Jan-11 to Aug-11)



N=11,168

24

Postpartum IUCDs Summary

- Safe and convenient way to provide an effective long term method
- Part of a re-focus on health benefits of FP
- Limitations of the method are few, especially postpartum precautions
- Insertion times include postplacental, postpartum and transcesarean
- Expulsion rates are related to provider skill

25

PPIUDs: Summary (cont.)

- Insertion times include immediate postpartum (postplacental, intracesarean) and early (<48 hours) postpartum—immediate postpartum insertion has a higher retention rate
- The main disadvantage of PPIUD versus interval IUD—higher expulsion rates—is related to provider skill… and this is why we are here.
- We must work together to correct myths and misinformation about the IUD/PPIUD!

26

IMPLANON

CHECK LIST ON INSERTION OF IMPLANON

Clinical Skills Checklists

Insertion of the Implant (Implanon)
(To Be Used by Learners and Trainers)

Learners: Study this tool together with the appropriate chapter in the Reference Manual to learn about and practice the correct steps needed to provide this clinical skill. Ask your colleagues to use this tool to follow along as you practice with anatomic models and gain experience with clients. Your colleagues should offer specific feedback using this tool to guide their observations.

Trainers: Use this tool when the learner is ready for assessment of competency in this clinical skill.
Place a **"✓"** in case box if task/activity is performed **satisfactorily**, an **"✗"** if it is **not** performed **satisfactorily**, or **N/O** if not observed.

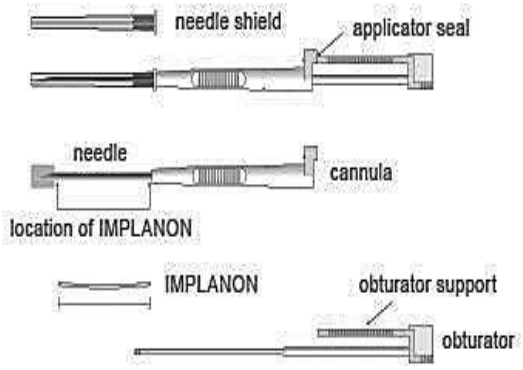
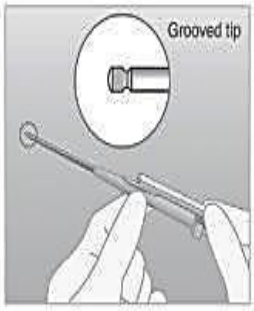
Satisfactory: Performs the step or task according to the standard procedure or guidelines

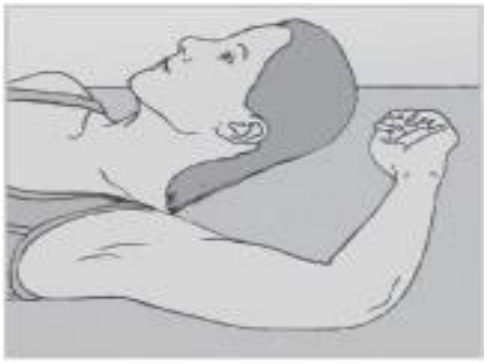
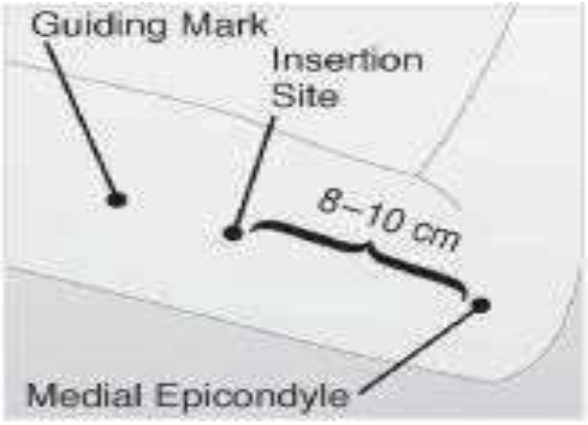
Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

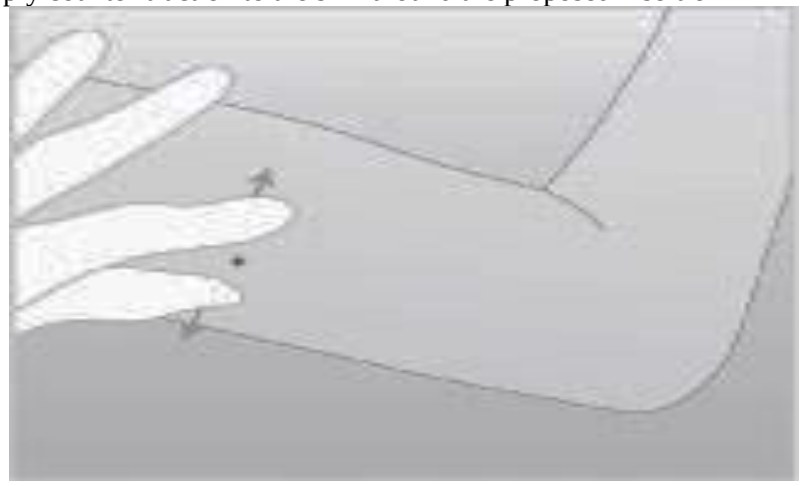
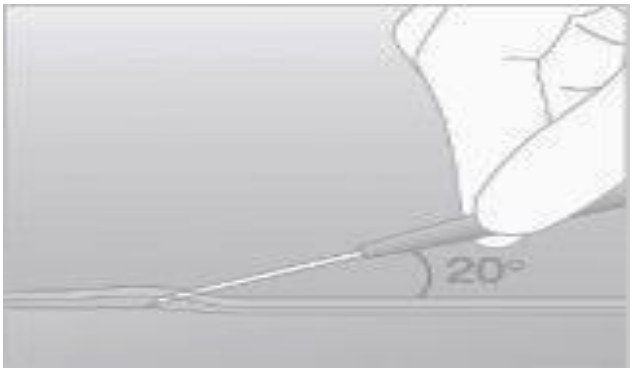
Not Observed: Step, task or skill not performed by learner during evaluation by trainer

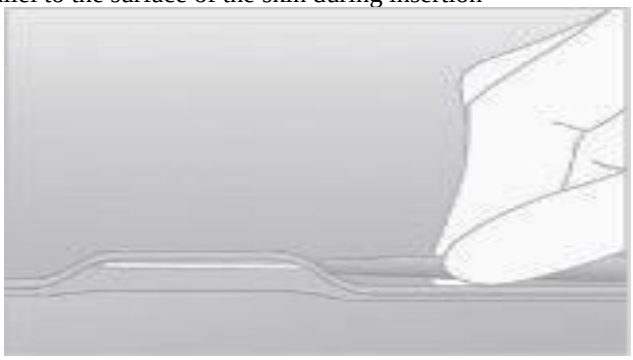
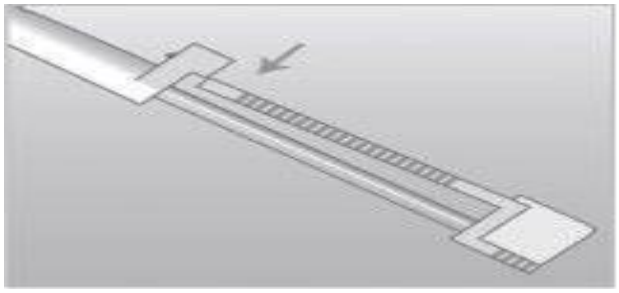
Learner_____ Date Observe: _____

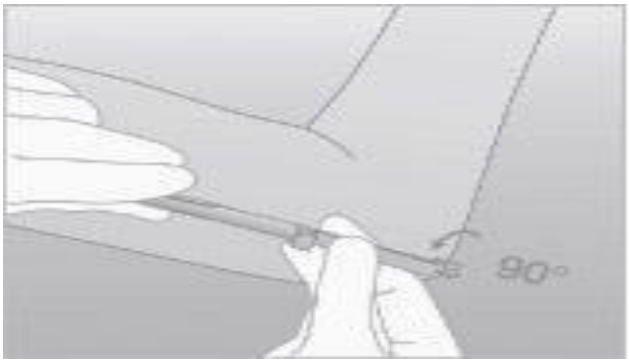
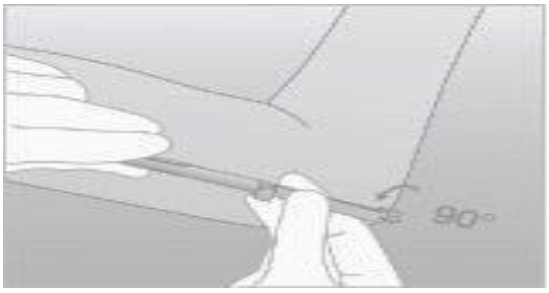
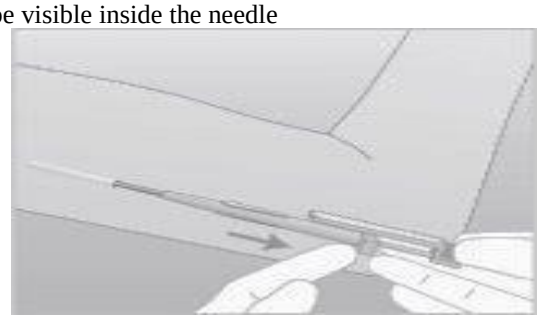
CHECKLIST FOR INSERTION OF THE IMPLANON					
STEP/TASK	**CASES**				
Pre-Insertion Tasks					
1. Reviews the woman's record to ensure that she has chosen the Implant.					
2. Checks that she has been appropriately **counseled and screened** for Implants insertion.					
3. Greets the woman with kindness and respect.					
4. **Confirms** that woman still wants Implant.					
Equipment needed					
5. A blister pack of IMPLANON.					

CHECKLIST FOR INSERTION OF THE IMPLANON					
STEP/TASK	**CASES**				
6. The following equipment is needed for IMPLANON insertion/removal: • examination table for the patient to lie on • sterile surgical 12x12 inch drape with hole in the center • 2 mosquito forcep • Small steel bowl • Kidney tray (small) • Sponge holding forcep (small size) • Sterile gloves • BP Knife handle • Pyodine solution • Sterile marker (optional) • local anesthetic (lidocaine 1% with no epinephrine) • 2 cc disposable syringe with needle • sterile gauze, Saniplast , gauze bandage					
7. Keep the implanon ready   					
Insertion procedure					
8. Confirm that the patient does not have allergies to IMPLANON, as well as the antiseptic and anesthetic to be used during insertion.					

CHECKLIST FOR INSERTION OF THE IMPLANON					
STEP/TASK	**CASES**				
9. Have the patient lie on her back on the examination table with her non-dominant arm flexed at the elbow and externally rotated so that her wrist is parallel to her ear or her hand is positioned next to her head 					
10. Wash both the hands with soap using the hand washing protocols. Air dry or use clean individual towel					
Identify the insertion site, which is at the inner side of the non-dominant upper arm about 8–10 cm (3–4 inches) above the medial epicondyle of the humerus. IMPLANON should be inserted subdermally just under the skin to avoid the large blood vessels and nerves that lie deeper in the subcutaneous tissue of the **sulcus** (this is a surface marking a hollow between the between biceps and triceps muscles) 					
11. Now wear sterile gloves in both hands.					
12. Mark the insertion site with a sterile marker. Make two marks: first, mark the spot where the IMPLANON rod will be inserted, and second, mark a spot a few centimeters proximal to the first mark (see above image). This second mark will later serve as a direction guide during IMPLANON insertion.**(OPTIONAL)**					
13. Clean the insertion site two times with an antiseptic solution i.e; Povidone iodine (Pyodene).					

CHECKLIST FOR INSERTION OF THE IMPLANON					
STEP/TASK	**CASES**				
13.Anesthetize the insertion area (for example, with anesthetic spray or by injecting 2 cc of 1% lidocaine just under the skin along the planned insertion tunnel)					
14. Set up the insertion kit or ask the assistant to open the pack and drop the applicator into the sterile area.					
15. Look for the IMPLANON rod, seen as a white cylinder inside the needle tip.					
16. Following visual confirmation, lower the IMPLANON rod back into the needle by tapping it back into the needle tip. Then remove the needle shield, while holding the applicator upright.					
17. **Note that IMPLANON can fall out of the needle.** Therefore, after you remove the needle shield, keep the applicator in the upright position until the moment of insertion.					
18. Keep the IMPLANON needle and rod sterile. If contamination occurs, use a new package of IMPLANON with a new sterile applicator.					
19. Apply counter-traction to the skin around the proposed insertion 					
20. At a slight angle (not greater than 20º), insert only the tip of the needle with the beveled side up into the insertion site 					

CHECKLIST FOR INSERTION OF THE IMPLANON					
STEP/TASK	**CASES**				
21. Lower the applicator to a horizontal position. Lift the skin up with the tip of the needle, but **keep the needle in the subdermal connective tissue.** 					
22. While "tenting" (lifting) the skin, gently insert the needle to its full length. Keep the needle parallel to the surface of the skin during insertion 					
23. If IMPLANON is placed too deeply, the removal process can be difficult or impossible. If the needle is not inserted to its full length, the implant may protrude from the insertion site and fall out.					
24. Break the seal of the applicator by pressing the obturator support 					

CHECKLIST FOR INSERTION OF THE IMPLANON					
STEP/TASK	**CASES**				
25. Turn the obturator 90º in either direction with respect to the needle 					
26. While holding the obturator fixed in place on the arm, fully retract the cannula. **Note: This procedure is opposite from an injection. Do not push the obturator. By holding the obturator fixed in place on the arm and fully retracting the cannula, IMPLANON will be left in its correct subdermal position. Do not simultaneously retract the obturator and cannula from the patient's arm** 					
27. Confirm that IMPLANON has been inserted by checking the tip of needle for the absence of IMPLANON. After IMPLANON insertion, the grooved tip of the obturator will be visible inside the needle 					
28. **Always verify the presence of IMPLANON in the patient's arm immediately after insertion by palpation.** By palpating both ends of the implant, you should be able to confirm the presence of the 40 mm rod.					
29. Apply small bandage/adhesive tape (Saniplast) over the insertion site for three to five days.					

CHECKLIST FOR INSERTION OF THE IMPLANON					
STEP/TASK	**CASES**				
30. Apply a pressure bandage with sterile gauze to minimize bruising. The patient may remove the pressure bandage in 24 hours					
Post-Insertion Tasks					
31. The applicator is for single use only. Dispose of the applicator in sharp container box					
32. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning them inside out and disposing of them.					
33. Performs hand hygiene.					
34. Complete the USER CARD and give it to the client to keep. Also, complete the client's medical record					
35. Reinforce the warning signs					
36. Explains client when to remove the adhesive tape and how to keep dry the incision area					
37. Discusses what to do if the client experiences any side effects or problems (e.g. pain, swelling, expulsion of rods)					

CHECK LIST ON REMOVAL OF IMPLANON

Clinical Skills Checklists

Insertion of the Implant (Implanon)

(To Be Used by Learners and Trainers)

Learners: Study this tool together with the appropriate chapter in the Reference Manual to learn about and practice the correct steps needed to provide this clinical skill. Ask your colleagues to use this tool to follow along as you practice with anatomic models and gain experience with clients. Your colleagues should offer specific feedback using this tool to guide their observations.

Trainers: Use this tool when the learner is ready for assessment of competency in this clinical skill.
Place a **"ü"** in case box if task/activity is performed **satisfactorily**, an **"û"** if it is **not** performed **satisfactorily**, or **N/O** if not observed.

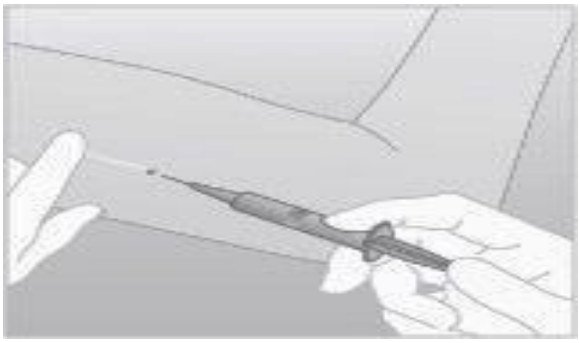
Satisfactory: Performs the step or task according to the standard procedure or guidelines

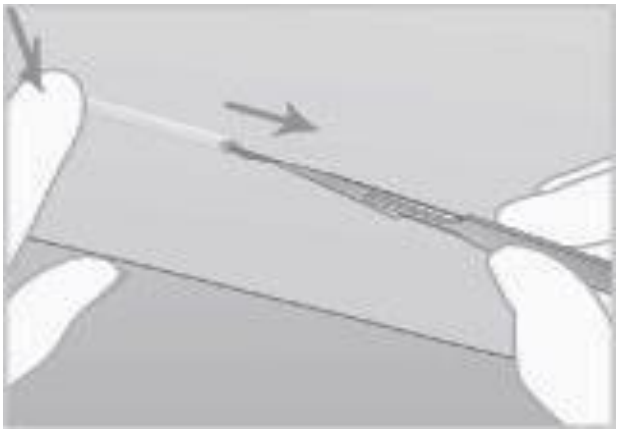
Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

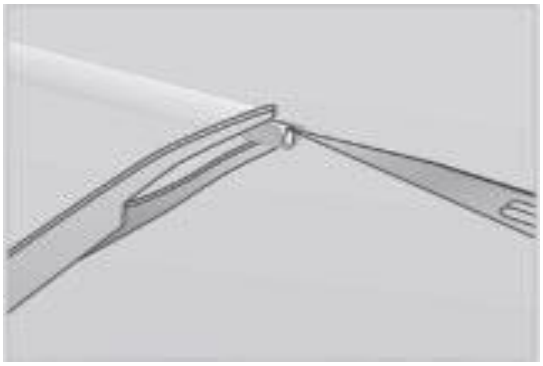
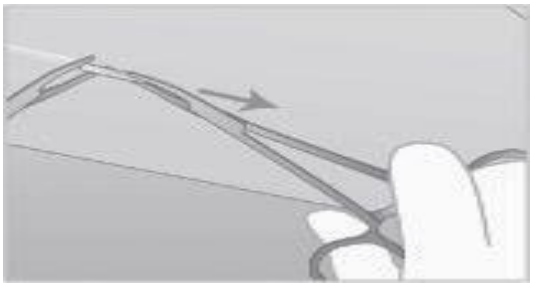
Not Observed: Step, task or skill not performed by learner during evaluation by trainer

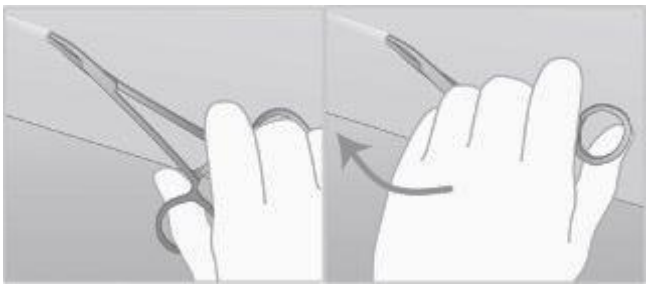
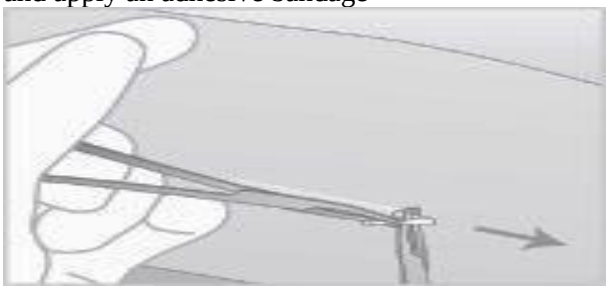
Learner _____ Date Observed _____

CHECKLIST FOR REMOVAL OF THE IMPLANON						
STEP/TASK	**CASES**					
Pre-Removal Tasks						
1. Consult the USER CARD that is kept by the patient. The arm in which IMPLANON is located should be indicated on the USER CARD						
2. Ask her about her reproductive intentions, if she needs continuing protection to make sure that she gets one before leaving the facility						
3. Find IMPLANON by palpation. If IMPLANON cannot be palpated, use either ultrasound with a high-frequency linear array transducer (10 MHz or greater) or magnetic resonance imaging to localize the implant. Consider conducting difficult removals with ultrasound guidance. Only remove a non-palpable implant once the location of IMPLANON has been established						
Equipment needed						
4. Remove IMPLANON under aseptic conditions.						
REMOVAL PROCEDURE						

CHECKLIST FOR REMOVAL OF THE IMPLANON					
STEP/TASK	**CASES**				
5.After confirming that the patient does not have any allergies to the antiseptic, wash the patient's arm and apply an antiseptic. Locate IMPLANON by palpation and mark the end closest to the elbow, for example, with a sterile marker 					
6. After determining the absence of allergies to the anesthetic agent or related drugs, anesthetize the arm, for example, with 0.5 to 1 cc 1% lidocaine at the site where the incision will be made (near the tip of IMPLANON that is closest to the elbow). Be sure to inject the local anesthetic **under** IMPLANON to keep the implant close to the skin surface. 					

CHECKLIST FOR REMOVAL OF THE IMPLANON					
STEP/TASK	**CASES**				
7. Make a 2–3 mm incision in the longitudinal direction of the arm at the tip of the implant closest to the elbow 					
8. Gently push IMPLANON toward the incision until the tip is visible. Grasp the implant with forceps (preferably curved mosquito forceps) and pull it out gently. 					

CHECKLIST FOR REMOVAL OF THE IMPLANON					
STEP/TASK	**CASES**				
9. If IMPLANON is encapsulated, make an incision into the tissue sheath and then remove IMPLANON with the forceps. 					
10. If the tip of the implant is still not visible after gently pushing it towards the incision, gently insert a forceps into the incision and grasp the implant. Turn the forceps around. 					

CHECKLIST FOR REMOVAL OF THE IMPLANON					
STEP/TASK	**CASES**				
11. With a second forceps, carefully dissect the tissue around IMPLANON and then remove IMPLANON. Be sure to remove the IMPLANON rod entirely. Confirm that the entire rod, which is 40 mm long, has been removed by measuring its length. 					
12. If the patient would like to continue using IMPLANON, insert a new IMPLANON rod immediately after the old IMPLANON rod is removed. The new IMPLANON can be inserted in the same arm, and through the same incision, or a new IMPLANON can be inserted in the other arm.					
13. After removing IMPLANON, close the incision with a butterfly closure and apply an adhesive bandage 					
14. Apply a pressure bandage with sterile gauze to minimize bruising.					
POST INSERTION TASKS					
15. Dispose of the removed implant appropriately in 0.5% chlorine solution before disposal in the dustbin.					
16. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning them inside out and disposing of them.					
17. Performs hand hygiene.					

Management of common side effects

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

SIDE EFFECT	MANAGEMENT

Irregular bleeding *(bleeding at unexpected times that bothers the client)*	• Reassure her that many women using implants experience irregular bleeding. It is not harmful and usually becomes less or stops after the first year of use.
	• For modest short-term relief, she can take 800 mg ibuprofen or 500 mg mefenamic acid 3 times daily after meals for 5 days, beginning when irregular bleeding starts.
	• If these drugs do not help her, she can try one of the following, beginning when irregular bleeding starts:
	  o Combined oral contraceptives with the progestin levonorgestrel. Ask her to take one pill daily for 21 days.
	  o 50 µg ethinyl estradiol daily for 21 days.
	• If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use

No monthly bleeding	• Reassure her that some women stop having monthly bleeding when using implants, and this is not harmful. It is similar to not having monthly bleeding during pregnancy. She is not infertile. Blood is not building up inside her. (Some women are happy to be free from monthly bleeding. • Exclude pregnancy
Heavy or prolonged bleeding	• Reassure her that some women using implants experience heavy or prolonged bleeding. It is generally not harmful and usually becomes less or stops after a few months. • For modest short-term relief, she can try any of the treatments for irregular bleeding, above, beginning when heavy bleeding starts. Combined oral contraceptives with 50 µg of ethinyl estradiol may work better than lower-dose pills. • To help prevent anemia, suggest she take iron tablets and tell her it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas). • If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use

SIDE EFFECT	MANAGEMENT
Ordinary headaches (non migrainous)	• Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever. • Any headaches that get worse or occur more often during use of implants should be evaluated.
Mild abdominal pain	• Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever. • Consider locally available remedies
Acne	• If client wants to stop using implants because of acne, she can consider switching to COCs. Many women's acne improves with COC use. • Consider locally available remedies.
Breast tenderness	• Recommend that she wear a supportive bra (including during strenuous activity and sleep). • Try hot or cold compresses. • Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever. • Consider locally available remedies
Mood changes or changes in sex drive	• Ask about changes in her life that could affect her mood or sex drive, including changes in her relationship with her partner. Give her support as appropriate. • Clients who have serious mood changes such as major depression should be referred for care. • Consider locally available remedies.
Weight changes	• Weight gain of more than 2 kg /month is alarming • Slight weight change needs reassurance and - Need to review dietary habits - Advise physical exercise
Pain after insertion or removal	• For pain after insertion, check that the bandage or gauze on her arm is not too tight. • Put a new bandage on the arm and advise her to avoid pressing on the site for a few days. • Give her aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever

SIDE EFFECT	MANAGEMENT
Infection at the insertion site *(redness, heat, pain, pus)*	• Do not remove the implants. • Clean the infected area with soap and water or antiseptic. • Give oral antibiotics for 7 to 10 days. • Ask the client to return after taking all antibiotics if the infection does not clear. If infection has not cleared, remove the implants or refer for removal. • Expulsion or partial expulsion often follows infection. Ask the client to return if she notices an implant coming out.
Abscess *(pocket of pus under the skin due to infection)*	• Clean the area with antiseptic. • Cut open (incise) and drain the abscess. • Treat the wound. • Give oral antibiotics for 7 to 10 days. • Ask the client to return after taking all antibiotics if she has heat, redness, pain, or drainage of the wound. If infection is present when she returns, remove the implants or refer for removal.
Expulsion *(when one or more implants begins to come out of the arm)*	• Rare. Usually occurs with infection. • If no infection is present, replace the expelled rod or capsule.

Severe pain in lower abdomen (suspected ectopic pregnancy or enlarged ovarian follicles or cysts)	• Many conditions can cause severe abdominal pain. Be particularly alert for additional signs or symptoms of ectopic pregnancy, which is rare but can be life-threatening.
	• In the early stages of ectopic pregnancy, symptoms may be absent or mild, but eventually they will become severe. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy:
	  o Unusual abdominal pain or tenderness
	  o Abnormal vaginal bleeding or no monthly bleeding—especially if this is a change from her usual bleeding pattern
	  o Light-headedness or dizziness
	  o Fainting
	• If ectopic pregnancy or other serious health condition is suspected, refer at once for immediate diagnosis and care.
	• Abdominal pain may be due to other problems, such as enlarged ovarian follicles or cysts.
	  o A woman can continue to use implants during evaluation.
	  o There is no need to treat enlarged ovarian follicles or cysts unless they grow abnormally large, twist, or burst. Reassure the client that they usually disappear on their own. To be sure the problem is resolving, see the client again in 6 weeks, if possible.

IMPLANON Data Collection Form

Serial Number	OPD Registration No	Name.	Husband's Name	Age	LMP	Postal Address & Phone No.	No. of living children	Gravida	Last Delivery	Previous Contraceptive Method used	Date of Implanon insertion	Counseled during (√)			Name of Counselor/ SBA	Implanon inserted by (Name)	Time of Implanon insertion (√)			Date for Follow up	Remarks
												ANC	PNC	Extended Postpartum Period			Post pregnancy after 21 days	Post Abortion	Other than Post Pregnancy		

Overview of Contraceptive Implants

2

What Are Contraceptive Implants?

- Long acting reversible contraceptive method

•3

What Are Contraceptive Implants?

- Hormonal implants are a progestin-only product; they contain no estrogen.
- The rods are inserted just under the skin (subdermally) on the inner side of a woman's upper arm by means of a minor surgical procedure with local anesthetic.
- They come in one-rod and two-rod variations, depending on the product. The main difference between products is their effective life, and the way in which you insert the rods.

Types of Implants?

- Progestin-filled rods or capsules that are inserted under the skin
- First generation implant
  - Norplant: 6-rod system, effective for at least 5 years
- Second generation implants
  - Jadelle, Sinoplant,Femplant : 2-rod system, effective for 4/5 years

Third generation implants

- Implanon: 1-rod system, effective for 3 years
- NXT Implanon 1 rod for 3 years

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Effective Life

Effective Life

- Should be inserted anytime before the expiration date (shelf life),
- The rods should be removed by the end of the final year of effective life.
- If desired, a new set of rods may be inserted in the same location immediately following removal.

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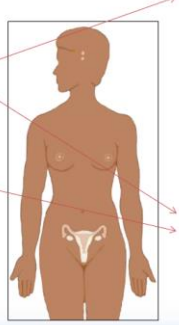
How do pregnancy prevent pregnancy

Mode of Action

- prevents ovulation by suppressing the LH surge
- Increases thickness of cervical mucus, reducing sperm penetration and motility
- Thins out endometrium where fertilized ovum gets implanted



7

How Effective Are They?

- One of the most effective and long-lasting methods:
  - Less than 1 pregnancy per 100 women using implants over the first year (5 per 10,000 women).
- Implants start to lose effectiveness sooner for heavier women:
  - For women weighing 80 kg or more, Jadelle implants become less effective after 4 years of use. These users may want to replace their implants sooner.
  - One can extrapolate the same of other implants, and may elect to remove them one year earlier than their effective life.

(Note that the protection afforded by the final year of a contraceptive implant in a heavier woman is still much more effective than most other methods.)

- Return of fertility after implants are removed: No delay.

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RELEASE OF HORMONE

- The release of the hormone is steady, with slightly higher serum levels seen in the first few weeks.
- There is a very gradual fall in serum levels over the three years of use.
- Serum levels are reduced in women who are taking liver enzyme inducing drugs such as Rifampicin, Phenytoin Sodium oral antibiotics or by gastrointestinal upsets

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Implants and STIs

Note: Because implants do not protect women from hepatitis B, AIDS, and other sexually transmitted infections (STIs), clients at risk for STIs should be encouraged to use a condoms in addition to their hormonal contraception method. This combination of barrier and hormonal contraception constitutes "dual protection" against unplanned pregnancy and STIs/HIV.

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What Are the Advantages of Contraceptive Implants?

- Very effective
- Easy to use
- Provide continuous protection for up to 3–5 years (depending on product)
- Convenient, comfortable, and reversible
- Immediate return to fertility
- Side effects resolve immediately after removal
- Few complications
- Suitable for nearly all women
- High continuation rates

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Who Can and Cannot Use Implants

Nearly all women can use implants safely and effectively, including women who:

- Have or have not had children
- Are not married
- Are of any age, including adolescents and women over 40 years old
- Have just had an abortion, miscarriage, or ectopic pregnancy
- Smoke, regardless of age or number of cigarettes
- Are breastfeeding (soon after childbirth)
- Have anemia now or in the past
- Have varicose veins
- Are living with HIV

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When to Begin

Women can begin using implants:

- Without a pelvic examination
- Without any blood tests or other routine laboratory tests
- Without cervical cancer screening
- Without a breast examination
- Even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant

Determining pregnancy

- **Pregnancy can be ruled out if any of these situations apply:**
  1. Is fully breastfeeding and has no menses and baby is less than 6 months
  2. Abstained from intercourse since last menses or delivery
  3. Had a baby in the past 4 weeks

Determining pregnancy (continued)

4. Started monthly bleeding within the past 7 days (5 days for Implanon/Implanon NXT)
5. Had miscarriage or abortion in past 7 days (5 days for Implanon/Implanon NXT)
6. Is using a reliable contraceptive method consistently and correctly
7. Negative pregnancy test or pelvic exam (if none of the above apply)

When to Initiate Implants

- First 7 days of menstrual cycle (5 days for Implanon/ Implanon NXT)
- After 7th day of menstrual cycle (5th for Implanon/Implanon NXT), rule out pregnancy and use backup method for 7 days
- Postpartum:
  - Immediately (for both breastfeeding and non-breastfeeding women)

When to initiate implants (continued)

- Post abortion or miscarriage:
  - Immediately; without backup
- Switching from another hormonal method:
  - Immediately if it was used consistently and correctly
- After using emergency contraceptive pills:
  - Insert within 7 days after start of next menstrual period (5 days for Implanon/Implanon NXT)
  - Provide with backup method during interim

Client records

Each implant client record should include the following:

- The date of the consultation and the name of the provider
- The medical and menstrual history (anything unusual should be noted)
- A record of the physical examination (anything unusual should be noted)
- Any laboratory tests performed
- A record of the counseling session and information provided
- A record of the procedure including anesthetic, technique, arm placement, and any complications
- Any medications given
- Detailed notes of the follow-up visit

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Common Side Effect: Irregular Vaginal Bleeding

First several months:

- Lighter bleeding and fewer days of bleeding
- Irregular bleeding
- Infrequent bleeding
- No monthly bleeding

After about 1 year:

- Lighter bleeding and fewer days of bleeding
- Irregular bleeding
- Infrequent bleeding

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Side Effects of Contraceptive Implants

Method	Cumulative Percentage of Women
	Jadelle (n = 600)
Vaginal discharge	24.3
Headache	23.5
Pelvic pain	16.7
Weight increase	12.0
Dizziness	10.7
Breast pain	8.3
Genital itching	8.2
Nervousness	7.7
Cervicitis	7.5
Nausea	6.7

Note: Women reported more than one condition.

Source: Sivin et al. 1997a.

Bleeding side effects

- Changes in menstrual bleeding patterns are most commonly reported side effect
- Bleeding side effects:
  - Vary for each woman and over time (e.g. irregular episodes of bleeding or spotting that may last longer than 8 days, less frequent bleeding, or no bleeding)
  - Are hard to predict
  - Are more common in the first months of use and tend to diminish over time.
- Counseling about bleeding changes is critical for continuation

How would you feel about these side effects?

Bleeding Side effects (continued)

Type of implant	Side Effect
Levonorgestrel Implants (Jadelle or Sino-implant [II])	irregular bleeding and/or frequent bleeding
Etonogestrel Implants (Implanon or Implanon NXT)	Amenorrhea and/or infrequent bleeding

Bleeding Side Effects

Problem	Action/Management	
Irregular bleeding	Reassure the client that this is common and not harmful Recommend a 5-day course of ibuprofen (up to 800 mg 3 times per day for 5 days) If no relief, offer COCs for 3 weeks If bleeding is heavy, iron tablets may prevent anemia	If side effects persist and are unacceptable to the client, help her choose another method
Amenorrhea	Reassure the client: no medical treatment necessary	

Non-bleeding side effects

Problem	Action/Management	
Common headaches	Reassure and suggest painkillers; evaluate headaches that worsened since implant initiation	If side effects persist and are unacceptable to the client, counsel about non-hormonal methods
Mild abdominal pain	Reassure; suggest pain- killers; follow-up if needed	
Breast tenderness	Recommend a supportive bra, compresses, or painkillers	
Weight change	Inform about healthy eating habits and exercise	

Non-bleeding side effects (continued)

Problem	Action/Management
Enlarged ovarian follicles or cysts	No treatment needed (unless they grow abnormally large, twist or burst)
Sever abdominal pain	Refer for immediate diagnosis and care especially if it occurs with signs of ectopic pregnancy such as abnormal vaginal bleeding, light headedness, dizziness, or fainting

Other side effects

- Headaches
- Acne
- Weight gain
- Dizziness
- Mood changes, including nervousness and depression

Possible complications

Problem	Action/Management	
Infection/Abscess at insertion site	Clean the infected area and treat the wound Give antibiotics for 7-10 days Remove if there is no improvement	Most likely to occur within the first 2 months
Difficulty with removal		Rare if inserted properly and removed by a trained provider
Expulsions (spontaneous)	If no infection is present, a fresh implant may be inserted through a new incision near the other rods or capsules to replace the one that was expelled	Rare; most occur within the first 4 months

Reasons for discontinuation

Problem	Action
Unexplained vaginal bleeding	Refer or evaluate by history and pelvic exam If an STI is diagnosed, treat with implants in place If no cause can be found, consider removing implants to make diagnosis easier
Migraines	If the client develops migraines with aura after implants are inserted, the implants should be removed Help client choose a method without hormones
Blood clots, liver or heart disease, stroke, or breast cancer	Remove implants Help client choose a method without hormones Treat or refer to a specialist for treatment

Reasons for discontinuation (continued)

Problem	Action
Heart Disease Due to Blocked or Narrowed Arteries (Ischemic Heart Disease)	A women who has one of these conditions can safely start implants, however if the condition develops while she is using implants Remove the implants or refer for removal Help her choose a method without hormones Refer for diagnosis and care if not already under care
Suspected Pregnancy	Assess for pregnancy, including ectopic pregnancy Remove the implants or refer for removal if she will carry the pregnancy to term. There are no known risks to a fetus conceived while a woman has implants in place

29

How to Prevent Client Dissatisfaction with Side Effects

- Side effects may cause concern among clients and cause early removal.
- Good counseling **before** insertion increases clients satisfaction and continuation rates.
- Careful explanation of the side effects **before** inserting implant rods, as well as **reassurance** that rarely are they a health risk, helps in decreasing concerns.

30

Correcting Misunderstandings

Implants:

- Stop working once they are removed. Their hormones do not remain in a woman's body.
- Can stop monthly bleeding, but this is not harmful. Blood is not building up inside the woman.
- Do not make women infertile.
- Do not move to other parts of the body.
- Substantially reduce the risk of ectopic pregnancy.

Effective ways to counteract rumors

- Build a personal relationship with the client.
- When a client mentions a rumor, always listen politely.
- Don't laugh or make the client feel stupid.
- Find out where the rumor came from and talk with the people who started it or repeated it.
- Explain the facts.

Effective ways to counteract rumors (continued)

- Use strong scientific facts
- Always tell the truth.
- Never try to hide side effects or problems that might occur.
- Clarify information with demonstrations and visual aids.
- Give examples of satisfied users, if they are willing to have their names used.
- Find out what else the client needs to know in order to have confidence.

MODULE – 3

NATURAL CONTRACEPTIVE METHODS

LACTATIONAL AMMENORRHOAEA METHOD (LAM)

FIVE QUESTIONS:

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?

LAM

IMPORTANT!

- BREASTFEEDING IS NOT THE SAME AS LAM!

•2

LAM Mechanism of Action

- Stimulation of nipple causes release of prolactin
- Prolactin and oxytocin result in increased milk production (which encourages suckling)
- Prolactin reduces estrogen and suppresses ovulation

•3

LAM Criteria: I

- Baby is being only breastfed
  - The baby is not receiving any other solid food or liquids; only breast milk
- Breastfeeding on demand
- Breastfeeding at least every 4 hours
  - No more than 4 hours between feeds during day
  - No more than 6 hours between feeds at night

•4

Baby is being only breastfed

- Why is this condition important?
- When baby receives any food, water, or other liquid:
  - The baby becomes full and will not want the breast milk as often.
  - The mother will not produce as much milk.
  - Infrequent suckling will reduce prolactin and lead to ovulation make the mother's fertility return

•5

Effectiveness of LAM

- LAM is 99.5% effective with consistent and correct use and more than 98% effective as typically used
- Effectiveness rates comparable to those of other modern methods

•6

Effectiveness of LAM

- LAM is 99.5% effective with consistent and correct use and more than 98% effective as typically used
- Effectiveness rates comparable to those of other modern methods

•7

LAM Criteria: 2

- Amenorrhea – Menstruation has not returned since the birth of the child
  - Bleeding during the first 2 months post-partum does not count as menstruation
  - Bleeding after 2 months post-partum can be an indication of the return of ovulation and the return of fertility

•8

LAM Criteria: 3

- The baby is less than 6 months old
  - Biologically appropriate cut-off point.
  - WHO recommends supplementing after 6 months.
  - Supplemental food will decrease suckling.

•9

Timings and types of integration

- During ANC
  - Recommended within FANC
  - Counseling on reproductive intentions, LAM, return to fertility, timing for starting contraception
  - Counseling for PPIUCD or sterilization
  - Limited association with postpartum FP use
- Immediate post-delivery
  - Opportunities during mother/baby checks/discharge
  - Counseling on reproductive intentions, return to fertility, timing for starting contraception
  - PPIUD and sterilization
  - Progestin-only for non-breastfeeding women
  - LAM
  - Stronger association with starting FP use by offering methods

•10

Timings and types of integration

- During ANC
  - Recommended within FANC
  - Counseling on reproductive intentions, LAM, return to fertility, timing for starting contraception
  - Counseling for PPIUCD or sterilization
  - Limited association with postpartum FP use
- Immediate post-delivery
  - Opportunities during mother/baby checks/discharge
  - Counseling on reproductive intentions, return to fertility, timing for starting contraception
  - PPIUD and sterilization
  - Progestin-only for non-breastfeeding women
  - LAM
  - Stronger association with starting FP use by offering methods

•11

Timings and types of integration: Extended postpartum period

- 1- 6 weeks postpartum consultation(s)
  - Opportunities during mother/baby checks
  - Counseling on reproductive intentions, return to fertility
  - Reinforce LAM, plan transition to other modern methods
  - If ending LAM, transition to IUD, pills, injectable, implant
  - Strong association with FP use
- Child health consultations
  - Opportunities during health / immunization visits
  - Referral or provision of method
  - Some evidence of association with FP use

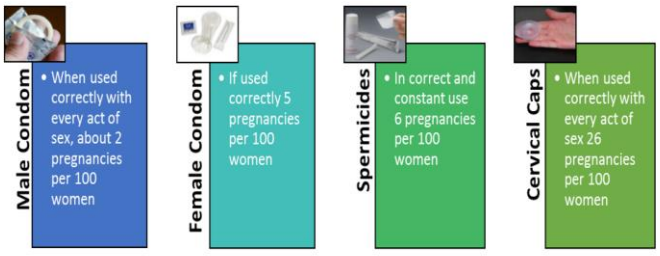
•12

Barrier Methods

Click to add subtitle

Barrier methods

- These methods include:
- Male and female condoms,
- Spermicides,
- Diaphragms, and
- Cervical caps.
-
- Male condoms are the commonly used method in Pakistan, the rest of the methods are detailed for knowledge purposes



Female condoms

-
- The Female Condom (FC) is a viable option for women to protect themselves from pregnancy and STIs including HIV. Female condom is the only currently available method which woman can initiate and in some ways control, which provides dual protection from both unwanted pregnancy and STIs including HIV.
-
- The female condom is a thin, soft, loose-fitting polyurethane plastic pouch-like device that lines the vagina. It has two flexible rings, an inner ring at the closed end, used to insert the device inside the vagina and hold it in place, and an outer ring which remains outside the vagina and covers the external genitalia.
-

Cervical Caps:

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

Spermicide:

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

Diaphragm:

- A soft latex cup that covers the cervix. Plastic and silicone diaphragms may also be available.
- The rim contains a firm, flexible spring that keeps the diaphragm in place. Used with spermicidal cream, jelly, or foam to improve effectiveness.
-
- Most diaphragms come in different sizes and require fitting by a specifically trained provider. A one-size-fits-all diaphragm is becoming available. It does not require seeing a provider for fitting. Works by blocking sperm from entering the cervix; spermicide kills or disables sperm. Both keep sperm from meeting an egg.

Medical Eligibility

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

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?

MODULE – 4

HARMONAL & PERMANENT METHODS

HARMONAL METHODS

PILLS

CASE STUDY

(Group Activity)

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?

COMBINED ORAL CONTRACEPTIVE PILLS

OBJECTIVES

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

1. Know mechanism of action, various types, efficacy, contraceptive and non-contraceptive advantages and limitations of the COCs
2. Use the MEC in helping the client choose the best suitable method for her
3. Understand the side effects of OCPs and how to manage them
4. Demonstrate effective counselling skills in order for a woman or couple to understand their reproductive options, choose OCPs, and use the chosen method safely and effectively.
5. How to deal with missed pill and their protocol

MECHANISM OF ACTION

1. Inhibition of ovulation by suppressing FSH and LH and hence no ovulation
2. Alternation of endometrium to make it unsuitable for implantation even if the ovum is fertilized.
3. Changes in cervical mucus, which make it hostile to the sperm.

IMPORTANT HEALTH BENEFITS

Fertility-related benefits:
1. Prevention of pregnancy
2. Offers protection against ectopic pregnancy

Menstrual benefits:
1. Menstrual cycle stabilization
2. Lesser iron deficiency anaemia due to lighter menstrual cycles
3. More regular menstrual cycles
4. Less dysmenorrhea
5. Less severe premenstrual symptoms

Protection from some cancers:
1. Protection against cancers e.g. endometrial and ovarian cancer
2. Protection against benign diseases e.g. benign breast diseases like fibrocystic and fibroadenomatosis disease decreased by 50-70%

1. COC can be started within 3-6 weeks after birth, in the absence of the menstruation, if the woman is not breastfeeding (during the breastfeeding period estrogen pills are not recommended due to the fact that it can reduce the quantity and the quality of the maternal milk)
2. COC administration can be started by women which are not breastfeeding on the occasion of any menstruation, with the previous mentioned precautions;
3. After 6 months from birth, if the woman continues to breastfeed, she hasn't had menstruation and she has correctly used LAM.

AFTER ABORTION ADMINISTRATION

Within the first 7 days after a complications-free abortion upon request or a 1st trimester or 2nd trimester spontaneous abortion after 7 days from abortion, in any moment before the menstruation reappears if the woman is sure that she is not pregnant; in this situation she will avoid sexual contacts or she will use an additional protection method within the first 7 days after starting to use COC;

1. Immediately after the woman has interrupted using another contraceptive method (it isn't necessary to wait for her next menstruation in order to start using COC)
2. She will either reconsider the contraceptive method, if the treatment is long-term
3. She will either continue taking the pills, but she will use an additional protection method (the same as in the case of omitted pills).

When to Discontinue COCP

- At least 4w before major surgery
- First onset of migraine with aura
- Pain or swelling in legs
- Chest pain with breathlessness or haemoptysis
- Cigarette smoker >35y
- Age 50y

GUIDELINES FOR INSTRUCTING ON USE OF COCS

1- Give pills	1. Give up to 1 year's supply (13 packs) depending on the woman's preference and planned use
2- Explain pill pack	1. Show which kind of pack—21 pills or 28 pills with 28-pill packs, point out that the last 7 pills are a different colour and do not contain hormones (some brands may differ). 2. Show how to take the first pill from the pack and then how to follow the directions or arrows on the pack to take the rest of the pills.
3- Give key instruction	1. Take one pill each day until the pack is empty. 2. Discuss cues for taking a pill every day. Linking pill taking to a daily activity such as cleaning her teeth may help her remember. 3. Taking pills at the same time each day helps to remember them. It also may help reduce some side effects.
4- Explain starting next pack	1. 28-pill packs- When she finishes one pack, she should take the first pill from the next pack on the very next day. 2. 21-pill packs- After she takes the last pill from one pack, she should wait 7 days no more and then take the first pill from the next pack. 3. It is very important to start the next pack on time. Starting a pack late risks pregnancy.
5- Provide backup method and explain use	1. Sometimes she may need to use a backup method, such as when she misses pills. 2. Backup methods include abstinence, male or female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. 3. Give her condoms, if possible. 4. If she misses 3 or more hormonal pills, she can consider ECPs.

WHAT TO DO IF YOU MISS TAKING THE PILL

MISSED COC	SUGGESTED ACTION
Key message	1. Take a missed hormonal pill as soon as possible. 2. Keep taking pills as usual, one each day. (She may take 2 pills at the same time or on the same day.)
Missed 1 or 2 pills? Started new pack 1 or 2 days late?	1. Take a hormonal pill as soon as possible. 2. Little or no risk of pregnancy.
Missed pills 3 or more days in a row in the first or second week? Started new pack 3 or more days late?	1. Take a hormonal pill as soon as possible. 2. Use a backup method for the next 7 days. 3. Also, if she had sex in the past 5 days, she can consider ECPs
Missed 3 or more pills in the third week?	1. Take a hormonal pill as soon as possible. 2. Finish all hormonal pills in the pack. Throw away the 7 no hormonal pills in a 28-pill pack. 3. Start a new pack the next day. 4. Use a backup method for the next 7 days. 5. Also, if she had sex in the past 5 days, she can consider ECPs

SIDE EFFECTS AND MANAGEMENT

Nausea/ Vomiting	Recommend the administration of pills during meals or in the evening, before going to bed
Inter-menstrual bleeding/ spotting	If the woman has started taking COC recently, recommend that she continue administering the pills; Verify whether the pills are being taken at the same time each day Explain that these phenomena naturally disappear after the first 3 months. Verify the correctness of the administration and ask her if she has had diarrhea, if she has vomited or if she has taken medicine (Rifampin, Griseofulvin, and seizure medication) Verify the existence of gynecological disorders or conditions.
Slight headache	Measure the arterial pressure Treat with analgesics and re-evaluate after one month. Verify whether the headache has installed after she has started taking COC. Suggest taking ibuprofen, aspirin, paracetamol, or other non-steroidal anti-inflammatory drug
Breast tenderness	Explain to the woman that this happens often at the beginning when taking COC (verify whether the woman is used to sleeping faced down; these women are usually the ones who complain). Verify to see if she is pregnant. Examine the breasts for nodules and galactorrhea.
Slight body weight gain	Weigh the woman. Ask if she has changed her lifestyle, if she has been eating more than before she started taking COC. Explain that due to the COC, the alimentary appetite can increase. Explain that during the first months, even if they do not eat more than before, most women may notice a slight weight gain, of around 1-2 kg, but that the weight will return to its initial value, if the woman will eat the same as before
Amenorrhea	Ask if she has had any bleeding (she could present a reduced menstrual bleeding, which she may not consider menstruation). Check whether the woman has correctly taken COC (omitting them might increase the risk of becoming pregnant; taking the pills without taking the break might lead to amenorrhea). Verify whether the woman is pregnant.

CASE STUDIES

29 years old woman, having a child, requests a modern and very sure contraceptive method, other than the pill, because she has taken contraceptive pills and however became pregnant and she has also noticed that she had gained weight (3-4 kg). How will you approach the case?

32 years old woman, with two children with ages of 5 and 2, request a contraceptive which would eventually also adjust her menstrual cycle as it is irregular, especially after her last delivery. You discover a systolic murmur in the mitral focus. Possible approaches/alternatives?

PROJESTIN-ONLY PILLS (POPs)

EXERCISE

- Can a woman who is breastfeeding safely use POPs?

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

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

- Do POPs cause cancer?

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

Progestogen Only Contraceptive Pill

Generations of POP

- 1st: norethindrone
- 2nd: norethisterone (*micronor*), levenorgesterol (*microval*)
- 3rd: desorgestrel (*cerazette*), gestodene

Mode of Action

- Cervical mucus changes
- Endometrial changes
- Variable effect on ovulation

Who is Eligible for POP?

- Lactation
- Older women and smokers
- Diabetes/obesity
- Hypertension
- Women's choice
- Oestrogen related contraindications

Who can and cannot use the mini-pill

Most women can safely use the mini-pill

But usually cannot use the mini-pill if:

- Breastfeeding 6 weeks or less

- May be pregnant

- Some other serious health conditions

Who can and cannot use the mini-pill

The Mini-Pill

Most women can safely use the mini-pill.

But usually cannot use the mini-pill if:

- Breastfeeding 6 weeks or less
- May be pregnant
- Some other serious health conditions:

Usually cannot use with any of these serious health conditions (if in doubt, check handbook or refer)

"We can find out if the mini-pill is safe for you. Usually, women with any of these conditions should use another method."

- Give pills and tell her to start when baby is 6 weeks old.
- If in doubt, use pregnancy checklist in Appendix 1 or perform pregnancy test.
- Ever had breast cancer.
- Serious liver disease or jaundice (yellow skin or eyes).
- Has blood clot in lungs or deep in legs. Women with superficial clots (including varicose veins) CAN use the mini-pill.
- Takes pills for tuberculosis (TB), fungal infections, or epilepsy (seizures/fits).
- Most women who have had stroke or problems with heart or blood vessels CAN use the mini-pill.

Next Move:

Client able to use the mini-pill: Go to next page.

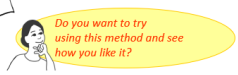
Client unable to use the mini-pill: Help her choose a method without hormones.

MP 2

Possible side-effects

If you choose this method, you may have some side-effects. They are not usually signs of illness.

- Common (when not breastfeeding): irregular bleeding, spotting, no monthly bleeding
- Less common: headache, tender breasts, dizziness



The Mini-Pill: ible side-effects

If you choose this method, you may have some side-effects. They are not usually signs of illness.

- Common (when not breastfeeding): irregular bleeding, spotting, no monthly bleeding
- Less common: headache, tender breasts, dizziness

- *"It can take time for the body to adjust."*
- Different people have different reactions to methods.

Discuss:

- *"If these side-effects happened to you, what would you think or feel about it?"*
- *"What would it mean to you?"*
- *"What would you do?"*
- Discuss any rumours or concerns. See Appendix 10 on myths.

- Most breastfeeding women do not have regular periods and so often do not notice effect of mini-pills on menstrual bleeding.
- In non-breastfeeding women, irregular periods, spotting, light bleeding between periods, and amenorrhoea (no bleeding) are common and normal.
- Tell client: skipping pills may make bleeding side-effects worse and risks pregnancy.

- Can take aspirin, paracetamol or ibuprofen for headache.

- Invite client to return for help any time.
- *"It is okay to switch methods any time."*
- For dealing with side-effects, see Returning Client tab.

Next Move:

Does client understand side-effects? Is she ready to choose method?

If she has decided to use method, go to next page.

If not, discuss further or consider other methods.

MP 3

INJECTABLES

Case Study
(Group Activity)

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?

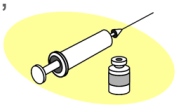
Naima has come back to the clinic for a reinjection. You check her records and note that she is 2½ weeks late. Naima reports that she experienced two episodes of 1–2 days of spotting in the past 2 months. Moreover, Naima is complaining that she has gained about 1.5 kilograms since she started the PIC.

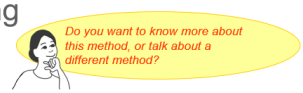
- What should you Naima advise about spotting?
- Does her spotting need to be treated using other hormones? When is it appropriate to give additional hormones?
- How should you address the weight gain?
- What about the delay in returning for injection? Should you give her the injection? Will she need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

Injectables

Long-Acting Injectable

- An injection every 2 or 3 months, depending on type
- Very effective
- Often takes longer to get pregnant after stopping
- Very safe
- Changes monthly bleeding
- No protection against STIs or HIV/AIDS





Mechanism of Action of DMPA

- DMPA acts in the following way:
- Inhibiting ovulation-by suppressing mid cycle peaks of LH and FSH
- Thickening of cervical mucus - due to depletion of oestrogen. The thick mucus prevents sperm penetration into the upper reproductive tract.
- Thinning of endometrial lining-due to high progesterone and depleted oestrogen,making it unfavourable for implantation of fertilized ovum.

Effectiveness

- It is a highly effective contraceptive method. With a standard regimen the first year effectiveness is 99.7% when the drug is used correctly; however the effectiveness decreases in typical use. The perfect use failure rate of 0.3% is lower in comparison to 0.5% of female sterilization, 0.8% of IUCD and 3% of combined oral contraceptives

Limitations

- DMPA is an appropriate long acting contraceptive method suitable in majority of the women, however it has some limitations like
- It doesnotprotectagainstSTI/RTIandHIVinfection.
- Once takenitsactioncannotbestoppedimmediately.
- It causes changes in the menstrual cycle and bleeding due to its inevitable effect on a woman's body hormones.
- Ithastoberepeatedeverythreemonthstoachievedesiredcontra ceptiveeffectiveness.
- Returnoffertilitytakes7-10monthsfromdateoflastinjection(Average4-6monthsafter3month.

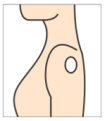
Limitations

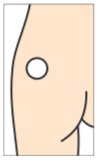
- DMPA is an appropriate long acting contraceptive method suitable in majority of the women, however it has some limitations like
- It does not protect against STI/RTI and HIV infection.
- Once takenitsactioncannotbestoppedimmediately.
- It causes changes in the menstrual cycle and bleeding due to its inevitable effect on a woman's body hormones.
- It has to be repeated every three months to achieved desired contraceptive effectiveness.
- Return of fertility takes 7-10 months from date of last injection (Average 4-6 months after 3 months.)

Return to Fertility

- DMPA may cause a delay in the return of fertility. Since one injection is effective for 3-4 months, the return of fertility takes 7-10 months from date of last injection (average 4-6 months after 3 months effectivity of last injection is over).
- Studies have also shown that ovulation/fertility return is not affected by duration of DMPA use or women's age.

Injection Sites





Post Injection Instruction to the Client

- Instruct client not to massage or apply hot fomentation to the injection site as the drug needs to stay there for a long time and release very slowly for the next three months.
- Instruct client that she must come after 90 days for a repeat injection and give her the scheduled date. Hand over the DMPA Client Card to her after explaining its content to her.
- Informtheclientthattheeffectofinjectionisimmediateifgivenbetwee n'dayone'to'dayseven' of her menstrual cycle. But if given after 'day seven' a backup contraceptive method (e.g. condom) should be used for 7 days.
- Assure the client that she is welcome to come back any time, if she feels any problem, wants another method, has a major menstrual change, has a major change in health status or thinks might be pregnant.
- Ensurepostinjectioncounselling.

FAQs

Can a woman who is at risk of Sexually Transmitted Infections (STIs) use DMPA?

Yes, women at risk for STIs can use DMPA. However, it does not protect against STI. A user of DMPA who may be at risk for STIs should be advised to use condoms correctly and consistently during every sexual intercourse.

If a woman does not have monthly bleeding while using DMPA, does this mean that she is pregnant?

No, most women using DMPA will not have monthly bleeding after getting her injections on time and there are less chances of becoming pregnant. Reassurance to client may help but if required offer her pregnancy test. Despite all this if she so desires help her choose another method.

Can a woman who is breastfeeding safely use DMPA?

Yes, this is a good choice for a breastfeeding mother. DMPA is safe for both the mother and the baby starting as early as 6 weeks after childbirth. It does not affect the quality and quantity of milk production.

How much weight do women gain when they use DMPA?

Women may gain on an average 1-2 kg per year when using DMPA. This weight gain may be related to age, diet or sedentary lifestyle. At the same time, some users of DMPA lose weight or have no significant change in weight.

Does DMPA cause abortion?

No, research on DMPA, indicates that it does not disrupt an existing pregnancy nor cause an abortion. DMPA should not be used to try to cause abortion.

Does DMPA make a woman infertile?

No, DMPA does not make a woman infertile however there may be delay in regaining fertility after discontinuing DMPA.

CHECKLIST FOR DMPA I/M CLINICAL SKILLS

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

Place a "ü" 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.		

Checklist for DMPA-SC Injection

This checklist should be used to evaluate DMPA-SC injection by service provider.

For each injection, tick the box(☐) for each step that is done correctly. If a step is done incorrectly or not done, write a **U** (unsatisfactory) in the box.

Provider Type: Lady Health Worker □ Lady Health Visitor □ Family Welfare Worker □ Family Welfare Assistant □

Provider participant ID: _____

Observer Name: _____ Date: _____

Injection steps	Observations					
	1	2	3	4	5	6
1. Washes hands						
2. Selects an injection site and cleans if needed.						
3. Opens the DMPA-SC pouch by tearing the notch.						
4. Holds the device by the port while mixing.						
5. Mixes the liquid by shaking the device vigorously (about 30 seconds).						
6. Checks to make sure the liquid is mixed and there is no damage to the device.						
7. Holds the device with the needle pointing upward during activation.						
8. Holds the device by the port while activating.						
9. Pushes the needle cap and port together to activate the device for use.						
10. Pinches the skin at the injection site to form a "tent".						
11. Holds the port of the device while inserting the needle.						
12. Inserts the needle into the tent of skin between the thumb and forefinger.						

13. Inserts the needle at a downward angle.						
14. Inserts the needle completely so that the port is in full contact with the skin.						
15. Moves fingers from the port to the reservoir while still pinching the skin.						
16. Presses the reservoir slowly to inject—taking about 5 to 7 seconds.						
17. Removes the device from the injection site while still pinching skin.						
18. Does not rub the injection site.						
19. Places the used device immediately into a sharps disposal container without replacing the needle cap.						
20. Circles today's injection date in calendar (and client booklet/card).						
21. Counts 13 weeks from today's injection date.						
22. Circles the next injection date on the calendar (and client booklet/card).						

EMERGENCY CONTRACEPTIVE

CASE STUDY

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.

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?

Emergency Contraception

Who May Need Emergency Contraception

- After voluntary sexual intercourse that took place with no contraceptive protection
- After incorrect or inconsistent use of regular contraceptive methods or when there has been an accidental failure of other contraceptive methods
- when a woman has been a victim of sexual assault and has had no contraceptive protection.

2

3

Method or User Failure

- Condom breakage or slippage;
- Miscalculation of the infertile period when using periodic abstinence or failure to abstain from sexual intercourse during the fertile days;
- Expulsion of an IUD;
- Failed coitus interrupts, when ejaculation has occurred in the vagina or on the external genitalia;
- Failure to take oral contraceptives for more than 3 days in a row;
- Being late for a contraceptive injection
- When not using any contraception
- In case of Contraceptive failure or misuse including:
  - Condom rupture or slippage
  - Missed pills
  - Late for an injection
  - IUD expulsion
  - In victims of sexual assault

4

Methods of Emergency Contraception

- Increased doses of combined oral contraceptives (COCs) containing ethinylestradiol and levonorgestrel (Yuzpe method)
- High doses of progestogen-only pills containing levonorgestrel
- Ulipristal acetate
- Copper-releasing IUDs

Adapted from WHO/FRH/FPP/98.19

Benefits of Emergency Contraception

- Safe and effective
- Can be prescribed beforehand with regular contraceptive
- Can be used after an unprotected intercourse
- Prevents unwanted pregnancy

6

Mechanism of Action

- Emergency contraceptive pills can inhibit or delay ovulation by 5-7 days
- Emergency contraceptive pills inhibit fertilization
- may prevent implantation by altering the endometrium.
- Emergency contraceptive pills do not interrupt pregnancy and thus are not a form of abortion.
- May interfere with ovum and sperm transport

Progestogen only pills (POP)

- 2 Tablets of 750 microgram of Levonorgestrel or
- 1 tablet of 150 micrograms (ECP)

(2 Tab are taken stat within 120 hours (5 days) after unprotected intercourse, but more effective if taken as soon as possible)

8

COC

- Two emergency contraceptive pill regimens can be used:The standard regimen consists of the "combined" oral pills.

Combined Oral contraceptives (COCs): the Yuzpe method

- **4 tablets** each of 30 micrograms of ethinylestradiol (Nova/ Famila)
- Tablets are taken as soon as possible within 120 hours (5 days) of Unprotected intercourse followed by a similar dose 12 hours later

- When high-dose pills containing 50 ug of ethinylestradiol and 250 ug levonorgestrel (or 500 ug dl-norgestrel) are available:
- Two pills should be taken as the first dose as soon as convenient but no later than 72 hours after unprotected intercourse.These should be followed by two other pills 12 hours later.

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Progesterone Only Pill (Em Kit)

- Levonorgestrel-only pills is equally effective at the Yuzpe regimen but has a significantly lower incidence of side-effects.
- When pills containing 750 ug(0.75mg) levonorgestrel are available
- One pill should be taken as the first dose as soon as convenient but no later than 72 hours after unprotected intercourse.This should be followed by another pill 12 hours later
- Em Kit DS has 1.5 mg levonorgesterol and can be taken as a single dose.

Emergency Contraception

10

12

Specific indications

- Unprotected SI
- Potential barrier failures
- Potential POP failure
  - 1 or more missed and UPSI in next 2d
- Potential IUD/IUS failure
  - expelled/removed
- Potential injectable failure
  - >14w depot

Side Effects

- Nausea
- Vomiting
- Irregular uterine bleeding
- Breast tenderness
- Headache
- Fatigue
- Abdominal discomfort
- Dizziness

IUCD as EC

13

Method of action of Cu-IUD

- Cu is toxic to ova and sperm
- Primarily inhibits fertilisation
- If fitted within 5 days of fertilisation, will prevent implantation
- Effective immediately after insertion
- Effectiveness is 98%

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Limitations

- The failure rate of emergency contraceptive pills ranges from 1 to 3 per hundred, and the failure rate of copper IUDs is below 1 per hundred.
- Can **Not** be used as a routine contraceptive method
  - Higher possibility of failure than a regular contraceptive
  - Increased chances of side effects (Yuzpe method)
- Gives no protection against STI
- Hormonal (Yuzpe) method is best avoided if there is an absolute contraindication to estrogen therapy

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Common Misbelief

Emergency contraception is a form of abortion.

Common Mis-belief

Women or couples may stop using regular contraception if emergency contraception is easily available.

PERMANENT METHODS

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

MODULE – 5

COUNSELING

Guide for PPFP Counseling

(To be completed by the Participants during Role Play)

Place a "ü" 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.		

STEP/TASK	OBSERVATIONS	
	YES	NO
• 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 – 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		

STEP/TASK	OBSERVATIONS	
	YES	NO
• 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 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?

COUNSELING

OBJECTIVES

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

1) Understand the importance of Good counselling skills
2) Demonstrate effective counselling skills in order for a woman or couple to understand their reproductive options, choose an FP method that best meets their needs, and use the chosen method safely and effectively.
3) To dispel myths that might discourage the uptake and continued use of FP methods.
4) Fulfil the criteria for a good counsellor
5) Understand and respect the client's rights. Earn the client's trust.
6) Understand the benefits and limitations of all contraceptive methods.
7) Understand the cultural and emotional factors that affect a client's (or a couple's) decision to use a particular contraceptive method.
8) Encourage the client to ask questions.
9) Use a non-judgmental approach, which shows respect and consideration to the client.
10) Present information in an unbiased, client-sensitive manner.

WHO PROVIDES COUNSELLING

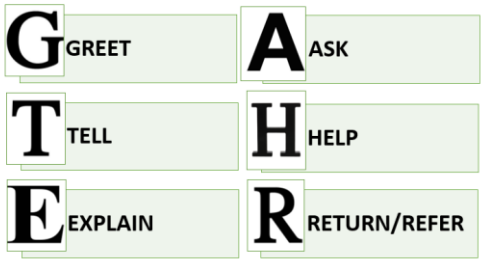
Information and counselling will commonly come from more than one source, but they should include service providers who are trained in FP counselling and who are knowledgeable about all available contraceptive methods

THE COUNSELLING PROCESS

Service providers should be aware of a number of factors about each client that could be important when selecting a method. These factors might include:

1. The reproductive goals of the woman or couple (i.e., the spacing, timing, or limiting of births)
2. Personal factors, including the time, travel costs, pain, or discomfort likely to be experienced
3. The need for protection against STIs and HIV

GATHER counselling TECHNIQUE



Six key points in helping the client remember are:

1. **Shortness**
2. **First Things First**
3. **Simplicity**
4. **Repetition**
5. **Organization**
6. **Specificity**

STEPS IN FAMILY PLANNING COUNSELLING

INFORMED CHOICE

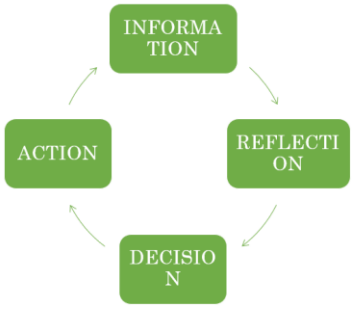
"Informed" means that:

1. Clients have the clear, accurate, and specific information required to make their reproductive choices, including a choice among FP methods.
2. Good-quality FP programs explain each FP method as needed, without overloading clients with information, and helping clients to use each method effectively and safely.
3. Clients understand their own needs because they have thought about their own situations through interpersonal communication and through mass-media messages.

"Choice" means that:

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

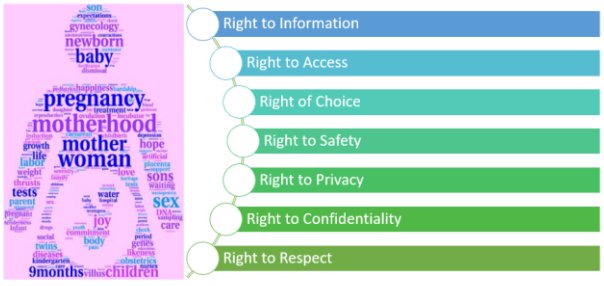
DECISION-MAKING PROCESS



CHARACTERISTICS OF A GOOD COUNSELLOR

1- KNOWLEDGE	Demographic context, National and global perspective	Govt. Policies regarding population	Anatomy and physiology of human reproductive system
2- SKILL	Empathetic	Tactful	Helpful
3- ATTITUDE	Positive. Pleasant and polite	Unbiased, Respectful, Attentive	Hard worker, Alert, Non-judgmental

RIGHTS OF CLIENT



DEALING WITH SENSITIVE ISSUES/SPECIFIC GROUPS

1. Services for Clients with Chronic Health Problems
2. Contraception for HIV-Infected Women
3. Special Needs of Abused Women
4. Counselling Men

MODULE – 6

MEDICAL ELIGIBILITY CRITERIA (MEC)

MEDICAL ELIGIBILITY CRITERIA

OBJECTIVES

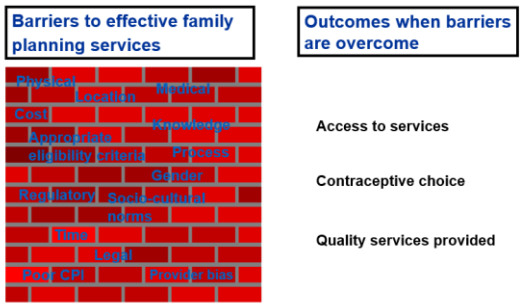
By the end of this session the participants will be able to

1. Have a clear concept of medical barriers
2. Know that for high quality service provision all barriers, medical and personal biases have to be taken down
3. Use MEC wheel confidently
4. Use MEC as a standard reference while counselling clients

PERSONAL AND SOCIAL BARRIERS

1- Lack of Priority for Family Planning
2- Gender
3- Age
4- Religious Opposition
5- Husband's Opinion
6- Lack of Knowledge
7- Geographical Accessibility
8- Socio- Cultural Norm
9- General Awareness
10- Myths, Rumors and Misconceptions
11- Confidentiality

Access Barriers



ADMINISTRATIVE BARRIERS

1. Unqualified health workers
2. Staff absenteeism,
3. Restricted opening and closing hours
4. Prolonged waiting times
5. Lack of motivation in staff
6. Poor knowledge of the health care providers
7. Unfriendly and non-professional attitude of staff
8. Sup optimal staff interpersonal skills, including trust
9. Culturally insensitive health care delivery
10. Poor commodity supply

ROLE OF PROVIDER BIASES IN THE QUALITY OF CARE

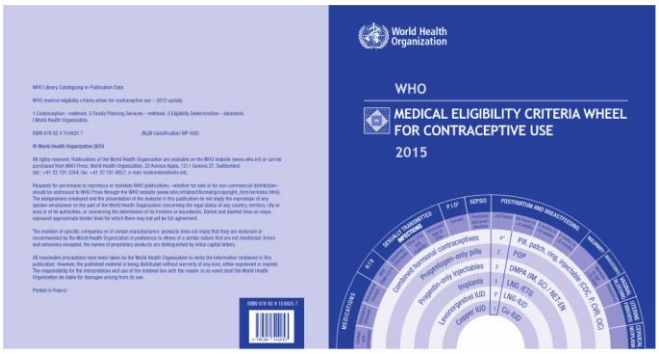
1) Lack of evidence-based, current knowledge and experience in providing modern contraceptives
2) Exaggerated fear of doing harm
3) Personal bias against particular family planning methods (e.g., IUD)
4) Personal bias against the use of family planning in specific situations or populations (e.g., unmarried adolescents)
5) Personal (and program) bias toward the non-family planning technical area (e.g., providers of immunizations or post abortion care programs may fear deleterious effects of integrating family planning into the program)
6) Being asked to do more without being supported to do more or having other tasks removed.

Medical eligibility criteria for contraceptive use (MEC)

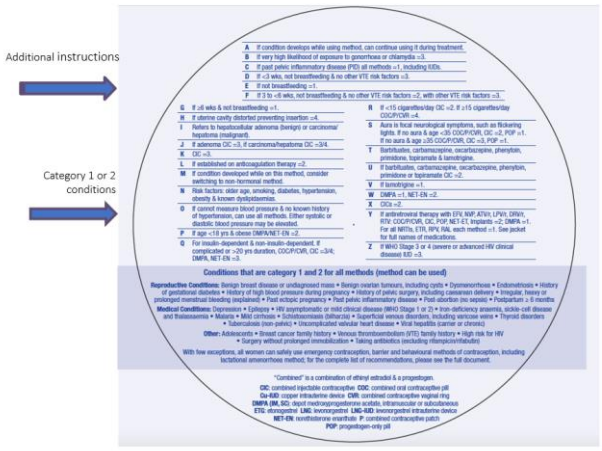
Purpose: who can safely use contraceptive methods?

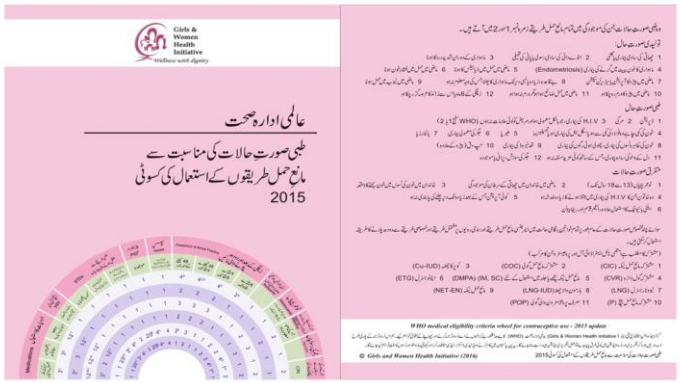
- Offers ≈ 2000 recommendations for 25 methods
  - Pre-existing medical conditions
  - Personal characteristics
  - Certain health problem
- Developed through consensus driven process during 3 consultations
  - Systematic review of scientific evidence
  - Adhered to WHO procedures for guideline development

The WHO MEC Wheel 2015



The wheel (front)





What is Medical Eligibility Criteria (MEC) ?

- Recommendations on the specific conditions (medical and non medical) to safely use contraceptive methods
  - Initiation
  - Continuation
- Evidenced based
  - Direct studies on users with and without the conditions
  - Theoretical considerations
  - Expert opinions

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Medical Eligibility Criteria

Category	Description	When clinical judgment is available
1	No restriction for use	Use the method under any circumstances
2	Benefits generally outweigh risks	Generally use the method
3	Risks generally outweigh benefits	Use of method not usually recommended, unless other methods are not available/acceptable
4	Unacceptable health risk	Method not to be used

Source: WHO, 2004.

ONLINE LINK FOR MEC WHEEL

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

MODULE – 7

INFECTION PREVENTION

Infection Prevention Checklist

(To be used by **Participants** for practice)

Place a "**ü**" in case box of step/task is performed satisfactorily, an "**û**" if it is not performed satisfactorily, or **N/O** if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step, task or skill not performed by participant during evaluation by trainer

STEP/TASK	
1. The facility is clean	
2. Antiseptics, disinfectants and other supplies are available in sufficient amounts	
3. Use puncture-proof sharps containers (cardboard box, hard plastic containers, or cans that are closed) with only a small opening for disposing of syringes with needle.	
4. Place a containe at point of use with 0.5% chlorine solution for decontamination of syringes and needles (before going into the sharp container).	
5. Make available the clean plastic containers with 0.5% chlorine solution for use (e.g. container is large enough to hold instruments and solution deep enough to completely cover all tools/instruments).	
6. Provide personnel protective equipment (Aprons, Closed-toed shoes, Masks, Eyewear and Heavy duty gloves for cleaning instruments) available and ready for use.	
7. Ensure the person in charge of waste wears eye protection and utility gloves.	
8. Perform the decontamination of instruments and other articles (immediately after use and before cleaning) properly.	
9. A new chlorine solution is prepared at the beginning of each day or sooner if needed and date/time labeled on the covered container.	
10. Soak the Instruments and other items in 0.5% chlorine solution for 10 minutes before taken to the washing/prep room. They should be completely submerged in solution (not partially).	
11. Area for cleaning instruments is separated from the procedure areas. There is at least one deep sink/basin with running water for washing instruments.	
12. Remove the soaked instruments from chlorine solution and clean in a separate procedure area.	
13. Scrub instruments and other items under the surface of water, completely removing all blood and other foreign matter.	
14. Rinse the instruments and other items thoroughly with clean water.	
15. Allow instruments/other items to air-dry, or dries with a clean towel (if autoclaving).	
16. Washe hands with running water and soap for 10-15 seconds and dries.	
17. The HLD (boiling)/sterilization process is performed properly according to the method utilized.	
18. For HLD, Instruments are boiled for 20 minutes starting from the time a rolling boil begins.	
19. After 20 minute, remove the instruments with HLD or sterile forceps, air dry and store in HLD containers.	
20. Collect soiled linen in leak proof containers/plastic bags without being pre-soaked.	
21. Clean linen using detergents without acid, ammonia, or ammonium. Add 2-3 tablespoons (or 30-60 ml) of 5% chlorine solution in the water.	
22. Wash hands with soap and water after removing gloves and other personal protective equipment.	
23. Collects waste in leak proof containers.	

STEP/TASK	
24. Provide Sufficient dustbins outside of the facility (in the grounds) exist for general waste to avoid littering.	
25. Maintain waste collection area clean and free of spills (walls, tables, floors).	
26. Collection person washes hands with soap and water after removing gloves and other personal protective equipment.	
27. Contaminated liquid waste (blood, urine, feces, and other body fluids) are disposed of in the following manner: a) Emptied into a toilet or sink from which water can be drained into a sewer system b) The sink is rinsed with water after the waste has been emptied	
28. Containers with sharps are incinerated.	
29. Solid waste (used dressings and other materials contaminated with blood and organic matter) are incinerated /buried.	

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Infection Prevention Practices

Importance of Infection Prevention

Without the proper precautions, the health care facility can actually cause the spread of infections and diseases.

Because

- During clinical procedures patients are at risk of infection during and immediately following the procedure.
- Health staff is at potential risk of infectious materials at their work place.
- Already sick patients are more susceptible to infections.
- Many of the people seeking services have infections that can be transmitted to other i.e Hepatitis B, C and HIV.

Who is at risk of infection

- **Health staff**
- **Patient**
- **Community**

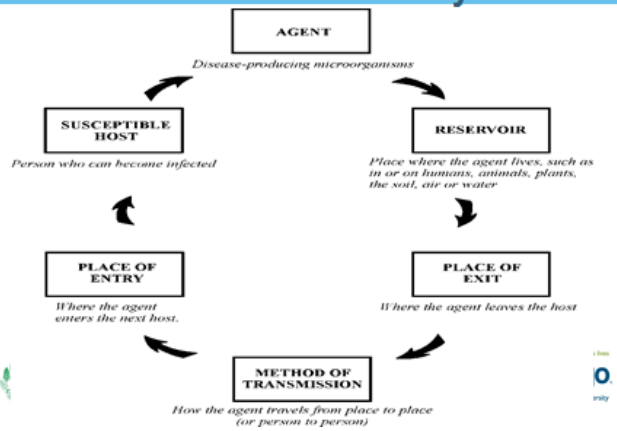
Risks of dying from:

Lightning	1 : 10,000,000
Plane crash	1 : 3,000,000
Car accident	1 : 10,000
Sky diving, bungee jumping	1: 1000

Risk of acquiring the disease after being stuck with a needle from a + client

HIV	4:1000
HCV	3–10:100
HBV	27–37:100

Understanding the Disease Transmission Cycle



Principles of Infection Prevention

- Provide safe health practices.
- Lower the expenses of health care services as prevention is cheaper than cost.
- Reduces risk of infection and disease transmission to the patient.
- Protects health care workers at all levels from exposure to infectious diseases.
- Promotes the use of effective waste management plan to limit the spread of infection to communities.

Achieving Infection Prevention

- Standard precautions
- Hand washing
- Gloving
- Using personal protective items
- Safe practices in procedure room
- Safe disposal of sharps
- Processing of instruments
- House keeping
- Waste disposal

Standard precautions

- Consider every person
- Wash hands
- Wear gloves
- Use physical barriers
- Use aseptic technique just before and during a clinical procedure .
- Use safe sharp handling practices .
- Safely dispose of infectious waste materials
- Process instruments, gloves and other items safely after use .

Hand Washing

Always wash your hands:

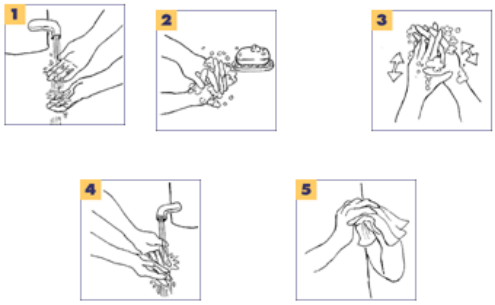
Immediately when you arrive at work

- Before examining each patient
- After examining each patient
- Before putting on gloves for clinical procedures (such as a pelvic exam or IUD insertion)
- After touching any instrument or object that might be contaminated with blood or other body fluids, or after touching mucous membranes
- After handling blood, urine, or other specimens
- After removing any kind of gloves (hands can become contaminated if gloves contain tiny holes or tears)
- After using the toilet or latrine

Types

- **Hand washing with plain soap and running water .**
- **Hand washing with antiseptic soap and running water.**
- **Alcohol hand rubs.**
- **Hand Scrubbing.**

Simple hand washing



Alcohol based handrubs

- Prepare alcohol based hand rub by mixing 100 ml of 70%alcohol with 2ml glycerin
- Used for hand hygiene between attending patients

apply approx. 5mls of the hand rub solution to the palm of the hand. Rub it over all surfaces of the hands and fingers until all the alcohol has evaporated

Gloving

- Wear gloves (clean, non-sterile) when touching blood, body fluids, secretions, excretions or mucous membranes.
- Change gloves between contacts with different patients.
- Change gloves between tasks/procedures on the same patient to prevent cross contamination between different body sites.
- Remove gloves immediately after use and before attending to another patient.

TYPES

1. Surgical gloves

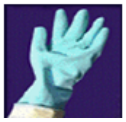
Used for all clinical procedures where there is a contact with the tissues under the skin or with the bloodstream. It permit greater movement during surgical procedure.

2. Single-use examination gloves

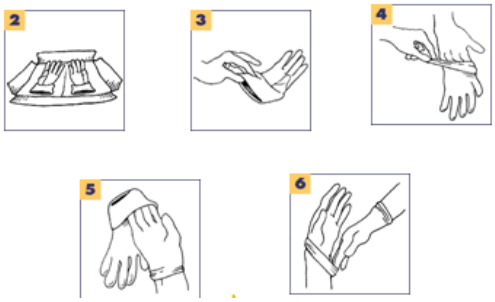
Used for procedures where there will be contact with intact mucous membranes or where the primary purpose of wearing gloves is to reduce the risk of exposure to blood or other body fluids
Examination gloves are usually made of latex or vinyl supplied in bulk in a box .. They should **not** be processed and reused.

3. Utility or heavy-duty household gloves

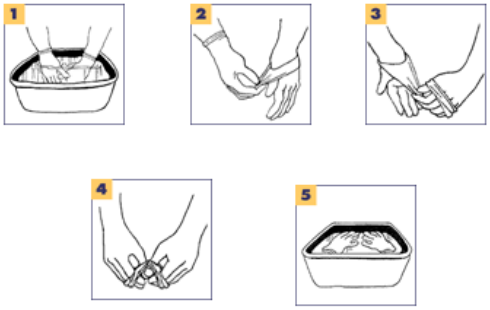
Used for handling contaminated instruments, waste, linens, performing housekeeping activities,. These gloves can be reused after cleaning. To protect from contaminates on the outside of the glove, always wash your hands *while still wearing the gloves*



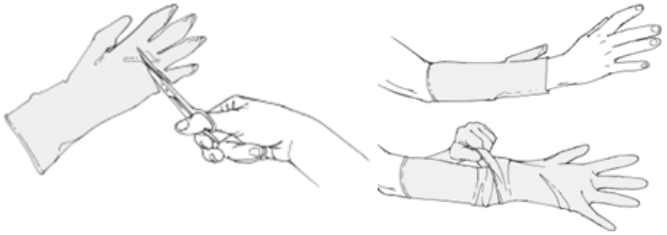
Steps of wearing gloves



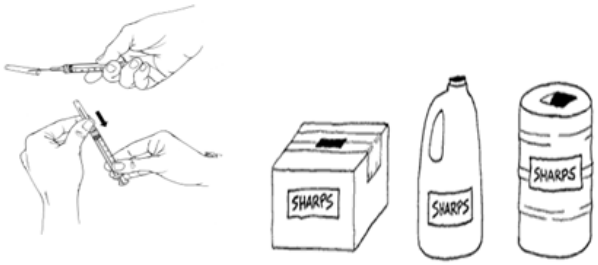
How to remove gloves



Elbow length gloves



Sharp Diposal



"Hands-Free" Technique

It includes anything sharp enough to puncture a glove e.g., loaded needle holders. The assistant or scrub nurse places a sterile kidney basin, or other suitable small container, on the operative field between her/himself and the surgeon

SP include...

House keeping

- Develop a cleaning schedules
- Always wear gloves (preferably thick utility gloves) when cleaning.
- Wash surfaces from top to bottom
- Change cleaning solutions whenever they appear to be dirty If the spill is large, cover (flood) the area with a disinfectant (0.5% chlorine) solution, mop up the solution, and then clean the area with a disinfectant cleaning solution.

WASTE MANAGEMENT

- Waste disposal is a crucial aspect of infection prevention in health care facilities Each facility should develop a waste management plan

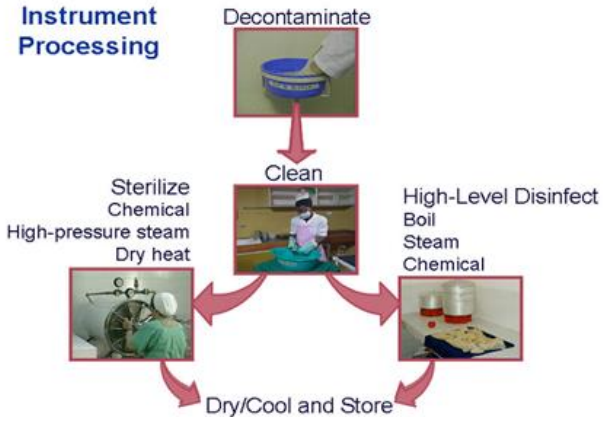
Components of a Waste-Management Plan

- **Sorting:** Separating waste by type at the place where it is generated.
- **Handling:** Collecting and transporting waste within the facility.
- **Interim storage:** Storing waste within the facility until it can be disposed of.
- **Final disposal:** Eliminating or transporting solid medical waste, liquid medical waste, sharps, and hazardous chemical waste from the health facility

Processing of instruments

- Proper processing of reusable instruments and other items in clinical procedures is critical for reducing infection transmission to the patient

SP include...



Decontamination

- *It kills viruses such as hepatitis B, other hepatitis viruses, and HIV and many other microorganisms and* makes items easier to clean by preventing blood, other body fluids, and tissue from drying on them but does not remove fluids, tissue, or dirt.
- Use a 0.5% chlorine solution for decontamination
- Soak for 10 mints in Chlorine solution, and then rinse with running water.

Formula

- % of chlorine available x 2 --- 1 = No of parts of water to be added to make 0.5% chlorine.

Cleaning

- Cleaning refers to scrubbing with a brush, detergent, and water to remove blood, other body fluids, organic material, tissue, and dirt.



High level disinfection

- Only acceptable alternative if sterilization is either not available.
- Destroys all microorganisms including vegetative bacteria, tuberculosis, yeasts and viruses except some bacterial endospores.
- High-level disinfection can be achieved by boiling in water, steaming (moist heat) or soaking instruments in chemical disinfectants.
- Always boil in a closed lid pan for 20 minutes.
- Start timing when the water begins to boil.
- Metal instruments should be completely covered with water during boiling.
- Do not add anything to the pot after timing begins.

COMPREHENSIVE PPFP SERVICES
Pre Course Knowledge Assessment Questionnaire

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:
Lahore is the capital of India.

T	(F)

POSTPARTUM FAMILY PLANNING			
1	The best way to correct a Family Planning rumor is to ignore it.	T	F
2	The doctor is the person best qualified to choose a contraceptive method for a woman in good health.	T	F
3	Pregnancy before the age of 18 years has no adverse effects on the clients health	T	F
HORMONAL CONTRACEPTIVES			
4	Oral contraceptive method is the best method of contraception for a woman who is breast-feeding her infant age 3 months.	T	F

5	Emergency contraceptive pills (ECPs) are effective if taken within 120 hours of unprotected intercourse	T	F
6	COCs is the combination of estrogen and progesterone	T	F
7	Excessive bleeding is the most common side effect experienced by the pill users	T	F
8	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
NATURAL AND BARRIER METHODS			
9	It is preferable to lubricate condoms before use.	T	F
10	One of the three criteria for effective lactational amenorrhea (LAM) is that the baby is exclusively breast fed.	T	F
IMPLATNS			
11	Women can have an Implanon inserted within 7 days following miscarriage or abortion.	T	F
12	Implanon can be given in Immediate Postpartum Period	T	F
13	Implanon can be used by breastfeeding women.	T	F
Counseling			
14	The Balanced Counseling Strategy Plus is a practical, interactive and client friendly strategy	T	F
15	Balanced Counseling Strategy plus uses key job aids Cards for counseling about Family Planning	T	F

Select the best suitable answer

16. **What is a common menstrual change among Implant users?**

a) Amenorrhea in about half of the users

b) Irregular menses in the first three months, which may later become regular

c) An increase in dysmenorrhea among 77% of users

17. **A contraceptive implant user MUST return to the clinic if she has**:

a) Pus and bleeding at the insertion site

b) Bruising at the insertion site

c) Irregular bleeding or spotting

18. **A woman who has a past history of deep vein thrombophlebitis:**

a) Cannot use a contraceptive implant (category 4)
b) Can use a contraceptive implant if there are no other available family planning options (category 3)
c) Can use a contraceptive implant (category 2)

19. **Referral agents can receive which of the following types of compensation:**

a) Reasonable compensation based on amount of time spent with a patient and travel costs
b) Bonuses for referral agents based on the number of patients who accept VS after counseling
c) Both a and b
d) None of the Above

20. **For health reasons, how long should women wait after <u>delivering a baby</u> before trying to become pregnant again?**

a. For at least 1 year
b. For at least 2 years
c. Until regular monthly periods have started again

21**. For health reasons, how long should women wait after <u>a miscarriage</u> before trying to become pregnant again?**

a. No wait is necessary
b. 3 months
c. 6 Months

22**. Which of following is TRUE about how postpartum anatomy and physiology affect IUCD insertion?**

a. When an IUCD is inserted 2 weeks postpartum, the risk of expulsion is very low because it is easier to reach the fundus.
b. The standard IUCD inserter tube can be used to place both interval IUCDs and postpartum IUCDs.
c. In order to reach the fundus, the uterus must be "elevated" (pushed up in the abdomen) to smooth out the vagino-uterine angle**.**

23**. Which of the following IP practices is acceptable?**

a. Surgical (metal) instruments that have been decontaminated and thoroughly cleaned can be safely used for insertion of the IUCD postpartum.
b. It is not necessary to use an antiseptic when inserting an IUCD immediately after delivery because the provider is still wearing sterile gloves.
c. To minimize the risk of staff contracting Hepatitis B or HIV/AIDS during the cleaning process, instruments used in IUCD insertion should be soaked first for 10 minutes in 0.5% chorine solution.

24. **Which of the following is a condition for which PPIUCD insertion is considered Category 4 (meaning the method should not be used), according to the World Health Organization's Medical Eligibility Criteria?**

a. AIDS
b. Puerperal sepsis
c. Cesarean section

COMPREHENSIVE PPFP SERVICES
Course Knowledge Assessment Questionnaire –Answer Key

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6	COCs is the combination of estrogen and progesterone	**T**	F
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Select the best suitable answer

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f. **6 Months**

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d. AIDS

e. **Puerperal sepsis**

f. Cesarean section

Appendix: Tips for Trainers

Creating a Positive Learning Environment

In addition to organizing the course, the trainer must be able to give presentations, conduct demonstrations, and lead other course activities – effectively and efficiently. This requires:

- Careful preparation;
- Timely execution of a plan for course preparation,
- Ensuring that the physical classroom and clinical environment are well suited to learning, and
- Effective training/facilitation skills (discussed in the next section).

Well-planned and well-executed classroom and clinical sessions help to create a positive learning environment. And a positive learning environment is critical to learning.

Being an Effective Clinical Trainer

Equally important as careful planning and preparation to creating a positive learning environment is skilled facilitation. Health professionals conducting clinical skills courses are continually changing roles. They are most like traditional **instructors** when they are presenting illustrated lectures (graphics slides presentations) and giving classroom demonstrations. Once they have demonstrated a clinical procedure, they shift to the role of the **coach** as the *learners* begin practicing. Throughout the course, they act as **trainers**—especially when conducting small group discussions and using role plays, case studies, and clinical simulations—as they help learners progress toward greater independence and confidence in the desired competencies.

Creating an Environment Where Learning Is Easy (or Easier)

The environment within which learning occurs has a tremendous impact on the quality of the learning experience. A positive learning environment maximizes the effectiveness of training, thereby helping learners to achieve the course objectives. Because the **clinical trainer sets the tone** for the course, how she/he delivers information is the key to establishing and maintaining a positive learning environment during training—in other words, **how** something is said is as important as **what** is said. The effective trainer **creates an atmosphere of capability**, one that supports the learners' sense that not only can they build competence in the new knowledge, skills, and attitudes being taught, they can ultimately master them and apply them in their work to improve services in the communities they serve. Learners need to feel that they can achieve, and the trainer helps to build that feeling by creating and maintaining a positive learning environment—largely through **effective facilitation**.

Characteristics of an Effective Trainer and Coach

An effective trainer has the following qualities:

- Is proficient in the skills to be taught
- Encourages learners in learning new skills
- Promotes open (two-way) communication
- Provides immediate feedback:
  - Informs learners whether they are meeting the course objectives
  - Does not allow a skill or activity to be performed incorrectly (i.e., gently guides the learner toward the correct way to do something as soon as she/he begins to make mistakes)
  - Gives positive feedback as often as possible
  - Avoids negative feedback and instead offers specific suggestions for improvement
- Seeks and is able to receive feedback:
  - **Asks for it** (Talk to clinical skills trainers—and learners—who will be direct with you about your performance. Ask them to be specific and descriptive about ways you can be more effective.)
  - **Directs it** (If you need additional information/input to answer a particular question or pursue a learning goal, ask for it. For example, during a demonstration, you might ask: "Does everyone have a clear view of how I am holding the instrument?")

- **Accepts it** (Do not defend or justify your behavior. Listen to what people have to say and thank them. Use what is helpful; quietly discard the rest.)

- Recognizes that training can be stressful and knows how to **manage learner as well as trainer stress**:
  - Uses appropriate humor
  - Observes learners and watches for signs of stress
  - Provides regular breaks
  - Provides changes in the training routine when needed
  - Focuses on learner successes as opposed to failures

Coaching is a training technique in which the trainer:

- Describes the skills and client interactions that the learner is expected to learn;
- Demonstrates (models) the skills in a clear and effective manner using learning aids, such as slide sets, videos, and anatomic models; and
- Provides detailed, specific feedback to learners as they practice the skills and client interactions, using the anatomic model and actual instruments (if appropriate), in a simulated clinical setting and as they provide services to actual clients during practicum.

The characteristics of an **effective coach** are basically the same as those of an **effective trainer**; the characteristics especially important for the coach include the following:

- Being patient and supportive
- Providing praise and positive reinforcement
- Correcting learners' errors while maintaining learners' self-esteem
- Listening and observing

Understanding How People Learn

Being an effective clinical skills trainer also depends on understanding how adults learn. The trainer must have a clear understanding of what the learners need and expect, and the learners must have a clear understanding of why they are there. Adults who attend courses to acquire new knowledge, attitudes, and skills share the characteristics described below.

They require learning to be **relevant**. The trainer should offer learners learning experiences that **relate directly to their current or future job responsibilities**. At the beginning of the course, the objectives should be stated clearly and linked to job performance. The trainer should take time to explain how each learning experience relates to the successful accomplishment of the course objectives.

They are highly **motivated** if they believe learning is relevant. People bring **high levels of motivation and interest** to learning. Motivation can be increased and channeled by the trainer who provides clear learning goals and objectives. To make the best use of a high level of learner interest, the trainer should explore ways to incorporate the needs of each learner into the learning sessions. This means that the trainer needs to know quite a bit about the learners, either from studying background information about them or by allowing learners to talk early in the course about their experience and learning needs.

They need **participation** and **active involvement** in the learning process. Few individuals prefer just to sit back and listen. The effective trainer will design learning experiences that **actively involve the learners in the training process**. Examples of how the trainer may involve learners include the following:

- Allowing learners to provide input regarding schedules, activities, and other events
- Questioning and feedback
- Brainstorming and discussions
- Hands-on work
- Group and individual projects
- Classroom activities

Adult learners desire a **variety** of learning experiences. The trainer should use a variety of learning methods, including the following:

- Audiovisual aids
- Illustrated lectures
- Demonstrations
- Brainstorming
- Small group activities
- Group discussions
- Role plays, case studies, and clinical simulations

They desire positive feedback. Learners need to know **how they are doing**, particularly in light of the objectives and expectations of the course. Is their progress in learning clinical skills meeting the trainer's expectations? Is their level of clinical performance meeting the standards established for the procedure? **Positive feedback provides this information.** Learning experiences should be designed to move from the known to the unknown or from simple activities to more complex ones. This progression provides positive experiences and feedback for the learner. To give positive feedback, the trainer can:

- Give verbal praise either in front of other learners or in private;
- Use positive responses during questioning;
- Recognize appropriate skills while coaching in a clinical setting; and
- Let the learners know how they are progressing toward achieving learning objectives.

They have **concerns about their abilities**. The trainer must recognize that many learners fear failure and embarrassment in front of their colleagues. Learners often have concerns about their ability to:

- Fit in with the other learners;
- Get along with the trainer;
- Understand the content of the training; and/or
- Perform the skills being taught.

They need an **atmosphere of safety**. The trainer should open the course with an introductory activity that will help learners feel at ease. It should communicate an atmosphere of safety so that learners do not judge one another or themselves. For example, a good introductory activity is one that acquaints learners with one another and helps them to associate the names of the other learners with their faces. Such an activity can be followed by learning experiences that support and encourage the learners.

They need to be recognized as **individuals** with unique backgrounds, experiences, and learning needs. A person's past experiences are a good foundation upon which the trainer can base new learning. To help ensure that learners feel like individuals, the trainer should:

- Use learners' names as often as possible;
- Involve all learners as often as possible;
- Treat learners with respect; and
- Allow learners to share information with others during classroom and clinical instruction.

Adult learners must maintain their **self-esteem**. Learners need to **maintain high self-esteem** to deal with the demands of a clinical training course. Often the clinical methods used in training are different from clinical practices used in the learners' clinics. The trainer must show respect for the learners, no matter what practices and beliefs they hold to be correct, and continually support and challenge them. This requires the trainer to:

- Reinforce those practices and beliefs embodied in the course content;

- Provide corrective feedback when needed, in a way that the learners can accept and use with confidence and satisfaction;
- Provide training that adds to, rather than subtracts from, their sense of competence and self-esteem; and
- Recognize learners' own career accomplishments.

They have **high expectations** for themselves and their trainer. People attending courses tend to set **high expectations both for the trainers and for themselves.** Getting to know their trainers is a real and important need. Trainers should be prepared to talk modestly, and within limits, about themselves, their abilities, and their backgrounds.

They have **personal needs** that must be taken into consideration. All learners have personal needs during training. Taking timely breaks and providing the best possible ventilation, proper lighting, and an environment as free from distraction as possible can help to reduce tension and contribute to a positive learning atmosphere.

Skill Development and Assessment: The Coaching Process

No matter what type of skill the trainer is demonstrating—whether a psychomotor or hand skill, a clinical decision-making skill, or a communication skill—the coaching methodology for skill development includes these steps or phases:

- **Demonstration** of the clinical skill by the trainer, using models, simulations, and an assessment tool (usually a checklist) to outline critical steps. For clinical decision-making, demonstration of the skill entails explaining to learners the rationale for each decision made. In this way, learners are walked through the thought process of a provider who is proficient in clinical decision-making.
- **Practice** of the skill by the learner (using the same checklist) with feedback from the trainer, first in simulation and then with clients.
- **Assessment** of the learner's skill competency by the trainer in simulation and then with clients (using the same checklist).

These three phases can be broken down further into the following steps:

- First, during interactive classroom presentations, **explain** the skill or activity to be learned.
- Next, using a video or slide set, show the skill or activity to be learned.
- Following this, **demonstrate** the skill or activity using an anatomic model (if appropriate), role play (e.g., counseling demonstration), or clinical simulation.
- Then, allow the learners to **practice** the demonstrated skill or activity with an anatomic model or in a simulated environment (e.g., role play, clinical simulation). The trainer functions as a coach during this step.
- After this, **review** the practice session and give constructive feedback.

- After adequate practice, **assess** each learner's performance of the skill or activity on models or in a **simulated situation**, using the competency-based checklist.
- After a certain level of competence is gained with models or **practice** in a simulated situation, have learners begin to practice the skill or activity with clients under a trainer's guidance.
- Finally, **assess** the learner's ability to perform the skill according to the standardized procedure, as outlined in the competency-based checklist.

During initial skill acquisition, the trainer demonstrates the skill as the learner observes. As the learner practices the skill, the trainer functions as a coach and observes and assesses performance. When demonstrating skill competency, the learner is now the person performing the skill as the trainer evaluates performance.

- **Assessment is a continuous process:** Formative assessment is used to help develop learner competence, while summative assessment is used to help evaluate and make decisions about learner competence.
- In **formative assessment**, the focus is on giving feedback to learners, helping them to improve their performance and prepare for later assessments. Formative assessment has been described as "assessment *for* learning."
- In **summative assessment**, the results are recorded and used to determine whether the learner should move on to a next phase in the course (such as from working with models to working with actual clients) and, ultimately, pass the course. Summative assessment is sometimes described as an "assessment *of* learning" and is used to formally assess and document learner progress at specific times.

Note: Assessment tools such as written knowledge assessments, skills checklists, and performance standards should not be modified by trainers. These tools have been created and validated by a group of experts to ensure that skills are developed and assessed in a standardized manner, and that the tools provide an accurate means of measuring learner competency and ultimately determining qualification.

Using Effective Presentation Skills

It is also important to use effective presentation skills. The trainer's ability to establish and maintain a positive learning climate during training depends on how she/he delivers information because the **trainer sets the tone** for the course. In any course, **how** something is said may be just as important as **what** is said. Some common techniques for effective presentations are listed below:

- **Follow a plan and use trainer's notes**, which include the session objectives, introduction, body, activity, audiovisual reminders, summary, and evaluation.
- **Communicate in a way that is easy to understand.** Many learners will be unfamiliar with the terms, jargon, and acronyms of a new subject. The trainer should use familiar words and expressions, explain new language, and attempt to relate to the learners during the presentation.
- **Maintain eye contact with learners.** Use eye contact to "read" faces. This is an excellent technique for establishing rapport and getting feedback on how well learners understand the content.
- **Project your voice** so that those in the back of the room can hear clearly. Vary volume, voice pitch, tone, and inflection to maintain learners' attention. Avoid using a monotone voice, which is guaranteed to put learners to sleep!

- **Avoid the use of slang or repetitive words, phrases, or gestures** that may become distracting with extended use.
- **Display enthusiasm about the topic and its importance.** Smile, move with energy, and interact with learners. The trainer's enthusiasm and excitement are contagious and directly affect the morale of the learners.
- **Move around the room.** Moving around the room helps ensure that the trainer is close to each learner at some point during the session. Learners are encouraged to interact when the trainer moves toward them and maintains eye contact.
- **Use appropriate audiovisual aids** during the presentation to reinforce key content or help simplify complex concepts.
- Be sure to ask both **simple and more challenging questions.**
- **Provide positive feedback** to learners during the presentation.
- **Use learners' names as often as possible.** This will foster a positive learning climate and help keep the learners focused on the presenter.
- Display a **positive use of humor** related to the topic (e.g., humorous stories, cartoons on a transparency or flip chart, cartoons for which learners are asked to create captions).
- **Provide smooth transitions between topics.** Within a given presentation, a number of separate yet related topics may be discussed. When shifts between topics are abrupt, learners may become confused and lose sight of how the different topics fit together in the bigger picture. Before moving on:
  - Providing a brief summary;
  - Asking a series of questions;
  - Relating content to practice; or
  - Using an application exercise (case study, role play, etc.).
- **Be an effective role model.** The trainer should be a positive role model in appearance (appropriate dress) and attitude (enthusiasm for the course) and by beginning and ending the session at the scheduled times.

Teaching Clinical Decision-Making

Clinical decision-making is the systematic process by which skilled providers make judgments regarding a client's condition, diagnosis, and treatment. Although the process can be difficult to teach, it can be broken down into a series of steps to facilitate discussion and learning, as shown below. As the trainer facilitates learning activities and assessments, she/he should identify—and encourage learners to try to identify—"where they are" in the clinical decision-making process. And depending on where they are, the trainer can employ a range of strategies to bring learners into, and help them navigate through, the clinical decision-making process.

- **Assessment or gathering information:** In the provision of implant services, this step may occur during counseling (e.g., learning about the couple's fertility intentions) or screening (e.g., identifying any medical reasons why the method should be withheld).
- **Diagnosis or interpreting the information:** In the provision of implant services, this step may occur after counseling and screening are completed (e.g., determining that a woman who has chosen the implant can safely have one inserted).
- **Implementation:** This step begins with ensuring that the woman has been properly counseled and screened and confirming her choice, continues with the actual insertion, and ends with post-insertion counseling. (*Is this method her choice? Is she having any problems?).*

An important strategy in teaching clinical decision-making is to be sure that learners are aware of this step-by-step process and what occurs in each step. They also must understand that although there is a sequence of steps for clinical decision-making, movement through the steps is rarely linear or sequential. Rather, it is an ongoing, circular process in which the provider moves back and forth between the steps as the clinical situation changes and different needs or problems emerge.

Another key strategy in teaching clinical decision-making is to provide as much experience and practice in decision-making as possible. This experience, together with clinical knowledge, is a key component of successful decision-making. Teachers should:

- Expose learners to as many and as wide a variety of clients as possible;
- Put learners in the clinical setting as early as possible and provide careful guidance as they gain their experience;
- Give learners as much structured independence as possible; they must be given the opportunity and time to draw their own conclusions and consider their own decisions; and
- Provide learners with a forum (e.g., case studies) for comparing their decisions with the decisions made by others.

Finally, the trainer should give learners feedback on how the clinical decision-making process was applied in a given situation. This will strengthen future performance more effectively than focusing on whether or not the "correct answer" was identified. In fact, a wrong answer for the right reason should receive more positive feedback than a right answer for the wrong reason.

Tools for teaching clinical decision-making, such as job aids, are presented throughout the learning resource package. The role plays have been designed to facilitate the teaching of decision-making by reinforcing the steps involved in the process. However, tools alone will not effectively teach clinical decision-making. The trainer must take an active role in discussing, questioning, explaining, and challenging learners about how decisions are being made each time one of these tools is used — for example, "What were you thinking when you asked the client that question?" "Why did you advise the client that the implant was not a good choice for her?" And this kind of interaction must continue as the learners move into the clinical setting to work with clients.

Clinical decision-making is a difficult skill to teach. But by beginning early in the course and continually providing practice opportunities and guidance—whether by using the tools included in this learning resource package or through experience with clients—trainers will help learners more fully understand the decision-making process and develop their decision-making skills. As a result, the quality of care received by clients will be improved.

Conducting Learning Activities

Every session (or learning activity) conducted during a course should begin with an **introduction** to capture learner interest and prepare the learner for learning. After the introduction, the trainer may deliver content using an **illustrated lecture, demonstration, small group activity,** or **other learning activity**. Throughout the presentation, **questioning** techniques can be used to encourage interaction and maintain learner interest. Finally, the trainer should conclude the presentation with a **summary** of the key points or steps.

Delivering Interactive Presentations

Introducing Presentations

The first few minutes of any presentation are critical. Learners might be thinking about other matters or wondering what the session will be like, or they might have little interest in the topic. The **introduction** should:

- Capture the interest of the entire group and prepare learners for the information to follow;
- Make learners aware of the trainer's expectations; and
- Help foster a positive learning climate.

The trainer can select from a number of techniques to provide variety and ensure that learners are not bored. Many introductory techniques are available, including the following:

- **Reviewing the session objectives.** Introducing the topic by a simple restatement of the objectives keeps the learner aware of what is expected of her/him.
- **Asking a series of questions about the topic.** The effective trainer will recognize when learners have prior knowledge concerning the course content and encourage their contributions. The trainer can ask a few key questions, allow learners to respond, discuss answers and comments, and then move into the body of the presentation.
- **Relating the topic to previously covered content.** When a number of sessions are required to cover one subject, relate each session to previously covered content. This ensures that learners understand the continuity of the sessions and how each relates to the overall topic. Where possible, link topics so that the concluding review or summary of one presentation can introduce the next topic.
- **Sharing a personal experience.** There are times when the trainer can share a personal experience to create interest, emphasize a point, or make a topic more job-related. Learners enjoy hearing these stories as long as they relate to the topic and are used only when appropriate.

- **Relating the topic to real-life experiences.** Many training topics can be related to situations most learners have experienced. This technique not only catches the learners' attention, but also facilitates learning because people learn best by "anchoring" new information to known material. The experience may be from the everyday world or relate to a specific process or piece of equipment.
- **Using a case study, clinical simulation, or other problem-solving activity.** Problem-solving activities focus attention on a specific situation related to the training topic. Working in small groups generally increases interest in the topic.
- **Using a video/DVD** or other audiovisual aid. Use of appropriate audiovisual aids can be stimulating and generate interest in a topic.
- **Giving a classroom demonstration.** Most clinical training courses involve equipment, instruments, and techniques that lend themselves to demonstrations, which generally increase learner interest.
- **Using a game, role play, or simulation.** Games, role plays, and simulations generate tremendous interest through direct learner involvement and therefore are useful for introducing topics.
- **Relating the topic to future work experiences.** Learners' interest in a topic will increase when they see a relationship between training and their work. The trainer can capitalize on this by relating the objectives, content, and activities of the course to real work situations.

Using Questioning Techniques

Questions can be used at any time to:

- Introduce a topic;
- Increase the effectiveness of the illustrated lecture;
- Promote brainstorming; or
- Supplement the discussion process.

Use a variety of questioning techniques to maintain interest and avoid a repetitive style.

- **Ask a question of the entire group.** The advantage of this technique is that those who wish to volunteer may do so; however, some learners might dominate while others might not participate.
- **Target the question to a specific learner by using her/his name before asking the question.** The learner is aware that a question is coming and can concentrate on the question and respond accordingly. The disadvantage is that once a specific learner is targeted, others might not concentrate on the question.
- **State the question, pause, and then direct the question to a specific learner.** All learners must listen to the question in case they are asked to respond. The primary disadvantage is that the learner receiving the question might be caught off guard and need to ask the trainer to repeat the question.

The key in asking questions is to avoid a pattern. The skilled trainer uses all three of the above techniques to provide variety and maintain the learners' attention. Other techniques include the following:

- **Use learners' names** during questioning. This is a powerful motivator and also helps ensure that all learners are involved.
- **Repeat a learner's correct response.** This provides positive reinforcement to the learner and ensures that the rest of the group heard the response.
- **Provide positive reinforcement for correct responses** to keep the learner involved in the topic. Positive reinforcement may take the form of praising a learner, displaying a learner's work, using a learner as an assistant, or using positive facial expressions, nods, or other nonverbal actions.
- **When a learner's response is partially correct**, the trainer should reward the correct portion and then improve the incorrect portion or redirect a related question to that learner or to another learner.
- **When a learner's response is incorrect**, the trainer should make a noncritical response and restate the question to lead the learner to the correct response.
- **When a learner makes no attempt to respond**, the trainer may wish to follow the above procedure or redirect the question to another learner. Come back to the first learner after receiving the desired response and involve her/him in the discussion.
- **When learners ask questions**, the trainer must determine an appropriate response by drawing upon personal experience and weighing the individual's needs against those of the group. If the question addresses a topic that is relevant but has not been previously discussed, the trainer can either:
  - Answer the question and move on; or
  - Respond with another question, thereby beginning a discussion about the topic.

Summarizing Presentations

A **summary** is used to reinforce the content of a presentation and provide a review of its main points. The summary should:

- Be brief;
- Draw together the main points; and
- Involve the learners.

Many summary techniques are available to the trainer:

- **Asking the learners for questions** gives learners an opportunity to clarify their understanding of the instructional content. This can result in a lively discussion focusing on those areas that seem to be the most troublesome.
- **Asking the learners questions** that focus on major points of the presentation helps the learners summarize what they have just heard.

- **Administering a practice exercise or test** gives learners an opportunity to demonstrate their understanding of the material. After the exercise or test, use the questions as the basis for a discussion by asking for correct answers and explaining why each answer is correct.
- **Using a game to review main points** provides some variety, when time permits. One popular game is to divide learners into two teams, give each team time to develop review questions, and then allow each team to ask questions of the other. The trainer serves as moderator by judging the acceptability of the questions, clarifying answers, and keeping a record of team scores. This game can be highly motivational and serve as an excellent summary at the same time.

Facilitating Group Discussions

The **group discussion** is a learning method in which most of the ideas, thoughts, questions, and answers are developed by the learners. The trainer typically serves as the **facilitator** and guides the learners as the discussion develops.

Group discussion is useful at the following times:

- At the conclusion of a presentation
- After viewing a video
- Following a clinical demonstration or skills practice session
- After reviewing a case study or clinical simulation
- After a role play
- Any other time when learners have prior knowledge or experience related to the topic

Attempting to conduct a group discussion when learners have limited knowledge of or experience with the topic often will result in little or no interaction and thus an ineffective discussion. When learners are familiar with the topic, the ensuing discussion is likely to **arouse learner interest, stimulate thinking, and encourage active participation.** This interaction affords the trainer an opportunity to:

- Provide positive feedback;
- Stress key points;
- Develop critical thinking skills; and
- Create a positive learning climate.

The trainer must consider a number of factors when selecting group discussion as the learning strategy:

- Discussions involving **more than 15 to 20 learners** are sometimes difficult to lead and might not give each learner an opportunity to participate.
- Discussion requires **more time** than an illustrated lecture because of the extensive interaction among the learners.

- A **poorly directed discussion may move off target** and never reach the objectives established by the trainer.
- **If control of the discussion is not maintained**, a few learners might dominate while others lose interest.

In addition to a **group discussion** that focuses on the session objectives, there are two other types of discussions that can be used in a training situation:

- **General discussion** that addresses learners' questions about a learning event (e.g., why one type of episiotomy is preferred over another)
- **Panel discussion** in which a moderator conducts a question-and-answer session with panel members and learners

Follow these key guidelines to ensure successful group discussions:

- **Arrange seating to encourage interaction** (e.g., tables and chairs set up in a U-shape or a square or circle so that learners face each other).
- **State the topic** as part of the introduction.
- **Shift the conversation** from the trainer to the learners.
- **Act as a referee** and intercede only when necessary.

  Example: "It is obvious that Seema and Radhika are taking two sides in this discussion. Seema, let me see if I can clarify your position. You seem to feel that . . . ."
- **Summarize the key points** of the discussion periodically.

  Example: "Let's stop here for a minute and summarize the main points of our discussion."
- Ensure that the discussion stays on the topic.
- Use the contributions of each learner and provide positive reinforcement.

  Example: "That is an excellent point, Rosminah. Thank you for sharing that with the group."
- Minimize arguments among learners.
- Encourage all learners to get involved.
- Ensure that no single learner dominates the discussion.
- Conclude the discussion with a summary of the main ideas. The trainer must relate the summary to the objective presented during the introduction.

Facilitating a Brainstorming Session

Brainstorming is a learning strategy that **stimulates thought and creativity** and is often used in conjunction with group discussions. The primary purpose of brainstorming is to generate a list of ideas, thoughts, or alternative solutions that focus on a specific topic or problem. This list may be used as the introduction to a topic or form the basis of a group discussion. Brainstorming requires that learners have some background related to the topic.

The following guidelines will facilitate the use of brainstorming:

- Establish ground rules.

  Example: "During this brainstorming session we will be following two basic rules. All ideas will be accepted and Jim will write them on the flip chart. Also, at no time will we discuss or criticize an idea. Later, after we have our list of suggestions, we will go back and discuss each one. Are there any questions? If not . . . ."

- Announce the topic or problem.

  Example: "During the next few minutes we will be brainstorming and will follow our usual rules. Our topic today is 'indications and contraindications for Jadelle and the WHO medical eligibility criteria.' I would like each of you to think of at least one indication. Maria will write these on the board so that we can discuss them later. Who would like to be first? Yes, Joel . . . ."

- Maintain a written record of the ideas and suggestions on a flip chart or writing board. This will prevent repetition and keep learners focused on the topic. In addition, this written record is useful when it is time to discuss each item.
- Involve the learners and provide positive feedback in order to encourage more input.
- Review written ideas and suggestions periodically to stimulate additional ideas.
- Conclude brainstorming by reviewing all of the suggestions and clarifying those that are acceptable.

Facilitating Small Group Activities

There are many times during training that the learners will be divided into several **small groups**, which usually consist of four to six learners. Examples of small group activities include the following:

- Reacting to a case study, which may be presented in writing or orally by the trainer, or introduced through video or slides
- Preparing a role play within the small group and presenting it to the entire group Dealing with a clinical situation/scenario, such as in a clinical simulation, which has been presented by the trainer or another learner
- Practicing a skill that has been demonstrated by the trainer using anatomic models

Small group activities offer many advantages, including:

- Providing learners an opportunity to **learn from each other,**
- **Involving** all learners,
- Creating a sense of **teamwork** among members as they get to know each other, and
- Providing for a **variety of viewpoints.**

When small group activities are being conducted, it is important that learners are not in the same group every time. The trainer can create small groups in different ways, such as:

- **Assigning** learners to groups,
- Asking learners to **count off** ("1, 2, 3," etc.) and having all learners with the same number in a group together,
- Asking learners to **form their own groups, or**
- Asking learners to **draw a group number** (or group name).

The room(s) used for small group activities should be large enough to allow different arrangements of tables, chairs, and teaching aids (models, equipment) so that individual groups can work without disturbing one another. The trainer should be able to move easily about the room to visit each group. If smaller rooms are available near the primary training room, consider having small groups go to them to work on their problem-solving activity, case studies, clinical simulations, or role plays. Note that it will be difficult to conduct more than one clinical simulation at the same time in the same room/area.

Activities assigned to small groups should be **challenging, interesting, and relevant**; should require **only a short time to complete**; and should be **appropriate for the backgrounds of the learners**. The small groups may be working on the same activity, or each group may be taking on a different problem, case study, clinical simulation, or role play. Regardless of the type of activity, there is usually a time limit. When this is the case, inform groups when there are 5 minutes left and when their time is up.

Instructions may be presented to the groups in several ways:

- On a hand-out
- On a flip chart
- On a transparency
- Verbally by the trainer

Instructions for small group activities typically include:

- Directions
- **Time limit**
- **A situation or problem** to discuss, resolve, or role play
- **Learner roles** (if a role play)
- Questions **for group discussion**
-

Once the groups have completed their activity, the clinical training trainer will **bring them together** as a large group to discuss the activity. The discussion might involve:

- **Reports** from each group,
- **Responses** to questions,
- **Role plays** developed in each group and presented by learners in the small groups,

- **Recommendations** from each group, and/or
- **Discussion of the experience** (if a clinical simulation).

The trainer should provide an effective summary discussion after small group activities. This provides closure and ensures that learners understand the point of the activity.

Conducting an Effective Clinical Demonstration

When a new clinical skill is being introduced, a variety of methods can be used to demonstrate the procedure. For example:

- Show **slides** or a **video** in which the steps and their sequence are demonstrated in accordance with the accepted performance standards.
- Use **anatomic models** such as the postpartum IUD clinical simulator to demonstrate the procedure and skills.
- Perform **role plays** in which a learner or surrogate client simulates a client and responds as a real client would.
- Demonstrate the procedure with clients in the clinical setting (clinic or hospital).

Whatever methods are used to demonstrate the procedure, the trainer should set up the activities using the "whole-part-whole" approach.

- Demonstrate the whole procedure from beginning to end to give the learner a visual image of the entire procedure or activity.
- Isolate or break down the procedure into activities (e.g., preoperative counseling, getting the client ready, preoperative tasks, performing the procedure, etc.) and allow practice of the individual activities of the procedure.
- Demonstrate the whole procedure again and then allow learners to practice the procedure from beginning to end.

When planning and giving a demonstration of a clinical procedure, either using anatomic models or with clients, if appropriate, the trainer should use the following guidelines:

- Before beginning, state the objectives of the demonstration and point out what the learners should do (e.g., interrupt with questions, observe carefully, etc.).
- Make sure that everyone can see the steps involved.
- Never demonstrate the skill or activity incorrectly.
- Demonstrate the procedure in as realistic a manner as possible, using instruments and materials in a simulated clinical setting.

- Include all steps of the procedure in the proper sequence, according to the approved performance standards. This includes demonstrating "nonclinical" steps such as pre- and postoperative counseling, communication with the client during surgery, use of recommended infection prevention practices, and so on.
- During the demonstration, explain to learners what is being done, especially any difficult or hard-to-observe steps.
- Ask questions of learners to keep them involved. Example: "What should I do next?" "What would happen if…?"
- Encourage questions and suggestions.
- Take enough time so that each step can be observed and understood. Remember that the objective of the demonstration is for learners to learn the skills, not for the trainer to show her/his dexterity and speed.
- Use equipment and instruments properly and make sure learners clearly see how they are handled.

In addition, when observing the trainer's performance during the initial demonstration, learners should use a clinical skills checklist developed specifically for the clinical procedure. Doing this:

- Familiarizes the learner with the use of competency-based clinical skills checklists;
- Reinforces the standard way of performing the procedure; and
- Communicates to learners that the trainer, although very experienced, is not absolutely perfect and can accept constructive feedback on her/his performance.

As the role model the learners will follow, the trainer must practice what she/he demonstrates (i.e., the approved standard method as detailed in the learning guide). Therefore, it is essential that the trainer use the standard method. During the demonstration, the trainer should also provide supportive behavior and cordial, effective communication with the client and staff to reinforce the desired outcome.

Managing Clinical Practice

Getting the most out of clinical practice requires that the trainer be well acquainted with the clinical practice sites. Ideally, the trainers should be staff from the hospital or clinic where the clinical practice for the training will take place. If that is not the case, then being very familiar with the health care facility before training begins will enable the trainer to develop a relationship with the staff, address any inadequacies in the situation, and prepare for the best possible learning experience for learners. Even the best planning, however, is not always enough to ensure a successful clinical practice experience. In the classroom, the trainer is able to control the schedule and activities to a large extent, but in the clinic the trainer must always be alert to unplanned learning opportunities that may arise at any time and be ready to modify the schedule accordingly.

Performing Clinical Procedures with Clients

The final stage of clinical skills development involves practicing procedures with clients. Anatomic models, no matter how realistic, cannot substitute entirely for the reality of performing the procedure with a living, breathing, feeling, and reacting human being. The disadvantages of using real clients during clinical skills training are obvious: Clients may be subjected to increased discomfort or even increased risk of complications when procedures are performed by unskilled clinicians. When possible and appropriate, learners should be allowed to work with clients only after they have correctly and consistently demonstrated the skills on an anatomic model or in a simulated situation. In this implants course, the learners are provided the opportunity to learn implant insertion techniques on Day 1. All learners should practice and be qualified in the procedure before they proceed to the clinical areas.

The rights of clients should be considered at all times during a clinical training course. The following practices will help ensure that clients' rights are routinely protected during clinical training:

- The right to bodily privacy must be respected whenever a client is undergoing a physical examination or procedure. The client should be draped appropriately for all examinations and procedures.
- The confidentiality of any client information obtained during counseling, history taking, physical examinations, or procedures must be strictly observed. Clients should be reassured of this confidentiality. Confidentiality can be difficult to maintain when actual cases are used in learning exercises such as case studies and clinical meetings. Such discussions always should take place in a private area where other staff and clients cannot overhear and should be conducted without reference to the client by name.
- When receiving counseling, undergoing a physical examination, or receiving postpartum family planning services, the client should be informed of the role of each person involved (e.g., trainers, individuals undergoing training, and support staff).
- The client's permission should be obtained before having a clinician-in-training observe, assist with, or perform any procedures. Understanding the right to refuse care from a clinician-in-training is important for every client. Furthermore, care should not be rescheduled or denied if the client does not permit a clinician-in-training to be present or provide services. In such cases, the trainer or other staff member should perform the procedure.
- The trainer should be present during any client contact in a training situation and the client should be made aware of the trainer's role. Furthermore, the trainer should be ready to intervene if the client's safety is in jeopardy or if the client is experiencing severe discomfort.
- The trainer must give coaching and feedback carefully during practice with clients. Corrective feedback in the presence of a client should be limited to errors that could harm or cause discomfort to the client. Excessive negative feedback can create anxiety for both the client and the clinician-in-training.
- Clients should be chosen carefully to ensure that they are appropriate for clinical training purposes. For example, learners should **not** practice with "difficult" clients until they are proficient in performing the procedure.

Creating Opportunities for Learning

Planning for Learning

The trainer should develop a plan for each day spent in the health care facility. The plan will provide a daily focus that is consistent with the learning objectives and help to ensure that all required skills will be adequately addressed. When preparing the plan, the trainer should consider the following points:

- Clinical practice should progress from basic to more complex skills. This not only helps ensure the safety and quality of care provided by learners, but also allows them to gain self-confidence as they demonstrate competency in the basic skills.
- To maximize these opportunities, the trainer should consider the following strategies:
  - Discuss with staff weeks before the training that there will be providers training in implant services and note the dates on which implant services will be available at no charge to clients.
  - Consider several clinic sites that have busy family planning clinics and ensure that transportation is available to take learners to various clinics.

In addition to daily practice of specific clinical skills, the **trainer's plan should include other areas of focus,** such as infection prevention, facility logistics, and client flow. Although these topics may not be directly assessed with a checklist or other tool, they play an important role in the provision of high-quality implant services. To make sure that learners give adequate attention to these topics, the trainer should design and develop activities such as the following:

- Observing the infection prevention practices used in the facility. Which recommended practices are being used, and which are not? Are they being used consistently and correctly? Why or why not?
- Reviewing facility-based records for the past several months to identify the types of family planning clients seen. Additional information could be obtained, such as the most common complications and side effects and how to manage them.

In the Health Care Facility

As has been mentioned, planning alone is not sufficient to guarantee a successful clinical practice. There are several strategies that a trainer can use in the health care facility to increase the likelihood of success.

- The trainer must **actively monitor** the skills each learner is able to practice, and with what frequency, so that each learner has adequate opportunities to develop competency.
- The **learners also should be encouraged to watch** for such learning opportunities. The trainer may then decide which, and how many, of the learners will be assigned to a particular client. The trainer and learners should remember that clinical experiences need to be shared equally.

- To take advantage of opportunities as they occur may require that the trainer **modify the plan for that day and subsequent days**, but with as little disruption as possible in the provision of services. Learners should be notified of any changes as early as possible so that they can be well prepared for each clinical day.
- In some training situations, all learners might not have the opportunity to work with all types of clients. The trainer will need to **supplement the work with clients with additional work on anatomic models and discussions.** The trainer will need to determine if a learner can be qualified as competent to provide implant services if she/he has not completed all the skills that are central to the objectives of the course.

Conducting Pre- and Post-Clinical Practice Meetings

Health care facilities do not always have meeting rooms, so the trainer must make every effort to find a space that:

- Allows **free discussion**, small group work, and practice on models; and
- Is **away from the client care area** if possible, so as to not interfere with efficient client care or other staff duties.

Pre-Clinical Practice Meetings

The trainer and learners should meet at the beginning of each clinical practice session. The meeting should be brief. The following items should be covered:

- The learning objectives for that day
- Any scheduling changes that may be needed
- Learners' roles and responsibilities for that day, including the work assignments and rotation schedule, if applicable
- Special assignments to be completed that day
- The topic for the post-clinical practice meeting, so that the learners can take special note of anything that happens during the day that would contribute to the discussion
- Questions related to that day's activities or from previous days, if they can be answered concisely; if not, they should be deferred until the post-clinical practice meeting

Post-Clinical Practice Meetings

The trainer should end each clinical practice day with a meeting to review the day's events and build on them as learning experiences. A minimum of 30 minutes is recommended. These meetings are used to:

- Review the day's learning objectives and assess progress toward their completion;
- Present cases seen that day, particularly those that were interesting, unusual, or difficult;

- Respond to questions concerning situations and clients in the health care facility or information in the reference manual;
- Plan for the next clinical session, making changes in the schedule as necessary; and
- Conduct additional practice with models if needed.

The Trainer as Supervisor

In the role of supervisor, the trainer must monitor learner activities in the health care facility so that:

- Each learner receives appropriate and adequate opportunities for skills practice;
- Learners do not disrupt the efficient provision of services within the facility or interfere with staff and their duties; and
- The care provided by each learner does not harm clients or place them in an unsafe situation.

The trainer must always be with learners when they are working with clients, especially when they are performing clinical procedures. Trainers might have more than one or two learners to supervise. Because the trainer cannot be with all of them at the same time, other methods of supervision must be used.

- Learners must understand what they can do independently and what requires trainer supervision, so that they can keep busy when the trainer is working with other learners. Learners should take responsibility for ensuring that they are supervised when necessary. However, the trainer holds the ultimate responsibility.
- Additional activities that require no direct supervision will give learners the opportunity to be actively engaged in learning when they are not with clients.
- Clinical staff also can act as supervisors if the trainer is confident of their clinical skills and ability to provide appropriate feedback. The possibility of having clinical staff supervise learners is another reason for the trainer to get to know the staff before training begins. During clinical site preparation, the trainer can observe the skills of the staff members and verify that they are competent, if not proficient, service providers. The trainer might also have the opportunity to assess staff members' coaching skills and even to work with staff members to improve their skills so that they can serve as role models and support learners.
- The more learners there are in a facility, the more the trainer relies upon the staff to act as trainers. The trainer has the ultimate responsibility for each learner, including final assessment of skill competency. For this reason, if multiple clinical sites are used during a course, a trainer must be assigned to each site.
- Because clinical staff usually are not involved in the classroom portion of a course, they do not get to know the learners and their abilities before the learners arrive at the facility. It is a good idea to share such information with the clinical staff if they will take over a large part of the learner supervision. Clinical staff should also be encouraged to do an initial assessment of learners' skills before allowing them to work with clients, so that they can feel confident that the learners are well prepared.

- Clinical staff should also be aware of the feedback the trainer would like to receive about learners.
  - Will it be oral, written, or both? If written feedback is needed, the trainer should design an instrument or form to guide the clinical staff. The trainer should develop a form that staff members can complete quickly and easily, should instruct the staff in its use, and should furnish enough copies of the form for staff to use.
  - How frequently will feedback be provided?
  - Should both positive and corrective feedback be provided?
  - Are there appropriate administrative channels through which the feedback should be transmitted? In some clinics, staff members provide their feedback to the individual in charge of the health care facility who then prepares a report for the trainer.
- When designing the feedback system, the trainer should keep in mind the time required to prepare and provide feedback. This will be extra work for the clinical staff, who already have a very busy schedule. It is best to keep the feedback system as simple and easy to use as possible.

The Trainer as Coach

One of the most difficult tasks for the trainer, and one with which even experienced trainers struggle, is to be a good coach and provide feedback in the clinical setting. No matter how comfortable a trainer is giving feedback in the classroom or while working with models, the situation changes in the facility. The clients, staff, and other learners are nearby, and the facility's emergency services need to keep running smoothly and efficiently. The trainer often feels pressured to keep things moving because other clients need to be seen. The trainer also needs to be available to all the learners. Spending too much time with any one client or learner has an impact on everyone.

Feedback Sessions

Feedback sessions before and after practice are often skipped in an effort to save time. However, these sessions are very important to the continued development of the learner's psychomotor or decision-making skills. Without adequate feedback and coaching, the learner might miss an important learning opportunity and take longer to achieve competency. Keep in mind that by this time the learner has already demonstrated competency on a model and may not need extensive feedback. To minimize disruption of services, the pre- and post-practice feedback sessions can take place in just a few minutes in a location away from the client care areas.

- The structure of the feedback session is essentially the same regardless of whether the session takes place before or after practice, and whether it is for a learner's performance with models or with clients.
- The learner should first identify personal strengths and the areas where improvement is needed.
- Next, the trainer should provide specific, descriptive feedback that includes suggestions of not only what to improve, but also how to improve.
- Finally, the learner and the trainer should agree on the focus of the practice session, including how they will interact while they are with the client. For example, they may agree that if the trainer places a hand on the learner's shoulder, it is a signal to stop and wait for further instructions.

The feedback session before practice should be given before the trainer and learner enter the room to work with the client. The feedback session after practice can be delayed until the client's care has been completed or the client is in stable condition and no longer needs continuous care. The trainer should try not to delay feedback any longer than necessary. Feedback is always more effective when given as soon after care as possible. This will also allow the learner to use the feedback with the next client for whom services are provided, if appropriate.

Feedback during a Procedure

Be sure the client knows that the learner, although already a service provider, is also still a learner. Reassure the client that the learner has had extensive practice and mastered the skill on models. The client should expect to hear the trainer talk to the learner and understand that it does not mean that something is wrong. Finally, the client should clearly understand that the trainer is a proficient service provider and is there to ensure that the procedure is completed safely and without delay.

Positive Feedback

Positive feedback is often easy to give and can be provided in the presence of the client. Trainers often think that hearing feedback, even positive feedback, will disturb the client. Many clients, however, find it comforting to hear the trainer give the learner positive feedback.

- Keep the feedback restrained and low-key; overly exuberant praise can be as worrisome to the client as hearing negative comments. Too much praise may cause the client to wonder, "What is being hidden?" "Why is it so surprising that this person is doing a good job?"
- Positive feedback can be conveyed by facial expression and tone of voice, rather than words, and still be highly effective.

At the same time, the **absence** of feedback of any kind can be disturbing to the learner. By this phase of skill development the learner is expected to do a good job, even with the first client, and is accustomed to hearing positive comments. To maintain the learner's confidence, continue to give positive feedback.

Corrective Feedback

Corrective feedback is difficult to give under any circumstances, but particularly when a client is present. It is important to keep such feedback low-key and restrained. There are a number of techniques that will make it easier.

- Often a look or hand gesture (e.g., a touch on the shoulder) can be as effective as words and less worrisome to the client.
- Simple suggestions to facilitate the procedure can be made in a quiet, direct manner. Do not go into lengthy explanations of why you are making the suggestion or offering an observation; save that for the post-practice feedback session.

- To help a learner avoid making a mistake, the trainer can calmly ask a simple, straightforward question about the procedure itself. If a step in a procedure is about to be missed, for example, asking the learner to name the next step before doing anything further could help avoid an error. This is not the time to ask hypothetical questions about potential side effects and complications, as this may distract the learner and alarm the client.
- Sometimes, even though they have had extensive practice on models, learners make mistakes that can potentially harm the client. In these instances, the trainer must be prepared to step in and take over the procedure at a moment's notice. This should be done calmly and with complete control to avoid unnecessarily alarming the client.

Where Practice Meets Reality

Practicing in simulation (or in a classroom) is necessary preparation for gaining practical experience in the clinical setting—but the "practicing," as such, continues. Ttrue skills competency can be achieved only by practicing with actual clients. This is because part of being competent is being able to provide high-quality services in real-life situations **with living, breathing people**—despite difficult emotions, unexpected findings, and other unanticipated occurrences. So, although trainers and learners will continue to use many of the tools and methods they became familiar with in the classroom, building on what they already know, no one knows what will actually happen in the clinical setting . . . not even the trainer. Ensuring that learners can practice and finally demonstrate the desired competencies in this "uncharted territory" requires careful planning, clear communication, flexibility, and a firm commitment to protecting the safety and rights of clients—on the parts of everyone involved: the trainer(s), learners, and clinical staff.

Appendix 3: Using the Reproductive Implant Training Arm (RITA) Correctly

To practice LARC insertion and removal, learners should use the training model as if it were an actual client. Follow all insertion and removal steps in the training manual. During insertion training, the trocar should pass between the skin tube and the foam core (muscle tissue). If resistance is felt, the trocar probably has cut into the foam core because it was inserted at too deep an angle.

Immediately after insertion practice, learners can practice the removal techniques. If they inserted some of the implants too deep, they will have difficulty removing them, just as would occur with an actual client.

How to Care for the Training Model:

- If the skin tube becomes sticky and dirty, it may be washed, dried, and recoated inside with powder.
- Rotate the skin tube each time you use it to make it last longer. Avoid making incisions close together.
- Do not store the model with more than one tension block in place. If more than one block is left in place, the rods will imprint the foam core, making removal of implants very difficult.
- To ensure that the tension of the skin tube remains uniform during insertion practice, insertions should be initiated from the middle of the model's surface and directed toward either end of the model.

Instructions for Using a Zoe Gynecologic Simulator

A ZOE Gynecologic Simulator is a model of a full-sized, adult female lower torso (abdomen and pelvis). It is a versatile training tool developed to help health professionals teach the processes and skills needed to perform many gynecologic procedures. ZOE models are ideal for demonstrating and practicing the following procedures:

- Bimanual pelvic examination, including palpation of normal and pregnant uteri
- Vaginal speculum examination
- Visual recognition of normal cervixes and abnormal cervixes
- Uterine sounding
- IUD insertion and removal
- Diaphragm sizing and fitting
- Laparoscopic inspection and occlusion of fallopian tubes (Falope rings or other clips)

- Minilaparotomy (both interval and postpartum tubal occlusion)
- Treatment of incomplete abortion using manual vacuum aspiration (MVA)

Contents of the Original Zoe Model

There are several models of ZOE Gynecologic Simulators now available, including an interval model and postpartum kit, so specific parts and accessories will vary. The original ZOE Gynecological Simulator kit includes the following:

Item	Quantity
Normal ante- and retroverted uteri with clear tops, attachments for round and ovarian ligaments as well as fallopian tubes, and normal patent cervical os for pelvic examination and IUD insertion	2
6–8 week uterus with dilated (open) cervical os, which allows passage of a 5 or 6 mm flexible cannula	1
10–12 week uterus with dilated (open) cervical os, which allows passage of a 10 or 12 mm flexible cannula	1
Postpartum uterus (20 week size) with attached fallopian tubes for practicing postpartum tubal occlusion by minilaparotomy	1
Cervixes (not open) for use in visual recognition:	
• Normal cervix	1
• Cervix with proliferation of columnar epithelium (ectropion)	1
• Cervix with inclusion (nabothian) cyst and endocervical polyp	1
• Cervix with lesion (cancer)	1
Normal cervixes with open os for IUD insertion/removal	5
Cervixes for 6–8 week and 10–12 week uteri (2 of each size)	4
Normal tubal fimbriae and ovaries (2 of each)	4
Fallopian tubes for tubal occlusion	8
Simulated round and ovarian ligaments (set of 2 each)	4
Extra thin cervical locking rings	3
Flashlight with batteries	1
Soft nylon carrying bag	1

Outer Skin

The outer skin of the model is foam-backed in order to simulate the feel of the anterior pelvic wall. The entire outer skin is removable to allow the model to be used for demonstration purposes (e.g., performing IUD insertion).

The 3 cm incision (reinforced at each end) located just below the umbilicus can be used to insert a laparoscope to look at the uterus, round ligaments, ovaries, and fallopian tubes, and to practice laparoscopic tubal occlusion. This incision also can be used for practicing postpartum tubal ligation by minilaparotomy.

The 3 cm incision located a few centimeters above the symphysis pubis is used for practicing interval minilaparotomy. This incision also is reinforced, which allows the skin to be retracted to facilitate demonstration of the minilaparotomy technique.

Cervixes

The normal cervixes have a centrally located, oval-shaped os, which permits insertion of a uterine sound, uterine elevator, or IUD. The abnormal cervixes are not open and can be used for demonstration only.

Each of the cervixes for treatment of incomplete abortion has a centrally located, oval-shaped os, which is dilated to allow passage of a 5 or 6 mm or 10 or 12 mm flexible cannula, respectively.

The normal cervixes and interchangeable uteri feature the patented "screw" design for fast and easy changing.

Assembly of the Original Zoe Model

To use the original ZOE pelvic model for demonstrations, or initially to learn how to change the parts (e.g., cervixes and uteri), you need to know how to remove the skin.

Removing and Replacing the Detachable Skin and Foam Backing

1. First, carefully remove the outer skin and its foam lining away from the rigid base at the "top" end of the model. ("Top" refers to the portion of ZOE nearest to the metal carrying handle located above the umbilicus.)
2. Lift the skin and foam up and over the legs, one leg at a time.
3. *Be as gentle as possible*. The detachable skin is made of material that approximates skin texture and it *can* tear.
4. If you wish to change the anteverted uterus and normal cervix that are shipped attached to the ZOE, first you must remove the uterus.
5. Start by pulling the round ligaments away from the wall.
6. Then grasp the uterus while turning the *wide* grey ring counterclockwise until the cervix and uterine body are separated.
7. To remove the *cervix*, turn the *thin* grey ring counterclockwise until it comes off.
8. You then can push the cervix out through the vagina.
9. To reassemble, simply reverse this process.
10. To replace the skin and foam lining, start by pulling them down over the legs.
11. Then make sure the rectal opening is aligned with the opening in the rigid base.
12. Pull the skin and foam over the top of the model.
13. Finally, make sure that both are pulled firmly down around the rigid base, and that the skin is smoothly fitted over the foam.

Once you understand how ZOE's anatomic parts fit together, we suggest you change them through the opening at the top of the model. This will help to preserve ZOE's outer shell as you will only have to remove it for demonstrations or to change the postpartum (20 week size) uterus.

The anteverted and retroverted uteri have transparent top halves and opaque lower halves for use in demonstrating IUD insertion. These uteri are supported by round ligaments attached to the pelvic wall. The round ligaments, ovaries, and fallopian tubes are removable.

To remove the uterus:

- Unscrew the wide locking ring attached to the uterus using a counterclockwise rotation.

To remove the cervix:

- Unscrew the thin locking ring immediately outside the apex of the vagina.
- The cervix should be pushed through the vagina and removed from the introitus.

To reassemble, proceed in reverse order.

Procedures with All Zoe Models

Speculum examination:

- Use a medium bivalve speculum.
- Prior to inserting the speculum, dip it into clean water containing a small amount of soap. (This makes inserting the speculum easier.)
- To see the cervix, fully insert the speculum, angle it posteriorly (as in the human, the vagina in the ZOE model is angled posteriorly), then open the blades fully.
- To increase the diameter of the opening, use the speculum thumb screw (Pederson or Graves speculum).

Passing instruments (uterine sound, uterine elevator, dilator, or cannula) through the cervical os:

- Apply a small amount of clean water containing a drop or two of soap solution to the cervix (just as you would apply it with antiseptic solution in a client). This will make passing the instrument through the cervical os easier.

Sounding the uterus, inserting an IUD, and interval minilaparotomy or laparoscopy:

- Use either the normal (nonpregnant) anteverted or retroverted uterus with a cervix having a patent os.

Postpartum minilaparotomy (tubal occlusion):

- Use the postpartum uterus (20 week size) with a cervix having a patent os.

Treatment of incomplete abortion using MVA:

- Use either the 6 to 8 week or the 10 to 12 week uterus (incomplete abortion) with

the appropriate size cervix.

Care and Maintenance of All Zoe Models

The specific model of ZOE Gynecological Simulator will vary, depending on the location of the training site and the procedures being performed, but the care and maintenance are the same for all of these models.

- ZOE is constructed of material that approximates skin texture. Therefore, in handling the model, use the same gentle techniques you would use when working with a client.
- To avoid tearing ZOE's skin when performing a pelvic exam, use a dilute soap solution to lubricate the instruments and your gloved fingers.
- Clean ZOE after every training session using a mild detergent solution; rinse with clean water.
- DO NOT write on ZOE with any type of marker or pen, as these marks may not wash off.
- DO NOT use alcohol, acetone, Betadine7, or any other antiseptic that contains iodine on ZOE. They will damage or stain the skin.
- Store ZOE in the carrying case and plastic bag provided with your kit.
- DO NOT wrap ZOE in other plastic bags, newspaper, plastic wrap, or any other kind of material, as these may discolor the skin.

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i Campbell MR and Graham WJ. 2006. Strategies for reducing maternal mortality: Getting on with what works. *Lancet* 368(9543): 1284–1299.

ii Conde-Agudelo A et al. 2005. Effect of the interpregnancy interval after an abortion on maternal and perinatal health in Latin America. *International Journal of Gynecology and Obstetrics* 89(Suppl 1): S34_S40.

iii Conde-Agudelo A, Rosas Bermudez A and Kafury-Goeta AC. 2006. Birth spacing and risk of adverse perinatal outcomes: A meta-analysis. *Journal of the American Medical Association* 295(15):1809–1823.

iv Da Vanzo J et al. 2004. "The Effects of Birth Spacing on Infant and Child Mortality, Pregnancy Outcomes, and Maternal Morbidity and Mortality in Matlab, Bangladesh." Rand Labor and Population Working Paper Series, WR-198. Rand Corporation: Santa Monica, California.

v Razzaque A et al. 2005. Pregnancy spacing and maternal mortality in Matlab, Bangladesh. *International Journal of Gynecology and Obstetrics* 89(Suppl 1): S41–S49.

vi Rutstein SO. 2005. Effects of preceding birth intervals on neonatal, infant and under-five years mortality and nutritional status in developing countries: Evidence from the Demographic and Health Surveys. *International Journal of Gynecology and Obstetrics* 89(Suppl 1): S7–S24.