Section 3.1

Training on Family Planning

Family planning

Purpose:

The objective of this session is to enhance skills of participant on provision of quality training as a mentor and strengthen knowledge and skills of participants on all contraceptive methods to improve maternal health and provision of services at family health center level.

Objectives:

- By the end of this course, learners will be able to:

- Identify and understand Key messages of HTSP (healthy timings and spacing for pregnancy)
- Participants will be able list and identify all contraceptive methods including emergency methods, which are available in Pakistan along with the accessibility.
- Importance of Family planning counselling at different level including pre-marital, antenatal and post-pregnancy FP Counselling using GATHER approach and follow up care.
- Screening client for eligibility criteria using MEC wheel.
- Non-Judgmental and comprehensive approach for provision for services for all clients, including young adolescent clients.
- Hands on and demonstration of IUCD insertion removal on pelvic dummies .

Total Time : ……..

Module 3.1.1:

Healthy Timing and Spacing of Pregnancy (HTSP):

Healthy timing and spacing helps to mediate better health outcomes for women, infants, newborns and family health system through planning healthy delay or space pregnancies taking in account the rights of informed choice, and within context of fertility intentions and desired family size.

Material

- **Video: Behram Khan ke Cricket Team https://www.youtube.com/watch?v=rQ36SkdMgwc**
- **Power point presentation**
- **Panaflex/ flyers on HTSP**
- **HTSP video https://www.youtube.com/watch?v=7tmYXW7DT_U**

Period: 30 Minutes

Instructions:

- Start session by showing a video clip yo participants " Behram Khan ki Cricket Team" and the picture of shattered dreams. Ask participants if they have seen similar cases around them in routine practice.
- Explain in detail and importance of HTSP interventions in improving family health system through Power point presentation.
- Follow the session by revising Key messages written on Panaflex/Flyers by asking participants to read them loud one by one.
- Show them slide on Pakistan's law on child marriage and child labor to the participants.
- If time permits. Ask participants to demonstrate role play for counselling on HTSP to:
  1. A newly married couple
  2. Client who has come for an Antenatal visit

Fig 3.1.1:

درست وقت اور مناسب وقفہ

ماں اور بچے کی صحت سب سے بڑھ کر ہے۔ اس لیے بچوں کی پیدائش میں کم از کم تین سال کا وقفہ کریں۔

18سال سے کم عمر میں حاملہ ہونا، ماں اور بچے دونوں کی صحت اور زندگی کے لیئے نقصان دہ ہو سکتا ہے

35سال کے بعد حاملہ ہونا ، ماں اور بچے کی صحت اور زندگی کے لیے نقصان دہ ہوسکتا ہے

2 بچوں کے درمیان 5 سال سے زیادہ کا وقفہ پیچیدگی کا باعث ہو سکتا ہے

اگر حمل ضائع ہو جائے اور اگلے حمل کا ارادہ ہو تو کم از کم 6 ماہ کا وقفہ کریں

Module 3.1.2:

Sexual and Reproductive rights of Client

Objectives:

By the end of this session:

- Participants will be able to identify sexual and reproductive rights of their client coming to their health facility.
- Learners must understand different scenarios client may present with and they should be capable of linking them with different client rights.
- Motivate providers for providing high quality services with nonjudgmental and unbiased approach to their clients.
- To communicate strategies on how cients right can be respected in sexual/ reproductive health

Time: 30 minutes

Material

- Ropes
- Cloth hanging clips
- Flip cards
- Pana flex / PowerPoint Slide

Instructions:

- Trainee will tie ropes across 2 sides of the room leaving space for participants to move across.
- Facilitators will attach flip cards of SHRH explanations (mentioning different health related scenarios) to the rope with distance with the cloth clips. Fig 2.1.2
- Divide participants into 4 groups and give 4 flip cards of SHRH (sexual and reproductive health rights) to each group. Fig 2.1.3
- Explain participants that they are given few sexual and reproductive health rights cards of client. Tell them explanation of each right is attached to the ropes already. Participants of each group must match the given SHRH cards that explains the scenarios already attached to the rope. After finding the match both cards will be attached together.
- Tell participants they have 15 minutes to find the given SHRH explanation.
- After 10 minutes facilitator can observe and may find that there are more than one cards that are attached to one explanation. Like wise participants may not be able to find match for their cards.
- Ask participants of other groups to help find the explained match for remaining SHRH rights.
- At the end session ask participants to come back to their seats. Show them Powerpoint slide/ panaflex with IPPH Sexual and reproductive rights and statements explaining the rights. Fig 2.1.4
- Ask participants to read the slide loud one by one .

Fig 3.1.2A:

SRHR Explaination

Sexual and Reproductive Health Rights Explanation Cards

No woman's life should be put to risk by reason of pregnancy.

No person should be subjected to female genital mutilation, forced pregnancy, sterilization or abortion.

Equality and freedom from the discrimination in one's sexual and reproductive life.

All sexual and reproductive health-care services should be confidential and all women have the right to autonomous reproductive choices.

Includes freedom from the restrictive interpretation of religious texts, beliefs, philosophies and customs as tools to curtail freedom of thought on sexual- and reproductive-health care and other issues.

Relating to sexual and reproductive health for all, including access to full information on the benefits, risks and effectiveness of all methods of fertility regulation, in order that all decisions taken are made on the basis of full, free and informed consent.

Recognizes that all persons have the right to protection against a requirement to marry without that person's full, free and informed consent.

Recognizes that all persons have the right to decide freely and responsibly the number and spacing of their children and to have access to the information, education and means to enable them to exercise this right and further recognizes that special protection should be accorded to women during a reasonable period before and after childbirth.

Includes the right of health-care clients to the highest possible quality of health care, and the right to be free from traditional practices which are harmful to health.

Includes the right of sexual and reproductive health service clients to new reproductive-health technologies that are safe, effective and acceptable.

Includes the right of all persons to seek to influence communities and governments to prioritize sexual and reproductive health and rights.

Including the rights of all women, men and young people to protection from violence, sexual exploitation and abuse.

Fig 3.1.2B:

SRHR Explaination

Sexual and Reproductive Health Rights Cards

1. **The Right to Life**
2. **The Right to Liberty and Security of the Person**
3. **The Right to Equality and to be Free from all Forms of Discrimination**
4. **The Right to Privacy**
5. **The Right to Freedom of Thought**
6. **The Right to Information and Education**
7. **The Right to Choose Whether or Not to Marry and to Found and Plan a Family**
8. **The Right to Decide Whether or When to Have Children**
9. **The Right to Health Care and Health Protection**
10. **The Right to the Benefits of Scientific Progress**
11. **The Right to Freedom of Assembly and Political Participation**
12. **12. The Right to be Free from Torture and Ill-Treatment**

Table 3.1.1:

IPPF Charter on Sexual and Reproductive Rights Vision 2000. London

1. The Right to Life	No woman's life should be put to risk by reason of pregnancy.
2. The Right to Liberty and Security of the Person	No person should be subjected to female genital mutilation, forced pregnancy, sterilization or abortion.
3. The Right to Equality and to be Free from all Forms of Discrimination	Equality and freedom from the discrimination in one's sexual and reproductive life.
4. The Right to Privacy	All sexual and reproductive health-care services should be confidential and all women have the right to autonomous reproductive choices.
5. The Right to Freedom of Thought	Includes freedom from the restrictive interpretation of religious texts, beliefs, philosophies and customs as tools to curtail freedom of thought on sexual- and reproductive-health care and other issues.
6. The Right to Information and Education	Relating to sexual and reproductive health for all, including access to full information on the benefits, risks and effectiveness of all methods of fertility regulation, in order that all decisions taken are made on the basis of full, free and informed consent.
7. The Right to Choose Whether or Not to Marry and to Found and Plan a Family	Recognizes that all persons have the right to protection against a requirement to marry without that person's full, free and informed consent.
8. The Right to Decide Whether or When to Have Children	Recognizes that all persons have the right to decide freely and responsibly the number and spacing of their children and to have access to the information, education and means to enable them to exercise this right and further recognizes that special protection should be accorded to women during a reasonable period before and after childbirth.
9. The Right to Health Care and Health Protection	Includes the right of health-care clients to the highest possible quality of health care, and the right to be free from traditional practices which are harmful to health.
10. The Right to the Benefits of Scientific Progress	Includes the right of sexual and reproductive health service clients to new reproductive-health technologies that are safe, effective and acceptable.
11. The Right to Freedom of Assembly and Political Participation	Includes the right of all persons to seek to influence communities and governments to prioritize sexual and reproductive health and rights.
12. The Right to be Free from Torture and ill-Treatment	Including the rights of all women, men and young people to protection from violence, sexual exploitation and abuse.

Conclusion:

Facilitator will conclude the session by explaining basic human rights and adolescents Sexual and Reproductive Health and Rights in detail and briefly discuss clients Centered Approach in Healthcare settings.

Facilitator's Note:

Client- centered Approach

It is an approach taken by the healthcare provider (HCP) where the client is aware of his/her needs and is respected for his/ her rights. In a client- centered approach, services provider places the needs, risks, concerns, and circumstances/ situation of every client at the center while providing care to the clients. Reproductive services that are accessible to, acceptable by and appropriate for adolescents and youth are called adolescent and youth friendly reproductive services. They area the right place and right style to be acceptable by adolescent and young people. Programs that promotes access to adolescent and youth sexual and reproductive health services are effective with adolescent friendly approach of facility joined with community acceptance.

Two-way communication interaction that encourage client to:

- Explore available options for addressing their sexual and reproductive health concerns.
- Thoughtfully carry out their decisions
- Make decisions on informed choice taking in account their needs and social circumstance.
- Aware of their sexual and reproductive health risks and issues .

Clients rights include to have information about sexual and reproductive health, access and prevail the services regardless of gender, religion, status , politicial beliefs, region color and marital status. Every client has the right to whether planning pregnancy or adopting planning method, method of their choice moreover they have the right to avoid unwanted pregnancy, safy from sexual violence and disease. Obtaining sexual and reproductive services also brings that client has the right to have privacy and assurance that all her information will be kept with confidentiality and will not be shared without his/her permission. In addition, clients also have right of protection from other health risks such as safety from infections through contaminated instruments or environment. Client have the right to be treated with politeness, attention and consideration and to feel comfortable while receiving sexual and reproductive health services .

Module 3.1.3

Communication Skills in Family Planning

Counselling Skills in Sexual and Reproductive health and Family Planning

Overall training objective:

To strengthen the counselling and communication skills of service providers to support use of the *Decision-Making Tool for Family Planning Clients and Providers.*

Enabling objectives: By the end of these sessions, participants will be able to:

- Explain about components of counselling and be able to integrate communication skills and counselling into sexual and reproductive health services.
- Understand and describe purpose, principles and benefits of counselling and use the knowledge, skills and attitudes of effective counsellors.
- Identify qualities of good counsellor keeping in mind client rights during counselling to provide quality service.
- Explain the decision-making process.
- Apply interpersonal communication skills during counselling process.
- Discuss how to deal with sensitive issues in sexual and reproductive health.
- Learn to follow family planning counselling steps with "GATHER" approach.
- Define importance of counselling with clients and need of family planning counselling during; pre-marital,
- Antenatal, Post-abortion and Post-partum period.

Total session time: 6 hrs

Material

- Presentations
- Flip charts
- Markers
- Videos
- Clinic set up with counselling materials
- Contraceptive basket

Instructions:

Main component of counselling will be explained through Power point presentation that will cover mainly, basic principles and component of family planning counselling, characteristics of of a good counselor and GATHER approach

- Ask participants to be attentive during each presentation slide as rest of the module and its activities will depend on the knowledge from the presented slides and their performance during activities will be part of the assessment.
- At the end of presentations tell learners that following are the topics that can effect counselling and its outcomes.
- Ask them one by one to read them out loud.

a. Why do sexual and reproductive health providers need good counselling skills.
b. Knowledge, skills and attitudes of effective counselors.
c. Tone of communication
d. Active listening
e. Using simple language
f. Positive reinforcement
g. Belief value and attitude
h. Decision making-process

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a. Why do sexual and reproductive health providers need good counselling skills? (1 hr)

Objective:

To understand why counselling is important and how it affects the provision of services.

Activity:

Divide the participants into 4 small groups for discussion (20 mins)
In groups of 3 to 4, ask the participants to reflect on an incident, and discuss:

o Ask group 1 and 2 about situation in their life when the received bad counselling and how they felt and/or reacted (it doesn't neccessarily have to be family planning counselling).
o The outcomes/results of bad counselling write down on flip charts.

o Ask group 3 and 4 about situation in their life when they received good counselling and how they felt/reacted.
o The outcomes/results of good counselling and write them on flip chart.

Feedback and discussion in plenary (20 mins)

- Ask the groups to report back on their findings into larger group
- Discuss and reflect.

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b. Knowledge, skills and attitudes of effective counselors (30 mins)

Objective:

- Leaner should describe the knowledge, skills and attitudes of effective counsellors

Activity:

1) Divide the participants into 3 groups :
In groups of 3 to 4, ask the participants to reflect on an incident, and discuss:

1. KNOWLEDGE of effective counsellors
2. SKILLS of effective counselors
3. ATTIDUDES of effective counsellors.

2) Group work (15 minutes)

- Ask each group to list on a flipchart the key qualities for their component
- Ask each group to report back.
- Discuss the profile of an ideal counsellor, and emphasize how counsellors must have up-to-date knowledge, both technical and communication skills, and appropriate attitudes.

C.Tone of voice (20 mins)

Objective:

- To understand how non-verbal communication (tone of voice) can influence counselling.

Props:

- Flip cards with the following words on them (one on each piece of paper):

FLIP CARDS:

- **Aggressive**
- **Bored**
- **Sad**
- **Interested**
- **Happy**
- **Friendly**
- **Indifferent**
- **Tired**
- **Angry**
- **Impatient**
- **Excited**
- **Empathetic**
- **Judgmental**

Activity:

- Bring all the participants into an open space in the room.
- Distribute the pieces of paper with the words on them (but ask them to keep them secret).
- Start by asking one member of the group to go to the centre of the circle and ask them to say, "Give me the oranges!" in the tone of voice reflecting the feeling of her/his piece of paper.
- Ask each member to take turns to go to the centre and say it.
- Ask the participants to reflect on the meaning of the game, i.e. how communication is not just about the meaning of the words, but also about the way the words are said.
- Ask the group:
  o What tone of voice should a family planning counsellor use?
  o How can the tone of voice enhance or interfere in the counselling process?

d. Active listening (30 mins)

Objective:

- To understand how non-verbal communication (tone of voice) can influence counselling.

Props:

- Prepare pieces of paper with the following 2 phrases on them:

  1.Paper A."Don't show any interest in what this person is telling you."
  OR
  2.Paper B."Show A LOT of interest in what this person is telling you."
- Flip chart
- Markers

Activity:

- Ask 2 participants for the role play. Hand over paper A to one participant who will play the role of provider and ask her to keep it a secret.
- Assign roles (One provider and other is client) and do the exercise (10 mins). Hand over paper A to the participant playing role of provider and ask her not to show the paper to anyone.
- Topic of counselling can be chosen by participant playing client role. For example
- What is my preferred family planning method ?
- After 3 minutes ask them to stop the play and call another group of 2 participants playing another role of provider and client.
- This time hand over paper B to participant playing the role of provider and ask her not to show the paper to any other learner.
- Topic of counselling can be chosen by participant playing client role. For example:
- Client with a history of infertility.
- After 3 minutes, stop the participants from talking any further.
- Ask the client of Paper B to describe how she felt talking to her provider. Ask if she felt comfortable. Ask, why?
- Ask the client of Paper B to describe how she felt listening to the provider. Ask if she felt comfortable. Ask why?
- Ask the group to think about the non-verbal communication behaviours involved in active listening skills.
- Ask the group to brainstorm on the communication actions that reflect no interest, and the actions that reflect interest. Write the answers on a flipchart.

Examples of no interest include:

- **No eye contact**
- **Looking at a watch or phone**
- **Reading papers on the desk**
- **Yawning**
- **Fidgeting**

Examples of interest include:

- **Maintaining eye contact**
- **Nodding the head**
- **Smiling**
- **Leaning forward**
- **Frowning**
  Expressing surprise by moving eyebrows

e. Using simple language (30 mins)

Objective:

- To learn how to explain complex medical terms.

Props:

- Write the following two sets of words on a flip chart and hide the words with coloured flip cards with numbers 1-10 (keep them hidden until later):

Words are:

1. **Sexually transmitted infection**
2. **IUD**
3. **Amenorrhea**
4. **Sexual intercourse**
5. **Ovulation**
6. **Infertility**
7. **Emergency contraception**
8. **Vaginal discharge**
9. **Medical eligibility**
10. **Ejaculation/discharge**
11. **Menstruation**

Activity:

- Explain participants that under each numerical number one medical terminology is hidden. Participants will choose the number themselves and explain the terminology under the number, in simple language. Assuming, how they will explain this to their client.
- One of the facilitators may play the role of client
- Now ask random participants to come one by one and choose any number, find hidden word, and explain it in simple language to the client.
- Give 2 minutes to each participant to explain.

- **Discussion (10 mins)**

Ask the group:
- o What did you learn?
- o Which terms were most difficult to explain? Why?
- o Which terms were easiest to explain? Why?
- o Did you have enough time? How could you explain these terms in less time?
- o How can you apply what you have learned in your work?

f. Positive reinforcement (20 mins)

Objective:

- To understand how clients need positive reinforcement during counselling.
- To learn ways to offer positive reinforcement.

Steps:

Conduct a brainstorming exercise and discussion (20 mins)

- Discuss with the whole group (in plenary) issues around positive reinforcement.
- Use the following questions to guide you. Record the group's answers on a flipchart:

a. What is positive reinforcement? Examples include:
   - o Praising a woman when she returns for IUD follow-up.
   - o Assuring a woman who forgot her pills that there is some action she can take.
   - o Reassuring a woman who is experiencing side-effects with a method that she can do something about them (i.e. switching methods, taking treatments, etc.

b. Now ask participants why is it important to provide positive reinforcement to clients? Answers include:
   - o To build trust.
   - o To empower the user of the method.
   - o To allow them to express their fears, concerns, anxieties and other feelings.
   - o To build a feeling of self-efficacy.

c. When to provide positive reinforcement? Answer: As much as possible! Specifically:
   - o When a client comes for follow-up.
   - o When a clients asks questions.
   - o When a client expresses concerns.
   - o At the first visit to the clinic.

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g. Beliefs, values and attitudes (30 minutes)

Objective:

- To understand how one's own beliefs, values and attitudes can affect interactions with clients, both positively and negatively.
- To be aware of one's own beliefs, values and attitudes in order to avoid imposing them on clients or having them become barriers to communication.

Probs for activity:

- Prepare a set of 10 belief statements to read out. Table 2.1.3 examples you could use. You can select 10 of these, and/or choose some other beliefs or attitudes that are common in the that culture, or community.
- Use, AGREE and DISAGREE Pana flexs. Stick them to the wall in an open space, where people can walk around freely, with AGREE and DISAGREE at opposite ends of the room.

Table 3.1.3.

Value and believe statements for Part 1.

- It is the man's responsibility to buy or get a condom.
- Women should be virgins when they marry.
- Young, unmarried women should not use the IUD.
- There is no such thing as rape within marriage.
- Family planning is a woman's responsibility.
- Breastfeeding is an effective and easy way to prevent pregnancy.
- If a client has already decided about a contraceptive method, there is no need for counselling.
- People with HIV should not have sex.
- People with HIV should not have children.
- If a person gets an STI, it is his or her own fault.
- Hormonal methods of contraception can be dangerous for a woman's health.
- Young men or women should not be allowed to be sterilized.
- Abstinence is a very effective method of HIV prevention.
- A woman who has been raped should be freely able to have an abortion.
- Emergency contraception can cause an abortion.
- Sexual and reproductive health programmes should spend more money on HIV treatment than HIV prevention.
- I would never provide counselling about fertility awareness-based methods, because their failure rates are very high.
- Condoms ruin the enjoyment of sex.
- Contraceptives should be readily available to adolescents.
- Married couples are not at risk for STIs or HIV.
- Sterilization carries greater risks than other methods of contraception.
- I think it is normal when 2 men or 2 women fall in love.
- Men have more sexual desire than women do.
- IUDs can cause serious infections.

Activity:

- Bring the group to the middle (5 mins)
- Bring all the participants into the open space in the room, in between the AGREE and DISAGREE posters.
- Explain that you will read some statements to them, and will ask them to judge the statement with their own beliefs, values and attitudes. Ask them to wander around. Explain that there are no "right answers".
- Read the statements (10 mins)
- Read each statement, one at a time.
- Ask the participants to move to the end of the room that they feel most comfortable with.
- No discussions about the statement or choice are allowed. They should ignore what other people are doing.
- They must decide based on their own beliefs.
- Discussion (15 mins)
- After reading all the statements, ask the group to return to their seats.

- Ask the group:
  - How did you feel about the exercise?
  - Was it easy or difficult to decide which side to go to?
  - Were you surprised about the decision of some of your colleagues?
  - Which statements had the most different beliefs? Why was that?
  - What happens when providers and clients hold differing beliefs about sexual and reproductive health issues?
  - Why is it important, for us as providers, to be aware of our own values, beliefs and attitudes?
  - What can we do as providers, when our beliefs make it hard discussing certain topics with clients?

Module 3.1.4

The decision-making process (50 mins)

The concept of Decision making process is to help clients in making "informed choices" about contraceptive methods and to give clients the information and help they need to use their chosen method successfully. It is an interactive process that helps providers engage their clients in the family planning consultation, and it promotes clients' participation in the contraceptive decision-making process. It helps in improving the quality of services at facility and community level.

Objective:

- To understand factors that affect decision-making.
- To understand the steps involved in decision-making for different clients and how to help clients with those steps.

Discussion Point of Facilitators

The process has been designed with several different uses in mind:

- **A decision-making process:**
  It helps clients/providers' decision-making regarding contraceptive method through a step-by-step decision making process to ensure that clients make the decision best suited to their needs and situation.

- **A problem-solving process:**
  Majority of family planning clients are returning clients who are already using a contraceptive method. Some of these clients may experience problems with their method and need counseling or else support to switch methods.

The process is based on the following key principles:

1. The client makes the decisions.
2. The provider helps the client consider and make decisions that best suit that client.
3. The client's wishes are respected whenever possible.
4. The provider responds to the client's statements, questions, and needs.
5. The provider listens to what the client says in order to know what to do next.

Types of Clients according to age and needs:

- Younger clients
- Older clients
- Post-partum clients
- Post-abortion clients
- Clients living with HIV/AIDS
- Clients who want to become pregnant

Types of FP Client seeking information on contraceptive methods:

Family planning (FP) clients typically fall into one of the following four categories:

1. New clients with a method in mind
2. New clients with no method in mind
3. Returning clients with no problems or concerns
4. Returning clients with problems or concerns.

Probs for activity:

For part 1:

- 3 flipchart with the headings: 1. "Individual factors", 2. "Social and cultural factors" and 3. "Service delivery factors."

For part 2:

- Prepare 4 flipchart pages, 2 with the heading "Client with a method in mind" and 2 with the heading "Client with no method in mind". "Returning client" and "client need Dual method"

a)Clients with a method in mind.

- Such clients have heard about different methods from friends, family or the media.
- Many will arrive at a clinic with a method already in mind.
- Such clients are more satisfied if they can use their preferred method.
- Clients should receive this method if it suits their expressed needs and situation and they have no medical reason to avoid it.

b)Clients with no method in mind.

Provide information on the needs and situation of the client before discussing method options. Provider and client consider together what the client's needs are

- If they have any previous experiences in family planning?
- What are their plans for having children?
- Does the client need STI/HIV/AIDS protection?
- What does her/his partner think? Etc.

Once the provider has heard the client's story, she/he can then help the client to consider options in light of these expressed needs. In this way, the time is used more efficiently, and the provider is discouraged from giving "information overload" about all the method options.

2)Returning clients:

Family planning clients not only need support in selecting a contraceptive method, but they may also need continuing support and reassurance to use that chosen method. Too often, clients leave with a method but without an offer of follow-up care and reassurance that they may return if they experience difficulties with their method.

The Decision-Making process offers guidance and counseling to the returning clients:

- It reminds the provider to check if the client is happy using their method, or if they would like to switch methods.
- It reminds providers of the particular follow-up issues for each method (e.g. resupply, late for injections, implant removal).
- It reminds providers to check for any new health conditions or problems that may affect method use.
- It gives guidance on how to counsel on side-effects and other problems the client may be experiencing.
- It reminds providers to offer clients condoms and recheck their dual protection needs. It therefore promotes critical continuity of care.

3)Dual Protection

Consideration of STI and HIV/AIDS prevention needs is a critical element of family planning decision making, and the tool encourages all clients to consider their dual protection needs:

Activity:

Part 1:

1)Factors affecting decision-making (15 mins)
Divide participants into 3 groups. Distribute one Flip chart to each group

1.Individual Factors
2.Social Factors
3.Cultural factors

- Ask the participants to brainstorm about what factors on given areas/ heading of flip chart, affect a client's decision about methods to use.
- Ask to write responses on the flipchart. (Table 3.1.2)

Discuss in plenary.

Key points for discussion:

o How might these factors affect decision-making?
o Would any of these factors be barriers to the client using the most appropriate method?
o How can a service provider help to overcome any barriers?

PART 2

Steps:

1) Decision-making processes (30 mins)

- Divide participants into 4 groups: give groups a flipchart entitled "Client with a method in mind" one "Client with no method in mind." One returning client not satisfied and one Dual method.
- Using the Decision-Making Tool's "Choosing method" section, ask participants to list the decision-making steps for their type of client. The steps are listed below in case they need help.
- Then, for each decision-making step, ask participants to list a few questions that they could ask a client to help them with decision-making.

Table 3.1.2

Possible responses:

Individual factors	Social and cultural factors	Service delivery factors
• Economic and social status • Age, parity, health status • Reproductive goals • Autonomy (social, economic, decision-making) • Status and nature of the client's relationship with a partner • Prior method experience • Method attributes (what client perceives as advantages and disadvantages) • Personal attitudes, religious and other beliefs, perceptions, preferences	• Social, cultural, and gender norms (for example, if the cultural norm dictates that sterilization is wrong) • Local laws and policies • Beliefs of family, friends, field workers and influential community members • Reputation of the clinic in the community • Access to information • Local rumours, myths or misinformation	• Access to services and method options available • Provider communication skills • Provider attitudes and biases • Targets, quotas, incentives for the provider • Quality of service environment and staff

- Ask the groups with "Client with a method in mind" to present in larger group one by one. Tell other participants if they have anything to add by the end of session.
- Next, the groups with "Client with no method in mind" to present their work one by one. By the end of session ask participants if they have anything to add.
- Discuss in plenary. Key points for discussion:
  o How is the decision-making process different for the two types of clients?
  o Is this process different from how you would normally counsel clients?

Decision-making steps in the Decision-Making Tool

Client with a method in mind	Client with no method in mind
1.Check if client understands method. 2.Ask questions to see if method suits client. 3.Check if client would like to know about other methods. 4.Check the client's need for dual protection.	1.Help client think about her/his situation and life and what seems most important about a method. 2.Help client compare methods and narrow down choices. 3.Check the client's need for dual protection.

Now conclude counselling session by making participants to play role on different difficult scenarios.

Participants will be accessed on tool given in Table 3.1.3

Table 3.1.3:

Assess your own counselling and communication skills

	Provider Behaviours	I could do better	I do okay	I do very well
	Listening skills			
1.	Find out reason for client visit			
2.	Maintain eye contact with the client			
3.	Concentrate fully on what the client is saying			
4.	Wait for the client to answer one question before asking another question			
5.	Let the client know you are listening by repeating what she/he said or nodding encouragement			
	Being responsive to the client			
1.	Respond to the client's questions and statements			
2.	Give full attention to client's fears and anxieties			
3.	Respect the client's opinions			
4.	Reassure the client about safety of contraceptives			
5.	If client brings up a misconception, respond with accurate information			
	Expressing positive emotions			
1.	Ask client about her/his feelings			
2.	Use an interested and friendly tone of voice			
3.	Respond to the client with positive words (not criticism or judgment)			
	Respect client choice			
1.	Ask client if she/he has a method in mind			
2.	Ask client her/his feeling about or experience with a method			

Provider Behaviours	I could do better	I do okay	I do very well
3. Ask client if he or she has questions in mind			
4. Ask open-ended questions (beginning with "how" or "what", for example "How would you feel about changing methods?" instead of "Do you want to change methods?")			
5. Reinforce important messages by asking client what has she or he understand			
Verifying the client's decision			
1. Ask reasons for the client's decision to adopt, continue using, or switch to a certain method			
2. Make sure the client understands consequences of decision to use or switch methods			
3. Check whether the client is satisfied with her/his initial decision on method use			
Giving information			
1. Use chart, model or method sample to help explain method 2. Explain how technical information is related to the client's personal situation 3. Discuss dual protection with the client (protection from pregnancy and STIs/HIV)			
Encouraging client participation			
1. Invite the client to speak freely and ask questions during consultation 2. Encourage client to return if she/he has any questions, problems or concerns			
Total Score			

Role Play Exercise

In groups of 3, choose scenarios from the list on the next page to practice family planning counselling using the Decision-Making Tool.

1 person to be the provider1 person to be the client
1 person to be an observer (to make notes on how both the provider and client behave)
Each member of the group should have a turn to be the provider.

After each scenario, discuss the role-play:

First, ask the "provider" to discuss how they felt the role play went, what went well, what they would do differently.

Second, ask the "client" to discuss how it went and how they felt as the client, what went well and any suggestions for the provider.

Third, ask the "observer" to discuss what they observed about the role-play, what they thought went well, what could have been done differently.

Role play for different client counselling Fig 3.1.4

01

Scenario 1: Couple wanting sterilization

A couple comes into the clinic wanting counselling on sterilization. She has 1 child and has had 2 abortions. They have not decided who should be sterilized and want to make a decision.

02

Scenario 2: Switching method

A woman comes into the clinic who has been using the pill. She would like to switch to the IUD because she wants an effective method but doesn't want to have to take a pill each day. She is married with 2 children and doesn't want any more children.

03

Scenario 3: Information on STIs and HIV

A woman comes into the clinic worried that she may have an infection. She does not understand what an STI is, and does not know about HIV. She is not married but is sexualy active.

04

Scenario 4: Male client

A man comes into the clinic as he has heard about vasectomy and would like some advice on this method of contraception.

Table 3.1.4 (Role Play Observer Check list)

Facilitator Check list

Provider performance	**Score** (please circle) 1=not done/not done well 2=done, but needs improvement 3=done well N/A=Not applicable			
1) When initiating counselling, the provider:				
a) welcomes the client with warmth and respect.	**1**	**2**	**3**	**N/A**
b) invites the client to speak freely and ask questions during the interaction.	**1**	**2**	**3**	**N/A**
c) asks and discovers reason for the client's visit.	**1**	**2**	**3**	**N/A**
d) when necessary, refers to the "Special needs" pages.	**1**	**2**	**3**	**N/A**
2) For RETURNING CLIENTS, the provider:				
a) asks if the client is satisfied using her/his method.	**1**	**2**	**3**	**N/A**
b) asks if the client is having any problems using the method, including unhappiness with or concerns about side-efects, and any fears.	**1**	**2**	**3**	**N/A**
c) checks if the client's needs or health condition have changed.	**1**	**2**	**3**	**N/A**
d) checks the client's dual protection needs.	**1**	**2**	**3**	**N/A**
3) For NEW CLIENTS, or returning clients switching to a new method, the provider:				
a) asks the client if she/he has a method in mind.	**1**	**2**	**3**	**N/A**
b) discusses potential methods in light of the client's needs and situation.	**1**	**2**	**3**	**N/A**
c) draws out the client's feelings (positive or negative) about using a method, such as misconceptions, concerns, and fears about potential side-effects.	**1**	**2**	**3**	**N/A**
d) invites the client to choose a method.	**1**	**2**	**3**	**N/A**
e) discusses dual protection choices with the client.	**1**	**2**	**3**	**N/A**
4) When discussing a method, the provider:				
a) discusses key attributes of chosen method.	**1**	**2**	**3**	**N/A**
b) checks whether the client is medically eligible to use the method.	**1**	**2**	**3**	**N/A**
c) discusses possible side-effects.	**1**	**2**	**3**	**N/A**

Provider performance	Score (please circle) 1=not done/not done well 2=done, but needs improvement 3=done well N/A=Not applicable			
d) explains clearly how to use the method, including what to expect, when to return etc.	**1**	**2**	**3**	**N/A**
e) decides with the client when to start the method.	**1**	**2**	**3**	**N/A**
f) tells the client what they need to remember when using the method, including informing her/him of warning signs.	**1**	**2**	**3**	**N/A**
g) checks that the client is confident in using the method.	**1**	**2**	**3**	**N/A**
h) offers condoms to the client to use for dual protection and/or back-up.	**1**	**2**	**3**	**N/A**
4) Throughout the interaction (for all types of clients), the provider:				
a) maintains good eye contact with the client.	**1**	**2**	**3**	**N/A**
b) responds to all the client's questions and statements.	**1**	**2**	**3**	**N/A**
c) checks that the client understands the information.	**1**	**2**	**3**	**N/A**
d) encourages the client to return if she/he has any problems, questions or concerns.	**1**	**2**	**3**	**N/A**
e) explains technical concepts in words that the client can understand.	**1**	**2**	**3**	**N/A**
f) encourages the client to make the decision(s).	**1**	**2**	**3**	**N/A**
g) when needed, asks the client to look at or points out something on the client pages.	**1**	**2**	**3**	**N/A**
h) when needed, uses a counselling aid in the appendix to help explain method.	**1**	**2**	**3**	**N/A**
i) seems comfortable using the flipchart	**1**	**2**	**3**	**N/A**
j) uses the flipchart throughout the consultation.	**1**	**2**	**3**	**N/A**

Module 3.1.5

Counselling for Post Pregnancy Family planning:

objective:

Main objective of this module is to enable participants towards nonjudgmental, thorough, and appropriate contraceptive counselling and demonstrationand referral for all clients that includes young and adolesecen counselling on family planning using GATHER Approach.

Period: 1. hr

Talking Comfortably about reproductive Health:

Props:

- Video- Talking comfortably about reproductive health
- GATHER Technique

Time: 15 mints

Instructions:

- Begin the session with playing video: talking comfortably about Reproductive Health. By the end of video discuss about difficulties faced by the clients and health care providers in talking about reproductive health issues.
- The Trainer will introduce GATHER technique of Counselling to the group a set of specific skills designed to facilitate (FP) and other reproductive health issues a set of specific skills designed to facilitate informed decision-making.

  The GATHER approach counselling has documented effectiveness in FP program

  G= Greet
  A= Ask
  T= Tell
  H=Help
  E= Explain
  R = Return

  Tell that next 2 hours will be spent in practicing the counselling skills using the same approach.

1. Counselling for Postpartum Family planning (GATHER APPROACH)

Props:

- Role play case scenario (role depend on available time)
- Check list on Postpartum Counseling

Time: 15 mints

Instructions:

- Distribute post-partum checklist Give 3 to 4 scenario for role play, depending on the available time.'
- Select 2 providers for each scenario. One to act as provider and other client. Discuss role only with the participant playing role of client. And let provider play her role of providing counseling. Other participants will observe according to check list
- At the end of role, pariticipants of role play will discuss what they think was good and what were the areas of improvement. Lastly remaining participants will share their feed back using checklist
- At the end of session, remind trainee that even after good counseling if client refuse to continue the method the method , it must be removed.

Table 3.1.5 (Counseling check list of Post-partum family planning)

Counselling check list Post-partum IUCD

Area	Counselling on PPIUCD	Comments	Y/N
GREET - Initiate to develop good rapport to start Counselling on PPFP			
1. Establish a trusting and supportive relationship	Introduce urself and greet client calling her name. Help her to be at ease and show respect		
2. Allows the women to talk and listens to her	Ask questions and encourage client to explain her needs. Listen carefully and support the women's informed decison		
3. Engages women's family members.	If women desire, include her family members and partner in the discussion with clients consent.		
Ask - Determine reproductive intentionss, knowledge of pregnancy risk and use of various contraceptives.			
4. ask any previous experience with family planning	Determine women knowledge about returning fertility and benefits of her desired birth spacing Ask if the women was using any method in past, her experience , any problem and reason for discontinuation.		
5. Assess partner/ family attitude about family planning	Explore about family knowledge about return of fertility and benefits of birth spacing and birth limiting		
6. Assesses reproducitve desire	Ask client about desired number of children, desire of spacing/ limiting etc.		
7. Assess need for protection against STIs	Assess women's need for protection from STIs, including HIV		
	Explain and promote condom as dual method for protection.		
8. Dtermine intrest in a particular family planning method	Ask about she herself has a preferred method to adopt on basis of previous experience or knowledge.		

Area	Counselling on PPIUCD	Comments	Y/N
Tell- Provide knoweldge about PPFP			
9. Provide information about benefits of Healthy Time spacing and limiting.	Advice client that for her and baby's better health it is important to wait atleast 2 years after birth for next pregnancy		
	Inform about return of fertility postpartum and risk with subsequent pregnancy. Explain how LAM and breastfeeding are different		
	Ensure to advise about social, economical and health benefits of healthy pregnancy and birth spacing or limiting		
10. Provide information about PPFP methods	Bbreifly explain the advantages, limitation and use of PPFP methods based on prior knwoledge of proivder including :		
	LAM		
	Postpartum Tubal ligation		
	PPIUCD		
	Implant		
	Condoms		
	POPs, COCs		
	DMPA/Syana Press		
	No-Scalpel vasectomy (male sterlization)		
	Allow women to touch and feel the FP items using contraceptive tray		
	Dispell and correct any misconception about family planning methods		
Help- Assist women making choice, giving her important information to make her decision			
11. help women to choose method.	Assure to give client important information that and answer her questions.		
	Assess her knowledge about the selected method, provide additional knowledge if needed		
12. Support women choice.	Acknowledge the women choice and advises her on the steps involved in providing her with chosen method.		
Explain and evaluate - first determine if client can safely use the method and provide key point as how to use the method.			
13. Evaluate the women's health and determine if she can sfaely use the method.	. Ask the women about medical and reproducitve history.		
14. Provide Key information on PPIUCD to the women	Effectiveness: prevent almost 99% of pregnancies		
	Mechansim of action: chemical change damages sperm before reaching eggs		

Area	Counselling on PPIUCD	Comments	Y/N
Tell- Provide knoweldge about PPFP			
	Mechansim of action: chemical change damages sperm before reaching eggs		
	Effective period: Can be used as long as upto 10-12 yrs and as short as women desires		
	Removal: Can be removed anytime depending on providers desire by trained provider		
	Return of Fertility: immdiate as soon after removal		
15. Discuss advantages of PPIUCD	Simple and convenient IUCD Placement, especialy immediately after delivery of the placenta		
	One rotuine follow up is recommended		
	Immediate return of ferility upon removal		
	Doesn't effect breast feeding or breast milk		
	Long acting and reversible method.		
16. Discuss Limitations	Heavier and more painful menses for some women, especially first few cycles after interval IUCD (less relevant or noticeable to postpartum woman)		
	Higher risk of expulsion than in interval IUCD		
	Doesn't protect from STIs		
17. Warning signs: Explain her to return as soon as any of the signs appaear.	Lower abdomainal pain, especialy if occuring within 20 days of insertion along with symptoms like, not feeling well. Abodminal distension, nausea vomiting and fever		
	Bleeding exessive or foul smelling discharge		
	Concern if client is not pregnant		
	Concern if IUCD has fallen		
18. Determine if women understand instructions	Encourage women to ask questions		
	Ask client to repeat key information points.		
Return- Plan for her next visit to the hospital and steps to be taken before delivery.			
19. Plans for further steps (in reference to PPIUCD decision)	Make notation in the woman's medical record about her PPFP method of Choice .		
	If a woman cannot make a decision ask her to think and decide it plan for afollow up discussion in next visit. Advise her to bring her spouse / family member with her		
	Provide inofrmation on when women should come back for her follow up visit		

Fig : 3.1. 5

Scenarios For Post-Partum Family Planning Counselling

Scenario 1: (LARC versus TL)
Sara is a 32 years old women, who has just given birth to her 5th child. She is not aware of Family planning methods. Doctor suggest her to have Tubal ligation, which Sara refused . The Nurse said that she would not be allowed to leave without IUCD insertion. Although Sara in daunt and doesn't know anything about the method, still she agreed.

1.How can Sara be given Informed Choice?

Key Point: As Client has refused sterilization, she should be counselled over all post partum FP Methods , considering whether she wants to breast feed or not.
*Give her a Basket of choice followed by detail counselling on chosen method. MEC wheel should be used in all cases in order to choose appropriate method.

Scenario 2: (Biased Approach)
18 years old Kulsoom. Came to Antenatal visit durong her First pregnancy. Service Provider counselled her for Post partum FP but doesn't suggest Kulsoom for long term (LARC) contraceptive method as she is Primigravida .

1 . What is your view and why ?
2 . Suggest appropriate FP method for the client .

Key Point: Counsellor should not be biased and should avoid imposing her opinion on the client. She should be counseling on all FP methods, including long term reversible methods. Client has the right to be given informed choice on all family planning methods.
*MEC Wheel should be used to choose appropriate method in any case and detailed counseling should be followed after informed Decision.

Types of counselling

objective:

- Participants know the importance of counselling at different levels
- Importance and need of counselling at all levels would be considered and applied according to need to get desired and affective results of Family planning.

Props:

- PowerPoint slides
- Brainstorming questionnaire before each topic:

  - What does that mean
  - When it is needed
  - Why is it important
  - How will it affect success of method

Discussion:

Tell participants that there are 3 levels of counselling

1. Individual counseling
2. Couple counselling
3. Group counselling

Individual counselling

You will find that in most cases individuals prefer privacy and confidentiality during communication or counselling with you (Fig.1) It is important to respect the needs and interests of a client by finding a private room or place where you can talk with them.

Figure: A Health Extension Practitioner giving individual counselling.

Couple counselling

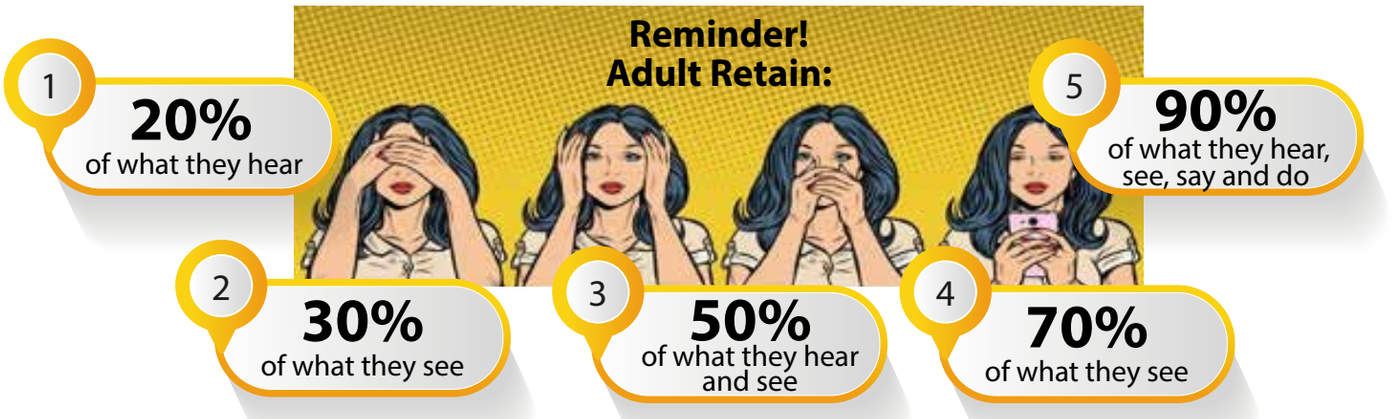
Couple counselling is when you give a counselling service to a couple or partners together (Figure 2) This is particularly common when they are thinking of using irreversible family planning measures, such as voluntary surgical methods.

Figure: A Health Extension Practitioner counselling a couple.

Figure: Group counselling and information sharing.

Group information sharing

Group information sharing is used when individual counselling is not possible, or if there are people in your village who are more comfortable in a group (Figure 3.3). In this situation, after greeting everyone in a friendly manner, you would explain to them the benefits of family planning, discuss briefly common myths and mistaken beliefs about family planning, and then inform the group about how to obtain appropriate contraception. It is a cost-effective way of information sharing and answering general questions, but people are not likely to share their more personal concerns with you in this setting.



FP- Counselling Check list

S.No	Tasks	Y/N
1	MEC Wheel, guidelines, client cards and consent forms available	
2	**MEC Wheel, guidelines, client cards and consent forms available**	
3	A sample of each method is available for each client consultation	
4	**Written and pictorial information FP leaflets, Flipchart/book available in language client can understand or pictorial for illiterate clients**	
5	**Greet Client politely**	
6	**Ensure privacy through out the session , by explaining that some personal/ possible disconcerting questions are asked from all client to ensure better care and confidentiality.**	
7	**Ask open ended questions to encourage client to speak**	
8	**Give time to client to give and receive information**	
9	**provider listen to client without interruption**	
10	**For new users ask client about sexual habits, support from family and partner on FP use, possible domestic violence, socioeconomic circumstances, past experience with FP and client FP need**	
11	**Screen client according to standards (medical Eliginility criteria)**	
12	**Explain Fp methods/services with concerned side effects and benefits**	
13	**Service information presented clearly and simple language used for counselling to ensure informed choice .**	
14	**for returing clients ask if client has problem or concerns with method in use**	
15	**Reassure that client clearly understand the given information and can skilfuly implement the decision by asking key messages**	
16	**Acertain follow up mechanism, by reassuring client that they are welcome to return anytime in case of concern.**	
17	Follow up date is written on card	
18	**Refferal system in place for services not provided in site**	
19	**Exclude Pregnancy**	
20	**In case of pregnancy provide anenatal services and counselling on post pregnancy Family planning**	

Module 4.1.1

Family Planning Methods

Before starting contraceptive methods learners should be aware of some basic terminologies used in Family planning.

Definations of different terminologies of FP

1.Reproductive Health:

"Reproductive health is defined by WHO as a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so.

2.Family Planning:

Family planning is the conscious effort to regulate the number and spacing of births through short-term, long-term temporary or long-term and permanent methods including emergency contraception.

3.Contraceptive Prevalence Rate:

Contraceptive prevalence rate is the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time.

4.Birth limiting:

Simply refers to situations where women do not want any more births.

5.Birth spacing:

The practice of maintaining an interval between births. The shorter the interval, the more vulnerable the infants is to disease, malnutrition, diarrhea and respiratory tract infections. Mothers are also more likely to be anemic and malnourished.

6.Unmet Need:

Women with unmet need are those who wants to stop or delay childbearing but are not using any method of contraception due to inaccessibility to the contraceptive services or product due to any reason.

Module 4.1.1

Family Planning Methods

7. Informed Choice:

All family planning clients have right to informed choice:

- Opportunity to freely choose among options and
- Complete, accurate information that is easy to understand about appropriate, available options.

Benefits of Informed Choice.

- Increases the chances of correct method use, reducing unwanted pregnancy
- Reduces fear and dissatisfaction related to side effects,
- making continuation more likely
- Increases client's ability to recognize serious warning signs, reducing health risks
- Promotes positive relationships between providers and clients

Overview of Contraceptive Methods.'

Learning Objectives:

- By the end of the session the participants will have:
- Identified different categories of contraceptives methods in reference their efficacy.
- Distinguished between short-acting /long-acting contraception and Hormonal/ nonhormonal methods.
- Compared and contrasted mechanism of action, advantages, disadvantages
- characteristics and instructions for each contraceptive method
- Described "dual protection" and "emergency contraception

Props:

- Power Point presentation
- Video on syana press
- IEC sheet on Missing pills for distribution
- Contraceptive Tray Including sample FP methods
- Standard days method Bead
- Flip chart on contraceptive methods (Fig 4.1.1)
- Slides and flip cards of brainstorming activities
- White board
- White sheet
- Broad Markers

Fig : 4.1.1

Contraceptive methodsEffectiveness

Contraception:

Contraception means preventing pregnancy. A contraceptive is a drug, device or method that prevents pregnancy when a couple has sexual relationship. There are many different contraceptive methods. Most are reversible that means woman can still be able to become pregnant after she has stopped using the method. Some are permanent like surgical interventions meaning woman will not be able to become pregnant in the future.

Less Effective Methods (72-82%)

1. Fertility Awareness Methods:

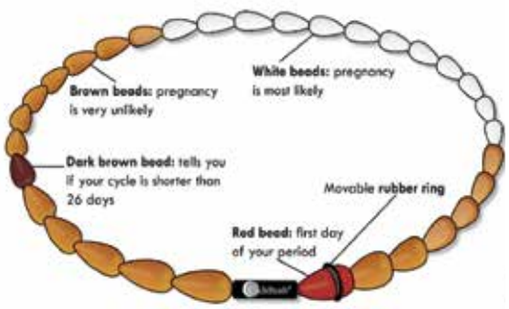
a) Calendar-based Method

i. Standard Day Method (SDM)
ii.Calender method

b) Symptoms-based method

i.Cervical secretion
ii.Basal body temperature
iii.Cycle rhythm method

Standard davs method:



Identifies days 8 - 19 of the cycle as fertile.

- For women with menstrual cycles between 26 and 32 days long.
- Helps a couple avoid unplanned pregnancy by knowing which days they should not have unprotected intercourse.
- Client uses a color-coded string of beads to help her track where she is in her cycle and know when she is fertile.
- applicable for women with cycles between 26 and 32 days long
- Couples who can use condoms or avoid sex b/w days 8 to19 of the cycle.

Brainstorming Activity:

Instructions:

Divide participants into 2 groups A and B. Tell them that examples will be given to the groups one by one to calculate safe days where length of the cycle of the cycle will be given. The group giving more right answers will be considered winner.

Cofacilitator will help the lead trainer to note down scoring of each group on white board and writing key points of given scenarios i.e:

First day of periods =
Total number of days of cycle =
Safe days (Answer given by group) =

- At the end, facilitator will ask the opponent group if the answer is correct. In case of wrong answer other group will be given chance to give the right answer and win scores

Table 4.1.1 Facilitator Que Card of Safe Days Method

Facilitators Que Card Safe Days Method

S.no	First day of period	Number of days in cycle	Safe Days
1	Jan 20	29	29th Jan-7th Feb
2	Dec 12	40	not applicable
3	March 15	26	24th Mar-2nd Apr
4	Oct 8	30	17th Oct-26th Oct
5	June 16	20	not applicable
6	April 19	26	28th Apr-7th May
7	Feb 5	28	14 Feb-23rd Feb

Cervical secretion/two day method:

Uses cervical secretions to indicate fertility.

- Women check daily the presence of secretions.
- Users pay attention to their secretions in the afternoon and evening and decide if it is her fertile day.
- If a woman notice any secretions the day and day before, she considers herself fertile that day and avoids unprotected intercourse .
- Two Day method users consider all secretions noticeable at the vulva as a sign of fertility (irrespective of color, consistency, stretchiness, or any other characteristic).

Back up methods during unsafe days:

If a person does not want to get pregnant, they should use a back-up method of birth control, such as condoms, or not have sex on cycle days 8 through 19. On the other hand, if a person does want to get pregnant, these are the days when pregnancy is most likely.

2. Withdrawal (coitus interruptus):

- Man withdraws his organ from his partner's vagina, and ejaculates outside the vagina, keeping semen away from her
- external genital
- Natural, so no side effects
- Doesn't cost anything
- Allows men to be an active part of preventing pregnancy
- Doesn't protect against STIs
- One of the least effective methods, because proper timing of withdrawal is often difficult to determine
  success depends on only male partner cooperation

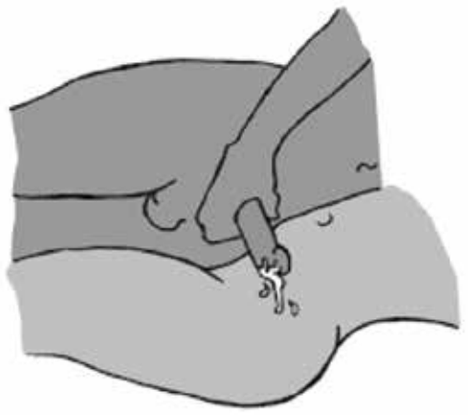


Fig 4.1.4 Withdrawal Method

3. Barrier Methods:

i.Female condom Plastic sheath with ring at both ends:

The female condom is a tube of soft plastic (polyurethane) that has a closed end. Each end has a ring or rim. The ring at the closed end is inserted deep into the woman's vagina over the cervix, like a diaphragm, to hold the tube in place. The ring at the open end remains outside the opening of the vagina Female condoms do not have any side effects except to individuals who are allergic to latex. The female condom does not have any effects on either the male or the female reproductive function.

ii.Male condom, it protects from STDs.

iii.Diaphragm

iv.Cervical caps

v.Sponge

4 .Spermicides:

Jellies, creams, foams, films, and suppositories. Spermicides are a type of contraceptive agent that works by killing sperm. Spermicides need to be placed in a woman's vagina prior to intercourse if they are to prevent viable sperm from reaching uterus.

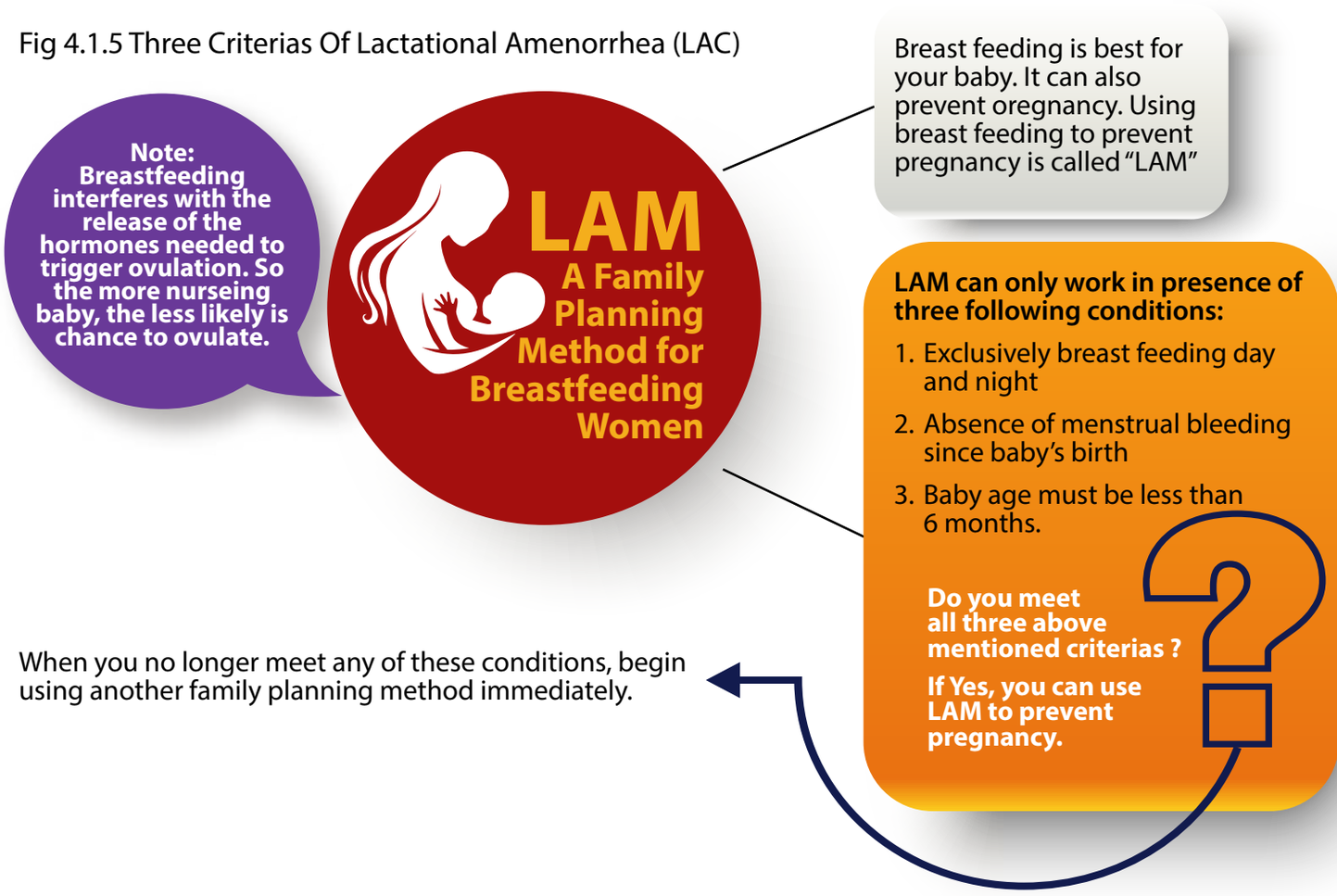
Highly Effective Method (90-94%)

5. Lactational Amenorrhea Method (LAM)

- women who exclusively breastfeed their baby around-the clock
- not started menstruating are very unlikely to get pregnant during the first six months after they give birth.

- Infant less than six months
- If any criteria change client need to start other method.
- LAM can be used immediately after childbirth.
- At least 98% effective
- No commodities/supplies required
- Improves breastfeeding and weaning patterns
- Women with HIV or who have AIDS can use LAM.
- LAM is most effective only within the first six months postpartum.
- It does not protect against sexually transmitted diseases (STDs), including HIV. Always use a condom to reduce the risk of STIs.

Fig 4.1.5 Three Criterias Of Lactational Amenorrhea (LAC)



6. Pills (POPs/COCs):

a. Progestin only Pills:

- ***Characteristics:*** Especially suitable for breastfeeding women and those who should not use estrogen
- Contain no estrogen
- Less progestin than COCs
- All pills in pack are active (available in pack of 21 and 28 pills)
- Continuous use, take one pill every day. After finishing 01 pack, start new pack from the next day.
- Must be taken at same time every day
- ***Mechanism of Action:*** Suppresses ovulation in ALL cycles.
- Thickens cervical mucus and creates thin endometrium – hampering sperm transport
- ***Side effects:*** include nausea, vomiting, bleeding irregularities from heavy bleeding to amenorrhea Hormonal Skin Patch

b .Combined Oral Pills (COC):

Explain Audience that COC characteristics like Mechanism of action and side effects and Limitations are same as of Combined Hormonal Injection (CIC)(will be discussed in CIC section).

Distribute Checklist after the session:

Check list Contraceptive Pills

Sr.no	Check List	Y/N
1	**Exclude pregnancy**	
2	**History excludes smoking and age over 35**	
3	**Major Medical problems (Diabetes, Migrane Heart Disease-Hypertension Greater than 160/100, DVT and Liver Disease, Blurring of Vision)Abnormal bleeding) and Breast Cancer - breast lump or discharge**	
4	**Tell the client when to start Pill and what to do if pills are missed**	
5	**Gynecological problems (e.g abnormal bleeding and Breast Cancer - breast lump or discharge**	
6	**Check BP, Pulse (especially at first visit)**	
7	**Confirm expiry date**	
8	**Asked about Last Menstrual Period (LMP) and breast feeding (upto 6 months), Pregnancy excluded**	
9	**Exclude contraindication through MEC criteria**	
10	Information on advantages, disadvantages, side effects and warning signs.	

Missed Pills:

- Idea of the session is to capable providers to cater different pills scenarios during their FP practice.
- Ask participants about their previous knowledge on Missing pills and how much frequently they encounter such cases in their routine practice.
- Ask them how they respond to such cases.
- Distribute sheet on missing pills backup card for client to all participants and ask them to read out the point loud, one by one. Reassure if candidates understand the important points
- Respond to the questions from group before moving to brainstorming activity.

Brainstorming Activity:

Instructions:

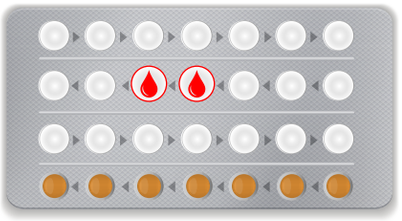
- Divide participants into group group A and B. Explain that each group will be shown a slide on missing pills case scenario, one by one.
- Explain that each case will hold 3 marks:
  - 1 mark for inadequate answer.
  - 2 marks will be allocated with only little missing information.
  - 3 marks of complete answer.
  - 1 negative mark for each wrong answer.
  - There will be no negative marking for the opponent group
- Each group will be given 3 minutes to prepare answer.
  Cofacilitator will help the lead trainer to note down scores of each group on white board.
- Now present first case slide to group A. After the bell rings call on group A to present comprehensive solution to group B.
  At the end group B will be given chance to give their feedback on the answer and win points from group A for any incomplete or wrong answers.
- Now Group B will be shown slide no 2 and to present their answer to Group A like wise
- Group winning more scores will be considered winner.

Fig 4.1.7 Slides of Brainstorming activity (Missing pills back up mechanism)

Scenario 1:

Missed 2 consecutive days on 2nd week

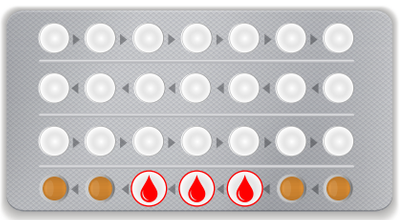
Ans: 1. Reassure client
2. Ask to continue the packet (without discarding any pill) unless shift to other method
3. Start with 2 pills



Scenario 2:

Client missed pills during last week for 3 days

Ans: 1. Reassure client
2. Discard the remaining pills
3. Start new pill pack

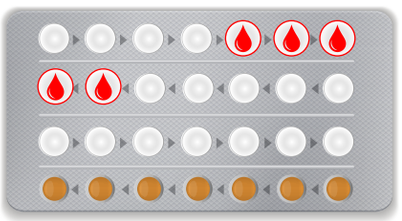


Scenario 3:

Missed pills for 5 contineously days during 1st and 2nd week.

Ans: Reassure client that chances of getting pregnant are low if she follows instructions:

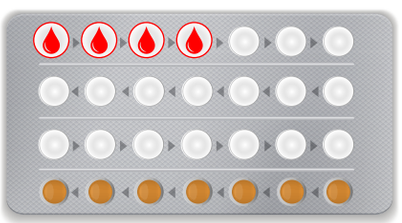
a. Continue the packet without discarding pills unless shift to another method
b. Use condoms/avoid sex for next 7 days
c. In case of coitus during last 5 days take ECP/emergency contraception immediately. (Sooner taken emergency contraception less likely is the chance of conception)



Scenario 4:

Late for 4 days to start new pill pack

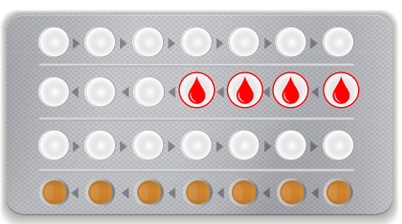
Ans: 1. Reassure client to continue the same pack without discarding pills, unless shift to other method
2. Use condom/avoid sex for next 7 days
3. Client can start first dose with 2 pills



Scenario 5:

Client forget to take pills for last 4 days in 2nd week

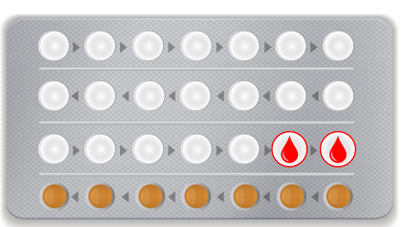
Ans: 1. Ask Client to continue pills with same pack unless shift to another method if client want
2. Use condoms /avoid sex for next 7 days as per need
3. If Client has a history of coitus during last 5 days ask to give ECP immediately.



Scenario 6:

Didn't take last 2 hormonal pill (3rd week)

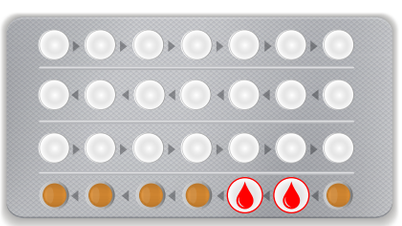
Ans: 1. Continue taking 2 hormonal pills and discard nonhormonal pills.
2. Use condoms for next 7 days
3. Use ECP if history of coitus in last 5 days



Scenario 7:

Missed 2 pills during last week

Ans: 1. Discard the pack with nonhormonal remaining pills
2. Start new packet
3. Reassure client on change of menstrual date.



The birth control patch

- is a thin plastic patch (1 3/4 inch square) placed directly on the skin of the woman.
- The birth control patch works by hormones that are absorbed from the patch into your system.
- The patch is worn for one week at a time and it is placed directly on the skin of buttocks, stomach, upper arm or upper torso.it acts by inhibiting the ovulation and by thickening cervical mucus preventing the sperm reaching the egg.
- The patch is replaced once a week on the same day each week for three weeks in a row.
- The patch is not worn during the fourth week to allow the menstrual flow to occur at this time. Patch is very effective method of contraception and its failure rate is very low.
- The birth control patch has side effects similar to those experienced by users of oral or other hormonal types of contraception.

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7. Injectables:

1.Combined Injectable Contraceptives:

- Contain progestin and estrogen
- Administered monthly: CIC are injected into the muscle of upper arm, thigh, or buttocks. After each shot, the hormone levels peak and then slowly decrease until the next injection. In order to be effective, one must get a combined contraceptive injection every 28 to 30 days

Injections have a failure rate of between less than 1% . It acts by inhibiting ovulation and thickening of cervical mucus preventing entry of sperm

- Provide more regular bleeding cycles
- ***Side effects are similar to users of combined oral contraceptives.***

Note:

one cannot go past 33 days from the date of your last injection.

2. New DMPA (Injection Syana Press):

Subcutaneous depot-medroxyprogesteronde (DMPASC)(depo -subQ provera 104)

- Given after 3 months like DMPA
- Easy to inject subcutaneously
- Low dose formulation
- Slower and more sustained absorption

Table: 4.1.2 Sayana Press Check list

Sr.no	Task	Y/N
1	**Exclude pregnancy/LMP**	
2	Follow informed choiuce and MEC selction criteria	
3	Place safty box and cotton swabs (Optional) within arm,s reach	
4	Wash hand	
5	Select the injection site (clean it if needed)	
6	Open the uniject pouch by tearing the notch	
7	**Check the expiry date and make sure the DMPA is at room temperature**	
8	**Hold the uniject by the port while mixing. Mix the DMPA by shaking it vigorously for 30 seconds**	
9	**Checks to make sure the DMPA is mixed and there is no damage to the uniject**	
10	Hold the uniject with the needle pointing upwad during activation with non dominant hand	
11	keep hold Uniject by the port while activating from Dominant hand	
12	**Push needle shield against port to full in order to activate the uniject for use**	
13	**Pinch out the skin to form a tent according to providers choice (i.e anterior surface of the thigh, posterior surface of the upper arm or para umblical area**	
14	Hold the port the Uniject while inserting the needle	
15	Insert the needle into the tent of skin between the thumb and forefingers	
16	Insert the needle at downward angle	
17	Insert the needle completely so that the port is in full contact with the injection site	
18	**Move fingers from the port to the reservoir while still pinching the skin**	
19	**Squeezes the reservoir slowly to inject the contraceptive taking about 5-7 seconds**	
20	Remove the Uniject from the skin	
21	Releases the fingers used to pinch the skin and create the tent	
22	**Discard the sued Uniject immediately into safety box without replacing the needle shield**	
23	clean surface with single sterilized swab if needed	
24	**Do not rub the injection site**	
25	**Recall take away messages**	

Super Effective Method (99%)

-Super effective methods are divided into 2 groups .

i.Long acting reversible (LARC)

ii.Long acting irreversible method.

Inform Participants that Super effective methods will be discussed in 2 different parts in order to cover hands on session also.

Long Acting Reversible Methods:

a) Mirena (T-shaped IUD)

b) IUCD (Mulitload/ Copper -T)

c) Jadelle

9. The Mirena:

- Coil is a T-shaped intrauterine device made of plastic. The IUD contains levonorgestrel, a type of hormone that prevents pregnancy.
- Mirena can remain in the body for up to five years because it releases the hormone over time. Patients should replace the IUD after five years.
- Mirena decreases menstrual blood loss by 62 to 94 percent after three months. The device reduces menstrual blood loss by 71 to 95 percent after six months of use.
- Its insertion and removal techniques are similar to copper –T IUD.
- Commonly used for therapeutic reason.

Inform participants that other super effective methods will be discussed in later sections including:

10. IUCD Insertion (along with hands on)

11. Implant (along with hands on)

12. Permanent methods

a. Tubal Ligation

b. NSVS

Module : 4.1.2

Emergency Contraceptive methods

Emergency contraception refers to methods of contraception that can be used to prevent pregnancy after unprotected sexual intercourse. These are recommended for use within 5 days but are more effective the sooner they are used after the act of intercourse.
This module on Emergency Contraceptive is designed for the providers in PAKISTAN who most often are tasked with providing FP services.

Learning objectives:

- Enabling participants to clarify the use and importance of emergency contraception in preventing unwanted/unplanned pregnancies.
- Can counsel and demonstrate about different emergency contraceptive methods .
- Explain how to use the methods
- Identify situations for indication of emergency contraception.
- Shifting clients to regular contraceptive methods use after emergency contraception.
- Participants will demonstrate counseling of EC clients.

Brain storming Discussion:

Include participants to discuss on their previous knowledge related to above objectives. Give chance to each participants to answer questions.
Depending on participants feedback, facilitator can decide the area for further detailed discussion on emergency contraception and their use.

Methods of emergency contraception

The 4 methods of emergency contraception are:

- ECPs containing UPA
- ECPs containing LNG
- combined oral contraceptive pills (not usually recommended due to more side effects like nausea and vomiting and menstrual irregularity)
- Copper-bearing intrauterine devices. (IUCD)

Emergency contraception pills (ECPs)

- ECPs are sometimes called "morning after" pills or postcoital contraceptives.
- Work primarily by preventing or delaying the release of eggs from the ovaries (ovulation). They do not work if a woman is already pregnant

Learning Objectives:

By the end of the training, trainees should be able to do the following:

i. Describe the characteristics of emergency contraceptive pills (ECP) in a manner that clients can understand:

a. What ECPs are and how they work (mechanism and onset of action)
b. Effectiveness
c. Side effects
d. Possible precautions or complications
e. ECP regimens
f. Key points for providers and clients

ii. Describe the indications for use of ECPs
iii. Demonstrate how to screen clients for ECP use
iv. Demonstrate counseling client on ECP

ECP Dose:

WHO recommends any of the following drugs for emergency contraception:

- ECPs with UPA (ulipristal), taken as a single dose of 30 mg (not available in Pakistan)
- ECPs with LNG taken as a single dose of 1.5 mg, or alternatively, LNG taken in 2 doses of 0.75 mg each, 12 hours apart.

Effectiveness

Ideally, ECPs with UPA, ECPs with LNG or COCs should be taken as early as possible after unprotected intercourse, within 120 hours. ECPs with UPA are more effective between 72–120 hours after unprotected intercourse than other ECPs.

Note:

Fertility returns soon after 24 hrs. from the use of ECP. Taking ECPs give protection for previous 5 days for unprotected coitus and, will not protect from pregnancy for more than 24 hours after she takes ECPs. In order stay protected from pregnancy, client must seek for continuous contraceptive methods.

Side Effects of ECP:

Ask participants about what common side effects they usually see with ECP use before showing pictorial images to describe side effects.

-At the end of session distribute checklist for emergency contraception to all participants.

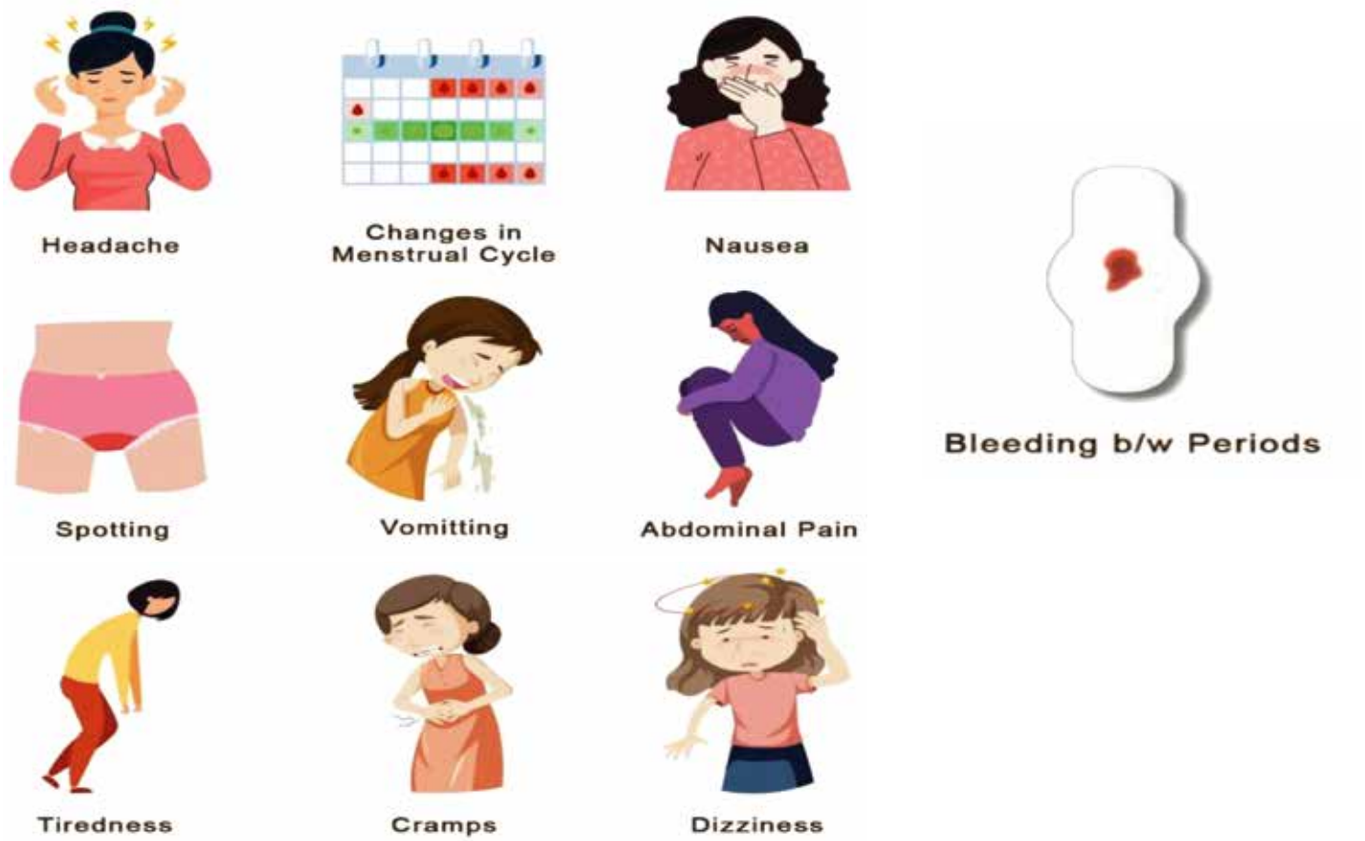


Table: 4.1.3

Condoms and Emergency Contraception

Sr.no	Check List	Yes	No
1	**Condom demonstration done correctly including; expiry date, storage, opening, fitting, removal, and disposal**		
2	Provider knows how to use (check expiry, how to open, use and disposal) and rupture/ leak		
3	**Provider educates client on what to do in case of Rupture and Leakage**		
4	**Emergency contraceptions: Offered and available**		
5	IUCD and EC pills as emergency contraception offered and available		
6	**Indication and instruction about ECP**		
7	**Time duration of Effectiveness for both ECP and Emergency IUCD**		
8	**How many times clients can use ECP in a month**		
9	Provide EC pills pack to all condom users/clients		
10	What to do if there is vomiting within 2 hrs of taking ECP, client given instructions(with food)		
11	**Possible side effects and their management**		
12	**Follow IUCD check list in case client express consent for IUCD insertion as emergency contraception**		

Module: 4.1.3

Dispelling Myths/ Misconceptions handling side effects:

Props:

- Power Point presentation on Contraceptive method
- Flip charts on family planning
- Cue cards for Counselling on Contraception – Greenstar social marketing app
- Cue card for Counselling adolescents on contraception- GSM App
- Video – Tawazan (Public service message by Population welfare department Sind)
- Counselling cards are as follows

✓ Duel protection
✓ Withdrawal method
✓ Standard Days method
✓ Monthly Injections
✓ Progestin only injection
✓ The Pill
✓ Male Condom
✓ Lactational Amenorrhea
✓ IUCDs
✓ Merina IUCD
✓ Hormonal Implant
✓ Emergency Contraceptive pills

- Flash Cards:
  FACTS
  MYTHS

Time: 2hrs

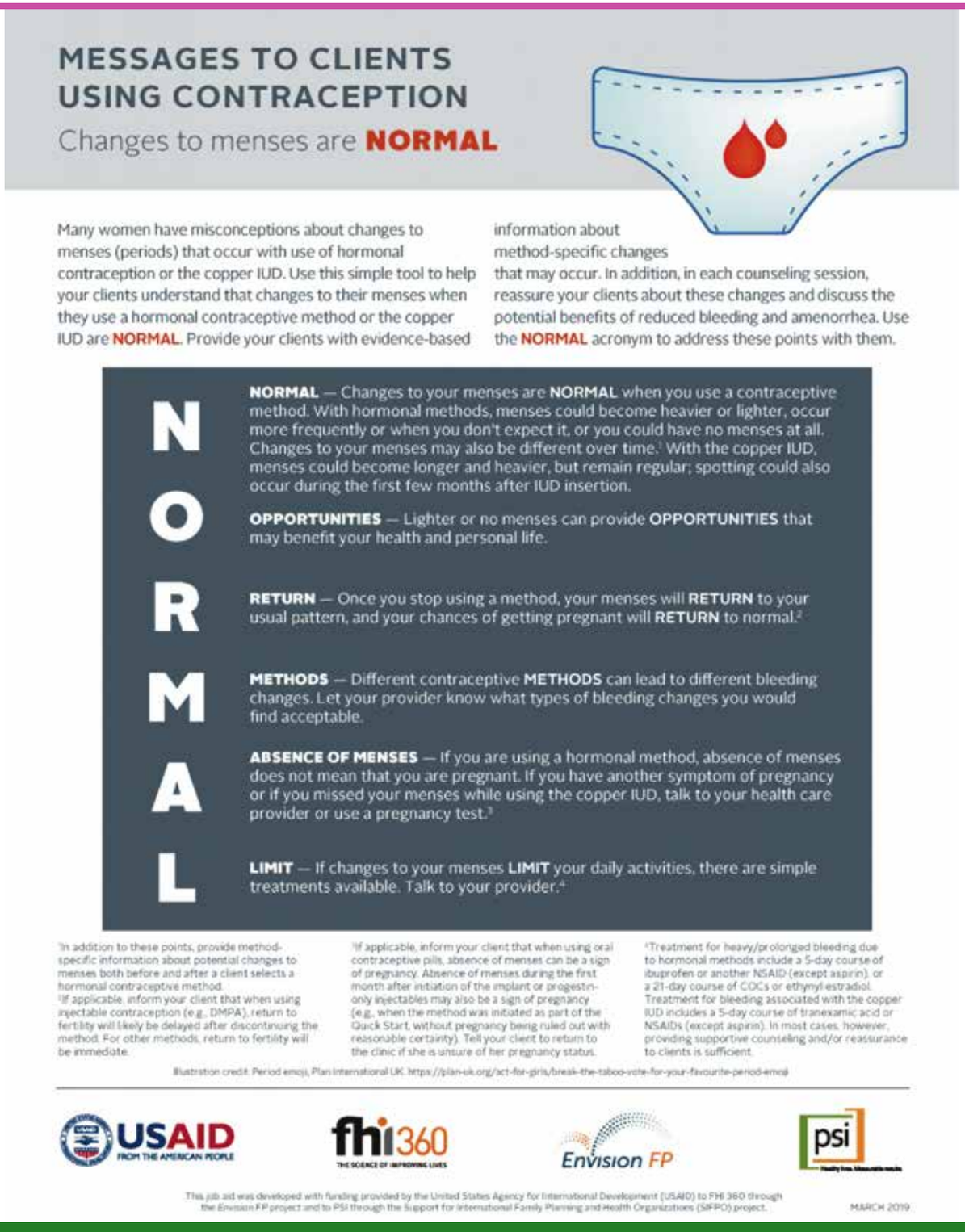
This activity will be divided in 2 parts 1 performed first day and 2nd consecutive day.

Day 1: Instruction for the role play 20 minutes

Day 2: Preparation time 30 minutes, Role play by all group 70 minutes.

Fig 4.

Counseling Tool for Menstrual Bleeding Changes



MESSAGES TO CLIENTS USING CONTRACEPTION

Changes to menses are **NORMAL**

Many women have misconceptions about changes to menses (periods) that occur with use of hormonal contraception or the copper IUD. Use this simple tool to help your clients understand that changes to their menses when they use a hormonal contraceptive method or the copper IUD are **NORMAL**. Provide your clients with evidence-based information about method-specific changes that may occur. In addition, in each counseling session, reassure your clients about these changes and discuss the potential benefits of reduced bleeding and amenorrhea. Use the **NORMAL** acronym to address these points with them.

N — **NORMAL** — Changes to your menses are **NORMAL** when you use a contraceptive method. With hormonal methods, menses could become heavier or lighter, occur more frequently or when you don't expect it, or you could have no menses at all. Changes to your menses may also be different over time.[1] With the copper IUD, menses could become longer and heavier, but remain regular; spotting could also occur during the first few months after IUD insertion.

O — **OPPORTUNITIES** — Lighter or no menses can provide **OPPORTUNITIES** that may benefit your health and personal life.

R — **RETURN** — Once you stop using a method, your menses will **RETURN** to your usual pattern, and your chances of getting pregnant will **RETURN** to normal.[2]

M — **METHODS** — Different contraceptive **METHODS** can lead to different bleeding changes. Let your provider know what types of bleeding changes you would find acceptable.

A — **ABSENCE OF MENSES** — If you are using a hormonal method, absence of menses does not mean that you are pregnant. If you have another symptom of pregnancy or if you missed your menses while using the copper IUD, talk to your health care provider or use a pregnancy test.[3]

L — **LIMIT** — If changes to your menses **LIMIT** your daily activities, there are simple treatments available. Talk to your provider.[4]

[1]In addition to these points, provide method-specific information about potential changes to menses both before and after a client selects a hormonal contraceptive method.
[1]If applicable, inform your client that when using injectable contraception (e.g., DMPA), return to fertility will likely be delayed after discontinuing the method. For other methods, return to fertility will be immediate.

[2]If applicable, inform your client that when using oral contraceptive pills, absence of menses can be a sign of pregnancy. Absence of menses during the first month after initiation of the implant or progestin-only injectables may also be a sign of pregnancy (e.g., when the method was initiated as part of the Quick Start, without pregnancy being ruled out with reasonable certainty). Tell your client to return to the clinic if she is unsure of her pregnancy status.

[4]Treatment for heavy/prolonged bleeding due to hormonal methods include a 5-day course of ibuprofen or another NSAID (except aspirin), or a 21-day course of COCs or ethynyl estradiol. Treatment for bleeding associated with the copper IUD includes a 5-day course of tranexamic acid or NSAIDs (except aspirin). In most cases, however, providing supportive counseling and/or reassurance to clients is sufficient.

Illustration credit: Period emoji, Plan International UK. https://plan-uk.org/act-for-girls/break-the-taboo-vote-for-your-favourite-period-emoji

This job aid was developed with funding provided by the United States Agency for International Development (USAID) to FHI 360 through the Envision FP project and to PSI through the Support for International Family Planning and Health Organizations (SIFPO) project.

MARCH 2019

Module 4.1.5

WHO Medical Eligibility Criteria (MEC) Wheel:

Introduction to MEC Wheel

Material:

- Power point presentation
- MEC wheel for participants
- Greenstar Social marketing App for MEC wheel
- Show 2015 WHO interactive MEC wheel link : http://srhr.org/mecwheel
- Case Scenarios sheet

Time: 30 minutes

Instructions:

- Using Power point presentation, introduce Medical eligibility Criteria(MEC) Wheel to the participants.
- Distribute MEC wheel to participants and explain the medical eligibility criteria using the Wheel.
- Show 2015 WHO interactive MEC wheel link : http://srhr.org/mecwheel
- Distribute case scenario of clients with medical conditions to all participants
- Ask participants to select appropriate contraceptive for the client using MEC wheel
- Facilitator at the same time will use MEC wheel link displayed on the screen that will help participants for better understanding.

Case Scenarios:

Case 1: The patient is 32 years old women with a history of tuberculosis who has just delivered her third baby. She is currently on T.B drugs including Rifampicin. She is wondering which contraceptive she should start in the postpartum period.

Her Contraceptive Options include : IUDs, implants, DMPA

Case 2: A 26-year-old women delivered vaginally a healthy baby at 40 weeks of gestation. She is breast feeding. She wants to space her next birth by atleast 4 years. She is interested in contraceptive implant. Is she eligible for the contraceptive implant before her discharge from the hospital?

Yes, the woman is eligible for an implant insertion. Implant are category 2 for women who breast feed.

Case 3: A 38 years old woman who is HIV positive delivered about 24 hrs ago. She is not on Anti retroviral (ARVs), is having fever, and having foul-smelling lochia. She doesn't want anymore children and asked for either IUD inserted or BTL done immediately. Is she eligible for these methods?

Not eligible for IUD or BTL due to sepsis

Case 4: A 24 years old woman give birth to a healthy baby boy at 37 weeks of gestation through normal vaginal delivery. She is now 6 weeks postpartum and is breast feeding. She would like to space her birth by at least 3 years. She has a history of hypertension during pregnancy. Are oral contraceptive methods appropriate for this patient?

Yes, this client is eligible for specific oral contraceptive methods i.e progesterone only-pills (POPs).
-History of hypertension and breastfeeding is classified as category 2 for the use progesterone-only pills.
-But use of combined pills is category 4 at 6 weeks and category 3 through less than 6

Day 1 Instructions:

AT the end of first day, the first part of this activity will be conducted as follows:

- Divide participants into 6 groups (according to number of participants)
- Distribute family planning flip chart and handouts of IEC material to the participants
- Assign one method of contraception including ECP to each group and ask them to prepare for their session using the given material
- Ask them to read about the assigned task in evening
- Explain participants to download Greenstar social marketing app where they can review and counselling cards and MEC wheel. Moreover, explain participants that now there are number of mobile family apps with multiple simple and complex features that include period tracking to record basal body temperature: Fertility Friend, Kindara, period calendar, Glow fertility etc.
- Discuss with participants to focus on counselling a client, with giving instructions on:
  - o When to start the method
  - o How to use the method
  - o Explain advantages and limitations
  - o How to manage side effects, myths and misconceptions
  - o What are important take away messages
- Lead trainer and facilitator show a role play on Post-partum IUCD to clarify the participants how they will prepare their session on specific methods.
- At the end of session wish everyone luck for good preparation of their session and entertaining learning

Instructions, Day 2:

- Announce that participants as 30 minutes to discuss their role play and sessions within their group and mentor
- Every group will be assigned 10 minutes to do role play where they will cover to provide specific information to the particular method to the client and large group.
- The group presenting injectables will give complete instructions on sayana press aswel
- After each presentation, ask for any questions or clarifications.
- Ask all participants to give first positive feedback.
- Following discussion of any error or addition to the prrsentation
- At the end of session trainer will ask participants about the difference between side effects and complications, myths and misconceptions.
- Explain that side effects should not be mistaken for complications and show some statements using
- Power point presentations
- Distribute Facts and Myths cards to all participants
- Ask participants to read the statement one by one and display their flashcards whether the statement is fact or myth.

Side Effects

Side effects are interventions that accompanies the desired effect. They are unwanted, but not unusual. These effects are mild, usually self-limiting and have no long-lasting consequences.

Complications

It is an event that occurs unexpectedly. Complications can cause harm, either temporarily or permanently. It can be avoided most of the time, but sometimes are unavoidable to achieve the desired effect.

Note for Facilitator:

It is important that participants should be aware of the fact that mostly fear and misconceptions about menstrual bleeding often contribute to discontinuation and avoiding use of contraception. On other hand, amenorrhea or reduced bleeding can have significant contraceptive health and lifestyle advantages for women, these potential benefits should be highlighted during counselling session.

Fig 4.1.2 Flip Card Fact/Myth

FACT

Myth

Update on Family Planning Methods and What are Greenstar Products

Probs:

- Power Point presentation
- Greenstar contraceptives displayed on a table
- Contraceptives available under Greenstar umbrella and their distribution

Time: 45 Minutes

Instructions:

- Discuss the history of family planning in the country, explore their professional experience with FP, beliefs, and biases
- Put all the contraceptives all contraceptives on the table and broadly introduce them, to the participants.
- Distribute Greenstar contraceptive list to the participants with brand names and price list.
- Show Power point presentation on each method and discuss the efficacy, mode of action, advantages of that particular FP method.
- Inform that that all FP services, including contraceptive surgery, are offered at different Greenstar clinics as well as district and taluka Headquater govt hospitals and RHC centers by trained providers:
  - **o Lady health wokrers are authorized to provide:** OCPs, condom and 2nd and subsequent doses of injectables only. (as per Sind Policy LHWs can now provide the first dose of injectable as well.
  - **o Community Midwives (CMWs) are authorized to provide:** OCPs, injectables, condoms and IUDs. CMW needs to refer the client to trained LHV or doctor for implant insertion or removal.
  - **o Lady health Visitors (LHV) are authorized to provide:** OCPs, Injectables, Condoms, IUDs (insertion and removal), and implant insertion. LHVs needs to refer the client to trained doctor for implant removal.
  - **o Doctors** are authorized to perform Contraceptive surgery, LARC methods (IUCD and implant insertion and removal, and all available contraceptive methods including Long acting irreversible method Vasectomy and Bilateral tubal ligation.
  - o Remind provider that only trained and certified providers can practice the mentioned services.

Table 2.1.7 List of Contraceptive Available in Greenstar

Name	Composition	Protection	Quantity in Packet	Price *(PKR)*	Manufacturer/ Distributor
OCPs					
Tab Novodol	*Ethinyl estradiol 0.03mg Levonorgestrel 0.15mg, Ferrous Fumarate EP 0.75mg*	3 cycles	84 tablets	90/-	Zafa/Greenstar

ECPs					
Tab ECP	*Levonorgestrel 0.75mg*	Once	2 tablets	20/-	Zafa/Greenstar
Tab Emkit	*Levonorgestrel 0.75mg*	Once	2 tablets	19.56/-	Zafa/ DKT
Injectables					
Inj. Femiject	*Estradiol valerate 5mg Norethisterone enanthate 50 mg*	1 month (I/M)	1 pc	65/-	Bayer Health Care/Greenstar
Inj. Novaject	*Norethisterone Oenanthate 200mg*	2 months (I/M)	1 pc	92/-	Greenstar
Inj. Depo Provera	*Medroxyprogesterone Acetate 150mg*	3 months (I/M)	1 pc	153/-	Pfizer/Greenstar
Inj. Sayana Press	*104 mg medroxyprogesterone acetate (MPA) in 0.65 mL suspension*	3 months (S/C)	1 pc	260/-	Pfizer/ Population Welfare Dept.
Intra Uterine Contraceptive Devices (IUCDs)					
Protect 5	*Cu 375 (Multiload)*	5 years	1 pc	250/-	Pregna/ Greenstar
Intra Uterine Contraceptive Devices (IUCDs)					
Protect 5	*Cu 375 (Multiload)*	5 years	1 pc	250/-	Pregna/ Greenstar
Safeload	*CuT 380 – A*	10 years	1 pc	240/-	Greenstar
Implants					
Jadelle	*Levonorgestrel 75 mg*	5 years	850/-	Population Welfare Department, Government of Sindh	
Condoms					
Sathi		Once	2 pcs	30/-	Greenstar
			4 pcs	50/-	
			8 pcs	100/-	
Sathi – plus		Once	3 pcs	45/-	Greenstar
Touch	Delay *(Blue)*	Once	3 pcs	70/-	Greenstar
	Dotted *(Green)*	Once	3 pcs	45/-	Greenstar
			6 pcs	65/-	
	Ribbed *(Red)*	Once	3 pcs	32/-	Greenstar
			6 pcs	48/-	
Do (3 in 1)	Ribbed, Delay, Dotted *(Black)*	Once	3 pcs	120/-	Greenstar

For more information:
Contact:
Poocho Help line Greenstar

24/7 Helpline

Module 4.1.4

IUCD (Interval) Insertion

Probs:

- Greenstar FP hand book on Family planning method
- Interval IUCD insertion check list
- Videos:

  ohttps://www.innovating-education.org/2018/02/iud-insertion-paragard/
  ohttps://www.innovating-education.org/2018/04/larc-insertion-difficult-iud-insertion/
  IUCD insertion dummy (pelvic dummy/ Zoye)
- Light source
- Pyodine solution
- Sterile Gloves
- IUCD kit including :
  - Medium seized instruments tray
  - Kidney tray
  - Gallipot
  - Cotton Swabs 2-3
  - Cusco's speculum
  - Sponge forcep
  - Dilator
  - Volselum
  - Uterine sound
  - IUCDs both Copper T and Multiload
  - Curved Scissors

Time: 2 hrs

- Videos 10 Mints
- Review of IUCD insertion checklist 10 Mints
- Demonstration 20 Mints
- Hands on 80 Mints

Instructions:

- Play video on IUCD insertion for better understanding of the training members
- Distribute Interval IUCD checklist to all candidates and ask them to read the point one by one as the
- facilitator will discuss the steps.
- The Lead trainer will than demonstrate the procedure using checklist and allow participants to observe the steps using the same checklist copy.

- Now make groups of 4-5 participants according to number IUCD stations set in training hall
- Ask participants to re-demonstrate IUCD insertion one by one on pelvic model.
- Each participant will be allocated 8 minutes to practice on the pelvic model. 2nd participant will play the role of client and other will assess using checklist.
- The Role of participants will shift to next participants after 8 minutes with the BELL RING unless all participants get the chance.
- Facilitator will assess using a separate checklist for each provider.
- Then show the video on difficult IUCD insertion.

No Touch Technique

No touch Technique means to insert loaded IUCD and instruments with such technique that doesn't allow them to touch unsterile surface (for example: hands, other surfaces like table, vagina and other instruments) it involves:

- Avoid touvhing IUCD directly, by loading IUD into inserter while IUD is still in the sterile package.
- Cleaning cervix thoroughly with antiseptic before inserting IUCD
- Do not touch vaginal walls and speculum blades with the uterine sound or loaded IUCD.
- Make single skillful attempt to pass uterine sound and IUCD through cervical canal.

Interval IUCD Removal Technique:

Material:

- Greenstar handbook on Family planning .
- Videos
- *https://www.innovating-education.org/2018/04/larc-removal-iud-removal/*
- *https://www.innovating-education.org/2018/04/larc-removal-difficult-iud-removal/*
- Interval IUCD removal checklist
- Covering sheet
  - Medium sized rectangular instrumental tray
  - Gallipot
  - Pyodine solution
  - Cotton swab
  - Sterile gloves
  - Light source
  - Cusco's speculum
  - Sponge forceps
  - Volsellum
  - Dilatorsize ¾
  - Long artey forcep
  - Cytobrush
  - IUCD Hook
  - 1% Lindocaine
  - D/S syringe

Time: 2 hrs

Videos	10 Mints
Demonstration	10 Mints
Practice	40 Mints

Checklist- IUCD Insertion

s.no	TASK	Yes	No
	Pre-insertion tasks		
1	Exclude pregnancy		
2	Check eligibility criteria according to MEC wheel		
3	Assure that client is informed about side effects inculding initial bleeding irregularities		
4	Assure client she can have IUCD removal any time she wants		
5	Consent before procedure		
6	Check product expiry and availability of sterile instrument		
7	Ask client to emplty bladder and clean prenium		
	Procedure		
8	Performe physical examination under proper light (per abdominal, per vaginal, bimanual and per speculum)		
9	Swab cervix and vagina with antiseptic		
10	Gently grasp anterior lip of cervix with valsellum forceps		
11	Sound uterus to check size and position .		
12	Load IUCD and take measurment according to the size of sound within IUCD pack without opening it completely		
13	Now open IUCD package		
14	Perform insertion with protocols (*No-touch technique)*		
15	Once reached fundus, insert IUCD using withdrawal technique		
16	In case of copper T use pull technique to leave the IUCD to the fundus of uterus		
17	Cut thread atleast 3 cm out of the external Os		
18	Light pyodine pressure swab at external os for 10 secs to control bleeding		
	Post-procedure tasks		
19	Process instruments and consumables appropriatly		
20	Provide client with information related to improtant information, warning signs and contact details to call or go in case of any complications or questions.		
21	Record insertion data according to protocols		
22	Screen for warnings signs (PAINS)		
23	Review key messages		
24	Give client a refferal card for follow up with date after 1 week and after 1st period post insertion		

Instructions:

- Play video to demonstrate the removal of interval IUCD.
- Later facilitator can demonstrate procedure for participants to observe.
- Allow participants to redemonstrate on the pelvic dummy.
- To ensure that participants have learned the techniques well, conduct assessment of IUCD removal, the same day.

- Divide participants according to number of facilitators and stations for individual hand on assessment of participants.
- Each participant will be allocated 6 minutes to practice on the pelvic model. 2nd participant will play the role of client while other will observe using checklist.
- The Role of participants will shift to next participants after 6 minutes with the BELL RING unless all participants get the chance.
- Facilitator will assess using a separate checklist for each provider.
- Then show the video on difficult IUCD removal.

Note: *Trainer can merge IUCD insertion with IUCD removal session to safe time according to convenience*

Management of complications with IUCD:

Objectives:
By the end of session participants will be able to:
- Identify different complications associated with IUCD insertion
- To counsel client on about key messages for identification and follow up plan in case complication
- participants will be able to manage/refer different complication.

Time : 60 mints

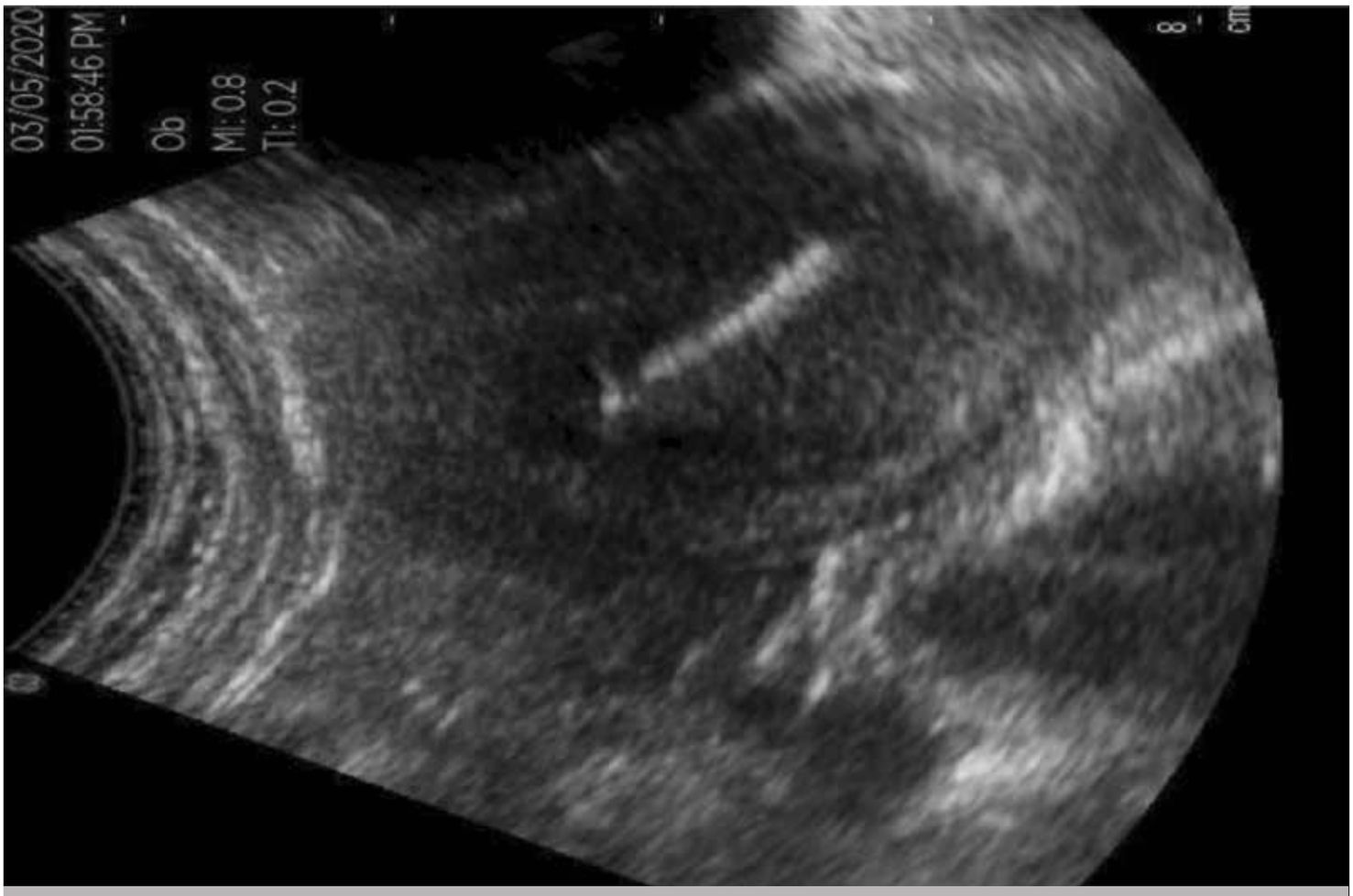
Material:

1. ***Power point presentation***
2. ***Flip charts***
3. ***Markers***
4. ***Four Flip cards with complications and related questions.***

i. ***Expulsion***
ii. ***Infection***
iii. ***Perforation***
iv. ***Pregnancy with IUCD***

Instructions:

- Divide participants into four groups and give one flip card to each group with 1 IUCD complication .
- Explain group that .Each card has following questions to be solved by group members in given time of 10 mintues. Questions include:
  - i.What signs and symptoms will client present in this scenario?
  - ii.What would be your differential diagnosis?
  - iii.Management and labs and investigations if required?
- After 10 minutes small group will present infront of the large group one by one.
- By the end of each group presentation ask other participants if they want to add any information or has any related questions.
- After group presentations present a case scenario over power point to discuss Missing thread complication and its management.



Case Scenario:

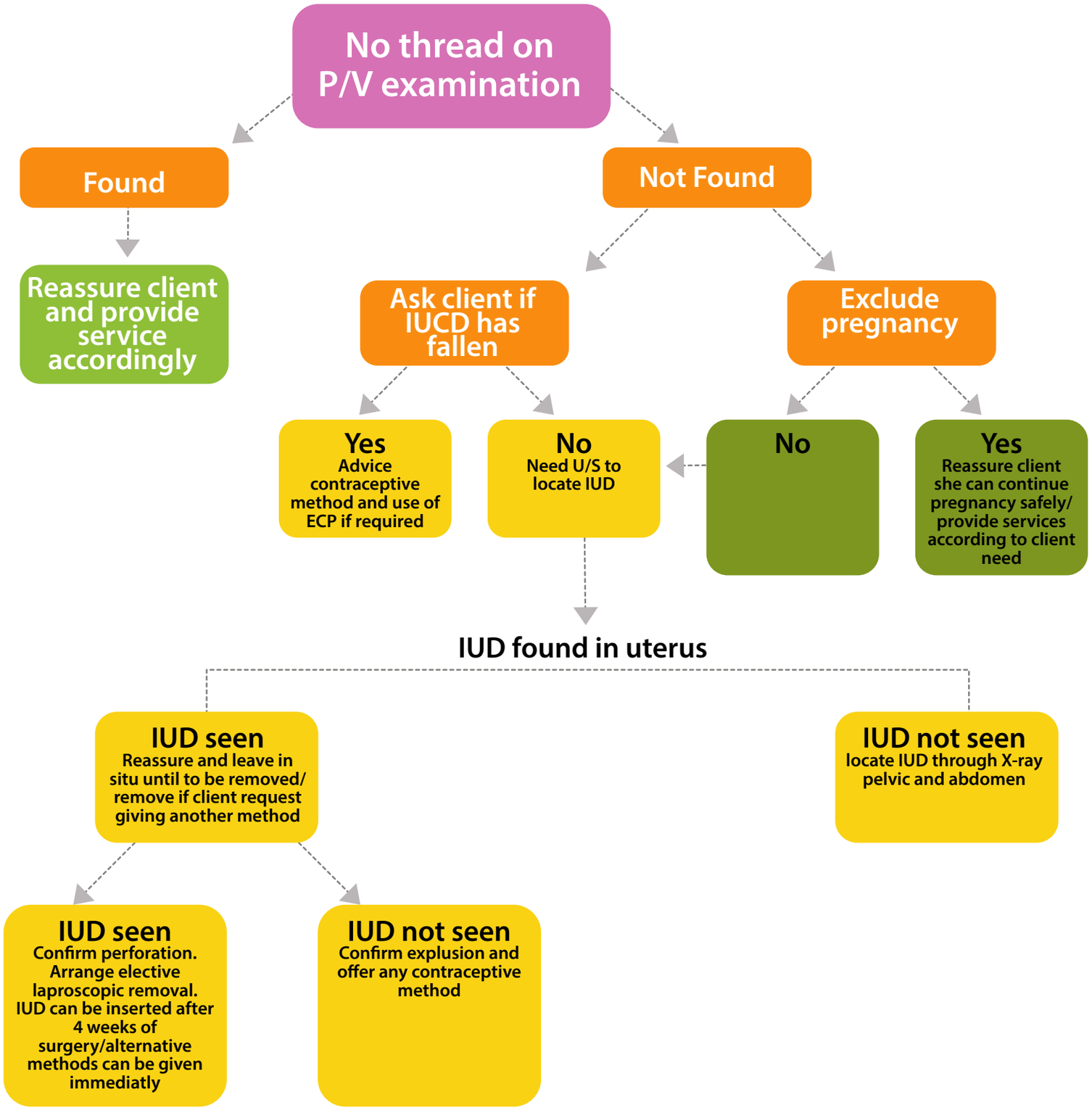
A 28 year-old married woman, Gravida 1 and Para 1, attend a Health Center for IUCD removal service after 7 years of protection and internally referred to limited obstetric ultrasound service room due to non- visualization of IUCD thread with Vaginal Speculum examination. An ultrasonography scan however, showed a centrally located copper-T 380A IUCD in the endometrial cavity. As a result, after dilatation of the cervix, a successful removal of the Copper-T 308A was conducted. The client received followed up care for 2 hours post-procedure and was then discharged.

Conclusions

This case highlights the importance of availing diagnostic and removal services in rural set ups to mitigate myths in the community. The availability of limited obstetric ultrasound scanning services can improve the diagnoses and management of conditions in clients. The reported case shows that although, the basic infrastructure was limited, ultrasound scanning and Long Acting Reversible Contraception (LARC) trained midwives can ensure the provision of safe IUCD removal services .

Fig. 4.1.3

Missing Thread Management



At the end describe step by step missing thread management through a flow chart.

Module 4.1.5

Implant

Implant Insertion and Removal Technique:

This training programme is aimed at Doctors,LHVs and Physician Associates already working in general practice and community sexual health services who want to develop the necessary knowledge, attitude and skills to support women seeking contraception

Learning Outcomes:

To provide a training programme that will equip the learner with the evidence based knowledge, attitude and skills to appropriately provide a subdermal implant and manage complications, side effects and removal.

Material:

- Power point presentation
- Videos on:
  - -Implanon Insertion Technique
  - -Jadelle Insertion technique
- Implant insertion checklist
- Arm model for Implant training
- Small rectangular instrument tray
- Gallipot with cotton swabs
- Pyodine solution
- Light source
- Implants
- Antiseptic/soap and water
- Sterile guaze
- Holding forceps
- Distilled water for injection 5 ml ampule
- Local anesthetic-2% xylocaine
- 5 ml syringe with needle
- Trocar
- Skin bandage

How to make 1% of local Anesthesia
Make 1% solution of local anesthetic by mixing 2.5 ml of 2% Xylocaine and 2.5 ml of distilled water

Time: 2 hrs

Power point presentation	40 Mints
Video	10 Mints
Review the implant insertion checklist	10 Mints
Demonstration	30 Mints
Practice/assesment on Arm model	100 Mints

Fact Sheet:

Contraceptive Implants are Progestin-only implants are small plastic rods that release a hormone in a woman's body to prevent pregnancy. They are inserted under the skin in a woman's upper non-dominant arm. Current systems consist of one (not available in Pakistan) or two rods.

Types of implants include:

1. Jadell

a two-rod system designed to deliver a steady daily dose of levonorgestrel over a period of five years.

2. Sino-implant (II): (Not available in Pakistan)

which has the same active ingredient as Jadelle and similar in size but is approved for use over a period of three years.Sino-implant (II) is now being sold under the global brand Levoplant.

3. Implanon/ NXT:

a single-rod system that releases a steady daily dose of the progestin etonogestrel for a period of up to three years. Implanon NXT is sometimes called Nexplanon. Implanon NXT/Nexplanon are newer versions of Implanon, which is no longer available, but some women may still have it and need removal.

Instructions:

- Explain implant in detail through power point presentation
- After presentation play videos, demonstrating the implanon and jadelle insertion and removal procedure.
- Distribute the procedure checklist to the participants and ask them to read the checklist one by one as you discuss the steps
- The video will be followed by a demonstration by the lead trainer on reproductive implant training arm for insertion and removal of implant using the checklist
- Divide participants according to umber of facilitators and stations. (preferably 3 participants in each group)
- Each participant will get 15 minutes to practice on Arm model. Next participant will play role of the client and others will assess/observe using checklist.
- After 15 minutes , the bell will rig and the role of the participants wil be shifted so that each participant get chance to practice on the model
- To ensure that participants have learned the technique well, facilitator will conduct individual assessment on insertion and removal on separate checklists for each participant, when participants were practicing and give feed back at the end of group sessions.

Checklist- Implant Insertion

S.no	Tasks	Yes	No
	Pre-Insertion Counselling		
1	Greet the client respectfully and with kindness		
2	Rule out pregnancy		
3	If client has already identified a method provide focused counseling on the method using counselling cards		
4	Discuss side effects, and efficacy. Confirm method choice.		
5	Review medical eligibility criteria. MEC		
6	Assess women knowledge on implant major side effects: confirm that client accept possible menstrual changes with implants		
7	describe insertion procedure and what to expect.		

	Pre-Insertion Preparation		
8	Takes appropriate steps to get ready for procedure according to protocol		
9	Checks to be sure client has thoroughly washed and rinsed her arm.		
10	Washes hands thoroughly and dries		
11	Places sterile or high-level disinfected drape under and over arm.		
12	Puts sterile or high-level disinfected gloves on both hands		
13	Set up sterile field with and place implant rods and trocar on it		
14	Preps insertion site with antiseptic solution		
15	Injects local anesthetic (1% without epinephrine) just under skin; raises a small wheal.		
	Insertion		
16	Advance needle about 4-5 cm and inject 1-2 ml of local anesthetic in each of two subdermal tracks.		
17	Inserts trocar directly sub dermally superficially, advance plunger to mark near the trocar hub.		
18	Remove plunger and load first rod into trocar		
19	Reinsert plunger and advance it until resistance is felt		
20	Hold plunger firmly in place with one hand and slide trocar out of incision until it reaches plunger handle.		
21	Withdraw trocar and plunger together until mark 2, nearest trocar tip, do not remove trocar from the skin		
22	Redirect trocar about 15 and advance trocar and plunger to mark 1.		
23	Insert 2nd rod using same technique.		
24	Palpates ends of rods to be sure the rods are placed correctly ("V" shape) and palpates incision to		
25	Check that ends of rods are about 5mm away from incision.		
26	*Post-insertion Tasks*		
27	Bring edges together and close it using surgical tape and apply pressure bandage		
28	Processes instruments and consumables appropriately before removing gloves		
29	Complete client record according to protocols.		
	Post-insertion Counselling		
30	Make return visit appointment and instruct the client regarding wound care		
31	Discusses what to do if client experiences any problems following insertions or side effects.		
32	ask client to tell key messages		
33	complete client card indicating when date of insertion and when she needs to return for removal.		

Module 4.1.4

Permanent Methods

Birth control, like sterilization, is a way for men and women to prevent pregnancy. Sterilization is a permanent form of birth control that is extremely effective at preventing pregnancy. But it is difficult to reverse if you change your mind, and it does not protect against STDs. Both men and women can be sterilized. For women, a tubal ligation is performed; for men, a vasectomy is performed.

Time : 40 Minutes

BTLn	25 minutes
VSCS	15 minutes

Material :

- Power point presentation
- Video: on bilateral tubal ligation
- Questionare on BTL and Vasectomy

FEMALE STERILIZATION/ Bilateral Tubal Ligation:

Objectives :

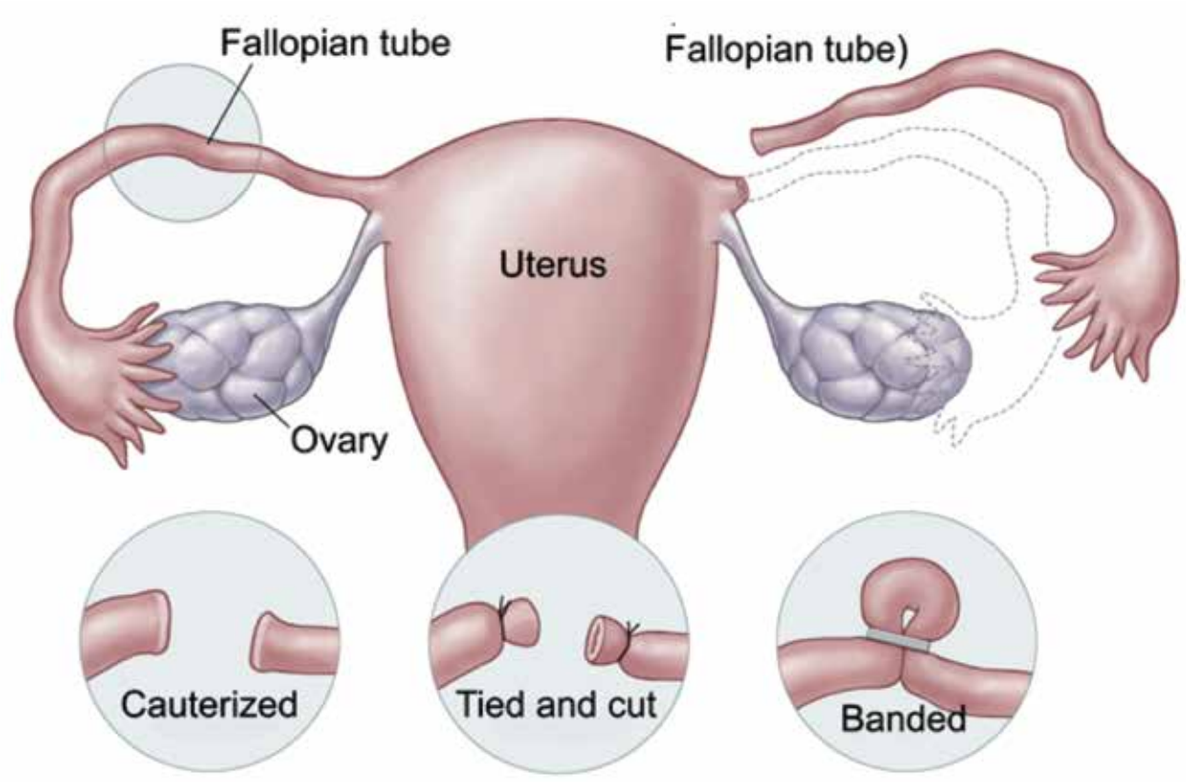
The end of session participants will be able to

- Demonstrate Counselling on BTL and help client make informed decision.
- Benefits, side effects and warning signs.
- Able to handle queries and questions raised by client and can make proper referrals for procedure and handling post procedure care.

Discussion:

- Tubal ligation is a surgical procedure used as birth control for women. During this procedure, the fallopian tubes are tied, clamped, cut, banded or sealed closed. This prevents an egg from moving from the ovary through the fallopian tube where it can be fertilized with sperm.
- Tubal ligation is performed in a hospital or outpatient surgical clinic under Anesthesia
- One or two small incisions are made in the abdomen, and a small laparoscope is inserted. Using instruments that are inserted through the laparoscope, the fallopian tubes are cut, tied, clamped, banded or sealed shut. The skin incisions are then stitched closed. The patient is able to return home within a few hours after the procedure.
- Tubal ligation can also be performed immediately after childbirth through a small incision near the navel or during a cesarean delivery

Tubal Ligation:



VASECTOMY

Vasectomy is a small operation that prevent sperm from getting to semen while ejaculating therefore blocking pregnancy. Vasectomy can only be performed by well trained certified physician in a sterlised envirment with good light source.

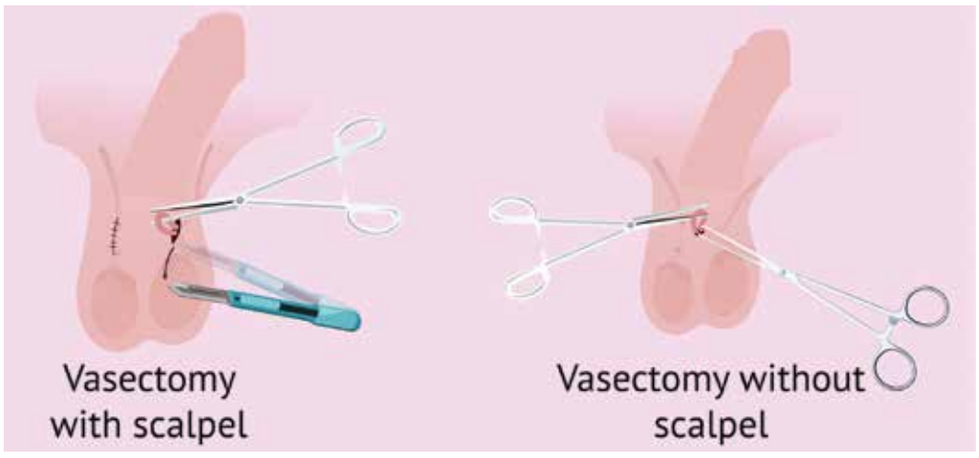
Conventinal Vasectomy :

Doctor makes cuts in scrotum to reach two tubes (vas deferens) one for each testicle. The doctor may remove a small piece of each tube and leave a short gap between the two ends tieing each one off with a stitch.

No-Scalpel Vasectomy:

The doctor feels for each vas deferens under scrotum and uses a clamp to hold it in place. They'll make a tiny hole in skin, stretch it open, and lift each vas deferens out, cut it, then seal it with searing, stitches, or both. How Effective Are Vasectomies? These procedures are nearly 100% effective.

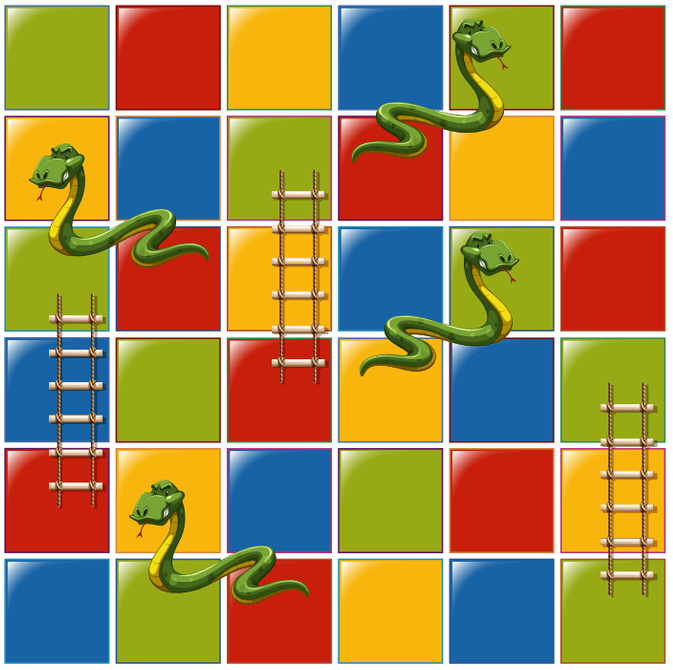
Procedure of vasectomy



Note:
There is separate training in order to perform Vasectomy and Bilateral tubal ligation. Both procedures are can be done in minimum Small OT set up according to protocols with high sterilization techniques and equipment. For permanent contraception/sterilization record should be importantly kept along with the consent forms of the couple.

Activity:

Snake game **Time: 1hrs**



Objectives:

- To update participants' knowledge on new guidance on the provision of contraceptive methods.

Advance preparation:

- Prepare the question cards. A set of suggested questions is given on page 2. You can prepare a set of cards/small sheets of paper, and write one question on each card, with the answer on the back. If the tool has been adapted, you may need to review and adapt the questions.
- Alternatively, you can play the game in a different way, by asking participant teams to come up with questions (see below).
- Prepare the board game. Draw a large snake divided up into segments of different colours (alternate segments of the snake's body into green, red, yellow, and blue). The more segments there are, and the longer the snake is, and the more opportunity for questions.

Steps:

1) Divide the participants into 2 teams. (5 mins)
2) Give instructions on how to play the game. (1 hr 25 mins)

- Give each team a set of question cards. Shuffle all the questions.
- The teams must take turns rolling the dice, moving along the snake, and answering the questions as follows:

Green: Whenever one group rolls a dice and get into a green spot- they will be answering 2 questions (and can win 2 points!!)

Red: Whenever one group rolls a dice and get into a red spot- they will be answering 1 question (and can win 1 point!!)

Yellow: Whenever one group rolls a dice and get into a yellow spot- they will not answer any question (and will not win any point...!)

Blue: Whenever one group rolls a dice and get into a blue spot- they will have to give back all their points and will not answer any question.

- Each team will keep a pile of questions and will nominate someone each time to ask the question(s) to the other team.

Table 4.1.1

Questionare for Snake

Sample questions for "Snake"

Questions and answers are given below, together with the page number in the tool that the answer can be found on.

The Pill (COCs)

Q: What is the main mechanism of action of the pill (COCs)?
A: Works mainly by stopping ovulation

Q: When can a client start to taking pills (COCs), without needing to use additional contraceptive protection?
A: Within the 5 first days of the start of her menstrual period.

Q: Can a woman who is 4 months postpartum and breastfeeding start to use the pill (COCs)?
A: No, she must wait until 6 months postpartum.

Q: When can a woman start to take COCs after an abortion?
A: She can start immediately.

Q: What would you advise a client who missed one pill (COC)?
A: She should take the missed pill as soon as she remembers, and continue taking pills as usual, one each day.

Q: In what circumstance does a woman who missed pills have to skip the pill-free week and go straight to the next pack?
A: If she missed 3 or more pills in week 3.

Q: List 3 return signs for COCs.
A: 3 from the following:

- **o Severe, constant pain in belly, chest, or legs**
- **o Very bad headaches**
- **o Migraine aura (a bright spot in vision before bad headaches).**
- **o Yellow skin or eyes**

A: For 3 months after the procedure.

Q: For how long should a woman rest after a sterilization procedure?

A: For 2 to 3 days.

Condoms and vaginal methods

Q: Which of these lubricants should NOT be used with a male condom?

1. Clean water
2. Baby oil
3. Spermicides

A: (2) Baby oil and all other oil-based lubricants should not be used.

Q: True or false: The male condom is less effective than the female condom.

A: False: The male condom is more effective.

Q: Up to how many hours before intercourse can the female condom be inserted?

A: Up to 8 hours ahead.

Q: Do spermicides help protect against STIs and HIV?

A: No. And women at high risk of HIV should not use them.

Q: When can a woman have a diaphragm fitted after childbirth?

A: She should wait 6 to 12 weeks after childbirth, depending on when the uterus and cervix return to normal size.

LAM and FAB

Q: What does the "A" in LAM stand for?

A: Amenorrhoea.

Q: Which of the following is NOT a condition of LAM:

1. Less than 6 months postpartum
2. Baby feeds well
3. Fully or nearly fully breastfeeding.
4. Periods have not returned.

A: (2) Baby feeds well.

Q: A woman has been using LAM. She is 5 months postpartum. She has started to feed her baby other foods. What should you advise her to do?

A: If she wants to stay protected from pregnancy, she should start using another contraceptive method NOW. LAM is no longer effective.

Q: **If a woman develops migraine headaches while using the pill, what should you advise her?**
A: She should switch to another method.

Q: **What should a pill-user do if she gets bad diarrhoea?**
A: She should follow the instructions for missed pills.

Q: **A woman returns to the clinic who had implants inserted 5 months ago. She is worried since she has not had a menstrual period in 2 months. She has no signs or symptoms of pregnancy. Should you:**

a) do a pregnancy test and advise her to have the implants removed; or

b) advise her that amenorrhoea (no monthly bleeding) is very common with implant use and reassure her that this is not a sign of illness.

A: **(B).**

Q: **How Effective Is Tubal Ligation?**
A: **Tubal ligation is not 99% effective at preventing pregnancy. There is a slight risk of becoming pregnant after tubal ligation.**

Q: **When can client return to its sexual activity after BTL or Vasectomy?'**
A: **Give it a few days. Use birth control until you get a test that shows that your semen is free of sperm. You can get this test once you've had 10-20 ejaculations after the vasectomy. If the results show there's still sperm in your semen, the doctor will ask you to come back later to take the test again.**

Q: **Can a Vasectomy Be Reversed?**
A: **Sometimes. But reversing a vasectomy isn't easy and doesn't always work. Don't get the procedure unless you're sure you won't want to father children in the future.**

Q: An HIV positive woman, living in an area with no safe water supply, wants to know if she can breastfeed the baby. What should you advise?

A: Advise her that she should breastfeed fully for 6 months, and then stop breastfeeding.

Q: List 2 advantages of fertility awareness-based methods.

A: 2 from among:

- Do not cause any side-effects.
- Can be effective if used correctly.
- Do not need to take any medication.
- Do not need to come back to the clinic regularly.
- Do not need to buy anything.
- Can be used by women who may not be able to use hormonal methods.

Q: True or false: When using the Standard Days Method, a user must abstain from sex or use condoms for 12 days in a row each cycle.

A: True.

General on contraception

Q: List the regular hormonal methods of contraception.

A: a. The pill (COCs)

b. The mini-pill (progestogen-only pills)

c. Monthly injectables

d. Long-acting injectables

e. Implants

Q: Which of these methods is the most effective at preventing pregnancy?

1. IUD
2. Pills
3. Injectables

A: IUD.

Q: List 3 conditions that can be used to rule out pregnancy.

A: 3 from among:

1. Menstrual bleeding started in last 7 days.
2. No sex since last period.
3. Gave birth in the past 4 weeks.
4. Have been fully or nearly fully breastfeeding AND gave birth in the past 6 months AND had no menstrual period since.
5. Had a miscarriage or abortion in the past 7 days.
6. Has been using a reliable method of contraception correctly and consistently.

Q: True or false: emergency contraceptive pills work by causing an abortion.

A: False. They do not cause abortion. They work mainly by stopping ovulation.

Copper-bearing IUD

Q: How does the copper-bearing IUD work?

A: It works mainly by stopping the sperm and egg from meeting.

Q: True or false: The copper IUD begins to rust in the uterus if not removed after 5 years.

A: False. The IUD does not rust in the body.

Q: A client comes to the clinic and wants to use the IUD. After a pelvic exam you find that she has vaginitis. Can she have the IUD inserted?

A: Yes, she can.

Q: An IUD user returns to the clinic after 1 year. She is pregnant. The strings are visible. What should you do?

A: Recommend IUD removal, but explain risk of miscarriage.

Q: True or false: An IUD user can take aspirin to help reduce bleeding problems.

A: False: She can take ibuprofen or similar medication, but NOT aspirin.

Q: Up to how many days in the menstrual cycle can a woman have the IUD inserted, without the need for extra protection?

A: Up to 12 days.

Q: A woman gave birth 24 hours ago. Can she have an IUD inserted now?

A: Yes. She can have it inserted up to 48 hours postpartum, or after 4 weeks.

Q: List 3 return signs for IUD.

A: 3 from among:

1. **Missed a period or thinks she might be pregnant.**
2. **IUD strings have changed length or are missing.**
3. **Might have an STI or HIV/AIDS.**
4. **Bad pain in lower abdomen.**

Vasectomy and Sterilization

Q: True or false: Vasectomy is more effective than female sterilization?

A: True. It is more effective.

Q: For how long must a man use an additional contraceptive method after getting a vasectomy before the procedure becomes effective?

Q: If a client is 10 days late for a monthly injection (CIC), does she need to use condoms/avoid sex for the next 7 days?

A: Yes. She must do so if she is more than 7 days late.

Implants

Q: Implants are made of how many plastic tubes?

A: 6 plastic tubes.

Q: True or false: implants contain progestogen and estrogen hormones.

A: False. They contain only progestogen.

Q: Why would a woman need to have her implants replaced after 4 years?

A: If she weighs more than 80 kg.

Q: A woman has been using pills and wants to switch to using implants. She is in week 3 of the cycle. Can she have the implants inserted now?

A: Yes.

Q: A woman returns to the clinic who has been using implants for the past 5 years. She weighs 75 kg. Should you:

a) Tell her to come back in 2 years to have her implants replaced?

Or

b) Advise her to have her implants replaced now?

A: (B) She should have her implants replaced now.

Q: List 2 common side-effects of implants?

A: 2 from among:

- **Light spotting or bleeding between periods**
- **Irregular bleeding.**
- **No monthly bleeding (amenorrhea).**

Emergency Contraception

Q: A woman comes into the clinic. She had unprotected intercourse 4 days ago. Can she take the emergency contraceptive pill?

A: Yes. She can take ECPs up to 5 days after unprotected sex.

Q: True or false: the emergency IUD is more effective than emergency contraceptive pills.

A: True. The IUD is more effective than the pills.

Long-acting Injectables

Q: What type of hormones do long-acting injectables contain?

A: Progestogen (NOT estrogen).

Q: What are 2 the most commonly used long-acting injectables, and how often must they be given

A: -DMPA, every 3 months.
-NET-EN, every 2 months.

Q: A 45 year old woman who smokes heavily would like to use DMPA. Can she use this method?

A: No: she has 2 or more risk factors for heart disease.

Q: If a woman comes to the clinic on day 10 of the menstrual cycle, but has not had sex for 2 weeks, and wants to start using long-acting injectables, what should the provider do?

A: 1. Give her an injection now.
2. Ask her to avoid sex or use condoms for the next 7 days.

Q: When after childbirth can a breastfeeding woman start using long-acting injectables?

A: From 6 weeks postpartum

Q: Up to how many days BEFORE her "due date" can a woman receive her DMPA injection?

A: She can come up to 2 weeks early for her injection.

Q: A woman comes to the clinic 3 weeks after her repeat injection date for DMPA; she has not had sex for the past month. What should you do?

A: •Give her the injection.
•Advise her to use condoms or avoid sex for the next 7 days.
•Discuss how she can remember next time.

Monthly Injectables

Q: True or false: Monthly injectables contain the same hormones as the combined pill (COCs).

A: True. They contain estrogen and progestogen hormones.

Q: Can a breastfeeding woman who is 3 months postpartum start using CICs?

A: No. She must wait until 6 months postpartum.

Q: Can a woman who is not medically eligible to take the pill (COCs) use the monthly injectable instead?

A: No, she cannot. P2 and MI2.

Q: True or false: Before giving the injection, you must swab the skin.

A: False. If the client's skin is visibility dirty, you should wash it. But no need to swab skin.

Q: Mention 3 common side-effects of pill use (COCs).

A: 3 from the following:

- **o Nausea/upset stomach**
- **o Spotting or bleeding between periods**
- **o Mild headache**
- **o Breast tenderness**
- **o Dizziness**
- **o Slight weight gain or loss**

Q: Can a woman with varicose veins use the pill (COCs)?

A: Yes.

Q: What type of pills would be recommended for a woman who is breastfeeding?

A: The mini-pill (progestogen-only pills).

Mini-pill (POPs)

Q: Describe the 2 mechanisms of action of the mini-pill (POPs)

A: 1) Thickens cervical mucus.

2) Can stop ovulation.

Q: True or false: common side-effects of the mini-pill include headaches, tender breasts and dizziness?

A: False: These side-effects are not common.

Q: If a woman is switching from injectables to the mini-pill, when should she start taking the pills?

A: At the time she would have had the repeat injection.

Q: When can a breastfeeding woman start using the mini-pill?

A: From 6 weeks postpartum.

Q: If a non-breastfeeding woman is late taking her mini-pill by 12 hours, what should she do?

A: -She should take the missed pill as soon as possible.

-She should avoid sexual intercourse or use a condom for the next 2 days, after restarting the pill.