



Family Planning Competency-Based Training

Facilitator's Guide

TABLE OF CONTENTS

Acronyms	<i>i-iii</i>
Foreword	<i>iv</i>
Acknowledgements	<i>v</i>
Technical Working Group	<i>vi</i>
Introduction	<i>vii</i>
Training Design	<i>viii-xii</i>
General Objective	
Specific Objectives	
Course Content	
Training Materials	
Training Methodology	
Facilitators	
Participants	
Course Composition	
Evaluation	
Follow-up	
How to Use the Training Manual	<i>xiii-xiv</i>
Who can use this manual	
Content	
Teaching Learning Process (TLP)	
Appendices	
The CD-ROM	
Schedule of Activities	<i>xv-xvi</i>
Module 1: The Philippine Family Planning Program	<i>1.1-1.2</i>
Session 1: Overview of the Family Planning Program	<i>1.3-1.19</i>
Session 2: Family Planning and Reproductive Health	<i>1.20-1.29</i>
Session 3: Maternal High Risk Factors	<i>1.30-1.35</i>
Session 4: Health Benefits of Family Planning	<i>1.36-1.40</i>
Module 2: Human Reproductive Anatomy and Physiology	<i>2.1-2.2</i>
Session 1: The Female Reproductive System	<i>2.3-2.17</i>
Session 2: The Male Reproductive System	<i>2.18-2.22</i>
Session 3: The Concept of Fertility and Joint Fertility	<i>2.23-2.29</i>
Module 3: FP Client Assessment	<i>3.1-3.2</i>
Session 1: The FP Service Record or FP Form 1 in Client assessment	<i>3.3-3.17</i>
Session 2: WHO Medical Eligibility Criteria for Contraceptive Use	<i>3.18-3.28</i>
Module 4: Infection Prevention in Family Planning Services	<i>4.1-4.2</i>
Session 1: The Disease Transmission Cycle and Infection Prevention	<i>4.3-4.9</i>
Definition of Terms	
Session 2: Infection Prevention Measures	<i>4.10-4.30</i>

Module 5: Fertility Awareness-Based Methods and Lactational Amenorrhea Method	5.1-5.2
Session 1: Fertility-Awareness based methods	5.3-5.16
Session 2: Lactational Amenorrhea Method (LAM)	5.17-5.24
Module 6: Hormonal Contraceptive Methods	6.1-6.2
Session 1: Low-Dose Combined Oral Contraceptives (Low-Dose COCs)	6.3-6.23
Session 2: Other Combined Contraceptives	6.24-6.36
Session 3: Progestin-Only Pills (POPs)	6.37-6.50
Session 4: Progestin-Only Injectables (POIs)	6.51-6.72
Module 7: Male Condom	7.1-7.2
Session 1: Male Condom	7.3-7.11
Module 8: Long Acting and Permanent Methods	8.1-8.2
Session 1: Intrauterine Device	8.3-8.16
Session 2: Permanent Methods	8.17-8.25
Module 9: FP for Special Populations	9.1-9.10
Module 10: Counseling for Family Planning	10.1-10.2
Session 1: Values Clarification	10.3-10.8
Session 2: Informed Choice and Voluntarism	10.9-10.22
Session 3: Types of Communication in FP/RH	10.23-10.29
Session 4: Effective Communication Skills	10.30-10.39
Session 5: Steps in Counseling Using the GATHER Approach	10.40-10.56
Module 11: Management of Family Planning Clinic Services	11.1-11.2
Session 1: Managing for Quality	11.3-11.7
Session 2: Facility-Based FP Services	11.8-11.11
Session 3: Management Support Systems	11.12-11.47
Session 4: Monitoring and Evaluation	11.48-11.52
Session 5: Service Delivery Network	11.53-11.55
Module 12: Action Planning	12.1-12.10
Annexes	
Level 1	1-82

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AO	Administrative Order
AOG	Age of Gestation
ARH	Adolescent Reproductive Health
ARMM	Autonomous Region of Muslim Mindanao
ARV	Antiretroviral Drugs
ASC	Ambulatory Surgical Clinic
ASL	Authorized Stock Level
BBT	Basal Body Temperature
BHW	<i>Barangay</i> Health Worker
BHS	<i>Barangay</i> Health Station
BIP	Basic Infertile Pattern
BMD	Bone Mass Density
BMI	Body Mass Index
BOM	Billings Ovulation Method
BP	Blood Pressure
BTL	Bilateral Tubal Ligation
BSPO	<i>Barangay</i> Supply Point Officer
CBHCO	Community-based Health Care Organization
CBMIS	Community-based Monitoring Information System
CBT	Competency-based Training
CDLMIS	Contraceptive Distribution Logistics Management Information System
CHD	Center for Health Development (formerly Regional Health Office)
CHO	City Health Office
CIC	Combined Injectable Contraceptive
CO	Central Office
COC	Combined Oral Contraceptive
COF	Contraceptive Order Form
CON	Condom
CPR	Contraceptive Prevalence Rate
CPS	Contraceptive Prevalence Survey
CR	Cardiac Rate
CSR	Contraceptive Self-Reliance
DMPA	Depot Medroxyprogesterone Acetate
DOH	Department of Health
DSWD	Department of Social Welfare and Development
DTUR	Dispensed To User Record
DVT/PE	Deep Vein Thrombosis/Pulmonary Embolism
EDR	Early Days Rule
EE	Ethinylestradiol
FAB	Fertility Awareness-Based Method
FEFO	First-to-expire, First-out
FHSIS	Field Health Services Information System
FP	Family Planning

FPS	Family Planning Survey
FSH	Follicle-Stimulating Hormone
HBV	Hepatitis B Virus
HCG	Human Chorionic Gonadotropin
HH	Household
HIV	Human Immunodeficiency Virus
HLD	High Level Disinfection
HMO	Health Maintenance Organization
HPV	Human Papillomavirus
ICPD	International Conference on Population and Development
ICV	Informed Choice and Voluntarism
IE	Internal Examination
IEC	Information, Education, and Communication
ILHZ	Interlocal Health Zone
IM	Intramuscular
IMAP	Integrated Midwives' Association of the Philippines
IUD	Intrauterine Device
IUS	Intrauterine System
LAM	Lactational Amenorrhea Method
LAPM	Long-Acting Permanent Methods
LCE	Local Chief Executive
LGU	Local Government Unit
LH	Luteinizing Hormone
LMP	Last Menstrual Period
LNG	Levonorgestrel
MNCHN	Maternal, Newborn, and Child Health and Nutrition
MCP	Maternity Care Package
MDG	Millennium Development Goals
MEC	Medical Eligibility Criteria
MIS	Management Information System
MOA	Memorandum of Agreement
MTPDP	Medium-Term Philippine Development Plan
MWRA	Married Women of Reproductive Age
NDHS	National Demographic and Health Survey
NDS	National Demographic Survey
NEDA	National Economic Development Authority
NET-EN	Norethisterone Enantate
NFP	Natural Family Planning
NGA	National Government Agency
NGO	Non-Government Organization
NOH	National Objectives for Health
NSD	Normal Spontaneous Delivery
NSV	No-Scalpel Vasectomy
OB-GYNE	Obstetrics-Gynecology
OC	Oral Contraceptive

PE	Physical Examination
PGR	Population Growth Rate
PFPP	Philippine Family Planning Program
PHIC	Philippine Health Insurance Corporation (PhilHealth)
PHO	Provincial Health Office
PID	Pelvic Inflammatory Disease
PLGM	Philippine League of Government Midwives
PMAC	Prevention and Management of Abortion and its Complications
PMP	Previous Menstrual Period
PNDF	Philippine National Drug Formulary
POC	Progestin-only Contraceptive
POI	Progestin-only Injectable
POP	Progestin-only Pill
POPCOM	Population Commission
POPDEV	Population and Development
PPO	Provincial Population Office
PR	Pulse Rate
PRC	Professional Regulation Commission
PRE	Population, Resources, and Environment
PROM	Premature Rupture of Membranes
RH	Reproductive Health
RHU	Rural Health Unit
RIV	Requisition and Issue Voucher
RPFS	Republic of the Philippines Fertility Survey
RTI	Reproductive Tract Infections
RUV	Relative Unit Value
SDM	Standard Days Method
STI	Sexually Transmitted Infections
STM	Sympto-thermal Method
TCL	Target Client List
TDM	Two-Day Method
TFR	Total Fertility Rate
TNA	Training Needs Assessment
TWG	Technical Working Group
USAID	United States Agency for International Development
VAWC	Violence Against Women and Children
VSC	Voluntary Surgical Contraception
WCPU	Women and Child Protection Unit
WHO	World Health Organization

FOREWORD

The Department of Health (DOH) has consistently improved training for health service providers to enhance their capabilities to deliver quality family planning (FP) services. In line with this commitment to achieve continuing quality improvement, the DOH together with partner agencies reviewed and updated the Family Planning Competency Based Training (FPCBT) Modules to keep pace with the new trends and developments in family planning.

This revised version of the FPCBT Manual is aligned with the 2006 FP Clinical Standards Manual and is consistent with current developments in responsible parenting policies. It adopts modern training approaches towards further enhancing the knowledge, skills, and attitude of service providers.

The overall objective of the training manual is to enable health service providers to safely administer and dispense FP services to, and share accurate information on the different modern FP methods with clients. It aims to improve the quality of FP services delivered by providers in both public, non-government organizations, and private health facilities. It contains up-to-date FP information drawn from actual experiences of family planning experts, and backed up by evidence-based medical information and effective FP practices recommended by highly credible international references, particularly the Medical Eligibility Criteria (MEC) for Contraceptive Use and Selected Practice Recommendations (SPR) of the World Health Organization.

The revised manual introduces an integrated, streamlined, and performance-based training design that builds on the motivation and commitment of the frontline service providers. The DOH hopes that all health service providers undergo the FPCBT to ensure the delivery of FP services that are consistent with and supportive of the country's commitments to the Millennium Development Goals and the Philippine Development Plan.

I strongly encourage the effective dissemination and utilization of this manual across the country as one of the tools towards achieving improved quality of health care.



ENRIQUE T. ONA, MD, FPCS, FACS
Secretary of Health

ACKNOWLEDGEMENTS

The DOH recognizes and expresses its full appreciation to all those who participated in the development, revision, pre-testing, final review, and editing of the manuals.

In particular, the DOH would like to thank the following:

- The United States Agency for International Development (USAID) in providing technical assistance in the overall process of developing the manual.
- The Technical Working Group whose members came from various sectors and agencies, who not only unselfishly shared their technical expertise and experiences but also took time out of their busy schedules and concurrent work to enhance, pretest, edit, and finalize the training manual.
- The individuals who were contracted for the development, pre-test, design, and layout of the manual.
- The FP trainers from the different CHDs and Local Government Units who provided technical inputs and insights and shared their experiences in conducting training activities at the local level. These FP trainers also served as facilitators during the pre-testing together with a group of health service providers.

The DOH is also grateful to those who contributed in one way or another in producing this training manual but whose names have not been mentioned.



GERARDO V. BAYUGO, MD, MPH, CESO III
OIC, Undersecretary of Health
Policy, Standards Development and Regulation
and Health Sector Financing Clusters

TECHNICAL WORKING GROUP

Chairperson:

Dir. Honorata L. Catibog, DOH-NCDPC-FHO

Members:

Dr. Lourdes Paulino, NCDPC-FHO

Dr. Florence Apale, NCDPC-FHO

Ms. Carole Bandahala, NCDPC-FHO

Dr. Consuelo Aranas, HealthGov

Dr. Rosario Marilyn Benabaye, HealthGov

Dr. Cesar Maglaya, HealthGov

Dr. Cynthia Garcia, PRISM1

Dr. Esmeraldo Ilem, Jose Fabella Hospital

Ms. Erlinda Villagarcia, Jose Fabella Hospital

Ms. Lety Daga, IMCCSDI

Ms. Elizabeth Valles, WFMFI

Ms. Evelyn Llano, DOH-HHRDB

Mr. Lydio Espanol, HealthPRO

Dr. Eduardo Tandingan, SHIELD

Dr. Ellen Bautista, SHIELD

Dr. Hendry Plaza, UNFPA

Dr. Jocelyn Ilagan, HPDP

Ms. Mito Rivera, IRH Philippines

Ms. Gladys Malayang, HDII

Dr. Jose Narciso Sescon, HDII

Technical Support and Secretariat:

Ms. Onofria de Guzman, NCDPC-FHO

Mr. Arnold Vega, HDII

Ms. Cyril Dalusong, HDII

Technical Reviewer:

Dr. Ricardo B. Gonzales

Design and Lay-out:

Toolbox Creatives Design, Inc.

INTRODUCTION

The integrated, modified family planning training system is performance-based which develops the knowledge, attitudes, and skills of participants on the requirements of quality FP service provision. The training system implements a basic approach that exposes participants to levels of training based on certain criteria which qualify them to the next higher level of training.

A higher level training course will develop more specialized skills in the intrauterine device, bilateral tubal ligation by minilap under local anesthesia and no scalpel vasectomy, and provision of natural family planning. Participants to this level of training must be professionally qualified to perform the skills taught in the respective course, have undergone the basic course, have satisfactorily integrated the skills learned in their provision of health services, and have the ability and opportunity to increase the client load for the service(s) they will be trained in.

In support of this training system and as a response to the request from the regional and provincial program managers and private health practitioners, HealthGov, PRISM, HPDP, SHIELD, IRHP, Dr. Jose Fabella Memorial Hospital and selected trainers from the CHDs provided technical assistance to DOH-NCDPC in revising the training materials. The revision will strengthen the training system and improve service provider performance ensuring high quality of family planning services.

The DOH-NCDPC assisted by HealthGov and other USAID Cooperating Agencies conducted two consultative workshops which were the initial activities in the revision of the training materials. These paved the way to the development of the 2010 FPCBT Basic Course Handbook. The DOH-NCDPC also formed a TWG to oversee the process of revising and pilot testing the revised training materials. The TWG conducted an orientation of public and private sector trainers and developed a system for rolling out the training for frontline health service providers.

The materials of this basic course are consistent with new developments in program policies and contraceptive technology, updates in the modern training approaches, and aligned with the 2006 FP Clinical Standards Manual. After two consultative workshops followed by several meetings with the FPCBT TWG to ensure efficiency of the curriculum, the 2010 version of the FPCBT Basic Course is made available for implementation.

General Objective

To prepare health service providers to counsel potential family planning clients and safely administer/dispense family planning methods to clients as part of quality service provision.

Specific Objectives

At the end of the training, participants will be able to:

1. Discuss the Philippine Family Planning Program (PFPP) as a health intervention to improve the health of all Filipinos with special attention to women and children.
2. Understand how FP contributes to the attainment of the millennium development goal in reducing maternal and child mortality.
3. Relate the action of available contraceptive methods to the human reproductive anatomy and physiology.
4. Explain the WHO recommendations for eliminating barriers to FP service provision and for safe use of the methods.
5. Discuss the guidelines for performing client assessment for FP use.
6. Demonstrate skills on client assessment using the FP Service Record (FP Form 1).
7. Determine suitability of clients for contraceptive use using the WHO MEC wheel, summary table, and checklist.
8. Discuss measures for preventing infections during the provision of FP services.
9. Explain the available contraceptive methods in terms of their:
 - Mechanism of Action
 - Effectiveness
 - Advantages and Disadvantages
 - Possible Side Effects
 - Usage
 - Warning Signs
10. Correct rumors and misconceptions on the contraceptive methods.
11. Identify the FP needs of the special population (i.e., adolescents, women over 40 years old, obese, and postpartum breastfeeding women).
12. Explain how values and attitudes can affect decision-making.
13. Discuss the rights of clients and the principles of informed choice and voluntarism.
14. Demonstrate effective communication skills.
15. Differentiate information-giving, motivation, and counseling.

16. Discuss the G-A-T-H-E-R approach to FP counseling.
17. Demonstrate the G-A-T-H-E-R approach to FP counseling.
18. Understand how to manage an FP clinic towards provision of quality services.
19. Formulate an action plan on improving the quality of FP services in their sites.

Course Content

The course contains 12 modules as follows:

1. Philippine Family Planning Program
2. Human Reproductive Anatomy and Physiology
3. FP Client Assessment
4. Infection Prevention in FP Services
5. Fertility-Awareness Based Methods
6. Hormonal Contraceptive Methods
7. Male Condom
8. Long-Acting and Permanent Methods
9. FP for Special Populations
10. Counseling for FP
11. Management of FP Clinic
12. Action Planning

Training Materials

Facilitator's Guide

The facilitator's guide contains the training design and schedule of training activities, pre-test, and post-test questionnaires. The guide also includes accompanying answer keys, observation checklists for evaluating the skills level of participants, teaching-learning processes as a guide for the conduct of the sessions (with accompanying Powerpoint presentations), narratives presenting the content of the sessions, and a post-course evaluation. It also provides the facilitators with inputs and a checklist in conducting the "Post-training Monitoring and Evaluation".

Participant's Manual

Serves as a reference manual and guide for the participants through each of the sessions of the course. It contains the training design, schedule of activities, learning objectives for each of the sessions, observation checklists to guide them as they develop their skills, and the content of the topics being presented. It also contains selected job aids (i.e., WHO MEC Summary Table, FP Form 1 and the DOH-prescribed FP clinic forms) which the participants are expected to use during the provision of FP services.

References

The Philippine Clinical Standards Handbook on Family Planning 2006 which defines the set of standards in FP practice serves as a guide for health service providers as they provide FP services.

The Family Planning: A Global Handbook 2007 contains important guidelines on family planning service provision. This will provide additional information for participants during and after the course.

Counseling Cue Card

The Counseling Cue Card is a job aid for the participants which serves as her/his guide as s/he performs counseling. Skills on the use of the cue card during client interaction are part of the course.

WHO MEC Wheel

The WHO MEC Wheel is a handy job aid to determine the suitability of temporary FP methods given certain client conditions.

Training Methodology

This is a five-day competency-based training. This means that the training focuses on developing the skills accompanied by the knowledge and attitude required to provide quality family planning services. The progression of skills development of participants will be measured by means of pre-established criteria (expected performance) in an observation checklist.

The course incorporates adult learning principles which builds on the participant's experiences and encourages active involvement in the learning process. As such, training methodologies such as discussions, individual and group exercises, demonstration and return demonstration, and role plays will be used in the conduct of the sessions.

Facilitators

The facilitators to this course may be trainers from both the public (i.e., CHD, province, municipality) and private (i.e., NGOs, professional groups, academe) sectors who:

- Have extensive technical knowledge on FP and the contraceptive methods.
- Have experience in conducting the Basic/Comprehensive FP Course or the FP Counseling Course.
- Are skilled in applying adult learning principles to her/his training sessions.
- Are skilled in applying “coaching” principles in assisting participants as they develop their skills.

Participants

The following are the criteria for selection of participants to the Basic Course for Service Providers:

- Health service providers practicing in areas that support family planning.
- Willingness to support family planning and provide services.
- Have the dedication to identify and reach out to potential FP clients by providing information and counseling on practicing FP and the use of the methods.

Course Composition

To maximize learning, it is suggested that the course be conducted within the recommended standard of 1:10 (trainer:trainee ratio) during didactic sessions and 1:5 (trainer:trainee ratio) during the skills practice sessions.

Evaluation

Participants

The participants' achievement will be measured in two areas:

1. *Knowledge*

This is measured by means of a post-test. A score of at least 75% in this written examination is considered satisfactory.

2. *Skills*

The participants' skills performance will be evaluated with the use of checklist. Successful completion of the course requires a satisfactory rating for each of the critical steps in the checklist.

The evaluation methods used in the course are described below:

Pre-test questionnaire

This written examination is administered before the start of the course to measure the baseline knowledge of the participant of the content of the course. Trainers use the results of this examination to tailor the conduct of the sessions in accordance with the learning needs of the participants, providing emphasis on areas where participants need more knowledge on.

Post-test questionnaire

This written knowledge assessment tool is given at the end of the course to measure knowledge acquisition. A score of at least 75% is considered as having satisfactorily completed the requirements of the course while a score of at least 80% indicates knowledge-based mastery of the content of the course. Participants scoring lower than 80% are advised and guided on using the reference manual to improve their knowledge.

Skills Performance Checklists

The checklists contain the steps of the skill being developed. Each skill being developed in the course has a specific skills performance checklist to measure the level of skills acquired by the participant. The participant must be rated "satisfactory" in each critical step to be evaluated as having met the objectives of the course.

Course

A post-course evaluation questionnaire is administered at the end of the course for participants to provide insights on the conduct of the course. These insights are used by trainers in identifying approaches for improving the implementation of the course.

Follow-up

Learning and evaluation do not end at the end of the course. Participants should be able to integrate their learnings in their health service provision. Some participants may encounter difficulties in integrating elements of quality family planning service provision in their sites. Others who have not achieved competency during the training course will need periodic supervision.

Participants observed during the post training follow-up and monitoring as having successfully integrated learnings of the course to their practice shall be awarded a Certificate of Completion with its corresponding CPE units. For these and other reasons, the trainer should discuss follow-up with each of the participants at their sites.

HOW TO USE THE MANUAL

Who Can Use This Manual

This training manual is designed for use by trainers/facilitators who have experience in conducting the Basic/Comprehensive FP Course, FP Counseling Course or any FP course which incorporates FP counseling. These trainers should have been oriented on the revised curriculum of the FPCBT Basic Course.

Though it may not be necessary that the trainer/facilitator be an expert in all of the modules, it is expected that s/he should have the knowledge and skills to be able to facilitate group work exercises as s/he will be conducting the course as part of a team. Individual members may choose a module, which they feel comfortable with.

Content

The manual contains the different modules included in the standard five (5) day basic family planning service provision course. It contains the elements for the provision of quality FP services.

Teaching Learning Process (TLP)

This manual prescribes an efficient way of facilitating each of the sessions. It is not meant to be restrictive but the trainer is given leeway to adopt a different approach as long as the objective/s of the session is/are obtained within the prescribed time allotment. The way the TLP was written ensures that the facilitators can easily conduct the sessions and its content are within standards.

The TLP was designed to veer away from the classical passive teaching methodologies. The curriculum puts great emphasis on ensuring that the participants take active participation in the learning process. Attempts are made to keep lectures at a minimum. However, in cases where lectures are the most appropriate methodology of choice, participatory activities are incorporated to enhance the lecture and check the participants' understanding of the subject matter.

The TLP contains the facts or information the participants need to learn, which the trainer/facilitator will highlight. It includes the appropriate narrative which the trainer/facilitator needs to be familiar with beforehand.

Appendices

The following items are in the appendices:

Assessment Tools

These are of two types: (1) written examination to determine the baseline and post-course knowledge of the participants, and (2) a checklist for determining the counseling skills. This section also contains the key or answers to the test.

Course Evaluation

This is a tool to determine how the participants look at the entire training course. This will help the trainer/facilitator improve the future conduct of the course.

Post-training follow-up checklist

This is a tool that determines how the participant-service provider has integrated the learnings of the course into health service provision. The trainer uses this checklist in assessing the extent of integration.

Other items included in the Appendices are the following:

- WHO MEC Summary Table
- Medical Eligibility Checklist
- Checklist for Provision of the SDM
- Skills Checklist on Progestin-Only Injectable Administration
- Counseling Skills Practice Checklist
- Summary Table for *Barangay* Health Stations
- Monthly Consolidation Table for Rural Health Units
- M1/FHSIS Report Form
- Q1 Form for FP
- Action Plan on Family Planning

The CD-ROM

The CD-ROM contains the electronic copy of the Facilitator's Guide and the powerpoint presentations which supplement the hard copy of this manual. For a more effective presentation, the trainer is expected to review the materials contained in the CD-ROM before presenting each session.

The powerpoint presentations are the standard content presentations for each specific session in the course. These are meant to complement the TLP and serve as a standard lecture for the session.

Schedule of Activities

TIME		MODULES/SESSIONS
Day 0		
		Arrival of facilitators and participants Facilitator's meeting
8:00-10:00	AM	<ul style="list-style-type: none"> • Registration • Opening Ceremonies <ul style="list-style-type: none"> ✓ Invocation ✓ National Anthem ✓ Welcome Remarks • Introduction of Participants • Pre-test • Leveling of Expectations • Overview and Mechanics of the Course
10:00-11:00		Module 1: The Philippine FP Program <ul style="list-style-type: none"> ✓ Session 1: Overview of the PFPP
11:00-11:30		<ul style="list-style-type: none"> ✓ Session 2: Family Planning and Reproductive Health
11:30-12:00		<ul style="list-style-type: none"> ✓ Session 3: Maternal High Risk Factors
12:00-1:00	PM	LUNCH BREAK
1:00-1:30		Module 1: The Philippine FP Program (continued) <ul style="list-style-type: none"> ✓ Session 4: Health Benefits of FP
1:30-2:30		Module 2: Human Reproductive Anatomy and Physiology <ul style="list-style-type: none"> ✓ Session 1: The Female Reproductive Anatomy and Physiology
2:30-3:00		<ul style="list-style-type: none"> ✓ Session 2: The Male Reproductive Anatomy and Physiology
3:00-3:30		<ul style="list-style-type: none"> ✓ Session 3: The Concept of Fertility and Joint Fertility
3:30-4:30		Module 3: FP Client Assessment <ul style="list-style-type: none"> ✓ Session 1: The FP Service Record in Client Assessment
4:30-5:30		<ul style="list-style-type: none"> ✓ Session 2: WHO Medical Eligibility Criteria for Contraceptive Use
5:30-6:30		Facilitator's Meeting
8:00-8:30	AM	Recap of Day 1
8:30-9:15		Module 4: Infection Prevention in FP Services <ul style="list-style-type: none"> ✓ Session 1: The Disease Transmission Cycle and Infection Prevention Definitions
9:15-10:30		<ul style="list-style-type: none"> ✓ Session 2: Infection Prevention Measures
10:30-11:30		Module 5: Fertility Awareness-Based Methods <ul style="list-style-type: none"> ✓ Session 1: Fertility Awareness-Based Methods
11:30-12:00		<ul style="list-style-type: none"> ✓ Session 2: Lactational Amenorrhea Method
12:00-1:00	PM	LUNCH BREAK
1:00-3:00		Module 6: Hormonal Contraceptive Methods <ul style="list-style-type: none"> ✓ Session 1: Low Dose Combined Oral Contraceptives
3:00-3:30		<ul style="list-style-type: none"> ✓ Session 2: Other Combined Contraceptives
3:30-4:00		<ul style="list-style-type: none"> ✓ Session 3: Progestin-Only Pills

4:00-5:30		✓ Session 4: Progestin-Only Injectable
5:30-6:30		Facilitator's Meeting
8:00-8:30	AM	Recap of Day 2
		Module 7: Male Condom
8:30-9:30		✓ Session 1: Male Condom
		Module 8: Long-acting and Permanent Methods
9:30-10:00		✓ Session 1: Intrauterine Device
10:00-11:00		✓ Session 2: Permanent Methods
11:00-12:00		Module 9: FP for Special Populations
12:00-1:00	PM	LUNCH BREAK
		Module 10: Counseling for FP
1:00-1:30		✓ Session 1: Values Clarification
1:30-3:00		✓ Session 2: Informed Choice and Voluntarism (ICV)
3:00-4:00		✓ Session 3: Types of Communication in FP/RH
4:00-6:00		✓ Session 4: Effective Communication Skills
6:00-7:00		Facilitator's Meeting
8:00-8:30	AM	Recap of Day 3
		Module 10: Counseling for FP (continued)
8:30-11:30		✓ Session 5: Steps in Counseling using the GATHER Approach
11:30-12:30	PM	LUNCH BREAK
		Module 10: Counseling for FP (continued)
12:30-5:30		✓ Role Play Practice: Steps in Counseling using the GATHER Approach
		Module 10: Counseling for FP (continued)
5:30-6:00		✓ Plenary: Summary of Role Play Practice
6:00-7:00		Facilitator's Meeting
8:00-8:30	AM	Recap of Day 4
		Module 11: Management of a Family Planning Clinic
8:30-9:00		✓ Session 1: Managing for Quality
9:00-9:30		✓ Session 2: Facility-Based FP Services
9:30-10:30		✓ Session 3: Management Support System
10:30-11:00		✓ Session 4: Monitoring and Evaluation
11:00-11:30		✓ Session 5: Service Delivery Networks
11:30-12:30	PM	LUNCH BREAK
12:30-5:00		Module 12: Action Planning
		✓ Introduction
		✓ Development of Action Plans
		✓ Plenary: Presentation of selected Action Plans
5:00-6:00		Closing Activities
		✓ Post-test
		✓ Course Evaluation
		✓ Closing Remarks
6:00-7:00		Facilitator's Meeting on Next Steps



MODULE 1



The Philippine Family Planning Program

Session 1: Overview of the Philippine Family Planning Program

Session 2: Family Planning and Reproductive Health

Session 3: Maternal High Risk Factors

Session 4: Health Benefits of Family Planning

MODULE 1: THE PHILIPPINE FAMILY PLANNING PROGRAM



MODULE OVERVIEW

This module provides information on the Philippine Family Planning Program (PFPP) and its evolution since it started more than 38 years ago. It will explain the general health status of the population and the Family Planning (FP) program coverage over the past years. Policies and strategies for nationwide implementation and the benchmarks that the program aims for on Family Planning practice will also be discussed. The module includes the integration of Family Planning with other Reproductive Health elements as well as the benefits of Family Planning. The module will also discuss the maternal high-risk factors to put into perspective the importance of ensuring quality Family Planning services. The need to make FP services accessible and available for all women and men of reproductive age to contribute to the reduction of maternal and child mortality will also be emphasized.



MODULE OBJECTIVES

At the end of the module, the participants will be able to:

1. Understand the Philippine Family Planning Program as an intervention to improve the health of all Filipinos with special attention to women and children.
2. Relate Family Planning to the reduction of maternal and child mortality.



MODULE SESSIONS

Session 1	Overview of the Philippine Family Planning Program
Session 2	Family Planning and Reproductive Health
Session 3	Maternal High-Risk Factors
Session 4	Health Benefits of Family Planning

Topics/Contents

Teaching-Learning Process



MODULE 1



THE PHILIPPINE FAMILY PLANNING PROGRAM (PFPP)

Greet participants.

Introduce the module by showing the slides and stating the module title, overview, objectives, and sessions.



OVERVIEW

- The module provides information on the Philippine Family Planning Program as a health intervention and its contribution to the reduction of maternal and child mortality.
- Overview of the program in terms of its evolution, FP coverage, policies, strategies, and its benchmarks
- Integration of Family Planning with other Reproductive Health elements
- Health benefits of FP and risk factors that affect maternal health



OBJECTIVES

At the end module, the participants must be able to:

- Explain the Philippine Family Planning Program (PFPP) as an intervention to improve the health of all Filipinos with special attention to women and children.
- Relate Family Planning to the reduction of maternal and infant mortality.



SESSIONS

Session 1 - **Overview of the Philippine Family Planning Program**

Session 2 - **Family Planning and Reproductive Health**

Session 3 - **Maternal High-Risk Factors**

Session 4 - **Health Benefits of Family Planning**

SESSION 1

OVERVIEW OF THE PHILIPPINE FAMILY PLANNING PROGRAM (PFPP)

LEARNING OBJECTIVES

At the end of the session, the participants must be able to:

1. Explain the evolution of the Philippine FP program.
2. Describe the PFPP in terms of its vision, mission, goal, and objectives.
3. Explain the Guiding Principles of the PFPP.
4. Explain the implementing guidelines and policies of the PFPP as stipulated in Administrative Order (AO) 50-A, series 2001, otherwise known as the National FP Policy.
5. Enumerate the FP program methods.
6. Enumerate the benchmarks on the implementation of a FP program.
7. Explain the health status and FP situation as it relates to the attainment of the MDGs on maternal mortality, under-five mortality, population growth rate, total fertility rate, FP unmet need, and the contraceptive prevalence rate.
8. Identify activities towards the improvement and attainment of program benchmarks.



METHODOLOGY

Illustrated Lecture-Discussion
Brainstorming
Group Discussion



TIME ALLOTMENT

1 hour



ADVANCE PREPARATION OF MATERIALS

- Powerpoint presentation
- Laptop Computer and LCD projector
- Screen Projector
- White board, marker pens, masking tapes
- Training manuals
- Newsprint with the matrix

Program Strategy	Hindering Factors	Activities

Topics/Contents

Teaching-Learning Process



SESSION 1



OVERVIEW OF THE PHILIPPINE FAMILY PLANNING PROGRAM (PFPP)

Introduce the session by saying that:

The Philippine Family Planning Program has been implemented for about 38 years.

In this session, participants will be oriented about the program that promotes FP as a health intervention to improve the health of women and children, contributing to the reduction of maternal and child mortality.



Learning Objectives

At the end of the session, the participants must be able to:

- ✓ Explain the evolution of the Philippine FP program.
- ✓ Describe the PFPP in terms of its vision, mission, goal, and objectives.
- ✓ Explain the Guiding Principles of the PFPP.
- ✓ Explain the implementing guidelines and policies of the PFPP as stipulated in AO 50-A, s. 2001, otherwise known as the National FP Policy.
- ✓ Enumerate the FP program methods.

Show slide and state the learning objectives.



Learning Objectives

- ✓ Enumerate benchmarks on the implementation of a FP program.
- ✓ Explain the health status and FP situation as it relates to the attainment of the Millennium Development Goals on maternal mortality, under-five mortality, population growth rate (PGR), total fertility rate (TFR), FP unmet need, and contraceptive prevalence rate (CPR).
- ✓ Identify activities towards the improvement and attainment of program benchmarks.

The Evolution of the PFPP

The Evolution of the PFPP

Evolution of the FP Program of the Philippines

Introduce the topic by telling participants that:

- The almost four decades of implementation of the FP program in the Philippines has gone through changes from the National Population Program to the present Philippine Family Planning Program.
- These changes were in response to the health needs at a given period.

Topics/Contents	Teaching-Learning Process
<p>1970 - 1985</p> <p>National Population Program</p> <ul style="list-style-type: none"> • Coordinating body was the Commission on Population (POPCOM). • FP service delivery implemented by the DOH, other National Government Agencies, Non-Government Organizations, and the private sector. • Aim was to achieve population control through a contraceptive-oriented approach. 	<p>Describe the evolution of the PFPP by presenting the slides.</p>
<p>1986 - 1993</p> <p>Philippine Family Planning Program</p> <ul style="list-style-type: none"> • Reorientation of the program from population control to health intervention for the improvement of the health of mothers and children. • FP program component transferred from the POPCOM to the DOH. • FP service delivery was devolved to the local government units (LGUs). • The DOH has been responsible for policy formulation, standards/guidelines setting, technical assistance provision, licensing and regulation. 	
<p>1994 - 1999</p> <ul style="list-style-type: none"> • International Conference on Population and Development (ICPD) Plan of Action <ul style="list-style-type: none"> • The Philippines was one of the 179 countries who are signatories of the ICPD. • Commitment to ensure universal access to reproductive health services, including FP, and equality for men and women. • DOH developed the Reproductive Health (RH) Policy. • FP as the core element of RH and integration of FP with other RH services. 	
<p>2000 - present</p> <ul style="list-style-type: none"> • AO no. 50-A , s. 2001: The National FP Policy <ul style="list-style-type: none"> • This prescribes the key policies for FP services focused on modern FP methods, including natural family planning. • Stipulates the guiding principles (four pillars) of program implementation • Millennium Development Goals (MDG) Summit <ul style="list-style-type: none"> • The Philippines is signatory to the commitment of achieving the goals. 	
<p>2000 - present</p> <ul style="list-style-type: none"> • Health goals: <ul style="list-style-type: none"> ✓ Improvement of maternal health and reduction of maternal deaths ✓ Reduction of child mortality ✓ Combating AIDS, malaria, and other emerging diseases • The Philippine Government decided to become Contraceptive Self-Reliant. • Maternal, Newborn, Child Health and Nutrition (MNCHN) strategy was introduced to address the need to reduce both maternal and infant mortality. • Administrative Order No. 005, series 2011: Guidelines in Ensuring Quality Standards in the Delivery of Family Planning Program and Services through Compliance to Informed Choice and Voluntarism. 	

Topics/Contents	Teaching-Learning Process
<p style="text-align: center;">The Philippine Family Planning Program</p> <hr/> <p>VISION</p> <p>To empower women and men to live healthy, productive, and fulfilling lives with the right to achieve their desired family size through quality, medically sound, and legally permissible FP methods.</p> <p>MISSION</p> <p>The DOH, in partnership with the LGUs, NGOs, private sector, and communities shall ensure the availability of FP information and services to all men and women of reproductive age who need them.</p> <p>GOAL</p> <p>To provide universal access to FP information and services whenever and wherever these are needed.</p> <p>OBJECTIVES</p> <ol style="list-style-type: none"> To help couples and individuals achieve their desired family size within the context of responsible parenthood and improve their RH to attain sustainable development. To ensure quality FP services are available in DOH-retained hospitals, LGU-managed health facilities, NGOs, and the private sector. 	<p>Describe the PFPP as presented on the slides: Its vision, mission, goal, and objectives.</p> <p>Tell participants that:</p> <ul style="list-style-type: none"> The PFPP vision, mission, goals, and objectives were formulated to address the FP needs of couples and individuals.
<p style="text-align: center;">GUIDING PRINCIPLES OF THE FP PROGRAM</p> <p style="text-align: center;">Guiding Principles of the FP Program</p>	<p>Tell participants that:</p> <ul style="list-style-type: none"> The design, management and implementation of the program abide by the following guiding principles known as the four pillars of PFPP.

Topics/Contents	Teaching-Learning Process
<p data-bbox="208 237 503 264">1. Respect for the sanctity of life</p> <ul data-bbox="260 333 758 378" style="list-style-type: none"> • Family Planning aims to prevent abortion and therefore can save the lives of both women and children. 	<p data-bbox="840 232 1389 300">Explain the Guiding Principles of the PFPP using the presentation slides.</p>
<p data-bbox="208 714 451 741">2. Respect for human rights</p> <ul data-bbox="260 788 765 927" style="list-style-type: none"> • Family Planning services will be made available using only medically and legally permissible methods appropriate to the health status of the client. Family planning services shall be provided regardless of the client's sex, number of children, sexual orientation, moral background, occupation, socio-economic status, cultural and religious belief. 	
<p data-bbox="208 1193 627 1220">3. The freedom of choice and voluntary decision</p> <ul data-bbox="260 1263 741 1330" style="list-style-type: none"> • Couples and individuals will make family planning decisions based on informed choice including their own moral, cultural or religious beliefs. 	
<p data-bbox="208 1659 511 1686">4. Respect for the rights of clients</p> <ul data-bbox="260 1774 727 1818" style="list-style-type: none"> • Couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children. 	

Topics/Contents

Teaching-Learning Process

POLICIES

1. Family Planning as a health intervention to promote the overall health of all Filipinos particularly women and children.
2. Family Planning as a means towards responsible parenthood. Planning for the future reflects the will and the ability to respond to the needs of the family and children.
3. FP information and services will be provided based on voluntary and informed choice for all women and men of reproductive age regardless of age, number of children, marital status, religious beliefs, and cultural values.
4. Only medically safe and legally acceptable FP methods shall be made available in all public, NGOs, and private health facilities.
5. Quality care must be promoted and ensured in providing FP services. Privacy and confidentiality should be strictly observed in the provision of services at all times.

Tell participants that:

- Policies, strategies, and components were also identified and developed to provide guidance on how the program is being implemented.

POLICIES

6. Efforts must be undertaken to orient clients on fertility awareness as the basic information to fully understand and appreciate FP.
7. Multi-agency participation is essential. Involvement of the private sector, academe, church, media, community, and other stakeholders must be encouraged at all levels of operation.
8. FP services, in the context of the RH approach, must be integrated with the delivery of other basic health services.
9. Sustainability of FP services and commodities must be promoted through the localization and adoption of the Contraceptive Self-Reliance Strategy.

Present the policies of the PFPP using the slides. Ask participants on their understanding of these policy statements.

Expound as needed.

STRATEGIES

- Focus service delivery to the urban and rural poor
- Re-establish the FP outreach program
- Strengthen FP provision in regions with high unmet needs
- Promote frontline participation of hospitals
- Mainstream modern natural FP
- Promote and implement CSR strategy
- Integration of FP with other RH elements
- Ensure quality of care through compliance to Informed Choice and Voluntarism principles
- Capacitate high volume service providers

Present the slides on program strategies:

Explain that implementation of these strategies will help the program attain its objectives, goal, and vision.

COMPONENTS

- Service Delivery
- Training
- Logistics Management
- IEC and Advocacy
- Monitoring and Evaluation
- Research and Development
- Management Information System

Tell participants that:

- The program has seven components as shown in the slides.
- Under the devolved set up, the LGUs are primarily responsible in implementing the components of the program.
- The DOH on the other hand, continues to provide policy directions and technical guidelines, set standards, conduct monitoring and evaluation, and perform regulatory functions.

Topics/Contents	Teaching-Learning Process
<p>THE FP PROGRAM METHODS</p> <p>Modern methods</p> <ul style="list-style-type: none"> ✓ Permanent methods <ul style="list-style-type: none"> Female sterilization Male sterilization ✓ Temporary methods <ul style="list-style-type: none"> • Supply methods <ul style="list-style-type: none"> - Pills - IUD - Injectable - Male condom • Fertility Awareness Based Method <ul style="list-style-type: none"> - Cervical Mucus/Billings Ovulation Method - Basal Body Temperature - Sympto-thermal Method - Standard Days Method - LAM 	<p>Enumerate the different modern FP program methods.</p> <p>Tell participants that:</p> <ul style="list-style-type: none"> • Traditional FP methods are not considered as program methods as these are less effective methods.
<p>FP BENCHMARKS (2003-2010)</p> <ul style="list-style-type: none"> • Reduced population growth rate from 2.3 to 1.9 • Reduced total fertility rate (number of children) that a woman could have during her reproductive period) from 3.5 to 2.1 <p>FP BENCHMARKS (2003-2010)</p> <ul style="list-style-type: none"> • Increased CPR from 48.9% to 80% • Increased usage of modern FP methods from 33.4% to 60% • Reduced FP unmet need from 17.3% to 8.6% 	<p>Explain that:</p> <ul style="list-style-type: none"> • The progress of the FP program will be measured based on the following parameters or benchmarks. • These benchmarks for FP are at the national and international program monitoring level. • There are no quota or targets at the individual service provider level. • The data and slide presentation will be updated as available.
<p>HEALTH AND FP SITUATION IN THE PHILIPPINES</p> <p>Health and FP situation in the Philippines</p> <p style="text-align: center;">Health and Family Planning Situation in the Philippines</p>	<p>Introduce this topic by telling participants that:</p> <ul style="list-style-type: none"> • A presentation of the health and family planning situation in the country will show us how the benchmarks have been achieved including improvements in the success indicators of the program. • If benchmarks are not achieved and the indicators are poor, program implementers should think of activities that will facilitate improvement in health performance.

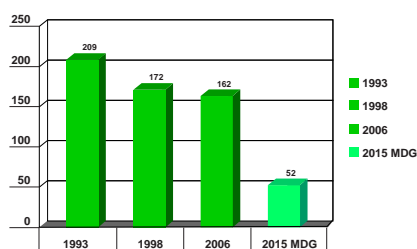
Topics/Contents

Teaching-Learning Process

Instruct participants to:

- Pay attention to the slide presentation as the information discussed will be used in the group work.
- Start thinking of the following based on their understanding of the health and family planning situation:
 - ✓ how far their local data are compared to the national data
 - ✓ what are the hindering factors that prevent improvement in their data/benchmarks
 - ✓ how are they addressing these factors/gaps, what activities are being undertaken in their areas to achieve the benchmarks and the Millennium Development Goals (MDGs)

Maternal Mortality Ratio (MMR)



Source: NSO, Philippines, 1993-2003
NSO, FPS, Philippines, 2006

Tell the participants that:

- The two targets of the MDGs relative to improvement on maternal health are:
 1. reduction in maternal deaths
 2. reduction in child mortality

Display the slide and discuss the maternal mortality ratio.

Ask participants:

- How will you interpret this graph?

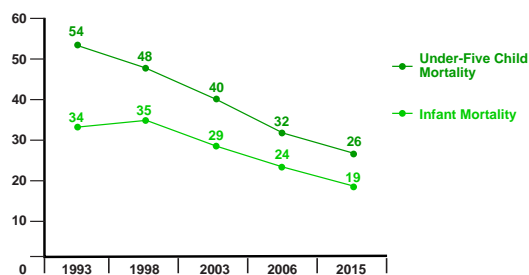
Responses should include but not be limited to:

- There is a slow decline in maternal mortality ratio from 209 maternal deaths per 100,000 livebirths in 1993 to 162 deaths per 100,000 livebirths in 2006.
- Millennium Development Goal target is 52 maternal deaths per 100,000 livebirths by 2015.
- With the slow rate of decrease of the MMR through the years, there still is a big gap towards the attainment of the MDG.

Topics/Contents

Teaching-Learning Process

Under-five Child and Infant Mortality



Source: NSO, NDHS, Philippines, 1993-2003
NSO, FPS, Philippines, 2006

MDG Targets in 2015:

Under-Five Child Mortality - 26 deaths per 1,000 LB

Infant Mortality Rate - 19 deaths per 1,000 LB

Flash the slide on the Under-Five Child Mortality and Infant Mortality Rate.

Ask participants to interpret the graph.

Interpretation should include but not be limited to:

- The Under-Five Mortality shows a declining trend from 54 deaths per 1,000 livebirths in 1993 to 40 in 2003 (32 deaths per 1,000 livebirths in 2006).
- The rate of decrease (1.4/year) as shown in the graph will be short towards the attainment of the target 26 deaths per 1,000 livebirths by 2015.
- The infant mortality rate shows a declining trend from 34 deaths per 1,000 livebirths in 1993 to 29 in 2003.
- The rate of decrease (average of 5/year), however will not enable the country to reach the MDG target of 19 deaths per 1,000 live births in 2015.

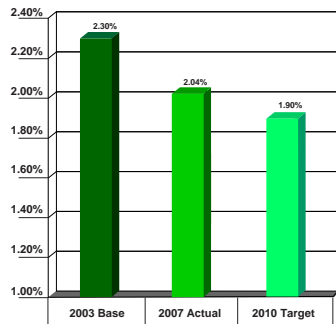
Tell participants that:

- FP can help women who are at risk for complications of pregnancy avoid getting pregnant, thus preventing maternal and infant mortality.
- Preventing maternal deaths also prevents infant deaths as studies show that (FPS, 2006) around 13 out of 1,000 babies die within their first month of life due to the same factors that interplayed when their mothers died.
- Thirty-two (32%) of maternal deaths can be prevented by FP interventions.

Topics/Contents

The Philippine Population in Relation to FP

Population Growth Rate



Source: Census, NSO, Phil, 2003 and 2007

Teaching-Learning Process

Display the slide on the Population Growth Rate (PGR).

Explain to the participants that:

- The Philippine population stood at 94.01 million in 2010 (NSO Projected Population, 2010) and is expected to grow annually at 2.04%.
- The Philippine population is expected to double in 29 years. The program aims to achieve PGR of 1.9% in 2010.

Ask participants:

- What does this mean in the light of available resources, health facility demand, and available services?

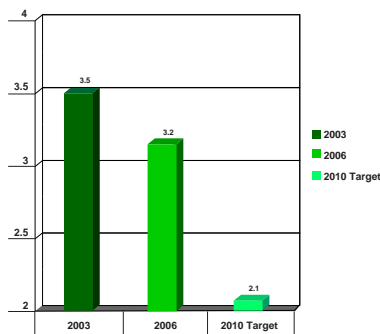
Responses should include but not be limited to:

- Increased facility demands
- Increased resources and services
- Increased budgetary requirements

Conclude discussion by saying:

- Family planning should be practiced:
 - ✓ To promote the health of mothers and children. Moreover, birth spacing should be at least three years.
 - ✓ To enable parents to provide their children with the quality basic services.
 - ✓ To match population with the available health resources and services.

Total Fertility Rate



Source: NSO, NDHS, Philippines, 2003
NSO, FPS, Philippines, 2006

Flash slide on the total fertility rate data.

Explain that:

- Total fertility rate (TFR) is the average number of children that a woman can have during her reproductive period (15-49 years old).
- TFR is declining slowly from 3.5 children per woman (NDHS, 2003) to 3.2 children per woman (FPS, 2006).
- However, the program aims to achieve a 2.1 TFR by 2010.
- With a 3.2 TFR, there is an excess of one child per woman from the target.

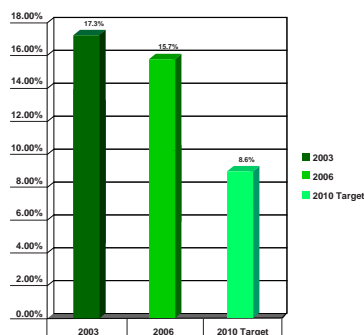
Topics/Contents

Teaching-Learning Process

What is Unmet Need for FP

Unmet need is the proportion of currently married women who are not using any modern methods of FP but do not want any more children or prefer to space births.

FP Unmet Need vs. MDG



Source: NSO, NDHS, Philippines, 2003
NSO, FPS, Philippines, 2006

Ask a participant to define unmet need for FP.

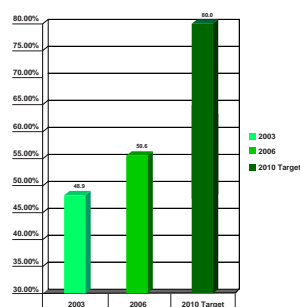
Write down the responses on the board. Supplement, if necessary, by showing the slide on the definition of unmet need.

Show the slide and explain the data presented on unmet need for FP.

Then explain to the participants that:

- The unmet need for FP services is still high from 17.3% in 2003 to 15.7% in 2006. The program aims to reduce it to half (8.6%) by 2010.
- The current data on TFR and Unmet Need show that there is a need for quality family planning services, where individuals and couples are able to access and achieve their desired reproductive intentions.

Contraceptive Prevalence Rate vs. MDG



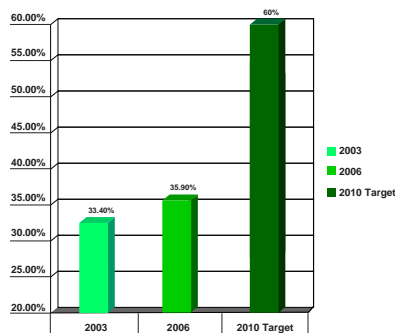
Source: NSO, NDHS, Philippines, 2003
NSO, FPS, Philippines, 2006

Display the slide and discuss the data presented on Contraceptive Prevalence Rate (CPR).

Tell participants that:

- There are two CPRs monitored by the program:
 1. Total CPR
The proportion of women of reproductive age using any FP method, whether traditional or modern.
 2. Modern CPR
The proportion of women of reproductive age using any modern FP methods within a given period.
- As shown in the slide, the increase in total CPR is very modest from 48.9% in 2003 to 50.6% in 2006. The MDG target is 80% in 2010.
- CPR for modern methods is still low but increasing from 33.4% in 2003 to 35.9% in 2006. The MDG target is 60% by 2010.

Modern FP Methods Use vs. MDG



Source: NSO, NDHS, Philippines, 2003
NSO, FPS, Philippines, 2006

Topics/Contents	Teaching-Learning Process
	<ul style="list-style-type: none"> • The current contraceptive prevalence rate on modern methods in the Philippines is still way below the country's MDG target. • The increase in contraceptive prevalence rate is directly dependent on the level of current FP users and unmet need for Family Planning.
	<p>Divide participants into five groups to correspond to the indicators (MMR, IMR, CMR, CPR for Modern Method, and Unmet Need).</p> <p>Each group will:</p> <ul style="list-style-type: none"> • analyze the graph/data assigned to the group. • identify the hindering factors in achieving the MDG and program benchmarks in their locality (e.g. why is the MMR still high in their locality?; delay in identifying complications during labor). • identify activities to be implemented to address each of the hindering factors identified according to their role as FP program managers or service providers. <p>Note: Review the program strategies as presented previously. Identify the program strategy that will improve the group's assigned indicator.</p> <p>What are the hindering factors in the implementation of activities for the strategy? What activities can be implemented in your localities to address the hindering factors?</p> <p>Each group assigns a secretary who will write the output of the group on the provided newsprint with the matrix (see advance preparation) and a rapporteur to present the output during plenary.</p> <p>Plenary:</p> <ul style="list-style-type: none"> • Each group's rapporteur presents the group's output. • Participants listen to the presentations. They supplement the presentation or ask questions for clarification.

Topics/Contents	Teaching-Learning Process
	<ul style="list-style-type: none"> • Facilitator supplements and consolidates the presentations.
<p style="text-align: center;">Summary</p>	<p>Summary</p> <p>Flash the slides of the objectives.</p> <p>Go over each of the objectives and ask the participants whether the objectives have been achieved.</p>



NARRATIVE:

MODULE 1: THE PHILIPPINE FAMILY PLANNING PROGRAM SESSION 1: OVERVIEW OF THE PHILIPPINE FAMILY PLANNING PROGRAM (PFPP)

THE EVOLUTION OF THE PHILIPPINE FP PROGRAM

The FP Program has been implemented for about 38 years, which started from a demographic perspective to a health intervention-oriented program.

In the year 1970 to 1985, PFPP started as a family planning service delivery component to achieve fertility reduction by a contraceptive-oriented approach.

During the year 1986 to 1993, the program was reoriented from mere fertility reduction to a health intervention by improving the health of women and children.

From 1994 to 1999, the family planning program underwent another shift that emphasized integration with other Reproductive Health (RH) programs giving importance to recognizing choice and rights of FP users. This shift was in line with the country's commitments made in the International Conference on Population and Development (ICPD), held in Cairo in 1994, and the Fourth World Conference on Women, held in Beijing in 1995.

During this period, the Philippines has adopted and developed a policy framework in with the goal of providing universal access to RH services with family planning as the flagship program. Implicit in the policy is the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable family planning methods of their choice including the right to access appropriate health care services that will enable women to go safely through pregnancy and childbirth, and provide couples the freedom to decide if, when, and how often to do so.

In the period between the year 2000 to the present, the national FP policy, AO NO. 50-A, s.2001, was formulated to prescribe the key policies of FP services in the country. Likewise, to signify the government's commitment to the Millennium Development Goals (MDGs) on the improvement of maternal and child health and nutrition and reduction of maternal and child mortality, the Maternal, Newborn, and Child Health and Nutrition (MNCHN) strategy was introduced in 2008.

1.16

THE PHILIPPINE FAMILY PLANNING PROGRAM



VISION:

To empower women and men to live healthy, productive, and fulfilling lives with the right to achieve their desired family size through quality, medically sound, and legally permissible FP methods.

- Quality: There are six facets of FP quality care: choice of method, technical competence, informing and counseling clients, interpersonal relations, mechanisms to encourage continuation and appropriateness and acceptability of services.

- Medically Sound: Sound medical treatment is defined as the use of medical knowledge or means to cure or prevent a medical disorder, preserve life, or relieve distressing symptoms.

- Legally Permissible: All FP interventions must be legal and must not violate any existing Philippine law.



MISSION:

The DOH, in partnership with the LGUs, NGOs, private sector, and communities shall ensure the availability of FP information and services to men and women who need them.



GOAL:

To provide universal access to FP information and services whenever and wherever these are needed.



OBJECTIVES:

1. The FP Program addresses the need to help couples and individuals achieve their desired family size within the context of responsible parenthood and improve their reproductive health to attain sustainable development.
2. It aims to ensure that quality FP services are available in DOH-retained hospitals, LGU-managed health facilities, NGOs, and the private sector.

GUIDING PRINCIPLES OF THE PFPP:

Family Planning Program services are to be delivered within the context of the following principles:

1. *Respect for the sanctity of life.* Family Planning aims to prevent abortion and therefore can save the lives of both women and children.
2. *Respect for human rights.* Family Planning services will be made available using only medically and legally permissible methods appropriate to the health status of the client. Family Planning services shall be provided regardless of the client's sex, number of children, sexual orientation, moral background, occupation, socio-economic status, cultural, and religious belief.
3. *The freedom of choice and voluntary decision.* Couples and individuals will make family planning decisions based on informed choice including their own moral, cultural or religious beliefs.
4. *Respect for the rights of clients to determine their desired family size.* Couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children.

Couples and individuals decide and may choose the methods that they will use based on informed choice and to exercise responsible parenthood in accordance with their religious and ethical values and cultural background, subject to conformity with universally recognized international human rights. This means that in any FP method service delivery, providers must give good counseling and ready access to contraceptive options, free of any provider bias for or against particular methods, so clients can exercise their rights to make informed and voluntary decisions based on accurate and up-to-date information.

Counseling helps clients choose and correctly use any contraceptive method and reassures a positive impact on method adoption, continuation, and client satisfaction. It enables clients to achieve their reproductive goals and good health outcomes (adopted from the Ten Guiding Principles for LAPM Service Programs, ACQUIRE/Engender Health, 2007).

FP POLICIES AND STRATEGIES

The **National FP Policy (Administrative Order No. 50-A, s. 2001)**, prescribes the key policies for FP services focused on modern FP methods including natural FP. Policy statements that guide FP program promotion and implementation are the following:

1. Family Planning as a health intervention to promote the over-all health of all Filipinos particularly our women and children by:

- preventing high-risk pregnancies
 - preventing unplanned pregnancies
 - reducing maternal deaths
 - responding to unmet needs of women
2. FP information and services will be provided based on voluntary and informed choice to all women and men of reproductive age regardless of age, number of children, marital status, religious beliefs, and cultural values.
 3. Only medically safe and legally acceptable FP methods shall be made available in all public, NGOs, and private health facilities.
 4. Quality care must be promoted and ensured in providing FP services. Privacy and confidentiality should be strictly observed in the provision of services at all times.
 5. Efforts must be undertaken to orient clients on fertility awareness as the basic information to fully understand and appreciate FP.
 6. Multi-agency participation is essential. Involvement of the private sector, academe, church, media, community, and other stakeholders must be encouraged at all levels of operation.
 7. FP services, in the context of the RH approach, must be integrated with the delivery of other basic health services.
 8. Sustainability of FP services and commodities must be promoted through the localization and adoption of the Contraceptive Self-Reliance (CSR) strategy (example: market segmentation and LGU empowerment, etc).

STRATEGIES:

1. Focus service delivery to the urban and rural poor;
2. Re-establish/strengthen the FP outreach program;
3. Strengthen FP provision in regions with high unmet need;
4. Promote frontline participation of hospitals;
5. Mainstream modern natural FP;
6. Promote and implement CSR strategy to include other non-commodity based methods (e.g. BTL, Vasectomy, Fertility Awareness-Based Methods);
7. Integration of FP with other RH services (example: maternal, neonatal, child and nutrition services, adolescent health services, etc.);
8. Ensuring quality care through compliance to informed choice and voluntarism principles;
9. Capacitate high volume providers.

COMPONENTS

- Service Delivery
- Logistics Management
- Information, Education, and Communication and Advocacy
- Monitoring and Evaluation
- Research and Development
- Management Information System
- Training

FP PROGRAM METHODS

Modern methods

- ✓ Permanent methods
 - Female sterilization/Bilateral Tubal Ligation
 - Male sterilization/Vasectomy
- ✓ Temporary Methods
 - Supply methods

- Pills
- Intrauterine Device
- Injectable
- Male condom
- Fertility Awareness Based Method
 - Billings Ovulation/Cervical Mucus Method
 - Basal Body Temperature
 - Sympto-thermal Method
 - Standard Days Method
 - Lactational Amenorrhea Method

THE HEALTH AND FP SITUATION IN THE PHILIPPINES

MATERNAL, INFANT AND UNDER-FIVE MORTALITY:

The Philippines was one of the 179 member states of the United Nations which reaffirmed its commitment to peace, security, poverty alleviation, reproductive health, and equality of men and women.

Two of the Millennium Development Goals (MDGs) are reduction in maternal and child mortality, which is a concern of service providers. This can be addressed through family planning as it can help women who are at risk during pregnancy and birthing. The country has shown improvements in the following:

- Maternal mortality ratio decreased from 209 (NDHS, 1993) to 162 maternal deaths per 100,000 livebirths (FPS, 2006). The MDG goal is 52 maternal deaths per 100,000 livebirths by 2015.
- Mortality rate of under-five children decreased from 54 (NDHS, 1993) to 40 (NDHS, 2003) per 1,000 livebirths to 32 deaths per 1,000 livebirths (FPS, 2006). The MDG is 26 deaths per 1,000 livebirths by 2015.
- Infant mortality rates declined from 34 (NDHS, 1993) to 29 deaths per 1,000 livebirths (NDHS, 2003). The MDG is 19 deaths per 1,000 livebirths by 2015.

THE PHILIPPINE POPULATION IN RELATION TO FP

- The Philippine population stood at 94.01 million in 2010 (NSO Projected Population, 2010) and is expected to grow annually at 2.04%. The Philippine population is expected to double in 29 years.
- Total fertility rate (TFR) declined very slowly from 3.5 children per woman (NDHS, 2003) to 3.2 children per woman (FPS, 2006). The program aims to achieve a 2.1 TFR by 2010. With a 3.2 TFR, there is one excess child per woman from the target.
- FP unmet need also declined from 17.3% (2003) to 15.7% (FPS, 2006). The program aims to reduce this by half (8.6%) by 2010.
- Total contraceptive prevalence rate (CPR) has increased from 15.4% (1968) to 48.9% (NDHS, 2003) to 50.6 (FPS, 2006). The MDG is CPR of 80% by 2010.
- Modern FP methods use from 33.4% (NDHS, 2003) to 35.9% (FPS, 2006). The MDG is 60% CPR for modern methods in 2010.

SESSION 2

FAMILY PLANNING AND REPRODUCTIVE HEALTH

LEARNING OBJECTIVES

At the end of the session, the participants must be able to:

1. Explain the Administrative Order (AO) on Reproductive Health (RH).
2. Explain what is RH.
3. Enumerate the 10 elements of RH.
4. Explain how FP could be integrated with the other RH elements.
5. Explain the Maternal, Newborn, and Child Health and Nutrition (MNCHN) strategy.



METHODOLOGY

Illustrated Lecture-Discussion
Brainstorming






TIME ALLOTMENT

30 minutes



ADVANCE PREPARATION OF MATERIALS

- Powerpoint presentation
- Laptop computer and LCD projector
- Screen projector
- White board, pens, masking tape
- Training manuals

Topics/Content	Teaching-Learning Process
<div style="display: flex; align-items: center;">  <div> <h2 style="margin: 0;">SESSION 2</h2> <hr style="border: 0.5px solid #008000; margin: 10px 0;"/>  <h3 style="margin: 0;">FAMILY PLANNING AND REPRODUCTIVE HEALTH</h3> </div> </div>	<p>Tell participants that this session will describe the concept of reproductive health, its elements and the rationale for integration with FP. It also situates FP in the context of Reproductive Health. It is important for health providers to appreciate the common link between and among FP and other RH elements.</p>
<div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: flex; align-items: center;">  Learning Objectives </div> <p>At the end of the session, the participants must be able to:</p> <ul style="list-style-type: none"> ✓ Explain the Administrative Order (AO) for Reproductive Health (RH). ✓ Define Reproductive Health. ✓ Enumerate the 10 elements of RH. ✓ Explain how FP could be integrated with the other RH elements. ✓ Explain the MNCHN strategy. 	<p>Show the slide and state the session objectives.</p>
<div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: flex; align-items: center;"> The Philippine RH Program & Policy </div> <ul style="list-style-type: none"> • In 1998, DOH issued AO 1-A establishing the Philippine RH Program, which defined the RH service package consisting of 10 elements to include FP as the core elements. • AO 43, s 1999 adopting the RH Policy to integrate RH services in all health facilities as part of basic package of health services. 	<p>Tell participants that the Philippines is one of the signatories to the 1994 International Conference on Population and Development Plan of Action. In support of this, the DOH issued two Administrative Orders in 1998 and 1999.</p> <p>Explain the administrative orders as presented on the slide.</p>
<p>Reproductive Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.</p>	<p>Ask participants to define Reproductive Health.</p> <p>Write the responses on the board and supplement if needed by showing the slide on RH definition.</p>

Topics/Contents

Teaching-Learning Process

Ten Elements of Reproductive Health

1. Family Planning
2. Maternal and Child Health
3. Prevention and Management of Reproductive Tract Infections (RTIs) including Sexually Transmitted Infections (STIs) and HIV/AIDS
4. Adolescent Reproductive Health
5. Prevention and Management of Abortion and its Complications
6. Prevention and Management of Breast and Reproductive Tract Cancers and other Gynecological Conditions
7. Education and Counseling on Sexuality and Sexual Health
8. Men's Reproductive Health and Involvement
9. Violence against Women and Children
10. Prevention and Management of Infertility and Sexual Dysfunctions

Present the 10 elements of reproductive health as written on the slide.

INTEGRATION OF FP WITH OTHER RH ELEMENTS

Family Planning links with other Reproductive Health Elements

Tell participants that :

- FP, as an integral element of Reproductive Health, can be provided to everyone in the reproductive age group together with other RH services.
- Clients consulting for a particular service may have other unmet RH needs that should also be provided. This client-centeredness of care is the cornerstone in the provision of a quality and comprehensive RH package of services. This simply means that no client will leave the facility with a need not addressed. This is also termed as the “one stop shop” on health care. Family Planning is foremost in the attainment of reproductive health as it allows couples to decide freely on the number and spacing of their children.

Maternal and Child Health and Nutrition

Central to the attainment of optimum maternal and child health and nutrition is proper birth spacing of at least three years to give ample time for the mother to regain her health and to properly care for her newborn. Through the use of safe and effective FP methods, the risks of pregnancy among “too young, too old, too frequent, and too many” can be avoided.

- Pregnant women and most mothers are sexually active and may have unmet need for FP.
- They should be reminded of available FP services so that they know when and where to consult.
- Breastfeeding mothers have specific needs for FP that should consider the quality and quantity of breastmilk for the health of the infant.

Explain how FP links with other RH elements as presented on the slide.

Topics/Contents	Teaching-Learning Process
<p data-bbox="228 237 743 259">Prevention and Management of RTIs, including STIs, HIV/AIDS</p> <ul data-bbox="268 344 758 584" style="list-style-type: none"> • Individuals who are sexually active and with unmet need for FP are at risk for sexually transmitted infections (STIs), HIV/AIDS. • Clients who are at risk of contracting STIs need dual protection through the use of FP methods such as condoms that also provide protection from pregnancy. • Risk assessment for STIs is part of determining the client's eligibility for Intrauterine Device use (both for initial and continuing use). 	
<p data-bbox="228 667 790 689">Prevention and Management of Abortion and its Complications</p> <ul data-bbox="268 763 688 1048" style="list-style-type: none"> • Abortions are the result of unplanned pregnancies. • One of the major causes of maternal deaths is due to the complications of unsafe abortion. • FP provides men and women with options for preventing unplanned pregnancies, which may result to abortion. • Women who resort to abortion have unmet needs for FP. • Proper management of complications consists of medical treatment and provision of FP counseling and services. 	
<p data-bbox="228 1137 749 1182">Prevention and Management of Breast and Reproductive Tract and Other Gynecological Conditions</p> <ul data-bbox="268 1263 763 1451" style="list-style-type: none"> • Provision of FP services presents an opportunity for screening and early detection of breast and reproductive tract cancers. • Combined oral contraceptives have been proven to reduce the risk of ovarian and endometrial cancers. Progestin-only contraceptives have a high protective effect against endometrial cancers. Progestin-only contraceptives have a high protective effect against endometrial cancers. 	
<p data-bbox="228 1543 765 1568">Education and Counseling on Sexuality and Sexual Health</p> <ul data-bbox="268 1648 715 1883" style="list-style-type: none"> • An understanding of basic concepts on fertility deepens the appreciation of gender roles and their differences and enhances the relationship between sexual partners. • Fertility management is an essential part of sexual health. • Sexuality education is a basic component of the FP program. • FP counseling and providing correct information on sexuality will help reduce unplanned pregnancies. 	

Topics/Contents

Teaching-Learning Process

Men's Reproductive Health and Involvement

- Men are crucial halves in the attainment of a couple's reproductive intentions and should be involved in FP.
- Male involvement is critical to the acceptance and continuous use of FP. This can be in the form of supporting their partner's use of FP, or by being acceptors themselves and in performing family obligations and other shared responsibilities such as child rearing.
- Men have their own specific health needs for FP that a comprehensive RH service should provide for.

Adolescent Reproductive Health

- Adolescents have the potential to be sexually active and need to be advised and counseled about safe and responsible sexual practices, including FP.
- Orientation on fertility awareness and counseling are basic services which help promote responsible sexuality among adolescents. Responsible sexuality will help reduce unplanned pregnancies and RTIs.

Prevention and Management of Infertility and Sexual Dysfunction

- Fertility awareness during FP counseling may provide the opportunity to discuss infertility and sexual dysfunction problems, which are normally difficult topics to bring out in the open.
- FP is not only for delaying pregnancies but also for achieving fertility through fertility awareness orientation, counseling, and referral to appropriate facilities.

Violence against Women and Children

- FP use maybe a sensitive issue in a family affected by a gender-related violence (e.g. women who are beaten up because they do not want to get pregnant). Health providers need to be tactful while ensuring that client's needs are met.
- Domestic violence, mostly with women as victims, is now recognized as an important public health issue.
- Sexual violence is one of the most common forms. This provides an opportunity to discuss and promote FP.

Topics/Contents	Teaching-Learning Process
<p data-bbox="232 210 385 237">MNCHN Strategy</p> <p data-bbox="194 250 288 273">Ensures that:</p> <ul data-bbox="269 300 736 564" style="list-style-type: none"> <li data-bbox="269 300 661 322">• Every pregnancy is wanted, planned, and supported; <li data-bbox="269 344 736 367">• Every pregnancy is adequately managed throughout its course; <li data-bbox="269 394 711 443">• Every delivery is facility-based and managed by skilled birth attendants; and <li data-bbox="269 465 730 564">• Every mother and newborn pair secures proper postpartum and postnatal care with smooth transitions to the women's health care package for the mother and child survival package for the newborn. 	<p data-bbox="827 219 1100 255">Tell participants that:</p> <ul data-bbox="827 259 1404 703" style="list-style-type: none"> <li data-bbox="827 259 1404 519">• There is also an integrated Maternal, Newborn, and Child Health and Nutrition (MNCHN) Strategy (DOH AO 2008-0029), which was instituted on September 2008. This aimed to address the need of rapidly reducing both maternal and infant mortality rates as part of the MDGs for the Philippines. <li data-bbox="827 555 1404 703">• The strategy includes the quality provision of family planning method of choice and meeting the unmet need for family planning information and services. <p data-bbox="827 743 1404 851">Explain to participants the immediate results of the MNCHN Strategy as presented in the slide.</p>



NARRATIVE

MODULE 1: THE PHILIPPINE FAMILY PLANNING PROGRAM SESSION 2: FAMILY PLANNING AND REPRODUCTIVE HEALTH

REPRODUCTIVE HEALTH POLICY

The Philippines is a signatory to the 1994 ICPD Program of Action. In 1998, DOH issued **AO 1-A establishing the Philippine RH program**, which defined the Reproductive Health (RH) service package consisting of 10 elements to include FP.

This was further strengthened through the issuance of **AO 43, s 1999 adopting the RH policy to integrate RH** services in all health facilities as part of a basic package of health services, thus ensuring a more efficient and effective referral system from primary to tertiary, public, and private facilities.

WHAT IS REPRODUCTIVE HEALTH?

Reproductive Health is defined as a state of “complete physical, mental and social well being, and not merely the absence of disease or infirmity in all matters relating to the reproductive health system and to its functions and processes” (UN ICPD, 1994).

Reproductive health care is defined as the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems.

TEN ELEMENTS OF REPRODUCTIVE HEALTH

The following are the 10 elements of Reproductive Health:

1. Family Planning
2. Maternal and Child Health
3. Prevention and Management of Reproductive Tract Infections (RTIs) including Sexually Transmitted Infections (STIs), and HIV/AIDS
4. Adolescent Reproductive Health
5. Prevention and Management of Abortion and Its Complications
6. Prevention and Management of Breast and Reproductive Tract Cancers and Other Gynecological Conditions
7. Education and Counseling on Sexuality and Sexual Health
8. Men's Reproductive Health and Involvement
9. Violence against Women and Children
10. Prevention and Management of Infertility and Sexual Dysfunctions

LINKING FP TO THE OTHER RH ELEMENTS

Clients consulting for a particular service may have other unmet RH needs that should also be provided. This client-centeredness of care is the cornerstone in the provision of quality, comprehensive RH package of services. This simply means that no client will leave the facility with a need not addressed. This is also termed as the “one stop shop” on health care.

Family planning, as an integral element of Reproductive Health, can be provided to everyone in the reproductive age group with other RH services. Family Planning is foremost in the attainment of reproductive health as it allows couples to decide freely on the number and spacing of their children. It can be linked to other RH elements.

1. Maternal and Child Health and Nutrition

Central to the attainment of optimum maternal and child health is proper birth spacing of at least three years. This period provides ample time for mothers to regain their health and to properly care for their newborn. Through the use of safe and effective FP methods, the risks of pregnancy among the “too young,” “too old,” “too frequent,” and “too many” can be avoided.

Pregnant women may have unmet need for FP. These women will benefit from being informed of FP services available in their localities.

Breastfeeding mothers have specific FP needs. To this end, there are methods that do not affect the quality and quantity of breast milk.

2. Prevention and Management of RTIs, including STIs, HIV/AIDS

Individuals who are sexually active with unmet FP needs are at risk for sexually transmitted infections like HIV/AIDS.

Family planning clients who are at risk of contacting STIs need dual protection through the use of a FP method such as the condom, which provides protection against STIs.

Risk assessment for STIs is part of determining a client’s eligibility for IUD use.

3. Prevention and Management of Abortion and Its Complications

Abortions are a result of unplanned pregnancies. One of the major causes of maternal deaths is due to the complications of unsafe abortion. Women who resort to abortion have unmet needs for family planning.

Family planning provides men and women with options for preventing unplanned pregnancies, which may result in abortion. Proper management of complications of abortion includes medical treatment and the provision of FP services (i.e., counseling).

4. Prevention and Management of Breast and Reproductive Tract Cancers and Other Gynecological Conditions

Provision of FP services presents an opportunity for screening and early detection of breast and reproductive tract cancers.

Combined oral contraceptives are proven to reduce the risk of ovarian and endometrial cancers. Progestin-only contraceptives have a high protective effect against endometrial cancers.

5. Education and Counseling on Sexuality and Sexual Health

An understanding of basic concepts on fertility deepens the appreciation of gender roles and enhances the relationship between sexual partners.

Fertility management and sexuality education are essential to sexual health.

Family planning counseling and provision of accurate information on sexuality helps reduce unplanned pregnancies.

6. Men's Reproductive Health and Involvement

Men are crucial halves in the attainment of a couple's reproductive intentions and should be involved in family planning.

Male involvement is critical to acceptance and continuous use of family planning methods. This can be in the form of:

- ✓ supporting their partner's use of FP
- ✓ being acceptors themselves
- ✓ performing family obligations and other shared responsibilities such as child rearing

Men have their own specific health needs for FP that a comprehensive RH service should provide for.

7. Adolescent Reproductive Health

Adolescents have the potential to be sexually active and need to be advised and counseled about safe and responsible sexual practices, including FP.

Orientation on fertility awareness and counseling are basic services, which will help promote responsible sexuality among adolescents. Responsible sexuality will help reduce unplanned pregnancies and RTIs particularly sexually transmitted infections like HIV/AIDS.

8. Prevention and Management of Infertility and Sexual Dysfunctions

Fertility awareness during FP counseling may provide the opportunity to discuss infertility and sexual dysfunction problems, which are normally difficult topics to bring out in the open.

FP is not only for delaying pregnancies but also for achieving fertility through fertility awareness orientation, counseling, and referral to appropriate facilities.

1.28

9. Violence Against Women and Children

FP use may be a sensitive issue in a family affected by a gender-related violence (e.g. women who are beaten up because they do not want to get pregnant). Health providers need to be tactful while ensuring that client needs are met.

Domestic violence, mostly with women as the victims, is now recognized as an important public health issue. Sexual violence is one of the most common forms. This provides an opportunity to discuss and promote FP.

THE INTEGRATED MATERNAL, NEWBORN, CHILD HEALTH AND NUTRITION (MNCHN) STRATEGY

The Integrated MNCHN Strategy (DOH AO 2008-0029) was instituted in September 2008 to address the need to reduce both maternal and infant mortality rates as part of the Millennium Development Goals (MDGs) for the Philippines.

The strategy includes the quality provision of family planning methods of choice and meeting the unmet needs for family planning services and information.

 **GOAL:**

Rapidly reduce maternal and neonatal mortality through local implementation of an integrated MNCHN strategy.

 **OBJECTIVES:**

- Develop, adopt, promote, implement, and evaluate an integrated MNCHN strategy for the rapid reduction of maternal and neonatal mortality.
- Engage all province-wide or city-wide health systems to adopt and implement the integrated MNCHN strategy.
- Provide targeted support to province-wide or city-wide health systems and specific population groups where the maternal and neonatal mortality problem is most severe.
- Achieve national MNCHN program targets for the following key indicators by 2010:
 - Increase modern contraceptive prevalence rate from 35.9% (FPS, 2006) to 60%.
 - Increase percentage of pregnant women having at least four antenatal care visits from 70% (NDHS 2003) to 80%.
 - Increase percentage of skilled birth attendants and facility-based births from 40% (NDHS 2003) to 80%.
 - Increase percentage of fully immunized children from 70% (NDHS, 2003) to 95%.

Immediate Results of the MNCHN Strategy:

- Every pregnancy is wanted, planned, and supported;
- Every pregnancy is adequately managed throughout its course;
- Every delivery is facility-based and managed by skilled birth attendants; and,
- Every mother-and-newborn pair secures proper postpartum and postnatal care with smooth transitions to the women's health care program for the mother and child survival package for the newborn.

SESSION 3

MATERNAL HIGH-RISK FACTORS



LEARNING OBJECTIVE

At the end of the session, the participants must be able to:

Discuss the maternal high risk factors in pregnancy and childbirth, its complications to mothers and infants.



METHODOLOGY

Illustrated Lecture-Discussion
Group work






TIME ALLOTMENT

30 minutes



ADVANCE PREPARATION OF MATERIALS

- Powerpoint presentation
- Laptop computer and LCD/overhead projector
- Screen projector
- White board, marker pens, masking tapes
- Training manuals
- Metacards

Topics/Contents	Teaching-Learning Process
 <h2 style="text-align: center;">SESSION 3</h2> <hr/>  <h3 style="text-align: center;">MATERNAL HIGH-RISK FACTORS</h3>	<p>Tell participants that:</p> <ul style="list-style-type: none"> • It is not enough for them to know the health benefits of family planning. • They should also understand some of the risk factors that affect maternal health. • Understanding these risk factors will enable them as service providers to anticipate the family planning needs of women and couples in terms of their risk factors.
<p> Learning Objective</p> <p>At the end of the session, the participants must be able to:</p> <p>Discuss the maternal high risk factors in pregnancy and childbirth, its complications to the mothers and infants.</p>	<p>Show the slide on session objective.</p>
<p>Maternal High-Risk Factors</p> <h2 style="text-align: center;">Maternal High-Risk Factors</h2>	<p>Tell participants that</p> <ul style="list-style-type: none"> • Maternal high-risk factors would refer to: <ul style="list-style-type: none"> - Too Young (mothers who are below 18 years of age), - Too Old (mothers who are 35 years old and above), - Too Many (mothers who have four or more pregnancies), - Too Close (birth interval of less than three years) and, - Too ill (mother having chronic diseases or disorders). • Mother’s age at birth, birth order, and birth interval all can affect a child’s chances of survival. These are major factors in increasing maternal and infant mortality. <p>Divide the participants into five groups. Assign a maternal high risk factor category for each group and discuss the following:</p> <ul style="list-style-type: none"> – Complications to the mother and its outcome – Complications to the infants

Topics/Contents

Teaching-Learning Process

Write responses on meta cards. Assign a reporter for the group to present the group outputs.

1. Too Young

✓ Pregnancy complications of mothers who are at young age (below 18 years old) include the following:

- Hemorrhage
- Iron deficiency anemia
- Toxemia of pregnancies
- Miscarriage
- Prolonged labor

✓ Infants of mothers who are too young are in danger of:

- Low birth weight
- Birth-related defects
- Prematurity
- High incidence of fetal deaths and morbidity

Supplement the participants' answers with the slide presentation.

2. Too Old

✓ Pregnancy complications of mothers who are at advanced age (35 years old and above) includes :

- Hemorrhage
- Prolonged labor
- Toxemia of pregnancies

✓ Infants born to older women also have a much greater risk of having the following birth defects:

- Heart defects
- Birth defects (e.g. cleft palate and lip)
- Down's syndrome
- Higher incidence of stillbirths and fetal deaths

3. Birth Number (Too Many)

A woman with four or more deliveries:

- is more likely to experience problems during pregnancy and labor and to require caesarean section.
- has a significantly higher risk of miscarriage and perinatal morbidity and mortality than women undergoing their second or third delivery.

4. Birth Interval (Too Close)

✓ Complications to mothers of birth intervals less than three years :

- anemia and malnutrition
- increased vulnerability to illnesses
- mothers are physically stressed and burdened by pregnancy, needs at least three years to regain her nutritional status

✓ Babies born less than three years will result to :

- the early weaning of the child from the mother oftentimes will result to the child's diarrheal disease and malnutrition
- low birth weight
- high infant deaths (1-1.5 times more likely to happen)
- lower resistance to communicable diseases

Topics/Contents	Teaching-Learning Process
<p data-bbox="227 241 749 275">5. Too ill or unhealthy or with medical conditions</p> <p data-bbox="208 297 769 365">Women with chronic medical conditions (i.e.,TB, cardiac disease, mental health condition, cancer) require treatment and therefore needs to postpone or limit pregnancy through family planning.</p> <ul data-bbox="304 392 769 488" style="list-style-type: none"> • Pregnancy complicates physiological processes of treatment and rehabilitation. • Pregnancy adds burden to a body already burdened by disease. <p data-bbox="208 510 333 533">Danger to infants</p> <ul data-bbox="304 560 758 607" style="list-style-type: none"> • Adverse effects caused by medicines used to treat the disease (e.g. congenital malformations, stillbirths) <p data-bbox="227 685 646 719">Key Messages Conditions</p> <ol data-bbox="236 763 785 1003" style="list-style-type: none"> 1. FP is a health intervention that contributes to the reduction of maternal and child mortality 2. FP is anchored on the following principles: <ul data-bbox="330 857 785 976" style="list-style-type: none"> - Respect for the sanctity of life - Respect for human rights - The freedom of choice and voluntary decisions - Respect for the rights of clients to determine their desired family size 3. FP saves lives and is pro-quality of life. 	



NARRATIVE

MODULE 1: THE PHILIPPINE FAMILY PLANNING PROGRAM SESSION 3 : MATERNAL HIGH-RISK FACTORS

Maternal high-risk factors refer to:

- Too Young (mothers who are below 18 years of age),
- Too Old (mothers who are 35 years old and above),
- Too Many (mothers who have four or more pregnancies),
- Too Close (birth interval of less than three years); and,
- Too ill (mothers having chronic diseases or disorders).

Mother's age at birth, birth order, and birth interval all affect a child's chances of survival. These are major factors in increasing maternal and infant mortality.

1. "Too Young"

Pregnancy complications of mothers who at young age (below 18 yrs of age) include the following:

- Hemorrhage/Anemia
- Toxemia
- Iron Deficiency Anemia
- Miscarriage/Stillbirth
- Prolonged labor

A teenage mother is prone to these complications because her reproductive system is not yet fully developed, and pregnancy interrupts her body's normal course of growth and development. These complications are compounded by the heavy social and economic responsibilities of parenthood for which they are rarely ready.

Infants of mothers who are too young are in danger of the following:

- Low birth weight
- Birth-related defects
- Prematurity
- High incidence of fetal death and morbidity

2. "Too Old"

Pregnancy complications of mothers who are at advanced age (35 years old and above) includes the following:

- Hemorrhage
- Prolonged labor
- Toxemia

As a woman's age advances, the muscles of her uterus also become less firm, making pregnancy and childbirth more difficult.

Infants born to older women are also at a much greater risk of having the following birth defects:

- Heart defects
- Birth defects (e.g. cleft palate and lip palate)
- Down's syndrome
- Higher incidence of stillbirths and fetal deaths

If childbirth could be postponed until the "too young" mother is old enough, and averted in mothers who are "too old" and "too ill," the impact on both maternal and infant mortality would be significant.

3. Birth Number ("Too Many")

- Women who have had four or more deliveries are more likely to experience problems during pregnancy and labor and to require Caesarean section, (which is often not readily available or cannot be performed early enough).
- This group has a significantly higher risk of miscarriage and perinatal mortality than women undergoing their second or third delivery.

4. Birth Interval ("Too Close")

- Complications to mothers of birth intervals of less than three years include:
 - ✓ Anemia and malnutrition
 - ✓ Increased vulnerability and illnesses
 - ✓ Physical stress
- Child birth interval of at least three years is good enough to ensure enough opportunity for the mother to completely recover her health and nutritional status.
- Babies born less than three years after early weaning of the child from the mother's breast which often times may result to:
 - ✓ Child diarrheal disease and malnutrition
 - ✓ Low birthweight
 - ✓ High infant deaths which is 1-1.5 times more likely to happen
- When birth interval is more than three years, children become more resistant to infections and communicable diseases.

5. Too ill or unhealthy or with medical condition

Women with chronic medical conditions like tuberculosis, cardiac disease, mental health condition, cancer or malignancies require treatment and therefore need to postpone or limit pregnancy through family planning.

- Pregnancy complicates physiological processes of treatment and rehabilitation
- Pregnancy adds burden to a body already burdened by disease.

This also poses danger to the infant due to adverse effects of medications used to treat the disease including congenital malformations and stillbirth.

Key Messages

1. Family Planning is a health intervention that promotes the health of women and children and reduces maternal and infant morbidity and mortality.
2. The PFPP is promoted and implemented based on the guiding principles of respect for the sanctity of life; respect for human rights; freedom of choice and voluntary decisions; and respect for the rights of clients to determine their desired family size.
3. FP saves lives and is pro-quality of life!

HEALTH BENEFITS OF FAMILY PLANNING



LEARNING OBJECTIVE

At the end of the session, the participants must be able to:
Identify the health benefits of family planning to mothers, children and fathers.



METHODOLOGY

Illustrated Lecture-Discussion
Group work





TIME ALLOTMENT

30 minutes



ADVANCE PREPARATION OF MATERIALS

- Powerpoint presentation
- Laptop computer and LCD projector
- Screen Projector
- White board, marker pens, masking tapes
- Training manuals
- Newsprint and pentel pens

Topics/Contents	Teaching-Learning Process
<div style="text-align: center;">  <h2 style="color: green; margin: 0;">SESSION 4</h2> <hr style="border: 0.5px solid green;"/>  <h3 style="color: green; margin: 0;">HEALTH BENEFITS OF FAMILY PLANNING</h3> </div>	<p>Explain to the participants that:</p> <p>The previous two sessions are the foundation for all of the family planning interventions and activities that they, as service providers are doing at the health facility level. Hence, what was presented was the “big picture.”</p> <p>This session will look at how family planning impacts on maternal and child health.</p>
<div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: flex; align-items: center;"> Learning Objective </div> <p style="margin-top: 20px;">At the end of the session, the participants must be able to:</p> <p>Identify the health benefits of family planning to mothers, children, and fathers.</p>	<p>State the objectives of the session as written on the slide.</p>
<div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: flex; align-items: center; margin-bottom: 20px;"> Health Benefits of FP </div> <div style="text-align: center; margin-top: 20px;"> <h2 style="color: green; margin: 0;">Health Benefits of Family Planning</h2> </div>	<p>Tell participants that:</p> <p>Family planning has been identified as an important intervention in reducing maternal and child mortality.</p> <p>For this session, participants will think of the specific benefits of FP to mothers, children, and fathers. Participants should be divided into three groups.</p> <p>Each group brainstorms on the benefits of family planning as follows:</p> <ul style="list-style-type: none"> Group 1: Health benefits of FP to mothers Group 2: Health benefits of FP to infants and children Group 3: Health benefits of FP to fathers <p>Each group’s output will be written on newsprint by an assigned secretary. Each output will be presented during plenary by an assigned rapporteur.</p>

Topics/Contents	Teaching-Learning Process
	<p>Allot 15 minutes for this activity. Each group presents their output in plenary while the other groups listen and comment/supplement.</p>
<p>A. Benefits to Mothers</p> <ul style="list-style-type: none"> • Reduction in Maternal Mortality and Morbidity <ul style="list-style-type: none"> ➤ Using an effective FP method reduces maternal deaths by preventing high-risk pregnancies among women who are too young, too old or too ill to bear children safely. ➤ Maternal deaths can be prevented if unplanned pregnancies are avoided and pregnancies are spaced by at least three years. ➤ FP prevents closely spaced pregnancies that leads to and worsen conditions such as anemia and maternal malnutrition. <p>A. Benefits to Mothers</p> <ul style="list-style-type: none"> • Non-contraceptive health benefits of Hormonal Contraceptives prevent/reduce: <ul style="list-style-type: none"> ➤ Ectopic pregnancy ➤ Ovarian cancer ➤ Endometrial cancer ➤ Ovarian cysts ➤ Benign breast disease ➤ Excessive menstrual bleeding and associated anemia ➤ Menstrual cramping, pain, and discomfort • All FP methods help women with HIV/AIDS avoid pregnancy, thus avoid bearing HIV-infected children. 	<p>Elaborate the groups' presentations by explaining the health benefits of family planning as presented on the slide.</p>
<p>B. Benefits to Infants and Children</p> <ul style="list-style-type: none"> • Reduction in Infant and Child Mortality and Morbidity <ul style="list-style-type: none"> ➤ Globally, an estimated 14.5 million infants and children under age five die every year, mainly from respiratory and diarrheal diseases complicated by malnutrition. ➤ Recent studies indicate that the lowest risks for fetal death, pre-term delivery, being small/undersized for gestational age, neonatal death, and low birth weight occur when births are spaced from three to five years (NDHS, 2003). 	

Topics/Contents	Teaching-Learning Process
<p data-bbox="228 226 545 248">B. Benefits to Infants and Children</p> <ul style="list-style-type: none"> <li data-bbox="221 286 628 309">• Reduction in Infant and Child Mortality and Morbidity <li data-bbox="294 338 774 409">➤ Properly spaced children of at least three years will be given the love, attention, care, and time from mothers and fathers to attend to their growth and development. <li data-bbox="294 439 774 483">➤ Fewer children in the family provide more opportunities for adequate food, clothing, good education, and good health. <li data-bbox="294 512 749 584">➤ Breastfeeding can protect infants against diarrheal and other infectious disease as well as protect mothers from postpartum hemorrhage. <p data-bbox="228 633 429 656">C. Benefits to Fathers</p> <ul style="list-style-type: none"> <li data-bbox="294 696 749 768">➤ Provides fathers who are suffering from chronic illnesses (i.e., Diabetes, Hypertension) enough time for treatment and recovery from those illnesses. <li data-bbox="294 786 722 857">➤ Lightens his burdens and responsibilities in supporting his family since he will only be providing for the number of children he can afford to support. <li data-bbox="294 875 758 920">➤ Enables him to give his children a good home, good education, and a better future. <li data-bbox="294 943 636 965">➤ Gives time for his own personal achievement. <li data-bbox="294 987 727 1032">➤ Enables him to have time and opportunity to relate with his wife and play with his children. <li data-bbox="294 1055 727 1099">➤ Affords extra resources and allows enough time to actively participate in community programs and projects. 	



NARRATIVE

MODULE 1: THE PHILIPPINE FAMILY PLANNING PROGRAM SESSION 4: HEALTH BENEFITS OF FAMILY PLANNING

A. Benefits to Mothers

- Significant reduction in maternal mortality and morbidity
 - Using an effective FP method reduces maternal deaths by preventing high risk pregnancies among women who are too young, too old, or too ill to bear children safely.
 - Maternal deaths can be prevented if unwanted pregnancies are avoided and pregnancies are spaced by at least three years.
 - FP prevents closely spaced pregnancies that leads to and worsen conditions such as anemia and maternal malnutrition.

- Non-contraceptive health benefits of hormonal contraceptives
 - Studies show that combined oral contraceptives provide significant non-contraceptive health benefits. They are known to prevent/reduce the incidence of the following diseases and conditions:
 - a. Ectopic pregnancy
 - b. Ovarian cancer
 - c. Endometrial cancer
 - d. Ovarian cysts
 - e. Benign breast disease
 - f. Excessive menstrual bleeding and associated anemia
 - g. Menstrual cramping, pain, and discomfort
 - All FP methods help women with HIV to avoid pregnancy, thus avoid bearing HIV-infected children.

B. Benefits to Infants and Children

- Reduction in infant and child mortality and morbidity
 - Globally, an estimated 14.5 million infants and children under age five die every year, mainly from respiratory and diarrheal diseases complicated by malnutrition.
 - Recent studies indicate that the lowest risks for fetal death, pre-term delivery, being undersized for gestational age, neonatal death, and low birth weight occur when births are spaced from three to five years (NDHS, 2003).
 - Properly spaced children of at least three years will be given the love, attention, care, and time from mothers and fathers attending to their growth and development.
 - Fewer children in the family will provide more opportunities for adequate food, clothing, good education, and good health for the children.
 - Breastfeeding can protect infants against diarrheal and other infectious disease and also protects mothers from postpartum hemorrhage.

C. Benefits to Fathers

- Provides fathers who are suffering from chronic illnesses (i.e., Diabetes, Hypertension) enough time for treatment and recovery from those illnesses.
- Lightens his burdens and responsibilities in supporting his family since he will only be providing few children he can afford to support.
- Enables him to give his children a good home, good education, and a better future.
- Gives time for his own personal achievement.
- Enables him to have time and opportunity to relate with his wife and play with his children.
- Affords him extra resources and enough time to actively participate in community programs and projects.



MODULE 10



Counseling for Family Planning

Session 1: Values Clarification

Session 2: Informed Choice and Voluntarism

Session 3: Types of Communication in FP/RH

Session 4: Effective Communication Skills

Session 5: Steps in Counseling using the G-A-T-H-E-R Approach

MODULE 10: COUNSELING FOR FAMILY PLANNING



MODULE OVERVIEW

Counseling plays an important role in providing quality family planning and reproductive health services. Through counseling, providers help clients make and carry out their own decisions or choices about reproductive health and family planning.

Good counseling leads to greater client satisfaction. A satisfied client promotes family planning and clinic services, returns when s/he needs to, and continues to use a chosen method. S/he also continues to patronize other services of the service center.

This module develops the service provider's skills on counseling. As such, it will strengthen the provider's understanding of values, client's rights, and skills on interpersonal communication as basic capabilities for counseling. The G-A-T-H-E-R approach is an efficient process for FP counseling as it consider clients' rights to well-informed, voluntary decision-making on FP. Counseling skills using the G-A-T-H-E-R approach will be developed as there will be opportunities to practice these skills.



MODULE OBJECTIVE

The objective of this module is to develop the participants' skills on counseling family planning clients.



MODULE SESSIONS

The module contains the following sessions:

Session 1	Values Clarification
Session 2	Informed Choice and Voluntarism
Session 3	Types of Communication in FP/RH
Session 4	Effective Communication Skills
Session 5	Steps in Counseling using the G-A-T-H-E-R Approach

Topics/Contents

Teaching-Learning Process



MODULE 10



COUNSELING FOR FAMILY PLANNING

Greet the participants.

Tell participants that:

- Counseling plays an important role in providing quality family planning and reproductive health services.
- Through counseling, providers help clients make and carry out their own decisions about reproductive health and family planning.
- Good counseling leads to greater client satisfaction, which consequently results in the promotion not only of family planning but also clinic services.

MODULE OVERVIEW

OVERVIEW

- Develops the service provider's skills on family planning counseling using the **G-A-T-H-E-R** approach.
- Strengthens the provider's understanding of values, clients' rights, and skills on interpersonal communication as basic capabilities for counseling.
- Enables the service provider to render quality FP/RH services through effective counseling brought about by the knowledge, attitude, and skills acquired from this learning module.

Present an overview of the module as written on the slide.

MODULE OBJECTIVE

OBJECTIVE

- To develop the participants' skills on counseling family planning clients.

State the module objective and sessions as written on the slide.

MODULE SESSIONS

SESSIONS

- Session 1** - Values Clarification
- Session 2** - Informed Choice and Voluntarism
- Session 3** - Types of Communication in FP/RH
- Session 4** - Effective Communication Skills
- Session 5** - The G-A-T-H-E-R Approach to FP Counseling

VALUES CLARIFICATION



LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Define the terms “values” and “attitudes”.
2. Examine participants’ own values.
3. Explain how values and attitudes influence the individual’s decision.
4. State the factors that affect clients’ decision making.



METHODOLOGY

Illustrated Lecture-Discussion
Exercise





TIME ALLOTMENT

30 minutes



ADVANCE PREPARATION OF MATERIALS

- Powerpoint presentation
- Laptop and LCD
- 2 meta cards with “AGREE” and “DISAGREE” written on each of them
- Tapes
- Whiteboard and appropriate marker

Topics/Contents	Teaching-Learning Process
 <h2 data-bbox="341 271 561 315">SESSION 1</h2>  <h3 data-bbox="341 369 581 443">VALUES CLARIFICATION</h3>	
<p data-bbox="169 571 283 595">Introduction</p> <p data-bbox="169 663 409 689">Learning Objectives</p> <ul data-bbox="208 763 696 857" style="list-style-type: none"> • Define the terms “values” and “attitudes”. • Examine participants’ own values. • Explain how values and attitudes influence the individual’s decision. • State the factors that affect clients’ decision making. 	<p data-bbox="790 584 1361 651">Introduce the session by stating the objectives as presented on the slide.</p>
<p data-bbox="169 969 346 994">Definition of Terms</p> <p data-bbox="185 1019 252 1043">Values</p> <ul data-bbox="208 1111 639 1272" style="list-style-type: none"> • Deeply held belief or idea that is treasured by the individual • Influenced by religion, educational, and cultural factors • Also influenced by personal experiences Examples: <ul style="list-style-type: none"> • Honesty • Integrity • Quality services 	<p data-bbox="784 987 1329 1055">Ask participants on their thoughts on what “values” are.</p> <p data-bbox="784 1066 1260 1093">Define values as written on the slide.</p> <p data-bbox="784 1104 1354 1171">Ask participants for examples of values before showing the examples part.</p>
<p data-bbox="185 1361 260 1386">Attitude</p> <ul data-bbox="208 1453 600 1597" style="list-style-type: none"> • Mental state and disposition that drive an individual to behave in certain ways • Involves an interplay of feelings, values, and beliefs Examples: <ul style="list-style-type: none"> • To do one’s best to be recognized • To do what is right always 	<p data-bbox="784 1357 1282 1384">Ask participants their idea of “attitude”.</p> <p data-bbox="784 1435 1292 1462">Define “attitude” as written on the slide.</p> <p data-bbox="784 1514 1295 1541">Ask participants’ examples of “attitude”.</p>
<p data-bbox="169 1686 443 1711">Examining One’s Own Values</p> <p data-bbox="169 1731 252 1756">Exercise</p> <p data-bbox="307 1854 573 1890">Agree or Disagree</p>	<p data-bbox="784 1709 1350 1816">Tell participants that after understanding the meaning of “values” and “attitudes”, there will be an exercise in examining one’s own values.</p> <p data-bbox="784 1861 1350 1968">Post the word “agree” at one side of the room and the word “disagree” at the opposite side of the room.</p> <p data-bbox="784 2013 1350 2040">Tell participants that you will read statements.</p>

Topics/Contents	Teaching-Learning Process
<p>Statements</p> <p>Family planning should be available for married people only.</p> <p>Use of a FP method is advisable only for women who have given birth.</p> <p>A woman can use a FP method of her choice even without the consent of her husband.</p> <p>A devout Catholic should only use a natural family planning method.</p> <p>The service provider is the best person to decide which method a woman should use.</p> <p>Statements</p> <p>Family planning methods should be made available to teenagers.</p> <p>It is necessary to get the consent of the husband for tubal ligation.</p> <p>Easy access to FP methods encourages promiscuity.</p> <p>Parents should not allow their daughters as much sexual freedom as they allow their sons.</p> <p>A child should have sex education in school.</p>	<p>Each one will go to the sign (agree or disagree) that best represents their feeling about the statement.</p> <p>Ask one or two participants from the group why she/he agrees or disagrees with the statement.</p> <p>Emphasize that there are no wrong answers to the statements.</p> <p>Flash the statements on the slide one at a time.</p>
<p>PROCESSING</p> <p>Insights</p> <ul style="list-style-type: none"> • No two people have the same values and attitudes. • People have different views because of their different experiences and values. • We, as service providers, have our own values that may be different from others. • Not accepting other's values leads to conflict and argument. • The counselor should not impose her/his own values to their clients. • Counselors must learn to respect others' values and beliefs especially when clients come to them for counseling. 	<p>Process the exercise by asking the following questions:</p> <ol style="list-style-type: none"> 1. What did you observe during the exercise? 2. Did everybody have the same responses to the statements? 3. How did people respond to each of the statements? 4. How did you feel about other people's responses specially when their views were contrary to yours? Why? <p>Possible answers: defensive, judgmental, ambivalent, afraid to express opinions, angry.</p> <p>Write the responses on the whiteboard.</p> <p>Summarize the exercise by recapitulating the insights of participants. The following insights, as written on the slide, may be added to those of the participants.</p>

Topics/Contents	Teaching-Learning Process
<p>FACTORS AFFECTING DECISION-MAKING</p>	<p>Ask the participants:</p> <ul style="list-style-type: none"> • What factors affect a client’s decision on whether to practice FP and what FP method to use. <p>Write responses on the board.</p>
<p>Insights</p> <ul style="list-style-type: none"> • Age • Number of children • Health status • Economic status • Religious beliefs • Relationship with spouse • Marital status • Word of mouth • Culture • Misconceptions • Politics • Significant personal experience 	<p>Present the factors on the slide and add responses of participants that are not on the list.</p> <p>Emphasize that there are a variety of factors that can affect the decision-making process.</p>
<p>CONCLUSION</p> <p>Learning Insights</p> <p>Learning Insights</p> <ul style="list-style-type: none"> • No two people have the same values and attitudes. • Understanding our own values can help us better understand our clients. • Reflecting our own values can help us set a limit so we do not influence our client’s decision by sharing our views. • Everyone has the right to her/his own values and attitudes, but these should not interfere with the way a person performs her/his responsibility as a counselor. • There are many factors that can influence client’s decision making process and these should be respected by the counselor. 	<p>Conclude the session by summarizing the learning insights as written on the slide.</p> <p>Introduce the next session by saying that:</p> <ul style="list-style-type: none"> • There are ways to ensure that the client’s values and decisions are maintained and these are by maintaining his or her rights.



NARRATIVE

MODULE 10: COUNSELING FOR FAMILY PLANNING SESSION 1: VALUES CLARIFICATION

DEFINITION OF TERMS

A **value** is a belief, idea, principle, or standard that is important and treasured by an individual. Values can be influenced by various factors (i.e., education, culture, religion, and personal experiences). It influences an individual's attitude and behavior. We acquire and change our values based on the experiences we have. Therefore, we acquire new values and may change old ones as influenced by the people we interact with, our education, age, marital status, health, and economic status, number of children, and sometimes by politics.

A value is strengthened by repetition and by adoption in one's lifestyle. Values enhance our personal growth and development, especially when affirmed by other people. Examples of values are honesty, integrity, honor, higher education, responsible parenthood.

People's diverse experiences lead them to different conclusions and decisions. The counselor must first be aware of her/his values and understand that others have a right to their own values which they also treasure. As such, the counselor realizes that she/he should not impose her/his own values on the client nor should these interfere with her/his responsibilities as a counselor.

Attitude is the observable, outward expression of one's belief and value.

Examples of attitudes are:

- Doing one's best to be recognized
- Doing the right thing at all times (for integrity)
- Caring for her/his children (for responsible parenting)

How client's values affect decision-making

Values are important and may be considered an individual's treasured possession. They are the principles that people use as a guide in coping with stress in their everyday lives.

Different people may have similar or different values, depending on their experience, education, environment, social exposure, religion, and culture. Values may change through the years but adequate information, exposure, experience, and education may help other people develop desirable values. So that if an individual is given adequate and appropriate information about certain conditions, situations, or practices, she or he will be guided through modeling to adopt new values. This can be true in making decisions regarding family planning.

The following are some common values that a family planning counselor may encounter:

- Rural mothers still prefer bigger families, while urban women are conditioned to have smaller families.
- Value for information and acceptance is seen when clients come to the clinic for FP services after learning of the availability of these services through mass media.
- Since clients highly value health and wellness, adverse rumors and misinformation are feared by most clients.
- The value for quality services translates to better acceptance of FP services.

- Health workers advice plays a vital role in client choices. Health workers are typically their first contact. Majority of clients' decisions are affected to a great extent when health workers give accurate information about family planning. Clients are likely to make voluntary decisions.
- Accessibility of the service center and the availability of a contraceptive method in a nearby clinic make clients more likely to avail themselves of family planning services.

Responsibility of the counselor in client's decision-making

The counselor should examine her/his values on family planning which she/he wants others to respect. The counselor should understand that clients have their own values, which may be contrary to her/his values and like her/him, clients want these to be respected.

It is the counselor's responsibility to understand the client's values and help the client make choices suitable to the client's values and priorities.

Factors influencing FP decision-making

These are some of the factors that influence clients in their FP decision-making:

- Age
- Marital status
- Number of children
- Health status
- Economic status
- Religious beliefs
- Relationship with spouse
- Fear of side effects

Key Learning Points

- No two people have the same values and attitudes.
- Understanding our own values can help us better understand and respect the values of the client.
- Reflecting on our own values can help us set limits so we do not influence our clients by sharing and imposing our own personal views.
- There are many factors that influence client's decisions. We must remember that these are the same factors that affect OUR decision-making but influence us in different ways.

SESSION 2

INFORMED CHOICE AND VOLUNTARISM



LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Describe the basic rights of the client.
2. Define quality care in health care services.
3. Discuss informed choice in terms of its definition, components, and importance.
4. Define voluntarism.
5. Discuss the principles of informed choice and voluntarism.
6. State the importance of informed choice and voluntarism.
7. Discuss informed consent as to its definition, elements, and importance.



METHODOLOGY

Lecture-Discussion
Brainstorming
Exercise





TIME ALLOTMENT

1 hour 30 minutes



ADVANCE PREPARATION OF MATERIALS

- Powerpoint presentation of Module 10, Session 2
- Computer and LCD
- Meta cards with clients' rights written on each
- Two meta cards with the following:
 - * Information, Training and Development
 - * Supplies, Equipment, and Infrastructure
- Copies of the "Informed Consent" form
- Tapes
- Whiteboard and appropriate marker

Topics/Contents	Teaching-Learning Process
 <h2 data-bbox="341 322 566 365">SESSION 2</h2>  <h3 data-bbox="341 421 680 490">INFORMED CHOICE AND VOLUNTARISM</h3>	<p data-bbox="790 219 1266 253">Introduce the session by saying that:</p> <ul data-bbox="790 295 1329 589" style="list-style-type: none"> • Making voluntary decisions based on correct, complete information on FP is a basic right of clients. • This session will make you aware of the basic rights of clients specifically on informed choice and voluntarism as a basis for providing quality FP services.
<p data-bbox="156 629 432 651">LEARNING OBJECTIVES</p> <p data-bbox="156 703 412 730">Learning Objectives</p> <ul data-bbox="169 792 738 958" style="list-style-type: none"> • Describe the basic rights of the client. • Define quality care in health care services. • Discuss informed choice in terms of its definition, components, and importance. • Define voluntarism. • Discuss the principles of informed choice and voluntarism. • State the importance of informed choice and voluntarism. • Discuss informed consent specifically its definition, elements, and importance. 	<p data-bbox="790 640 1345 674">State the objectives as written on the slide.</p>
<p data-bbox="169 1025 432 1048">BASIC RIGHTS OF CLIENTS</p> <p data-bbox="185 1079 398 1106">Basic Rights of Clients</p> <ul data-bbox="373 1144 558 1379" style="list-style-type: none"> • INFORMATION • ACCESS • CHOICE • SAFETY • PRIVACY • CONFIDENTIALITY • DIGNITY • COMFORT • CONTINUITY OF CARE • FREE EXPRESSION 	<p data-bbox="790 1050 1339 1155">Elicit from participants what they think the basic rights of clients are. Write responses on the board.</p> <p data-bbox="790 1200 1329 1270">Show slide of clients rights to supplement the participants' answers.</p>
<p data-bbox="185 1476 398 1503">Basic Rights of Clients</p> <ul data-bbox="169 1547 722 1713" style="list-style-type: none"> • Information. To learn about the benefits and availability of family planning • Access. To obtain services regardless of sex, creed, color, marital status, or location • Choice. To decide freely whether or not to practice family planning and which method to use • Safety. To be able to practice safe and effective family planning • Privacy. To have a private environment during counseling and services <p data-bbox="185 1778 398 1805">Basic Rights of Clients</p> <ul data-bbox="169 1823 733 1989" style="list-style-type: none"> • Confidentiality. To be assured that personal information will remain confidential • Dignity. To be treated with courtesy, consideration, and attentiveness • Comfort. To feel comfortable when receiving services • Continuity of Care. To receive FP services and supplies as long as needed • Free expression. To express views on the services offered 	<p data-bbox="790 1462 1345 1568">As you go through each of the clients' rights, ask participants (at random) their understanding of each basic rights.</p>

Topics/Contents	Teaching-Learning Process
DEFINING QUALITY IN HEALTH SERVICES	
Quality in Health Services	
<p style="text-align: center;">Exercise</p>	<p>Tell the participants that different people have their own definition of “quality”. Then ask, “what does quality mean to you?” Do an exercise to expound the meaning of quality.</p> <p>Ask participants:</p> <ul style="list-style-type: none"> • Write the answers to the following questions on separate meta cards. • Imagine you are clients. <ul style="list-style-type: none"> - What would you expect of a quality service? What would you like to see? - What would you like to know and learn? - What would you like your health facility to have? What services should it offer? - How would you want your mother, sister, spouse, or a child be treated if they come to this facility for health care? - How would you describe a model facility? <p>Post on one side of a wall meta cards with clients’ rights written on it as headings and on another side of the wall the meta cards with the following:</p> <ul style="list-style-type: none"> • Information, Training and Development (as one meta card) • Supplies, Equipment, Infrastructure (as the other meta card) <p>Ask participants to post their meta cards under the heading of the basic right which they think is appropriate for each of their meta cards.</p> <p>Review the meta cards under each heading. Get the consensus and agreement of participants.</p> <ul style="list-style-type: none"> • What do you, as staff of a facility, need in order to be able to deliver quality services?

Topics/Contents	Teaching-Learning Process
	<p>Again, review responses on the meta cards and categorize into the following headings as to what they think is needed in what is written on each of the meta cards.</p> <ul style="list-style-type: none"> ✓ “Information, Training and Development” ✓ “Supplies, Equipment, and Infrastructure”
<p>INSIGHTS</p> <p>Insights</p> <ul style="list-style-type: none"> • Quality service means ensuring that clients' rights are upheld during the provision of these services. • In order to deliver quality service, there are requirements that need to be complied with. 	<p>Conclude the exercise by providing some insights as written on the slide.</p> <p>Acknowledge the participants' contribution in defining quality of care by saying that, their definition of quality closely matches with definition of quality health care services.</p>
<p>Informed Choice Definition</p> <p>Informed Choice</p> <ul style="list-style-type: none"> • Involves effective access to information on reproductive choices and counseling services to help clients choose and use appropriate FP methods as well as health care facilities and supplies. • Requires full information about the risks and benefits of the methods available. • Refers to making a decision without coercion, undue influence, or fraud. • Helps couples choose the FP method deemed most suitable to them. 	<p>Draw from participants their ideas on “informed choice”.</p> <p>Summarize their responses by stating what informed choice is as presented on the slide.</p>
<p>Components</p> <p>Components of Informed Consent</p> <ul style="list-style-type: none"> • Provision of information to client on reproductive choices, including counseling on pregnancy, breastfeeding, and infertility • Provision of appropriate and balanced information about the different FP methods • Provision of comprehensive information on the correct usage of the chosen method • Provision of counseling services to ensure comprehension of the information that could help the client make a sound decision • An effort to ensure that various methods are available to the user either through the service provider or through referral to another facility 	<p>Expound on the components of informed consent as presented on the slide.</p>
<p>Importance</p> <p>Importance of informed Choice</p> <ul style="list-style-type: none"> • Ensures that clients receive information needed to make an informed decision • Ensures that the clients make decisions based on their own free will • Ensures client's satisfaction and continuity of usage • Reduces incidence of regrets • Serves as evidence of client's request for services 	<p>Ask participants at random to express their ideas on the importance of informed choice.</p> <p>After a number of participants have given their ideas, flash the slide that shows the importance of informed choice and add the ideas of participants.</p>

Topics/Contents	Teaching-Learning Process
<p>Voluntarism</p> <p>Voluntarism</p> <p>Decision-making on choice of FP method is based on free choice and not obtained through any special inducements or forms of coercion.</p>	<p>Tell participants the definition of voluntarism as presented on the slide.</p>
<p>The Principle of Informed Choice and Voluntarism</p> <p>The Principle of Informed Choice and Voluntarism</p> <ul style="list-style-type: none"> • Broad range of modern FP methods should be made available at the clinic with referral system for methods not available at the clinic; • Service providers and <i>Barangay</i> Health Workers (BHWs) should not be subjected to quotas or targets; • There will be no payment of incentives, bribes, gratuities or financial rewards to (1) any client for becoming an FP acceptor, or (2) service providers for achieving a quota or target. 	<p>Tell participants:</p> <ul style="list-style-type: none"> • the principle of informed consent and voluntarism as written on the slide. • that FP programs must be compliant with these principles to ensure informed choice and voluntarism.
<p>EXERCISE</p> <p>Answer YES if there is ICV compliance; NO if there is no ICV compliance.</p> <ul style="list-style-type: none"> • A community health worker is required to bring three BTL and five IUD acceptors to the clinic each month for a good performance evaluation. • An LGU provides a week's worth of rice to new FP acceptors. • A community-based food program requires participants to use a method of FP in order to receive food. • There are no educational posters on the walls, no brochures available, and no health talks given. • Telling a 27-year old mother that she cannot undergo BTL because is she too young. 	<p>Check the participants' understanding of the ICV principle by asking them to respond to the following situations:</p> <p>Ask participants to answer "YES" - if the situation is ICV compliant; "NO" - if not ICV compliant.</p> <ul style="list-style-type: none"> • A community health worker is required to bring three BTL and five IUD acceptors to the clinic each month for a good performance evaluation. (No) • An LGU provides a week's worth of rice to new FP acceptors. (No) • A community-based food program requires participants to use a method of FP in order to receive food. (No) • There are no educational posters on the walls, no brochures available, and no health talks given. (No) • Telling a 27-year old mother that she cannot undergo BTL because is she too young. (No)

Topics/Contents	Teaching-Learning Process
<p>Importance of Informed Choice and Voluntarism</p> <p>Importance of ICV</p> <p>Informed choice and voluntary decisions leads to:</p> <ul style="list-style-type: none"> • Better method use • Client compliance • Continued method use • Client's satisfaction • Access to a range of contraceptives which leads to high rate of contraceptive use 	<p>Ask participants for their ideas on the importance of Informed Choice and Voluntarism.</p>
<p>Informed Consent Definition</p> <p>Informed Consent</p> <ul style="list-style-type: none"> • Informed Consent is the written voluntary decision of a client to accept a particular FP method or to undergo a sterilization procedure. • Informed Consent is the documentation of the client's voluntary decision to practice or accept family planning specifically the surgical method of contraception. • The client is asked to sign an Informed Consent form prior to performance of the surgical procedure. 	<p>Define Informed Consent as written on the slide.</p>
<p>INFORMED CONSENT FORM</p>	<p>Give copies of the “Informed Consent” form to participants.</p>
<p>Elements of Informed Consent</p> <p>Elements of Informed Consent</p> <ol style="list-style-type: none"> 1. Availability of reversible contraceptive methods if they dislike surgical or permanent method 2. It is a surgical procedure 3. There are risks and benefits of sterilization 4. Ending of fertility 5. Procedure is permanent 6. Not a protection against STI 7. Have an option to decide against the procedure at anytime 	<p>Tell participants the elements of informed consent as written on the slide.</p> <p>Participants point out the element on the Informed Consent form as it is explained.</p> <p>Point out and emphasize that the signature of the spouse is not a requirement but he/she can sign as a witness.</p>

Topics/Contents	Teaching-Learning Process
<p data-bbox="213 203 514 230">Importance of Informed Consent</p> <p data-bbox="228 259 529 286">Importance of Informed Consent</p> <ul data-bbox="213 342 769 584" style="list-style-type: none"> • Ensures that the client receive adequate information needed to help her/him make a sound decision regarding fertility • Ensures that the client make a voluntary decision • Impresses upon the client that he/she is making an important and irrevocable decision • Diminishes regret after the surgical procedure, thus enhancing acceptability and prestige of the FP program • Helps to assure satisfied and well informed clients • Serves as evidence of the client's request and can provide protection against charges of induced or uninformed sterilization 	<p data-bbox="832 226 1357 297">Ask participants on their ideas about the importance of informed consent.</p> <p data-bbox="832 338 1381 445">Tell them some of the examples of the importance of informed consent as written on the slide</p>
<p data-bbox="213 674 315 701">SUMMARY</p> <ul data-bbox="205 748 766 844" style="list-style-type: none"> • Quality health services uphold client's rights. • Ensuring informed choice and voluntarism upholds client's rights. • Accomplishing the informed consent form specifically for surgical FP methods protects the service provider from complaints of client dissatisfaction. 	<p data-bbox="832 696 1378 768">Summarize the session by stating the key points as written on the slide.</p> <p data-bbox="832 808 1392 954">Encourage questions from participants. Flash the session objectives and ask participants if there are items that were not attained.</p>



NARRATIVE

MODULE 10: COUNSELING FOR FAMILY PLANNING SESSION 2: INFORMED CHOICE AND VOLUNTARISM

Rights of the Client

The goal of health service delivery is quality of care. Since the practice of Family Planning has been recognized as the right of individuals and couples, delivery of quality services ensure the protection and upholding of these rights. These so called “rights” that are embodied in international covenants and the Philippine Constitution include the clients right to:

- **Information.** Clients have the right to accurate, appropriate, understandable, and clear information related to reproductive health and sexuality, and to health overall. Informational materials for clients (e.g. flyers on FP methods, all-method posters) should be made available in all parts of the health care facility.
- **Access to service.** Clients have the right to services that are affordable, are available at convenient times and places, are fully accessible with no physical barriers, and have no inappropriate eligibility requirements or social barriers, including discrimination based on sex, age, marital status, fertility, nationality or ethnicity, social class, religion, and sexual orientation.
- **Informed Choice.** Is the right of individuals or couples to make a voluntary, well-considered decision that is based on options, information, and understanding. It is the responsibility of the service provider to confirm that a client has made an informed choice or to help the client reach an informed choice.
- **Safe services.** Clients have the right to safe services that require skilled providers, attention to infection prevention, and appropriate and effective medical practices. Safe services also mean proper use of service-delivery guidelines, quality assurance mechanism within the facility, counseling and instructions for clients, and recognition and management of complications related to medical practice.
- **Privacy.** Clients have the right to a private environment during services and counseling. This means that a facility must have an area where clients cannot be seen or heard during counseling, physical examination, and clinical procedures.
- **Confidentiality.** Clients have the right to be assured that personal information shall not be disclosed. This includes maintaining secrecy about the client’s history, results of examination, and counseling and record keeping.
- **Dignity.** Clients have the right to be treated with courtesy, respect, and consideration. The service provider gives utmost attention to the client’s need.
- **Comfort.** Clients have the right to be at ease and relaxed while in a health facility for services. Service providers need to ensure that clients are as comfortable as possible during the procedures.
- **Free Expression.** Clients have the right to express their views on the services being offered. Clients should be encouraged to express their views freely, even when their views differ from those of the service providers.
- **Continuity of Care.** All clients have the right to continuity of services, supplies, referrals, and follow-up necessary to maintain their health. Clients have the right to receive services and supplies for as long as they need it. This can either be through the service provider or by referral.

The needs of the health care staff

The health care personnel desire to perform their duties well. However, if they lack administrative support and critical resources, they will not be able to deliver the high-quality service to which clients are entitled.

Health care staff need:

- **Information, training, and development** – Health care staff need knowledge, skills, and on-going training, and exposure to professional development opportunities to remain up-to-date in their field and to continuously improve the quality of services they deliver.
- **Supplies, equipment, and infrastructure** – Health care staff need reliable, sufficient inventories of supplies, instruments, and working equipment, as well as the infrastructure necessary to ensure the uninterrupted delivery of high quality services.

Quality of Care

The provision of quality Family Planning services is the main goal of the Philippine Family Planning Program. In support of this, the Department of Health has issued Administrative Order 0005 series of 2011. This quality of care is important to all service providers and service facilities, whether public or private. But how do you know if the service you deliver is of quality?

One parameter of quality service is ensuring that clients' rights are protected and upheld during the provision of services. Since Family Planning is considered as one of the rights of clients, it is the responsibility of the service provider to uphold this right. This concept is ensured during the counseling process, where the counselor uses her/his knowledge and skills in providing accurate, adequate, and appropriate information to help clients make a well-informed decision. The whole process ensures that the clients' rights are not violated. Thus, guaranteeing the delivery of quality service, which is vital in any health service facility.

The other aspect of quality service is the ability of the service provider to deliver and provide FP services. As such, the delivery of quality service is influenced by a number of factors, which the service provider is exposed to. This includes the condition of her/his work environment, the information and training she/he receives, and the equipment and supplies available to her/him.

Informed Choice

Informed choice requires full information about the risks and benefits of the methods available. Informed choice involves effective access to information on reproductive choices and to the necessary counseling, services, and supplies that help individuals choose and use appropriate family planning methods.

Informed choice helps couples make various reproductive choices, including the possibility of choosing pregnancy.

Informed choice refers to making a decision regarding a particular method or procedure without coercion, undue influence or fraud.

Five Major Components of Informed Choice

- Provision of information to couples and individuals on reproductive choices, including counseling concerning pregnancy, breastfeeding, and infertility.
- Provision of counseling to ensure comprehension of information and assist in decision-making.

- Provision of appropriate information on a range of family planning methods, including the advantages/disadvantages on accessing services and supplies.
- Provision of comprehensive information on the correct use of the client’s chosen method.
- Efforts to ensure that a range of methods is available to the user either through the service provider or through referral to another agency.

Informed choice increases client satisfaction in using a method, decreasing reservations or fears of possible side effects, and ensures continuous use of the method.

Counseling assures that each client is guided to make a well-informed and voluntary decision that is best suited to her or his individual needs.

Voluntarism

Voluntarism is decision-making on the choice of a family planning method based on free choice and not obtained by any inducements or forms of coercion.

Compliance to Informed Choice and Voluntary Decision Principle

The following explains the principle of informed choice and voluntary decision for better understanding and compliance:

Key Points of the Principle	Clarification/Interpretation	Illustrative Examples of non-compliance/ vulnerability
Service providers and <i>Barangay</i> Health Workers (BHWs) should not be subject to quotas and targets.	A quota or target is a predetermined number of births, FP acceptors, or acceptors of a particular method that a service provider or a BHW is assigned or required to achieve. Indicators for planning, budgeting, and reporting are exempted.	Dr. Achiever decides that the best way to motivate his staff to increase contraceptive prevalence rate in the province is to assign numerical goals for FP new acceptors.
There will be no payment of incentives, bribes, gratuities or financial rewards to (1) any individual in exchange for becoming an FP acceptor, or (2) personnel for achieving a quota or target.	The restriction on provider payment is based on achieving a quota or target expressed as a “predetermined number” (or incentives provided to acceptors in exchange for accepting a particular method). Incentives, bribes, gratuities, financial rewards should not be a form of inducement to accept a particular method.	Local Government Unit A provides a sack of rice and cash to every individual who accepts a permanent family planning method.
No person shall be denied any right or benefit based on their decision not to accept FP.	Health facilities shall not deny any right or benefit, including the access to participate in any program of general welfare or the right of access to health	Local Government Unit B denies access to supplemental food programs for indigents who are not FP acceptors.

Key Points of the Principle	Clarification/Interpretation	Illustrative Examples of non-compliance/ vulnerability
	<p>care, as a consequence of the individual's decision not to accept family planning services.</p>	
<p>Comprehensible information about benefits and risks of the chosen method, including conditions that might render the method inadvisable (i.e., contraindications) plus side effects shall be provided.</p> <p>This requirement may be satisfied through counseling, brochures, posters, or package inserts.</p>	<p>Provide comprehensive information on the range of methods and services or information in order for a particular client to make an informed decision on what method to use.</p>	<p>In a busy health center with one provider, FP clients are routinely given pills without any explanation about common side effects or warning signs of complications. Moreover, clients are not offered access to information on a full range of family planning choices.</p>
<p>Broad range of family planning services/methods should be available and a referral system installed for methods/services not offered in the facility.</p>	<p>During counseling, potential FP clients should be made aware of all the modern FP methods. If some methods are not available like IUD and BTL which requires certain level of skills from providers, the provider should be able to refer the clients to a facility where the services are available.</p>	<p>Maria went to Clinic A for FP counseling. Lorna, the midwife of Clinic A, told Maria that they offer IUD insertion, which she can readily avail of. When she agreed, the midwife inserted the IUD, without discussing the health benefits of using the method, conditions that would make the method inadvisable, and known side effects of the method.</p>
<p>Abortion and/or lobbying for abortion as a method of family planning is not allowed.</p>	<p>Practice of abortion is not legal in the country and is in no way accepted as a family planning method. This is stipulated in Administrative Order 50-A: National FP Policy, under the guiding principle in the delivery of FP services. Program beneficiaries are not allowed to join advocacy activities lobbying for abortion as a FP method.</p>	<p>Alberta missed her menstruation last month. She asked her friend, Dr. A, if she can have an abortion. Dr. A discreetly performed dilatation and curettage. This was later on discovered because of complications.</p>

Key Points of the Principle	Clarification/Interpretation	Illustrative Examples of non-compliance/vulnerability
<p>Voluntary Surgical Contraception (VSC) as a method of family planning should be provided out of the acceptor's own decision based on a broad range of information without any inducement or coercion. Informed consent forms should be explained and signed by the acceptor prior to the performance of the procedure.</p>	<p>Service providers should ensure that informed consent have been discussed and secured from every VSC acceptors prior to the performance of the procedure. The six elements should be explained to the clients.</p>	<p>A woman, who had a baby two months earlier, comes into a health clinic for VSC. Prior to the procedure, the woman was not informed on the risks and benefits of VSC, the availability of alternative family planning options, the purpose of the operation and irreversibility, and the option to withdraw consent at any time prior to operation. The woman also did not sign an informed consent form for the procedure.</p>
<p>Family Planning IEC materials particularly wall chart on FP methods should be available at the facility.</p>	<p>The ICV wall charts which contain all the different modern FP methods on their mechanism of action, advantages and disadvantages, and possible side effects should be prominently displayed in all clinics that provide FP services to enable clients to make an informed choice and voluntary decision-making. The wall charts are available in local languages.</p>	<p>Clinic A was one of the clinics provided with FP IEC materials together with an ICV wall chart, which contains a list of all the FP methods. The Mayor of Municipality Z, however, prevents the service providers to place any materials in the walls of the rural health unit.</p>

Informed Consent

Informed consent is the written voluntary decision of a client to accept a particular FP method or to undergo a sterilization procedure. It is important that the service provider asks the client to sign in the appropriate (“Acknowledgement”) part of the FP Form 1 before client leaves the clinic to attest to informed choice.

For surgical sterilization procedures (i.e., BTL and vasectomy), the client is asked to sign an informed consent form prior to surgery. Below is the Department of Health “Informed Consent Form”. This has been translated in the main dialects of the Philippines to ensure that clients understand its provisions. Take note that spousal consent is not necessary as signature of the spouse is not included in this form. However, the spouse may sign as a witness.

Importance of Informed Consent

- a. Among clients who prefer temporary or spacing methods:
 - Ensures that the clients receive the information they need to make informed, well-considered decision regarding fertility.
 - Ensures that the client makes the decision on their own free will.
 - Helps to assure satisfied and well-informed clients.
 - Reduces the incidence of regrets, thus enhancing the program’s acceptability and prestige.
- b. Among clients who have decided to undergo surgical contraception:
 - Diminishes regret after the surgical procedure.
 - Impresses upon clients that they are making an important and irrevocable decision.
 - Serves as evidence of the client’s request and protects against charges of induced or uninformed sterilization.

DEPARTMENT OF HEALTH

INFORMED CONSENT FORM FOR
VOLUNTARY SURGICAL CONTRACEPTION CLIENTS

I, _____ the undersigned, request that a sterilization via
(client's name)
_____ be performed on my person.
(specify the procedure)

I make this request of my own free will without having been forced, pressured, or given any special inducement. I understand the following:

1. There are temporary methods of contraception available to me and my partner.
2. The procedure to be performed on me is a surgical procedure, the details of which have been explained to me.
3. This surgical procedure involves risks, in addition to benefits, both of which have been explained to me.
4. The procedure should be considered permanent. However, no surgical procedure can be guaranteed to work 100% on all people. There is a small failure rate. If the procedure is successful, I will be unable to have any more children.
5. This surgical procedure will not protect me and my partner from sexually transmitted infections (STIs), including HIV (the virus that causes AIDS).
6. I can decide against the procedure at any time, before the operation is performed (and no medical, health or other benefits or services will be withheld from me as a result).

Signature or mark of client

Date

Signature of attending physician or delegated assistant

Date

If the client cannot read, a witness of the client's choosing, of the same sex, and speaking the same language must sign the following declaration:

I, the undersigned, attest to the fact that the client has affixed his/her thumbprint or mark in my presence.

Signature of mark of witness

Date

TYPES OF COMMUNICATION IN FP/RH



LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Define information-giving, motivation and counseling.
2. Differentiate information-giving, motivation, and counseling.
3. Explain the relationship of the three types of FP/RH communication.
4. Explain the importance of counseling.



METHODOLOGY

Illustrated Lecture-Discussion
Brainstorming
Group Work



TIME ALLOTMENT

1 Hour






ADVANCE PREPARATION OF MATERIALS

- Powerpoint presentation of Module 10, Session 3
- Computer and LCD
- Whiteboard and appropriate marker
- Markers
- Tapes
- Three Manila papers with the following grid:

Type	Goal	Content Direction	Bias	Location
Motivation or Promotion				
Information-Giving				
Counseling				

Three sets of meta cards with the following written on each one:

- Influence an individual or group to adopt a certain practice or behavior
- Provide facts
- Assist the client make a free and informed decision
- Advantages of FP and the methods
- Facts about FP and the methods
- Facts, client's needs, situation, opinion, and feelings
- Two-way
- One-way
- One-way
- Biased
- May be biased
- Not biased
- Anywhere
- Anywhere
- Private

Topics/Contents	Teaching-Learning Process
 <h2 style="text-align: center;">SESSION 3</h2> <hr/>  <h3 style="text-align: center;">TYPES OF COMMUNICATION IN FP/RH</h3>	
<p>Introduction</p> <hr/> <p> Learning Objectives</p> <ul style="list-style-type: none"> • Define information-giving, motivation, and counseling. • Differentiate information-giving, motivation, and counseling. • Explain the relationship of the three types of communication in FP/RH. • Explain the importance of counseling. 	<p>Introduce the session by stating the objectives of the session.</p>
<p>Types of Communication in FP/RH</p> <ul style="list-style-type: none"> • Information-giving • Motivation • Counseling 	<p>Tell participants the three types of communication in FP/RH as written on the slide.</p>
<p>Definition of Terms</p> <hr/> <p>1. Information-Giving</p> <ul style="list-style-type: none"> • is a way of providing people with facts about family planning methods • can be communicated one-on-one, in a group, or on a mass scale through the use of print materials and media • can either be complete or limited but always accurate and correct • can be given anywhere 	<p>Define information-giving, motivation, and counseling as written on the slide.</p>

Topics/Contents

Teaching-Learning Process

2. Motivation

- includes all efforts to encourage people to practice family planning
- may be one-on-one or may involve the media
- includes a wide range of information on FP that can attract the interest of the general public or a target audience
- emphasizes the benefits
- is usually biased with an attempt to influence an individual or group to adopt a certain practice or behavior

After defining each type of communication, ask participants to give examples for each.

3. Counseling

- is a two-way communication process between the provider and the client
- is a process wherein the provider assists the client in making a free and informed decision about her/his fertility.
- considers the client's reproductive needs, living situation, opinion, and feelings
- does not just give facts but also enables the client to apply information about family planning in their particular circumstances and make informed choices.

Differentiating the three types of FP/RH Communications

Differentiating Types of Communication in FP/RH

Type	Goal	Content Direction	Bias	Location
Motivation or Promotion				
Information-Giving				
Counseling				

Show participants the matrix on the “Types of FP Communication” in a grid as shown on the slide.


Divide participants into three groups. Each group is given a set of manila paper with the grid and meta cards with the description of the types of communication written on them.

Each group discusses and pastes on their manila paper the meta cards in appropriate boxes.

Explain each of the headings as:

- Goal: what the type of communication wishes to achieve
- Content: the message that the type of communication gives
- Direction: whether one-way or two-way communication
- Bias: whether the type of communication is biased or not
- Location: where the interaction takes place.

The group that finishes first with all boxes filled in correctly wins the exercise.

Topics/Contents	Teaching-Learning Process
<p data-bbox="216 203 691 230">Relationship of the Types of FP/RH Communication</p> <p data-bbox="228 275 707 302">Relationship of the Types of FP/RH Communication</p> 	<p data-bbox="835 210 1235 241">Show the diagram on the slide.</p> <p data-bbox="835 284 1361 353">Ask participants at random to explain the diagram.</p> <p data-bbox="835 396 1161 427">Explanation is as follows:</p> <ul data-bbox="835 472 1384 1032" style="list-style-type: none"> • Information-giving overlaps with both motivation and counseling. To accomplish both, one needs to give accurate facts. Motivation provides the advantages but not the disadvantages of a particular behavior while counseling needs to give all facts (e.g. advantages, disadvantages, possible side effects). • Motivation and counseling do not overlap because one cannot do motivation and at the same time do counseling. • It is acceptable to motivate clients to practice family planning but not to use a particular method.
<p data-bbox="216 1178 456 1205">Importance of Counseling</p> <p data-bbox="228 1240 471 1267">Importance of Counseling</p> <ul data-bbox="216 1317 774 1480" style="list-style-type: none"> • Clients tend to be more satisfied with the services provided them and the FP method they accepted • Clients tend to be more compliant in using their chosen method • Clients tend use their chosen method longer • Better tolerance of the possible side-effects of the chosen method since clients have been initially informed • Lesser worries or no worries at all, since clients are satisfied with the method 	<p data-bbox="835 1171 1401 1240">Ask participants to mention their ideas on the importance of Counseling.</p> <p data-bbox="835 1283 1376 1352">Possible answers are those written on the slide.</p> <p data-bbox="835 1395 1303 1464">Incorporate some of the participants' responses.</p>



NARRATIVE

MODULE 10: COUNSELING FOR FAMILY PLANNING SESSION 3: TYPES OF COMMUNICATION IN FP/RH

Definition of Information-giving, Motivation, and Counseling

Information-giving is a way of providing people with facts about family planning and the methods. This can be communicated one-on-one, in a group, or on a mass scale. The information may be complete or limited and can be given anywhere. However, there may be some overlaps between promoting and information-giving, depending on how complete and accurate the information is.

Some examples of information-giving:

- a nurse in a clinic shows a film on the various contraceptive methods to a group of women who are waiting for medical checkup
- a client is given a brochure on the temporary methods of contraception by a field worker

Information-giving activities provide facts about methods and can be done in person (either individually or in group) or through print materials and other media. While the information presented may be complete or limited, it must be accurate and correct.

Motivation (also known as promotion) includes all efforts to encourage people to practice family planning. It may be interpersonal or it may involve the mass media. The messages should include a wide range of information on family planning and reproductive health concerns that can attract the interest of the general public or a target audience.

Motivational messages are made up of information emphasizing the benefits of a method being promoted. No special setting is required for these activities.

Motivational activities encourage the use of family planning. These activities may be conducted in person or through the media. While they can convey useful information, these activities are usually biased. They often attempt to influence an individual or group to adopt a certain practice or behavior.

Some examples of motivational messages:

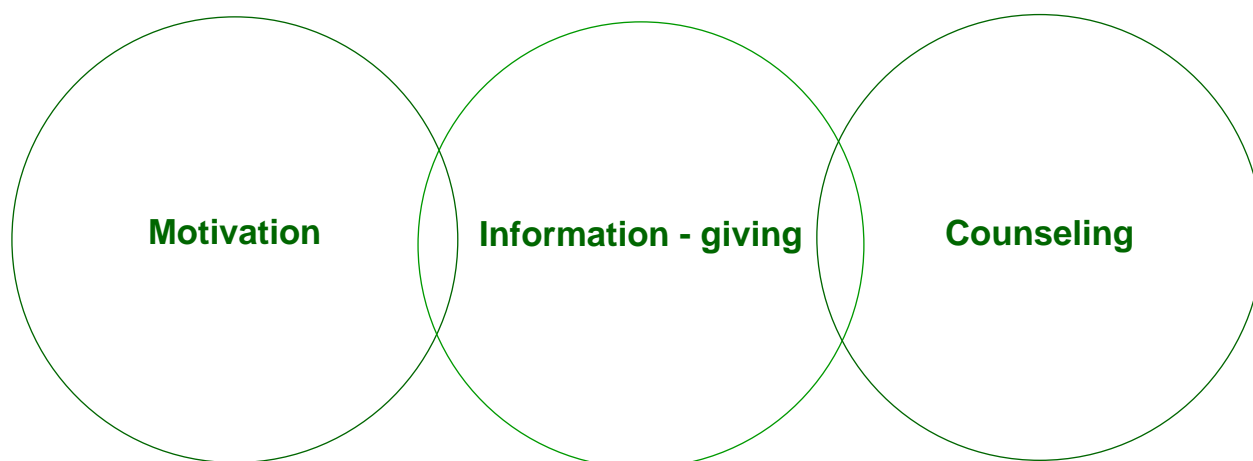
- a billboard that promotes the use of a specific brand of contraception
- an advertisement in a men's magazine that promotes the use of condoms to prevent pregnancy and STI transmission

Counseling is a two-way communication process between the provider and the client. The goal of this communication is to assist the client in making a free and informed decision about his or her fertility. This is done considering the client's reproductive needs, living situation, opinions, and feelings.

Counseling activities focus on helping individuals make choices about fertility. Counseling goes beyond just giving facts; it enables clients to apply information about family planning to their particular circumstances and to make informed choices. It includes a discussion of the client's feelings regarding fertility. Counseling always involves two-way communication. The client and the counselor spend time talking, listening, and asking questions.

While motivation and information-giving can be done anywhere, it is important that counseling occur in a private atmosphere since personal information is shared.

TYPES OF FAMILY PLANNING COMMUNICATION DIAGRAM



TYPES OF FAMILY PLANNING COMMUNICATION

Type	Goal	Content	Direction	Bias	Location
Motivation or Promotion	Influence an individual or group to adopt a certain practice or behavior.	Advantages of family planning and the methods	One-way	Biased	Anywhere
Information-Giving	Provide facts	Facts about family planning and the methods	One-way	May be biased	Anywhere
Counseling	Assist the client make a free and informed decision	Facts, client's needs, situation, opinion, and feelings	Two-way	Not biased	Private

EFFECTIVE COMMUNICATION SKILLS

 **LEARNING OBJECTIVES**

At the end of the session, the participants will be able to:

1. Identify good non-verbal communication skills.
2. Describe the appropriate tone of voice to be used by a counselor.
3. Ask closed, open, and probing questions effectively.
4. Demonstrate active listening.
5. Describe paraphrasing and clarifying.
6. Use simple language when telling clients about contraceptive methods.

**METHODOLOGY**

Illustrated Lecture-Discussion

Brainstorming

Exercise

**TIME ALLOTMENT**

2 hours

**ADVANCE PREPARATION OF MATERIALS**

- Powerpoint presentation of Module 10, Session 2
- Computer and LCD
- Tapes
- Whiteboard and appropriate marker
- Meta cards (at least two different colors)
- Masking tape
- On two separate pieces of newsprint paper, write the headings **POSITIVE** and **NEGATIVE** (see exercise on “Non-Verbal Communication”).
- On separate pieces of paper or cards, write with big letters the different types of emotions and feelings such as anger, boredom, shame, nervousness, and happiness.
- Prepare sentences in separate pieces of paper for volunteer-participants to read in neutral tone and in a tone of voice reflecting the different emotions:
“Mrs., pang-ilang anak mo na nga ito?” Or, “Ano ang maitutulong ko sa iyo?”.

- Write the following words on three pieces of newsprint paper:

Newsprint 1:




- ⊙ uterus
- ⊙ ejaculation
- ⊙ scrotum
- ⊙ contraception
- ⊙ vas deferens
- ⊙ masturbation
- ⊙ testicles
- ⊙ menstruation
- ⊙ orgasm
- ⊙ sexually transmitted Infections

Newsprint 2:

- ⊙ vagina
- ⊙ hormone
- ⊙ fertilization
- ⊙ semen
- ⊙ ovary
- ⊙ vasectomy
- ⊙ fallopian tubes
- ⊙ cervix
- ⊙ pills

Newsprint 3:

- ⊙ intercourse
- ⊙ lactational amenorrhea method
- ⊙ penis
- ⊙ vaginal discharge
- ⊙ ovulation
- ⊙ clitoris
- ⊙ lactation
- ⊙ egg cells

Topics/Contents	Teaching-Learning Process
 <h2 data-bbox="357 264 583 309">SESSION 4</h2>  <h3 data-bbox="357 365 740 443">EFFECTIVE COMMUNICATION SKILLS</h3>	<p data-bbox="835 237 1110 271">Tell participants that:</p> <ul data-bbox="835 315 1397 645" style="list-style-type: none"> • A health care provider who aims to be efficient in delivering health services must have good communication skills. • A good family planning counselor must be an effective communicator. • This session introduces the key concepts of interpersonal communication, which is one of the foundations of effective counseling.
<p data-bbox="200 696 318 719">Introduction</p> <p data-bbox="221 768 456 797"> Learning Objectives</p> <ul data-bbox="252 869 765 1010" style="list-style-type: none"> • Identify good non-verbal communication skills. • Describe the appropriate tone of voice to be used by a counselor. • Ask closed, open, and probing questions effectively. • Demonstrate active listening. • Describe paraphrasing and clarifying. • Use simple language when telling clients about contraceptive methods. 	<p data-bbox="835 752 1298 819">Introduce the session by stating the objectives as written on the slide.</p>
<p data-bbox="216 1115 519 1137">NON-VERBAL COMMUNICATION</p> <ul data-bbox="252 1193 718 1238" style="list-style-type: none"> • Cues that portray feelings or opinions that are not verbally stated • What counselors do not say is as important as what they say 	<p data-bbox="835 1137 1345 1205">Describe non-verbal communication as written on the slide.</p>
<p data-bbox="216 1285 519 1308">NON-VERBAL COMMUNICATION</p> <h2 data-bbox="404 1417 583 1451">EXERCISE</h2>	<p data-bbox="835 1301 1361 1368">Ask the participants to write examples of non-verbal cues on meta cards.</p> <p data-bbox="835 1413 1384 1480">Post two pieces of newsprint with the words “positive” and “negative”.</p> <p data-bbox="835 1525 1384 1704">Ask participants to identify whether the non-verbal cue(s) they have written on their meta card(s) are positive non-verbal cues or negative non-verbal cues and post them in the newsprint with the appropriate heading.</p> <p data-bbox="835 1749 1384 1895">Review the list in the POSITIVE newsprint to remove the non-verbal cues not related to client interaction or those that are not positive.</p> <p data-bbox="835 1939 1384 2040">Review the list of the negative non-verbal cues and remind participants that they need to avoid exhibiting these.</p>

Topics/Contents	Teaching-Learning Process
<p>Tone of Voice</p> <p>Tone of Voice</p> <ul style="list-style-type: none"> The counselor's tone of voice is important in building rapport or establishing a comfortable environment for the client 	<p>Tell participants about the tone of voice as written on the slide.</p>
<p>Tone of Voice</p> <p style="text-align: center;">EXERCISE</p>	<p>Call on five volunteers.</p> <p>Distribute to volunteers' pieces of cards with the different emotions and feelings (anger, boredom, shame, nervousness, and happiness) written on them.</p> <p>Ask each volunteer to read the prepared sentences first in a neutral tone and then repeat them using the tone of voice appropriate for the emotion or feeling that is written on their cards. Sample sentences include "Mrs., pang-ilang anak nyo na nga ito?" and "Ano ang maitutulong ko sa iyo?"</p> <p>Have the rest of the group guess which emotion was demonstrated.</p> <p>Summarize this exercise by asking participants:</p> <ul style="list-style-type: none"> If they were clients, which tone of voice would they want to hear from the service provider? It is then this tone of voice that they, as service providers, should have when interacting with clients. Which tones of voice are inappropriate in a family planning setting?
<p>Asking Questions Effectively</p> <p>Asking Questions</p> <p>Types of questions</p> <ol style="list-style-type: none"> Closed Open Probing <p>Asking Questions</p> <p>CLOSED QUESTIONS</p> <ul style="list-style-type: none"> Answerable by yes, no, a number, or a few words. Used to: <ul style="list-style-type: none"> Start a session To gather data that may need further exploration 	<p>Tell participants that:</p> <ul style="list-style-type: none"> FP counseling is based on the needs and situation of the client. To know the needs of clients, the counselor must be able to gather information from the client in a helpful, non-threatening way. Obtaining the necessary information requires asking appropriate questions and asking them effectively. There are three types of questions: <ol style="list-style-type: none"> Closed questions Open questions Probing questions

Topics/Contents	Teaching-Learning Process
<p data-bbox="232 230 396 253">Asking Questions</p> <p data-bbox="216 293 362 315">OPEN QUESTIONS</p> <ul data-bbox="216 342 785 439" style="list-style-type: none"> • Have many possible answers • Encourage the client to talk about her or his thoughts, feelings, knowledge, and beliefs • Often begin with "how" or "what". The following are examples of open questions. <p data-bbox="216 461 777 510">NOTE: WHY questions may be intimidating or seem judgmental. It is preferable to use WHAT as in "what are your reasons for ... " or "what makes you think ..."</p> <p data-bbox="232 555 396 577">Asking Questions</p> <p data-bbox="216 622 388 645">PROBING QUESTIONS</p> <ul data-bbox="216 672 765 745" style="list-style-type: none"> • Help a counselor clarify the client's responses to open-ended questions. • There is some overlap between open-ended questions and probing questions. • Probing questions follow closed or open questions. <p data-bbox="232 819 396 842">Asking Questions</p> <p data-bbox="232 913 307 936">Examples:</p> <ul data-bbox="232 938 785 1055" style="list-style-type: none"> • "You said that you were concerned about the potential bleeding associated with DMPA. How would you feel about a method that does not cause menstrual disturbances?" • "You told me that your husband wants to use a reliable method of contraception. What are your thoughts about bilateral tubal ligation?" 	<p data-bbox="835 230 1397 297">Ask participants what their ideas on each of these types of questions are.</p> <p data-bbox="835 338 1397 371">Describe each type as presented on slides.</p> <p data-bbox="835 416 1397 483">Ask for examples from the participants after describing each type.</p>
<p data-bbox="216 1144 294 1167">Exercise</p> <p data-bbox="232 1200 310 1223">Exercise</p> <ul data-bbox="216 1267 777 1413" style="list-style-type: none"> • How old are you? • Does your husband allow you to use family planning methods? • What can you say about not having many children to feed and send to school? • What do you think your wife will say if she learned that you have a sexually transmitted infection? • How long have you been the using IUD? <p data-bbox="232 1507 310 1529">Exercise</p> <ul data-bbox="216 1585 769 1731" style="list-style-type: none"> • Do you think you can return to the clinic every month for check-up? • You said you have two children and not ready to have another child. What do you feel about consulting a FP counselor? • What problems will you have about having to come to the clinic every month for checkup? • How old is your youngest child? 	<p data-bbox="835 1149 1408 1261">Tell participants to say whether the following questions as written on the slide are open, closed, or probing questions.</p> <p data-bbox="835 1294 1342 1361">Call participants at random to give their answers.</p> <ul data-bbox="835 1368 1408 2029" style="list-style-type: none"> • How old are you? (C) • Does your husband allow you to use family planning methods? (C) • What can you say about not having many children to feed and send to school? (O) • What do you think your wife will say if she learned that you have a sexually transmitted infection? (O) • How long have you been using the IUD? (C) • Do you think you can return to the clinic every month for check-up? (C) • You said you have two children and not ready to have another child. What do you feel about consulting a FP counselor? (P) • What problems will you have about having to come to the clinic every month for check-up? (O) • How old is your youngest child? (C)

Topics/Contents	Teaching-Learning Process
	<p>Summarize the exercise by saying that:</p> <ul style="list-style-type: none"> • There may be some overlap between open and probing questions. • A good rule to remember is that probing questions often follow a closed or an open question. • Open questions seek to find the client's opinions and feelings.
<p>Active Listening</p> <p>Active Listening</p> <p>Listening to another person in a way that communicates understanding, empathy, and interest</p>	<p>Tell participants that:</p> <ul style="list-style-type: none"> • The complementing step in asking good questions is active listening. • For a useful, effective communication process, it is not only necessary that one is skillful at asking questions effectively, but is also an active listener. <p>Describe active listening as it is written on the slide.</p>
<p>Active Listening</p> <p>EXERCISE</p>	<p>Exercise</p> <p>Pair the participants. One member of each pair will be the speaker and the other will be the listener.</p> <p>Set aside the "listeners" and instruct them to not speak or react to what the speaker says for three minutes. After three minutes or when the signal is given, they start actively interacting with the speakers.</p> <p>Set aside the "speakers" and instruct them to talk about any interesting topic with their partner "listener".</p> <p>After another three minutes, process the exercise by asking the following questions.</p> <p>Ask the speakers:</p> <ul style="list-style-type: none"> • How did it feel to talk without interruption? • As the speaker, did you feel that you were understood? If yes, how was that conveyed to you? • Which non-verbal behaviors conveyed understanding? Which did not?

Topics/Contents	Teaching-Learning Process
	<p>Ask the listeners:</p> <ul style="list-style-type: none"> • How did it feel to not be able to speak? <p>Write participants' responses on the board. Process by consolidating the experiences/ learning insights of the participants.</p>
<p>Paraphrasing</p> <p>Paraphrasing</p> <ul style="list-style-type: none"> • Restating the client's message simply • Guidelines: <ol style="list-style-type: none"> 1. Listen to the client's basic message 2. Restate to the client a simple summary of what you believe is her/his basic message 3. Do not add any new ideas 4. Observe a cue or ask for a response from the client that confirms or denies the accuracy of the paraphrasing done 5. Do not restate negative images client may have made about themselves 	<p>Tell participants that:</p> <ul style="list-style-type: none"> • Even when the counselor is using the communication skills learned thus far to the best of his or her ability, there is always the chance that an important piece of information will be missed. <p>Describe paraphrasing and its guidelines as written on the slide.</p>
<p>Paraphrasing</p> <p>Example:</p> <ul style="list-style-type: none"> • Client: "I want to use the IUD, but my sister said that it can travel around your body and stick to the baby's head." • Counselor: "So you want to use IUD but you have concerns about its possible effects on you and your baby?." 	<p>Give an example of paraphrasing.</p>
<p>Clarifying</p> <p>Clarifying</p> <ul style="list-style-type: none"> • Making a guess about the client's message for the client to confirm or deny • Guidelines: <ul style="list-style-type: none"> • Admit that you want to have a clear understanding of what the client is telling. • Restate the client message as you understood it, asking the client if your interpretation is correct. • Ask questions beginning with phrases such as "Do you mean that". Or "Are you saying" • Do not use clarifying excessively as this will make the client feel that they had been cut off or they have failed to communicate clearly. 	<p>Describe clarifying (<i>paglilinaw</i>) and its guidelines as written on the slide.</p>
<p>Clarifying</p> <p>Example:</p> <ul style="list-style-type: none"> • Client: I am using the pill and like it, but my sister says that with DMPA, I do not need to remember to take anything. • Counselor: Let me see if I understand you. You are thinking about switching from the pill to DMPA because DMPA would be more convenient for you. 	<p>Give an example of clarifying as written on the slide.</p>
<p>Using Simple Language</p> <p>Using Simple Language</p> <ul style="list-style-type: none"> • Another way of making clients comfortable during counseling is using words that they can understand. • Avoid using technical, medical terms which may intimidate clients. 	<p>Tell participants about using simple language as written on the slide.</p>

Topics/Contents	Teaching-Learning Process																						
<p data-bbox="169 203 392 230">Using Simple Language</p> <p data-bbox="341 376 534 414">Group Work</p>	<p data-bbox="791 219 1263 248">Divide participants into three groups.</p> <p data-bbox="791 293 1323 394">Give each group prepared newsprint with the terms commonly used when doing counseling.</p> <p data-bbox="827 439 1005 468">Newsprint 1:</p> <table data-bbox="827 472 1255 685"> <tr> <td>uterus</td> <td>ejaculation</td> </tr> <tr> <td>scrotum</td> <td>contraception</td> </tr> <tr> <td>vas deferens</td> <td>masturbation</td> </tr> <tr> <td>testicles</td> <td>menstruation</td> </tr> <tr> <td>orgasm</td> <td></td> </tr> <tr> <td>sexually transmitted infections</td> <td></td> </tr> </table> <p data-bbox="827 730 1005 759">Newsprint 2:</p> <table data-bbox="827 763 1219 943"> <tr> <td>vagina</td> <td>hormone</td> </tr> <tr> <td>fertilization</td> <td>semen</td> </tr> <tr> <td>ovary</td> <td>vasectomy</td> </tr> <tr> <td>fallopian tubes</td> <td>cervix</td> </tr> <tr> <td>pills</td> <td></td> </tr> </table> <p data-bbox="827 987 1005 1016">Newsprint 3:</p> <p data-bbox="827 1021 1232 1305">intercourse lactational amenorrhea method penis vaginal discharge ovulation clitoris lactation egg cells</p> <p data-bbox="791 1350 1313 1417">Each group translates in their dialect the terms in their respective newsprint.</p> <p data-bbox="791 1462 1346 1529">Give 15 minutes for each group to agree on simple terms for the technical words written on their newsprint.</p> <p data-bbox="791 1574 1346 1603">Each group presents their output in plenary.</p>	uterus	ejaculation	scrotum	contraception	vas deferens	masturbation	testicles	menstruation	orgasm		sexually transmitted infections		vagina	hormone	fertilization	semen	ovary	vasectomy	fallopian tubes	cervix	pills	
uterus	ejaculation																						
scrotum	contraception																						
vas deferens	masturbation																						
testicles	menstruation																						
orgasm																							
sexually transmitted infections																							
vagina	hormone																						
fertilization	semen																						
ovary	vasectomy																						
fallopian tubes	cervix																						
pills																							
<p data-bbox="341 1794 573 1832">CONCLUSION</p>	<p data-bbox="791 1637 1350 1738">Review the objectives and whether these have been attained by asking participants to respond to these.</p>																						

MODULE 10: COUNSELING FOR FAMILY PLANNING

SESSION 4: EFFECTIVE COMMUNICATION SKILLS

A health care provider, who aims to be efficient in delivering health services must have good communication skills.

A good family planning counselor must be an effective communicator. She/He practices all the basic skills necessary for good communication. These are:

- Non-verbal communication
- Tone of voice
- Asking good questions
- Active listening
- Paraphrasing and clarifying
- Simple language

Non-verbal Communication

In many cases, what we do not say is almost as important as what we say. In other words, our body position and other non-verbal mannerisms communicate feelings to the client. Also, many of these non-verbal behaviors are culturally bound. What may be acceptable in one part of the country may be considered rude in other parts.

Tone of Voice

Like non-verbal communication, how we say something is almost as important as what we say. Our tone of voice can be used to project feelings and thoughts that can be picked up by the client in either a negative or positive way.

Asking questions

Asking good question is one of the main functions of a family planning counselor. We ask questions to:

- Know, investigate, clarify, and gain deeper understanding of facts, issues, feelings, and opinions
- Encourage another person to communicate, elaborate, and be frank about his or her own knowledge, thoughts, and feelings
- Direct communication towards a certain issue
- Make a person feel that we are interested in what the client has to say

Questions can be used to:

- Assess the needs of the client
- Find out what the client already knows about family planning
- Learn how the client feels
- Help the client reach a decision
- Help the client act on a decision

There are three types of questions that a family planning counselor should know:

- **Closed questions**

These are questions that can be answered by yes, no, a number, or a few words. Counselors can use closed questions to start sessions, gather data that can indicate areas that need further exploration. Closed questions can be used to get information, such as a medical history. The following are examples of closed questions:

- How old are you?
- Which family planning methods have you used?
- How many children do you want to have?
- When did you decide that you did not want to have any more children?

• Open Questions

These types of questions have many possible answers. They can encourage the client to talk about her or his thoughts, feelings, knowledge, and beliefs.

These questions often begin with “how” or “what”. The following are examples of open questions.

- What do you know about condoms?
- How do you feel about not having children?
- How did you decide that you are not ready for tubal ligation?
- What does your partner think about you using contraception?

Note: “Why “ questions may be intimidating or seem judgmental. It is preferable to use “what” as in “what are your reasons for “ or “what makes you think”

• Probing questions

Probing questions help a counselor clarify the client’s responses to open-ended questions. An example of a probing question is “Can you tell me how your friend’s experience made you decide to go for DMPA?”.

There is some overlap between open-ended questions and probing questions. The difference between these types of questions is clearer in actual discussions with clients when they appear in context. Probing questions follow open questions. Some additional examples are:

- “You said that you were concerned about the potential bleeding associated with DMPA. How would you feel about a method that does not cause menstrual disturbances?”
- “You told me that your husband wants to use a reliable method of contraception. What are your thoughts about bilateral tubal ligation?”

10.38

Active Listening

Listening to another person in a way that communicates understanding, empathy and interest.

Paraphrasing and Clarifying

As with all communication processes, sometimes one party or the other - either the client or the counselor - wants to make sure that he or she does in fact understand what is being said. This is done by paraphrasing and clarifying.

- Paraphrasing is restating the client’s message in a simple manner. Counselors use paraphrasing to make sure that they have understood what a client said and to let the client know that they are trying to understand her or his basic message.

Paraphrasing supports the client and encourages her/him to continue speaking. Example: *Client:* “ I want to use the IUD, but my sister said that it travels around your body and sticks to the baby’s head.”

Counselor: “ You want to use the IUD but you have concerns about its possible effects on you and your baby?.”

Guidelines for Paraphrasing:

1. Listen to the client's basic message.
 2. Restate to the client a simple summary of what you believe is the basic message. Do not add any new idea.
 3. Observe a cue or ask for response from the client that will confirm or deny the accuracy of the paraphrase.
 4. Do not restate negative images clients may have made about themselves in a way that confirms this perception. For example, if the client says "I feel stupid asking this," it is not proper to say "You feel ignorant".
- **Clarifying** is making an educated guess about the client's message for the client to confirm or deny. Like paraphrasing, clarifying is a way of making sure the client's message is understood. This to clear up confusion if a client's response is vague or not understandable.

Example: *Client*: "I am using the pill and like it, but my sister says that with DMPA, I do not need to remember to take anything."

Counselor: "Let me see if I understand you. You are thinking about switching from the pill to DMPA, because DMPA would be more convenient for you."

Guidelines for clarifying:

1. Admit that you do not have a clear understanding of what the client is telling you.
2. Restate the client's message as you understand it, asking the client if your interpretation is correct. Ask questions beginning with phrases such as "Do you mean that..." or "Are you saying..."
3. Clients should not be made to feel they have been cut off or have failed to communicate. Therefore, do not use clarifying excessively.

Using Simple Language

A large part of what a counselor does is provide information so that the client has sufficient knowledge to make an informed decision about her or his contraceptive options. The problem is that clients must get technical medical information about contraception methods or human anatomy and reproductive physiology. As a result, one of the things that a counselor must do is use language that the client understands.

THE G-A-T-H-E-R APPROACH TO FAMILY PLANNING COUNSELING



LEARNING OBJECTIVES

At the end of the session, the participants must be able to:

1. Explain the G-A-T-H-E-R approach to counseling.
2. Describe each step in the G-A-T-H-E-R approach to counseling.
3. Use the approved counseling cue card/flip chart (whichever is available) as an aid when counseling clients.
4. Explain the tasks of the counselor for each of the G-A-T-H-E-R steps of counseling.
5. Explain the importance of each of the G-A-T-H-E-R steps of counseling.
6. Enumerate the task of the FP counselor during each of the G-A-T-H-E-R steps of counseling.
7. Determine that the woman is not pregnant.
8. Assess client's reproductive needs, risks for STIs, status of relationship with partner, and knowledge on FP methods.
9. Use the FP Service Record (or any approved assessment form) as a tool for undertaking assessment.
10. Use appropriate types of questions (i.e., closed, open-ended, probing) during assessment of the client.
11. Describe available family planning (FP) methods based on client's reproductive need.
12. Discuss appropriate FP methods in terms of:
 - Mechanism of action
 - Effectiveness
 - Advantages and Disadvantages
 - Possible side effects
13. Correct rumors and misconceptions.
14. Identify the reasons for clients' return visits.
15. Demonstrate counseling using the G-A-T-H-E-R approach.



METHODOLOGY

Illustrated Lecture-Discussion
Brainstorming
Role playing








TIME ALLOTMENT

8 Hours and 30 minutes



ADVANCE PREPARATION OF MATERIALS

- Powerpoint presentation of Module 10, Session 5
- Computer and LCD
- Tapes
- Whiteboard and appropriate marker
- Counseling cue cards
- Role play situations
- MEC wheel
- FP Form 1 (FP Service Record)
- Samples of available contraceptives
- MEC Checklists

Topics/Contents	Teaching-Learning Process
<div style="text-align: center;">  <h2 style="color: green;">SESSION 5</h2> </div> <hr/> <div style="text-align: center;">  <h3 style="color: green;">STEPS IN COUNSELING USING THE G-A-T-H-E-R APPROACH</h3> </div>	<p>Link the session with previous sessions by saying that:</p> <ul style="list-style-type: none"> • Counseling is an integral part of the provision of quality FP services. • Most of the modules of this course are to prepare them for this crucial task. • This session is an application of what has been learned in the previous modules/sessions.
<p>Introduction</p> <p> Learning Objectives</p> <ul style="list-style-type: none"> • Explain the G-A-T-H-E-R approach to counseling. • Describe each step in the G-A-T-H-E-R approach to counseling. • Use the approved counseling cue card/flip chart (if available) as an aid when counseling clients. • Enumerate the tasks of the FP counselor during each of the G-A-T-H-E-R steps of counseling. • Explain the tasks of the counselor for each of the G-A-T-H-E-R steps of counseling. • Explain the importance of the G-A-T-H-E-R steps of counseling. <p> Learning Objectives</p> <ul style="list-style-type: none"> • Determine that the woman is not pregnant. • Assess client's reproductive needs, risks for STIs, status of relationship with partner, and knowledge on FP methods. • Use the FP Service Record (or any approved assessment form) as a tool for undertaking assessment. • Use appropriate types of questions (i.e., closed, open-ended, probing) during assessment of the client. • Describe available family planning (FP) methods based on client's reproductive need. <p> Learning Objectives</p> <ul style="list-style-type: none"> • Discuss appropriate FP methods in terms of: <ul style="list-style-type: none"> • Mechanism of action • Effectiveness • Advantages and Disadvantages • Possible side effects • Correct rumors and misconceptions. • Identify the reasons for clients' return visits. • Demonstrate counseling using the G-A-T-H-E-R approach. 	<p>State the objectives of the session as presented on the slide.</p>
<p>The G-A-T-H-E-R Approach</p> <div style="text-align: center; margin: 10px 0;"> <p>GREET ASK/ASSESS TELL HELP EXPLAIN RETURN/REFER</p> </div> <div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; margin: 10px auto; width: fit-content;"> <ul style="list-style-type: none"> • Six steps of counseling • Guide for doing counseling • Not all steps are applied in the same way for all clients </div>	<p>Tell participants what G-A-T-H-E-R means as written on the slide.</p> <p>To augment the presentation, tell participants that:</p> <ul style="list-style-type: none"> • G-A-T-H-E-R simplifies the counseling process. • Not all the steps are applied for all clients in the same way. Each individual client's needs determine the counselor's level of emphasis of each of the steps. Some clients may need a step repeated, while others may need only a brief exposure to a step. • Each of the steps as represented by the acronym will be discussed in detail during the session.

Topics/Contents	Teaching-Learning Process											
<p>The “G” (Greet) Step</p> <p>The “G” (Greet) Step</p> <p>Importance</p> <ul style="list-style-type: none"> • Establish rapport with the client • Make the client comfortable • Assure confidentiality 	<p>Explain the importance of greeting clients as written on the slide.</p>											
<p>The “G” (Greet) Step</p> <p>Tasks</p> <ul style="list-style-type: none"> • Greet client and give full attention • Introduce yourself • Offer a seat • Ask the reason for the visit and how you can help • Ensure confidentiality 	<p>Describe the tasks of the counselor during the “greet” step as written on the slide.</p>											
<p>The “A” (Ask/Assess) Step</p> <p>The “A” (Ask/Assess) Step</p> <p>Importance</p> <ul style="list-style-type: none"> • Tailor succeeding discussions while helping client choose a method • Identify client’s knowledge on FP and FP methods • Identify conditions that may make client unsuitable for particular FP method <p>The “A” (Ask/Assess) Step</p> <p>Tasks</p> <ul style="list-style-type: none"> • Ask client about self (use FP Form 1) <ul style="list-style-type: none"> ✓ General/demographic data ✓ Medical/obstetrical history • Check for medical conditions that will not warrant the use of specific FP method based on the WHO MEC • Assess reproductive needs <ul style="list-style-type: none"> ✓ Ask client if she plans to have another pregnancy, if yes, when she plans to have this 	<p>Describe the “A” (ask/assess) step in terms of its importance and the tasks of the counselor as written on the slide.</p>											
<p>The “A” (Ask/Assess) Step</p> <table border="1" data-bbox="232 1518 678 1865"> <thead> <tr> <th rowspan="2" style="writing-mode: vertical-rl; transform: rotate(180deg);">M E T H O D S</th> <th colspan="3">REPRODUCTIVE NEEDS</th> </tr> <tr> <th>Short term (< 3 yrs)</th> <th>Long term (≥ 3 yrs)</th> <th>Permanent</th> </tr> </thead> <tbody> <tr> <td></td> <td>Condom, LAM, FAB methods, Pills, DMPA, IUD</td> <td>FAB methods, Pills, DMPA, IUD</td> <td>BTL, Vasectomy, DMPA, IUD</td> </tr> </tbody> </table>	M E T H O D S	REPRODUCTIVE NEEDS			Short term (< 3 yrs)	Long term (≥ 3 yrs)	Permanent		Condom, LAM, FAB methods, Pills, DMPA, IUD	FAB methods, Pills, DMPA, IUD	BTL, Vasectomy, DMPA, IUD	<p>Tell participants that:</p> <ul style="list-style-type: none"> • This is a list of FP methods appropriate to the reproductive need of clients. • This means that the counselor tells about the methods appropriate to the reproductive need of the client. <p>Example: A client whose reproductive need is permanent does not need to hear about FAB methods and pills except if the client insists. Likewise, a client who still wants to have a child, does not need to hear about the BTL and vasectomy.</p>
M E T H O D S		REPRODUCTIVE NEEDS										
	Short term (< 3 yrs)	Long term (≥ 3 yrs)	Permanent									
	Condom, LAM, FAB methods, Pills, DMPA, IUD	FAB methods, Pills, DMPA, IUD	BTL, Vasectomy, DMPA, IUD									

Topics/Contents	Teaching-Learning Process
<p>The “A” (Ask/Assess) Step</p> <p>Tasks</p> <ul style="list-style-type: none"> Assess client's knowledge and experience on FP <ul style="list-style-type: none"> ✓ What does the client know about FP? ✓ Has client used any method? How long? Is she satisfied with the method used? Assess for violence committed against partner (VAW) <ul style="list-style-type: none"> ✓ How is relationship with husband/partner? ✓ Does partner know about her coming to clinic? ✓ Will partner support client's use of FP method? 	<p>Ask participants:</p> <ul style="list-style-type: none"> Why does the counselor ask about client's knowledge and experience on FP and its methods? <p>Responses may include but not be limited to:</p> <ul style="list-style-type: none"> Check if what the client knows is a fact and not a misconception. Correct misconceptions or misinformation, if any. Tailor the counselor's "tell" so that s/he may reinforce correct information. Counselor does not need to repeat what the client already knows. Know previous methods used and the reason(s) for discontinuing.
<p>The “A” (Ask/Assess) Step</p> <p>Task</p> <ul style="list-style-type: none"> Assess for STI Risk <ul style="list-style-type: none"> ✓ Why assess for STI risk? <ul style="list-style-type: none"> FP clients are sexually active, thus, they need to know about STIs If client gets STI, she/he needs counseling about risks, symptoms and treatment and need supply of condoms IUD should not be provided to clients with STI risks 	<p>Ask participants:</p> <ul style="list-style-type: none"> Why assess client's risk for STIs? <p>Responses may include but not be limited to:</p> <ul style="list-style-type: none"> Assessing STI risk is important because: <ul style="list-style-type: none"> this is a good opportunity for the client to know whether or not she is at risk for STIs. the IUD is not the best method for those with high individual risk for STIs. clients with risk for STIs are advised to use the condom.
<p>The “A” (Ask/Assess) Step</p> <p>Task</p> <ul style="list-style-type: none"> Assess for STI Risk <ul style="list-style-type: none"> ✓ Questions that are asked in assessing STI risk: <ul style="list-style-type: none"> How is your relationship with your partner? Have you or your partner ever been treated for STIs in the past? Do you think your partner might have STI? <p>The “A” (Ask/Assess) Step</p> <p>Task</p> <ul style="list-style-type: none"> Assess for STI Risk <ul style="list-style-type: none"> ✓ Questions that are asked of the woman: Do you have: <ul style="list-style-type: none"> Unusual discharge from the vagina? Itching or sores in or around the vagina? Pain or burning sensation? <p>The “A” (Ask/Assess) Step</p> <p>Task</p> <ul style="list-style-type: none"> Assess for STI Risk <ul style="list-style-type: none"> ✓ Questions that are asked of the man: Do you: <ul style="list-style-type: none"> Experience pain or burning sensation on urination? Have open sores in the genital area? Have pus from the penis? Have swollen penis or testicles? 	<p>Present the questions asked to assess STI risk as written on the slide.</p>

Topics/Contents	Teaching-Learning Process
<p>The “A” (Ask/Assess) Step</p> <p>Task</p> <ul style="list-style-type: none"> Determine that the woman is not pregnant: <ul style="list-style-type: none"> Menstrual period started within the last seven days Gave birth within the last four weeks Had an abortion within the last seven days Gave birth within the last six months, is fully breastfeeding, and has not yet had her menstrual period Has not had sexual intercourse since last menstrual period Uses a modern/reliable family planning method correctly <p><i>Even if she has been using a family planning method but her last menstrual period is more than five weeks ago, and she has had sex, pregnancy cannot be ruled out except if she using a progestin-only injectable.</i></p>	<p>Remind participants that:</p> <ul style="list-style-type: none"> clients who are pregnant do not need to use a FP method. As such, the counselor must be reasonably sure that the client is not pregnant before providing a FP method.
<p>The “A” (Ask/Assess) Step</p> <p>Task</p> <ul style="list-style-type: none"> REVISIT CLIENTS <ul style="list-style-type: none"> Ask if client's situation has changed since the last visit Ask if reproductive needs have changed Ask if client has new concerns Ask if client has problems with the method Reassess for STI/HIV risk 	<p>For revisit clients, the following tasks are performed by the counselor.</p> <p>Present the tasks as written on the slide.</p>
<p>The “T” (Tell) Step</p> <p>Importance</p> <ul style="list-style-type: none"> Provide information of FP methods based on her/his reproductive need and knowledge <p>Tasks</p> <ul style="list-style-type: none"> Tells the client about FP methods based on her/his needs: short-term, long-term, permanent Tells how the method works Explains effectiveness, advantages, disadvantages, possible side effects of each of the appropriate methods Corrects misconceptions 	<p>Describe the “T” (tell) step in terms of its importance and the tasks of the counselor.</p> <p>Explain that:</p> <ul style="list-style-type: none"> this step is not performed for revisit clients who are satisfied with their method and wish to continue using it. for clients not satisfied with their chosen method, this step is performed but tailored to what the client already knows about the other methods appropriate for her/his reproductive need.
<p>The “H” (Help) Step</p> <p>Importance</p> <ul style="list-style-type: none"> Helps the client make a decision <p>Tasks</p> <ul style="list-style-type: none"> Asks client what method she/he heard during the “Tell” step that interests her/him. Checks client's suitability for her/his chosen method using the MEC Checklist for the chosen FP method. Reminds client of the possible side effects of the method chosen. Asks client how she/he can tolerate possible side effects. Asks client if there is anything not understood; repeats information, as needed. <p>The “H” (Help) Step</p> <p>If client decides not to use a method</p> <ul style="list-style-type: none"> Tells her/him about: <ul style="list-style-type: none"> Risk of pregnancy Availability of pre-natal services Being able to return should she/he want to use an FP method 	<p>Describe the “H” (help) step in terms of its importance and the tasks of the counselor.</p> <p>Tell that:</p> <ul style="list-style-type: none"> this step is not performed for revisit, continuing user clients.

Topics/Contents	Teaching-Learning Process
<p>The “E” (Explain) Step</p> <p>Importance</p> <ul style="list-style-type: none"> • How to use the chosen method is explained • Method is provided, if appropriate and available <p>The “E” (Explain) Step</p> <p>Tasks</p> <ul style="list-style-type: none"> • Explains how to start and use the chosen method • Describes warning signs, what to do should it occur • Confirms client’s understanding of what has been said by asking client to repeat what has been said in her/his own words • Corrects misunderstanding <p>The “E” (Explain) Step</p> <p>For revisit clients</p> <ul style="list-style-type: none"> • Asks client: <ul style="list-style-type: none"> • How she/he uses the present method and what the warning signs are • To repeat instructions on how to use and what to do for warning signs • Corrects mistakes or misunderstandings 	<p>Describe the “E” (explain) step in terms of its importance and the tasks of the counselor.</p>
<p>The “R” (Return/Refer) Step</p> <p>Important opportunity to:</p> <ul style="list-style-type: none"> • Reinforce the decision clients have made to plan their family • Discuss any problems they have with their chosen method • Take seriously the client’s concern with a supportive attitude and should never be dismissed <p>The “R” (Return/Refer) Step</p> <p>Tasks</p> <ul style="list-style-type: none"> • Tells client when and where to return for <ul style="list-style-type: none"> • routine follow-up • next visit • Encourage client to come back for any problems, including warning signs • If chosen method/service is not available, refers client to other service provider or facility <p>DO YOU HAVE ANY QUESTIONS?</p>	<p>Describe the “R” (refer/re-visit) step in terms of its importance and the tasks of the counselor.</p>
<p>ROLE PLAY</p>	<p>Tell participants that they will observe a demonstration of the G-A-T-H-E-R approach to FP counseling.</p> <p>Choose a co-facilitator or a participant to act as a client.</p> <p>Review the “Skills Checklist on Counseling” with participants. Tell participants that they will be using the checklist to provide feedback.</p> <p>Demonstrate counseling.</p> <p>Process the demonstration by asking participants:</p> <ul style="list-style-type: none"> • What have they observed? Were there steps which they think they will find difficult to perform? <p>Encourage participants to ask questions.</p>

Topics/Contents	Teaching-Learning Process
	<p>Divide participants into groups with each group having a facilitator.</p> <p>In each group, participants practice performing counseling.</p> <p>Distribute the performance checklist for counseling. Review the tasks with the participants.</p> <p>For each of the role play situations, a participant acts as a counselor and the other as client. Other members of the group observe the role play and later provide feedback on the performance of the “counselor”.</p> <p>During the feedback session, the facilitator asks:</p> <ul style="list-style-type: none"> • “counselor”- how did she/he feel about her/his performance. What did she/he do well? How can she/he improve her/his performance? • “client” – how did she/he feel about how she/he was counseled? Did she/he feel that her/his needs were addressed? Was the counselor able to help her/him in decision making? What are ways to improve this counseling session? • Other participants – Using the checklist, what tasks were done well and which ones need improvement? <p>Supplement and summarize feedback after each practice.</p>
<p>Summary</p>	<p>Ask each group facilitators in plenary to summarize their group’s performance by stating common strengths and difficulties, and points for improvement.</p>



NARRATIVE

MODULE 10: COUNSELING FOR FAMILY PLANNING

SESSION 5: STEPS IN COUNSELING USING THE G-A-T-H-E-R APPROACH

A simplified concept in family planning counseling is **G-A-T-H-E-R**. The acronym stands for **greet, ask/assess, tell, help, explain, and return** for follow-up or **referral**. This is the suggested guide of steps and topics to cover while the provider and client engage in an interactive two-way discussion of the client's needs, feelings, and risks. The steps help the client go through the process of learning, weighing choices, making decisions and carrying out these decisions. In the role of helping the client choose a method, the counselor uses a specific set of skills and knowledge for each step.

G-A-T-H-E-R provides a useful framework, that simplifies the counseling process. The counseling process depends on the needs and situation of the client, so that the length and the content of these steps vary.

G-A-T-H-E-R is an acronym which stands for the six steps of family planning counseling. The acronym serves as a guide for the counselor as she performs counseling.

Not all the steps are applied to all clients in the same way. Each individual client's needs determine the counselor's level of emphasis of each of the steps. Some clients may need a step repeated, while others may need only a brief exposure to a step.

G-A-T-H-E-R stands for:

G: Greet the client.

A: Ask the client about herself/himself, assess her/his knowledge, needs and risks (including risks for sexually-transmitted infections like HIV/AIDS).

T: Tell the client about family planning methods based on her/his needs and knowledge.

H: Help the client choose a method.

E: Explain how to use the method.

R: Return for follow-up and refer for services.

The “G” (Greet) Step

This step relates to how a counselor can begin to establish a relationship/rapport with the client during their first meeting. A good relationship develops when both counselor and client share common goals, are open and communicative, and respect and trust each other. This session introduces the norms of counseling, which sets the stage for a positive relationship.

The following are the tasks in the **G** step.

- As soon as you meet the client, give your full attention.
- Greet client politely, introduce yourself, and make client comfortable by offering a seat.
- Ask the reason for the visit and how you can help.
- Assure the client that anything that is discussed during the session will be kept confidential.

The “A” (Ask/Assess) Step

The A step which is the second step in the G-A-T-H-E-R technique **asks** clients about themselves and **assesses** their reproductive needs, family planning knowledge, STI risks, and relationship with partner.

The tasks of the “A” step are:

- Ask the client about self (use FP form I). This will include:
 - General data
 - Medical/OB-Gyne history
 - Physical examination, if necessary
- Check if there are any existing medical conditions that will not warrant the use of a specific FP method.
- Assess the client’s reproductive need
 - Ask the client if she/he plans to have another baby
 - Ask client when she/he plans to have their next baby
 - Client’s reproductive need can be classified into three categories

METHODS	REPRODUCTIVE NEEDS		
	Short term (< 3 yrs)	Long term (≥ 3 yrs)	Permanent
	Condom, LAM, FAB methods, Pills, DMPA, IUD	FAB methods, Pills, DMPA, IUD	BTL, Vasectomy, DMPA, IUD

- Ask client’s knowledge and previous use of FP
 - What do you know about FP?
 - Have you used any method in the past? If yes, what method and for how long? Are you satisfied with the method? If no, why?
 - Correct any misconceptions if there are.
- Assess client’s STI Risks
 - Find out if the client knows or suspects that her/his partner may be engaging in sex with other partners or if the client herself/himself might have other partners by asking indirect questions beginning with
 - ✓ How is your relationship with your husband/wife/partner? Or ask:
 - ✓ Have you or your partner ever been treated for STIs in the past?
 - For a woman, ask:
 - Do you have any of the following?
 - ✓ Unusual discharge from your vagina?
 - ✓ Itching or sores in or around your vagina?
 - ✓ Pain or burning sensation on urination?
 - For a man, ask:
 - Do you have any of the following
 - ✓ Pain or burning sensation on urination?
 - ✓ Open sores anywhere in your genital area?
 - ✓ Pus coming from your penis?
 - ✓ Swollen testicles or penis?
 - If answer is YES to any of the questions above, refer the client for treatment. Talk to the client about the use of condom.

- Assess for Violence Against Women (VAW) – you may ask the following questions
 - ◉ How is your relationship with your husband or partner?
 - ◉ Does he know about your coming here in the clinic?
 - ◉ Is he willing to cooperate or support you in using FP method?

For any indication of VAW, refer client to the nearest Women’s Crisis Center.

- Assess the possibility of pregnancy.

The provider can be reasonably sure that the woman is not pregnant if:

- ◉ Her menstrual period started within the last seven days
- ◉ She gave birth within the last four weeks
- ◉ She had an abortion or miscarriage within the last seven days
- ◉ She gave birth within the last six months, is fully breastfeeding, and has not yet had a menstrual period
- ◉ She has not had sexual intercourse since her last menstrual period
- ◉ She uses a modern/reliable family planning method correctly

Even if she has been using a planning family method correctly but her last menstrual period is more than five weeks ago and she has had sex, pregnancy cannot be ruled out. An exception is if she is using a progestin-only injectable.

- If not reasonably sure that the woman is not pregnant, the counselor should ask her about signs of pregnancy.

Early signs of pregnancy

- Late menstrual periods
- Breast tenderness
- Nausea
- Vomiting
- Weight gain
- Always tired
- Mood changes
- Changed eating habits
- Urinating more often

Later signs of pregnancy (more than 12 weeks from last menses)

- Larger breasts
- Darker nipples
- More vaginal discharge
- Enlarging abdomen
- Movements of a baby

- If the woman has had several of these signs, she may be pregnant.
- If the woman’s answer or the physical examination cannot rule out pregnancy, she can either:
 - ◉ Have a pregnancy test or,
 - ◉ Wait until her next menstrual period before starting a method. In the meantime, her partner can use the condom.
- Assess the client’s condition using the FP Service Record to identify the health status of the client and abnormal conditions he/she may have. Findings of this assessment may then be looked up in the WHO Medical Eligibility Criteria (MEC Wheel or summary table) to determine suitability of the client for using the chosen method.
- *Category 3* and *4* conditions indicate that the method cannot be provided.

Revisit Clients

The following are the tasks for revisit clients during the “A” step:

- ◉ Ask if their situation has changed since their last visit

- ⦿ Ask whether reproductive needs have changed
- ⦿ Ask them whether they have new concerns
- ⦿ Ask them if they have any problems related to their method
- ⦿ Re-assess STI / HIV risk and client's relation with partner

The “T” (tell) Step

The counselor **tells** a client about the family planning methods suitable for her/him based on reproductive needs and health status. A client who wants to use family planning should know the basic information about the available methods before she/he decides to use one. What she/he needs to know depends on reproductive needs, health status, those that interest her/him, and what she/he already knows about these appropriate methods. These information should have been taken during the previous ask/assess, (A step).

The tasks under the T step are:

- Tell the client about the FP methods in terms of:
 - ⦿ What the method is
 - ⦿ How each method works
 - ⦿ The advantages of each method
 - ⦿ The disadvantages of each method
 - ⦿ The possible side effects of each method
- Correct rumors and misconceptions the client may have.
- Use IEC materials such as samples of contraceptives, leaflets, table flip charts, cue cards, etc.

The “H” (help) Step

After providing the client with the information on FP methods appropriate to her/his reproductive needs and health status, the client is then helped to make voluntary, well-informed decisions. It is the counselor's role to help clients make sound decisions.

The primary task of the **H step** is to **help** the client make a decision on what FP method she/he would want to use. Other tasks include:

- Asking the client if there is anything she/he did not understand; repeat information as needed.
- Asking the client what additional information is needed to help her/him make a decision.
- Asking the client what method during the “tell” step interested her/him the most.
- Determines client's suitability for her/his chosen method using the specific MEC Checklist for the chosen FP method.
- Asks the client how she/he will tolerate possible side effects of the chosen method.
- If the client decides not to use a method, tell the client about:
 - ⦿ Possibility of pregnancy
 - ⦿ Availability of pre-natal services
 - ⦿ Assure the client that they can return to see you at any given time should they decide to use a FP method.

The “E” (explain) Step

After a thorough assessment of the client during the “A” step, tell the client about appropriate family planning methods during the “T” step and help the client to choose a method in the “H” step, the client finally chooses a method she/he can use. The counselor then provides the method and explains the “E” step and how to use the method.

The main tasks of the counselor in the E step are the following:

- Explain to the client how to start and use the chosen FP method.
- Explain the warning signs of the chosen FP method and what to do and where to go should she/he experience any one of these warning signs.
- Confirm client's understanding of what has been said by asking her/him to repeat what you have said in client's own words. Correct misunderstandings.
- Provide the method, if appropriate and available.
- Give the clients informational materials on the method chosen.

Revisit Clients

Ask clients to:

- Tell you how she/he uses the present method and the warning signs for the method.
- Repeat instructions on how to use the method and/or the warning signs if what client said were incomplete or incorrect.

The “R” (refer/revisit) Step

The “R” return/refer step of the **G-A-T-H-E-R** is the final, equally important step of the counseling process. During this step, the counselor can potentially do two things: first, the counselor may inform the client about when to return, for both routine and emergency follow-up; and second, the counselor may need to refer a client for evaluation of a medical problem or for a contraceptive method that is not available.

Routine and emergency follow-up are defined as:

- ◉ Routine follow-up is defined as a visit that the client makes to get supplies, or have a routine (or scheduled) check-up.
- ◉ An emergency follow-up visit is when a client experiences a warning sign or complication. If this should occur, the client should seek medical help immediately.

It is important to emphasize to the client that counseling does not end after she/he has made a decision in choosing a family planning method. The support should be continuous to ensure client's satisfaction and safety while using the chosen method.

Return/follow-up visits provide support to clients because it is an important opportunity to:

- Reinforce the decision clients have made to plan their family.
- Discuss any problems they are having with their chosen method. Clients' concerns and complaints should never be dismissed but taken seriously with a supportive attitude.
- Answer questions they may have.
- Explore changes in their current health status or life situation, which may indicate a need to switch to another contraceptive method or to stop using any method.

The tasks of the R step are:

- Tell the client when and where to go for routine follow-up.
 - ◉ Schedule the next visit before client leaves.
 - ◉ Assure that s/he should not hesitate to come back for any problems, specially warning signs.
- Refer client for methods and/or services you do not provide. Provide client with a referral note.

During return/follow-up visits, the counselor:

- Reviews the chart for the details of the health history.
- Asks the client how s/he feels with the method and if s/he has any questions.
- If s/he is having any problems with the method, assesses the nature of the problem and discusses possible solutions.

- If the problem is a side-effect, assesses how severe it is and offers suggestions for managing it or refers the client for treatment.
- If the client is not using the method any more, asks why not (it may be due to problems related to misunderstanding, side-effects or supply).
- If the client still wishes to continue using a contraceptive, answers her/his questions and provides information that will enable her/him to continue with a contraceptive of choice.
- If the client is still using the method, determines if it is being used correctly. Asks the client how s/he is using the method. Re-enforces instructions on the correct use of the method, if necessary.
- Ensures that the client receives re-supplies and an appropriate examination, if necessary.
- Assists the client in selecting another contraceptive method if the client is not satisfied with the chosen method, if her/his situation has changed, or if the method is no longer safe.
- If the client wishes to become pregnant, helps her to stop her method and provides information on the return of fertility. Emphasizes the importance of antenatal care, which the midwife can provide.

Bear in mind that especially for revisit clients, counseling should be conducted again, using the appropriate G-A-T-H-E-R steps. The tasks enumerated above may fall under the different steps of the G-A-T-H-E-R Approach.

ROLE PLAY SITUATIONS

1. A 25-year-old woman with two children wants to wait at least five years before she has another child. She has never used family planning and knows very little about available methods.
2. A 21-year-old with two children wants to wait three years before having another child. She is returning to the clinic for more pills. She started taking pills about a year ago.
3. A 21-year old woman in her second year of post-graduate college has one child, and she wants to have her next child after she finishes her education in three years. She has never used family planning, and she knows nothing about modern methods.
4. A 26-year-old female consulted for an FP method. She prefers to take the pills, and just had her menstruation 10 days ago she has not had sexual intercourse since her last menses. She wanted to have a child after three years. How will you advise her on starting the pills?
5. A 38-year-old woman who has four children wants no more. She is currently using the pill and has used the injectable in the past. She knows about these two methods but very little about sterilization.
6. A 22-year-old woman with a one-year old child comes to the clinic to inquire about FP. She wants to postpone pregnancy for two years. She practiced LAM. After discussing appropriate methods to her, she eventually chooses the SDM.
7. A 24-year-old postpartum mother went to the FP clinic for consultation. She is fully breastfeeding her 1st baby for 1½ month. She is afraid she will not be able to continue breastfeeding, since she is required to report to her office the following week. She prefers to take pills to prevent pregnancy.
8. A 36-year old mother of five went to your FP clinic for advice. She had an abortion five days ago. She doesn't want to undergo the same experience and wanted something to protect her from becoming pregnant. The client does not want the pills.
9. A previous client came back to your clinic for advice. She missed her pills for three days and is afraid she will get pregnant. She had sex with her husband two days ago. What would you tell her as FP counselor?

10. A woman with two children who has been using the pills for three months comes into the clinic for consultation. She would want to try the injectable as she doesn't want to take a pill each day.
11. A woman with two children has been taking the pills for two months now. She returns to the clinic with complaints of nausea during pill intake.
12. A woman who had her 4th injection of DMPA has been worried of not having menses for the past two months.

COUNSELING SKILLS PRACTICE CHECKLIST

PARTICIPANT _____ COURSE DATE _____

Instruction: Check the appropriate column for each of the tasks.

Key: 2= Yes 1= Yes, but needs improvement 0= No NA= Not applicable	2	1	0	NA
Interpersonal Communication				
1. Maintains eye contact with the client.				
2. Uses simple language that the client understands.				
3. Uses appropriate tone of voice.				
4. Exhibits positive non-verbal communication.				
5. Uses the cue card effectively.				
6. Asks open-ended, closed and probing questions effectively.				
7. Listens attentively to client's response and concerns.				
COUNSELING PROCESS				
1. Greets client and introduces self.				
2. Offers the client a seat.				
3. Asks reason for client's visit.				
4. Respects clients right by:				
– Ensuring confidentiality				
– Providing privacy				
5. Invites client to speak freely.				
New Clients				
6. Uses the FP Form 1 to obtain relevant information.				
7. Assesses the client's reproductive needs (short-term, long-term, permanent)				
8. Asks client if s/he has a method in mind and what s/he knows about the method.				
9. Assesses what the client knows about FP methods.				
10. Asks if client has previously used an FP method and reason for discontinuing.				
11. If postpartum, assesses the client's willingness to breastfeed.				
12. Assesses reproductive health needs of clients				
• Risk for STIs				
• Gender-based violence (VAW)				
13. Checks what possible methods client can use by using the WHO Medical Eligibility Criteria (i.e., wheel or summary table).				
14. Corrects rumors and misconceptions.				

Key: 2= Yes 1= Yes, but needs improvement 0= No NA= Not applicable	2	1	0	NA
15. Tells the client about available methods based on her/his knowledge and reproductive needs. <ul style="list-style-type: none"> • Mode of action • Advantages and disadvantages • STI and HIV prevention • Possible side effects 				
16. Allows the client to choose a method among those previously presented to him/her.				
17. Determines suitability of the chosen method using the method specific MEC checklist.				
18. Helps the client make a decision by asking her how s/he will cope with potential side effects of the chosen method.				
19. Correctly explains to the client how to use the chosen method.				
20. Offers condoms to clients with risk for STIs for dual protection and/or back-up.				
21. Correctly explains the warning signs and what s/he should do if any of these occurs.				
22. Checks at appropriate times if client has understood the information or instructions given.				
23. Asks the client to repeat all instructions in her/his own words.				
24. Tells the client when to return for routine follow-up, if needed.				
25. Refers the client for methods or services not offered at counselor's site.				

Key: 2= Yes 1= Yes, but needs improvement 0= No NA= Not applicable	2	1	0	NA
<i>Return Clients</i>				
1. Greets the client and introduces self, if needed.				
2. Offers the client a seat.				
3. Retrieves client's records.				
4. Re-assures confidentiality and provides privacy.				
5. Asks if the client's situation, including her/his reproductive needs, had changed since the last visit.				
6. Asks the client if s/he has problems with the method s/he is using.				
7. If client is satisfied with her/his present method:				
• Asks the client to repeat how s/he uses the method.				
• Asks the client to repeat warning signs of the method s/he is using and emphasizes that immediate consultation should be sought if any of these occurs.				
• Gives client re-supply of the method s/he is using.				
• Tells the client when to return for follow-up, if needed.				
8. If client is not satisfied with the method:				
• Tells the client that there are other methods that s/he can use to meet his/her needs				
• Tells the client about appropriate methods for her/his reproductive need.				
• Helps the client make a decision by determining how s/he will cope with potential side effects.				
• Explains how to use the chosen method, including what to do for warning signs.				
9. Refers the client for methods or services not offered at the clinic.				

COMMENTS/RECOMMENDATIONS:

10.56

Trainer's Signature: _____



MODULE 11



Management of Family Planning Clinic Services

Session 1: Managing for Quality

Session 2: Facility-Based FP Services

Session 3: Management Support Systems

Session 4: Monitoring and Evaluation

Session 5: Service Delivery Network

MODULE 11: MANAGEMENT OF FAMILY PLANNING CLINIC SERVICES

MODULE OVERVIEW

It is important for doctors, nurses, midwives, health supervisors, and other health workers to know the essentials of family planning (FP) clinic services management. Learning how to manage FP services in clinics is an important requisite for providing good quality health care. Standard operating procedures and requirements have to be set and followed for an effective and efficient management of FP services.

MODULE OBJECTIVE

At the end of the module, the participants will be able to:
Improve competency in managing FP clinic services to provide quality health care.

MODULE SESSIONS

Session 1	Managing for Quality
Session 2	Facility-Based FP Services
Session 3	Management Support Systems
Session 4	Monitoring and Evaluation
Session 5	Service Delivery Network

Topics/Contents

Teaching-Learning Process



MODULE 11



MANAGEMENT OF FAMILY PLANNING CLINIC SERVICES

Greet the participants.

Present the Module Overview, Objective and Sessions as presented in the slide.



OVERVIEW

- Learning how to manage FP services in clinics is an important requisite for providing good quality health care.
- It is important for service providers to know the essentials of management of FP clinic services
- This module will provide the information that will support the service providers in the effective and efficient managing of FP clinic services.



OBJECTIVE

At the end of the module, the participants will be able to:
Improve their management skills for quality FP clinic services.



SESSIONS

- Session 1** - Managing for Quality
- Session 2** - Facility-Based FP Services
- Session 3** - Management Support Systems
- Session 4** - Monitoring and Evaluation
- Session 5** - Service Delivery Network

MANAGING FOR QUALITY



LEARNING OBJECTIVES

At the end of the session, participants must be able to:

1. Define quality.
2. Explain the three principles in managing for quality FP service provision.



TIME ALLOTMENT

30 minutes



METHODOLOGY

Illustrated Lecture-Discussion
Brainstorming



ADVANCE PREPARATION OF MATERIALS

- LCD
- Laptop computer
- Whiteboard
- Powerpoint presentation of Module 11
- Manila paper, permanent markers, whiteboard markers
- Meta cards, tape
- Review manual and powerpoint presentations

Topics/Contents

Teaching-Learning Process



SESSION 1



MANAGING FOR QUALITY

Introduce the session by telling participants that:

- Quality should be the goal of any health service provision.
- Quality of care is an important aspect in the provision of FP services and managing for quality should be our goal. In other words, aim for service delivery excellence in providing health care services.
- Quality in health services was introduced in Module 10, Session 2: “Informed Choice and Voluntarism.” This module has emphasized the service providers compliance to the principles of informed choice and voluntarism.
- This session will discuss in detail principles in managing FP clinic services towards the attainment of “quality.”



Learning Objectives

At the end of the session, the participants will be able to:

- Define quality.
- Explain the three principles in managing for quality FP service provision.

State the objectives of the session as presented on the slide.

Definition of Quality

Definition

- **Quality** is the most desirable outcome of a health intervention in terms of:
 - ✓ maximum well-being for the client considering both the risks and benefits, or the gains and losses; and
 - ✓ provider satisfaction

Ask participants:

- From what you remember, what is the meaning of “quality services” as discussed in Module 10, Session 2?

Write responses on the whiteboard and review each one for clarification.

Responses should include but not be limited to:

- Services which you would want for yourself or members of your family.
- Ensuring that clients’ rights are upheld during the provision of health services.

Consolidate the responses by presenting the definition of “quality” as written on the slide.

Explain as needed.

Topics/Contents	Teaching-Learning Process
<p>Three principles in managing for quality</p> <ol style="list-style-type: none"> 1. Clients come first. 2. Quality Management Triangle <ul style="list-style-type: none"> • Quality planning and design • Quality control • Quality improvement 3. Requirements in Delivering Quality FP Clinic Services 	<p>Enumerate the three principles for managing quality FP services as written on the slide.</p>
<p>1. Clients come first</p> <ul style="list-style-type: none"> • Client-centered care • Helps clients achieve their reproductive goals. • Includes upholding the principles of clients' rights, informed choice, voluntarism and informed consent. 	<p>Ask participants what is client-centered service.</p> <p>Responses should include but not be limited to:</p> <ul style="list-style-type: none"> • In providing services, clients want: <ul style="list-style-type: none"> ✓ Respect ✓ Understanding ✓ Fairness ✓ Provision of accurate information ✓ Competence of service provider ✓ Convenient services ✓ Services that provide results in achieving their own reproductive goals
<p>2. Quality Management Triangle</p> <div data-bbox="357 1317 614 1550" data-label="Diagram"> </div> <p><i>(adapted from Population Reports, Volume XXVI, Number 3 November, 1998)</i></p>	<p>Explain the Quality Management Triangle while showing the slide, as follows:</p> <ul style="list-style-type: none"> • Quality Management Triangle <ul style="list-style-type: none"> ✓ Quality planning and design-sets objectives, allocates resources, and establishes guidelines to ensure effectiveness and safety, maximize access, and increase clients' satisfaction. ✓ Quality control-monitors program activities and staff performance to ensure that they meet quality objectives. ✓ Quality improvement-seeks to keep raising the level of care no matter what its current level is by forming staff teams to solve problems.

Topics/Contents

Teaching-Learning Process

3. Requirements for Quality FP Services

- Appropriate health facility infrastructure
- Competent staff
- Adequate logistics

Explain the requirements for quality FP services as the slide is presented.

Ask participants what they understand by each of these requirements. Examples of responses may be:

- Appropriate health facility infrastructure
 - ✓ Clean environment
 - ✓ Room that provides privacy for counseling and examination
 - ✓ Comfortable waiting area
 - ✓ Adequate water supply
- Competent staff
 - ✓ Staff trained in providing quality FP services
 - ✓ Compliant to principles of informed choice and voluntarism (ICV)
- Adequate logistics
 - ✓ Functional equipment/instruments
 - ✓ Continuous supply of contraceptives

Summary

Ask participants for questions or comments.



NARRATIVE

MODULE 11: MANAGEMENT OF FAMILY PLANNING CLINIC SERVICES

SESSION 1: MANAGING FOR QUALITY

MANAGING FP CLINIC SERVICES FOR QUALITY

Quality of care is an important aspect in the provision of FP services and managing for quality should be our goal. In other words, aim for service delivery excellence in providing health care services. Quality should be the goal of any health service provision.

Quality is attaining the maximum well-being for the client considering both the risks and benefits which also results in provider satisfaction.

There are three principles in managing a FP service towards quality. These are:

1. **Clients come first.** Client-centered care provides what clients want- respect, understanding, fairness, accurate information, competence, convenience, and results. The best care helps clients achieve their own reproductive goals.

2. Quality Management Triangle



- Quality planning and design - sets objectives, allocates resources, and establishes guidelines to ensure effectiveness and safety, maximize access, and increase clients' satisfaction.
- Quality control - monitors program activities and staff performance to ensure that they meet quality objectives.
- Quality improvement - seeks to keep raising the level of care - no matter what its current level - often by forming staff teams to solve problems.

(adapted from Population Reports, Volume XXVI, Number 3 November, 1998)

3. Requirements in delivering quality FP services

Three elements are required to enable a health facility to deliver the appropriate FP services.

These include:

- appropriate **health facility infrastructure** and a conducive environment;
- presence of **competent staff**; and
- **adequate logistics** in terms of functional equipment/ instruments and continuous supply of contraceptives and other materials

FACILITY-BASED FP SERVICES

LEARNING OBJECTIVES

At the end of the session, participants will be able to:

1. Identify the components of a facility-based FP services.
2. Explain each of the components of a facility-based FP services.



TIME ALLOTMENT

30 minutes





METHODOLOGY

Lecture-discussion
Brainstorming



ADVANCE PREPARATION OF MATERIALS

- LCD
- Laptop computer
- Whiteboard
- Powerpoint presentation of Module 11
- Manila paper, permanent markers, whiteboard markers
- Metacards, tape
- Review manual and powerpoint presentations

Topics/Contents	Teaching-Learning Process
 <h2 style="color: #008000;">SESSION 2</h2>  <h3 style="color: #008000;">FACILITY-BASED FP SERVICES</h3>	<p>Introduce the session by stating the title and objectives of the session as presented on the slide.</p>
<p>LEARNING OBJECTIVES</p> <p>Learning Objectives</p> <p>At the end of the session, participants will be able to:</p> <ul style="list-style-type: none"> • Identify the components of a facility-based family planning services. • Explain each of the components of a facility-based family planning services. 	
<p>Components of a Facility-Based FP Services</p> <h3 style="color: #008000;">Components of a Facility-Based FP Services</h3>	<p>Ask participants:</p> <p>What activities related to family planning are being performed in your facilities?</p> <p>Write down responses on the board.</p> <p>Responses should include:</p> <ol style="list-style-type: none"> 1. FP Promotion 2. FP Counseling 3. Provision of FP Methods 4. Infection prevention and control 5. Referral of clients <p>Review responses and categorize as appropriate.</p> <p>Some responses may fall under any of the above components.</p>
<p>FP Promotion</p> <ul style="list-style-type: none"> • Emphasis on the benefits of practicing FP • Awareness on the links of FP to other RH elements • Giving of correct information about FP and FP methods • Provision of full information on each FP method as the basis of clients in making their decisions and choice 	<p>Explain each of the components of a facility-based FP service as presented in the slides.</p>

Topics/Contents

Teaching-Learning Process

FP Counseling

- Two-way, face-to-face communication in which the FP service provider helps a client make a voluntary decision about her/his fertility and make an informed choice on what method to use.

Provision of FP Methods

- Includes provision of all medically approved, safe, effective, and legally acceptable modern Family Planning methods.
- The following services are performed, as needed:
 - Physical assessment of clients including pelvic examination
 - Screening for common and other gynecological problems (i.e., RTIs, STIs, cervical cancer, breast cancer)
 - Management/referral for services not available in the facility
 - Simple laboratory procedures

Infection Prevention and Control

- Prevention of the spread of infection during the provision of FP methods
- Aims to protect both clients and providers from the spread of infectious disease

Referral of Clients

- Referral encompasses sending a client to or receiving a client sent by other clinics or service providers for any FP or related services that the other clinic can ably deliver.
 - What needs to be referred?
 - Where should clients be referred?
 - How do you refer?

11.10



NARRATIVE

MODULE 11: MANAGEMENT OF FP CLINIC SERVICES SESSION 2 : FACILITY-BASED FP SERVICES

FACILITY-BASED FP SERVICES

The major components of FP services in health facilities should include the following:

1. FP Promotion

- Emphasis on the health benefits of practicing FP
- Awareness on the links of FP to other health developments;
- Giving of correct information about FP and FP methods;
- Provision of full information on the effectiveness, mechanism of action, advantages, and disadvantages or side effects of each FP method as the basis of clients in making their decisions and choice.

2. FP Counseling

FP counseling is a service provided to individual clients through a two-way, face-to-face communication in which the FP service provider helps the identified client make an informed, voluntary decision (ICV) about her/his fertility and make an informed choice.

3. Provision of FP Methods

These include provision of all medically approved, safe, effective, and legally acceptable modern methods. The following services are provided, as needed:

- Physical assessment of clients including pelvic examination;
- Screening for common and other gynecological problems (i.e., RTIs, STIs, cervical cancer, breast cancer)
- Management/referral for services not available in the facility
- Simple laboratory procedures

4. Infection prevention and control

Infection control in FP refers to the prevention of the spread of infection during the provision of FP methods. It aims to protect both the clients and providers from the spread of infectious diseases.

5. Referral of clients

Referral and follow-up of clients are additional services that can be given depending on the condition of the clients and the existing capacity of the health facility to address the need of the client. Referral encompasses sending a client to or receiving a client sent by other clinics or service providers for any FP or related services that the other clinic can ably deliver.

- What needs to be referred?
 - Difficult IUD removal
 - Other FP services not available in the clinic
 - Voluntary Surgical Sterilization (VSS) services
 - Complicated infertility cases
 - Medical problems
 - RTI and other complicated gynecological problems
 - Suspicious Pap smears
- Where should clients be referred?
 - Government hospital or clinic
 - Non-government hospital or clinic
- How do you refer?
 - A referral form is filled up indicating the name and condition of the client. In turn, referral centers or hospitals will indicate the action taken with the patient, then send the accomplished form back to the referring unit/center.

MANAGEMENT SUPPORT SYSTEMS



LEARNING OBJECTIVES

At the end of the session, participants will be able to :

1. Discuss the different management support systems necessary for efficient and effective delivery of quality FP services.
2. Discuss the various records and reports being used in the health facility.



TIME ALLOTMENT

One (1) hour





METHODOLOGY

Illustrated Lecture-discussion
Brainstorming



ADVANCE PREPARATION OF MATERIALS

- LCD
- Laptop computer
- Whiteboard
- Powerpoint presentation of Module 11
- Manila paper, permanent markers, whiteboard markers
- Meta cards, tape
- FP forms: FP Form 1, Target Client List (TCL), Contraceptive Distribution and Logistics Management Information System Forms (CDLMIS), FHSIS Forms version 2008
- Review manual and powerpoint presentations

Topics/Contents	Teaching-Learning Process
 <p>SESSION 3</p>  <p>MANAGEMENT SUPPORT SYSTEMS</p>	<p>Introduce the session by showing the slides and stating the objectives of the session.</p>
<p>Learning Objectives</p> <p>At the end of the session, participants will be able to:</p> <ul style="list-style-type: none"> • Discuss the different management support systems necessary for efficient and effective delivery of quality FP services. • Discuss the various records and reports being used in the health facility. 	
<p>Management Support Systems</p> <p>Management Support Systems</p> <ol style="list-style-type: none"> 1. Work and Financial Planning 2. Staff Development 3. Logistics Management 4. Resource Mobilization 5. Management Information System (MIS) 	<p>Tell the participants that:</p> <p>To deliver quality FP services, there are management support systems that need to be in place.</p> <p>Enumerate the management support systems that need to be present in a facility as presented on the slide.</p> <p>Discuss each of these support systems in detail.</p>
<p>1. Work and Financial Planning</p> <p>Definition</p> <ul style="list-style-type: none"> • This is the process of evolving a definitive direction and plan of action to respond to the demand for FP services <p>Principles in Work Planning</p> <ul style="list-style-type: none"> • Objectives and activities aligned with the vision/goal of the LGU/Organization and the overall direction of the National Family Planning Program; • Use of evidence-based information generated through program reviews, records analysis, or updated census and survey information; • Participation of all health staff and other stakeholders (i.e., private sector); • Realistic resources and funding. 	<p>Discuss "Work and Financial Planning" as presented on slides.</p> <p>Expound, as needed.</p>

Topics/Contents	Teaching-Learning Process
<p data-bbox="158 203 354 230">2. Staff Development</p> <p data-bbox="185 275 263 302">Training</p> <ul data-bbox="158 336 727 477" style="list-style-type: none"> • Process of developing staff competencies so they can effectively perform their expected functions and tasks. • Ensures capability of staff to deliver quality FP services. • Ensures availability of quality services despite fast turnover of staff in a facility. • Should be accompanied by a strong advocacy for budgetary support for staff development from local officials and mobilization of funds from other resources. <p data-bbox="185 600 299 627">Supervision</p> <ul data-bbox="158 667 743 853" style="list-style-type: none"> • Process of organizing and overseeing the work of subordinates responsible for performing certain assigned functions and tasks. • Performed to: <ul data-bbox="205 763 743 853" style="list-style-type: none"> • Find out what is happening in the actual performance of staff in all aspects of their work. • Guide, support, and assist the staff in carrying out their assigned tasks well. • Renew the enthusiasm of staff for the work they are doing. 	<p data-bbox="788 253 1334 322">Discuss "Staff Development" as presented on the slides.</p> <p data-bbox="788 367 1063 400">Expound, as needed.</p>
<p data-bbox="185 1037 417 1064">3. Logistics Management</p> <p data-bbox="158 1144 236 1171">Definition</p> <p data-bbox="158 1171 727 1211">Process which ensures that the health facility has sufficient FP commodities and supplies, necessary equipment or instruments for delivering quality FP services</p> <p data-bbox="185 1350 307 1377">Components</p> <ul data-bbox="158 1424 749 1565" style="list-style-type: none"> • Forecasting - process of determining the commodity requirements (supplies and other services) of all identified clients • Procurement - process of acquiring commodities from suppliers at affordable prices and ensuring custodial requirements to safeguard the quality of commodities • Financing - process by which the health facility decides on how the FP commodity required by identified clients will be resourced. <p data-bbox="185 1686 307 1713">Components</p> <ul data-bbox="158 1765 743 1951" style="list-style-type: none"> • Allocation and distribution - process which involves the determination of how much and where the various commodities and services will be placed to make them available to clients. <ul data-bbox="205 1839 487 1906" style="list-style-type: none"> • CDLMIS Forms • Supplies ledger cards • Requisition and Issue Vouchers (RIV) • Storage - process of ensuring that FP commodities are properly kept and maintained in good condition to avoid wastage and maintain their quality. 	<p data-bbox="788 1037 1354 1106">Discuss the "Logistics Management" system as presented on the slides.</p> <p data-bbox="788 1151 1063 1184">Expound, as needed.</p>

Topics/Contents	Teaching-Learning Process
<p>Guidelines for Storage of FP Commodities</p> <ol style="list-style-type: none"> Clean and disinfect the storage area. Provide adequate lighting and ventilation. Store contraceptives away from direct sunlight, fluorescent lights, and electric motors. Keep contraceptives in original boxes which have protective coatings. <p>Guidelines for Storage of FP Commodities</p> <ol style="list-style-type: none"> Stack cartons at least 4 inches off the floor and at least one foot away from the outer wall to allow air to circulate freely and to protect the contraceptives from being damaged due to water and other environmental conditions. Maintain updated stock cards. Write the expiration dates on the outside of the cartons and boxes and arrange the cartons in such a way that the supplies nearing expiry will be the first to be distributed/used. <p>Guidelines for Storage of FP Commodities</p> <ol style="list-style-type: none"> Secure storage areas from thieves and curious adults and children. Separate and return expired and damaged contraceptives to the delivery teams. Store all supplies of OCs, IUDs, condoms, and injectables in one place to make it easier for the delivery teams to count. 	<p>Ask participants:</p> <ul style="list-style-type: none"> Where and how do you store FP commodities? <p>Call on a few participants at random to respond to the question.</p> <p>Supplement responses by presenting the “Guidelines for Storage of FP Commodities”.</p>
<p style="text-align: center;">FUNCTIONS OF FP SERVICE PROVIDERS IN LOGISTICS MANAGEMENT</p>	<p>Ask participants what they think are their functions in logistics management.</p> <p>Write responses on the whiteboard.</p> <p>Responses should include but not be limited to:</p> <ul style="list-style-type: none"> Inventory Allocation of contraceptives and other supplies based on projection of client load Distribution of contraceptives and other supplies Ensure appropriate storage of contraceptives, other supplies, and equipment Update and maintain records and reports Ensure proper use and care of equipment <p>Review responses.</p> <p>Acknowledge correct responses and ask concerned participant/s to provide clarifications on vague responses.</p>

Topics/Contents	Teaching-Learning Process
<p style="text-align: center;">Resource Mobilization</p> <p>Description</p> <ul style="list-style-type: none"> • It involves generating and sustaining the active and coordinated participation of all stakeholders at all levels to facilitate program implementation and service delivery. • Resources encompass finances, logistics, and personnel including time/person-hours and technical expertise. <p>Mechanisms</p> <ul style="list-style-type: none"> • Generation of additional resources for FP services entail: • Mobilizing the support and participation of stakeholders from the national, regional, NGOs, local, and community levels. • Establishment of sustainable financing schemes for FP services (e.g. PhilHealth benefit packages) 	<p>Present the slide on resource mobilization.</p>
<p style="text-align: center;">Management Information System</p> <p>Definition</p> <p>The collection, processing, and analysis of program-related information essential in policy-making, planning, and designing interventions appropriate to the needs of clients</p> <p>Community-Based Management Information System (CBMIS)</p> <ul style="list-style-type: none"> • Set of sequenced and continuous steps that allows health care providers to identify eligible clients who do not avail of appropriate service delivery interventions. • The tool used covers not only FP but also selected MCH indicators. • Useful in identifying clients with FP unmet needs and FP users. • Provides and prompts alternative service delivery interventions. <p>Facility-Based Recording and Reporting System</p> <p>Considers the following:</p> <ul style="list-style-type: none"> • what data to collect • who collects the data • where the data will be recorded and stored • who will use/analyze the data • what reports shall be generated from the data 	<p>Define management information system as presented on the slide.</p> <p>Tell participants that:</p> <ul style="list-style-type: none"> • One of the important tools used for the management information system is the Community-Based Management Information System (CBMIS). <p>Tell participants that:</p> <ul style="list-style-type: none"> • Other sources of information which provides insights for managing services for quality are the facility's records and reports. <p>Discuss facility-based recording and reporting system as presented on the slides.</p>

Topics/Contents

A. FP Service Record or FP Form 1

- The basic record form used in the FP program, which corresponds to the individual treatment record form used in other programs.
- It contains essential information about the client that enables the health worker to provide quality FP service.
- It is filled out by the service provider during client interaction and is updated every time the client returns for a follow-up visit.

FP Service Record or FP Form 1

Teaching-Learning Process

Ask participants what records they have in their facility.

Describe the FP Service Record as presented on the slide.

Remind participants that filling-up of this form was practiced in an earlier session.

B. Field Health Service Information System Recording Forms

1. Target Client List (TCL) for FP
2. Summary table for BHS for FP
3. Monthly consolidation table for RHUs

1. Target Client List (TCL) for FP

- Will include all eligible women 15-49 yrs old and men who are receiving FP service
- Useful because it:
 - ✓ contains data which helps the health worker plan and carry out patient care and service delivery;
 - ✓ facilitates the monitoring and supervision of service delivery activities;
 - ✓ facilitates the preparation of reports;
 - ✓ provides clinic-level information that can be accessed for future studies.
- The TCL should be by FP method and be updated immediately after a client visits the facility

Target Client List (TCL) for FP

Tell participants that the FHSIS recording forms are the following:

- The “Target Client List” is another essential record accomplished similarly like the FP Form 1

Describe the TCL as presented on the slide.

Show other FHSIS recording forms.

Topics/Contents

Teaching-Learning Process

FHIS Report for the Quarter: Year: **Q1**
 Municipality/City Name: Projected Population of the Year: **RHU**
 Province: FHSR-201-01a

NAMES	FAMILY PLANNING						Total	Allot. Men
	1st	2nd	3rd	4th	5th	6th		
001	001	001	001	001	001	001	001	001
1. Family Planning								
2. Contraception								
3. IUD								
4. IUD (M)								
5. IUD (F)								
6. IUD (M)								
7. IUD (F)								
8. IUD (M)								
9. IUD (F)								
10. IUD (M)								
11. IUD (F)								
12. IUD (M)								
13. IUD (F)								
14. IUD (M)								
15. IUD (F)								
16. IUD (M)								
17. IUD (F)								
18. IUD (M)								
19. IUD (F)								
20. IUD (M)								
21. IUD (F)								
22. IUD (M)								
23. IUD (F)								
24. IUD (M)								
25. IUD (F)								
26. IUD (M)								
27. IUD (F)								
28. IUD (M)								
29. IUD (F)								
30. IUD (M)								
31. IUD (F)								
32. IUD (M)								
33. IUD (F)								
34. IUD (M)								
35. IUD (F)								
36. IUD (M)								
37. IUD (F)								
38. IUD (M)								
39. IUD (F)								
40. IUD (M)								
41. IUD (F)								
42. IUD (M)								
43. IUD (F)								
44. IUD (M)								
45. IUD (F)								
46. IUD (M)								
47. IUD (F)								
48. IUD (M)								
49. IUD (F)								
50. IUD (M)								
51. IUD (F)								
52. IUD (M)								
53. IUD (F)								
54. IUD (M)								
55. IUD (F)								
56. IUD (M)								
57. IUD (F)								
58. IUD (M)								
59. IUD (F)								
60. IUD (M)								
61. IUD (F)								
62. IUD (M)								
63. IUD (F)								
64. IUD (M)								
65. IUD (F)								
66. IUD (M)								
67. IUD (F)								
68. IUD (M)								
69. IUD (F)								
70. IUD (M)								
71. IUD (F)								
72. IUD (M)								
73. IUD (F)								
74. IUD (M)								
75. IUD (F)								
76. IUD (M)								
77. IUD (F)								
78. IUD (M)								
79. IUD (F)								
80. IUD (M)								
81. IUD (F)								
82. IUD (M)								
83. IUD (F)								
84. IUD (M)								
85. IUD (F)								
86. IUD (M)								
87. IUD (F)								
88. IUD (M)								
89. IUD (F)								
90. IUD (M)								
91. IUD (F)								
92. IUD (M)								
93. IUD (F)								
94. IUD (M)								
95. IUD (F)								
96. IUD (M)								
97. IUD (F)								
98. IUD (M)								
99. IUD (F)								
100. IUD (M)								

D. Other records

- two way referral slips

Important for keeping track of FP supplies in the health facility:

- Supplies Ledger Cards
- Requisition and Issue Voucher
- CDLMIS forms

Tell participants the other important records in a health facility.



NARRATIVE

MODULE 11: MANAGEMENT OF FP CLINIC SERVICES SESSION 3: MANAGING SUPPORT SYSTEMS

To deliver quality FP services, there are management support systems that are needed to be in place. For example, in the provision of FP services which is a basic activity, you need trained staff and adequate logistics.

1. Work And Financial Planning
2. Staff Development
3. Logistics Management
4. Resource Mobilization
5. Management Information System

WORK AND FINANCIAL PLANNING

This is the process of evolving a definitive direction and plan of action to respond to the demand for FP services among identified population groups. It involves the selection of appropriate approaches and interventions in light of the particular condition or situation of the identified groups. Planning must observe the following principles:

- objectives and activities aligned with the vision/goal of the LGU/Organization and the overall direction of the National Family Planning Program;
- use of evidence-based information generated through program reviews, records analysis, or updated census information;
- participation of all health staff and other stakeholders (i.e., private sector)
- realistic resources and funding.

Guide in Preparing a Work and Financial Plan for FP

A. Review of Program Accomplishment and Situation Analysis

1. Conduct health facility self-assessment and identify clinic requirements in terms of staff, training, and logistics – contraceptives based on Contraceptive Self-Reliance, clinic supplies, IEC materials; service record forms
2. Review program accomplishments and needs
 - 2.1 identify strengths or best practices
 - 2.2 identify and summarize gaps/weaknesses
3. Install or update the CBMIS and identify selected population
 - 3.1 those with unmet FP needs
 - 3.2 current FP users
 - 3.3 FP clients who dropped out
4. Prioritize identified clients to be served
 - Priority I: Pregnant/postpartum mothers below 18 years or above 35 years, parity of four or higher, child interval of less than three years, low level of education, poor obstetrics/gynecological history.
 - Priority II: Immediate postpartum, postabortal, lactating mothers of malnourished children below five years.

Priority III: Couples suffering from tuberculosis, malaria, heart and kidney diseases, STI/ HIV/AIDS, and with metabolic diseases such as diabetes mellitus and thyroid disorders

B. Preparing the Work and Financial Plan

1. Set goals and objectives for next year based on assessment results
2. Identify strategies and activities to realize the objectives
3. Determine the focal person/staff responsible for the activity
4. Specify the time frame/schedule of activities
5. Estimate the amount of resources/funds needed and identified sources
6. Specify the success indicators to facilitate monitoring of accomplishments

C. Submission of Work and Financial Plan

1. Integrate FP work and financial plans with the health facility's overall annual plan
2. Submit to the LGU Planning and Development Office and LCE for approval
3. Request budget allocation or funding support from key stakeholders

(Source: Adapted from 1997 FP Clinical Standards Manual)

STAFF DEVELOPMENT

• Training

Training is the main vehicle for enhancing and ensuring the capability of staff to deliver quality FP services. It is the process of developing staff competencies so they can effectively perform their expected functions and tasks.

All providers of FP services must undergo appropriate training (see Table 4 in participants workbook).

Given the fast turnover of staff in the health facility, it is important that a staff development plan be in place and updated yearly. This must be accompanied by a strong advocacy for budgetary support from local officials and mobilization of funds from other resources.

• Supervision

This is the process of organizing and overseeing the work of subordinates responsible for performing certain assigned functions and tasks. It is a personal interface between the supervisor and supervisee, which must be undertaken regularly for the effective operation of the program and for sustaining staff morale and commitment.

Supervision is essential for two reasons: (a) to find out what is happening in the actual performance of staff in all aspects of their work, and (b) to renew the enthusiasm of staff for the work they are doing. The overall guiding principles of supervision are to guide, support, and assist the staff in carrying out their assigned tasks well (Table 4).

Guide in Staff development

A. Training of Staff

1. Conduct/update an inventory of the training status of health staff.
2. Conduct training needs analysis (TNA) among staff.
3. Discuss TNA results with staff.
4. Identify gaps in competencies and identify appropriate training courses
5. Prepare the staff development plan specifying the following:
 - 5.1 name of staff to be trained
 - 5.2 specific training course to attend
 - 5.3 projected schedule for training
 - 5.4 potential sources of funds for training
6. Coordinate with the provincial/city or regional health office for training opportunities for your health staff in specific training courses.
7. Mobilize resources to support staff training.
8. Send staff to training and reassign other staff to take on the trainee's tasks.
9. Monitor the application of knowledge and skills learned during the training program.
10. Maintain training certificates and training records.

B. Supervision of Staff

1. Organize the work of clinic staff and volunteer workers responsible for implementing/delivering FP services and general clinic operations, including:
 - 1.1 infection control and good housekeeping
 - 1.2 equipment and supplies maintenance
 - 1.3 provision of service to FP/RH clients
 - 1.4 proper recording and reporting
2. Designate the supervisor of an individual or group of staff who will perform specific tasks and reflect these designations in the organizational chart
3. Prepare the supervisory plan by:
 - 3.1 identifying staff who need supervision
 - 3.2 prioritizing the specific program area where supervision is necessary
 - 3.3 scheduling when supervision visit/session will be undertaken
4. Implement the supervision.
5. Document the results of the supervision.
6. Give feedback to the supervisee.
7. Develop an action plan with the supervisee to address gaps identified.

LOGISTICS MANAGEMENT

This is the process of ensuring that the health facility has sufficient FP commodities and supplies to meet the needs of FP clients and has the necessary set of equipment or instruments to use in delivering quality FP services. With the eventual phase out of donated contraceptives from USAID (condoms were phased out beginning 2003, pills completely phased out in 2007 and injectables in 2008), health facilities need to start securing the continuous supply of contraceptives to serve their current and potential FP users. The CSR Strategy (AO no. 158 s.2004) issued by DOH stipulates guidelines that LGUs should follow.

The needed logistics and management system encompasses the following concerns:

A. Forecasting

It is the process of determining the commodity requirements (supplies and other services) of all identified clients. It requires profiling the clients in terms of their capacity to pay to determine the segment which should continue to benefit from the limited public resources or those who should avail of services from the private sector.

Steps in forecasting:

1. Identify the selected groups or clients for whom the LGU or health facility will be providing contraceptives.
2. Establish the desired contraceptive mix for the identified groups.
3. Decide on the following options
 - Option 1: forecast the total requirement of the whole population based on demographic data such as number of married women of reproductive age (MWRA) with FP unmet need and current users
 - Option 2: forecast requirements based on the average consumption of the identified population to include potential acceptors
 - Option 3: forecast requirements needed based on available resources of the LGUs for FP commodities
4. Determine the amount needed for procurement.

B. Procurement and financing

Procurement is the process of acquiring commodities from suppliers at affordable prices and ensuring custodial requirements to safeguard the quality of commodities.

Financing is the process by which the health facility decides on how the FP commodity required by identified clients will be resourced—to be paid out of pocket, given free by the LGU, or through subsidies or sponsorship by concerned stakeholders, or through Philippine Health Insurance Corporation (PhilHealth or PHIC) benefit packages.

Guide in Procurement and Financing:

1. Consider the different options in financing the FP commodity requirements of clients

Option 1: allocate budget to procure contraceptives for free distribution

Option 2: make available contraceptives for sale at cost recovery basis or at margins above cost

Option 3: allow consigned supplies from social marketing sources or commercial sources to be made available to clients in LGU outlets

2. Decide which of the following options to adopt in procuring FP commodities

Option 1: direct and separate purchase by the LGU of FP commodities from national or regional-level suppliers or retained hospitals, or distributors of FP products (e.g., DKT)

Option 2: purchase of FP commodities as part of the regular procurement of drugs/ medicines conducted by the LGU

Option 3: bulk procurement through the established interlocal health zone (ILHZ) where the LGU belongs or as part of the procurement

C. Allocation and distribution

This process involves determining how much and where the various commodities and services will be placed to make them available to different identified clients.

This requires the identification of actual clients to make sure that the commodities are placed in appropriate structures or outlets where they can be easily accessed.

FP commodities from DOH and those procured by LGUs should be allocated and distributed using the CDLMIS Modified Forms as stated in AO 158 s. 2004.

11.24

These forms consist of :

- Inventory Report
- Contraceptive Order Form (COF)
- BHS Contraceptive Order Worksheet
- Summary Delivery Report
- Dispense to User Record

(See Appendices 1a-e, Philippine Clinical Standards Manual on Family Planning).

Guide in Allocation and Distribution:

1. **At health facility level I** (e.g. BHS)

- 1.1 Issue contraceptives directly to clients or to BHWs or other community volunteers
- 1.2 Determine the quantity to be requested to level II facility (e.g. RHU) using the Dispensed To User Record (DTUR) and by filling out columns of the BHS worksheets.
- 1.3 Place the order for contraceptives to immediate level (e.g. RHU) using the BHS Worksheet
- 1.4 Keep the record of issuances of contraceptives made to clients or other workers (e.g. DTUR)

2. At Levels II-III health facilities (e.g. RHUs/hospital)

- 2.1 Review and issue the requested supplies reflected in the BHS Worksheet submitted by the facilities
- 2.2 Keep and maintain the Contraceptive Supplies Folder with copies of CDLMIS Forms of all health facility I units (e.g. BHS) within your coverage

3. At the interlocal health zone or provincial level (if applicable)

- 3.1 Determine the quantity of contraceptives to give to facilities based on data on the contraceptive order form (COF)
- 3.2 Keep and maintain the Contraceptive Supplies Folder with copies of all CDLMIS Forms (e.g. COF) of all health facilities (RHU/hospital) within your coverage

D. Storage

This is the process of ensuring that FP commodities are properly kept and maintained in good condition to avoid wastage and maintain their quality.

Guidelines for Storage of FP commodities

1. Clean and disinfect the storage area.
2. Provide adequate lighting and ventilation.
3. Store contraceptives away from direct sunlight, fluorescent lights, and electric motors.
4. Keep contraceptives in original boxes which have protective coatings.
5. Stack cartons at least four inches off the floor and at least one foot away from the outer wall to allow air to circulate freely and to protect the contraceptives from being damaged due to water and other environmental conditions; maintain updated stock cards.
6. Maintain updated stock cards.
7. Write the expiration dates on the outside of the cartons and boxes and arrange the cartons in such a way that the supplies which will expire first are used first (FEFO).
8. Secure storage areas from thieves and curious adults and children.

9. Separate and return expired and damaged contraceptives to the delivery teams.
10. Store all supplies of OCs, IUDs, condoms, and injectables in one place to make it easier for the delivery teams to count.

Functions of the FP worker in logistics management

Given the above processes and requirements in logistics management, the health facility worker must always see to it that supplies are sufficient, that no stock runs out, and that the equipment are in good working condition.

Specifically, the FP worker should: (show slide on the functions of an FP worker)

1. make a regular inventory of all commodities, supplies, and equipment;
2. allocate and distribute correctly and on time the contraceptives and other supplies (IEC materials, forms, etc.) based on client needs;
3. ensure appropriate storage of contraceptives, other supplies, and equipment;
4. update and maintain records and reports;
5. monitor proper use and care of equipment. There are two types of equipment - the expendable equipment for short-term use, and the non-expendable equipment, which refer to items used for a longer time and therefore need proper care and maintenance.

RESOURCE MOBILIZATION

Mobilizing additional resources is paramount to the effective and efficient management of FP clinic services.

There are different mechanisms to generate additional resources for FP services.

Generation of additional resources for FP services entail:

- mobilizing the support and participation of the different stakeholders from the national, regional, local, and community levels
- establishment of sustainable financing schemes for FP services, such as availing of certain Philippine Health Insurance Corporation Benefit Packages where FP services are compensable.

MANAGEMENT INFORMATION SYSTEM (MIS)

MIS involves the collection, processing, and analysis of program-related information essential in policy-making, planning, and designing interventions appropriate to the needs of selected clients.

COMMUNITY-BASED MANAGEMENT INFORMATION SYSTEM consists of a set of sequenced and continuous steps that allows health care providers to identify eligible selected clients who do not avail of appropriate health services in a given locality. It provides and prompts alternative service delivery interventions. Since its inception in the mid-1990s, the CBMIS tool has been expanded to cover not only FP but also selected maternal and child health indicators.

FACILITY-BASED RECORDING AND REPORTING SYSTEM

A. Recording form for FP

1. FP SERVICE RECORD (FP FORM 1)
 - The basic record form used in the FP program, which corresponds to the individual treatment record form used in other programs.
 - It contains essential information about the client that enables the health worker to provide quality FP service.
 - It is filled out by the service provider and is updated every time the client returns for a follow-up visit.

2. TARGET CLIENT LIST FOR FP
 - contains data which helps the health worker plan and carry out patient care and service delivery;
 - facilitates the monitoring and supervision of service delivery activities;
 - facilitates the preparation of reports;
 - provides clinic-level information that can be accessed for future studies

3. SUMMARY TABLE FOR BHS FOR FP

4. MONTHLY CONSOLIDATION TABLE FOR RHUs FOR FP

B. Reporting Forms for FP

1. FHSIS/M1 BHS forms - monthly reporting form that the midwife fills up to report the accomplishments from the first day to the last day of the month and submits to the nurse at the RHU/MHC for consolidation.

2. FHSIS/Q1 RHU forms - quarterly reporting form from the municipality / city. It contains the consolidated three months reports of all the BHSs and the RHU/MHC for health service delivery during the quarter.

C. Other records

- There are forms kept in the health facility which include the CDLMIS recording and inventory forms, supplies ledger cards, and requisition and issue vouchers (RIV), which are important for keeping track of the availability of FP supplies in the health facility. Likewise, NFP charts for NFP user and two-way referral slips used in referring clients when services are not available in the health facility.

FAMILY PLANNING SERVICE RECORD*

SIDE A

MEDICAL HISTORY

HEENT

Epilepsy/Convulsion/Seizure
 Severe headache/dizziness
 Visual disturbance/ blurring of vision
 Yellowish conjunctiva
 Enlarged thyroid

CHEST/HEART

Severe chest pain
 Shortness of breath and easy fatiguability
 Breast/axillary masses
 Nipple discharges (specify if blood or pus)
 Systolic of 140 and above
 Diastolic of 90 & above
 Family history of CVA (strokes), heart attack, asthma, rheumatic heart diseases

ABDOMEN

Mass in the abdomen
 History of gallbladder disease
 History of liver disease

GENITAL

Mass in the uterus
 Vaginal discharge
 Intermenstrual bleeding
 Postcoital bleeding

EXTREMITIES

Severe varicosities
 Swelling or severe pain in the legs not related to injuries

SKIN

Yellowish skin

HISTORY OF ANY OF THE FOLLOWING

Smoking
 Allergies
 Drug intake (anti-tuberculosis, anti-diabetic, anticonvulsant)
 STI/HIV/AIDS/PIDS
 Bleeding tendencies (nose, gums, etc.)
 Anemia
 Diabetes

OBSTETRICAL HISTORY

Number of pregnancies:
 _____ Full Term _____ Premature
 _____ Abortion _____ Living Children

Date of last delivery ____/____/____
 Type of last delivery _____
 Past menstrual period _____
 Last menstrual period _____

Number of days menses
 _____ Scanty _____ Moderate _____ Heavy
 _____ Painful _____ Regular

OBSTETRICAL HISTORY

Hydatidiform mole (within the last 12 months)
 Ectopic pregnancy

STI RISKS

With history of multiple partners

For Women:

Unusual discharge from vagina
 Itching or sores in or around vagina
 Pain or burning sensation
 Treated for STIs in the past

For Men:

Pain or burning sensation
 Open sores anywhere in genital area
 Pus coming from penis
 Swollen testicles or penis
 Treated for STIs in the past

PHYSICAL EXAMINATION

Blood pressure: _____ mm/Hg
 Weight _____ kg/lbs
 Pulse Rate: _____ /min

CONJUNCTIVA

Pale
 Yellowish

NECK

Enlarged thyroid
 Enlarged lymph nodes

BREAST

Mass Right Breast Left Breast
 Nipple discharge
 Skin-orange peel or dimpling
 Enlarged axillary lymph nodes

THORAX

Abnormal heart sounds/cardiac rate
 Abnormal breath sounds/respiratory rate

ABDOMEN

Enlarged liver
 Mass
 Tenderness

EXTREMITIES

Edema
 Varicosities

PELVIC EXAMINATION

PERINEUM

Scars
 Warts
 Reddish
 Laceration

UTERUS

Position
 Mid
 Anteфлекed
 Retroфлекed

VAGINA

Congested
 Bartholin's cyst
 Warts
 Skene's Gland
 Discharge
 Rectocele
 Cystocele

Size

Normal
 Small
 Large
 Mass

Uterine Depth: _____ cms.
 (for intended IUD users)

CERVIX

Congested
 Erosion
 Discharge
 Polys/cysts
 Laceration

ADNEXA

Mass
 Tenderness

Consistency

Firm
 Soft

RISKS FOR VIOLENCE AGAINST WOMEN (VAW)

History of domestic violence or VAW
 Unpleasant relationship with partner
 Partner does not approve of the visit to FP clinic
 Partner disagrees to use FP

Referred to: DSWD WCPU NGOs
 Others (specify: _____)

ACKNOWLEDGEMENT:

This is to certify that the Physician/Nurse/Midwife of the clinic has fully explained to me the different methods available in family planning and I freely choose the _____ method.

 Client Signature

 Date

CLIENT NO.: _____ **TYPE OF ACCEPTOR:** New to the Program Continuing User **PREVIOUSLY USED METHOD** _____ **DATE/TIME** _____

NAME OF CLIENT: _____ **NAME OF SPOUSE:** _____

Last Name _____ Given Name _____ MI _____ Date of Birth (mm/dd/yy) _____ HIGHEST EDUC _____ OCCUPATION _____

NO. OF LIVING CHILDREN: _____ **PLAN MORE CHILDREN:** Yes _____ No _____ **REASON FOR PRACTICING FP:** _____

METHOD ACCEPTED: COC Patch POP Injctable Condom IUD BTL VSC LAM SDM BBT Billing/Cervical Mucus/Ovulation Method Sympto-thermal

AVERAGE MONTHLY INCOME: _____ **BARANGAY** _____ **MUNICIPALITY** _____ **PROVINCE** _____

Reminder: Kindly refer to PHYSICIAN for any checked (✓) mark prior to provision of any method for further evaluation.

Instructions for completing the FP Service Record or FP Form 1

Side A

1. Fill out or check the required information at the far right of the form:
 - Client number, date and time client was interviewed
 - Client name: maiden name, family name first, date of birth, education, and occupation
 - Spouse name: family name first, date of birth, education, and occupation
 - Complete address of the client: number of the home, street, *barangay*, municipality and province
 - Average monthly income in peso
 - Choose “yes” or “no” for the couple’s plan for more children
 - Choose “new” or “continuing/current user” for type of acceptor
 - Number of living children
 - Previously used method
 - Reasons for practicing FP: completed desired family size, economic reasons and others
 - Check among the list of FP methods the method accepted
2. Fill in the required information on medical, obstetrical/ gynecological history, physical examination, pelvic examination, client signature, and date.
3. Refer to a physician for any abnormal history/findings prior to provision of any method for further evaluation.

Side B

1. Fill in the required information at the far left of the form on client number and name, date of birth, education, occupation, and address.
2. On the first column, record the date when the service was delivered to the client.
3. On the second column, record the method accepted/number of supplies given.
4. On the third column, record the following:
 - Medical observations
 - Complaints
 - Services rendered, procedures/interventions done (lab, treatment)
 - Reasons for stopping or changing the methods
 - Laboratory results
5. On the fourth column, record the name of the provider with the corresponding signature.
6. On the fifth column, record the next service date or appointment date.

Instructions for Completing the Target Client List (TCL) for Family Planning

The TCL is filled out by health workers when providing services and is updated every time a client comes back for a follow-up visit. It has the following purposes:

1. it helps the health worker plan and carry outpatient care and service delivery,
2. it facilitates the monitoring and supervision of service delivery activities,
3. it facilitates the preparation of reports,
4. it provides clinic-level data that can be accessed for further studies.

In the Right Upper Corner of the TCL form (front page) - put the name of FP method. This page includes listing of all clients who accepted any modern FP method for the first term or new to the program or currently using a specific FP method e.g. pill, so each specific method will have a separate TCL.

Column 1: DATE (OF REGISTRATION) - Indicate in this column the date month, day, and year a client made the first clinic visit or the date when client re-start to avail FP service.

Column 2: FAMILY SERIAL NUMBER - Indicate in this column the number that corresponds to the number written on the family folder or envelope or individual treatment record. This column will help you to easily facilitate retrieval of the record.

Column 3: CLIENT'S NAME - Write the client's complete name. (Given name, middle initial and family name)

Column 4: ADDRESS - Record the client's present permanent place of residence (number of the house, name of the street, *barangay*, municipality and province) for monitoring follow-up of clients.

Column 5: AGE - Indicate in this column the age of female client or wife as of last birthday. In the case of a client of a male client, indicate the age of client's wife.

Column 6: No. of living children - Indicate number of living children.

Column 7: TYPE OF CLIENT AND CODES OF CLIENTS - Write on this column the code of the following client categories.

Code	Type of Client
NA	<ul style="list-style-type: none"> • New Acceptor (NA) - A client using a contraceptive method for the first time or who is new to the program.
CU	<ul style="list-style-type: none"> • Current Users (CU) - FP clients who have been carried over from the previous month and adding the new acceptors of the previous month and other acceptors (RS, CC, and CM) of present month minus the dropout of present month. Current users constitute specific FP methods used during the month (condoms, injectables, IUD, LAM, NFP, pills, male sterilization, and female sterilization).
RS	<ul style="list-style-type: none"> • Other Acceptors who are included under current users <ul style="list-style-type: none"> - Re-Starter (RS) - These are acceptors who have stopped FP practice for at least one month and have resumed using the same method in the same clinic.
CC	- Changing Clinic (CC)
CM	- Changing Method (CM)

Column 8: PREVIOUS METHOD - Refers to last method used prior to accepting a new method. Enter in this column the codes as indicated below the front page of Target Client List
** Previous Method.

Column 9: FOLLOW-UP VISITS - Write the next scheduled date of visit in the appropriate column for the month followed by a slash, e.g., 3-31/. When the client returns for the scheduled visit, write the date at the right of the slash, e.g., 3-31/3-29. A client who is scheduled for a particular month but fails to make the clinic visit will have only one date entered for that particular month.

Column 10:DROPOUT - If a client fails to return for the next service date, he or she is considered a dropout. Enter the date the client became a dropout under column "Date" and indicate the reason under column "Reason." Validate client first prior to dropping out from the record.

11.34

Column 11:REMARKS - Indicate in this column the date and reason for every referral made (to other clinics) and referral received (from other clinics), which can be due to medical complications or unavailable family planning services and other significant findings to client care.

Method Dropouts : (when is a client considered dropout from the method)

1. LACTATIONAL AMENORRHEA METHOD (LAM)

- has her menses any time within six months postpartum (bleeding or spotting within 56 days postpartum is not considered as menses); or
- practices mixed regular feeding and/or regularly introduces solid food, liquid, vitamins within the first six months or not exclusively breastfeeding her baby or;
- when the child reaches six months old

2. NATURAL FAMILY PLANNING (NFP)

- a. Basal Body Temperature Method - If the user fails to chart her own fertile and infertile periods, she is considered a dropout.

- b. Cervical Mucus or Billings Ovulation Method - If the user fails to chart her own fertile and infertile periods, she is considered a dropout.
- c. Sympto-thermal Method - If the user fails to chart her own fertile and infertile periods, she is considered a dropout.
- d. Standard Days Method - If the user has no indication of (a) SDM use through beads or (b) knowledge of first day of menstruation or cycle length.

Note: Validate chart monthly if client needs to be dropped.

3. PILLS

- If the client

- fails to return for a re-supply/clinic visit on the scheduled date unless client was validated getting supply from other sources other than the clinic;
- gets supply and/or transfers to another clinic; the client is considered as a current user in the clinic where she transferred, but is a dropout in her former clinic;
- desires to stop the pills for any reason.

4. INJECTABLE (DMPA)

- If the client

- fails to return for more than two weeks from the scheduled date of injection unless client was validated getting supply from other sources other than the clinic;
- gets herself injected with DMPA in another clinic; the client is considered a current user in the clinic where she transferred, but is a dropout in her former clinic;
- stops to receive the injection for any reason.

5. INTRAUTERINE DEVICE (IUD)

- If the client

- does not return to the clinic for checkup for three to six weeks; not later than three months after her first post-insertion menses or has not been followed-up for two years;
- requests for IUD removal;
- has had her IUD expelled.

6. CONDOM

- If the client

- fails to return for a re-supply/clinic visit on scheduled visit unless client was validated getting supply from other sources other than the clinic;
- gets supply from another clinic and/or transfers to another clinic; the client is considered a current user in the clinic where she transferred, but is a dropout in her former clinic;
- stops using the method for any other reason.

7. VOLUNTARY SURGICAL CONTRACEPTION

- Tubal ligation – if the client is already menopausal (average: 50 years old);
- Vasectomy – indefinite

NOTE TO SERVICE PROVIDERS:

For client using pills or injectables or IUD or condoms or tubal ligation and vasectomy: validate client first whether she/he is using the method or not before dropping her/him out from the record.

Summary Table

for BARANGAY HEALTH STATIONS

NAME OF BHS: _____

MUNICIPALITY OF: _____

PROVINCE/CITY: _____

REGION: _____

FAMILY PLANNING (Part 1 of 2)

INDICATORS	TARGET	JAN	FEB	MAR	1st Q	APR	MAY	JUNE	2nd Q	JULY	AUG	SEPT	3rd Q	OCT	NOV	DEC	4th Q	TOTAL
1. Total New Acceptors																		
▶ Female Sterilization																		
▶ Male Sterilization																		
▶ Pills																		
▶ IUD																		
▶ Injectables (DMPA)																		
▶ NFP-CM																		
▶ NFP-BBT																		
▶ NFP-LAM																		
▶ NFP-SDM																		
▶ NFP-STM																		
▶ Condom																		
▶ LAM																		
2. Total Other Acceptors																		
▶ Female Sterilization																		
▶ Male Sterilization																		
▶ Pills																		
▶ IUD																		
▶ Injectables (DMPA)																		
▶ NFP-CM																		
▶ NFP-BBT																		
▶ NFP-LAM																		
▶ NFP-SDM																		
▶ NFP-STM																		
▶ Condom																		
▶ LAM																		

MONTHLY CONSOLIDATION TABLE for RURAL HEALTH UNITS

NAME OF RHU: _____

MUNICIPALITY OF: _____

PROVINCE/CITY: _____

REGION: _____

FAMILY PLANNING (Part 4 of 4)

Month: _____ Year: _____

INDICATORS	N A M E O F B H S											
4. Total Current Users												
▶ Female Ster/BTL												
▶ Male Ster/Vasectomy												
▶ Pills												
▶ IUD												
▶ Injectables (DMPA)												
▶ NFP-CM												
▶ NFP-BBT												
▶ NFP-STM												
▶ NFP-SDM												
▶ NFP-LAM												
▶ Condom												



FHSIS REPORT for the MONTH _____ YEAR: _____
 Name of BHS: _____
 Municipality/City of: _____
 Province: _____
 Projected Population of the Year: _____
For submission to RHU

FHSIS version 2008

M1
BHS

MATERNAL CARE		No.			
Pregnant women with 4 or more Prenatal visits					
Pregnant women given 2 doses of Tetanus Toxoid					
Pregnant women given TT2 plus					
Preg.women given complete iron w/folic acid supplementation					
Preg.women given Vitamin A supplementation					
Postpartum women with at least 2 postpartum visits					
Postpartum women given complete iron supplementation					
Postpartum women given Vitamin A supplementation					
PP women initiated breastfeeding w/in 1 hr.after delivery					
FAMILY PLANNING	Current User	Acceptors		Dropout	Current User
	(Begin Mo.)	New	Other		(End Mo.)
a. Female Sterilization/BTL					
b. Male Sterilization/Vasectomy					
c. Pills					
d. IUD					
e. Injectables (DMPA)					
f. NFP-CM					
g. NFP-BBT					
h. NFP-STM					
i. NFD-Standard Days Method					
j. NFP-LAM					
k. Condom					

SEE BACK PAGE

Instructions for completing the FHSIS Report Form/M1-BHS for FP

This report form collects information on family planning methods seen at the BHS during the current month.

Fill up the M1-BHS form for FP as follows:

Write on the space provided the total number of current users who have been carried over from the previous month to current users beginning of the month on column (2); the total no. of new acceptors of the previous month on column (3); the total no. of other acceptors (CC, CM or Restart) of the present month for each of the FP methods in column (4); total no. of dropout for current month for each method in column (5) and no. of current users end of month in column (6). To get the total current users of specific method at the end of the month, apply this formula.

Current users of the previous month carried over at the beginning of the month, plus the new acceptors of the previous months, plus the other acceptors (CC, CM or Restart) of the present/current month minus the dropouts of the present month is equal to the current users at the end of the month.

Formula:		Current users of previous month carried over to beginning of next month	
	+	New acceptors of previous month	
	+	Other acceptors of present month	
	-	Dropouts of present month	
	=	Current users at the end of the month	

e.g. To get Current Users end of month of January 2010

		Number of current users carried over from the previous month (EO Dec. 2009) to (January 2010) beginning of the month	= 20
+		new acceptors of previous month (Dec. 2009)	= 5
+		other acceptors of present month (Jan. 2010)	= 5
-		dropouts of present month (Jan. 2010)	= 5
=		Current Users at the end of month (Jan. 2010)	= 25

“New Acceptors” includes clients who are new to the program.

“Other Acceptors” includes changing method (CM); Changing Clinic (CC); Restart (RS) which are considered current users

- For FSTR/BTL - there will be no new acceptors at the BHS and RHU level, only indicate referrals in the box.
- For FPSTR/BTL - the female client is considered a current user up to 50 years old, beyond this, the client is considered a dropout to the method.
- For MSTR/Vasectomy - the male client is considered current user if the client is still alive or living.
- For each dropout from a “Program Method” (e.g. Pill or IUD or condom, etc.) during the month, subtract the number of drop-outs from each method.
- For Changing Clinic (CC) - if a client who transferred to another clinic is still using the same method, the client should be dropped from the record in the previous clinic and be registered/counted as current user in the clinic where she/he transferred.

FHSIS Report for the Quarter: _____ Year: _____

Municipality/City: _____

Province: _____ Projected Population of the Year: _____

Q1
RHU

FHSIS v. 2008 - Q Form

<i>FAMILY PLANNING</i>								
Indicators	Current Users (beginning of the quarter)	Acceptors		Drop-Out	Current Users (End Qtr.)	CPR Col.6/TP x 14.5%	Interpretation	Recommendations/ Actions Taken
		New	Others ^a					
Col.1	Col.2	Col.3	Col.4	Col.5	Col.6	Col.7	Col.8	Col.9
a. Female Ster/BTL								
b. Male Ster/ Vasectomy								
c. Pills								
d. IUD								
e. Injectables (DMPA)								
f. NFP-CM								
g. NFP-BBT								
h. NFP-SYM								
i. NFP-SDM								
j. NFP-LAM								
k. Condom								

^a Others include CM, CC and RS

For Quarterly Form Q1 - RHU Form for FP

Formula - To get Current Users end of quarter (EO March 2010)

Jan 2010

	Current Users beginning of the month (Jan. 2010 is a carry over of Current Users from previous month)-EO Dec 2009	= 20
+	New Acceptors of previous month (Dec. 2009)	= 5 (get from TCL)
+	Other Acceptors of present month (Jan. 2010)	= 5 (get from TCL)
-	Dropouts of present month (Jan. 2010)	= 5 (get from TCL)
<hr/>		
=	Current Users end of (January 2010)	= 25

Feb 2010

	Current Users beginning of the month (Feb. 2010 is a carry over of Current Users from previous month)-EO Jan. 2010	= 25
+	New Acceptors of previous month (Jan. 2010)	= 10 (get from TCL)
+	Other Acceptors of present month (Feb. 2010)	= 10 (get from TCL)
-	Dropouts of present month (Feb. 2010)	= 5
<hr/>		
=	Current Users end of (February 2010)	= 40

March 2010

	Current Users beginning of the month (March 2010 is a carry over of Current Users from previous month)-EO Feb. 2009	= 40
+	New Acceptors of previous month (Feb. 2009)	= 10 (get from TCL)
+	Other Acceptors of present month (March 2010)	= 10 (get from TCL)
-	Dropouts of present month (March 2010)	= 5 (get from TCL)
<hr/>		
=	Current Users end of quarter (March 2010)	= 55

MONITORING, EVALUATION AND FOLLOW-UP



LEARNING OBJECTIVE

At the end of the session, participants will be able to:
Define monitoring, evaluation, and follow-up.



TIME ALLOTMENT

30 minutes






METHODOLOGY

Lecture-discussion
Brainstorming



ADVANCE PREPARATION OF MATERIALS

- LCD
- Laptop computer
- Whiteboard
- Powerpoint presentation of Module 11
- Manila paper, permanent markers, whiteboard markers
- Meta cards, tape
- Review manual and powerpoint presentation

Topics/Contents	Teaching-Learning Process
 <h2 data-bbox="384 313 603 358">SESSION 4</h2>  <h3 data-bbox="384 414 658 492">MONITORING AND EVALUATION</h3>	
<p data-bbox="219 705 454 739"> Learning Objectives</p> <p data-bbox="211 784 619 828">At the end of the session, participants will be able to: Define monitoring, evaluation, and follow-up.</p>	<p data-bbox="823 694 1387 772">Show the Learning Objective as stated in the slide.</p>
<p data-bbox="227 1176 478 1209">Monitoring and Evaluation</p> <p data-bbox="211 1243 501 1265">Results of monitoring and evaluation</p> <ul data-bbox="211 1288 744 1512" style="list-style-type: none"> • generate information that will be used to further improve and enhance the provision of FP services, • facilitate the implementation of relevant FP related activities, • troubleshoot problem areas, and • provide managers and staff basis for making sound decisions for policy formulation, planning, and program interventions. 	<p data-bbox="823 1164 1262 1198">Introduce the topic by saying that:</p> <ul data-bbox="823 1232 1372 1579" style="list-style-type: none"> • Monitoring, evaluation, and follow-up are important processes to keep track of the progress and status of program implementation and to assess if the desired outputs and outcomes are being met as planned • State the importance of monitoring and evaluation as presented on the slide.
<p data-bbox="227 1646 415 1680">Definition of Terms</p> <ul data-bbox="211 1792 776 1870" style="list-style-type: none"> • Monitoring is the process of keeping track of the progress of implementing FP activities at regular intervals to measure improvement and changes from what were originally targeted and designed. 	<p data-bbox="823 1646 1403 1724">Define monitoring as presented on the slide. Tell participants that:</p> <ul data-bbox="823 1758 1403 2027" style="list-style-type: none"> • Monitoring: <ul data-bbox="917 1836 1403 2027" style="list-style-type: none"> ✓ Is a <i>routine process</i> used to determine the extent to which a program has been effectively implemented at different levels, in time and at what cost.

Topics/Contents	Teaching-Learning Process
	<ul style="list-style-type: none"> ✓ May include tracking of inputs and outputs ✓ Uses record-keeping, regular reporting systems, health facility observation, client surveys. ✓ Basically an internal activity ✓ Carried out regularly, for example, monthly, quarterly, half-yearly or annually.
<p data-bbox="185 712 362 741">Definition of Terms</p> <ul style="list-style-type: none"> • Evaluation is the process of determining the extent and quality of changes brought about by implementing FP activities and providing FP services to clients or beneficiaries at periodic intervals. 	<p data-bbox="793 719 1350 790">Define evaluation as presented on the slide. Tell participants that:</p> <ul style="list-style-type: none"> ✓ Episodic assessment of overall achievements; examines what has been achieved or what impact has been made ✓ Evaluation can be both internal and external ✓ Evaluation links particular outputs or outcomes directly to an intervention ✓ Three levels of evaluation: <ol style="list-style-type: none"> 1. Process/Output evaluation 2. Outcome evaluation 3. Impact evaluation
<p data-bbox="185 1489 362 1518">Definition of Terms</p> <ul style="list-style-type: none"> • Follow-up refers to the clinic's responsibility of looking after the needs of clients who had been initially provided with FP or other RH-related services 	<ul style="list-style-type: none"> • Follow-up refers to the clinic's responsibility of looking after the needs of clients who had been initially provided with FP or other RH-related services to: <ul style="list-style-type: none"> ✓ find out if clients are satisfied and are correctly using the method they chose; ✓ provide appropriate commodities/supplies; ✓ answer clients' questions and reassure them about the possible/temporary side effects of using FP and other services;

Topics/Contents	Teaching-Learning Process
	<ul style="list-style-type: none">✓ check for any medical complications and refer them for further medical evaluation as needed; ✓ find out reasons for discontinuance of the method or failure to comply with scheduled date of visits.



NARRATIVE

MODULE 11: MANAGEMENT OF FP CLINIC SERVICES

SESSION 4: MONITORING AND EVALUATION

Monitoring, evaluation, and follow-up are important processes to keep track of the progress and status of program implementation and to assess if the desired outputs and outcomes are being met as planned.

• **Monitoring**

- ✓ Is a routine process used to determine the extent to which a program has been effectively implemented at different levels, in time and at what cost.
- ✓ May include tracking of inputs and outputs
- ✓ Uses record-keeping, regular reporting systems, health facility observation, client surveys.
- ✓ Basically an internal activity
- ✓ Carried out regularly, for example, monthly, quarterly, half-yearly or annually.

• **Evaluation**

- ✓ Episodic assessment of overall achievements; examines what has been achieved or what impact has been made
- ✓ Evaluation can be both internal and external
- ✓ Evaluation links particular outputs or outcomes directly to an intervention
- ✓ Three levels of evaluation:
 1. Process/Output evaluation
 2. Outcome evaluation
 3. Impact evaluation

• **Follow-up** refers to the clinic's responsibility of looking after the needs of clients who had been initially provided with FP or other RH-related services to:

- ✓ find out if clients are satisfied and are correctly using the method they chose;
- ✓ provide appropriate supplies;
- ✓ answer clients' questions and reassure them about possible/temporary side effects of using an FP method and other services;
- ✓ check for medical complications and refer them for further medical evaluation as needed;
- ✓ find out reasons for discontinuance of the method or failure to comply with scheduled date of visits

SERVICE DELIVERY NETWORKS



LEARNING OBJECTIVE

At the end of the session, participants will be able to:
Discuss the minimum standards for the different levels of FP service outlets.



METHODOLOGY

Lecture-discussion
Brainstorming



TIME ALLOTMENT

30 minutes



ADVANCE PREPARATION OF MATERIALS

- LCD
- Laptop computer
- Whiteboard
- Powerpoint presentation of Module 11
- Manila paper, permanent markers, whiteboard markers
- Meta cards, tape
- Review manual and powerpoint presentations

Topics/Contents

Teaching-Learning Process



SESSION 5



SERVICE DELIVERY NETWORKS

Learning Objective

Show slide on learning objectives for the session:



Learning Objectives

At the end of the session, participants will be able to:
Discuss the minimum standards for the different levels of FP service outlets.

Tell the participants that FP services are made available to clients through the network of health facilities in both the public and private sector. However, these services vary in comprehensiveness and degree depending on the capacity of the facility. The table below provides the various FP service outlets with the minimum standards for each level.

Minimum Standards for FP Service Outlets

FP Service Facility	Minimum Set of FP Services	Minimal Staffs/With Training Required	Basic Resource Requirement
Level I	1. FP promotion 2. FP counselling 3. Provision of FP methods: pills, injectables, condoms, fertility awareness-based methods, NFP, NFP-SDM and LAM, LAM, SDM, condoms, pills, and injectables, with counselling and referral for IUD, BT, and NSV	Midwife and/or nurse trained on: - Basic FP or CBT Level I - ICS - Counselling - NFP - SDM - Fertility awareness orientation Recommended Additional courses: - CBMS - Orientation on CSR	Basic clinic equipment/instruments/supplies: stethoscope, BP apparatus, weighing scale, examination table, gynecology lamp, instrument tray, adequate supplies of contraceptives at authorized stock levels based on CSR rates, condoms, pills, and injectables, AD or disposable syringes with needles, BBT thermometer, NFP charts, cycle beads, Forms FP Form 1, target client list, MESC checklist by FP method, Clinic service records, Referral slips, CBMS forms IEC materials
Level II	All services offered in Level I PLUS: - Risk assessment by physician or nurse - IUD insertion - No-scalpel vasectomy - IUD insertion and/or referral for BT, NSV - Diagnosis and management of RTIs - Cancer screening (Pap smear) - Cervical cancer screening	Nurse and/or midwife trained on: - above training courses PLUS: - Comprehensive FP Training or CBT Level II - No-scalpel vasectomy training for physician - Physician and nurse trained in BT	All resources available in Level I PLUS: IUD insertion and removal kit (ovum forceps, sterile sound, alginate forceps) Sterilizer or stove with covered pan Sterile gloves, Microscope Laboratory facilities for RTI diagnosis Acetic acid wash kit, Pap smear kit, NSV kits (Vas dissecting forceps, Vas fixing clamp), NSV drugs and supplies
Level III	All services offered in Level II PLUS: - Infertility workup and referral - Management of other RTIs and gynecological diseases	A team composed of a physician/gynaecologist, nurse and/or midwife trained on the above courses PLUS: Physician and nurse trained in BT	All resources available in Level II PLUS: BT, drugs and supplies operating room, minilap kit, Laboratory kit Other related equipment, drugs and supplies
Level IV	All of the above PLUS: - Management of major complications	Basic clinic facilities: Midwife, nurse, medical specialists, Obstetrician-gynaecologist, Anaesthesiologist, General surgeon, Urologist	Tertiary hospital requirements

Show and discuss the slides on minimum standards for family planning service outlets.

Summary / Key Messages

Summarize the module using the slide presentation on Summary/Key Messages

Key Learning Points

- Understanding the different aspects of FP service provision will lead to quality health care delivery.
- The various components of the management support systems are needed to be in place to be able to deliver quality FP services.
- Having accurate, timely, and complete recording and reporting is vital to the management of FP service delivery.
- Regular monitoring and evaluation is necessary to plan and provide appropriate and quality services to our clients.
- Compliance to Informed Choice and Voluntarism is important to ensure quality FP health care provision.



NARRATIVE

MODULE 11: MANAGEMENT OF FP CLINIC SERVICES

SESSION 5: SERVICE DELIVERY NETWORK

FP services are made available to clients through the network of health facilities in both the public and private sector. However, these services vary in comprehensiveness and degree depending on the capacity of the facility. The table below provides the various FP Service Outlets with the minimum standards for each level.

FP Service Facility	Minimum Set of FP Services	Minimum Staffing With Training Required	Basic Resource Requirement
Level I Health facility with the capacity to provide fertility awareness-based methods; NFP, SDM, and LAM; condoms, pills, and injectables, with counseling and referral for IUD insertion, BTL, and NSV	<ol style="list-style-type: none"> 1. FP promotion 2. FP counseling 3. Provision of FP methods: pills, injectables, condoms, fertility awareness-based methods: NFP, NFP, SDM, and LAM; LAM, SDM 4. Referral for IUD, BTL, NSV 5. Risk assessment by history 6. Management of minor side effects 7. Routine check up of clients 8. Follow-up of dropouts 9. Referral for major complications of contraceptives 	Midwife and/or nurse trained on: <ul style="list-style-type: none"> - Basic FP or FPCBT Level I - ICS - Counseling - NFP - SDM - Fertility awareness orientation Recommended Additional courses: <ul style="list-style-type: none"> - CBMIS - Orientation on CSR 	Basic clinic equipment/instruments/supplies: stethoscope, BP apparatus, weighing scale, examination table, gooseneck lamp, instrument tray, adequate supplies of contraceptives at authorized stock levels based on CSR plan: condoms, pills, and injectables, AD or disposable syringes with needles, BBT thermometer, NFP charts, cycle beads; Forms FP form 1, Target client list, MEC checklist by FP method; Clinic services records, Referral slips, CBMIS forms IEC materials
Level II Health facility with the capacity to provide the above PLUS: IUD insertion and/or NSV Referral for BTL	All service offered in Level I PLUS: Risk assessment by physical exam' IUD insertion No scalpel vasectomy Management of complications Diagnosis and management of RTIs Cancer screening (Acetic acid wash/Pap smear) Counseling on infertility	Nurse and/or midwife trainee on: above training courses PLUS: Comprehensive FP Training or FPCBT Level 2 (IUD Skills Training) No-scalpel vasectomy training for physicians	All resources available in Level I PLUS: IUD insertion and removal kit (ovum forceps, uterine sound alligator forceps) Sterilizer or stove with covered pan Sterile gloves, Microscope Laboratory facilities for RTI diagnosis Acetic acid wash kit, Pap smear kit, NSV kits (Vas dissecting forceps, Vas fixating clamp), NSV drugs and supplies
Level III Health facility with the capacity to provide Level I & II PLUS: BTL	All services offered in Level II PLUS: BTL Infertility workup and referral Management of other RTIs and gynecological diseases	A team composed of a physician/surgeon, nurse and/or midwife trained on the above courses PLUS: Physician and nurse trainee in BTL	Surgical record forms All resources available in Level II PLUS: BTL drugs and supplies operating room, minilap kit, Laparotomy kit Other related equipment, drugs and supplies
Level IV Health facility with the capacity to provide the above and management of major complications	All of the above PLUS: Management of major complications	Basic lab facilities Midwife, nurse, medical specialists, Obstetrician-gynecologist, Anesthesiologist, General surgeon, Urologist	Tertiary hospital requirements



MODULE 12



Action Planning



LEARNING OBJECTIVE

At the end of the session, participants will be able to:

- Develop an action plan that will integrate the principles and skills learned in the course to their job.



TIME ALLOTMENT

2 hours



METHODOLOGY

Lecturette-discussion
Brainstorming
Individual/Group work
Plenary presentation



ADVANCE PREPARATION OF MATERIALS

- LCD
- Laptop computer
- Manila paper, permanent markers, whiteboard markers
- Powerpoint presentation

Topics/Contents

Teaching-Learning Process



MODULE 12



ACTION PLANNING

Tell participants that:
Now that they have completed the inputs of the course, they have to draft an action plan, which integrates the principles and skills learned into their jobs.



Learning Objective

At the end of the session, the participants will be able to:

- Develop an action plan that integrates the principles and skills learned in the course to their job.

Show slide on the learning objective for the session.

- **Action planning** is the process of planning what needs to be done, when it needs to be done, by whom it needs to be done, and what resources or inputs are needed to do it.
- It is the process of operationalising the strategic objectives.

Introduce this activity by defining “Action Plan” using the slide.

Elements of an Action Plan

- statement of what must be achieved (the outputs or result areas);
- spelling out of the steps or activities that have to be done to achieve what needs to be achieved;
- time schedule when each activity must take place, how long it is likely to take;
- a clarification of who will be responsible in ensuring that each step is successfully completed (who);
- a clarification of the inputs/resources that are needed to implement the activity.

State the elements of an action plan as presented on the slide.

Topics/Contents							Teaching-Learning Process																																																				
<table border="1"> <thead> <tr> <th rowspan="2">OBJECTIVES</th> <th rowspan="2">ACTIVITIES</th> <th rowspan="2">PERFORMANCE INDICATORS</th> <th rowspan="2">TIME FRAME</th> <th colspan="2">RESOURCE REQUIREMENT</th> <th rowspan="2">RESPONSIBLE PERSON</th> </tr> <tr> <th>ITEMS</th> <th>COST</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>							OBJECTIVES	ACTIVITIES	PERFORMANCE INDICATORS	TIME FRAME	RESOURCE REQUIREMENT		RESPONSIBLE PERSON	ITEMS	COST																																											<p>Introduce the “Action Plan” matrix.</p> <p>Tell participants that this is the matrix they will use in developing their action plans.</p>	
OBJECTIVES	ACTIVITIES	PERFORMANCE INDICATORS	TIME FRAME	RESOURCE REQUIREMENT		RESPONSIBLE PERSON																																																					
				ITEMS	COST																																																						
<p>Objectives by Components</p> <p>1. Service Delivery</p> <ul style="list-style-type: none"> To provide quality FP services, including FP counseling to all clients specially to those with unmet FP needs. To provide FP counseling to men and women of reproductive age. To maintain a functional two-way referral system. To supervise and monitor BHWs in the promotion of FP services, including home/community FP information dissemination. 							<p>The following are the recommended objectives by components that they will be providing activities for.</p> <p>Present these objectives as written on the slide.</p>																																																				
<p>Objectives by Components</p> <p>2. Logistics Management</p> <ul style="list-style-type: none"> To ensure that the health facility has sufficient FP commodities and supplies to meet. The needs of their current and potential users, equipment, and instruments to use in FP provision. To use the CDLMIS in terms of storage, distribution, inventory control, authorized stock level, recording, and reporting using the appropriate forms. To segment clients who can and cannot afford to purchase their chosen method. 																																																											
<p>Objectives by Components</p> <p>FP methods in line with the CSR strategy for proper distribution of free clinic FP commodities to the poor.</p> <p>3. Information, Education, Communication (IEC)</p> <ul style="list-style-type: none"> To ensure availability of FP IEC materials. To organize and conduct FP information education activities in the community and clinic. <p>4. Advocacy and Resource Mobilization</p> <ul style="list-style-type: none"> Networking with stakeholders (e.g. local officials, civic organizations, NGOs) to ensure availability and sustainability of FP commodities and services. 																																																											

Topics/Contents	Teaching-Learning Process
<p>Objectives by Components</p> <p>5. Management Information System</p> <ul style="list-style-type: none"> • To ensure timely accomplishment and submission of necessary reports vital to strategic planning and decision-making. <p>6. Monitoring and Evaluation</p> <ul style="list-style-type: none"> • To keep track of the progress of FP-related initiatives. • To evaluate the satisfaction of clients on FP services provided by the facility. 	
<p style="text-align: center;">Individual Work</p>	<p>Distribute the action plan matrix to participants.</p> <p>Instruct participants to fill up the matrix with their activities, expected outcomes, time frame, resources needed and costing, as needed, and responsible person(s) for completing the activity.</p> <p>Remind participants that the responsible person(s) should include themselves as this is an action plan for their implementation.</p> <p>Divide participants into groups corresponding to the number of facilitators. Facilitators in each of the groups guide participants as they develop their action plans.</p> <p>Some examples are given in the matrix but participants are encouraged to think of activities that are workable for them in their areas of assignment. Ask a number of participants at random to present their action plan.</p>



NARRATIVE

MODULE 11: ACTION PLANNING

Action planning is the process of planning what needs to be done, when it needs to be done, by whom it needs to be done, and what resources or inputs are needed to do it. It is the process of operationalising the strategic objectives.

Most action plans consist of the following elements:

- statement of what must be achieved (the outputs or result areas);
- spelling out of the steps or activities that have to be done to achieve what needs to be achieved;
- some kind of a time schedule for when each activity must take place and how long it is likely to take (when);
- a clarification of who will be responsible for making sure that each step is successfully completed (who);
- a clarification of the inputs/resources that are needed to implement the activity.

Developing an action plan that indicates how and when new skills will be applied increases the opportunity that training will be translated into action. This ensures that the trainee is able to establish how her/his newly acquired skill would positively contribute to the improvement of her/his performance and how this will impact on program goals and objectives.

The trainer assists the trainees develop an action plan that is realistic, which reflects the principles and skills taught in the course. During the post-training monitoring of the trainees (three to six months after the training), the trainer determines to what extent the action plan has been achieved and assists the trainee in resolving issues that impede the implementation of the action plan.

ACTION PLAN on FAMILY PLANNING (sample) (State period covered)

CHD: _____ Province: _____ Municipality/City: _____

Barangay: _____ Date: _____

Prepared by: _____

OBJECTIVES	ACTIVITIES	PERFORMANCE INDICATORS	TARGET	TIME FRAME	RESOURCE REQUIREMENT		RESPONSIBLE PERSON
					Items	Cost	
A. Service Delivery							
To provide quality FP services, including FP counseling, to all clients specially to those with unmet FP needs.	Identify clients with FP unmet needs using the CBMIS or do a masterlisting of all woman of reproductive age 15-49 y/o who are using and not using any FP methods. If using, to specify the methods.	List of clients in the community with FP unmet needs	Number of clients with FP unmet needs				
	Plan for alternative service delivery interventions for clients with unmet FP needs.(eg. outreach activity; integrating FP during activity	Workplan with alternative interventions	Number of outreach activities; health activities integrating FP education/ services				
To provide FP counseling to men and women of reproductive age.	Review the master list of WRA with unmet need and target client list regularly to plan and carry out FP client care. Conduct of FPAS/Counseling activities and provision of chosen method.	List of clients counseled on FP	Number of clients for FP counseling/ FPAS number of clients provided with chosen method				
To capacitate health provider and upgrade health facilities.	• Conduct of training for health personnel in various FP courses. • Procure equipt/ instruments (IUD kit, BTL/NSV kit)						

OBJECTIVES	ACTIVITIES	PERFORMANCE INDICATORS	TARGET	TIME FRAME	RESOURCE REQUIREMENT		RESPONSIBLE PERSON
					Items	Cost	
A. Service Delivery							
To maintain a functional two-way referral system.	Map all facilities providing FP service (public and private facilities) for referral of clients needing FP services not available in the clinic (e.g. BTL, vasectomy, IUD insertion), public health facilities.	List of referral facilities for specific FP methods	Regionwide Provincewide Municipalwide				
	Accomplish referral slip for referral of clients	Referral slip of clients made	Number of clients referral for BTL/Vasectomy/IUD insertion in public/private facilities				
	Follow-up results of referral	Feedback slip on referral made	Number of clients with feedback slip				
B. Logistics Management							
To ensure that health facility has sufficient FP commodities and supplies to meet the needs of their current and	<ul style="list-style-type: none"> Forecast/determine commodity requirements of all identified clients for the year. Procurement of FP supplies. Determine the segment of clients who should benefit for free commodities and those who 						

OBJECTIVES	ACTIVITIES	PERFORMANCE INDICATORS	TARGET	TIME FRAME	RESOURCE REQUIREMENT		RESPONSIBLE PERSON
					Items	Cost	
potential users; equipment/instruments to use in FP provision.	should avail from private sector						
	<ul style="list-style-type: none"> •Allocate budget to procure contraceptives for the poor •Provide equipment/instrument for use in FP provision •Making available consigned/commercial FP products in the facility for non-poor 						
	Practice proper storage of FP commodities						
To use CDLMIS in terms of storage, distribution, inventory control, authorized stock level, recording, and reporting using appropriate forms.	Inventory control of FP contribution quarterly						
	Prepare and submits logistics report						
	Identification of poor and non-poor WRA	List of poor and non-poor WRA					
To segment clients as to who can and cannot afford to buy their chosen FP methods.							

OBJECTIVES	ACTIVITIES	PERFORMANCE INDICATORS	TARGET	TIME FRAME	RESOURCE REQUIREMENT		RESPONSIBLE PERSON
					Items	Cost	
C. Information, Education and Communication (IEC)							
To ensure availability of FP IEC materials.	Reproduction of IEC materials and distribution						
To organize and conduct FP information activities in the community and clinic.	Conduct regular community health education which includes FP						
D. Advocacy and Resource Mobilization							
Networking with stakeholders (e.g. local officials, civic organizations, NGOs) to ensure availability and sustainability of FP commodities and services.	Lobbying with LCEs to get financial support for FP commodities/activities						
	Conduct advocacy activities for LCEs or Benefits of FP in terms of health of constituents and development of their community						

OBJECTIVES	ACTIVITIES	PERFORMANCE INDICATORS	TARGET	TIME FRAME	RESOURCE REQUIREMENT	RESPONSIBLE PERSON
E. Monitoring and Evaluation						
To keep track of the progress of FP- related initiatives.	Masterlisting and updating of women and men of reproductive age (15-49 years old)					
	Conduct of Program Implementation Review annually					
	Conduct monitoring visits to the health facilities					
To evaluate client satisfaction on FP services provided by the facility.	Follow up drop-outs/defaulters					
	Conduct exit interview with clients regarding service provision					
To supervise and monitor BHWs in the provision of FP services, including home/community FP information dissemination.	Monitor and Provide TA or Coach BHWs during health education on FP as needed					



MODULE 2



Human Reproductive Anatomy and Physiology

Session 1: The Female Reproductive System

Session 2: The Male Reproductive System

Session 3: The Concept of Fertility and Joint Fertility

MODULE 2: Human Reproductive Anatomy and Physiology



MODULE OVERVIEW

This module provides an overview of the basic anatomy and physiology of both male and female reproductive systems. The knowledge gained from this module will help service providers understand better the mode of action of the family planning methods related to the human reproductive anatomy and physiology.








MODULE OBJECTIVE

The objective of this module is to explain human reproductive anatomy and physiology as basic knowledge in the effective delivery of family planning methods.



MODULE SESSIONS

Session 1	The Female Reproductive System
Session 2	The Male Reproductive System
Session 3	The Concept of Fertility and Joint Fertility

Topics/Contents	Teaching-Learning Process
<p data-bbox="161 203 381 230">Overview of the Module</p> <div data-bbox="200 398 691 696">  <h2 data-bbox="330 432 550 472">MODULE 2</h2>  <h3 data-bbox="330 533 675 607">Human Reproductive Anatomy and Physiology</h3> </div>	<p data-bbox="790 221 1078 253">Greet the participants.</p> <p data-bbox="790 297 1059 329">Tell participants that:</p> <ul data-bbox="827 374 1361 741" style="list-style-type: none"> <li data-bbox="827 374 1361 517">– This module is the foundation of the knowledge of contraceptive technology that will be shared with them during the course. <li data-bbox="827 562 1361 741">– Knowing the anatomy and physiology of the female and male reproductive system will make them understand better how the different family planning methods work. <p data-bbox="790 786 1287 853">Present the overview of the module as presented on the slide.</p>
<p data-bbox="181 913 335 945"> OVERVIEW</p> <ul data-bbox="181 1025 738 1167" style="list-style-type: none"> <li data-bbox="181 1025 738 1077">• This module provides an overview of the basic anatomy and physiology of both the male and female reproductive system. <li data-bbox="181 1099 738 1167">• Knowledge gained from this module will help service providers understand better the mode of action of the family planning methods related to the human reproductive anatomy and physiology. 	
<p data-bbox="181 1323 341 1355"> OBJECTIVE</p> <ul data-bbox="181 1464 733 1509" style="list-style-type: none"> <li data-bbox="181 1464 733 1509">• To explain human reproductive anatomy and physiology as basic knowledge to the effective delivery of family planning methods. 	<p data-bbox="790 1330 1365 1397">State the objective of the module as presented on the slide.</p>
<p data-bbox="181 1727 330 1758"> SESSIONS</p> <p data-bbox="181 1854 534 1877">Session 1 - The Female Reproductive System</p> <p data-bbox="181 1906 514 1928">Session 2 - The Male Reproductive System</p> <p data-bbox="181 1957 592 1980">Session 3 - The Concept of Fertility and Joint Fertility</p>	<p data-bbox="790 1733 1345 1765">Enumerate the sessions within the module.</p>

THE FEMALE REPRODUCTIVE SYSTEM



LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Identify the parts of the external and internal female reproductive system.
2. Discuss the functions of the parts of the female reproductive system.
3. Describe the physiological changes that occur during a woman's menstrual cycle.
4. Relate the female reproductive anatomy and physiology to the mechanisms of action of modern FP methods.



METHODOLOGY

Illustrated Lecture-Discussion
Brainstorming
Exercise



TIME ALLOTMENT

1 hour



ADVANCE PREPARATION OF MATERIALS

- Powerpoint presentation of Module 2, Session 1
- Computer and LCD projector
- Sets of metacards with the steps of the Menstrual Cycle
 - Low levels of estrogen and progesterone
 - Shedding of the endometrium
 - Follicle Stimulating Hormone secreted
 - Follicles in the ovary mature
 - Estrogen secretion
 - Thickening of the endometrium
 - Luteinizing Hormone surge
 - Ovulation
 - Corpus luteum formed
 - Progesterone levels increase
 - Corpus luteum regresses
 - Low levels of estrogen and progesterone
- Marker pens, tapes
- Whiteboard and whiteboard marker
- Manila paper

Topics/Contents

Teaching-Learning Process



SESSION 1



THE FEMALE REPRODUCTIVE SYSTEM

Introduction

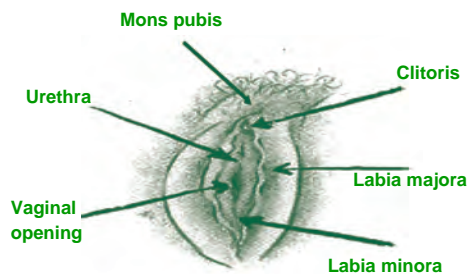


Learning Objectives

- Identify the parts of the external and internal female reproductive system.
- Discuss the functions of the parts of the female reproductive system.
- Describe the physiological changes that occur during a woman's menstrual cycle.
- Relate the menstrual cycle to the mechanisms of action of modern FP methods.

Female External Reproductive Organ

Female External Reproductive Organ



Introduce the session by stating the objectives as presented on the slide.

Show a diagram of the female external reproductive organ without the label.

Emphasize to participants that **external** means “what can be seen outside”.

Point to parts in the following sequence:

1. Mons pubis
2. Vaginal opening
3. Labia majora
4. Labia minora
5. Urethral opening
6. Clitoris

As you point to the unlabeled part, describe the part (as a clue) and ask a participant or a number of participants at random (until you get the correct answer or offer the answer).

Click the advance arrow of the computer to show the correct answer.

Ask participant(s) to tell the function of the part identified.

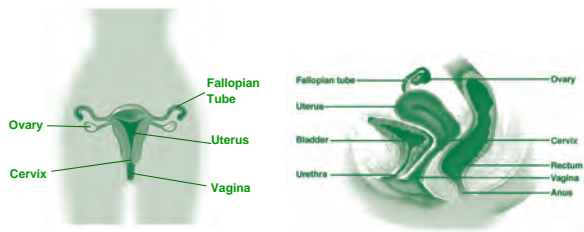
Responses must be:

Topics/Contents	Teaching-Learning Process
	<p>1. Mons Pubis The mons pubis is a pad of fatty tissue that covers the pubic bone area. The mons pubis is a protective structure covered with pubic hair and serves as a cushion during sexual intercourse and also helps in protecting the internal reproductive organs.</p> <p>2. Vaginal opening The vaginal opening serves as the entrance to the vaginal canal or birth canal. The vaginal opening is elastic and flexible as it widens during sexual excitement, allowing the entrance of the penis. During childbirth, it allows the passage of the baby during delivery. It also allows the flow of menstrual blood from the uterine cavity to the exterior.</p> <p>3. Labia majora Is one of two sets of lip-like structures on either side of the vaginal opening. The labia majora is the outer lip, which is covered by pubic hair.</p> <p>4. Labia minora Is the other set of lip-like structure located on either side of the vaginal opening. The labia minora is the inner lip, which is devoid of pubic hair. The labia majora and minora protects the vaginal opening and are together referred to as the vulva.</p> <p>5. Urethra Above the vagina is the urinary opening called urethra. This is a tubular structure through which urine leaves the body.</p> <p>6. Clitoris The clitoris is a peanut-sized structure located above the urinary opening. The clitoris is a sensitive organ that when stimulated brings forth sexual arousal for most women.</p>

Topics/Contents

Female Internal Reproductive Organs

Female Internal Reproductive Organs



Teaching-Learning Process

Tell participants that after learning the anatomy and physiology of the female external reproductive organ, they will now learn the internal (inside) parts.

Show a diagram of the female internal reproductive organ without the label.

Point to parts in the following sequence:

1. vagina
2. cervix
3. uterus
4. ovary
5. fallopian tubes

As you point to the unlabeled part, describe the part (as a clue) and ask a participant or a number of participants at random (until you get the correct answer or offer the answer).

Click the advance arrow of the computer to show the correct answer.

Ask participant(s) to tell the function of the part identified.

Responses must be:

1. Vagina/vaginal canal

The **vagina** is the organ for copulation. It is also the passage of the baby during delivery.

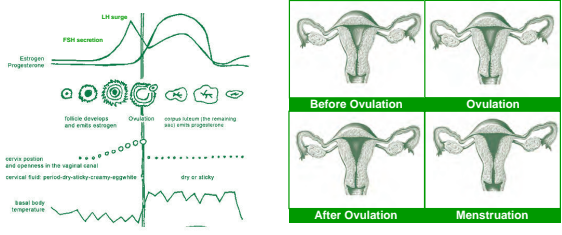
2. Cervix

The **cervix** is the lowest part of the uterus which has an opening to the vagina. On speculum examination, the cervix looks like a small round ball at the end of the vaginal canal. Blood during menstruation and the fetus during vaginal delivery passes through the cervix. The sperm passes through its opening to the uterus for fertilization to occur.

Glandular cells line the cervical canal, producing cervical mucus under the influence of the hormone

Topics/Contents	Teaching-Learning Process
	<p>estrogen. The sperm depends on the consistency of the cervical mucus for survival and transport. During the fertile period, the mucus is thin and watery, allowing the sperm to easily pass through the cervix. During the infertile period, the mucus is thick and sticky, making the sperm difficult to pass through the cervix to the uterus.</p> <p>3. Uterus The uterus is a hollow, muscular organ which is about the size of a closed fist. It lies between the bladder and the rectum. It is in the uterus where implantation of the fertilized ovum and pregnancy takes place.</p> <p>4. Endometrium The endometrium is the lining of the uterus which covers the cavity of the uterus. It sloughs off during menstruation when no pregnancy occurs and provides nourishment to the developing fetus during the early part of pregnancy.</p> <p>5. Ovaries The ovaries are the woman's primary sex glands where important hormones, estrogen, and progesterone, are produced. These hormones function to prepare the endometrium to receive a fertilized ovum. During the woman's fertile period, one egg matures and will be released from the ovary. This is called the ovulation period. After the egg has been released from the ovary, it enters one of the fallopian tubes where fertilization takes place. Fertilization is the process of the union of the sperm and egg.</p> <p>- An egg may be fertilized for up to 24 hours (one day) after it is released.</p>

Topics/Contents	Teaching-Learning Process
	<ul style="list-style-type: none"> - If the sperm and egg do not meet within 24 hours, the egg is usually absorbed in the reproductive system. - If pregnancy does not take place, menstruation will occur about two weeks after the egg leaves the ovary. <p>6. Fallopian tubes</p> <p>The fallopian tubes are tubular structures that are attached to the sides of the body of the uterus. Close to its fimbriated (fan-shaped) opening are two pearly white structures called ovaries. This structure receives the mature egg from the ovaries and it is here where fertilization occurs.</p> <p>After the above explanation, click the forward arrow to show the side view of the reproductive organs.</p> <p>Tell participants that the diagram shows:</p> <ul style="list-style-type: none"> • the anatomical relationship of the internal reproductive organs to other organs like the bladder and the rectum. • that the urethral opening of the female is separate from the vaginal opening, unlike in the male where the urethra has both excretory and reproductive functions.
<p>The Menstrual Cycle</p> <p>Menstrual Cycle</p> <ul style="list-style-type: none"> • Begins on the first day of menstrual bleeding and ends the day before menstrual bleeding occurs again. • Average length is 26-35 days. • Menstrual bleeding normally lasts from three to five days. 	<p>Explain the menstrual cycle as presented on the slide.</p>

Topics/Contents	Teaching-Learning Process
<p>Menstrual Cycle</p> <p>Exercise</p> <p>January 5 then February 3</p> <p>January 24 then February 19</p> <p>March 14 then April 12</p> <p>March 7 then April 9</p>	<p>Flash the next slide.</p> <p>To check the understanding of the length of a menstrual cycle, ask participants to determine the cycle lengths of the given menstrual periods. The examples given in the exercise are the dates of the first day of menstrual bleeding of one cycle to the first day of menstrual bleeding of the next cycle. Participants should use a calendar for easy computation. Provide five minutes for computation.</p> <p>Ask participants at random to give the answers.</p>
<p>Phases of the Menstrual Cycle</p> <p>Menstrual Cycle</p> <ul style="list-style-type: none"> • Phases of the menstrual cycle <ul style="list-style-type: none"> ✓ Pre-Ovulatory Phase ✓ Ovulatory Phase ✓ Post-Ovulatory Phase 	<p>State the phases of the menstrual cycle as presented on the slides.</p> <p>Tell participants that:</p> <ul style="list-style-type: none"> – The menstrual cycle is influenced by hormones secreted by the brain and the ovaries. – These hormones cause physiologic changes in the uterus and other body parts.
<p>Menstrual Cycle</p> 	<p>Explain the menstrual cycle using the diagram.</p> <p>Pre-Ovulatory Phase</p> <ul style="list-style-type: none"> - On the first day of the menstrual cycle, estrogen and progesterone levels are low. This causes the shedding of the endometrium as menstrual bleeding. - The low levels of estrogen and progesterone, stimulates the brain to secrete Follicle-Stimulating Hormone (FSH). This hormone, as it is called, stimulates the follicles in the ovary to mature (one of these follicles will later further mature to be released during ovulation.) - The maturing follicles in the ovary produce estrogen. As the follicles mature further, the estrogen levels increase.

Topics/Contents

Teaching-Learning Process

Ovulatory Phase

- When estrogen levels peak, the brain is stimulated to produce a surge of the Luteinizing Hormone (LH). This sudden increase of the luteinizing hormone causes the release of the mature ovum, a process which is called ovulation.
- Ovulation usually occurs 12-16 days before the onset of the next menses.
- Once ovulation occurs and the egg has gone into the fallopian tube, it can be fertilized by the male sperm for only up to one day (24 hours).
 - The cervical mucus is wet, slippery, stretchy, and clear.
 - There is a feeling of vaginal wetness.
 - The cervix is soft and open.

Post Ovulatory Phase

- After ovulation, the remaining follicles, which underwent initial maturation are transformed into the **corpus luteum**.
- The corpus luteum in the ovary further produces estrogen in smaller amount and progesterone in greater amount.
- If there is no fertilization, the corpus luteum regresses. As the corpus luteum regresses, the production of progesterone and estrogen decreases.
- When estrogen and progesterone levels are low, the endometrium is shed off and menstruation occurs.

Topics/Contents	Teaching-Learning Process
	<ul style="list-style-type: none"> - Due to the decreased levels of estrogen and progesterone, the endometrium sheds off. - As the level of estrogen increases, the endometrium thickens. - The endometrium thickens by multiplication and proliferation of the cells. The thickening of the endometrium progresses until ovulation. - After ovulation, due to the effect of progesterone, the endometrial cells previously produced swell with water and glucose to prepare for a possible pregnancy. - When there is no pregnancy, the corpus luteum shrinks, the estrogen and progesterone levels decrease and the endometrium sheds off. <p>Other effects of estrogen and progesterone:</p> <ul style="list-style-type: none"> - Estrogen causes the production of mucus to become increasingly wet and lubricative. - Higher levels of progesterone causes the following changes to occur in the woman's reproductive system: <ul style="list-style-type: none"> • The cervical mucus becomes pasty and is no longer slippery and stretchy. • The vagina feels dry (this type of mucus does not allow sperm to travel into the uterus and prevents the sperm from living more than a few minutes to a few hours). • The cervix becomes firm; the cervical opening closes so that sperm cannot pass through to the uterus.

Topics/Contents	Teaching-Learning Process
	<ul style="list-style-type: none"> The basal body temperature increases and remains high for the rest of the cycle because progesterone is thermogenic. <p>Explain what happens if fertilization occurs as written on the slide.</p>
<p>Fertilization</p> <p>What happens if fertilization occurs</p> <ul style="list-style-type: none"> The fertilized egg produces Human Chorionic Gonadotropin (HCG) hormone. What happens due to HCG: <ul style="list-style-type: none"> ✓ Corpus luteum is maintained ✓ Estrogen and progesterone is sustained ✓ No shedding of the endometrium ✓ No menstruation ✓ Pregnancy test is positive 	<p>Further explain the effects of HCG as follows:</p> <ul style="list-style-type: none"> The corpus luteum is maintained so that the estrogen and progesterone production is sustained. Due to the sustained levels of estrogen and progesterone, the endometrium is maintained and menstruation does not happen. Causes the pregnancy test to read positive.
<p>Relating FP to the Menstrual Cycle</p> <p>Menstrual Cycle</p> <ul style="list-style-type: none"> Relating FP to the menstrual cycle changes <ul style="list-style-type: none"> Why are women on hormonal contraceptives not ovulating? Why are most women on the progestin-only injectable, like DMPA, not having menses? Why is the temperature higher after ovulation? Why does the cervical mucus thicken? 	<p>Ask participants the following questions, which are related to the action of the family planning methods (correct response is given):</p> <ul style="list-style-type: none"> <i>Why are women on hormonal contraceptives not ovulating?</i> <p>Women taking the hormonal contraceptives have consistently high levels of estrogen and/or progesterone. The brain is not stimulated to produce FSH so that no follicles mature for ovulation.</p> <ul style="list-style-type: none"> <i>Why are most women on the progestin-only injectable, like DMPA, not having menses?</i> <p>The endometrium is not developed because the estrogen effect (i.e., priming of the endometrium) is surpassed by the higher progestin levels. So there is no endometrium to shed off.</p> <ul style="list-style-type: none"> <i>Why is the temperature higher after ovulation?</i> <p>After ovulation, progesterone levels are high. Progesterone is thermogenic (i.e., giving high temperatures). The presence of progesterone in high levels signifies that ovulation has already occurred.</p>

Topics/Contents	Teaching-Learning Process
	<p data-bbox="832 226 1408 297">- <i>Why does the cervical mucus thicken in women using progestin-only contraceptives?</i></p> <p data-bbox="856 338 1408 409">Progesterone causes the cervical mucus to thicken.</p>
<p data-bbox="417 636 561 674" style="text-align: center;">Summary</p>	<p data-bbox="832 450 1318 488">Divide participants into groups of five.</p> <p data-bbox="832 528 1386 600">Give each group a set of metacards on the steps of the menstrual cycle.</p> <p data-bbox="832 640 1401 712">Ask each group to arrange the metacards in sequence on a manila paper.</p> <p data-bbox="832 752 1354 824">The first group to finish with all the steps correctly arranged is the winner.</p> <p data-bbox="832 864 1408 936">Review the steps of the menstrual cycle with participants.</p>



NARRATIVE

MODULE 2: HUMAN REPRODUCTIVE ANATOMY AND PHYSIOLOGY SESSION 1: THE FEMALE REPRODUCTIVE SYSTEM

THE FEMALE EXTERNAL REPRODUCTIVE ANATOMY

The **vaginal opening** serves as the entrance to the vaginal canal or birth canal. The vaginal opening is elastic and flexible as it widens during sexual excitement, to allow the entrance of the penis. During childbirth, it allows the passage of the baby during delivery. It also allows the flow of menstrual blood from the uterine cavity to the exterior.

On either side of the vaginal opening are two sets of vaginal lips that protect the vaginal opening. The outer lips are called the **labia majora**, which are covered by pubic hair while the inner lips are the labia minora are not covered with hair. The **vulva** refers to both labia majora and minora.

Above, the vagina is the urinary opening called the **urethra**. This is a tubular structure through which urine leaves the body.

The **clitoris** is a peanut-sized structure located above the urinary opening. The clitoris is a sensitive organ that when stimulated brings forth sexual arousal for many women.

The **mons pubis** is a pad of fatty tissue that covers the pubic bone area. The mons pubis is a protective structure that is covered with pubic hair and serves as a cushion during sexual intercourse and also helps to protect the internal reproductive organs.

FEMALE INTERNAL REPRODUCTIVE ANATOMY

The **uterus** is a hollow, muscular organ which lies between the bladder and the rectum, where the implantation of fertilized ovum and pregnancy takes place. A lining called endometrium covers the cavity of the uterus.

During the menstrual cycle, the amount of blood in the endometrium increases to help sustain and nourish pregnancy. If pregnancy does not occur, this sloughs off and results to **menstruation**.

Menstrual blood leaves the uterus through the cervix. The **cervix** usually looks like a small, round ball seen during speculum examination. The cervix has an opening that allows the entry of sperm for fertilization to take place.

Glandular cells line the cervical canal and produce cervical mucus under the influence of the hormone estrogen. The sperm depend on the consistency of the cervical mucus for survival and transport. During the fertile period, the mucus is thin and watery allowing the sperm to easily pass through the cervix. During the infertile period, the mucus is said to be thick and sticky making the sperm difficult to pass the cervix to the uterus. During labor, the cervix also dilates to allow the passage of the baby during delivery through the **vaginal canal**.

The **fallopian tubes** are tubular structures that are attached to sides of the body of the uterus. Close to its fimbriated (fan-shaped) opening are two pearly white structures called ovaries. The fallopian tubes receive the mature egg from the ovaries and it is here where fertilization takes place.

The ovaries are the woman's primary sex glands where important hormones, estrogen and progesterone, are produced. These hormones function to prepare the endometrium to receive a fertilized ovum.

A woman has more than seven million potential eggs (primary oocytes) while still a fetus. By birth, the number has fallen to one or two million, and by puberty to about 300,000. Only 300 to 400 eggs reach maturity. During the woman's fertile period, one egg matures and will be released from the ovary. This is called the ovulation period.

After the egg has been released from the ovary, it enters one of the fallopian tubes where fertilization takes place. Fertilization is the process of the union of the sperm and egg.

- An egg may be fertilized for up to 24 hours (one day) after it is released.
- If the sperm and egg do not meet within 24 hours, the egg is usually absorbed in the reproductive system.

If pregnancy does not take place, menstruation will occur about two weeks after the egg leaves the ovary.

THE MENSTRUAL CYCLE

The menstrual cycle begins on the first day of menstrual bleeding and ends on the day before menstrual bleeding begins again.

The length of a woman's menstrual cycle can normally vary by a few days from cycle to cycle. A menstrual cycle is usually 26 to 35 days long, but some women may have shorter or longer cycles and this can be normal for them.

Menstrual bleeding normally lasts from three to five days.

The Phases of the Menstrual Cycle

The menstrual cycle has three phases:

1. *Pre-Ovulatory Phase*

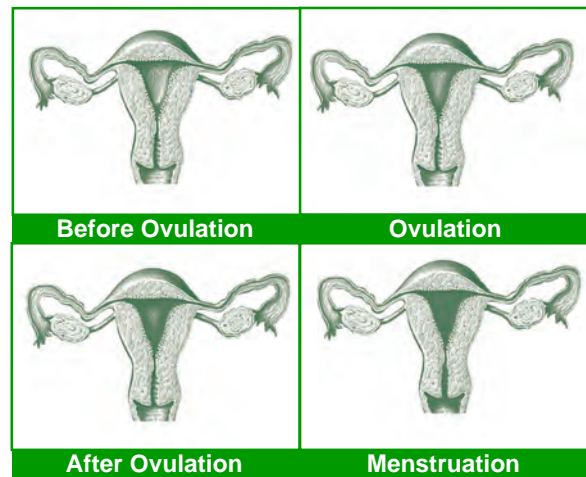
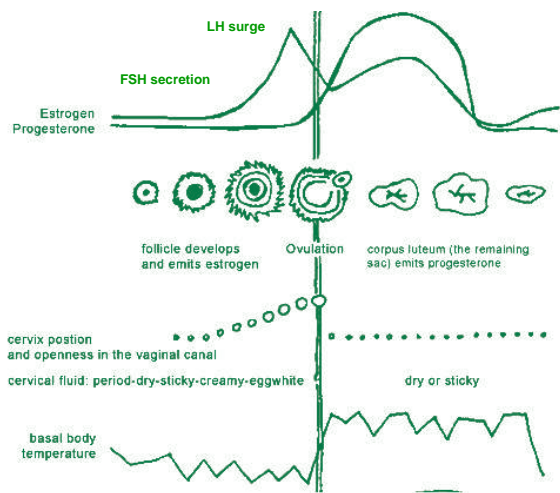
- On the first day of the menstrual cycle, estrogen and progesterone levels are low. This causes the shedding of the endometrium as menstrual bleeding.
- The low levels of estrogen and progesterone stimulates the brain to produce Follicle-Stimulating Hormone (FSH). This hormone, as it is called, stimulates the follicles in the ovary to mature. One of these follicles will later further mature to be released during ovulation.
- The maturing follicles in the ovary produce estrogen. As the follicles mature further, the estrogen levels increase.
- Estrogen causes:
 - ✓ endometrium to thicken by cell multiplication and proliferation
 - ✓ the production of mucus to become increasingly wet and lubricative

2. Ovulatory Phase

- When estrogen levels peak, the brain is stimulated to produce as Luteinizing Hormones (LH). This sudden increase of luteinizing hormone causes the release of the mature ovum, a process which is called **ovulation**.
- Ovulation usually occurs 12-16 days before the onset of the next menses.
- Once ovulation occurs and the egg has gone into the fallopian tube, it can be fertilized by the male sperm for only up to one day (24 hours).
- During this phase:
 - The lining of the uterus continues to thicken.
 - The egg is mature and is finally released.
 - The cervical mucus is wet, slippery, stretchy, and clear.
 - There is a feeling of vaginal wetness.
 - The cervix is soft and open.

3. Post-Ovulatory Phase

- After ovulation, the remaining follicles that underwent initial maturation are transformed into the corpus luteum.
- The corpus luteum in the ovary produces estrogen in smaller amounts and progesterone in greater amounts. This causes a drop in estrogen levels with higher levels of progesterone.
- Progesterone causes the following changes to occur in the woman's reproductive system:
 - The cervical mucus becomes pasty and is no longer slippery and stretchy.
 - The vagina feels dry (this type of mucus does not allow sperm to travel into the uterus and prevents the sperm from living more than a few minutes to a few hours.)
 - The cervix becomes firm; the cervical opening closes so that sperm cannot pass through to the uterus.
 - The basal body temperature increases and remains high for the rest of the cycle.
- When there is no fertilization, the corpus luteum regresses. As the corpus luteum regresses, the production of progesterone and estrogen decreases.
- When estrogen and progesterone levels are low, menstruation occurs.



When fertilization occurs, the fertilized egg produces the Human Chorionic Gonadotropin (HCG) hormone.

Effects of HCG:

- The corpus luteum is maintained so that the estrogen and progesterone production is sustained.
- Due to the sustained levels of estrogen and progesterone, the endometrium is maintained and menstruation does not happen.
- Causes the pregnancy test to read positive.

FP AND PHYSIOLOGICAL CHANGES IN A WOMAN

- Why are women on hormonal contraceptives not ovulating?
Women taking the hormonal contraceptives have consistent high levels of estrogen and/or progesterone. The brain is not stimulated to produce FSH so that no follicles mature for ovulation.
- Why are most women on the progestin-only injectable, like DMPA, not having menses?
The endometrium is not developed because the estrogen effect (i.e., priming of the endometrium) is surpassed by the higher progestin levels. So there is no endometrium to shed off.
- Why is the temperature higher after ovulation?
After ovulation, progesterone levels are high. Progesterone is thermogenic (e.g. giving high temperature). The increased levels of progesterone, observed as an increase in basal body temperature, signifies that ovulation has already occurred.
- Why does the cervical mucus thicken in women using progestin-only contraceptives?
Progesterone causes the cervical mucus to thicken.

THE MALE REPRODUCTIVE SYSTEM



LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Identify the parts of the external and internal male reproductive system.
2. Explain the functions of the parts of the male reproductive system.



METHODOLOGY

Illustrated Lecture-Discussion Exercise






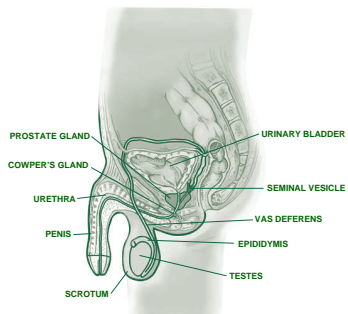
TIME ALLOTMENT

30 minutes



ADVANCE PREPARATION OF MATERIALS

- Powerpoint presentation of Module 2, Session 2
- Computer and LCD projector

Topics/Contents	Teaching-Learning Process
<div style="text-align: center;">  <h2 style="margin: 0;">SESSION 2</h2> </div> <hr/> <div style="text-align: center;">  <h3 style="margin: 0;">THE MALE REPRODUCTIVE SYSTEM</h3> </div>	
<p>Introduction</p> <hr/> <p> Learning Objectives</p> <ul style="list-style-type: none"> • Identify the parts of the external and internal male reproductive system • Explain the functions of the parts of the male reproductive system 	<p>Introduce the session by stating the objectives as presented on slide.</p>
<p>Male Reproductive System</p> <hr/> <p>Male Reproductive System</p> <div style="text-align: center;">  </div>	<p>Flash slide with the unlabeled diagram of the Male Reproductive System.</p> <p>Point to parts in the following sequence:</p> <ol style="list-style-type: none"> 1. Testes 2. Epididymis 3. Vas deferens 4. Seminal vesicle 5. Prostate gland 6. Cowper's gland (paraurethral gland) 7. Urethra 8. Penis 9. Scrotum <p>As you point to the unlabeled part, describe the part (as a clue) and ask a participant or a number of participants at random (until you get the correct answer or offer the answer).</p> <p>Ask participant(s) to tell the function of the part identified.</p> <p>Responses must be:</p> <p>1. Testes The testes are the pair of male sex glands that produce sperm and testosterone. Sperm are the male sex cells. Testosterone is the major</p>

Topics/Contents

Teaching-Learning Process

male hormone responsible for the development of sperm and secondary male sex characteristics. The normal sperm count is 60 million/ml.

A man is fertile everyday from puberty (age eight to 12) and for the rest of his life.

2. Epididymis

The epididymis are small tubes at the base of the testes. Once produced, the sperm are stored in these tubes where further maturation occurs.

3. Vas deferens

This is also known as the sperm duct as the sperm travels to this tube from the epididymis. The vas deferens are the tubes that get cut during vasectomy.

4. Seminal vesicle

This structure produces fluid that enters the vas deferens to nourish the sperm.

5. Prostate gland

Gland situated at the base of the urinary bladder that surrounds part of the urethra. The prostate gland produces a thin, milky, and alkaline fluid, which forms part of the semen. The alkalinity of the fluid it produces protects the sperm from the acidic environment of the urethra and vagina.

6. Cowper's gland

This gland is located at the sides of the urethra which is also known as the paraurethral gland. This gland secretes more alkaline fluid which contributes to the seminal fluid (semen).

Topics/Contents	Teaching-Learning Process
	<p>7. Urethra Semen travels out of the man's body through the urethra, the tube that runs through the center of the penis. In males, the passage way for urine and sperm are the same. A man cannot urinate and release semen at the same time.</p> <p>8. Penis This is the male organ for copulation. It is made up of spongy erectile tissues. When a man becomes sexually excited, it becomes erect; it stiffens and grows both in width and length. An erect penis is about five to seven inches long and about an inch or an inch-and-a-half in diameter.</p> <p>9. Scrotum The scrotal sac is the wrinkled skin pouch, which contains and protect the testes or testicles. The scrotum controls the temperature of the testicles ideal for sperm production. When it is cold, the scrotum contracts so that the testicles come closer to the body for warmth. In a warm environment, the scrotum is relaxed so that the testicles are away from the body to make it cooler.</p> <p>Ask participants:</p> <ul style="list-style-type: none"> – Based on your knowledge of the male reproductive anatomy, how does vasectomy prevent pregnancy? <p>Vasectomy involves cutting and blocking the vas deferens. Sperm cannot pass through so that semen does not have sperm to fertilize the ovum.</p>



NARRATIVE

MODULE 2: HUMAN REPRODUCTIVE ANATOMY AND PHYSIOLOGY SESSION 2: THE MALE REPRODUCTIVE SYSTEM

THE MALE EXTERNAL REPRODUCTIVE ANATOMY

The **penis** is the male organ for copulation. It is made up of spongy erectile tissues. When a man becomes sexually excited, it becomes erect; it stiffens and grows both in width and length. An erect penis is about five to seven inches long and about an inch or an inch-and-a-half in diameter.

The **scrotal sac or scrotum** is the wrinkled skin pouch, which contains and protects the testes or testicles. The scrotum controls the temperature of the testicles, which is normally about six degrees celsius lower than the body temperature, ideal for sperm production.

THE MALE INTERNAL REPRODUCTIVE ANATOMY

- A man is fertile everyday from puberty (age eight to 12) and for the rest of his life.
- The **testes** are the pair of male sex glands that produce sperm and testosterone. Sperm is the male sex cells. Testosterone is the major male hormone responsible for the development of sperm and secondary male sex characteristics.
- Normal sperm analysis: count - 60 million/ml; motility - 60%; morphology - 30% or more of normal morphology; volume - 1-6 ml per ejaculate; ph-7.2 to 7.8; liquefaction- less than 20 minutes.
- Under optimal conditions, the life span of the sperm is up to three to five days.
- Once sperm are produced, they travel to the epididymis, where they start to mature. The **epididymis** are small tubes at the base of the testes.
- When a man ejaculates, the sperm leave the epididymis and travel through a pair of tubes called the **vas deferens**, also known as sperm ducts.
- The vas deferens allows the passage of sperm to the **seminal vesicles**, the glands that produce a fluid that enters the vas deferens to nourish the sperm. The vas deferens are the tubes that get cut during vasectomy.
- After the fluid from the seminal vesicles mixes with the sperm, this mixture continues to travel through the vas deferens to the **prostate gland**, which is situated at the base of the urinary bladder and that surrounds part of the urethra. This gland produces a thin, milky, and alkaline fluid which forms part of the semen.
- Semen with sperm travels out of the man's body through the **urethra**, the tube that runs through the center of the penis. In males, the passage way for urine and sperm are the same. A man cannot urinate and release semen at the same time.
- Before the semen leaves the man's reproductive system, the **Cowper's gland** releases a small amount of fluid. This fluid further makes the seminal fluid alkaline so that sperm are not destroyed as it passes the urethra during ejaculation.

SESSION 3

THE CONCEPT OF FERTILITY AND JOINT FERTILITY



LEARNING OBJECTIVE

At the end of the session, the participants will be able to:

1. Explain the concept of fertility and joint fertility.



METHODOLOGY

Illustrated Lecture-Discussion
Game






TIME ALLOTMENT

30 minutes



ADVANCE PREPARATION OF MATERIALS

- Powerpoint presentation of Module 2, Session 3
- Computer and LCD projector
- Easel sheets or whiteboard
- Markers/Pens

Topics/Contents	Teaching-Learning Process
<div style="text-align: center;">  <h2 style="margin: 10px 0;">SESSION 3</h2> <hr/>  <h3 style="margin: 10px 0;">THE CONCEPT OF FERTILITY AND JOINT FERTILITY</h3> </div>	
<p>Introduction</p> <hr/> <p> Learning Objective</p> <ul style="list-style-type: none"> • Explain the concept of fertility and joint fertility. 	<p>Introduce the session by stating the objectives as presented on the slide.</p>
<p>Definitions</p> <hr/> <p>Definitions</p> <ul style="list-style-type: none"> • Fertility <ul style="list-style-type: none"> ✓ Capacity of a woman to conceive and bear a child. ✓ Capacity of a man to have a woman conceive. • Joint Fertility <ul style="list-style-type: none"> ✓ The united and equal contribution of the male and female in the decision and ability to have a child. <p style="background-color: #008000; color: white; padding: 5px; text-align: center;">It is necessary for both a man and a woman to be fertile for conception.</p>	<p>Ask participants about their idea of Fertility.</p> <p>Write their ideas on easel sheet or whiteboard. Consolidate the participants' ideas by saying that:</p> <ul style="list-style-type: none"> – Fertility is the ability of a woman to bear children and a man to get a woman pregnant. – It is necessary for both a man and a woman to be fertile for them to bear a child. This brings us to the concept of Joint Fertility. – When we refer to joint fertility, we focus on both male and female fertility, not separately, but in a joint or combined perspective. Joint fertility involves contributions from both the male (sperm) and the female (egg) resulting to the conception of a child. – Joint or combined fertility involves the united and equal contribution of the male and female in the decision and ability to have a child.
<p>Concept of Fertility and Joint Fertility</p> <hr/> <p>Joint Fertility</p>	<p>Ask participants at random to interpret the “Joint Fertility Diagram” flashed on the slide.</p> <p>Explain male and female fertility using the diagram. Tell participants about:</p>

Topics/Contents



Teaching-Learning Process

Male Fertility

- ✓ Males, after they reach puberty, are always fertile and are able to make females pregnant at any time.
- ✓ Male fertility ends at death.

Female Fertility

- ✓ Unlike males, females are fertile only on certain days of a menstrual cycle, which is during ovulation.
- ✓ Fertilization occurs when there are sperm cells available to fertilize the ovum at the time of ovulation.
- ✓ Female fertility ends at menopause which occurs at 50 years of age (at an average).

Review of the Module

Module Exercise

Group participants into three groups.

All three groups face the front. Questions will be asked and a member of the group who knows the answer comes forward to give the answer. If the answer is correct, a point is given to the group. If the answer is incorrect, the other two groups are given the chance to have its member come forward and respond to the question.

The group with the most number of correct answer wins.

Questions:

1. Fluid from the seminal vesicles, the Prostate and Cowper's glands is called _____. (Answer: semen or seminal fluid)
2. The testes produces _____ and _____. (Answer: sperm and testosterone)
3. The ovary produces _____ and _____. (Answer: estrogen and progesterone)

Topics/Contents	Teaching-Learning Process
	<p>4. _____ involves the united and equal contribution of the male and female in the decision and ability to have a child. (Answer: Joint or Combined Fertility)</p> <p>5. This hormone is produced by the fertilized egg and causes sustained levels of estrogen and progesterone, so that the endometrium is maintained and menstruation does not happen (Answer: Human Chorionic Gonadotropin)</p> <p>6. The _____ refers to both labia majora and minora (Answer: Vulva)</p> <p>7. During the fertile period of a woman, the cervical mucus is _____ allowing the sperm to easily pass through the cervix (Answer: thin and watery)</p> <p>8. The pre-ovulatory phase starts with _____ (Answer: menstrual bleeding)</p> <p>9. In what phase of the menstrual cycle does the Luteinizing Hormone peak? (Answer: ovulatory)</p> <p>10. How do you calculate the length of the menstrual cycle? (Answer: The menstrual cycle begins on the first day of menstrual bleeding and ends on the day before menstrual bleeding begins again)</p> <p>11. What is the effect of hormonal contraceptives on ovulation? (Answer: Women taking hormonal contraceptives have consistent high levels of estrogen and/or progesterone. The brain is not stimulated to produce FSH so that no follicles mature for ovulation)</p>
<p>Summary</p> <p>Do You Have Any Questions???</p>	<p>Encourage participants to ask questions for clarification.</p> <p>Respond to participants' questions. Thank participants for their attention and participation.</p>



NARRATIVE

MODULE 2: HUMAN REPRODUCTIVE ANATOMY AND PHYSIOLOGY SESSION 3: THE CONCEPT OF FERTILITY AND JOINT FERTILITY

Fertility is the capacity of the woman to conceive and bear a child and the capacity of a man to have a woman conceive.

When we refer to **joint fertility**, we focus on both male and female fertility, not separately, but in a joint or combined perspective. Joint fertility involves contributions from both the male (sperm) and the female (egg) resulting to the conception of a child.

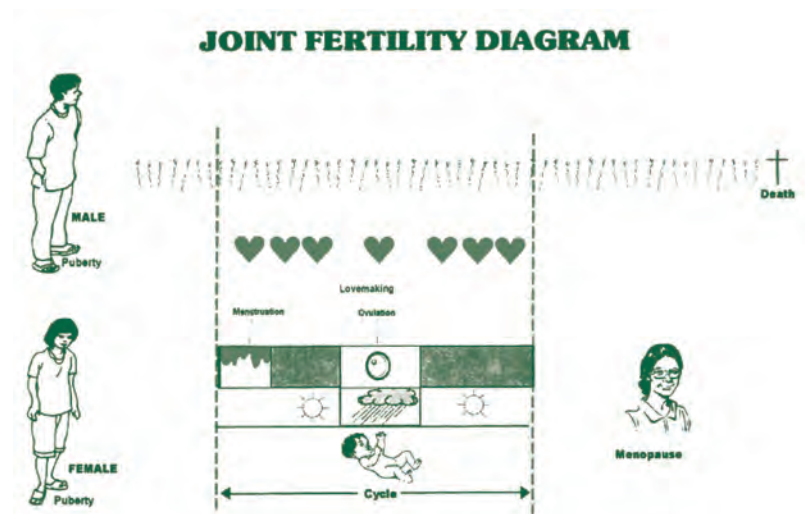
Male Fertility

- Males, after they reach puberty, are always fertile and are able to make females pregnant at any time.
- Male fertility ends at death.

Female Fertility

- Unlike males, females are fertile only on certain days within a menstrual cycle, which is during ovulation. On other days, they are infertile.
- Fertilization occurs when there are sperm cells available to fertilize the ovum at the time of ovulation.
- Female fertility ends at menopause which occurs at 50 years of age (at an average).

Joint or combined fertility involves the united and equal contribution of the male and female in the decision and ability to have a child.



PUBERTY

Puberty refers to the process of physical changes by which a child's body becomes an adult body capable of reproduction. In a strict sense, this refers to the bodily changes of sexual maturation. Puberty is initiated by hormone signals from the brain to the gonads (the ovaries and testes). In response, the gonads produce a variety of hormones that stimulate the growth, function, or transformation of the brain, bones, muscle, skin, breasts, and reproductive organs. During puberty, major differences of size, shape, composition, and function develop in many body structures and systems. The most obvious of these are referred to as secondary sex characteristics.

SIGNS OF PUBERTY

IN FEMALES

Girls begin the process of puberty about one to two years earlier than boys. The process begins at age nine to 14 years.

1. Breast development

The first physical sign of puberty in females is usually a firm, tender lump under the center of the areola(e) of one or both breasts, occurring on average at about 10.5 years of age. Within six to 12 months, the swelling has clearly begun in both sides, softened, and can be felt and seen extending beyond the edges of the areolae. By another 12 months, the breasts are approaching mature size and shape, with areolae and papillae forming a secondary mound. In most young women, this mound disappears into the contour of the mature breast.

2. Pubic hair

Pubic hair is often the second change of puberty noticed in females. The pubic hair is usually visible first along the labia. Within another six to 12 months, the hair is too many to count and appear on the pubic mound as well. Later, the pubic hair densely fill the "pubic triangle" and spread to the thighs. Sometimes, it appears as abdominal hair upward towards the navel.

3. Vagina, uterus, ovaries

The mucosal surface of the vagina also changes in response to increasing levels of estrogen, becoming thicker and a duller pink in color (in contrast to the brighter red of the prepubertal vaginal mucosa). Whitish secretions (physiologic leukorrhea) are a normal effect of estrogen as well. In the next two years following the development of the breast, the uterus and ovaries increase in size, and follicles in the ovaries reach larger sizes. The ovaries usually contain small follicular cysts visible by ultrasound.

4. Menstruation and fertility

The first menstrual bleeding is referred to as menarche, and typically occurs about two years after the first signs of breast development. The average age of menarche is about 11.75 years. Menses (menstrual periods) are not always regular and monthly in the first two years after menarche. Ovulation is necessary for fertility, but may or may not accompany the earliest menses. In postmenarchal girls, about 80% of the cycles are anovulatory in the first year after menarche (about 13 years), 50% in the third (about 15 years) and 10% in the sixth year (about 18 years).

During this period, also in response to rising levels of estrogen, the lower half of the pelvis relaxes and the hips widen (providing a larger birth canal). Fat tissue increases to a greater percentage of the body composition than in males, especially in the typical female distribution of breasts, hips, buttocks, thighs, upper arms, and pubis.

Progressive differences in fat distribution as well as sex differences in local skeletal growth contribute to the typical female body shape by the end of puberty. By age 10, the average girl has 6% more body fat than the average boy, but by the end of puberty, the average difference is nearly 50%.

5. Body odor and acne

Rising levels of androgens can change the fatty acid composition of perspiration, resulting in a more "adult" body odor. This often precedes breast and pubic hair development by one or more years. Another androgen effect is increased secretion of oil (sebum) from the skin. This change increases the susceptibility to acne, a characteristic affliction of puberty in its severity.

IN MALES

Boys begin the process of puberty at about 10 to 17 years old. The following are the physical changes during puberty:

1. Testicular size, function, and fertility

This is the first physical manifestation of puberty in males. The testes start producing testosterone and sperms. Sperm can be detected in the morning urine of most boys after the first year of pubertal changes (and occasionally earlier). Potential fertility is reached at about 13 years old in boys, but full fertility will not be gained until 14 to 16 years of age, although some go through the process faster, reaching it only a year later.

2. Pubic hair

Pubic hair often appears on a boy shortly after the genitalia begin to grow. The pubic hairs are usually first visible at the dorsal (abdominal) base of the penis. After another six to 12 months, the hairs are too many to count and which become more dense to fill the "pubic triangle". These also spread to the thighs and upward towards the navel, as part of the developing abdominal hair.

3. Body and facial hair

In the months and years following the appearance of pubic hair, other areas of skin which respond to androgens (testosterone) develop heavier hair in roughly the following sequence: underarm (axillary) hair, perianal hair, upper lip hair, sideburn (preauricular) hair, periareolar hair, and the rest of the beard area. Arm, leg, chest, abdominal, and back hair become heavier more gradually.

There is a large range in amount of body hair among adult men, and significant differences in timing and quantity of hair growth among different ethnic groups.[13]

Chest hair may appear during puberty or years after. Not all men have chest hair.

4. Voice change

Under the influence of androgen, the voice box, or larynx, grows in both sexes. This growth is far more prominent in boys, causing the male voice to drop and deepen. This sometimes occurs abruptly but rarely "overnight," by about one octave. Full adult pitch is attained on the average, by age 15.

5. Male musculature and body shape

By the end of puberty, adult men have heavier bones and nearly twice as much skeletal muscle.

6. Body odor and acne

Rising levels of androgens can change the fatty acid composition of perspiration, resulting in a more "adult" body odor. Another androgen effect is increased secretion of oil (sebum) from the skin and the resultant variable amounts of acne. Acne can not be prevented or diminished easily, but it typically fully diminishes at the end of puberty.



MODULE 3



FP Client Assessment

Session 1: The FP Service Record or FP Form 1 in Client Assessment

Session 2: WHO Medical Eligibility Criteria for Contraceptive Use

MODULE 3: FP CLIENT ASSESSMENT

MODULE OVERVIEW

In all primary health care units, RH services should be available and provided. It is the service provider's responsibility to assess the reproductive health status of the clients.

The health provider should therefore have the necessary knowledge and skills to adequately and accurately assess the health needs, as well as, the health status of clients seeking to improve the quality of their lives.

Client assessment is the first stage common to any health care service provision, and an important step prior to provision of FP services. The client's FP needs and data on medical status & conditions are taken to ensure that they are medically eligible for their chosen FP method.






MODULE OBJECTIVE

At the end of this module, participants must be able to perform a complete FP client assessment based on evidence based global standards.

MODULE SESSIONS

This module will cover the following:

Session 1	The FP Service Record or FP Form 1 in Client Assessment
Session 2	WHO Medical Eligibility Criteria for Contraceptive Use

Topics/Contents	Teaching-Learning Process
 <h2 data-bbox="337 347 556 392">MODULE 3</h2>  <h3 data-bbox="337 448 556 526">FP CLIENT ASSESSMENT</h3>	<p data-bbox="791 235 1262 302">Greet the participants. Introduce the module by saying that:</p> <ul data-bbox="885 347 1356 795" style="list-style-type: none"> • Client assessment is the first step to any health care service provision. • Client assessment enables the health service provider to identify the health needs and status of the client. • The client's FP needs and health condition are obtained to ensure that the client is medically eligible for their chosen FP method.
<h4 data-bbox="180 873 337 907"> OVERVIEW</h4> <ul data-bbox="235 1019 697 1097" style="list-style-type: none"> • This module provides the necessary knowledge and skills to assess the health needs and status of FP clients and document these using standard forms. 	<p data-bbox="791 873 1262 940">State the overview of the module as presented on the slide.</p>
<h4 data-bbox="180 1299 337 1332"> OBJECTIVE</h4> <ul data-bbox="235 1456 697 1534" style="list-style-type: none"> • At the end of this module, participants must be able to perform a complete FP client assessment based on evidence based global standards 	<p data-bbox="791 1299 1324 1366">State the module objectives as presented on the slide.</p>
<h4 data-bbox="180 1736 337 1769"> SESSIONS</h4> <p data-bbox="180 1870 729 1892">Session 1 - The use of FP Service Record or Form 1 in Client Assessment</p> <p data-bbox="180 1915 682 1937">Session 2 - WHO Medical Eligibility Criteria for Contraceptive Use</p>	<p data-bbox="791 1724 1293 1758">Enumerate the sessions of the module.</p>

THE FP SERVICE RECORD IN CLIENT ASSESSMENT



LEARNING OBJECTIVES

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

1. Define client assessment.
2. Explain the purpose of client assessment in FP.
3. Describe the steps of FP client assessment.
4. Describe the FP Service Record or FP Form 1 with its components.
5. Demonstrate use of the FP Service Record.
6. Explain the guidelines on physical examination in FP service provision.
7. Enumerate the steps in physical examination of FP clients.
8. Explain the purpose of laboratory examination in FP service provision.
9. Describe commonly performed laboratory examination in FP service provision.



METHODOLOGY

Lecturette-Discussion
Role Play
Group work







TIME ALLOTMENT

1 hour



ADVANCE PREPARATION OF MATERIALS

- Powerpoint presentation
- FP Form 1
- Laptop and LCD projector
- Flipchart, whiteboard and markers
- Metacards, pentel pens, masking tapes

Topics/Contents	Teaching-Learning Process
 <h2 data-bbox="341 340 558 383">SESSION 1</h2>  <h3 data-bbox="341 443 702 517">THE USE OF FP FORM 1 IN CLIENT ASSESSMENT</h3>	<p data-bbox="793 215 1263 248">Introduce the session by saying that:</p> <ul data-bbox="887 293 1350 734" style="list-style-type: none"> <li data-bbox="887 293 1350 434">• In doing client assessment, the health care provider must be able to gather information from the client and document these. <li data-bbox="887 479 1350 546">• The FP Form 1 is also known as the FP Service Record. <li data-bbox="887 591 1350 734">• The FP Form 1 guides the health care provider in gathering relevant information from the client and documenting these.
<p data-bbox="174 797 412 824"> Learning Objectives</p> <p data-bbox="174 871 558 893">At the end of this session, participants must be able to:</p> <ul data-bbox="174 927 644 1061" style="list-style-type: none"> <li data-bbox="174 927 362 949">• Define client assessment. <li data-bbox="174 954 644 976">• Explain the purpose of client assessment in FP service provision. <li data-bbox="174 981 495 1003">• Describe the steps of FP client assessment. <li data-bbox="174 1008 417 1030">• Describe the FP Service Form 1. <li data-bbox="174 1034 495 1057">• Demonstrate use of the FP Service Form 1. <p data-bbox="174 1099 412 1126"> Learning Objectives</p> <p data-bbox="174 1167 558 1189">At the end of this session, participants must be able to:</p> <ul data-bbox="174 1223 691 1330" style="list-style-type: none"> <li data-bbox="174 1223 683 1245">• Explain the guidelines on physical examination in FP service provision. <li data-bbox="174 1249 597 1272">• Enumerate the steps in physical examination of FP clients. <li data-bbox="174 1276 683 1299">• Explain the purpose of laboratory examinations in FP service provision. <li data-bbox="174 1303 691 1326">• Describe commonly performed laboratory examination in FP/RH service. 	<p data-bbox="793 797 1271 871">State the overview of the sessions as presented on the slide.</p>
<p data-bbox="174 1391 522 1413">Client Assessment in Family Planning</p> <h2 data-bbox="310 1525 597 1599">The Family Planning Client Assessment</h2>	<p data-bbox="793 1420 1059 1453">Tell participants that:</p> <ul data-bbox="793 1498 1350 1565" style="list-style-type: none"> <li data-bbox="793 1498 1350 1565">• Client assessment is an important process in the provision of family planning services.
<p data-bbox="174 1765 275 1787">Definition</p> <ul data-bbox="174 1861 707 1995" style="list-style-type: none"> <li data-bbox="174 1861 707 1906">• Is a process by which the health worker learns about the health status and the FP needs of the client. <li data-bbox="174 1928 456 1951">• Initial step is to take the clinical history. <li data-bbox="174 1973 511 1995">• Data obtained are documented and evaluated. 	<p data-bbox="793 1756 1350 1823">Define Client Assessment using the prepared slide.</p>

Topics/Contents	Teaching-Learning Process
<p>Purpose</p> <ul style="list-style-type: none"> • Establishes the client's health status. • Determines the client's eligibility for using a contraceptive method. • Determines whether the client is in good health, needs further examination and management including closer follow-up and/or referral. • Identifies the need for additional procedures and/or laboratory examination. 	<p>State the purposes of client assessment in family planning service provision as presented on the slides.</p>
<p>Steps in Client Assessment</p> <p>Steps of FP Client Assessment</p> <ol style="list-style-type: none"> 1. Prepare the client <ul style="list-style-type: none"> • Greet client cordially and ensure comfort. • Establish rapport with the client. • Establish the purpose of the visit. • Explain to the client the procedures to be performed (including physical and/or laboratory examination, if needed). • Encourage the client to ask questions openly. 2. Take and record the client's health history using the FP Service Form 1. <p>Steps of FP Client Assessment</p> <ol style="list-style-type: none"> 3. Discuss with the client: <ul style="list-style-type: none"> • Findings based on the history. • Need to perform further examination like physical and/or laboratory examination. • Need for referral for laboratory examination or further management. • Need and schedule of follow-up visit(s). 	<p>State the steps in doing FP client assessment as presented on slides.</p> <p>Emphasize to the participants that:</p> <ul style="list-style-type: none"> • Only those procedures that are essential as recommended by the WHO (Applicability of procedures and examination for contraceptive use) should be performed. • Additional examinations (i.e., physical or laboratory) are performed to validate abnormal findings during client assessment. <p>Example:</p> <p>It is not necessary to do a physical examination on a client requesting for a condom. However, if there is a complaint of urethral discharge, examination of the genitals and collection of urethral discharge for smear should be performed. In this case, the additional examinations are performed because of the signs of infection and not for determining his suitability for using the condom.</p>
<p>The Family Planning Service Record / FP Form 1</p> <p>The Family Planning Service Form 1 (FP Service Form 1)</p>	<p>Tell participants that:</p> <ul style="list-style-type: none"> • The FP Service Record 1 is the DOH standard form for assessing and documenting a FP client's condition and health status.

Topics/Contents

Teaching-Learning Process

The Family Planning Service Record/FP Form 1

Component

1. Personal data
2. Medical history (past and family)
3. Reproductive history
 - Menstrual history
 - OB history
 - FP history
 - Risk for STIs
 - VAWC
4. Present illness or health concern

1. Personal Data

1. Complete name of client
2. Name of husband
3. Client's age, sex
4. Occupation, average family monthly income
5. Educational attainment
6. Address

2. Medical History

- Past illnesses
 - Hospitalizations
 - Accidents/Injuries
 - Allergies
 - Surgeries
- Immunizations
- Habits (smoking, drinking, substance abuse, etc.)
- Family History (cerebrovascular accident, heart disease)

3. Reproductive History

Menstrual History

- **Menarche** - age of onset of menstruation
- **Last Menstrual Period (LMP)** - first day of last menstrual period including the number of days, character (scanty, moderate, or heavy) of menstrual flow and accompanying symptoms
- **Previous Menstrual Period (PMP)** - first day of menstrual period prior to the mentioned LMP.

3. Reproductive History

Obstetrical History

- **Gravidity (G)** – number of pregnancies regardless of outcome
- **Parity (P)**- number of pregnancies reaching viability (>20 weeks AOG)
- **Other information (F-P-A-L)**
 - Full-term pregnancies
 - Pre-term pregnancies
 - Abortions
 - Living children

Distribute FP Form 1 to participants.

State the components of the FP Service Record 1 as presented on the slide.

Show the slides on the basic information needed in client history-taking using the FP Form 1 as a guide. As you tell participants each of the components of the FP Form 1 (as presented on the slide):

- Point to these on the form.
- Ask participants the importance of each component.

Brainstorm ideas of participants by asking:

- Why is it important to accomplish the FP Form 1 completely and accurately?

Write responses on the whiteboard. Responses should include but not be limited to:

- Know the health status of the client
- Know whether referral is needed
- Identify precautions as to the use of any of the FP methods

Supplement as needed.

Topics/Contents	Teaching-Learning Process
<p>3. Reproductive History</p> <p>FP History</p> <ul style="list-style-type: none"> • FP method currently being used <ul style="list-style-type: none"> • duration of use • satisfaction with use • FP method previously used <ul style="list-style-type: none"> • duration of use • reason/s for discontinuation or shifting • Reproductive goals/ intents <ul style="list-style-type: none"> • to achieve desired number of children • to limit or to space 	<p>Ask participants:</p> <ul style="list-style-type: none"> • Why is it important to ask about the FP History? <p>Responses should include but not be limited to:</p> <ul style="list-style-type: none"> • Know client's experience (satisfaction or dissatisfaction) in using FP methods. • Make sure that client's knowledge of FP methods is factual and not a misconception or myth. Reasons for discontinuation may be due to wrong information or perception. • Establish the reproductive goal so that FP methods presented to client are appropriate to his/her reproductive goal. For instance, permanent methods should not be offered if the reproductive need is for spacing.
<p>3. Reproductive History</p> <p>Risk for STIs</p> <p>Ask the client the following questions:</p> <ul style="list-style-type: none"> • Do you suspect your partner to have another sexual partner? • Do you think your sex partner might have an STI? • Have you or your partner ever been treated for STIs? 	<p>Ask participants:</p> <ul style="list-style-type: none"> • Why is the risk for STIs determined? <p>Responses should include but not be limited to:</p> <ul style="list-style-type: none"> • FP clients are sexually active people who need to know about STIs. • If the client is likely to get STIs, the client needs a supply of condoms and counseling about risks, symptoms, and treatment. (For the midwife, referral of these clients to facilities where the above services may be provided should be done) • IUD should not be provided to clients with STI risks.
<p>3. Reproductive History</p> <p>Risk for STIs</p> <ul style="list-style-type: none"> • Do you or your partner experience the following: <ul style="list-style-type: none"> • Unusual (pus-like, foul smelling) discharge from the vagina/urethra? • Itching and/or sores around the genital area? 	<p>State the questions asked in determining a client's risk for STI as presented on slides.</p>

Topics/Contents

Teaching-Learning Process

3. Reproductive History

VAWC

Ask the client the following questions:

- How is your relationship with your husband or partner?
- Does he know about your coming to the clinic?
- Is he willing to cooperate or support you in using a FP method?

Ask participants:

- Why do you need to determine if the client is a victim of gender violence?

Responses should include but not be limited to:

- The client's use of a FP method may be affected by the support of a "cruel" husband.
- Use of a contraceptive may subject the client to violent opposition from an oppressive partner
- In such cases, methods that do not require cooperation of the partner and are private are appropriate.
- There may be a need to refer the client to the nearest Women's Crisis Center where she can be counseled.

4. Present Health Status or Concerns

- Present complaint or concern
- Onset, nature, and duration of present complaint or concern
- Accompanying symptoms and precipitating/aggravating factors
- Measures or medications taken to relieve symptoms and precipitating/aggravating factors
- Prior consultations or medications

State the information needed to determine the present health status of the client as presented on the slide.

Exercise on Filling up the Form 1

- Role Play
- Part 1 – Personal Data
- Part 2 – Medical History

Role Play in the use of the FP Form 1

A facilitator role plays with a volunteer from among the participants how to use the FP Form 1.

- Ask the participants to observe and fill out the forms themselves based on the responses of the client in the role play
- Ask participants for comments and questions of clarification

Ask two volunteers from among the participants to return demonstration the use of the FP Form 1.

- One participant plays the role of the service provider while the other plays the role of the client.

Topics/Contents	Teaching-Learning Process
	<ul style="list-style-type: none"> • Ask other participants to provide feedback on the return demonstration by pointing out good points and areas for improvement on: <ul style="list-style-type: none"> – communication skills (verbal and non-verbal cues, eye to eye contact, asking questions, using simple language, etc.); – the completeness of the information; and – other ways of gathering the information in a manner that is client sensitive.
<p data-bbox="216 656 415 678">Physical Examination</p> <h2 data-bbox="337 819 660 855">Physical Examination</h2>	<p data-bbox="832 667 1103 701">Tell participants that:</p> <ul style="list-style-type: none"> • The next step, in assessing a patient after history-taking, is usually the physical examination. • However, since the FP client is not considered a “patient”, the physical examination is not always necessary for the provision of the FP methods.
<p data-bbox="232 1039 330 1061">Guidelines</p> <ul style="list-style-type: none"> • It is not always necessary to ensure the SAFE USE of an FP method. • The WHO Applicability of procedures can serve as the guide that will tell which of the procedures or examinations may be necessary. • Performed during the initial visit only to confirm conditions suspected or noted during the client history-taking. <p data-bbox="232 1339 330 1361">Guidelines</p> <ul style="list-style-type: none"> • Performed at any time to evaluate client's complaints related to the use of an FP method. This is to ensure that the client has not developed conditions which are precautions to the continued use of the method • Performed to identify complications which may have risen from the use of an FP method. 	<p data-bbox="832 1034 1389 1099">Explain the guidelines on performing physical examination as presented on the slides.</p>
<p data-bbox="216 1590 605 1612">Steps in Performing Physical Examination</p> <p data-bbox="232 1650 286 1673">Steps</p> <div data-bbox="221 1720 782 1800" style="background-color: #008000; color: white; padding: 5px;"> <p data-bbox="241 1727 326 1749">Remember</p> <ul style="list-style-type: none"> • Proceed from head to toe • Inspect first, palpate later </div> <p data-bbox="260 1848 398 1870">1. Take vital signs</p> <ul style="list-style-type: none"> • Blood Pressure • Pulse Rate • Respiratory Rate • Temperature 	<p data-bbox="832 1601 1232 1635">Emphasize to participants that:</p> <ul style="list-style-type: none"> • The physical examination is not routinely done for FP method provision. • However, the following are the steps for physical examination if it needs to be performed. <p data-bbox="832 1901 1401 1966">Describe the steps in performing the physical examination as presented on the slides.</p>

Topics/Contents	Teaching-Learning Process
<p>Steps</p> <p>2. Prepare client</p> <ul style="list-style-type: none"> • Make the client comfortable. • If doing an internal exam: Ask client to void/empty bladder and wash perineum. • Assure privacy and confidentiality. • Explain the procedures (what is going to happen and why). <p>Steps</p> <p>3. Prepare needed instruments and supplies</p> <ul style="list-style-type: none"> • Prepare the instruments and supplies ahead of the actual physical examination (PE) especially when there is no knowledgeable assistant around. <p>4. Conduct the physical examination</p> <ul style="list-style-type: none"> • If the health provider is a male, the female client may request a companion while the physical examination is being conducted/performed. 	
<p>Laboratory Examinations</p> <p style="text-align: center;">Laboratory Examinations</p>	<p>Ask participants:</p> <ul style="list-style-type: none"> • What conditions of the FP clients will you need a laboratory examination? • How many of you work in facilities with laboratories completely capable of confirming client's conditions? <p>Further say that:</p> <ul style="list-style-type: none"> • Not all of you have comprehensive laboratory facilities. • Laboratory examinations are rarely required in providing FP services.
<p>Purpose</p> <ul style="list-style-type: none"> • Laboratory tests are NOT ALWAYS REQUIRED (refer to WHO Applicability chart). • Performed to further investigate abnormal findings on history taking and/or PE. 	<p>Present the slide that explains the purpose of doing laboratory examinations.</p>

Topics/Contents	Teaching-Learning Process
<p data-bbox="232 241 479 264">Hemoglobin Determination</p> <ul data-bbox="232 302 666 515" style="list-style-type: none"> • To confirm and determine severity of anemia in a pale client. • Normal ranges depend on age and sex of client • Normal ranges are: <ul data-bbox="326 448 517 515" style="list-style-type: none"> • Adult males: 14-18 gm/dl • Adult women: 12-16 gm/dl <p data-bbox="232 544 514 566">Other Laboratory Examinations</p> <ul data-bbox="232 600 784 862" style="list-style-type: none"> • Wet Smear - to find the causative agent of existing vaginitis- monilia, trichomonas or gardnerella • Gram Stain - to determine the microorganism causing the STI- gonococci or chlamydia • Pap Smear - cervical secretions collected and examined under a microscope in order to look for pre-malignant or malignant changes • Acetic Acid - abnormal cells may be identified by applying acetic acid to areas of suspected cervical lesions 	<p data-bbox="832 241 1392 313">Present the slides on laboratory examinations which are requested for FP/RH services.</p> <p data-bbox="832 353 1042 387">Emphasize that:</p> <ul data-bbox="832 432 1392 689" style="list-style-type: none"> • These examinations are requested for the confirmation of abnormal findings in the history and physical examinations or as part of good health practice. • These examinations are not required for the provision of FP methods.
<p data-bbox="216 913 302 936">Summary</p>	<p data-bbox="832 936 1273 969">Flash the slides on the objectives.</p> <p data-bbox="832 1010 1387 1081">Ask participants if they have any questions on the topic.</p> <p data-bbox="832 1122 1400 1155">Respond to participants' questions/concerns.</p> <p data-bbox="832 1196 1403 1267">Ask questions of participants related to each of the objectives.</p>



NARRATIVE

MODULE 3: FP CLIENT ASSESSMENT MODULE OVERVIEW

SESSION 1: THE FP SERVICE RECORD 1 IN CLIENT ASSESSMENT

Client assessment is the process by which the health worker learns about the health status, the FP needs, and the eligibility of the client for contraceptive use. The first step to assessing a client is to take the client's clinical history.

Data about the client's health are gathered through medical history taking, physical examination, and needed laboratory examination, which is analyzed to see if the client is in good health or needs further evaluation and management and/or referral. It is a **MUST** that all clients who attend FP/ RH clinics undergo assessment.

Purpose

Client assessment is important as it:

- Establishes the client's health status.
- Determines the client's eligibility for using a contraceptive method.
- Determines whether the client is in good health, needs further examinations and management including closer follow-up and/or referral.
- Identifies the need for additional procedures and/or laboratory examinations.

Steps in Client Assessment:

The following are the specific steps in client assessment.

1. Note that for each step, client comfort and privacy should always be considered.
 - a. Greet client cordially.
 - b. Establish rapport with the client.
 - c. Establish the purpose of the visit.
 - d. Explain to the client procedures to be performed (including physical and/ or laboratory examinations, if needed).
 - e. Encourage the client to ask questions openly/freely.
2. Take and record client's health history using the Family Planning Service Record Form 1 (FP Form 1)
3. Discuss with the client the:
 - a. Findings based on the history.
 - b. Need to perform further examination like physical and/or laboratory examination, if necessary.
 - c. Need for referral for laboratory examinations or further management, if necessary.
 - d. Need and schedule of follow-up visit(s).

Only those procedures that are essential as recommended by the WHO (Applicability of procedures and examinations for contraceptive use) should be performed. Additional examinations (i.e., physical or laboratory) are performed to validate abnormal findings during client assessment.

Example:

It is not necessary to do a complete physical examination including a pelvic exam on a client requesting for a condom. However, if there is a complaint of urethral discharge, a pelvic exam and collection of urethral discharge for smear should be performed. In this case, the additional examinations are performed because of the signs of infection and not for determining his suitability for using the condom.

CLIENT HISTORY-TAKING

Client history-taking is the process of gathering data by interviewing the client about past and present medical/reproductive health status. Obtaining the client's history during the initial visit is important in identifying needs and factors or conditions that may affect suitability for using FP method(s). It is, therefore, the responsibility of the service provider to be able to elicit such information prior to the provision of a method.

Client history-taking enables the service provider to:

1. Assess the client's reproductive health status and identify the RH needs of the client.
2. Identify risk factors or areas for precaution in the use of an FP method.
3. Properly record and verify data gathered in FP Form 1.

FP Form 1

The FP Form 1 lists the possible illnesses relevant to possible FP method use. Family Planning visits are not due to illness, thus the following information are requisite in the context of FP method use, whether initial or follow up visits.

A. Personal Data

1. Complete name of client
2. For proper identification and documentation, take complete name of client including middle name. Note that under the present Family Code of the Philippines, an unmarried pregnant woman (this includes live-in partners) retains her maiden name
3. Name of husband/partner/guardian
 - This is in cases of emergencies or for purposes of guardianship or consent
4. Client's age, sex, marital status, date, and place of birth
5. Religion, occupation, average family monthly income
 - To determine client's preferences and practices
 - To determine financial capacity for needed examinations, feasibility of using cheaper forms/methods
6. Educational attainment
 - To be able to adjust level of instruction and communication
 - To determine ability to follow complicated instructions/ precautions
7. Address
 - To be able to determine if client can have good follow up or visit clients when necessary
 - In cases of emergencies

B. Medical History

This includes the following information:

- Past illnesses
- Accidents/Injuries
- Allergies
- Habits (smoking, drinking, substance abuse, etc.)
- Family history

This includes the following information:

- Health status of immediate family members and living relatives
- Risk factor for cancer, heart disease, diabetes, hypertension, kidney disease

C. Reproductive History

1) Menstrual History

- Menarche = age of onset of menstruation
- LMP (Last Menstrual Period) = first day of last menstrual period, including the usual number of days of menstrual flow, character of flow (scanty, moderate, or heavy), and accompanying symptoms
- PMP (Previous Menstrual Period) = first day of menstrual period prior to the mentioned LMP. This is important to establish accuracy of mentioned LMP, and to establish regularity or irregularity of menstrual periods).
- Usually, this is the best time to inform clients that “regularity” of menstrual flow is not based on the menstrual flow occurring every same day or week of every month. Rather, it is based on the number of days between the two LMPs (first day of two menstrual periods). The normal average interval number of days is 25-35 days.

For example, it may happen that a woman with the following menstrual periods will appear to have very irregular menses but is actually having her menses regularly:

- 2nd week of January (say, January 7);
- 1st week of February (February 2);
- Then again in February but in the last week (February 28);
- Then in the third week of March (March 21).

2) OB History

Completing the **OB score** is one way of evaluating the obstetric history of the client, which provides information relevant to FP method use (birth spacing and/or birth limiting). The **OB score** measures the gravidity (G), parity (P) of a woman. **Gravidity (G)** refers to number of pregnancies borne by the mother, irrespective of the pregnancy outcome. **Parity (P)** refers to the number of pregnancies reaching viability (>20 weeks AOG). Other relevant information needed are:

- Full-term pregnancies
- Preterm pregnancies
- Abortions or miscarriages (ectopic/ molar)
- Current living children

3) FP History

- FP method currently being used
 - ✓ Duration of use
 - ✓ Satisfaction with use
- FP method previously used
 - ✓ Duration of use
 - ✓ Reason/s for discontinuation or shifting
- Reproductive goals/ intents
 - ✓ To achieve/maintain desired number of children
 - ✓ To limit or to space

4) Risk for Sexually-transmitted Infections (STIs)

The following are reasons for assessing an FP client's risk for STIs:

- FP clients are sexually active people who need to know about factors which put them at risk for STIs.
- If the client is likely to get STIs, the client needs a supply of condoms and counseling about risks, symptoms, and treatment. Counseling includes correct and consistent use of condoms.
- FP clients with a high individual risk for STIs may need to be referred to facilities providing STI services (i.e., counseling and/or treatment).
- IUD should not be provided to clients with high risks for STI.

A basic screening history for STI risk should be included in the history-taking, which should include the following:

1. Presence of abnormal vaginal and or urethral discharge.
2. Abnormal vaginal bleeding with the last two menstrual periods.
3. Pain or burning sensation during urination.
4. History of genital tract problem such as vaginal discharge, ulcers or skin lesions around the genital area.
5. Partners of the client who have been treated for a genital tract problem in the last three months.
6. Having more than one sex partner in the last two months and/or their sex partner having other sex partner/s.

5) Violence Against Women

It is important to assess a potential FP client's exposure to gender violence because her continued use of an FP method may be affected by the kind of support she gets from a "cruel" husband. The use of a contraceptive may subject the client to violent opposition from an oppressive partner. In such cases, methods that do not require cooperation of the partner (e.g. FAB method, condom) and that are private (e.g. Direct) are more appropriate. The service provider needs to ask the following questions:

- How is your relationship with your husband/partner?
- Does he know about your coming to the clinic?
- Is he willing to cooperate or support you in using an FP method?

There may be a need to refer the client to the nearest Women's Crisis Center where she can be counseled.

When faced with clients who complain of side effects and complications or who have reproductive concerns, the following information should be obtained:

D. Present Health or Concern

Ask the client about possible:

1. Present complaint or concern
2. Onset, nature, and duration of present complaint or concern
3. Accompanying symptoms and precipitating/aggravating factors
4. Measures or medications taken to relieve symptoms and precipitating/ aggravating factors
5. Prior consultations or medications

PHYSICAL EXAMINATION

Purpose of a Physical Examination

A general physical examination is not necessary at all times in ensuring the SAFE USE of a FP method. The WHO Applicability of procedures can serve as the guide that will tell which of the procedures or examinations may be necessary.

Physical examination when necessary will also help the FP service provider to:

- Confirm abnormal conditions suspected or noted during the client history-taking.
- Evaluate the health of the client while she uses an FP method to make sure she has not developed conditions which need precautions to the use of the contraceptive method.
- Confirm complications from side effects which may have arisen from the use of an FP method.

There are two golden rules to remember when conducting the physical examination:

- a. Proceed from head to toe.
- b. Inspect first, palpate later.

There are basically four general steps in conducting a general physical examination:

1. Take vital signs

- a. Blood Pressure
- b. Pulse Rate
- c. Respiratory Rate
- d. Temperature

2. Prepare client

- a. Make the client comfortable.
- b. If doing an internal exam: Asking client to void/empty bladder and wash perineum.
- c. Assure privacy and confidentiality.
- d. Explain the procedures or what is going to happen and why.

3. Prepare needed instruments and supplies

- a. Prepare the instruments and supplies ahead of the actual PE especially when there is no knowledgeable assistant around.

4. Conduct the physical examination

- a. If the health provider is a male, the female client may request a companion during the physical examination.

OTHER PHYSICAL EXAMINATION THAT MAY BE DONE WHEN NECESSARY

Breast Examination – According to the applicability in WHO MEC, a breast exam does not contribute to the safe and effective use of any contraceptive method. However, in light of providing quality reproductive health care, a breast examination can be done during initial visits of all new clients and yearly as part of a general checkup.

Abdominal Examination

1. Abdominal examination is done to check for tenderness, organ enlargements, or masses.
2. Tenderness in one or both lower quadrants may suggest the presence of pelvic inflammatory disease.

3. In non-pregnant women, the uterus is not palpable by this examination. An abdominal mass may suggest tumor or malignancy.

Pelvic Examination

1. Pelvic examination is done to detect any pelvic abnormality or pathologic condition that may be a precaution to the use of a specific FP method (e.g. IUD, BTL).
2. It is also done to obtain specimen/s for laboratory examination/s, which may be necessary in providing RH/FP care. These examinations include:
 - a. Pap smear
 - b. Wet vaginal smear for trichomoniasis, moniliasis, or bacterial vaginosis
 - c. Gram staining for gonorrhea and chlamydia

LABORATORY EXAMINATION

In some cases, findings in the history taking or physical examination may have to be confirmed or worked out through the use of selected laboratory tests. Laboratory tests are **NOT ALWAYS REQUIRED** (refer to WHO Applicability chart) but are only performed when needed. Every FP service provider must be familiar with these tests and how to interpret their results so that s/he is knowledgeable about: (1) when to request the tests; and (2) how these tests can help him/her best manage the client's case.

Hemoglobin determination

Hemoglobin determination will tell whether a person has anemia or not.

The normal ranges for hemoglobin depend on the age and, beginning in adolescence, the sex of the person. The normal ranges are:

- Adult males: 14-18 gm/dl
- Adult women: 12-16 gm/dl

Other Laboratory Examinations

There are other laboratory examinations requested in FP/RH services:

- Wet Smear - to find the causative agent of existing vaginitis- monilia, trichomonas or gardnerella
- Gram Stain - to determine the microorganism causing the STI- gonococci or chlamydia
- Pap Smear - cervical secretions collected examined under a microscope in order to look for pre-malignant or malignant changes
- Acetic Acid - abnormal areas of the cervix are viewed by applying acetic acid to the cervix.

SESSION 2

WHO MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE

LEARNING OBJECTIVES

At the end of this session, participants must be able to:

1. Describe the WHO Medical Eligibility Criteria for contraceptive use.
2. Define the four categories of the WHO MEC for temporary methods.
3. Explain the recommendations for eligibility for the MEC categories for the permanent and FAB methods.
4. Discuss the WHO MEC on “Applicability of Various Procedures for Contraceptive Use”.
5. Discuss how to be reasonably sure that the woman is not pregnant using the checklist.



METHODOLOGY

Lecturette-Discussion
Case Studies
Group work






TIME ALLOTMENT

1 hour



ADVANCE PREPARATION OF MATERIALS

- WHO Medical Eligibility Criteria (MEC) for Contraceptive Use
- WHO MEC Wheel
- WHO Applicability of various procedures or tests for contraceptives methods
- Powerpoint presentation
- Computer and LCD or overhead projector
- Whiteboard and markers
- Metacards, pentel pens, masking tapes

Topics/Contents	Teaching-Learning Process															
 <h2 style="color: #008000; margin: 0;">SESSION 2</h2>  <h3 style="color: #008000; margin: 0;">WHO MEDICAL ELIGIBILITY CRITERIA (MEC)</h3>	<p>Introduce the next session by showing the slide on the session title.</p>															
<div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: inline-block;"> Learning Objectives</div> <p>At the end of this session participants must be able to:</p> <ul style="list-style-type: none"> • Explain the use the WHO-MEC. • Demonstrate the use of the MEC Wheel. 	<p>Tell the participants the Specific Learning Objectives of this session as presented on the slides</p>															
<div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: inline-block;">Overview of the WHO Medical Eligibility Criteria</div> <div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: inline-block; margin-top: 10px;">WHO Medical Eligibility Criteria (MEC) for Contraceptive Use:</div> <ul style="list-style-type: none"> • WHO MEC is an available reference tool for assessing clients on their eligibility for initiating and continuing the use of a specific contraceptive method based on certain criteria developed from evidence based standards. 	<p>Explain to the participants what the WHO MEC for Contraceptive Use using the slide presentation.</p>															
<div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: inline-block;">Simplified MEC Categories for Temporary Methods</div> <div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: inline-block; margin-top: 10px;">Simplified MEC Categories for Temporary Methods</div> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="background-color: #d9ead3;">Category</th> <th style="background-color: #d9ead3;">With Clinical Judgment</th> <th style="background-color: #d9ead3;">With Limited Clinical Judgment</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td> <td>Use the method in any circumstances</td> <td>Use the method</td> </tr> <tr> <td style="text-align: center;">2</td> <td>Generally use the method</td> <td>Use the method</td> </tr> <tr> <td style="text-align: center;">3</td> <td>Use of the method not usually recommended unless other, more appropriate methods are not available or acceptable</td> <td>Do not use the method</td> </tr> <tr> <td style="text-align: center;">4</td> <td>Method not to be used</td> <td>Do not use the method</td> </tr> </tbody> </table>	Category	With Clinical Judgment	With Limited Clinical Judgment	1	Use the method in any circumstances	Use the method	2	Generally use the method	Use the method	3	Use of the method not usually recommended unless other, more appropriate methods are not available or acceptable	Do not use the method	4	Method not to be used	Do not use the method	<p>Show the prepared slide on the four categories of the WHO MEC. Tell the participants that the four category classification framework can be simplified, as shown in the slide, in two categories when resources for clinical judgment are limited.</p>
Category	With Clinical Judgment	With Limited Clinical Judgment														
1	Use the method in any circumstances	Use the method														
2	Generally use the method	Use the method														
3	Use of the method not usually recommended unless other, more appropriate methods are not available or acceptable	Do not use the method														
4	Method not to be used	Do not use the method														

Topics/Contents

Teaching-Learning Process

Permanent methods

Simplified MEC Categories for Permanent Methods

Category	Eligibility Criteria
A (Accept)	There is no medical reason to deny sterilization to a person with this condition.
C (Caution)	The procedure is normally conducted in a routine setting, but with extra preparation and precautions.
D (Delay)	The procedure is delayed until the condition is evaluated and/or corrected. Alternative temporary methods of contraception should be provided.
S (Special/ Refer)	The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anesthesia, and other backup medical support. For these conditions, the capacity to decide on the most appropriate procedure and anesthesia regimen is also needed. Alternative temporary methods of contraception should be provided if referral is required or there is otherwise any delay.

Show the slide on the simplified MEC categories for Permanent Methods.

Tell the participants that the categories for permanent methods are different.

Fertility awareness-based methods

Simplified MEC Categories for Fertility Awareness-Based Methods

Category	Eligibility Criteria
A (Accept)	There is no medical reason to deny the particular FAB method to a woman in this circumstance.
C (Caution)	The method is normally provided in a routine setting, but with extra preparation and precautions. For FAB methods, this usually means that special counseling may be needed to ensure correct use of the method by a woman in this circumstance.
D (Delay)	Use of this method should be delayed until the condition is evaluated or corrected. Alternative temporary methods of contraception should be offered.
NA	Not Applicable

Show the slide on the simplified MEC categories for Fertility Awareness Based (FAB) Methods.

Tell the participants that the categories for FAB have its own MEC category.

WHO MEC Wheel for Contraceptive use

- Contains the medical eligibility criteria for starting use of contraceptive methods.
- Tells FP service providers if a client with a known medical condition is able to use contraceptive methods safely and effectively.

Discuss the WHO MEC Wheel for Contraceptive Use by showing the slide presentation.

WHO MEC Wheel for Contraceptive use

Recommendations on six common types of contraceptives:

- Low dose COCs
- CICs - Cyclofem and Mesigyna
- Progestin-only pills
- DMPA and NET-EN
- Implants - Norplant, Jadelle, Implanon
- Copper T380A IUD

Topics/Contents	Teaching-Learning Process																																																																																										
<p data-bbox="213 203 555 226">Activity on the use of the MEC WHEEL</p> <h2 data-bbox="310 371 691 412" style="text-align: center;">Using the MEC Wheel</h2>	<p data-bbox="832 203 1397 376">Divide the participants into small groups with one facilitator each. Let participants use the MEC Wheel to recommend the types of FP Methods based on the conditions of the client listed below:</p> <ul data-bbox="868 421 1295 701" style="list-style-type: none"> • History of deep vein thrombosis • Smoking • Over 35 years old • Has high blood pressure (specify systolic/diastolic) • Increased risk of STI • Unexplained vaginal bleeding • Diabetic <p data-bbox="832 741 1397 808">Supplement the responses of the participants as needed.</p>																																																																																										
<p data-bbox="213 831 652 882">WHO MEC on Applicability of Various Procedures or Test for Contraceptive Use</p> <p data-bbox="213 920 511 943">WHO MEC Wheel for Contraceptive use</p> <ul data-bbox="213 1025 758 1167" style="list-style-type: none"> • Specified examinations/procedures are required for only a few of the FP methods. • The use of the WHO MEC on Applicability of Various Procedures and Tests shows that a THOROUGH or COMPLETE physical examination MAY NOT BE WARRANTED, if the client is decided on a FP method. 	<p data-bbox="832 842 1103 871">Tell participants that:</p> <ul data-bbox="832 916 1392 1543" style="list-style-type: none"> • The WHO MEC on Applicability of Various Procedures and Tests recommends procedures and tests necessary prior to the provision of contraceptive methods. • The recommendations are based on evidence for the safe and effective use of the contraceptive methods. • The WHO MEC on Applicability of Various Procedures and Tests shows that, based on evidence, a THOROUGH or COMPLETE physical examination does not contribute substantially to safe and effective use of all contraceptive methods and should not be made a routine for FP clients. 																																																																																										
<table border="1" data-bbox="338 1592 649 1794"> <thead> <tr> <th>Specific Situation</th> <th>COC</th> <th>CIC</th> <th>POP</th> <th>POI</th> <th>Implants</th> <th>IUD</th> <th>Condom</th> <th>BTL</th> <th>Vasectomy</th> </tr> </thead> <tbody> <tr> <td>Breast exam by provider</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>NA</td> </tr> <tr> <td>Pelvic/Gential Exam</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>A</td> <td>C</td> <td>A</td> <td>A</td> </tr> <tr> <td>Cervical cancer screening</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>NA</td> </tr> <tr> <td>Routine lab tests</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> </tr> <tr> <td>Hemoglobin test</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>B</td> <td>C</td> <td>B</td> <td>C</td> </tr> <tr> <td>STI risk assessment: Med Hx & PE</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>A</td> <td>C</td> <td>C</td> <td>C</td> </tr> <tr> <td>STI/HIV screening: Lab tests</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>C</td> <td>B^a</td> <td>C</td> <td>C</td> <td>C</td> </tr> <tr> <td>BP screening</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> <td>C</td> <td>C</td> <td>A</td> </tr> </tbody> </table> <p data-bbox="338 1794 581 1800"><small>Adapted from: WHO Medical Eligibility Criteria for Contraceptive Use, Third Edition, 2004</small></p> <p data-bbox="338 1816 649 1883"> <small> * Class A = essential and mandatory in all circumstances for safe and effective use of the contraceptive method Class B = contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context. The risk of not performing an examination or test should be balanced against the benefits of making the contraceptive methods available. Class C = does not contribute substantially to safe and effective use of the contraceptive method. </small> </p> <p data-bbox="338 1899 649 2063"> <small> Notes: The Medical Eligibility Criteria for Contraceptive Use, Third Edition, 2004 states that: * If a woman has a very high individual likelihood of exposure to gonorrhea or chlamydia infection, she should generally not have an IUD inserted unless other methods are not available or not acceptable. If she has current purulent cervicitis or gonorrhea or chlamydia infection, then she should not have an IUD inserted until these conditions are resolved and she is otherwise medically eligible. Women at high risk of HIV infection should not use spermicides containing nonoxonyl-9. Using diaphragms and cervical caps with nonoxonyl-9 is not usually recommended for women at high risk of HIV infection unless other more appropriate methods are not available or not acceptable. The contraceptive effectiveness of diaphragms and cervical caps without nonoxonyl-9 has been insufficiently studied and should be assumed to be less than that of diaphragms and cervical caps with nonoxonyl-9. It is desirable to have blood pressure measurements taken before initiation of COCs, CICs, POPs, POIs, and implants. However, blood pressure measurements are unavailable in many settings, pregnancy morbidity and mortality risks are high, and hormonal methods among the few methods widely available. In such settings, women should not be denied the use of hormonal methods simply because their blood pressure cannot be measured. ^a For procedures performed using local anesthesia with epinephrine. </small> </p>	Specific Situation	COC	CIC	POP	POI	Implants	IUD	Condom	BTL	Vasectomy	Breast exam by provider	C	C	C	C	C	C	C	C	NA	Pelvic/Gential Exam	C	C	C	C	C	A	C	A	A	Cervical cancer screening	C	C	C	C	C	C	C	C	NA	Routine lab tests	C	C	C	C	C	C	C	C	C	Hemoglobin test	C	C	C	C	C	B	C	B	C	STI risk assessment: Med Hx & PE	C	C	C	C	C	A	C	C	C	STI/HIV screening: Lab tests	C	C	C	C	C	B ^a	C	C	C	BP screening	-	-	-	-	-	-	C	C	A	<p data-bbox="832 1588 1392 1805">Walk the participants through the Applicability Chart and point out the required exams for selected methods. Check the WHO MEC tool (see table) on what particular physical examination and/or laboratory exam is needed for a specific FP method.</p> <p data-bbox="832 1850 1392 1917">Let the participants note that for most FP methods, there is no need for examinations.</p>
Specific Situation	COC	CIC	POP	POI	Implants	IUD	Condom	BTL	Vasectomy																																																																																		
Breast exam by provider	C	C	C	C	C	C	C	C	NA																																																																																		
Pelvic/Gential Exam	C	C	C	C	C	A	C	A	A																																																																																		
Cervical cancer screening	C	C	C	C	C	C	C	C	NA																																																																																		
Routine lab tests	C	C	C	C	C	C	C	C	C																																																																																		
Hemoglobin test	C	C	C	C	C	B	C	B	C																																																																																		
STI risk assessment: Med Hx & PE	C	C	C	C	C	A	C	C	C																																																																																		
STI/HIV screening: Lab tests	C	C	C	C	C	B ^a	C	C	C																																																																																		
BP screening	-	-	-	-	-	-	C	C	A																																																																																		

Topics/Contents

Teaching-Learning Process

How to determine if a woman is NOT pregnant

How to be reasonably ensure the woman is not pregnant

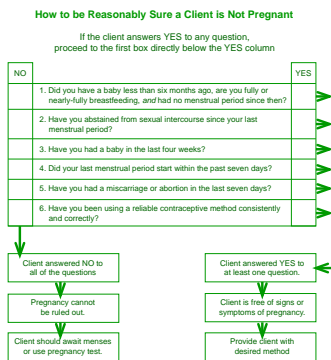
- A health provider can usually tell if a woman is not pregnant by asking a few questions.
- A pregnancy test and physical examination are usually not needed.
- A woman should not use an FP method while she is pregnant.

Tell the participants that:

- A woman should not use an FP method while she is pregnant except for condoms which should be used as protection against STI.

A health provider can usually tell if a woman is not pregnant by asking some questions. A pregnancy test and physical examination are usually not needed.

Checklist on how to be reasonably sure if the woman is not pregnant



Show the slide on the checklist on “How To Be Reasonably Sure a Client Is Not Pregnant.”

Review the items of the checklist with participants.

Ask participants if they have any questions.

Summary and Key Learning Points on Client Assessment

Summary and Key Learning Points

- The health provider needs to have the necessary knowledge and skills to be able to adequately and accurately assess the health needs, as well as the health status, of clients seeking to improve the quality of their lives.
- Client assessment is the first stage common to any health care service, and an important step prior to the provision of FP services.

Show the slide on the summary and key learning points to summarize the module.

3.22

Summary and Key Learning Points

- Client's FP needs and data on medical status and conditions are obtained to ensure that they are medically eligible for their chosen FP method.
- Client Assessment involves the following components:
 - ✓ History-taking
 - ✓ Physical and Laboratory examinations

Summary and Key Learning Points

- The WHO Medical Eligibility Criteria is an available reference tool for assessing clients on their eligibility for initiating and continuing the use of a specific contraceptive method based on certain criteria.



NARRATIVE

MODULE 3: FP CLIENT ASSESSMENT SESSION 2: WHO MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE

WHO MEC is an available reference tool for assessing clients on their eligibility for initiating and continuing the use of a specific contraceptive method based on certain criteria developed from evidence based standards.

The WHO MEC is recommended for assessing clients who may want to start or continue using a method. It gives recommendations based on the latest clinical evidence available on the safety of the methods for people with certain health conditions. On the basis of these recommendations, possible conditions of clients wanting to initiate or continue using a contraceptive method are classified under one of the following four categories listed below.

The four categories of the **WHO MEC** are:

Category 1: A condition for which there is **NO RESTRICTION** on the use of contraceptive method. **PROVIDE** the **METHOD**.

Category 2: A condition where **THE ADVANTAGES** of using the method generally **OUTWEIGH** the theoretical or proven **RISKS**. This indicates that the method can be **GENERALLY** used, but that **CAREFUL FOLLOW-UP** may be required.

Category 3: A condition where the **THEORETICAL OR PROVEN RISKS** usually **OUTWEIGH** the **ADVANTAGES** of using the method. Use of this method **IS NOT RECOMMENDED UNLESS OTHER MORE APPROPRIATE METHODS ARE NOT AVAILABLE** or **ACCEPTABLE**.

Category 4: A condition which represents an **UNACCEPTABLE HEALTH RISK** if the contraceptive method is used. **DO NOT PROVIDE** the method.

WHO Category	With Clinical Judgment	With Limited Clinical Judgment
1	Use the method in any circumstances	Use the method
2	Generally use the method	Use the method
3	Use of the method not usually recommended unless other, more appropriate methods are not available or acceptable	Do not use the method
4	Method not to be used	Do not use the method

The following are the Summary Tables for each of the permanent and FAB methods:

Simplified MEC Categories for Permanent Methods

Category	Eligibility Criteria
A (Accept)	There is no medical reason to deny sterilization to a person with this condition.
C (Caution)	The procedure is normally conducted in a routine setting, but with extra preparation and precautions.
D (Delay)	The procedure is delayed until the condition is evaluated and/or corrected. Alternative temporary methods of contraception should be provided.
S (Special/Refer)	The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anesthesia, and other backup medical support. For these conditions, the capacity to decide on the most appropriate procedure and anesthesia regimen is also needed. Alternative temporary methods of contraception should be provided if referral is required or there is otherwise any delay.

Simplified MEC Categories for Fertility Awareness-Based Methods

Category	Eligibility Criteria
A (Accept)	There is no medical reason to deny the particular FAB method to a woman in this circumstance.
C (Caution)	The method is normally provided in a routine setting, but with extra preparation and precautions. For FAB methods, this usually means that special counseling may be needed to ensure correct use of the method by a woman in this circumstance.
D (Delay)	Use of this method should be delayed until the condition is evaluated or corrected. Alternative temporary methods of contraception should be offered.
NA	Not Applicable

3.24

Programmatic implications of the WHO MEC

Programmatic issues that need to be addressed include:

- Informed choice
- Elements of quality of care
- Essential screening procedures for administering the methods
- Provider training and skills
- Referral and follow up for contraceptive use as appropriate

In the application of the eligibility criteria to programs, service delivery practices that are essential for the safe use of the contraceptive should be distinguished from practices that may be appropriate for good health care but are not related to the use of the method. The promotion of good health care practices unrelated to safe contraception should be considered neither as a prerequisite nor as an obstacle to the provision of a contraceptive method, but rather as complement to it.

WHO MEC Wheel for Contraceptive Use

The WHO MEC Wheel contains the medical eligibility criteria for starting use of contraceptive methods. It is an abridged version of the Medical Eligibility Criteria for Contraceptive Use, Third Edition (2004). It guides FP service providers to determine if a woman presenting with a known medical or physical condition is suitable for safely and effectively using various contraceptive methods.

The wheel includes recommendations on initiating use of six common types of contraceptives:

1. Combined pills (low dose combined oral contraceptives, with 35 < ethinylestradiol)
2. Combined injectable contraceptives (Cyclofem and Mesigyna)
3. Progestin-only pills
4. Progestin-only injectables, DMPA (a 3-monthly injectable) and NET-EN (a 2-monthly injectable)
5. Progestin-only implants (Norplant, Jadelle, and Implanon)
6. Copper-bearing IUD

The guidance in the wheel applies to initiation of contraceptive methods. Recommendations for continuation of method use, if a woman develops a medical condition while using the method can be found in the MEC guideline.

Applicability of various procedures or test for contraceptive use

Some examinations or procedures may be done before providing a method of contraception. Those with known medical problems or other special conditions may need additional examinations or tests before being deemed appropriate candidates for a particular method of contraception.

The applicability of various procedures or tests for contraceptive use is part of the WHO Medical Eligibility Criteria for Contraceptive Use, Third Edition, 2004. It focuses on the relationship of the procedures or tests to the safe initiation of a contraceptive method. They are not intended to address the appropriateness of these examinations or tests in other circumstances. For example, some of the procedures or tests that are not deemed necessary for safe and effective contraceptive use may be appropriate for good preventive health care or for diagnosing or assessing suspected medical conditions.

The following Applicability Chart shows the required exams for selected methods. Check the WHO MEC Tool (see table) on a particular physical examination and/or laboratory exam for a specific FP Method.

For most FP methods, there is no need for examinations.

Table 13. Applicability* of various procedures or tests for contraceptives methods.

Specific Situation	COC	CIC	POP	POI	Implants	IUD	Condom	BTL	Vasectomy
Breast exam by provider	C	C	C	C	C	C	C	C	NA
Pelvic/Genital Exam	C	C	C	C	C	A	C	A	A
Cervical cancer screening	C	C	C	C	C	C	C	C	NA
Routine lab tests	C	C	C	C	C	C	C	C	C
Hemoglobin test	C	C	C	C	C	B	C	B	C
STI risk assessment: Med Hx & PE	C	C	C	C	C	A ¹	C ²	C	C
STI/HIV screening: Lab tests	C	C	C	C	C	B ¹	C ²	C	C
BP screening	³	³	³	³	³	C	C	A	C ⁴

Adapted from: WHO Medical Eligibility Criteria for Contraceptive Use, Third Edition, 2004

- *Class A = essential and mandatory in all circumstances for safe and effective use of the contraceptive method
- Class B = contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context. The risk of not performing an examination or test should be balanced against the benefits of making the contraceptive methods available.
- Class C = does not contribute substantially to safe and effective use of the contraceptive method.

Notes

The Medical Eligibility Criteria for Contraceptive Use, Third Edition, 2004 states that:

¹ If a woman has a very high individual likelihood of exposure to gonorrhea or chlamydial infection, she should generally not have an IUD inserted unless other methods are not available or not acceptable. If she has current purulent cervicitis or gonorrhea or chlamydial infection, then she should not have an IUD inserted until these conditions are resolved and she is otherwise medically eligible.

² Women at high risk of HIV infection should not use spermicides containing nonoxynol-9. Using diaphragms and cervical caps with nonoxynol-9 is not usually recommended for women at high risk of HIV infection unless other more appropriate methods are not available or not acceptable. The contraceptive effectiveness of diaphragms and cervical caps without nonoxynol-9 has been insufficiently studied and should be assumed to be less than that of diaphragms and cervical caps with nonoxynol-9.

³ It is desirable to have blood pressure measurements taken before initiation of COCs, CICs, POPs, POIs, and implants. However, blood pressure measurements are unavailable in many settings, pregnancy morbidity and mortality risks are high, and hormonal methods among the few methods widely available. In such settings, women should not be denied the use of hormonal methods simply because their blood pressure cannot be measured.

⁴ For procedures performed using local anesthesia with ephedrine.

Determining if a woman is NOT pregnant

A woman should not use an FP method while she is pregnant except for condoms which should be used when protection against STI is needed.

A health provider can usually tell if a woman is not pregnant by asking the following questions. Pregnancy test and physical examination are usually not needed.

It is reasonably certain that a woman is not pregnant if:

- Her menstrual period started within the last seven days.
- She gave birth within the last four weeks.
- She had an abortion or miscarriage within the last seven days.
- She gave birth within the last six months, is breastfeeding often, and has not yet had a menstrual period

The diagram (found next page) summarizes and provides an algorithm of how a service provider can be reasonably sure that a potential FP client is not pregnant. It also provides recommendation for actions.

If the woman has had sex and her last period was five weeks ago or more, pregnancy cannot be ruled out. Even if she used an effective contraception, except DMPA, consider early signs of pregnancy.

- Delayed menstrual period
- Breast tenderness
- Nausea
- Vomiting
- Weight change
- Frequent tiredness
- Mood changes
- Changed eating habits
- Frequent urination

Late Signs of Pregnancy: *(If it has been more than 12 weeks since her last menstrual period)*

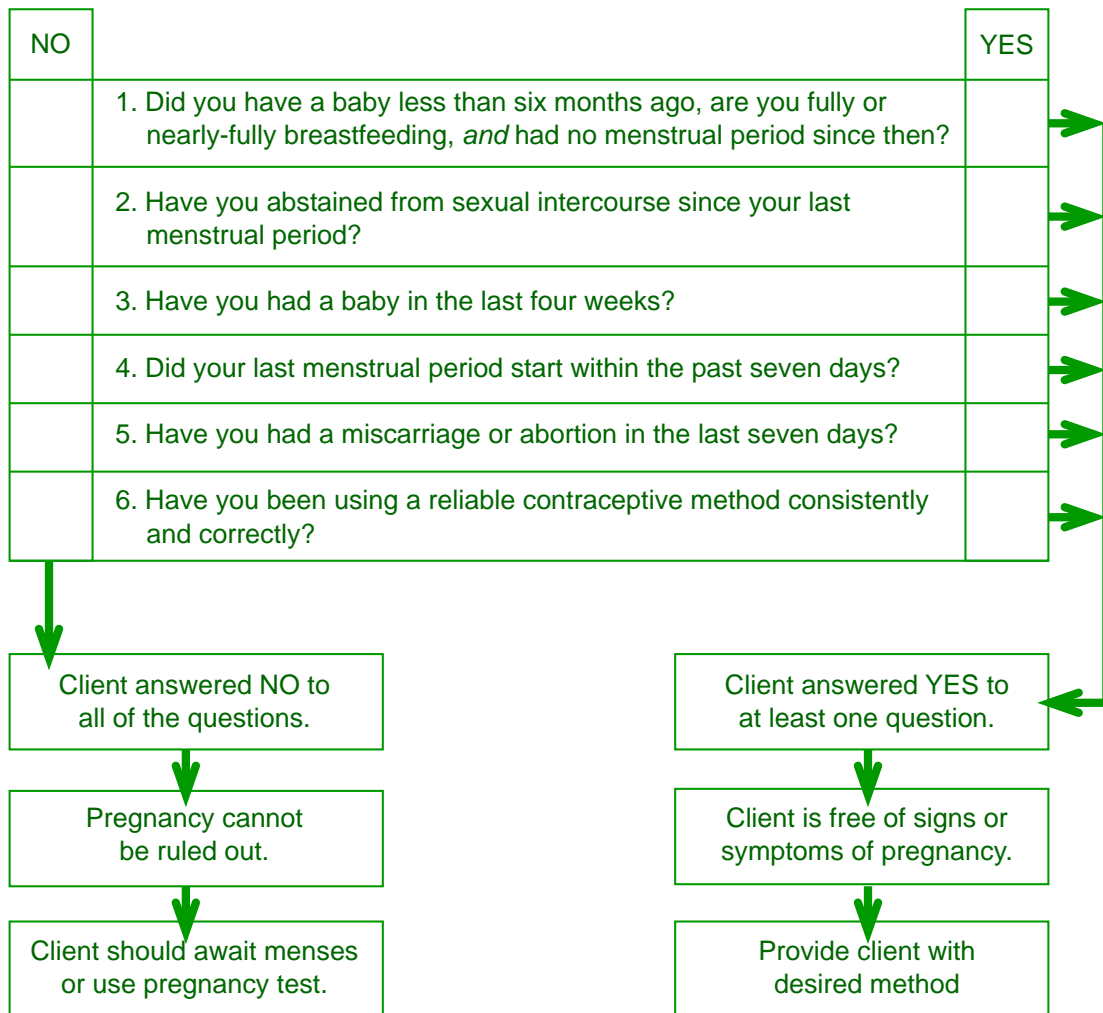
- Larger breasts
- Darker nipples
- More vaginal discharge
- Enlarged abdomen
- Movements of a baby

If she exhibited several of these signs, she may be pregnant. Confirm by doing a physical examination.

If her answers cannot rule out pregnancy, she should either have a pregnancy test, if available, or wait until her next menstrual period before starting a method. Give her condoms to use until then, with instructions and advice on how to use them.

How to be Reasonably Sure a Client is Not Pregnant

If the client answers YES to any question, proceed to the first box directly below the YES column



SUMMARY AND KEY LEARNING POINTS

3.28

The health provider needs to have the necessary knowledge and skills to be able to adequately and accurately assess the health needs, as well as the health status of clients seeking to improve the quality of their lives.

Client assessment is the first stage common to any health care service, and an important step prior to provision of FP services.

Client's FP needs and data on medical status and conditions are obtained to ensure that they are medically eligible for their chosen FP method. Client assessment involves the following components:

- History-taking
- If needed: physical and laboratory examination

The WHO Medical Eligibility Criteria is an available reference tool for assessing clients on their eligibility for initiating and continuing the use of a specific contraceptive method based on certain criteria.



MODULE 4



Infection Prevention in Family Planning Services

Session 1: The Disease Transmission Cycle and Infection
Prevention Definitions

Session 2: Infection Prevention Measures

MODULE 4: INFECTION PREVENTION IN FP SERVICES



MODULE OVERVIEW

Infection prevention is an important element of quality service provision.

Correct infection prevention techniques during the provision of FP services is crucial to the safety of both clients and service providers. The purpose of this module is for service providers to practice appropriate infection prevention techniques.







MODULE OBJECTIVES

At the end of this module, participants will be able to understand the appropriate infection prevention practices to reduce the risk of disease transmission during the provision of FP services.



MODULE SESSIONS

Session 1:	The Disease Transmission Cycle and Infection Prevention Definitions
Session 2:	Infection Prevention Measures

Topics/Contents	Teaching-Learning Process
<div style="display: flex; align-items: center;">  <div style="margin-left: 20px;"> <h2 style="margin: 0;">MODULE 4</h2> <hr style="border: 0.5px solid black;"/>  <h3 style="margin: 0;">INFECTION PREVENTION IN FAMILY PLANNING SERVICES</h3> </div> </div>	<p>Greet participants.</p> <p>Tell participants that:</p> <ul style="list-style-type: none"> • Infection prevention is an important element of quality service provision. • The practice of correct infection prevention techniques during the provision of FP services is crucial to the safety of both clients and service providers.
<div style="background-color: #008000; color: white; padding: 5px; display: flex; align-items: center;">  OBJECTIVE </div> <p>• At the end of this module, participants will be able to understand the appropriate infection prevention practices to reduce the risk of disease transmission during the provision of FP services.</p>	<p>Show and explain the module objective as presented on the slide.</p>
<div style="background-color: #008000; color: white; padding: 5px; display: flex; align-items: center;">  SESSIONS </div> <p>SESSION 1 - The Disease Transmission Cycle and Infection Prevention Definitions</p> <p>SESSION 2 - Infection Prevention Measures</p>	<p>Enumerate the sessions in this module as presented on the slide.</p>

THE DISEASE TRANSMISSION CYCLE



LEARNING OBJECTIVES

At the end of the session, participants will be able to:

1. Discuss the disease transmission cycle.
2. Explain infection prevention as it relates to family planning service provision.
3. Define infection prevention terms and processes.



METHODOLOGY

Lecturette-Discussion
Brainstorming



TIME ALLOTMENT

45 minutes



ADVANCE PREPARATION OF MATERIALS

- LCD or overhead projector, powerpoint presentation
- Laptop computer (if using LCD)
- Whiteboard
- Manila paper
- Permanent markers, whiteboard markers
- Metacards, tape

Topics/Contents

Teaching-Learning Process



SESSION 1



THE DISEASE TRANSMISSION CYCLE AND INFECTION PREVENTION DEFINITIONS

Introduce the session by stating the objectives as presented on the slides.



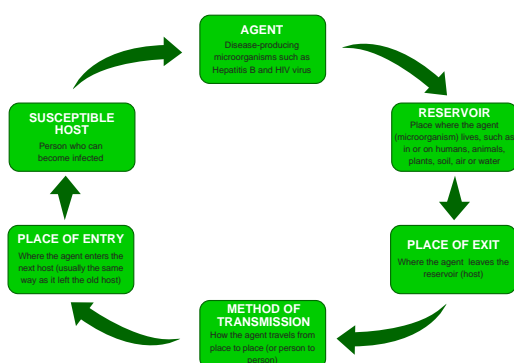
Learning Objectives

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

- Discuss the disease transmission cycle.
- Discuss asepsis, antisepsis, decontamination, cleaning, high-level disinfection, and sterilization

The Disease Transmission Cycle

The Disease Transmission Cycle



Show the slide on the disease transmission cycle.

Ask a participant to explain what the diagram means. Explain the diagram by telling participants that:

- The **agent** refers to the infectious microorganisms (germs) which can cause disease such as:
 - * Bacteria = staphylococcus, clostridia tetani which causes tetanus
 - * Viruses = Hepatitis B, HIV
 - * Fungi and parasites
- Where the agent lives is the **reservoir**. This can be humans, animals, plants, soil, air, and water. In humans, the reservoir is usually, the blood, body fluids, and tissues.

Topics/Contents	Teaching-Learning Process
	<ul style="list-style-type: none"> • The place of exit is the manner by which the agent leaves the reservoir and is transmitted from place to place or person to person. • The mode of transmission could be through: <ol style="list-style-type: none"> 1. Contact - direct transfer of microorganisms through touch, sexual intercourse, fecal/oral transmission, and droplets. 2. Vehicle - materials that serve as means of transfer of the microorganisms. These can be blood (HIV, HBV) water (cholera, shigella), food (salmonella) or instruments and other items used during procedures. 3. Airborne – carried by air currents (measles, TB) 4. Vector – invertebrate animals can transmit microorganisms (mosquito for malaria and yellow fever) • The place of entry is the manner by which the agent enters another host. Usually, the mode of entry is the same way that the agent left the old host. The organisms can be passed through mucous membranes or broken skin, such as cuts and scratches, and puncture wounds from needle sticks with used needles. • The next person who gets infected is the susceptible host. <p>Emphasize to participants that:</p> <ul style="list-style-type: none"> • To prevent diseases caused by the agent (organisms that cause infection), the cycle must be broken at any point. • Breaking the cycle at any point requires infection prevention measures, which will be discussed in more detail later.

Topics/Contents	Teaching-Learning Process
<p data-bbox="172 208 363 230">Infection Prevention</p> <p data-bbox="188 271 435 293">Infection Prevention in FP</p> <ul data-bbox="172 331 703 640" style="list-style-type: none"> • Refers to the measures used in preventing the spread of infection during the provision of FP services. • Aims to: <ul data-bbox="193 450 703 591" style="list-style-type: none"> * Minimize infections during the provision of FP services such as during DMPA injections, IUD insertion and removal, and voluntary surgical procedures. * Prevent the transmission of serious life threatening diseases such as hepatitis B and AIDS to both the clients and service providers. • Procedures are simple, effective, and inexpensive 	<p data-bbox="815 226 1369 293">Discuss the concept of infection prevention as it applies to FP using the slide.</p>
<p data-bbox="188 689 368 712">Protective Barriers</p> <p data-bbox="172 752 344 775">Protective Barriers</p> <ul data-bbox="172 792 751 1037" style="list-style-type: none"> • Physical, mechanical, or chemical processes, which help prevent the spread of infectious microorganisms from client to client, client to staff, or vice versa. • Example: <ul data-bbox="193 920 560 1037" style="list-style-type: none"> • Handwashing • Use of gloves • Correct use of antiseptics and disinfectants • Proper processing of instruments and other items • Proper disposal of sharps and wastes 	<p data-bbox="815 685 1353 752">Define terms used in infection prevention as presented on the slides.</p>
<p data-bbox="188 1128 293 1151">Antisepsis</p> <ul data-bbox="172 1211 746 1256" style="list-style-type: none"> • The prevention of infection by killing or inhibiting the growth of microorganisms on skin and other body tissues through a chemical agent (antiseptic). <p data-bbox="280 1308 727 1330">What antiseptics do you use in your clinic?</p>	<p data-bbox="815 1111 1034 1133">Ask participants:</p> <ul data-bbox="815 1182 1369 1249" style="list-style-type: none"> • Given what antisepsis is, what antiseptics do you use in your clinic? <p data-bbox="815 1294 1369 1406">Write responses on whiteboard. Response should include but not be limited to:</p> <ul data-bbox="815 1447 1082 1585" style="list-style-type: none"> • Alcohol • Betadine solution • Hydrogen peroxide • Chlorhexidine <p data-bbox="815 1630 1369 1742">It is important that the list should contain only chemicals used for the skin, mucosa, and other body tissues.</p> <p data-bbox="815 1787 1369 1854">Eliminate from the list those that are used for instruments and for cleaning.</p>

Topics/Contents	Teaching-Learning Process
<p data-bbox="233 219 347 241">Disinfection</p> <ul data-bbox="233 293 699 338" style="list-style-type: none"> • Is the process that eliminates most, but not all, disease causing microorganisms from inanimate objects. <p data-bbox="288 400 699 454">What disinfectants are available in your clinic?</p>	<p data-bbox="855 210 1075 241">Ask participants:</p> <ul data-bbox="855 282 1394 349" style="list-style-type: none"> • What disinfectants are available in their facilities? <p data-bbox="855 394 1417 497">Write responses on whiteboard. Responses should include but not be limited to:</p> <ul data-bbox="879 501 1394 609" style="list-style-type: none"> • Chlorine solution (e.g. Zonrox, Purex) • Lysol • Glutaraldehyde (e.g. Cidex) <p data-bbox="855 647 1417 714">Eliminate from the list those being used for body tissues.</p> <p data-bbox="855 757 1070 788">Emphasize that:</p> <ul data-bbox="855 828 1417 1120" style="list-style-type: none"> • Disinfectants cannot be used as antiseptics because they are too strong and will irritate body tissues. • Antiseptics cannot be used as disinfectants as they are too weak to be able to kill microorganisms on inanimate (non-living) things like instruments and gloves.
<p data-bbox="233 1171 320 1193">Cleaning</p> <ul data-bbox="233 1252 772 1296" style="list-style-type: none"> • The process of physically removing all visible blood, bodily fluids, or foreign material such as dust or soil from skin or inanimate objects. 	<p data-bbox="855 1155 1075 1187">Ask participants:</p> <ul data-bbox="855 1227 1278 1258" style="list-style-type: none"> • How do you clean used items? <p data-bbox="855 1301 1136 1332">Response should be:</p> <ul data-bbox="855 1375 1417 1559" style="list-style-type: none"> • Dissolving powder detergent in water, placing used items in the detergent solution, making sure that all dirt or soil is removed from the items, and thoroughly rinsing with clean water.
<p data-bbox="233 1619 453 1641">High-Level Disinfection</p> <ul data-bbox="233 1686 711 1731" style="list-style-type: none"> • Eliminates all microorganisms except some bacterial endospores. • Performed by boiling or the use of chemicals. 	
<p data-bbox="233 1850 347 1872">Sterilization</p> <ul data-bbox="233 1957 759 2002" style="list-style-type: none"> • Process that eliminates all microorganisms (bacteria, viruses, fungi, and parasites), including bacterial endospores from inanimate objects . 	



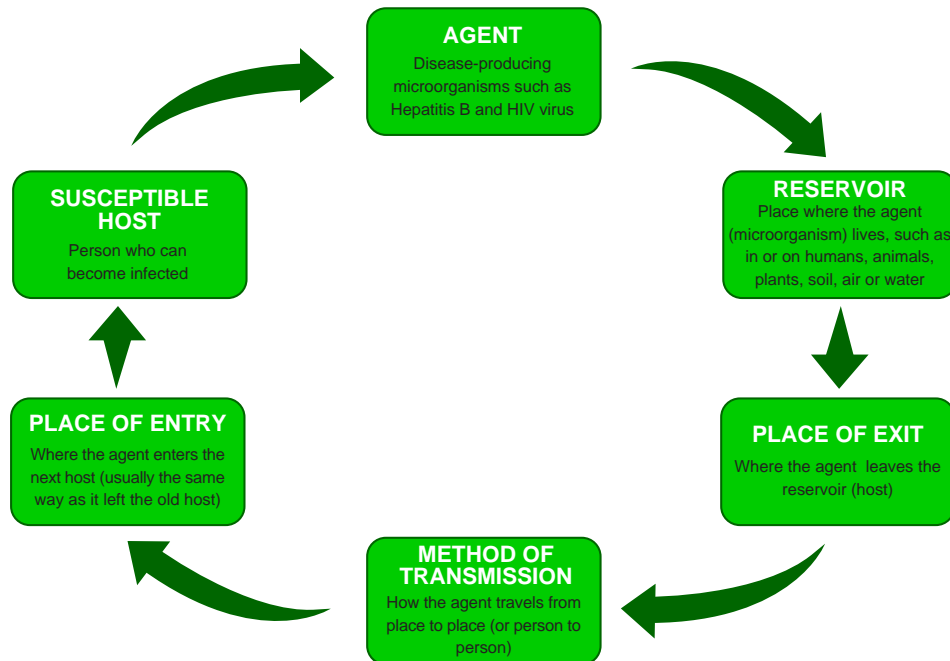
NARRATIVE

MODULE 4: INFECTION PREVENTION IN FP SERVICES

SESSION 1: THE DISEASE TRANSMISSION CYCLE

Infection prevention in family planning refers to the prevention of the spread of infection during the provision of FP services. It aims to protect both the clients and providers from the spread of infectious diseases. Infection prevention procedures are simple, effective, and inexpensive.

The diagram below illustrates the transmission and proliferation of infection.



- The **agent** refers to the infectious microorganisms (germs) which can cause disease such as:

- * Bacteria = staphylococcus, clostridia tetani which causes tetanus
- * Viruses = Hepatitis B, HIV
- * Fungi and parasites

4.8

- Where the agent lives is the **reservoir**. This can be humans, animals, plants, soil, air or water. In humans, the reservoir is usually, the blood, body fluids, and tissues.

- The **place of exit** is the manner by which the agent leaves the reservoir and is transmitted from place to place or person to person.

- The **mode of transmission** could be through:

1. Contact - direct transfer of microorganisms through touch, sexual intercourse, fecal/oral transmission and droplets.
2. Vehicle - materials that serves as a means of transfer of the microorganisms. This can be blood (HIV, HBV) water (cholera, shigella), food (salmonella) or instruments and other items used during the procedures.
3. Airborne - carried by air currents (measles, TB).
4. Vector - invertebrate animals can transmit microorganisms (mosquito for malaria and yellow fever).

- The **place of entry** is the manner by which the agent enters another host. Usually, the mode of entry is the same way that the agent left the old host. The organisms can be passed through mucous membranes or broken skin, such as cuts and scratches, and puncture wounds from needle sticks with used needles.
- The next person who gets infected is the **susceptible host**. To prevent diseases caused by the agent (organisms that cause infection), the cycle must be broken at any point. Breaking the cycle at any point requires infection prevention measures, which will be discussed in more detail later.

DEFINITION OF TERMS

Protective barriers are physical, mechanical or chemical processes, which help prevent the spread of infectious microorganisms from client to client, clinic staff to client and vice versa, due to lack of infection prevention practices or from contaminated instruments or equipment.

Infection prevention relies on barriers between the host and microorganisms.

Asepsis and aseptic techniques are procedures used in health care settings to describe the combination of efforts made to prevent entry of microorganisms into any area of the body where they are likely to cause infection. The goal of asepsis is to reduce microorganisms on animate (living) surfaces (skin and tissue) and inanimate objects (surgical instruments) to a safe level or to eliminate the microorganisms completely. Examples are handwashing, surgical scrub, use of antiseptics, use of properly processed instruments, and use of gloves.

Antiseptics is the prevention of infection by killing or inhibiting the growth of microorganisms on skin and other body tissues through a chemical agent (antiseptic). One example is the use of Povidone-Iodine applied as an antiseptic solution on the cervix before IUD insertion.

Decontamination is the process that makes inanimate (non-living) objects safer for handling by staff before cleaning by soaking in disinfectant like 0.5% chlorine solution. Such objects include large objects (e.g. examination tables) and surgical instruments and gloves contaminated with blood or body fluids (such as in BTL or vasectomy instruments).

Cleaning is the process of physically removing all visible blood, bodily fluids, or foreign material such as dust or soil from skin or inanimate objects. Wash or scrub with a brush with liquid soap or detergent and water. Avoid bar soap or powdered soap, which can stay on the equipment. Rinse and dry. While cleaning, wear utility gloves and personal protective equipment like goggles, mask, apron, and enclosed shoes.

Disinfection is the process that eliminates most, but not all, disease-causing microorganisms from inanimate objects. High-level disinfection (HLD), through boiling, by steaming or with chemicals such as chlorine, glutaraldehydes, and formaldehydes, eliminates most microorganisms except some bacterial endospores. HLD is done with instruments or supplies such as vaginal specula, uterine sounds, and gloves for pelvic examinations.

Sterilization is the process that kills all infectious microorganisms, including bacterial endospores, with a high-pressure steam autoclave, a dry-heat oven, chemicals or radiation. Sterilize instruments such as scalpels and needles that touch tissue beneath the skin.

SESSION 2

INFECTION PREVENTION MEASURES



LEARNING OBJECTIVES

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

1. Explain the principle of standard precautions.
2. Discuss the "protective barriers" which disrupt the transmission of infection such as:
 - a. Handwashing
 - b. Using gloves
 - c. Using antiseptics
 - d. Processing instruments and other items
 - e. Proper management of wastes
3. Develop a plan to ensure proper waste management in their respective facilities.



METHODOLOGY

Lecturette-Discussion
Group work
Brainstorming
Exercise



TIME ALLOTMENT









1 hour and 15 minutes



ADVANCE PREPARATION

- LCD or overhead projector
- Laptop computer (if using LCD)
- Whiteboard
- Powerpoint presentation of Module 4
- Manila paper
- Permanent markers, whiteboard markers
- Meta cards, tape
- Supplies for handwashing demonstration: such as dye or poster paint, handkerchiefs for blindfolding participant while doing hand washing, used newspaper
- Manila papers with the following matrix for a waste management workplan

Waste Generated	Frequency of Collection	Type of Storage	Method of Disposal	Responsible Person

Topics/Contents	Teaching-Learning Process
<div style="text-align: center;">  <h2 style="margin: 0;">SESSION 2</h2> </div> <hr style="width: 50%; margin: 10px auto;"/> <div style="display: flex; align-items: center; justify-content: center;">  <h2 style="margin: 0;">INFECTION PREVENTION MEASURES</h2> </div>	<p>Introduce the session by saying that:</p> <ul style="list-style-type: none"> • The previous session was a review of the disease transmission cycle, which explains how diseases are spread. • It was also learned from that session that to stop infection, the cycle must be broken at different points of the disease transmission cycle. • This session introduces the different processes that intervene with the continuity of the cycle, thereby, breaking the cycle of disease proliferation.
<p>Introduction</p> <hr/> <p> Learning Objectives</p> <p>At the end of the session, participants will be able to:</p> <ul style="list-style-type: none"> • Explain the principle of standard precautions. • Discuss the “protective barriers” which disrupt the transmission of infection such as: <ul style="list-style-type: none"> • Handwashing • Using gloves • Using antiseptics • Processing instruments and other items • Proper management of wastes • Develop a plan to ensure proper waste management in their respective facilities. 	<p>State the objectives of the session as presented on the slide.</p>
<p>Standard Precautions</p> <p>Consider every person as potentially infectious</p> <div style="display: flex; flex-direction: column; gap: 5px;"> <div style="display: flex; align-items: flex-start;">  <p style="margin: 0;">Wash your hands.</p> </div> <div style="display: flex; align-items: flex-start;">  <p style="margin: 0;">Wear gloves, eye protection or face shields, and gowns, when appropriate.</p> </div> <div style="display: flex; align-items: flex-start;">  <p style="margin: 0;">Correctly process instruments, other items used in clinical procedures, and client-care equipment</p> </div> <div style="display: flex; align-items: flex-start;">  <p style="margin: 0;">Prevent injuries with sharps.</p> </div> <div style="display: flex; align-items: flex-start;">  <p style="margin: 0;">Maintain correct environmental-cleanliness and waste-disposal practices</p> </div> </div>	<p>Tell participants that:</p> <ul style="list-style-type: none"> • “Standard Precautions” are designed for the safety and care of all people in a health care facility – whether a sick patient, a woman receiving IUD services, or a health care worker. • The “Standard Precautions” principle instructs us to consider every person as potentially infectious. • This means that every person, including you, can transmit an infection. <p>Elaborate on the different components and considerations in implementing the standard precautions:</p> <ul style="list-style-type: none"> • Wash hands – the most important

Topics/Contents	Teaching-Learning Process
	<p>procedure for preventing cross contamination (person to person or contaminated object to person).</p> <ul style="list-style-type: none"> • Wear gloves and other physical barriers <ul style="list-style-type: none"> * Gloves are worn (on both hands) before touching broken skin (e.g. wounds and abscesses), mucous membranes, blood or other body fluids (secretions and excretions), soiled instruments, and contaminated waste materials, or for performing invasive procedures. * Physical barriers (protective goggles, face masks, aprons, etc.) are worn if splashes and spills of blood or other body fluids are anticipated. • Use antiseptic agents properly. • Process instruments, gloves, and other items correctly using recommended procedures. • Handle sharps correctly by not recapping or bending needles and dispose of them in sharps containers. • Safely dispose of infectious waste materials to protect those who handle them and prevent injury or spread of infection to the community.
<p style="text-align: center;">Handwashing</p>	<p>Tell participants that:</p> <ul style="list-style-type: none"> • Handwashing is the SIMPLEST and MOST IMPORTANT infection prevention procedure in any health care facility. • Handwashing removes many microorganisms from the skin, preventing transmission of infection from person to person.

Topics/Contents	Teaching-Learning Process
<p>When to Do Handwashing</p> <p>When to do...</p> <p>Before</p> <ul style="list-style-type: none"> • the day's work • examining a client • administering injections or drawing blood • performing a procedure (IUD or pelvic exam) • handling clean, disinfected, or sterilized supplies for storage • putting on sterile gloves • going home <p>When to do...</p> <p>After</p> <ul style="list-style-type: none"> • any situation in which the hands may be contaminated, such as handling instruments or touching body secretions or excretions • examining a client • removing gloves • personal use of toilet • blowing nose, sneezing, or coughing 	<p>Ask participants at what particular instances do they wash their hands in their facilities.</p> <p>Write responses on the board. Present the slides and acknowledge responses given by participants.</p>
<p style="text-align: center;">EXERCISE</p>	<p>Exercise:</p> <ol style="list-style-type: none"> 1. Ask for three volunteers among the participants. 2. Ask the volunteers to wear the gloves provided to them. 3. Blindfold the volunteers. 4. Put poster paints on the gloved hands of the blindfolded participants and instruct them to simulate the motions of handwashing. 5. After 20 seconds, ask the volunteers to stop. 6. Remove the participants' blindfolds, ask them to show their hands to the class. <p>Processing:</p> <ol style="list-style-type: none"> 1. Ask participants to check if all parts of the volunteers' gloved hands were covered with poster paint. 2. Tell participants that if some parts are not covered, these areas represent parts of the hand which were not properly washed. 3. Tell participants that: <ul style="list-style-type: none"> * Proper handwashing is important for infection prevention. * A procedure that is always performed has actually not been performed correctly.

Topics/Contents

Teaching-Learning Process

Supplies for Handwashing

Supplies needed...

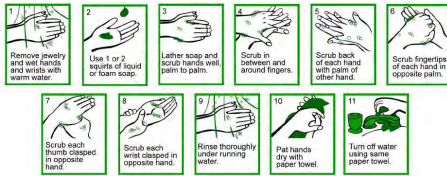
- Clean water (water may be running or from a bucket, but it must be clean)
- Soap
- Soap dish that drains and keeps the soap dry
- Clean, dry towel
- Plastic container
- Alcohol, if no running water is available

REMEMBER

Alcohol handrubs do not remove dirt or organic material such as blood. If your hands are dirty, wash them with soap and running water.

Enumerate the supplies needed for handwashing as written on the slide.

How to Do Handwashing



Tips

- No jewelry or nail polish should be worn.
- If there is no running water, use a dipper (*tabo*) to pour water on the hands at the beginning and when rinsing.
- Rinse the soap before putting it back in the soap dish.
- Avoid touching the sink as it may be contaminated.
- Wash hands for 15-30 seconds.
- Air-dry hands or dry with a personal towel.
- Use the towel or a paper towel to turn off the faucet.

Present the steps of proper handwashing using the slides.

Encourage participants to ask questions as the steps and the tips for handwashing are presented.

Gloves

Tell participants that:

- Gloves provide a barrier against potentially infectious microorganisms in blood, other body fluids, tissues, and medical waste.

Why Use Gloves

- To protect the health care provider from contact with potentially infectious substances like body fluids of clients.
- To protect the client from infections that might be present on the skin of the health care provider.

Tell participants why gloves should be used and the types of gloves as presented on the slides.

Gloves



Three types

- **Utility gloves** for handling contaminated items, medical or chemical waste, and performing housekeeping activities.
- **Non-sterile, examination gloves** for contact with intact mucous membranes or for reducing the provider's risk of exposure (e.g. routine pelvic examination). These gloves should be disposed after one use.
- **Sterile, surgical gloves** for contact with the bloodstream or with tissue under the skin like surgical procedures.

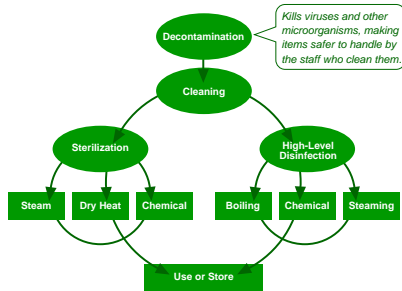
Topics/Contents	Teaching-Learning Process																																
<p style="background-color: #008000; color: white; padding: 2px;">What gloves to wear</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="background-color: #d9ead3;">TASK</th> <th style="background-color: #d9ead3;">Gloves Needed</th> <th style="background-color: #d9ead3;">Preferred Gloves</th> <th style="background-color: #d9ead3;">Acceptable Gloves</th> </tr> </thead> <tbody> <tr> <td>Blood pressure check</td> <td>no</td> <td></td> <td></td> </tr> <tr> <td>Temperature check</td> <td>no</td> <td></td> <td></td> </tr> <tr> <td>Injection</td> <td>no</td> <td></td> <td></td> </tr> <tr> <td>Blood drawing</td> <td>yes</td> <td>exam</td> <td>HLD, surgical</td> </tr> <tr> <td>Pelvic examination</td> <td>yes</td> <td>exam</td> <td>HLD, surgical</td> </tr> <tr> <td>Handling and cleaning instruments</td> <td>yes</td> <td>utility</td> <td>utility</td> </tr> <tr> <td>Handling contaminated waste</td> <td>yes</td> <td>utility</td> <td>utility</td> </tr> </tbody> </table>	TASK	Gloves Needed	Preferred Gloves	Acceptable Gloves	Blood pressure check	no			Temperature check	no			Injection	no			Blood drawing	yes	exam	HLD, surgical	Pelvic examination	yes	exam	HLD, surgical	Handling and cleaning instruments	yes	utility	utility	Handling contaminated waste	yes	utility	utility	<p>Exercise</p> <p>Show the slide on the exercise on “What Gloves To Wear”.</p> <p>Call on participants at random to answer. Clarify, as appropriate.</p>
TASK	Gloves Needed	Preferred Gloves	Acceptable Gloves																														
Blood pressure check	no																																
Temperature check	no																																
Injection	no																																
Blood drawing	yes	exam	HLD, surgical																														
Pelvic examination	yes	exam	HLD, surgical																														
Handling and cleaning instruments	yes	utility	utility																														
Handling contaminated waste	yes	utility	utility																														
<p style="background-color: #008000; color: white; padding: 2px;">Using Antiseptics</p>	<p>Tell participants that:</p> <ul style="list-style-type: none"> Using antiseptics is another protective barrier against infection. <p>Present this topic using the slides.</p>																																
<p style="background-color: #008000; color: white; padding: 2px;">Antiseptics</p> <ul style="list-style-type: none"> Chemicals which kill or inhibit many, though not all, microorganisms while causing little damage to tissue. Commonly used: <ul style="list-style-type: none"> * 70% isopropyl alcohol * Iodine and iodophor solutions 																																	
<p style="background-color: #008000; color: white; padding: 2px;">Usage</p> <ul style="list-style-type: none"> Alcohol should never be used on mucous membranes and open wounds. Iodophors (Betadine) require two minutes of contact time to release the free iodine. 																																	
<p style="background-color: #008000; color: white; padding: 2px;">Processing Instruments and Other Items</p> <p style="text-align: center; color: #008000; font-weight: bold; margin-top: 10px;">Processing Instruments and Other Items</p> <div style="text-align: center; margin-top: 10px;"> <pre> graph TD Decontamination([Decontamination]) --> Cleaning([Cleaning]) Cleaning --> Sterilization([Sterilization]) Cleaning --> HighLevelDisinfection([High-Level Disinfection]) Sterilization --> Steam[Steam] Sterilization --> DryHeat[Dry Heat] Sterilization --> Chemical1[Chemical] HighLevelDisinfection --> Boiling[Boiling] HighLevelDisinfection --> Chemical2[Chemical] HighLevelDisinfection --> Steaming[Steaming] Steam --> UseOrStore[Use or Store] DryHeat --> UseOrStore Chemical1 --> UseOrStore Boiling --> UseOrStore Chemical2 --> UseOrStore Steaming --> UseOrStore </pre> </div>	<p>Tell participants that:</p> <ul style="list-style-type: none"> Proper processing of instruments is critical for reducing infection transmission during clinical procedures. The four steps for processing instruments and other items include: <ol style="list-style-type: none"> decontamination cleaning sterilization (preferred) or high-level disinfection (acceptable) use or storage <p>Show a diagram of “Processing of Instruments and Other Items” as presented on slides.</p>																																

Topics/Contents

Teaching-Learning Process

Decontamination

- is the process that makes inanimate (nonliving) objects safer for handling by staff (especially cleaning personnel).
- done before cleaning using a disinfectant like chlorine solution (0.5%).



Tell participants that:

- Decontamination is the first step in processing instruments and other soiled items like gloves.

Decontamination

• Preparing 0.5% chlorine solution

- Parts of water/part of chlorine

$$\frac{\% \text{ concentrated chlorine}}{\% \text{ desired chlorine concentration}} - 1$$

$$\frac{5}{.5} - 1 = 9 \text{ parts water/part of water}$$

1 part chlorine in 9 parts water

Tell participants how to prepare a 0.5% chlorine solution for decontamination using a prepared concentrated chlorine solution.

Decontamination

• Preparing 0.5% Chlorine Solution

- Grams of chlorine powder or granules/ liter of water

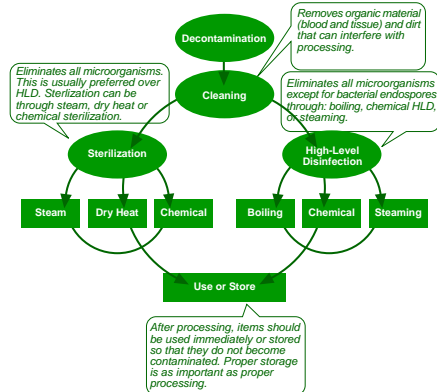
$$\frac{\% \text{ desired concentration} \times 1000}{\% \text{ concentrate of granules}}$$

$$\frac{.5 \times 1000}{30} = .0166 \times 1000 = 16.7 \text{ grams/liter}$$

17 grams of 30% chlorine granules/powder in 1 liter of water

Tell participants how to prepare a 0.5% chlorine solution for decontamination using chlorine granules/powder.

4.16



Present the other steps for processing instruments and other items as presented on the slide.

Topics/Contents	Teaching-Learning Process
<p data-bbox="208 197 385 221">Waste Management</p> <p data-bbox="299 324 694 358" style="text-align: center;">WASTE MANAGEMENT</p>	<p data-bbox="840 215 1110 248">Tell participants that:</p> <ul data-bbox="840 286 1381 584" style="list-style-type: none"> <li data-bbox="840 286 1381 398">• In the provision of health care services such as family planning and maternal care, wastes are generated. <li data-bbox="840 443 1381 584">• Poor management of waste exposes healthcare workers, waste handlers, and the community to infections, toxic effects, and injuries.
<p data-bbox="225 647 307 672">Purpose</p> <p data-bbox="208 714 741 759">Prevents the spread of infections to clinic personnel, clients, visitors and the community.</p> <ul data-bbox="208 786 780 904" style="list-style-type: none"> <li data-bbox="208 786 780 808">• Reduces the risk of accidental injury to staff, clients, and community. <li data-bbox="208 810 780 833">• Reduces bad odors. <li data-bbox="208 835 780 857">• Attracts fewer insects and animals, which may be vectors of infectious agents. <li data-bbox="208 860 780 904">• Reduces the possibility of the soil or ground water contamination with chemicals or microorganisms. 	<p data-bbox="840 642 1292 745">State the purpose for proper waste management as presented on the slide.</p>
<p data-bbox="208 943 354 967">Kinds of Wastes</p> <p data-bbox="225 994 377 1019">Kinds of Wastes</p> <p data-bbox="208 1064 323 1086">General Wastes</p> <p data-bbox="208 1113 691 1158">non-hazardous waste that pose no risk of injuries or infections similar to household trash.</p> <p data-bbox="208 1184 401 1207">Hazardous Medical Wastes</p> <p data-bbox="208 1234 691 1256">these are wastes that can cause injuries or are potentially infectious.</p>	<p data-bbox="840 972 1373 1039">Present the kinds of wastes as written on the slide.</p>
<p data-bbox="225 1312 475 1337">Hazardous Medical Wastes</p> <ul data-bbox="208 1370 784 1585" style="list-style-type: none"> <li data-bbox="208 1370 784 1393">• Infectious - these contain pathogens in sufficient concentration to cause diseases <li data-bbox="208 1395 784 1417">• Pathological - consists of human tissues or fluids <li data-bbox="208 1420 784 1464">• Pharmaceutical - expired, unused, and contaminated pharmaceutical products, drugs, vaccines <li data-bbox="208 1467 784 1512">• Chemicals - these are discarded solid, liquid, and gaseous chemicals used in cleaning, housekeeping, and disinfecting procedures <li data-bbox="208 1514 784 1536">• Sharps - items that could cause cuts and puncture wounds <li data-bbox="208 1538 784 1585">• Pressurized containers - full or emptied aerosol cans with pressurized liquid gas or powdered materials 	<p data-bbox="840 1308 1342 1411">Explain the types of hazardous wastes generated from RH clinics and birthing homes.</p>
<p data-bbox="225 1657 475 1682">Process of Waste Disposal</p> <ol data-bbox="341 1738 664 1906" style="list-style-type: none"> <li data-bbox="341 1738 664 1760">1. Sorting or segregation and containerization <li data-bbox="341 1785 424 1807">2. Handling <li data-bbox="341 1832 471 1854">3. Interim Storage <li data-bbox="341 1879 464 1901">4. Final Disposal 	<p data-bbox="840 1659 1350 1727">Enumerate the four aspects of processing instruments and other items.</p>

Topics/Contents	Teaching-Learning Process
<p data-bbox="178 264 597 293">Sorting and Containerization</p> <ul data-bbox="161 338 581 501" style="list-style-type: none"> • Categorizing wastes at the point of generation • Reduces the amount of wastes that need special handling • Segregation <ul data-bbox="178 409 555 501" style="list-style-type: none"> • Black container: general, dry, non-infectious waste • Green container: general, wet, non-infectious waste • Yellow container: infectious, pathologic waste • Sharp, puncture proof container with lid: needles, blades 	<p data-bbox="793 264 1339 338">Explain each of the aspect of waste disposal using the presentation slides.</p>
<p data-bbox="178 618 597 647">Handling</p> <ul data-bbox="161 692 699 808" style="list-style-type: none"> • Handle medical waste as little as possible before disposal. • When waste containers are full, close plastic containers and place in larger containers at interim storage areas. • ALWAYS wear heavy, utility gloves when handling medical waste. • ALWAYS wash hands after handling waste and after removing gloves. 	
<p data-bbox="178 913 597 943">Interim Storage</p> <ul data-bbox="161 981 711 1167" style="list-style-type: none"> • Storing of waste in the facility prior to collection. • Interim storage should not be more than two days. • Place waste in an area that is minimally accessible to clinic staff, clients, and visitors. • Ensure that wastes are collected regularly, ideally on a daily basis. 	
<p data-bbox="178 1263 597 1292">Final Disposal</p> <ul data-bbox="161 1323 735 1503" style="list-style-type: none"> • General wastes <ul data-bbox="178 1346 735 1391" style="list-style-type: none"> * Collected by the municipal garbage collector and transported to the final dump sites. • Solid Medical Wastes <ul data-bbox="178 1435 735 1503" style="list-style-type: none"> * Burying in a space at the back of the facility in a pit. * Transporting waste to an off-site disposal site done by the waste collector of hospital medical wastes. 	
<p data-bbox="178 1585 597 1615">Final Disposal</p> <ul data-bbox="161 1659 664 1890" style="list-style-type: none"> • Liquid Medical Wastes <ul data-bbox="178 1682 664 1778" style="list-style-type: none"> * Pour liquid waste down a sink, drain or flushable toilet. * Drains should not run through open gutters. * Rinse the sink or toilet thoroughly with disinfectant. * Decontaminate container and wash hands before removing gloves. • Sharps <ul data-bbox="178 1823 664 1890" style="list-style-type: none"> * Use sharps puncture proof containers. * Dispose of sharps containers when 3/4 full. * Burying sharps is the safest way to dispose them. 	

Topics/Contents	Teaching-Learning Process
<p data-bbox="213 203 362 226">Handling Sharps</p> <p data-bbox="330 333 664 367" style="text-align: center;">HANDLING SHARPS</p>	<p data-bbox="843 210 1114 244">Tell participants that:</p> <ul data-bbox="843 286 1365 427" style="list-style-type: none"> • In health care settings, injuries from needles and other sharp items are the most common cause of infections from blood-borne pathogens. <p data-bbox="843 472 1056 506">Ask participants:</p> <ul data-bbox="843 548 1373 618" style="list-style-type: none"> • What instances can a health worker get injured by sharps? <p data-bbox="843 660 1386 763">List responses, add to the list. The list should contain but is not limited to the following:</p> <ul data-bbox="843 806 1386 1099" style="list-style-type: none"> • When health care workers recap, bend, or break hypodermic needles • When health care workers are struck by a person carrying unprotected sharps • When sharps show up in unexpected places, like between linens • When clients move suddenly during injections
<p data-bbox="232 1162 385 1187">Handling Sharps</p> <ul data-bbox="224 1232 660 1346" style="list-style-type: none"> • Use each needle and syringe only once. • Do not disassemble needle and syringe after use. • Do not recap, bend or break needles prior to disposal. • Decontaminate needle and syringe prior to disposal. • Dispose of needle and syringe in a puncture-proof container. 	<p data-bbox="843 1155 1397 1189">Explain how to handle sharps using the slide.</p>
<p data-bbox="232 1491 435 1516">Use of Multidose Vials</p> <ul data-bbox="224 1565 785 1731" style="list-style-type: none"> • Check the vial to be sure there are no leaks or cracks. • Check the solution to be sure that it is not cloudy and no particulate matter. • Wipe the top of the vial with a cotton swab soaked with 60-70% alcohol. Allow to dry. • Use a new needle and syringe for each new person. <ul data-bbox="239 1686 785 1709" style="list-style-type: none"> * Never use a contaminated needle or syringe that has been used previously. • Do not leave needles in multiple dose vials. 	<p data-bbox="843 1485 1397 1554">Explain how to use multidose vials using the presentation slide.</p>
<p data-bbox="232 1827 385 1852">Important Points</p> <ul data-bbox="224 1888 680 2029" style="list-style-type: none"> • Wear utility gloves. • Transport solid contaminated waste in covered containers. • Dispose of all sharp items in puncture resistant containers. • Carefully pour liquid waste down a utility drain or flushable toilet. • Decontaminate gloves and containers before cleaning. • Wash hands after handling infectious wastes. 	<p data-bbox="843 1821 1334 1890">Emphasize important points on Waste Management using the slides.</p>

Topics/Contents

Teaching-Learning Process

Waste Management Workplan

Ask participants to write on metacards the kinds of wastes they are generating from their maternal care and FP practice. Arrange the metacards by removing duplications and group according to types of waste.

Each participant then develops a workplan using the matrix below.

Waste Generated	Frequency of Collection	Type of Storage	Method of Disposal	Responsible Person

Ask three to four participants to present their output.

Alternative:

Group participants working in the same facility. Participants in the groups discuss and develop a workplan. The rapporteur presents the group's output in plenary.

Summary and Key Messages

- To create an infection-free environment, it is important that the rationale for each of the recommended infection prevention processes (and its limitations) be clearly understood by clinic staff at all levels - from service providers to cleaning and maintenance staff.

Give the Key Messages as you conclude the module.

Summary and Key Messages

- Because it is not possible to know in advance if a client is infected with Hepatitis B or HIV, all items from all clients must be handled as if they were contaminated. All clients must be treated as if they were infected.

Encourage participants to ask questions.

Do you have any questions???

Thank You

Appreciate the cooperation and attention of the participants.



NARRATIVE

MODULE 4: INFECTION PREVENTION IN FP SERVICES

SESSION 2: INFECTION PREVENTION MEASURES

STANDARD PRECAUTIONS

Standard Precautions are designed for the safety and care of all people in a health care facility – whether a hospitalized patient, a woman receiving IUD services, or a health care worker.

Because many people with blood-borne viral infections (i.e., hepatitis B [HBV] or C [HCV], HIV) do not feel or look ill, standard precautions are to be applied consistently, regardless of the (known or unknown) health status of those who are providing or receiving care.

When applied consistently, standard precautions act as protective barriers between microorganisms and individuals, and are considered as highly effective means of preventing the spread of infection.

The following considerations and actions help to form such barriers, as well as provide the means for implementing the standard precaution:

- **Consider every person** (client or staff) as potentially infectious and susceptible to infection.
- **Wash hands** – the most important procedure for preventing cross-contamination (person to person or contaminated object to person).
- **Wear gloves** (on both hands) before touching anything wet, broken skin, mucous membranes, blood or other body fluids (secretions and excretions), soiled instruments, and contaminated waste materials or for performing invasive procedures.
- **Use physical barriers** (protective goggles, face masks, and aprons) if splashes and spills of blood or other body fluids are possible (e.g. when cleaning instruments and other items).
- Use **antiseptic agents** for cleansing skin or mucous membranes before surgery, cleaning wounds, or doing hand rubs or surgical hand scrubs with an alcohol-based antiseptic product.
- Use **safe work practices** such as not recapping or bending needles, safely passing sharp instruments, and suturing (when appropriate) with blunt needles.
- Safely **dispose of infectious waste materials** to protect those who handle them and prevent injury or spread of infection to the community.
- Finally, **process instruments, gloves, and other items** after use by first decontaminating and thoroughly cleaning them, and then either sterilizing or high-level disinfecting (HLD) them, using recommended procedures. Again, in the context of IUD services, HLD is the recommended method of final processing.

PROTECTIVE BARRIERS

Having a physical, mechanical or chemical "barrier" between microorganisms and an individual (i.e., client, patient, and health worker) is an effective means of preventing the spread of disease. The barrier serves to break the disease transmission cycle. Protective barriers are designed to prevent the spread of infection from person to person, and from equipment, instruments, and environmental surfaces to people and vice versa.

Barriers include the following:

1. Handwashing
2. Wearing gloves
3. Using antiseptic solutions
4. Processing of instruments

HANDWASHING

Hand washing is the SIMPLEST, BASIC and MOST IMPORTANT infection prevention procedure in any clinic. It removes many microorganisms from the skin, helping to prevent transmission of infection from person to person.

1. When to do handwashing

Before

- the day's work
- examining a client
- administering injections or drawing blood
- performing a procedure (IUD insertion and removal or pelvic exam)
- handling clean, disinfected, or sterilized supplies for storage
- putting on sterile gloves
- going home

After

- any situation in which the hands may be contaminated, such as handling instruments or touching body secretions or excretions
- examining a client
- removing gloves
- personal use of toilet
- blowing nose, sneezing, or coughing

2. Supplies needed for hand washing:

- Clean water (water may be running or from a bucket, but it must be clean)
- Soap (bar or liquid)
- Soap dish that drains and keeps the soap dry (bar)
- Clean, dry towel
- Plastic container with faucet

3. Steps of Handwashing

- Remove jewelry and wet hands and wrists with water.
- Use one or two squirts of liquid or foam soap.
- Lather soap and scrub hands, palm to palm.
- Scrub in between and around fingers.
- Scrub back of each hand with palm of the other hand.
- Scrub fingertips of each hand in opposite palm.
- Scrub each thumb clasped in opposite hand.
- Scrub each wrist clasped in opposite hand.
- Rinse thoroughly under running water.
- Turn off water using paper towel.



Handwashing Tips

Important considerations during handwashing:

- If there is no running water, use a dipper (*tabo*) to pour water on the hands at the beginning and when rinsing.
- Position the hands and wrists downward as you wet them so that the water flows down.
- If using bar soap, rinse the soap before putting it back in the soap dish.
- Avoid touching the sink as it is probably contaminated.
- Wash hands for 15-30 seconds.
- Point hands down when rinsing them with running water.
- Air-dry hands or dry with an unused, dry portion of a clean cotton towel not used by others.
- Use the towel or a paper towel to turn off the faucet.
- If water is not available, 70% of isopropyl alcohol can be used if hands are not visibly soiled.

USING GLOVES

Gloves are used to protect the health care provider from contact with potentially infectious substances and to protect the client or patient from infections that might be present on the skin of the health care provider.

The Three Kinds of Gloves

1. **Surgical gloves** – used when contact with the bloodstream or with tissue under the skin like for surgical procedures, pelvic examination or women in labor.
2. **Single use examination gloves** – used when there will be contact with intact mucous membranes or when the primary purpose of gloving is to reduce the provider's risk of exposure (i.e., routine pelvic examination). These gloves should be disposed after one use.
3. **Utility or heavy duty household gloves** – used for handling contaminated items, medical or chemical waste and performing housekeeping activities.

ANTISEPTICS

Antiseptics are chemicals, which kill or inhibit many, though not all, microorganisms while causing little damage to tissue. Cleaning the client's skin with antiseptic solution is an important infection prevention measure.

Antiseptic solutions should be used in the following situations:

- Skin or vaginal preparations for procedures such as minilaparotomy, laparoscopy, vasectomy, IUD insertion, and injections.
- Handwashing with 70% alcohol before touching clients who are unusually susceptible to infection (e.g. newborn babies or immune suppressed persons).

Note:

- *Alcohol should never be used on mucous membranes because it irritates the membranes.*
- *Antiseptics should not be used as disinfectants.*

COMMONLY USED ANTISEPTICS

Iodine and Iodophor Solutions

Povidone-Iodine is the most common Iodophor and is available globally.

Note: Iodophors manufactured for use as antiseptics are not effective for disinfecting inorganic objects and surfaces. These iodine solutions have significantly less iodine than chemical disinfectants (Rutala, 1996).

Iodophors have a broad spectrum of activity. They kill vegetative bacteria, mycobacterium, viruses and fungi; however, they require up to two minutes of contact time to release free iodine, which is the active chemical. Once released the free iodine has rapid killing action.

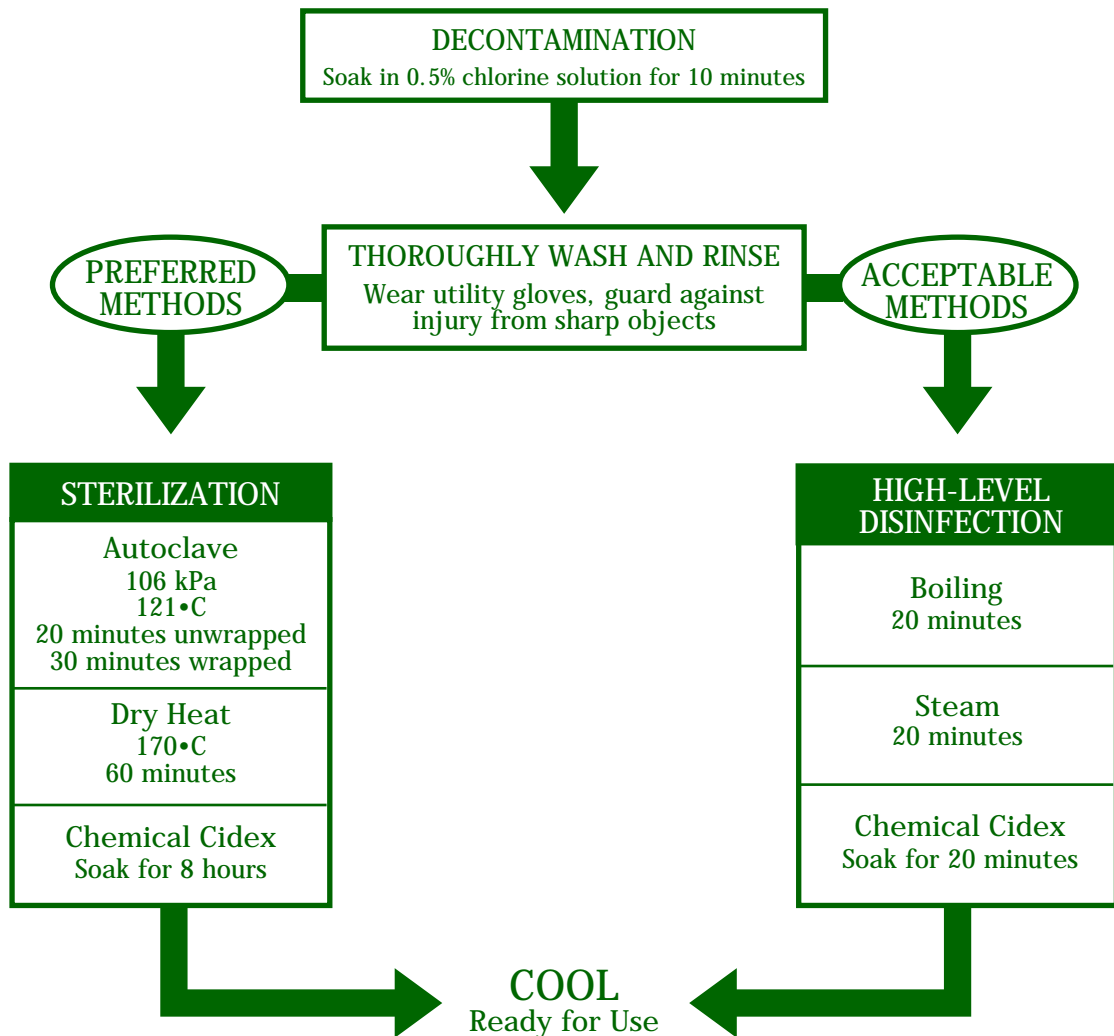
70% Alcohol Solution

Alcohol functions well to inhibit the growth and reproduction of many microorganisms, including bacteria, fungi, protozoa, and viruses.

Alcohol is a good solvent that dissolves and carries away non-organic impurities that are responsible for things like odor. It cannot, however, clean hands that are visibly dirty. Its antiseptic action does cause a burning sensation on open flesh, as anyone who has ever used alcohol to clean a wound can testify.

PROCESSING OF INSTRUMENTS

- Proper processing of instruments is critical for reducing infection transmission during clinical procedures.
- The four steps for processing instruments and other items include:
 1. decontamination
 2. cleaning
 3. sterilization (preferred) or high-level disinfection (acceptable)
 4. use or storage



Wrapped sterile packs can be stored for up to one week. Unwrapped items should be stored in a sterile or high-level disinfected container with a tight fitting lid or used immediately.

PREPARING DECONTAMINATING SOLUTION

From concentrated 5% chlorine solution

$$\frac{\text{Parts of water/part of chlorine}}{\% \text{ concentrated chlorine}} - 1$$

$$\frac{\% \text{ desired chlorine concentration}}{\% \text{ concentrated chlorine}} - 1$$

$$\frac{.5 - 1}{.5} = 9 \text{ parts water/part of water}$$

1 part chlorine in 9 parts water

From concentrated chlorine granules containing 30% chlorine

$$\frac{\text{Grams of chlorine powder or granules/liter of water}}{\% \text{ desired concentration} \times 1000}$$

$$\frac{\% \text{ concentrate of granules}}{\% \text{ desired concentration} \times 1000}$$

$$\frac{.5 \times 1000}{30} = .0166 \times 1000 = 16.7 \text{ grams/liter}$$

17 grams of 30% chlorine granules/powder in 1 liter of water

USE AND DISPOSAL OF SHARPS

In health care settings, injuries from needles and other sharp items are the most common cause of infections from blood-borne pathogens. It is important therefore that sharps are handled with care and to dispose them properly after use. Below is the list of instances when health care providers can be injured by sharps:

- When health care workers recap, bend, or break hypodermic needles
- When health care workers are struck by a person carrying unprotected sharps
- When sharps show up in unexpected places, like between linens
- During procedures in which they use many sharps, cannot see their hands, or are working in a small, confined space (like during gynecologic procedures)
- When health care providers handle and dispose of waste that contains used sharps
- When clients move suddenly during injections

GIVING INJECTIONS

Tell participants some hints to minimize risks when giving injections:

- Always warn the client before giving an injection.
- Always use new or properly processed needle and syringe for every injection.
- Steps for giving injections:
 - * Wash injection site with soap and water if the area is visibly dirty.
 - * Swab the area with antiseptic (alcohol solution) in circular motion starting from the intended injection site going outward.
 - * Allow the alcohol to dry for better efficacy.
 - * Inform client that you are about to inject.

RECAPPING NEEDLES

- Whenever possible, dispose of needles immediately without recapping them.
- But if recapping is necessary, follow the “one hand technique”.

1. Place the cap on a flat surface and remove hand from the cap.
2. With one hand, hold the syringe and use the needle to scoop up the cap.
3. When the cap covers the needle completely, use the other hand to secure the cap on the needle hub. Be careful to hold the cap at the bottom only (near the hub).

USE OF MULTIDOSE VIALS

In some clinic settings, injectable medications may come in multidose vials (e.g. vaccines, local anesthetic) intended for use for more than one client. Infections may be transmitted through these vials if proper procedures are not followed. The following are infection prevention tips when using multidose vials:

- Check the vial to be sure there are no leaks or cracks.
- Check the solution to be sure that it is not cloudy and no particulate matter.
- Wipe the top of the vial with a cotton swab soaked with 60-70% alcohol. Allow to dry.
- Use a new needle and syringe for each new person.
 - * Never use a contaminated needle or syringe that has been used previously.
- Do not leave needles in multiple dose vials.

WASTE MANAGEMENT

Healthcare waste is defined as the total waste stream from a health care facility. Most of it (75-90%) is similar to domestic waste, examples of which are paper, plastic packaging, glass, cartons/boxes, etc. that have not been in contact with patients.

A smaller proportion (10-25%) is infectious waste that requires special treatment because of the risks that it poses both to human health and the environment. Exposure to this waste can result in disease or injury.

The purpose of proper waste management:

- Prevents the spread of infections to clinic personnel, clients, visitors and the community.
- Reduces the risk of accidental injury to staff, clients, and community.
- Reduces bad odors.
- Attracts fewer insects and animals which may be vectors of infectious agents.
- Reduces the possibility of the soil or groundwater contamination with chemicals or microorganisms.

TYPES OF WASTES

1. General waste

These are non-hazardous wastes that pose no risk of injuries or infections. These are similar in nature to household trash. Examples are: paper, boxes, packaging materials, bottles, plastic containers, and food-related trash.

2. Hazardous medical waste

Hazardous wastes generated in the rural health unit and birthing homes are classified as:

- Infectious** - all wastes that are susceptible to contain pathogens (or their toxins) in sufficient concentration to cause diseases to a potential host (e.g. excreta, tissue swabs, blood bags, and dressings, etc).
- Pathological** - consist of human tissues or fluids (e.g. body parts, blood, blood products and other body fluids, placentas, and product of conception), materials containing fresh or dried blood or body fluids such as bandages and surgical sponges.
- Pharmaceutical** - these are expired, unused, and contaminated pharmaceutical products, drugs, vaccines that are no longer needed. It also includes discarded items used in handling pharmaceuticals such as bottles, or boxes with residues, gloves, masks, connecting tubings, and drug vials.
- Chemicals** - these are the discarded solid, liquid, and gaseous chemicals used in cleaning, housekeeping, and disinfecting procedures.
- Sharps** - items that could cause cuts, puncture wounds, including hypodermic and suture needles, scalpel blades, blood tubes, infusion sets, and other glass items that have been in contact with potentially infectious materials (such as glass slides and coverslips).
- Pressurized containers** - consist of full or emptied containers or aerosol cans with pressurized liquid gas or powdered materials.

Since the disposal of medical waste is frequently a problem, it is useful to develop a medical waste management plan and a staff be assigned the responsibility of waste disposal.

The Four Aspects of Hazardous (Medical) Waste Management

The management of waste must be consistent from the point of generation to the point of final disposal. The path between these two points can be segmented into four steps.

1. Sorting or segregation and containerization

Only a small percentage of the waste generated by a healthcare facility are medical wastes that must be specially handled to reduce the risk of infections or injury. Therefore, sorting the waste at the point at which it is generated can greatly reduce the amount that needs special handling.

The correct segregation/sorting of waste at the point of generation relies on a clear identification of the different categories of waste and the separate disposal of the waste in accordance with the categorization chosen. To encourage segregation at source, reusable containers with plastic liners of correct size and thickness are placed as close to the point of generation as possible. They should be properly color coded.

- Black** plastic lining for general, dry, non-infectious waste
- Green** plastic lining for general, wet, non-infectious waste
- Yellow** for infectious/pathological waste

Needles and other sharps pose the greatest risk of injury, and should be disposed in special sharps containers such as heavy cardboard boxes, tin cans with lid, and plastic bottles.

2. Handling

Handle medical waste as little as possible before disposal. When waste containers are 3/4 full, the liners are closed with plastic strings and are placed in larger containers at the interim storage areas. Always wear heavy utility gloves when handling medical waste. Always wash your hands after handling wastes and after removing your gloves.

3. Interim storage

In order to avoid both the accumulation and decomposition of waste, it must be collected on a regular daily basis. Waste should never be stored in the facility for more than one or two days. If it is necessary to store medical waste on-site before final disposal, waste should be placed in an area that is minimally accessible to clinic staff, clients and visitors.

4. Final disposal

General wastes, similar to household waste, can be collected by the regular municipal garbage collector and transported into the final dump sites.

Solid Medical Waste

There are three options for the disposal of solid medical waste: burning waste, burying waste, and transporting waste to an off-site disposal site.

In our country, burning waste is not applicable because of the Clean Air Act. So the remaining options are:

- a.) Burying, if there is a space at the back of one's facility to dig a pit
- b.) Transporting waste to an off-site disposal site. This is done by the waste collector of hospital medical wastes.

Building and using a waste-burial pit

1. Choose an appropriate site that is at least 50 meters away from any water source to prevent contamination of water source. The site should have proper drainage, be located downhill from the wells, be free of standing water, and be in an area that does not flood. The site should not be located on land that will be used for agriculture or development.
2. Dig a pit one to two meters wide and two to five meters deep. The bottom of the pit should be 1.8 meters above the water table.
3. Fence in the area to keep out animals, scavengers, and children.
4. Keep waste covered. Every time waste is added to the pit, cover it with a 10 to 30cm layer of soil.
5. Seal the pit when the level of waste reaches 30 to 50 cm of the surface of the ground. Fill the pit with dirt, seal it with concrete, and dig another pit.

Liquid medical waste

The following are the procedures when disposing liquid medical wastes:

1. Carefully pour liquid waste down a sink, drain or flushable toilet.
2. Before pouring liquid waste down a sink, drain, or toilet, consider where the drain empties. It is hazardous for liquid waste to run through open gutters that empty onto the grounds of the facility.
3. Rinse the sink, drain, or toilet bowl thoroughly with water to remove residue waste – again avoid splashing. Clean these areas with a disinfectant cleaning solution at the end of the day or more frequently if heavily soiled.
4. Decontaminate the container that held the liquid waste by filling it with 0.5% chlorine solution for 10 minutes before washing.
5. Wash your gloved hands after handling liquid waste before removing gloves.

TIPS IN HANDLING WASTES:

- Always wear utility gloves.
- Transport solid contaminated waste in covered, leak proof containers.
- Wear utility gloves.
- Transport solid contaminated waste in covered containers.
- Dispose of all sharp items in puncture resistant containers.
- Carefully pour liquid waste down a utility drain or flushable toilet.

- Decontaminate gloves and containers before cleaning.
- Wash hands after handling infectious wastes.

SUMMARY

Creating an infection-free health facility environment protects the clients, clinic staff, and the community from infections. To achieve this, it is important that the rationale for each of the recommended infection prevention processes be clearly understood by clinic staff at all levels - from the supervisor to the health service provider up to the cleaning staff. Since it is not possible to identify infected individuals, standard precaution must be practiced to prevent spread of infection.



MODULE 5



Fertility Awareness-Based Methods and Lactational Amenorrhea Method

Session 1: Fertility Awareness-Based Methods (FAB)

Session 2: Lactational Amenorrhea Method (LAM)

MODULE 5: Fertility Awareness-Based Methods and Lactational Amenorrhea Method

MODULE OVERVIEW

This module discusses the different Natural Family Planning Methods as part of providing a broad range of FP services in the Philippine Family Planning Program. Based on the WHO Medical Eligibility Criteria and the DOH Clinical Standards Manual of 2006, there are six natural family planning methods, also called the Fertility Awareness-Based (FAB) Methods.





MODULE OBJECTIVE

At the end of this module, the participants will be able to understand FAB and LAM as contraceptive methods.

MODULE SESSIONS

The module contains the following sessions:

Session 1	Fertility Awareness-Based Methods
Session 2	Lactational Amenorrhea Method (LAM)

Topics/Contents	Teaching-Learning Process
<p data-bbox="175 206 470 230">Module Overview and Objective</p> <div data-bbox="205 300 315 517">   </div> <h2 data-bbox="338 331 558 371">MODULE 5</h2> <h3 data-bbox="338 430 711 580">FERTILITY AWARENESS-BASED METHODS AND LACTATIONAL AMENORRHEA METHOD</h3>	<p data-bbox="793 215 1031 248">Greet participants.</p> <p data-bbox="793 291 1350 360">Link this module to Anatomy and Physiology by saying that:</p> <p data-bbox="793 405 1350 546">Understanding the anatomy and physiology of a woman can help the couple use the FAB method correctly and effectively as a contraceptive method.</p> <p data-bbox="793 591 1350 660">This will help the woman appreciate the fertile and infertile periods in the menstrual cycle.</p>
<div data-bbox="175 748 602 786">  OVERVIEW AND OBJECTIVE </div> <ul data-bbox="185 837 722 1025" style="list-style-type: none"> • This module discusses the different natural family planning methods as part of providing a broad range of FP services in the PFPP. • Knowledge gained from this module will help service providers expand the choices of clients for a wide range of FP methods. • At the end of this module, participants will be able to understand FAB and LAM as contraceptive methods. 	<p data-bbox="793 748 1329 817">Present the overview and objective of the module as written on the slide.</p>
<div data-bbox="175 1171 602 1209">  SESSIONS </div> <p data-bbox="241 1330 583 1350">Session 1 - Fertility Awareness-Based Methods</p> <p data-bbox="241 1375 558 1395">Session 2 - Lactational Amenorrhea Method</p>	<p data-bbox="793 1167 1350 1200">Enumerate the sessions within the module.</p>

FERTILITY AWARENESS-BASED METHODS



LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Define Fertility Awareness-Based (FAB) Methods.
2. Identify the signs of the fertile and infertile phases of the menstrual cycle.
3. Describe the different FAB methods in terms of mode of action and effectiveness.
4. Instruct women on the use of the Standard Days Method (SDM).
5. State the advantages and disadvantages of FAB methods.
6. Discuss who can and can not use the FAB methods using the WHO MEC and Checklist for FAB Methods.



METHODOLOGY

Lecture-Discussion
Role play
Brainstorming





TIME ALLOTMENT

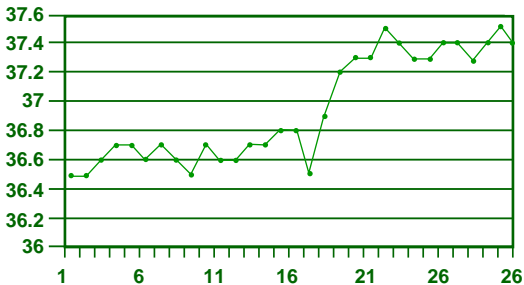
1 hour

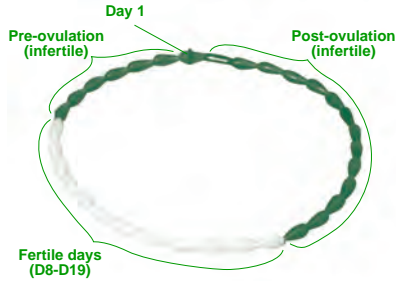


ADVANCE PREPARATION OF MATERIALS

- Powerpoint presentation of Module 5, Session 1
- Computer and LCD projector
- SDM cyclebeads kit
- MEC Checklist or MEC wheel
- Marker pens, tapes
- Whiteboard and whiteboard marker
- Manila paper

Topics/Contents	Teaching-Learning Process
 <h2 data-bbox="346 271 566 315">SESSION 1</h2>  <h3 data-bbox="346 371 660 483">FERTILITY AWARENESS-BASED METHODS</h3>	
<h4 data-bbox="158 595 272 618">Introduction</h4> <h4 data-bbox="174 645 413 674">Learning Objectives</h4> <ul data-bbox="169 712 718 976" style="list-style-type: none"> • Define Fertility Awareness Based (FAB) Methods. • Identify the signs of fertility during the menstrual cycle. • Describe each of the FAB methods in terms of mode of action and effectiveness. • Instruct women on the use of the Standard Days Method (SDM). • State the advantages and disadvantages of FAB methods. • Discuss who can and cannot use the FAB methods using the MEC checklist. 	<p data-bbox="793 640 1313 745">Introduce the session by stating the objectives as written on the presentation slides.</p>
<h4 data-bbox="169 1016 498 1046">Fertility Awareness-Based Methods</h4> <h4 data-bbox="185 1072 279 1102">Definition</h4> <p data-bbox="169 1144 362 1167">FP methods which involve:</p> <ul data-bbox="263 1193 738 1361" style="list-style-type: none"> • Determination of the fertile and infertile periods of a woman • Observation of the signs and symptoms of fertility and infertility during the menstrual cycle • Timing of sexual intercourse to achieve or avoid pregnancy <p data-bbox="169 1317 738 1361">• Effectiveness depends on the couple's ability to identify fertile and infertile periods and motivation to practice abstinence when required</p>	<p data-bbox="793 1032 1339 1137">Tell participants about Fertility Awareness-Based methods as written on the presentation slides.</p>
<h4 data-bbox="169 1453 326 1482">Signs of Fertility</h4> <h4 data-bbox="185 1509 341 1538">Signs of Fertility</h4> <ul data-bbox="263 1610 733 1827" style="list-style-type: none"> • Changes in the cervical mucus: determines the beginning and end of the fertile days. • Changes in the basal body temperature: determines when ovulation has passed and the fertile days have ended. • The first day of menstruation is the sign for keeping track of a woman's menstrual cycle. 	<p data-bbox="793 1464 1063 1494">Tell participants that:</p> <p data-bbox="793 1543 1354 1688">There are two main naturally occurring fertility signs that a woman can observe to determine when she can or cannot become pregnant. These are:</p> <ol data-bbox="793 1727 1354 2056" style="list-style-type: none"> 1. Changes in the cervical mucus. These changes within the menstrual cycle determine the beginning and end of the fertile days. 2. Changes in the basal body temperature. The basal body temperature can be used to determine when ovulation has passed and the fertile days have ended.

Topics/Contents	Teaching-Learning Process																																																																																																																																																																																																																												
<p>The FAB Methods</p> <p>The FAB Methods</p> <ol style="list-style-type: none"> 1. Cervical Mucus Method/Billings Ovulation Method (CMM/BOM) 2. Basal Body Temperature Method (BBT) 3. Sympto-Thermal Method (STM) 4. Standard Days Method (SDM) 	<p>Enumerate the FAB Methods as presented on the slides.</p>																																																																																																																																																																																																																												
<p>1. Cervical Mucus/Billings Ovulation Method</p> <p>Cervical Mucus/Billings Ovulation Method</p> <ul style="list-style-type: none"> • Based on the daily observation of what a woman sees and feels at the vaginal area throughout the day. • Cervical mucus changes indicate whether days are fertile or infertile and can be used to avoid or achieve pregnancy. • The woman is instructed to observe and record her feeling of dryness or wetness in her vaginal area during the day. She abstains from sexual intercourse during the fertile, "wet" days. • With perfect (correct) use, this method is 97% effective. However, with typical use, it is 80% effective. 	<p>Tell participants about the Cervical Mucus/Billings Ovulation Method as written on the slide.</p>																																																																																																																																																																																																																												
<p>Cervical Mucus/Billings Ovulation Method</p> <table border="1" data-bbox="220 1003 783 1294"> <thead> <tr> <th>CYCLE DAY</th> <th>1</th><th>2</th><th>3</th><th>4</th><th>5</th><th>6</th><th>7</th><th>8</th><th>9</th><th>10</th><th>11</th><th>12</th><th>13</th><th>14</th><th>15</th><th>16</th><th>17</th><th>18</th><th>19</th><th>20</th><th>21</th><th>22</th><th>23</th><th>24</th><th>25</th><th>26</th><th>27</th><th>28</th><th>29</th><th>30</th><th>31</th> </tr> </thead> <tbody> <tr> <td>Month January Date</td> <td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td>20</td><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td><td>28</td><td>29</td><td>30</td><td>31</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Month January Date</td> <td>R</td><td>R</td><td>R</td><td>R</td><td>R</td><td>D</td><td>D</td><td>D</td><td>D</td><td>D</td><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td></td><td></td><td></td><td></td> </tr> <tr> <td>What do you feel?</td> <td>W</td><td>W</td><td>W</td><td>W</td><td>W</td><td>D</td><td>D</td><td>D</td><td>D</td><td>D</td><td>W</td><td>W</td><td>W</td><td>W</td><td>W</td><td>D</td><td>D</td><td>D</td><td>D</td><td>D</td><td>D</td><td>D</td><td>D</td><td>D</td><td>D</td><td>D</td><td>D</td><td>D</td><td>D</td><td>D</td> </tr> <tr> <td>What is seen?</td> <td>W</td><td>W</td><td>W</td><td>W</td><td>W</td><td>N</td><td>N</td><td>N</td><td>N</td><td>N</td><td>P</td><td>P</td><td>P</td><td>P</td><td>P</td><td>S</td><td>S</td><td>S</td><td>S</td><td>S</td><td>S</td><td>S</td><td>S</td><td>S</td><td>S</td><td>S</td><td>S</td><td>S</td><td>S</td><td>S</td> </tr> <tr> <td>Intercourse</td> <td></td><td></td><td></td><td></td><td></td><td>♥</td><td>♥</td><td>♥</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Medication Taken / fever</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table>	CYCLE DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Month January Date	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31													Month January Date	R	R	R	R	R	D	D	D	D	D	X	X	X	X	X	1	2	3	4	5	6	7	8	9	10	11					What do you feel?	W	W	W	W	W	D	D	D	D	D	W	W	W	W	W	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	What is seen?	W	W	W	W	W	N	N	N	N	N	P	P	P	P	P	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	Intercourse						♥	♥	♥																							Medication Taken / fever																															<p>Show a sample of an accomplished BOM chart.</p> <p>Explain that: On the 4th day after the last day of wetness, all dry days are absolutely infertile days. On dry days following menstruation, have intercourse on alternate nights. Alternatively, the Two Day mucus-based method rule states that two dry days (no secretions observed for two consecutive days) signify that intercourse will not result in pregnancy.</p>
CYCLE DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31																																																																																																																																																																																														
Month January Date	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31																																																																																																																																																																																																									
Month January Date	R	R	R	R	R	D	D	D	D	D	X	X	X	X	X	1	2	3	4	5	6	7	8	9	10	11																																																																																																																																																																																																			
What do you feel?	W	W	W	W	W	D	D	D	D	D	W	W	W	W	W	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D																																																																																																																																																																																															
What is seen?	W	W	W	W	W	N	N	N	N	N	P	P	P	P	P	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S																																																																																																																																																																																															
Intercourse						♥	♥	♥																																																																																																																																																																																																																					
Medication Taken / fever																																																																																																																																																																																																																													
<p>2. Basal Body Temperature</p> <p>Basal Body Temperature</p> <ul style="list-style-type: none"> • Based on the changes in a woman's resting body temperature, which is lower before ovulation until it rises to a higher level after ovulation. • Infertile days begin from the fourth day of the high temperature reading to the last day of the cycle. • All days from the start of the menstrual cycle up to the third high temperature reading are considered fertile days. • Effectiveness: 99% (perfect use) and 80% (typical use) 	<p>Tell participants about the BBT as presented on the slides.</p>																																																																																																																																																																																																																												
<p>Basal Body Temperature</p> 	<p>Show a diagrammatic sample of a BBT chart. Emphasize that:</p> <ul style="list-style-type: none"> – An ovulatory cycle is biphasic with the first half with lower BBT readings and a second half with relatively sustained higher temperatures. – A woman is considered fertile all throughout the first half of the cycle reading. 																																																																																																																																																																																																																												

Topics/Contents	Teaching-Learning Process
<p>3. Sympto-thermal Method</p> <p>Sympto-thermal Method</p> <ul style="list-style-type: none"> Based on the combination of the Basal Body Temperature and Billings Ovulation Method together with other signs (breast engorgement, unilateral lower abdominal pain), which indicate that the woman is fertile or infertile. Effectiveness as correctly used: 98% 	<p>Tell participants about the method as written on the slide.</p>
<p>4. Standard Days Method</p> <p>Standard Days Method</p> <ul style="list-style-type: none"> Calculation of fertile and infertile days for menstrual cycles of 26 to 32 days. Works for women with menstrual cycles of 26-32 days. Identifies cycle days 8-19 as the woman's fertile period. Colored beads are used to help the woman keep track of her fertile and infertile days. 	<p>Tell participants about the SDM as written on the slide.</p>
<p>How to Use the Cycle Beads</p> <p>Standard Days Method</p> 	<p>Show participants a sample of the CycleBeads and at the same time flash the slide.</p>
<p>Standard Days Method</p> <p>How To Use</p> <ol style="list-style-type: none"> Assess the length of the menstrual cycle if it falls within the range of 26-32 days. <ul style="list-style-type: none"> If the cycle length is less than 26 days or more than 32 days, the client cannot use the method. If the cycle meets the criteria, provide an SDM card and CycleBeads, which can be used in marking the days of the cycle. <p>Standard Days Method</p> <p>How To Use</p> <ol style="list-style-type: none"> Show the woman the CycleBeads and instruct her on how to use it. On the first day of the menstrual cycle (i.e., first day of menstrual bleeding), she puts the ring on the red bead. She moves the ring to a bead each day. The brown beads signify infertile days, while the white beads signify fertile days. When the ring is on a white bead, she abstains from sexual intercourse. 	<p>Explain to participants “How to Use the SDM CycleBeads”.</p>

Topics/Contents	Teaching-Learning Process
<p>Standard Days Method</p> <p>How To Use</p> <p>7. Draw the client's attention to the dark brown and black beads.</p> <ul style="list-style-type: none"> • If menstrual bleeding occurs before the dark brown bead, her cycle is less than 26 days. • If the ring has reached the black bead and still no menstrual bleeding, her cycle is more than 32 days. <p>8. If either condition happens twice in a year, she cannot reliably use the SDM as her FP method.</p>	
<p>Special Cases</p> <p>Standard Days Method</p> <p>Women With Special Conditions</p> <ul style="list-style-type: none"> • Shifting from pills <ul style="list-style-type: none"> ✓ Menstrual cycles prior to the use of pills were 26-32 days ✓ The current cycle is expected to be 26-32 days • Shifting from injectables <ul style="list-style-type: none"> ✓ Last injection at least three months ago ✓ Menses have returned ✓ Menstrual cycle prior to use of injectable was within 26-32 days ✓ Last menstrual cycle was within 26-32 days 	<p>Tell participants how women with special cases can use the SDM as presented on the slide.</p>
<p>Standard Days Method</p> <p>Women With Special Conditions</p> <ul style="list-style-type: none"> • Recently used the IUD <ul style="list-style-type: none"> ✓ IUD has been removed ✓ Menstrual cycles while using the IUD were within 26-32 days ✓ Last menstrual cycle is within 26-32 days • Postpartum and/or breastfeeding <ul style="list-style-type: none"> ✓ Menstruation has returned ✓ Has had at least four normal menstrual periods ✓ Expects current cycle to be within 26-32 days 	
<p>Standard Days Method</p> <p>Return Visit</p> <ul style="list-style-type: none"> • Instruct client to return <ul style="list-style-type: none"> ✓ Within seven days of her next menstrual period (bring CycleBeads, card and partner, if possible) ✓ For warning signs and precautions <ul style="list-style-type: none"> - If menstruation starts before the rubber ring reaches the dark brown beads, the cycle is less than 26 days. - If a day has pass since the rubber ring has reached the black bead and menstruation has not come yet, cycle is more than 32 days. 	<p>Tell participants that:</p> <ul style="list-style-type: none"> – The first time this happens, take note and mark the client card. – The second time this happens, within a 12 month period, go back to the service provider for another FP method. <ul style="list-style-type: none"> • If cycle is 42 days or over, have a pregnancy test. If the result is positive, refer to prenatal care. If negative, advise another method. – SDM counseling can generally be provided in a one client visit. However, clients should be encouraged to come for follow-up and return for additional information and services. <p>Tell participants when clients are encouraged to return for follow-up as written on the slide.</p>

Topics/Contents	Teaching-Learning Process
<p style="text-align: center;">Role Play</p>	<p>Distribute the checklist on providing SDM to participants.</p> <p>Review with participants the tasks in providing SDM.</p> <p>Have participants in triads practice the tasks in providing SDM (one will practice on providing SDM, the other a client, and another an observer).</p> <p>The observer notes the tasks of providing the SDM using a checklist. The service provider gives instructions on SDM use. The other participant plays the role of a client.</p> <p>Each participant plays different roles. After everyone has demonstrated how to use, ask participants whether they have difficulty in practicing the tasks.</p> <p>Respond to participants' issues/difficulties on the use of the SDM CycleBeads.</p>
<p style="text-align: center;">Advantages of FAB Methods</p> <p style="text-align: center;">Advantages of FAB Methods</p> <ul style="list-style-type: none"> • Effective when used correctly and consistently. • No physical side effects. • No prescription required. • Inexpensive; no medication involved. • No follow-up medical appointments required. • Better understanding of the couple about their sexual physiology and reproductive functions. • Encourage shared responsibility for family planning. • Foster better communication between partners. 	<p>Ask the participants after they have learned about the FAB methods, about what they think are their advantages.</p> <p>Call on participants at random.</p> <p>Write down their responses.</p> <p>Show the slides on the advantages and add additional information given by participants.</p>
<p style="text-align: center;">MEC Checklist</p>	<p>Tell participants to turn to p. 5.6 of their handbook for the MEC Checklist for FAB Methods.</p> <p>Explain how to use the MEC checklist for the FAB method by emphasizing that:</p> <ul style="list-style-type: none"> • If the woman answers NO to ALL of the questions, then she can use any of the FAB methods she wants. • If the answer is YES to the questions, follow the instructions. • No condition restrict the use of FAB but some conditions can make them harder to use effectively (e.g. no time to observe and chart).

Topics/Contents	Teaching-Learning Process
	<p>Discuss each question and instructions in the checklist.</p>
<p>Summary</p> <p>Key Points on FAB Methods</p> <ul style="list-style-type: none"> • Fertility awareness based methods require partner's cooperation. • A woman or couple must be aware of body changes or keep track of fertile and infertile days according to the rules of the specific FAB method being practiced. • To avoid pregnancy, the couple should abstain from sexual intercourse during the fertile phase. To achieve pregnancy, the couple can time sexual intercourse during the fertile phase. • FAB methods have no side effects or health risks. 	<p>Summarize the session by asking participants at random to read the key points as written on the slide.</p> <p>Ask participants if they have questions. Review the session objective.</p> <p>Introduce the next session.</p>



NARRATIVE

MODULE 5: FERTILITY AWARENESS-BASED METHODS AND LACTATIONAL AMENORRHEA METHOD SESSION 1 : FERTILITY AWARENESS-BASED METHODS

Fertility Awareness-Based (FAB) methods are family planning methods that focus on the awareness of the beginning and end of the fertile time of a woman's menstrual cycle. These methods involve:

- Determination of the fertile and infertile periods of a woman within the menstrual cycle.
- Observation of the signs and symptoms of infertility and fertility during the menstrual cycle.

Effectiveness: All FAB Methods are above 95% effective.

SIGNS OF FERTILITY

There are two main naturally occurring fertility signs that a woman can observe to determine when she can or cannot become pregnant. These are:

1. Changes in the cervical mucus: Cervical mucus can be used to determine the beginning and end of the fertile days.
2. Changes in the basal body temperature: Basal body temperature can be used to determine when ovulation has passed and the fertile days have ended.
3. The first day of menstruation is the sign for keeping track of a woman's menstrual cycle.

5.10

THE FAB METHODS

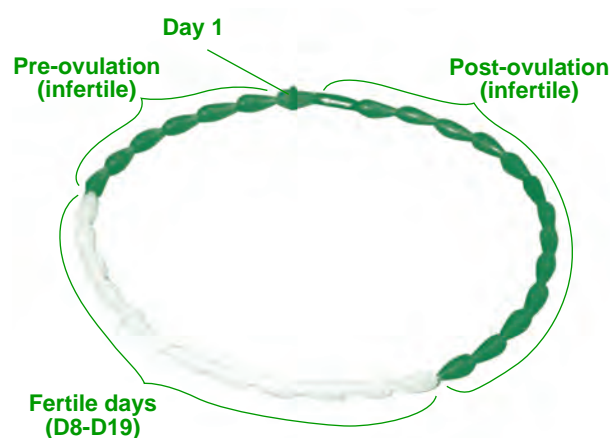
1. **CERVICAL MUCUS/BILLINGS OVULATION METHOD (CMM/BOM)** is based on the daily observation of what a woman sees and feels at the vaginal area throughout the day. Cervical mucus changes indicate whether days are fertile or infertile and can be practiced by couples to avoid or achieve pregnancy. On the 4th day after the last day of wetness, all dry days are absolutely infertile days. On dry days following menstruation, couples can engage in sexual intercourse on alternate nights only. With perfect (correct) use, this method is 97% effective. However, with typical use, it is 80% effective. Alternatively, the Two Day Mucus-Based Method rule states that two dry days (no secretions observed for two consecutive days) signify that intercourse will not result in pregnancy.
2. **BASAL BODY TEMPERATURE (BBT)** is based on a woman's resting body temperature (i.e., body temperature after three hours of continuous sleep or rest), which is lower before ovulation until it rises to a higher level beginning around the time of ovulation. Her infertile days begin from the fourth day of the high temperature reading to the last day of the cycle. All days from the start of the menstrual cycle up to the third high temperature reading are considered fertile days. With perfect use, this method is 99% effective, while with typical use, its effectiveness is 80%.
3. **SYMPTOTHERMAL METHOD (STM)** is based on the combined technology of the Basal Body Temperature (i.e., the resting body temperature) and the Cervical Mucus/Billings Ovulation Method (i.e., observations of mucus changes at the vaginal area throughout the day). This is considered together with other signs (i.e., breast engorgement, unilateral lower abdominal pain), which indicate that the woman is fertile or infertile. This method is 98% effective as correctly used.
4. **STANDARD DAYS METHOD (SDM)** is based on a calculated fertile and infertile periods for menstrual cycle lengths that are 26 to 32 days. Women who are qualified (i.e., with 26 to 32 days menstrual cycles) to use this method are counseled to abstain from sexual intercourse on days 8-19 to avoid pregnancy. Couples on this method use a device, the color-coded "CycleBeads", to mark the fertile and infertile days of the menstrual cycle. SDM is 95.25% effective with correct use and 88% effective with typical use.

How to use the CycleBeads

Assess the length of the menstrual cycle if it falls within the range of 26-32 days by considering the following information:

- The last menstrual period (LMP)
 - The previous/past menstrual period (PMP)
 - When she expects her next menses
- If the cycle length is less than 26 days or more than 32 days, the client cannot use the method.
- If the cycle meets the criteria, provide an SDM card and cycle beads, which can be used in marking the days of the cycle

Show the woman the CycleBeads and instruct her how to use it:



- On the first day of the menstrual cycle (i.e., first day of menstrual bleeding), she puts the ring on the red bead and marks with an “x” the date on the calendar.
- She moves the ring to a bead each day. It is recommended that she moves the ring every morning upon waking up so that she does not forget. The brown beads signify infertile days while the white beads signify fertile days.
- When the ring is on a white bead, she abstains from sexual intercourse.

Draw the client’s attention to the dark brown and black beads. Tell her that if she experiences menstrual bleeding before the dark brown bead, this means that her cycle is short and less than 26 days. If the ring has reached the black bead and she still does not experience menstrual bleeding, then her cycle is more than 32 days. If either happens twice in a year, she cannot reliably use the SDM as her FP method.

Women with Special Conditions

Contraceptive shifters may also use SDM provided the following criteria are met:

- Shifting from pills
 - Menstrual cycles were within 26-32 days before taking the pills
 - Current cycle is expected to be within 26-32 days

- Shifting from injectables
 - At least three months have passed since the last injection
 - Menses have returned
 - Menstrual cycle was within 26-32 days before using
 - Last menstrual cycle was within 26-32 days
- Recently used IUD
 - IUD has been removed
 - Menstrual cycles while using the IUD were within 26 to 32 days
 - Last menstrual cycle was within 26-32 days
- Postpartum and/or Breastfeeding
 - Menstruation has returned
 - Has had at least four normal menstrual periods
 - Expects current cycle to be within 26 to 32 days

Advantages of FAB methods:

- Effective when used correctly and consistently
- No physical side effects
- No prescription required
- Inexpensive; no medication involved
- No follow-up medical appointments required
- Better understanding of the couple about their sexual physiology and reproductive functions
- Encourage shared responsibility for family planning
- Foster better communication between partners
- All FAB Methods can be used for spacing, limiting or achieving pregnancy

Disadvantages of FAB methods:

- May inhibit sexual spontaneity
- Except for SDM, need extensive training - takes about two to three cycles to accurately identify the fertile period and how to effectively use it.
- Require consistent and accurate record keeping and close attention to body changes.
- Require periods of abstinence from sexual intercourse, which may be difficult for some couples.
- Require rigid adherence to daily routine of awaking at a fixed time, without any disturbance before taking the temperature (specific for BBT and STM).
- Can be used only by women whose cycles are within 26-32 days (Specific to SDM).
- Offer no protection against STI, HIV/AIDS.

Key Points on the FAB Methods:

- Fertility awareness-based methods require cooperation of both partners.
- A woman or couple using FAB methods must be aware of body changes or keep track of fertile and infertile days according to the rules of the specific FAB method being practiced.
- To avoid pregnancy, the couple should abstain from having sexual intercourse during the fertile phase. To achieve pregnancy, the couple can time sexual intercourse during the fertile phase.
- FAB methods have no side effects or health risks.
- SDM can be used by women with 26-32 days menstrual cycles.

Medical Eligibility Checklist for Fertility Awareness-Based (FAB) Methods

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use any fertility awareness-based method she wants. If she answers YES to a question below, follow the instructions. No conditions restrict use of these methods, but some conditions can make them harder to use effectively.

1. Do you have a medical condition that would make pregnancy especially dangerous? (Medical Conditions and Method Choice).
 No YES She may want to choose a more effective method. If not, stress careful use of fertility awareness-based methods to avoid pregnancy.
2. Do you have irregular menstrual cycles? Vaginal bleeding between periods? Heavy or long monthly bleeding? For younger women: Are your periods just starting? For older women: Have your periods become irregular, or have they stopped?
 No YES Predicting her fertile time with only the calendar method may be hard or impossible. She can use basal body temperature (BBT) and/or cervical mucus, or she may prefer another method.
3. Did you recently give birth or undergo an abortion? Are you breastfeeding? Do you have any other condition that affects the ovaries or menstrual bleeding, such as stroke, serious liver disease, hyperthyroid, or cervical cancer?
 No YES These conditions do not restrict use of fertility awareness-based methods. But these conditions may affect fertility signs, making fertility awareness-based methods hard to use. For this reason, a woman or couple may prefer a different method. If not, they may need more counseling and follow-up to use the method effectively.
4. Have you had any infections or diseases that may change cervical mucus, basal body temperature, or menstrual bleeding, such as vaginal infections or sexually transmitted infections (STI), pelvic inflammatory disease in the last three months?
 No YES These conditions may affect fertility signs, making fertility awareness-based methods hard to use. Once an infection is treated and reinfection is avoided, however, a woman can use fertility awareness-based methods more easily.
5. Do you take any drugs that affect cervical mucus, such as mood-altering drugs, lithium, tricyclic antidepressants, or anti-anxiety therapies?
 No YES Predicting her fertile time correctly may be difficult or impossible using only the cervical mucus method. She may use BBT and/or the SDM, or she may prefer another method.

Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable pertaining to the client.

CHECKLIST FOR PROVISION OF THE SDM

NAME OF COURSE: _____ **Dates:** _____

Instructions: Put a (v) in the space provided for if the trainee performed the task “satisfactorily”, (x) if the task was performed “unsatisfactorily”, and (NO) if the task was “not observed”.

TASKS	PRACTICES						
	1	2	3	4	5	6	7
1. Once the client has chosen to use the SDM, determines the length of the client’s menstrual cycle by reviewing her last and past menstrual periods and asking when she expects her next menses.							
2. Determines the client’s cycle length by reviewing her menstrual history.							
3. If the cycle meets the criteria, provides the client with a SDM card and cyclebeads.							
4. If the cycle length is less than 26 days or more than 32 days, explains to the client that she cannot use the SDM and helps her choose another method.							
5. If woman has recently used another FP method, determines whether she has the following criteria: <ul style="list-style-type: none"> • If client recently used the pills, her last two cycles after stopping the pills were within 26-32 days. • If client recently used the injectable, her last injection was at least three months ago and that her cycles were within 26-32 days prior to use of the injectable. • If client recently used an IUD, her IUD has been removed and her menstrual cycles are within 26-32 days. 							
6. Describes the SDM CycleBeads while showing the client the beads and telling her that: <ul style="list-style-type: none"> • The red bead represents the first day of menstrual bleeding. 							
<ul style="list-style-type: none"> • The brown beads represent the “infertile” days. 							
<ul style="list-style-type: none"> • The white beads (days 8-19) represent the “fertile” days. 							
7. Instructs the client on the use of the SDM by telling her to: <ul style="list-style-type: none"> • Put the ring on the red bead on the first day 							

5.14

TASKS	PRACTICES						
	1	2	3	4	5	6	7
of her menses and mark with an “x” this date on the SDM card/calendar.							
<ul style="list-style-type: none"> Move the ring to a bead each day every morning. 							
8. Tells the client that she should abstain from sexual intercourse on white-bead days if she wants to avoid pregnancy.							
9. Draws the client’s attention to the dark brown and black beads and tells her that: <ul style="list-style-type: none"> If she experiences menstrual bleeding before the dark brown bead, her cycle is short and less than 26 days. 							
<ul style="list-style-type: none"> If the ring reaches the black bead and she has not experienced menstrual bleeding, then her cycle is long and more than 32 days. 							
10. Warns the client that if either of the above events happens at least twice in a year, she cannot reliably use the SDM as her FP method.							
11. Asks the client to repeat the instructions on SDM use in her own words.							
12. Corrects or clarifies instructions, as needed.							
13. Asks client what issues or difficulties might arise during fertile days (during white bead days).							
14. Asks client about possible ways she can handle the fertile days.							
15. Asks client for questions and concerns and responds to these.							
16. Tells the client to come to the clinic: <ul style="list-style-type: none"> Within seven days of her next menstrual period bringing with her the CycleBeads, client card, and if possible, her partner. 							

TASKS	PRACTICES						
	1	2	3	4	5	6	7
<ul style="list-style-type: none"> Menses occur before the dark brown bead or has not occurred upon reaching the black bead. 							
<ul style="list-style-type: none"> After menses for the next three menstrual periods. 							
17. Refers the client for methods or services not offered at the counselor's site, if use of the CycleBeads is not appropriate.							
18. Fills up information in the Client Register and record client as New Acceptor.							
19. Provides information materials on the method.							

5.16

LACTATIONAL AMENORRHEA METHOD

LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Describe the Lactational Amenorrhea Method (LAM).
2. Explain the criteria for LAM.
3. Explain the mechanism of action, effectiveness, advantages, and disadvantages of LAM.
4. Explain who can use LAM using the LAM algorithm and the MEC checklist.
5. Enumerate the FP methods appropriate for postpartum breastfeeding women.



METHODOLOGY

Illustrated Lecture-Discussion
Brainstorming






TIME ALLOTMENT

30 minutes



ADVANCE PREPARATION OF MATERIALS

- Powerpoint presentation of Module 5, Session 2
- Computer and LCD
- Marker pens, tapes
- Whiteboard and whiteboard marker
- Manila paper

Topics/Contents	Teaching-Learning Process
<div style="text-align: center;">  <h2 style="color: green; margin: 0;">SESSION 2</h2> </div> <hr style="border: 0.5px solid green;"/> <div style="display: flex; align-items: center;">  <div> <h3 style="color: green; margin: 0;">LACTATIONAL AMENORRHEA METHOD (LAM)</h3> </div> </div>	<p>Link this session to that on FAB by saying that:</p> <ul style="list-style-type: none"> – LAM is also one of the family planning methods being promoted under the Philippine Family Planning Program. – Like the FAB methods, it is considered as a natural method, as its contraceptive action is based on the natural effect of breastfeeding among postpartum women. – Since the health benefits to the infant of breastfeeding has been established, women should be encouraged to breastfeed and, at the same time, benefit from its contraceptive effects.
<p>Introduction</p> <hr style="border: 0.5px solid green;"/> <p>Learning Objectives</p> <ul style="list-style-type: none"> • Describe the LAM. • Explain the criteria for LAM. • Explain the mechanism of action, effectiveness, advantages, and disadvantages of LAM. • Explain who can use LAM using the LAM algorithm and the MEC checklist. • Enumerate the FP methods appropriate for postpartum breastfeeding women. 	<p>State the objectives of the session as written on the slide.</p>
<p>What is LAM</p> <hr style="border: 0.5px solid green;"/> <p>What is LAM</p> <div style="display: flex; align-items: center; margin-top: 20px;"> <div style="flex: 1;"> <p>L ACTATIONAL (breastfeeding)</p> <p>A MENORRHEA (no menses)</p> <p>METHOD</p> </div> <div style="flex: 1; text-align: center;">  </div> </div>	<p>Tell participants that LAM stands for:</p> <p>Lactational means related to breastfeeding Amenorrhea means no menses Method</p>
<p>What is LAM</p> <ul style="list-style-type: none"> • Contraceptive method that relies on the condition of infertility that results from specific breastfeeding patterns. • Use of breastfeeding as temporary family planning method. 	<p>Tell participants about LAM as written on the slide.</p>

Topics/Contents	Teaching-Learning Process
<p>Criteria for LAM</p> <p>A woman is practicing LAM when the following conditions are met:</p> <ol style="list-style-type: none"> 1. Exclusively breastfeeding 2. Amenorrhea 3. Infant is less than six months old 	<p>Tell participants that:</p> <ul style="list-style-type: none"> – LAM is having all these three conditions present (criteria for LAM): <ol style="list-style-type: none"> 1. Woman exclusively breastfeeds her infant 2. Amenorrhea 3. Infant is less than six months old <p>Explain what each of these conditions are as related to LAM.</p>
<p>Criteria for LAM</p> <p>1. Full or nearly full breastfeeding</p> <ul style="list-style-type: none"> • Breastfeeds on demand • No more than four hours interval between breastfeeding during the day and six hours at night • Uses both breasts for feeding 	<p>Flash the slide.</p> <p>Explain the concept, exclusive breastfeeding as follows:</p> <ul style="list-style-type: none"> – Exclusive means no supplements of any sort are given. Infant receives no other liquid or food, not even water in addition to breast milk. – "Nearly full" means very small amounts (one or two swallows) of water, vitamins or antibiotics, as medically prescribed. <p>Emphasize that:</p> <ul style="list-style-type: none"> – Whatever is the breastfeeding practice (full or nearly full), keep in mind that the requirement is that the breastfeeding interval should not be longer than four hours during the day and not longer than six hours during the night. – Breastmilk is the best source of nutrition for the infant. It is recommended that exclusive breastfeeding be practiced during the first six months postpartum.
<p>Criteria for LAM</p> <p>2. Amenorrhea</p> <ul style="list-style-type: none"> • Menses have not yet returned • Bleeding within the eight weeks postpartum period is not considered as menstrual bleeding for breastfeeding women 	<p>Explain the next criteria as presented on the slide.</p>

Topics/Contents	Teaching-Learning Process
<p>Criteria for LAM</p> <p>3. Infant is less than six months old</p> <ul style="list-style-type: none"> • Effectiveness of breastfeeding in inhibiting ovulation diminishes over time. • Ovulation resumes in 20-50% of women near the end of the six month postpartum period even when fully breastfeeding and amenorrheic. 	<p>Explain the criteria as presented on the slide.</p>
<p>Mechanism of Action</p> <ul style="list-style-type: none"> • Works primarily by preventing the release of eggs from the ovaries (ovulation). • Frequent breastfeeding temporarily prevents the release of the hormones that cause maturation and release of the ovum. 	<p>State the mechanism of action of LAM as written on the slide. Encourage participants to ask questions or share insights.</p>
<p>Effectiveness</p> <ul style="list-style-type: none"> • As perfect use = 99.5% effective • Perfect use means that the woman: <ul style="list-style-type: none"> ✓ Has started breastfeeding as soon as possible after birth ✓ Has avoided separation from her baby to be able to breastfeed as required ✓ Breastfeeds the infant on demand with no more than four hours interval during the day and six hours at night time. • As typically used = 98% effective 	<p>Explain effectiveness of LAM as presented on the slide. Encourage participants to ask questions of clarification or share insights.</p>
<p>Advantages</p> <ul style="list-style-type: none"> • Can be started immediately after delivery • Economical and easily available • Does not require prescription • No side effects or precautions for use • No commodities or supplies needed • Fosters mother-child bonding • Serves as a bridge to using other methods • Consistent with religious and cultural practices 	<p>Ask participants on what they think are LAM's advantages. Call on participants at random. Write down their responses. Show the advantages and add information shared by participants.</p>

Topics/Contents	Teaching-Learning Process								
<p>Disadvantages</p> <p>Disadvantages</p> <ul style="list-style-type: none"> • Full or nearly full breastfeeding pattern may be difficult for some women to maintain • The duration of the method's effectiveness is limited to a brief six-month postpartum period • There is no protection against sexually transmitted infections, including HIV 	<p>Ask participants after they have learned about LAM on what they think are its disadvantages.</p> <p>Call on participants at random. Write down their responses.</p> <p>Show the slides on the disadvantages and add information shared by participants.</p>								
<p>MEC Checklist on the Use of LAM</p> <p>Medical Eligibility Checklist for Lactational Amenorrhea Method (LAM)</p> <p>Ask the client the questions below. If the answers NO to ALL of the questions, then she CAN use LAM. If she answers YES to a question below, follow the instructions.</p> <ol style="list-style-type: none"> 1. Has your baby 6 months old or older? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>If she answers YES, she cannot use LAM. Help her choose another method. If she is breastfeeding, a nonhormonal method is best.</small> 2. Has your menstrual period returned? (Bleeding in the first 6 weeks after childbirth does not count.) <input type="checkbox"/> No <input type="checkbox"/> Yes <small>After 6 weeks since childbirth, if a woman has 3 straight days of menstrual bleeding, or her menstrual period has returned, she cannot use LAM. Help her choose another method. If she is breastfeeding, a nonhormonal method is best.</small> 3. Have you begun to breastfeed less often? Do you regularly give the baby other food or liquid? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>If the baby's feeding pattern has just changed, explain that she must fully or nearly fully breastfeed—day and night—to protect against pregnancy. At least 85% of her baby's feedings should be breastfeeds. If she is not fully or nearly fully breastfeeding, she cannot use LAM as effectively. Help her choose another nonhormonal method.</small> 4. Has a health care provider told you not to breastfeed your baby? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>If she is not breastfeeding, she cannot use LAM. Help her choose another method. A woman should not breastfeed if she is taking prescription drugs, including, but not limited to, antipsychotics, antidepressants, benzodiazepines, sedatives, tranquilizers, or other drugs. If the baby has a specific infant metabolic disorder, or possibly if she has active viral hepatitis, HIV, or other conditions that could be transmitted to the baby through breastfeeding.</small> 5. Do you have AIDS? Are you infected with HIV, the virus that causes AIDS? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>When infectious diseases are many babies, she could be encouraged to breastfeed. HIV may be passed to the baby in breast milk; however, when infectious diseases are a low risk and safe, affordable food for the baby is available, advise her to feed her baby and other food. Help her choose a family planning method other than LAM. (Some other infectious conditions, such as active viral hepatitis, can also be transmitted during breastfeeding.)</small> <p>Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.</p>	<p>Ask participants to refer to p. 5.12 of their handbook.</p> <p>Review with participants the MEC Checklist on the Use of LAM.</p>								
<p>Appropriate FP Methods for Postpartum Breastfeeding Women</p> <p>Choice of FP Methods for Postpartum Breastfeeding Women</p> <table border="1" data-bbox="263 1317 721 1518"> <thead> <tr> <th colspan="2">Categories of Choice of FP methods for postpartum breastfeeding women.</th> </tr> </thead> <tbody> <tr> <td>1st choice: Nonhormonal methods other than LAM</td> <td>Intrauterine device, condom, tubal ligation, natural family planning, or vasectomy (for the woman's partner)</td> </tr> <tr> <td>2nd choice: Progestin-only methods</td> <td>DMPA and progestin-only pills (both of which can be initiated after 6 weeks postpartum)</td> </tr> <tr> <td>3rd choice: Methods containing estrogen (only after 6 months)</td> <td>Combined oral contraceptives (COCs are recommended only after 6 months when complementary foods are introduced and the baby is less dependent on breast milk as its sole source of nutrition.) Estrogen can reduce breast milk volume.</td> </tr> </tbody> </table> <ul style="list-style-type: none"> • Refer to a Natural Family Planning Provider if the woman prefers to use Natural or FAB Methods. The postpartum breastfeeding woman is eligible for use of the Breastfeeding Mucus Method, with or without the return of her menses after delivery. 	Categories of Choice of FP methods for postpartum breastfeeding women.		1st choice: Nonhormonal methods other than LAM	Intrauterine device, condom, tubal ligation, natural family planning, or vasectomy (for the woman's partner)	2nd choice: Progestin-only methods	DMPA and progestin-only pills (both of which can be initiated after 6 weeks postpartum)	3rd choice: Methods containing estrogen (only after 6 months)	Combined oral contraceptives (COCs are recommended only after 6 months when complementary foods are introduced and the baby is less dependent on breast milk as its sole source of nutrition.) Estrogen can reduce breast milk volume.	<p>Tell participants that:</p> <ul style="list-style-type: none"> • The health benefits of breastfeeding cannot be ignored. • Breastfeeding is promoted by the program because of its health benefits. • Breastfeeding should not be sacrificed for the sake of contraception. • For this reason, the following FP methods are categorized according to their use in conjunction with breastfeeding.
Categories of Choice of FP methods for postpartum breastfeeding women.									
1st choice: Nonhormonal methods other than LAM	Intrauterine device, condom, tubal ligation, natural family planning, or vasectomy (for the woman's partner)								
2nd choice: Progestin-only methods	DMPA and progestin-only pills (both of which can be initiated after 6 weeks postpartum)								
3rd choice: Methods containing estrogen (only after 6 months)	Combined oral contraceptives (COCs are recommended only after 6 months when complementary foods are introduced and the baby is less dependent on breast milk as its sole source of nutrition.) Estrogen can reduce breast milk volume.								
<p>Summary</p> <p>Key Points on LAM</p> <ul style="list-style-type: none"> • A family planning method based on breastfeeding. • Can be effective for up to six months after childbirth, as long as monthly bleeding has not returned and the woman is fully or nearly fully breastfeeding. • Requires breastfeeding often, day and night. 	<p>Summarize the session by asking participants at random to read the key points as written on the slide.</p> <p>Ask participants if they have any questions. Review session objective.</p>								



NARRATIVE

MODULE 5: FERTILITY AWARENESS-BASED METHODS AND LACTATIONAL AMENORRHEA METHOD SESSION 2: LACTATIONAL AMENORRHEA METHOD

The Lactational Amenorrhea Method (LAM) is a contraceptive method that relies on the condition of infertility that results from specific breastfeeding patterns. LAM is the use of breastfeeding as a temporary family planning method. “Lactational” pertains to breastfeeding. “Amenorrhea” means not having menstrual bleeding.

There are three criteria that must be met to use LAM:

1. The woman exclusively breastfeeds infant.

- Exclusively breastfeeding may be interpreted as:
 - a. Exclusive means no supplements of any sort are given. Infant receives no other liquid or food, not even water in addition to breast milk.
 - b. Very small amount (one or two swallows) of water, vitamins or antibiotics as medically prescribed.
 - c. Simply put, the woman should use both breasts to breastfeed her baby on demand with no more than a four-hour interval between any two daytime feeds and no more than a six-hour interval between any two night time feeds.

2. Amenorrhea. Mother’s monthly bleeding has not returned. In the first eight weeks postpartum (i.e., in the first 56 days postpartum), there is often continued spotting. This is not considered to be a menstrual period if the woman is fully lactating.

3. Infant is less than six months old. If she is fully breastfeeding and her menses have not returned, the effectiveness of LAM diminishes over time. Ovulation resumes in 20% to 50% of women near the end of the six-month postpartum.

If any of the criteria is not met, it can no longer be considered LAM.

MECHANISM OF ACTION

Works primarily by preventing the release of eggs from the ovaries (ovulation). Frequent breastfeeding temporarily prevents the release of the natural hormones that cause ovulation.

EFFECTIVENESS

The effectiveness of LAM as consistently followed is at 99.5%, if typically used, it is at 98%.

Mothers should initiate breastfeeding as soon as possible after birth, and avoid separation from the baby as much as possible. Breastfeed the infant on demand day and night, with no more than a four-hour interval between any two daytime feeds, and no more than a six-hour interval between any two night time feeds.

ADVANTAGES OF LAM

1. It can be started immediately after delivery.
2. It is economical and easily available.
3. It does not require prescription.
4. No action is required at the time of intercourse.
5. There are no side effects or precautions for its use.

6. No commodities or supplies are required for clients or for the family planning program.
7. Fosters mother-child bonding
8. It serves as a bridge to using other methods because LAM is only for a limited time.
9. It is consistent with religious and cultural practices.

DISADVANTAGES OF LAM

1. Exclusively breastfeeding pattern may be difficult for some women to maintain.
2. The duration of the method's effectiveness is limited to a brief six-month postpartum period. If a mother and child are separated for extended periods of time (because the mother works outside of the home), the breast feeding practice required for LAM cannot be followed.
3. There is no protection against sexually transmitted infections, including HIV.
4. In addition, it may be difficult to convince some providers who are unfamiliar with the method that LAM is a reliable contraceptive.

NOTE: If returning to a clinic will be difficult for the client, provide a complementary family planning method for use, when needed. Use condoms with LAM if there is a risk of STI/HIV infection.

WHO CAN USE LAM

The MEC Checklist on the Use of LAM

Medical Eligibility Checklist for Lactational Amenorrhea Method (LAM)

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use LAM. If she answers YES to a question below, follow the instructions.

1. Is your baby six months old or older?
 No YES She cannot use LAM. Help her choose another method. If she is breastfeeding, a non-hormonal method is best.

2. Has your menstrual period returned? (Bleeding in the first eight weeks after childbirth does not count.)
 No YES After eight weeks since childbirth, if a woman has two straight days of menstrual bleeding, or her menstrual period has returned, she cannot use LAM. Help her choose another method. If she is breastfeeding, a non-hormonal method is best.

3. Have you begun to breastfeed less often? Do you regularly give the baby other food or liquid?
 No YES If the baby's feeding pattern has changed, explain that she must fully or nearly fully breastfeed – day and night – to protect against pregnancy. At least 85% of her baby's feedings should be breastfeeds. If she is not fully or nearly fully breastfeeding, she cannot use LAM as effectively. Help her choose another non-hormonal method.

4. Has a health care provider told you not to breastfeed your baby?
 No YES If she is not breastfeeding, she cannot use LAM. Help her choose another method. A woman should not breastfeed if she is taking mood-altering drugs, reserpine, ergotamine, antimetabolites, cyclosporine, cortisone, bromocriptine, radioactive drugs, lithium or certain anticoagulants. If her baby has a specific infant metabolic disorder, or if she has active viral hepatitis, breastfeeding is also inadvisable. All others can and should breastfeed for the health benefits.

5. Do you have AIDS? Are you infected with HIV, the virus that causes AIDS?

No YES

Where infectious diseases kill many babies, she could be encouraged to breastfeed. However, HIV may be passed on to the baby in breast milk. When infectious diseases are at a low risk and safe, and affordable food for the baby is available, advise her to feed her baby other food. Help her choose a family planning method other than LAM (some other infectious conditions, such as active viral hepatitis, can also be transmitted during breastfeeding).

Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.

CHOOSING AN FP METHOD FOR POSTPARTUM BREASTFEEDING WOMEN

The health benefits of breastfeeding for infants have been established. For this reason, the Philippine Maternal and Child Health Program has instituted measures to ensure that breastfeeding is promoted in facilities providing maternal and child health services. One such measure is the issuance of the “Milk Code,” which promotes breastfeeding and discourages milk formula for infants.

Pregnant women during their prenatal consultations are counseled for breastfeeding practice immediately after delivery. Maternal and child health service providers are mandated to assist women implement breastfeeding as soon as possible after delivery.

5.24

Having placed high priority on breastfeeding, the table below categorizes the recommended family planning methods for breastfeeding postpartum women, who for some reason may not be qualified for LAM.

Categories of Choice of FP methods for postpartum breastfeeding women.	
1st choice: Non-hormonal methods other than LAM	Intrauterine device, condom, tubal ligation, natural family planning, or vasectomy (for the woman’s partner)
2nd choice: Progestin-only methods	DMPA and progestin-only pills (both of which can be initiated after six weeks postpartum)
3rd choice: Methods containing estrogen (only after six months)	Combined oral contraceptives (COCs are recommended only after six months when complementary foods are introduced and the baby is less dependent on breast milk as its sole source of nutrition). Estrogen can reduce breast milk volume.

KEY POINTS ON LAM

- A family planning method based on breastfeeding.
- Can be effective for up to six months after childbirth, as long as monthly bleeding has not returned and the woman is fully or nearly fully breastfeeding.
- Requires breastfeeding often, day and night.
- Refer to a Natural Family Planning Provider if the woman prefers to use Natural Family Planning or FAB Methods. The postpartum breastfeeding woman is eligible to use the Breastfeeding Mucus Method, with or without the return of her menses after delivery.



MODULE 6



Hormonal Contraceptive Methods

Session 1: Low-Dose Combined Oral Contraceptives (Low-Dose COCs)

Session 2: Other Combined Contraceptives

Session 3: Progestin-Only Pills (POPs)

Session 4: Progestin-Only Injectables (POIs)

MODULE 6: HORMONAL CONTRACEPTIVE METHODS



MODULE OVERVIEW

There are currently three hormonal contraceptive methods included in the Philippine Family Planning Program. These are: oral contraceptives (combined and progestin-only) and the progestin-only injectable.

The **low-dose combined estrogen-progestin (Low-dose COCs)** is one of the most popular reversible contraceptive combination developed to date. Women worldwide in both developed and developing countries use it safely.

Progestin only pills (POPs) contain small amount of progestin-only. They are highly recommended oral contraceptive for breastfeeding women because it does not interfere with milk production.

Progestin-only injectable contraceptives are also progestin only preparation given intramuscularly.



MODULE OBJECTIVE

At the end of the module, participants will be able to demonstrate how to safely and effectively provide low-dose combined oral contraceptives (low-dose COCs), progestin-only pills (POPs) and progestin-only injectables (POIs).



MODULE SESSIONS

The module contains the following sessions:

Session 1	Low-Dose Combined Oral Contraceptives (Low-Dose COCs)
Session 2	Other Combined Contraceptives
Session 3	Progestin-Only Pills (POPs)
Session 4	Progestin-Only Injectables (POIs)

Topics/Contents

Teaching-Learning Process



MODULE 6



HORMONAL CONTRACEPTIVE METHODS

Greet participants.
Introduce the module by telling participants that:

- The previous module has described the Fertility Awareness-Based Methods, which are known as the natural methods of family planning.
- This module will discuss a group of artificial family planning methods that is known to be the hormonal methods.
- Hormonal methods contain one or both of the naturally occurring female hormones, estrogen and progesterone.

OVERVIEW

There are currently three hormonal contraceptive methods included in the Philippine Family Planning Program.

- Low-dose combined estrogen-progestin/Low-dose combined oral contraceptives (COCs)
- Progestin-only pills (POPs)
- Progestin-only injectable (POIs)

Give the overview to the module as presented on the slide.

Tell participants that:

- There is a new type of hormonal contraceptive, the combined injectable contraceptive (CICs) given on a monthly basis, which is already available in the Philippines but not yet part of the program.
- There are other modes of delivery of hormonal contraceptives such as patch, implants, spray, gel, vaginal ring, and intrauterine device/system.

OBJECTIVE

- To demonstrate how to safely provide low-dose combined oral contraceptives (low-dose COCs), progestin-only pills (POPs), and progestin-only injectables (POI).

Tell the participants the module objectives as presented on the slide.

SESSIONS

- Session 1** - Low-dose Combined Oral Contraceptives (Low-dose COCs)
- Session 2** - Other Combined Contraceptives
- Session 3** - Progestin-only Pills (POPs)
- Session 4** - Progestin-only Injectable Contraceptive (DMPA)

Tell the participants the four sessions in the module.

LOW-DOSE COMBINED ORAL CONTRACEPTIVES (LOW-DOSE COCS)

LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Describe low-dose COCs.
2. Relate the mechanism of action of the COC with the menstrual cycle.
3. Explain the effectiveness of the COC.
4. Enumerate the advantages and disadvantages of the COC.
5. Discuss the possible side effects of the COCs and the management of these.
6. Identify conditions suitable for COCs based on the WHO MEC and checklist.
7. Explain possible side effects (including warning signs) and its appropriate management.
8. Explain the guidelines in providing the COCs, including how to start, what to do for missed pills, and follow-up of clients.
9. Enumerate the “warning signs” of COC use.
10. Manage possible problems on using the COC.
11. Correct myths and misconceptions on the low dose COCs.



METHODOLOGY

Illustrated Lecture-Discussion
Brainstorming
Exercise





TIME ALLOTMENT

2 hours



ADVANCE PREPARATION OF MATERIALS


- LCD or overhead projector
- Laptop computer (if using LCD)
- Whiteboard
- Powerpoint presentation on Module 6, Session 1
- Manila paper
- Permanent markers, whiteboard markers
- Metacards, tape

Topics/Contents	Teaching-Learning Process
<div style="text-align: center;">  <h2 style="margin: 10px 0;">SESSION 1</h2> <hr style="width: 30%; margin: 10px auto;"/>  <h3 style="margin: 10px 0;">LOW-DOSE COMBINED ORAL CONTRACEPTIVES</h3> </div>	<p>Introduce this session by telling participants that:</p> <ul style="list-style-type: none"> • COCs are one of the most popular hormonal contraceptives, which is widely accepted and available. • Current preparations of COCs have been improved to ensure safety, effectiveness, and ease of use.
<div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: flex; align-items: center;"> Learning Objectives </div> <p>At the end of the session, the participants will be able to:</p> <ul style="list-style-type: none"> • Describe the low-dose COCs. • Relate the mechanism of action of the COC with the menstrual cycle. • Explain the effectiveness of the COC. • Enumerate the advantages and disadvantages of the COC. • Discuss the possible side effects of the COCs and the management of these. • Identify conditions suitable for COC use based on the WHO MEC and checklist. • Enumerate the warning signs of complications of the COCs. • Explain the guidelines in providing the COCs, including follow-up. • Manage problems on using the COCs. • Correct myths and misconceptions on the COCs. 	<p>State the objectives of the session as presented on the slide.</p>
<div style="text-align: center; padding: 20px;"> <h2 style="color: #008000;">What do you know about the COCs?</h2> </div>	<p>Ask participants to write on metacards what they know or heard about the COCs (contraceptive pills). Write one idea for each metacard.</p> <p>Post metacards on the board/wall.</p> <p>Tell participants that at the end of the session, all of these information shall be discussed.</p>
<div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: flex; align-items: center;"> Description </div> <div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: flex; align-items: center; margin-top: 10px;"> Description </div> <ul style="list-style-type: none"> • Known as pills or oral contraceptives • Contains hormones similar to the woman's natural hormones - estrogen and progesterone 	<p>Describe the low dose COC, including its types, as presented on slides. Encourage participants to ask questions of clarification or share insights.</p>

Topics/Contents	Teaching-Learning Process
<p>Two Types</p> <p>Two Types</p> <ul style="list-style-type: none"> • 28 pills - has 21 "active" pills, which contain hormones, followed by seven "inactive or reminder" pills of a different color. The reminder pills do not contain hormones • 21 pills - contains only the 21 "active" pills 	
<p>Mechanism of Action</p> <p>Mechanism of Action</p> <ul style="list-style-type: none"> • Prevents ovulation • Thickens the cervical mucus, which makes it difficult for sperm to pass through <p><i>Low-dose COCs do not disrupt an existing pregnancy</i></p>	<p>Describe the mechanism of action as presented on the slide.</p> <p>Relate the mechanism of action to the menstrual cycle by asking participants:</p> <ul style="list-style-type: none"> • How does the COC prevent ovulation? <p>Correct explanation is:</p> <ul style="list-style-type: none"> • Decreased estrogen and progesterone levels triggers the secretion of FSH. • Due to the sustained high levels of estrogen and progestin, as an effect of taking the pills, FSH secretion does not happen. • No FSH secretion means no follicles in the ovary maturing. • There will be no matured ovum for ovulation. <p>Emphasize that the low dose COCs do not disrupt pregnancy.</p>
<p>Effectiveness of the COC</p> <p>Effectiveness</p> <ul style="list-style-type: none"> • Correct and consistent use • Proper storage, observance of shelf life and expiration date • Vomiting or Diarrhea • Drug Interaction 	<p>Discuss the effectiveness of the COC and the factors that affect this as presented on slide.</p> <p>Tell participants that:</p> <ul style="list-style-type: none"> • The overall continuation rate among COC users is low, as 25-50% of users have stopped using the method within the first year of use. • Most women stop for non-medical reasons.

Topics/Contents	Teaching-Learning Process
	<p>Explain the factors that affect effectiveness of the pills as:</p> <ol style="list-style-type: none">1. Correct and consistent use.<ul style="list-style-type: none">- Low-dose COCs should be taken within the 1st seven days of the menstrual cycle (days 1-7).- Low-dose COCs must be taken daily, preferably at the same time of the day or night.- If client missed pills or started late, clients are advised to follow the recommended practice for managing missed pills.2. Proper storage, observance of shelf life and expiration date.<p>Pills should be stored at room temperature with proper ventilation. Too much heat may harden the pills and reduce the bio availability of the hormone content of the pills.</p>3. Vomiting or Diarrhea<p>If the client vomits within two hours after taking a pill, she should take another pill from another pack as soon as possible, then keep taking pills as usual.</p><ul style="list-style-type: none">- If with vomiting or diarrhea for more than two days, follow instructions for one or two missed pills as discussed below. She should be instructed to seek consultation for the diarrhea or vomiting.4. Drug Interaction<p>Effectiveness may be lowered when taken with certain drugs such as rifampicin and most anticonvulsants.</p>

Topics/Contents	Teaching-Learning Process
<p data-bbox="212 203 501 230">Advantages and Disadvantages</p> <p data-bbox="400 349 620 456" style="text-align: center;">Advantages and Disadvantages</p>	<p data-bbox="842 226 1358 297">Ask participants what they think are the advantages of the COCs.</p> <p data-bbox="842 338 1425 409">Responses should include but not be limited to:</p> <ul data-bbox="940 416 1425 1120" style="list-style-type: none"> • Safe as proven by extensive studies • Reversible, rapid return of fertility • Convenient, easy to use, no need to do anything at the time of sexual intercourse • Has significant non-contraceptive benefits <ul style="list-style-type: none"> * Monthly periods regular and predictable * Reduces symptoms of gynecologic conditions such as painful menses and endometriosis * Reduces the risk for ovarian and endometrial cancer * Decreases risk of iron-deficiency anemia * Can be used at any age from adolescence to menopause <p data-bbox="842 1160 1302 1196">Supplement responses as needed.</p> <p data-bbox="842 1236 1358 1308">Ask participants what they think are the disadvantages of the COCs.</p> <p data-bbox="842 1348 1425 1420">Responses should include but not be limited to:</p> <ul data-bbox="940 1426 1425 1944" style="list-style-type: none"> • Requires regular and dependable supply • Client-dependent – effectiveness depends on the compliance to daily routine of taking the pills. Often not used correctly and consistently lowers its effectiveness. There is a need for strong motivation to take pills correctly. • Offers no protection against STIs/HIV. • Not appropriate for lactating women (unless there is no other method available and risk of pregnancy is high) as it can suppress lactation.

Topics/Contents	Teaching-Learning Process																				
<p style="background-color: #008000; color: white; padding: 2px;">Possible Side Effects</p> <p style="background-color: #008000; color: white; padding: 2px;">Possible Side Effects</p> <ul style="list-style-type: none"> • Nausea (first three months) • Spotting or bleeding between menstrual periods • Mild headaches • Breast tenderness • Amenorrhea 	<p>Explain that:</p> <ul style="list-style-type: none"> • Side effects are not diseases/illnesses, will resolve spontaneously, thus, will not require medical management. • Not all users of the method will experience side effects. • Minor side effects (common in the first three months) may include: spotting (especially if a woman forgets to take her pills or takes them late), amenorrhea, nausea, breast tenderness, headaches, slight weight gain, and in rare cases, depression, which some women may find difficult to tolerate. <p>Present the possible side effects of COCs as presented on slides. Encourage participants to ask questions of clarification or share insights.</p>																				
<p style="background-color: #008000; color: white; padding: 2px;">Management of Possible Side Effects</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #008000; color: white;">SIDE EFFECTS</th> <th style="background-color: #008000; color: white;">POSSIBLE CAUSE(S)</th> <th style="background-color: #008000; color: white;">MANAGEMENT</th> </tr> </thead> <tbody> <tr> <td>Amenorrhea/ scanty menses</td> <td> <ul style="list-style-type: none"> • Possible pregnancy • Inadequate endometrial build-up </td> <td> <ul style="list-style-type: none"> • Check for pregnancy • Reassurance </td> </tr> <tr> <td>Spotting/breakthrough bleeding</td> <td> <ul style="list-style-type: none"> • Missed pills • More common with low dose COCs • Taking pills at different times of the day • Vomiting and/or diarrhea within 2 hours of intake • Drug interaction </td> <td> <ul style="list-style-type: none"> • Encourage regular intake of pills at the same time each day • Avoid missing pills • Take another pill from another pack when diarrhea or vomiting occurs within 2 hours of intake • Change method if taking rifampicin or anti-convulsants </td> </tr> <tr> <td>Nausea</td> <td> <ul style="list-style-type: none"> • Possible flu or infection • Possible pregnancy • Taking pills on an empty stomach </td> <td> <ul style="list-style-type: none"> • Check for flu, infection or pregnancy • Take pills at bedtime or with food </td> </tr> <tr> <td>Headaches</td> <td> <ul style="list-style-type: none"> • Estrogen effect </td> <td> <ul style="list-style-type: none"> • Take analgesics (paracetamol) • Refer if getting worse </td> </tr> <tr> <td>Breast tenderness</td> <td> <ul style="list-style-type: none"> • Effect of hormones in pills </td> <td> <ul style="list-style-type: none"> • Recommend use of supportive bra • Take pain relievers • Try hot or cold compress </td> </tr> </tbody> </table>	SIDE EFFECTS	POSSIBLE CAUSE(S)	MANAGEMENT	Amenorrhea/ scanty menses	<ul style="list-style-type: none"> • Possible pregnancy • Inadequate endometrial build-up 	<ul style="list-style-type: none"> • Check for pregnancy • Reassurance 	Spotting/breakthrough bleeding	<ul style="list-style-type: none"> • Missed pills • More common with low dose COCs • Taking pills at different times of the day • Vomiting and/or diarrhea within 2 hours of intake • Drug interaction 	<ul style="list-style-type: none"> • Encourage regular intake of pills at the same time each day • Avoid missing pills • Take another pill from another pack when diarrhea or vomiting occurs within 2 hours of intake • Change method if taking rifampicin or anti-convulsants 	Nausea	<ul style="list-style-type: none"> • Possible flu or infection • Possible pregnancy • Taking pills on an empty stomach 	<ul style="list-style-type: none"> • Check for flu, infection or pregnancy • Take pills at bedtime or with food 	Headaches	<ul style="list-style-type: none"> • Estrogen effect 	<ul style="list-style-type: none"> • Take analgesics (paracetamol) • Refer if getting worse 	Breast tenderness	<ul style="list-style-type: none"> • Effect of hormones in pills 	<ul style="list-style-type: none"> • Recommend use of supportive bra • Take pain relievers • Try hot or cold compress 	<p>Explain how to manage possible side effects as presented on slides. Encourage participants to ask questions for clarification or share insights.</p>		
SIDE EFFECTS	POSSIBLE CAUSE(S)	MANAGEMENT																			
Amenorrhea/ scanty menses	<ul style="list-style-type: none"> • Possible pregnancy • Inadequate endometrial build-up 	<ul style="list-style-type: none"> • Check for pregnancy • Reassurance 																			
Spotting/breakthrough bleeding	<ul style="list-style-type: none"> • Missed pills • More common with low dose COCs • Taking pills at different times of the day • Vomiting and/or diarrhea within 2 hours of intake • Drug interaction 	<ul style="list-style-type: none"> • Encourage regular intake of pills at the same time each day • Avoid missing pills • Take another pill from another pack when diarrhea or vomiting occurs within 2 hours of intake • Change method if taking rifampicin or anti-convulsants 																			
Nausea	<ul style="list-style-type: none"> • Possible flu or infection • Possible pregnancy • Taking pills on an empty stomach 	<ul style="list-style-type: none"> • Check for flu, infection or pregnancy • Take pills at bedtime or with food 																			
Headaches	<ul style="list-style-type: none"> • Estrogen effect 	<ul style="list-style-type: none"> • Take analgesics (paracetamol) • Refer if getting worse 																			
Breast tenderness	<ul style="list-style-type: none"> • Effect of hormones in pills 	<ul style="list-style-type: none"> • Recommend use of supportive bra • Take pain relievers • Try hot or cold compress 																			
<p style="background-color: #008000; color: white; padding: 2px;">Who can use COCs</p> <p style="background-color: #008000; color: white; padding: 2px;">Simplified MEC Category System</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="background-color: #008000; color: white;">WHO CAT.</th> <th style="background-color: #008000; color: white;">DEFINITION</th> <th style="background-color: #008000; color: white;">With clinical judgement</th> <th style="background-color: #008000; color: white;">With limited clinical judgement</th> </tr> </thead> <tbody> <tr> <td style="background-color: #008000; color: white;">1</td> <td style="background-color: #008000; color: white;">No restriction for the use of the contraceptive method</td> <td style="background-color: #008000; color: white;">Use the method in any circumstances</td> <td style="background-color: #008000; color: white;">Use</td> </tr> <tr> <td style="background-color: #008000; color: white;">2</td> <td style="background-color: #008000; color: white;">The advantage of the method generally outweigh the theoretical or proven risks</td> <td style="background-color: #008000; color: white;">Generally use the method</td> <td style="background-color: #008000; color: white;">Use</td> </tr> <tr> <td style="background-color: #008000; color: white;">3</td> <td style="background-color: #008000; color: white;">The theoretical or proven risks usually outweigh the advantages of using the method</td> <td style="background-color: #008000; color: white;">Use of the method not usually recommended unless other, more appropriate methods are not available or acceptable</td> <td style="background-color: #008000; color: white;">Do not use</td> </tr> <tr> <td style="background-color: #008000; color: white;">4</td> <td style="background-color: #008000; color: white;">An unacceptable health risk of the contraceptive method if used</td> <td style="background-color: #008000; color: white;">method not to be used</td> <td style="background-color: #008000; color: white;">Do not use</td> </tr> </tbody> </table> 	WHO CAT.	DEFINITION	With clinical judgement	With limited clinical judgement	1	No restriction for the use of the contraceptive method	Use the method in any circumstances	Use	2	The advantage of the method generally outweigh the theoretical or proven risks	Generally use the method	Use	3	The theoretical or proven risks usually outweigh the advantages of using the method	Use of the method not usually recommended unless other, more appropriate methods are not available or acceptable	Do not use	4	An unacceptable health risk of the contraceptive method if used	method not to be used	Do not use	<p>Introduce the WHO MEC by saying that the MEC is:</p> <ul style="list-style-type: none"> • A listing of conditions/characteristics for medical screening of clients with recommendations for prevention or restriction of the use of FP methods. • These recommendations of the WHO Scientific Working Group are evidence-based. <p>Present the WHO Categories of recommendations as presented on the slide.</p>
WHO CAT.	DEFINITION	With clinical judgement	With limited clinical judgement																		
1	No restriction for the use of the contraceptive method	Use the method in any circumstances	Use																		
2	The advantage of the method generally outweigh the theoretical or proven risks	Generally use the method	Use																		
3	The theoretical or proven risks usually outweigh the advantages of using the method	Use of the method not usually recommended unless other, more appropriate methods are not available or acceptable	Do not use																		
4	An unacceptable health risk of the contraceptive method if used	method not to be used	Do not use																		

Topics/Contents	Teaching-Learning Process
<p style="text-align: center;">Exercise</p>	<p>Tell participants that:</p> <ul style="list-style-type: none"> • Clients' conditions are identified from a thorough history-taking using the FP Form 1. <p>Ask participants to categorize the following conditions based on the WHO MEC and identify whether client can or cannot use the COC.</p> <p>Choose from the conditions below.</p> <p>Category 1: Use the method without restriction. The following women can use COCs:</p> <ul style="list-style-type: none"> • Have no children yet • Post-abortion • Have pelvic inflammatory disease (PID - history or current) • With mild non-migranous headaches • With varicose veins • Have gestational trophoblastic disease • Have tuberculosis, unless taking rifampicin <p>Category 2: Generally use the method but with more than the usual follow-up</p> <ul style="list-style-type: none"> • Smokes cigarettes but under 35 • Have superficial thrombophlebitis • With cervical cancer awaiting treatment <p>WHO CANNOT USE COCs?</p> <p>Category 3: DO NOT USE the method unless no other appropriate method is available under close supervision by a physician</p> <ul style="list-style-type: none"> • Less than 21 days postpartum • Mild compensated cirrhosis <p>Category 4: DO NOT USE THE METHOD</p> <ul style="list-style-type: none"> • Raised BP (160/100 or more) • Breast cancer within the past five years • Benign or malignant liver tumor • Severe (decompensated) cirrhosis

Topics/Contents	Teaching-Learning Process														
<p>When to Start</p> <p>POSTABORTION</p> <ul style="list-style-type: none"> • May start immediately after an abortion. • No back-up method needed if the COCs started within the first seven days following the abortion. 															
<p>Missed Pills</p>	<p>Tell participants that:</p> <ul style="list-style-type: none"> • Missed pills are the most common cause of contraceptive failure • As such, the following are guidelines on missed pills. <p>Present the instructions on missed pills as presented on slides.</p> <p>Tell participants that:</p> <ul style="list-style-type: none"> • It is suggested that remaining “active” pills, which were missed are not discarded. • These can be used for times when additional intakes are required like when the client vomits or is experiencing diarrhea. 														
<p>Warning Signs</p> <p>Warning Signs</p> <table border="1" data-bbox="310 1299 697 1523"> <thead> <tr> <th colspan="2">J-A-C-H-E-S</th> </tr> </thead> <tbody> <tr> <td>J</td> <td>Jaundice</td> </tr> <tr> <td>A</td> <td>Abdominal pain, severe</td> </tr> <tr> <td>C</td> <td>Chest pain, shortness of breath</td> </tr> <tr> <td>H</td> <td>Headache, severe</td> </tr> <tr> <td>E</td> <td>Eye problems, brief loss of vision, seeing flashes of light or zigzag lines</td> </tr> <tr> <td>S</td> <td>Severe leg pains</td> </tr> </tbody> </table> <p>SEEK IMMEDIATE CONSULTATION</p>	J-A-C-H-E-S		J	Jaundice	A	Abdominal pain, severe	C	Chest pain, shortness of breath	H	Headache, severe	E	Eye problems, brief loss of vision, seeing flashes of light or zigzag lines	S	Severe leg pains	<p>Tell participants the warning signs for complications while using the COCs as presented on the slides. Encourage participants to ask questions for clarification or share insights.</p>
J-A-C-H-E-S															
J	Jaundice														
A	Abdominal pain, severe														
C	Chest pain, shortness of breath														
H	Headache, severe														
E	Eye problems, brief loss of vision, seeing flashes of light or zigzag lines														
S	Severe leg pains														
<p>Follow-Up</p> <p>Follow-Up</p> <ul style="list-style-type: none"> • Return to the clinic: <ul style="list-style-type: none"> ✓ Three months after initiation and annually, thereafter. ✓ At any time when any of the “warning signs” occur. • During the annual visit, perform as needed and for good medical practice: <ul style="list-style-type: none"> ✓ Physical and pelvic examination ✓ Breast examination for breast cancer screening ✓ Procedures for cervical cancer screening 	<p>Present the guidelines on “Follow-Up” of clients on COCs as presented on slides. Encourage participants to ask questions of clarification or share insights.</p> <p>Emphasize that:</p> <ul style="list-style-type: none"> • COCs do not cause breast and cervical cancers • These procedures are usually performed as part of good medical practice 														

Topics/Contents	Teaching-Learning Process
<p style="text-align: center;">Correcting Misconceptions</p>	<p>Review with participants the metacards containing the information on what they know about the COCs.</p> <p>For each information, ask participants whether this is a fact or a misconception. For the misconceptions, ask participants for the correct information based on what they have learned on the COCs.</p> <p>Below are some responses to possible misconceptions on the COC:</p> <ol style="list-style-type: none"> 1. Low-dose COCs appear to have no apparent overall effect on the risk for breast cancer. 2. Low-dose COCs may be used by healthy, non-smoking women throughout their reproductive lives, starting in the teen-age years and into their forties. 3. Clients should be provided with enough pills for more than three cycles, provided they have a safe place to store them and the program has enough stocks. Give them more than three cycles only after they have completed a three-month trial period on the low dose COCs. 4. A woman is protected for as long as she takes the pill regularly. 5. COCs do not disrupt an existing pregnancy. 6. Does not cause birth defects and will not harm the fetus even if the woman becomes pregnant while taking the pills or accidentally starts the pill when she is already pregnant. 7. Most women do not gain or lose weight due to COCs. 8. Generally, COCs do not change the mood or sex drive of a woman. 9. COCs cannot be used as a pregnancy test.

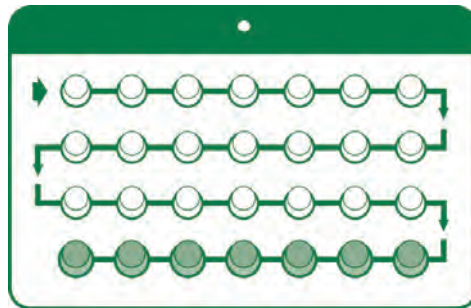
Topics/Contents	Teaching-Learning Process
	<p>10.COCs are safe for women with varicose veins.</p> <p>11.COCs can be safely taken by a woman throughout her life.</p> <p>12.Women younger than age 35 who smoke cigarettes can use low dose COCs.</p> <p>13.COCs should be taken at the same time each day to reduce side effects and ensure consistent use.</p>
<p>Key Message</p> <p>Key Message</p> <ul style="list-style-type: none"> • Compliance is increased in low-dose COCs users when proper counseling is performed. • Low-dose COCs are safe, effective, and reversible. They are some of the most extensively studied medications ever used by human beings. Serious side effects are very rare. • Low-dose COCs have many non-contraceptive health benefit. <p>Key Message</p> <ul style="list-style-type: none"> • Low-dose COCs may be used by healthy, nonsmoking women throughout their reproductive lives. • Clients should be provided with enough pills for more than three cycles, provided they have a safe place to store them and the program has enough stocks. Give more than three cycles when they have completed a three-month trial period on the low-dose COCs. <p>Key Message</p> <ul style="list-style-type: none"> • Low-dose COCs appear to have no apparent overall effect on risk of breast cancer. • Low-dose COCs do not protect against STIs and HIV. Women at risk of infection must also be offered condoms. • Low-dose COCs are not recommended for breastfeeding women because they can reduce milk supply. 	<p>Ask participants:</p> <ul style="list-style-type: none"> • What have you learned about the COCs? <p>Call on a few participants at random.</p> <p>Supplement by presenting the key messages as written on the slides.</p>



NARRATIVE

MODULE 6: HORMONAL CONTRACEPTIVE METHODS SESSION 1: LOW-DOSE COMBINED ORAL CONTRACEPTIVES (LOW-DOSE COCs)

Low-dose COCs, otherwise known as pills or oral contraceptives, contain hormones similar to the woman's natural hormones - estrogen and progesterone. They are taken daily to prevent conception.



Most women use low-dose COCs successfully when properly counseled on how to use them and what potential side effects to expect. Service delivery for low-dose COCs can and should be relatively uncomplicated.

Two types of pill packets are available in the Philippines. One type has 28 pills in a packet, with 21 "active" pills containing hormones and seven "inactive or reminder" pills of a different color. The reminder pills do not contain hormones. Another type of pills contain only the 21 "active/hormone containing" tablets.

Monophasic pills provide the same amount of estrogen and progesterone in every hormonal pill.

Biphasic pills have the first 10 pills with one dosage and the next 11 pills having another level of estrogen and progestin.

Triphasic pills have the first seven pills or so with one dosage, the next seven pills have another dosage and the last seven pills with yet another dosage.

All prevent pregnancy in the same way.

Differences in side effects, effectiveness, and continuation appear to be slight.

Other types of hormonal contraceptives are in the form of patch, implant, spray, gel, vaginal ring, and intrauterine device.

Mechanism of Action

Low-dose COCs prevent ovulation by suppressing follicle-stimulating hormone (FSH) and luteinizing hormone (LH). It also causes thickening of the cervical mucus, which makes it difficult for sperm to pass through.

Low-dose COCs do not disrupt an existing pregnancy.

Effectiveness

Low-dose COCs are effective, if perfectly used at 99.7%, as typically used at 92% effectiveness.

- Many women may not take the pills correctly and risk becoming pregnant. The most common mistakes are starting new packets late and running out of pills.
- The overall continuation rate among low-dose COCs users is low:
 - ✓ 25%-50% of women will stop the low-dose COCs within one year
 - ✓ Most women stop for non-medical reasons

Factors affecting effectiveness:

1. Correct and consistent use.

Low-dose COCs must be taken daily, preferably at the same time of the day or night.

Low-dose COCs should be started within the 1st seven days of the menstrual cycle (days 1-7).

If client missed pills, advise them to follow the recommended practice for managing missed pills

2. Proper storage, observance of shelf life and expiration date.

Pills should be stored at room temperature with proper ventilation. Too much heat may harden the pills and reduce the bioavailability of the hormone content of the pills.

3. Vomiting or Diarrhea

If the client vomits within two hours after taking a pill, she should take another pill from another pack as soon as possible, then keep taking pills as usual. If with vomiting or diarrhea for more than two days, follow instructions for one or two missed pills above. The client is advised to seek consultation for persistence of vomiting or diarrhea.

4. Drug Interactions

Effectiveness may be lowered when taken with certain drugs such as rifampicin and most anti-provocations.

Advantages of COCs

- Safe as proven by extensive studies
- Reversible, rapid return of fertility
- Convenient, easy to use, no need to do anything at the time of sexual intercourse
- Has significant non-contraceptive benefits
 - Monthly periods regular and predictable
 - Reduces symptoms of gynecologic conditions such as painful menses and endometriosis
 - Reduces the risk for ovarian and endometrial cancer
 - Decreases risk of iron-deficiency anemia
 - Can be used at any age from adolescence to menopause

Disadvantages of COCs

- Requires regular and dependable supply
- Client-dependent – effectiveness depends on the client's compliance to daily routine of taking the pills, often not used correctly and consistently, which lowers its effectiveness. There is a strong motivation needed to take pills correctly.
- Offers no protection against STIs/HIV
- Not most appropriate choice for lactating women (unless there is no other method available and risk of pregnancy is high) as it can suppress lactation
- Effectiveness may be lowered when taken with certain drugs such as rifampicin and most anti-convulsants
- Increased risk to users over 35 years old who smoke and have other health problems

WHO CAN USE COCs?

Category 1: Use the method without restriction. The following women can use COCs:

- Have no children yet
- 18-39 years old
- Have just had an abortion or a miscarriage
- Have heavy painful menstrual periods or iron deficiency anemia
- Have irregular menstrual periods
- Have history of ectopic pregnancy
- Post-abortion
- With simple goiter
- With non-migrainous headache
- With irregular menstrual bleeding/dysmenorrhea
- Have pelvic inflammatory disease (PID - history or current)
- With benign breast disease
- With cervical ectropion/erosion
- With ovarian/endometrial cancer
- With mild non-migrainous headaches
- With varicose veins
- With malaria
- Have thyroid disease
- Have endometriosis
- Have increased STI/HIV risk (advise condom use)
- Have STI (history or current)
- HIV-positive or have AIDS
- Have gestational trophoblastic disease
- Have a history of pregnancy-related diabetes
- Have benign ovarian tumors, uterine fibroids
- Have hepatitis (carriers or not active disease)
- Have tuberculosis, unless taking rifampicin
- Have schistosomiasis

Category 2: Generally use the method but with more than the usual follow-up

- 40 years old or more
- Body mass index of 30 kg/m² or more
- Smokes cigarette but under 35
- Are breastfeeding more than six months postpartum
- Have history of high blood pressure during pregnancy
- Have superficial thrombophlebitis
- With cervical cancer awaiting treatment
- Have diabetes without vascular, kidney, eye or nerve disease
- Have migraine headaches without aura and under 35 years old
- With unexplained vaginal bleeding before evaluation
- Have a history of deep vein thrombosis or pulmonary embolism (DVT/PE)
- Have undiagnosed breast mass

WHO CANNOT USE COCs?

Category 3: DO NOT USE the method

- Smoking less than 15 cigarettes a day in a woman aged 35 years or more
- Raised blood pressure 140-159/90-99 mm Hg
- Migraine without aura in a woman aged 35 years or more (if migraine develops during use of COCs, it becomes a category 4 contraindication)

- History of breast cancer with no evidence of disease for five years
- Breastfeeding from six weeks to less than six months postpartum
- Less than 21 days postpartum
- Mild compensated cirrhosis
- History of cholestasis related to past COC use
- Symptomatic gall bladder disease
- Drug treatment affecting liver enzymes: rifampicin and certain anticonvulsants

Category 4: DO NOT USE THE METHOD

- Breastfeeding and less than six weeks postpartum
- Current and history of ischaemic heart disease or stroke
- Smoking 15 or more cigarettes per day in a woman aged 35 years or more
- Raised BP (160/100 or more)
- Hypertension with vascular disease
- Diabetes mellitus with vascular complications (hypertension, nephropathy, retinopathy or neuropathy) of more than 20 years duration
- Past or present evidence of DVT/PE
- Major surgery with prolonged immobilization
- Complicated vascular heart disease
- Breast cancer within the past five years
- Acute viral hepatitis
- Benign or malignant liver tumor
- Severe (decompensated) cirrhosis

Possible Side Effects and Management

Possible side effects which are common during the first three months of use of the COC are:

- spotting (especially if a woman forgets to take her pills or takes them late)
- amenorrhea
- nausea
- breast tenderness
- headaches

SIDE EFFECTS	POSSIBLE CAUSE(S)	MANAGEMENT
Amenorrhea/ scanty menses	<ul style="list-style-type: none"> • Possible pregnancy • Inadequate endometrial build-up 	<ul style="list-style-type: none"> • Check for pregnancy • Reassurance
Spotting/breakthrough bleeding	<ul style="list-style-type: none"> • Missed pills • More common with low dose COCs • Taking pills at different times of the day • Vomiting and/or diarrhea within two hours of intake • Drug interaction 	<ul style="list-style-type: none"> • Encourage regular intake of pills at the same time each day • Avoid missing pills • Take another pill from another pack when diarrhea or vomiting occurs within two hours of intake • Change method if taking rifampicin or anti-convulsants
Nausea	<ul style="list-style-type: none"> • Possible flu or infection • Possible pregnancy 	<ul style="list-style-type: none"> • Check for flu, infection or pregnancy

SIDE EFFECTS	POSSIBLE CAUSE(S)	MANAGEMENT
	<ul style="list-style-type: none"> • Taking pills on an empty stomach 	<ul style="list-style-type: none"> • Take pills at bedtime or with food
Headaches	<ul style="list-style-type: none"> • Estrogen effect 	<ul style="list-style-type: none"> • Take analgesics (Paracetamol) • Refer if getting worse
Breast tenderness	<ul style="list-style-type: none"> • Effect of hormones in pills 	<ul style="list-style-type: none"> • Recommend use of supportive bra • Take pain relievers • Try hot or cold compress

Warning Signs

- J** - Jaundice
- A** - Abdominal pain (severe)
- C** - Chest pain
- H** - Headaches (severe)
- E** - Eye problems such as brief loss of vision, seeing flashes of light or zigzag lines
- S** - Severe leg pains

The above signs may not be due to COC use. However, if these signs occur in a client using the COC, she is instructed to immediately seek consultation for proper investigation and management of the underlying problem.

Procedural points about the delivery of low-dose COCs:

Guidelines in Initiating Use of COCs

- Advise the client to take one pill a day regularly, preferably at the same time, even if she is not having sex daily.
- A pack of 21 pills containing the “active” hormones estrogen and progestogen. This requires a seven-day rest period before starting a new pack.
- A 28-day pack would contain seven additional placebo or non-hormone tablets of a different color to enable the woman to finish the pack and start a new one immediately. No rest period required.
- It is best that COCs are taken within the first five days of the menstrual period since conception is virtually nil at this time.
- If a woman started COC after the 7th day of onset of her menses, she should practice abstinence or use back up contraceptive for the next seven days.

1. When is the best time to start low-dose COCs?

It is **best** for the woman to start taking low-dose COCs within the first five days of the menstrual period since conception is virtually nil at this time. If started after the 7th day of her menses, she should abstain or use a back up contraceptive for the next seven days. Low-dose COCs may be started anytime you can be reasonably sure that the client is not pregnant.

2. When can low-dose COCs be started postpartum?

For post partum women:

- Encourage feeding infant with breastmilk for two years. However if for whatever reason, she wants to stop breastfeeding & use a COC, the following guidelines apply.
 - If fully or nearly fully breastfeeding for more than six months, and no menses yet:
 - ✓ Start at any time for as long as reasonably certain that the woman is not pregnant.

- ✓ Use back-up for the first seven days of use
- If fully or nearly fully breastfeeding for more than six months, and menses have returned = start within seven days of menses
- If not breastfeeding = start at three weeks after delivery

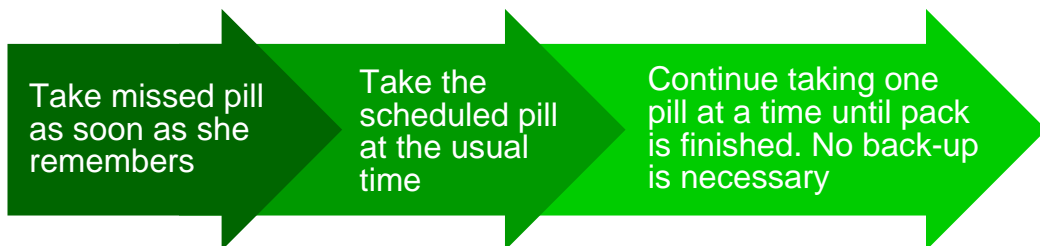
3. May low-dose COCs be started immediately post-abortion?

After abortion, she may begin low-dose COCs immediately. No back-up contraceptive is needed, if she begins within the first seven days following abortion.

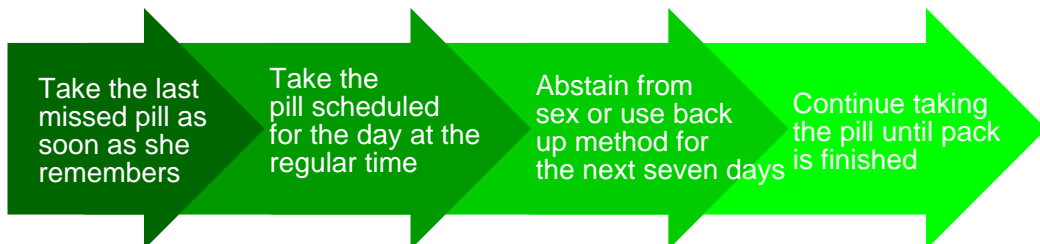
Missed Pills

Missed pills are the most common cause of contraceptive failure and COC side effects like spotting and/or withdrawal bleeding. Managing missed pills therefore is a very important aspect that service providers should know and properly implement.

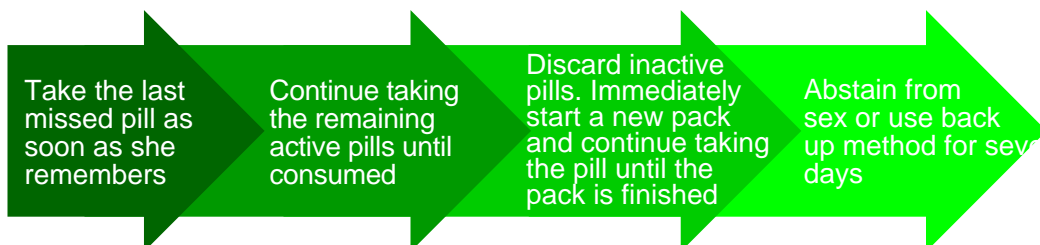
If a woman misses one or two active COC pill in any day of the first three weeks or starts a pack one day late



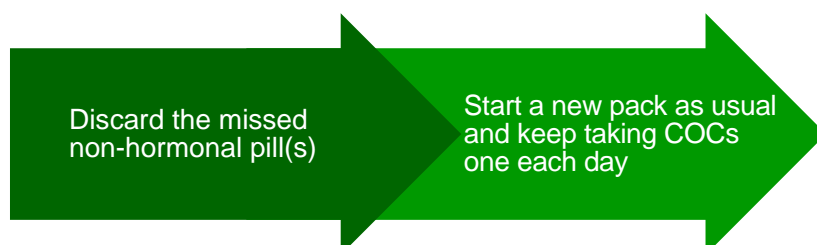
If a woman misses three or more active COC pills in the first two weeks or starts a pack two or more days late



If a woman misses three or more active pills on the third week



If a woman misses any non-hormonal pill (any of the last seven pills in a 28-pill pack)



Guidelines and Instructions for Follow-up

Clients should be advised to return to the clinic three months after initiation, then annually thereafter. However, the client should return to the clinic at anytime for any problem or questions that may arise.

Clients should be provided with enough pills for more than three cycles, provided they have a safe place to store them and the program has enough stocks. Give them more than three cycles only after they have completed a three-month trial period on the low-dose COCs.

During the annual follow-up, a physical and pelvic examination may be done as a part of good medical practice. Cervical and breast cancer screening are usually undertaken.

Inform client of the appropriate outlets for re-supply of pills. Clients should use the same preparation unless otherwise advised by the provider.

Correcting myths and misconceptions

Compliance and continued use of COCs are increased when:

- Clients are properly counseled
- Client's questions and concerns are thoughtfully responded to
- Accurate, detailed and understandable information is provided.

The following are facts on the low-dose COCs:

1. Low-dose COCs appear to have no apparent overall effect on risk of breast cancer.
2. Low-dose COCs may be used by healthy, non-smoking women throughout their reproductive lives, starting in the teen-age years and into their forties.
3. Clients should be provided with enough pills for more than three cycles, provided they have a safe place to store them and the program has enough stocks. Give them more than three cycles only after they have completed a three-month trial period on the Low-dose COCs.
4. Low-dose COCs do not protect against STIs and HIV. Women at risk of infection must also be offered condoms.
5. Low-dose COCs are not recommended for breastfeeding women because they can reduce the milk supply.
6. A woman is protected only as long as she takes the pill regularly.
7. COCs do not disrupt an existing pregnancy.
8. Does not cause birth defects and will not harm fetus even if the woman becomes pregnant while taking the pills or accidentally starts the pill when she is already pregnant.
9. Most women do not gain or lose weight due to COCs.
10. COCs do not change mood or sex drive of a woman.
11. COCs cannot be used as a pregnancy test.
12. COCs are safe for women with varicose veins.
13. COCs can be safely taken by a woman throughout her life.
14. Women younger than age 35 who smoke can use low dose COCs.
15. COCs should be take at the same time each day to reduce side effects and for consistent use.

KEY MESSAGES

- Low-dose COCs are safe, effective, and reversible. They are some of the most extensively studied medications ever used by human beings. Serious side effects are very rare.
- Low-dose COCs have many non-contraceptive health benefits.
- Low-dose COCs may be used by healthy, non-smoking women throughout their reproductive lives, starting in the teen-age years and into their forties.
- Clients should be provided with enough pills for more than three cycles, provided they have a safe place to store them and the program has enough stocks. Give them more than three cycles only after they have completed a three-month trial period on the Low-dose COCs.
- Low-dose COCs do not protect against STIs and HIV. Women at risk of infection must also be offered condoms.
- Low-dose COCs are not recommended for breastfeeding women because they can reduce milk supply.

Medical Eligibility Checklist for Combined Oral Contraceptives (COCs)

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use combined oral contraceptives (COCs). If she answers YES to a question below, follow the instructions.

1. Do you smoke cigarettes and are you 35 or older?
 No YES Urge her to stop smoking. If she is 35 or older and will not stop smoking, do not provide COCs. Help her to choose a method without estrogen.
2. Do you have high blood pressure?
 No YES If you cannot check blood pressure (BP) and she reports high BP, do not provide COCs. Refer for BP check if possible or help her choose a method without estrogen. If there is no report of high BP, it is okay to provide COCs.

Check if feasible:

If BP is below 140/90, it is okay to give COCs without further BP readings. If systolic BP is 140 or higher or diastolic BP is 90 or higher, do not provide COCs. Help her choose another method. (One BP reading in the range of 140-159/90-99 is not enough to diagnose high BP. Offer condoms or spermicide for use until she can return for another BP check, or help her choose another method if she prefers. If BP reading at next check is below 140/90, she can use COCs and further BP readings are not necessary.) If systolic BP is below 160 or higher or diastolic BP is 100 or higher, she also should not use DMPA or NET-EN.

3. Are you breastfeeding a baby less than six months old?
 No YES Can provide COCs now with instructions to start when she stops breastfeeding or six months after childbirth – whichever comes first. If she is not fully or almost fully breastfeeding, also give her condoms or spermicide to use until her baby is six months old. Other effective methods are better choices than COCs when a woman is breastfeeding whatever her baby's age.
4. Do you have serious problems with your heart or blood vessels? Have you ever had such problems? If so, what problems?
 No YES Do not provide COCs if she reports heart attack or heart disease due to blocked arteries, stroke, blood clots (except superficial clots), severe chest pain with unusual shortness of breath, diabetes for more than 20 years, or damage to vision, kidneys, or nervous system caused by diabetes. Help her choose another effective method.
5. Do you have or have you ever had breast cancer?
 No YES Do not provide COCs. Help her choose a method without hormones.
6. Do you have jaundice, cirrhosis of the liver, a liver infection or tumor? (Are her eyes or skin unusually yellow?)
 No YES Perform physical exam or refer client. If she has serious active liver disease (jaundice, painful or enlarged liver, active viral hepatitis, liver tumor), do not provide COCs. Refer for care as appropriate. Help her choose a method without hormones.

7. Do you often get severe headaches, perhaps on one side or pulsating, that cause nausea and are made worse by light and noise or moving about (migraine headaches)?
 No YES If she is 35 or older, do not provide COCs. Help her choose another method. If she is under age 35, but her vision is distorted or she has trouble speaking or moving before or during these headaches, do not use COCs. Help her choose another method. If she is under age 35 and has migraine headaches without distortion of vision or trouble or moving, she can use COCs.
8. Are you taking medicines for seizures? Are you taking rifampin (rifampicin) or griseofulvin?
 No YES If taking phenytoin, carbamazepine, barbiturates, or primidone for seizures or rifampin or griseofulvin, provide condoms to use along with COCs or, if she prefers, help her choose another effective method if she is on long-term treatment.
9. Do you think you are pregnant?
 No YES Assess whether pregnant (see How to tell if a woman is not pregnant). If she might be pregnant, also give her condoms or spermicide to use until it is reasonably certain that she is not pregnant. Then she can start COCs.
10. Do you have gall bladder disease? Ever had jaundice while taking COCs? Planning surgery that will keep you from walking for a week or more? Had a baby in the past 21 days?
 No YES If she has gall bladder disease now or takes medicine for gall bladder disease, or if she has had jaundice while using COCs, do not provide COCs. Help her choose a method without estrogen. If she is planning surgery or she just had a baby, can provide COCs with instruction on when to start them later.

Be sure to explain the health benefits, risks and side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.

OTHER COMBINED CONTRACEPTIVES

LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Describe the contraceptive patch.
2. Explain the effectiveness of the patch.
3. Enumerate the advantages and disadvantages of the contraceptive patch.
4. Discuss the possible side effects of the patch.
5. Identify conditions suitable for use of the patch.
6. Explain the guidelines for providing the patch, including how to start and what to do for missed patch changes.
7. Describe the combined injectable contraceptives (CIC).
8. Explain the mechanism of action of the CIC.
9. Enumerate the advantages and disadvantages of the CIC.
10. State the effectiveness of the CIC.
11. Discuss the possible side effects of the CIC.
12. Determine conditions suitable or unsuitable for CIC use.
13. Explain how to use the CIC.
14. Enumerate the “warning signs” for CIC use.



METHODOLOGY

Illustrated Lecture-Discussion
Brainstorming
Group work






TIME ALLOTMENT


30 minutes




ADVANCE PREPARATION OF MATERIALS

- LCD or overhead projector
- Laptop computer (if using LCD)
- Powerpoint presentation on Module 6, Session 1
- Permanent markers, whiteboard markers
- Manila paper

Topics/Contents	Teaching-Learning Process
<div style="text-align: center;">  <h2 style="color: green; margin: 10px 0;">SESSION 2</h2>  <h3 style="color: green; margin: 10px 0;">OTHER COMBINED CONTRACEPTIVES</h3> </div>	<p>Introduce this session by telling participants that:</p> <ul style="list-style-type: none"> • There are other forms of combined hormonal contraceptives which have similar features with the low-dose COCs. • Available in the Philippines are the contraceptives patch (Eura) and the combined injectable (Norifam).
<div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: flex; align-items: center;"> Learning Objectives </div> <ul style="list-style-type: none"> • Explain the mechanism of action of the CIC. • Enumerate the advantages and disadvantages of the CIC. • State the effectiveness of the CIC. • Discuss the possible side effects of the CIC. • Determine conditions suitable or unsuitable for CIC use. • Explain how to use the CIC. • Enumerate the "warning signs" for CIC use. 	<p>State the objectives of the session as presented on the slide.</p>
<div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: flex; align-items: center;"> Learning Objectives </div> <ul style="list-style-type: none"> • Explain the mechanism of action of the CIC. • Enumerate the advantages and disadvantages of the CIC. • State the effectiveness of the CIC. • Discuss the possible side effects of the CIC. • Determine conditions suitable or unsuitable for CIC use. • Explain how to use the CIC. • Enumerate the "warning signs" for CIC use. 	
<div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: flex; align-items: center;"> The Contraceptive Patch </div> <div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: flex; align-items: center; margin-top: 10px;"> The Contraceptive Patch </div> <div style="text-align: center; margin-top: 20px;">  </div>	

Topics/Contents	Teaching-Learning Process
<p>Description</p> <p>Description</p>  <p>Form of combined (estrogen + progestin) contraceptive applied to the skin that contains estrogen and progestin.</p> <p>Hormones are slowly absorbed and released in the bloodstream causing inhibition of ovulation.</p>	<p>Describe the contraceptive patch as presented on the slide.</p>
<p>Mechanism of Action</p> <ul style="list-style-type: none"> • Inhibits ovulation • Thickens the cervical mucus 	<p>Describe the mechanism of action as presented on the slide.</p>
<p>ADVANTAGES AND DISADVANTAGES</p> <p>Advantages</p> <ul style="list-style-type: none"> • Effective (99%) • No daily pill intake • Regulates menstrual flow • Can be stopped at any time by the client • Does not interrupt sex • Increased sexual enjoyment • Convenient and simple to use • Safe <p>Disadvantages</p> <ul style="list-style-type: none"> • May be less effective in women with body weight greater than 90 kg • Affects quantity and quality of breastmilk • Has to replace patch weekly • Does not protect against sexually-transmitted infections • Increased risk to users over 35 years old who smoke and have other health problems 	<p>Present the advantages and disadvantages of the patch as presented on the slides. Ask participants for additional responses to these topics.</p>
<p>Possible Side Effects</p> <p>Possible Side Effects</p> <ul style="list-style-type: none"> • Skin irritation or rashes at the site of the patch • Headache • Menstrual bleeding irregularities • Nausea • Breast tenderness 	<p>Explain that:</p> <ul style="list-style-type: none"> • Side effects are not diseases/illnesses and will resolve spontaneously, thus, will not require medical management. • Not all users of the method will experience side effects. <p>Present the possible side effects of the patch as presented on slides. Encourage participants to ask questions of clarification or share insights.</p>

Topics/Contents	Teaching-Learning Process
<p data-bbox="236 241 395 268">Who Cannot Use</p> <ul data-bbox="288 322 734 656" style="list-style-type: none"> • Pregnant • Smoking and are 35 years old or over • Thirty-five years old or over and stopped smoking less than a year ago • Breastfeeding • Overweight • History of current thrombosis • History or current heart disease 	<p data-bbox="837 248 1109 282">Tell participants that:</p> <ul data-bbox="837 327 1417 618" style="list-style-type: none"> • The WHO MEC is useful in identifying conditions of clients which may or may not use the method. • The patch, as a newly-accepted method, is not included in the WHO MEC. However, the recommendations made for the COCs will apply due to the composition of the patch.
<p data-bbox="236 741 352 768">How to Start</p> <p data-bbox="215 842 718 864">Having menses or switching from non-hormonal methods or POP</p> <ul data-bbox="215 864 794 954" style="list-style-type: none"> ✓ Any day within the first five days of the menstrual cycle ✓ Any time it is reasonably certain that she is not pregnant. If more than five days since menses started, she can start using the patch but should avoid unprotected sex for the next seven days. Condom use is advisable. <p data-bbox="215 976 421 999">Switching from injectables</p> <ul data-bbox="215 999 791 1043" style="list-style-type: none"> ✓ Immediately, if it is reasonably certain she is not pregnant. No need to wait for menses. 	<p data-bbox="849 741 1414 808">Present the information on slides on how to start the patch.</p>
<p data-bbox="236 1149 352 1176">How to Start</p> <p data-bbox="215 1240 600 1263">After childbirth, breastfeeding, and no menses yet</p> <ul data-bbox="215 1263 735 1285" style="list-style-type: none"> ✓ After she stops breastfeeding or at six months (whichever comes first) <p data-bbox="215 1308 480 1330">After childbirth, not breast feeding</p> <ul data-bbox="215 1330 794 1442" style="list-style-type: none"> ✓ Within three weeks after childbirth. No need to wait for resumption of menses. ✓ After three weeks, any time it is reasonably certain that she is not pregnant. She will need to abstain from sex or use extra protection for seven days. ✓ If not reasonably sure she is not pregnant, wait for menses before using the patch. 	<p data-bbox="853 1149 1409 1216">Encourage participants to ask questions or share insights.</p>
<p data-bbox="236 1666 344 1693">How to Use</p> <p data-bbox="215 1798 312 1821">Patch cycle:</p> <p data-bbox="215 1843 766 1888">Apply a new patch once a week, every week, for three weeks (21 days). Stop for seven days (patch-free days).</p>	<p data-bbox="842 1666 1114 1700">Tell participants that:</p> <ul data-bbox="938 1704 1417 1850" style="list-style-type: none"> • The effectiveness of the method depends on its correct use. • The following slides provide information on how to use the patch. <p data-bbox="842 1890 1385 1957">Present the instructions on patch use and changing as presented on slides.</p>

Topics/Contents	Teaching-Learning Process														
<p>Missed Patch Changes</p> <p>Forgot to change at the beginning of a monthly cycle:</p> <ul style="list-style-type: none"> • Apply one as soon as remembered and record this as your first patch day. • Use back-up method for the next seven days. <p>Forgot to change one or two days in the middle of the cycle:</p> <ul style="list-style-type: none"> • Change patch as soon as remembered. • Back-up method is not needed. <p>Forgot to change by more than two days in the middle of the cycle:</p> <ul style="list-style-type: none"> • Put on a new patch as soon as possible. Begin a new four-week patch cycle. • Record the day and use back-up method for the next seven days. <p>Forgot to remove 3rd patch:</p> <ul style="list-style-type: none"> • Remove as soon as remembered. • No need to change patch change day or use back-up contraception. 	<p>Tell participants what to do for missed patch changes as presented on the slides.</p>														
<p>Warning Signs</p> <p>Warning Signs</p> <table border="1" data-bbox="264 786 655 1012"> <thead> <tr> <th colspan="2">J-A-C-H-E-S</th> </tr> </thead> <tbody> <tr> <td>J</td> <td>Jaundice</td> </tr> <tr> <td>A</td> <td>Abdominal pain, severe</td> </tr> <tr> <td>C</td> <td>Chest pain, shortness of breath</td> </tr> <tr> <td>H</td> <td>Headache, severe</td> </tr> <tr> <td>E</td> <td>Eye problems, brief loss of vision, seeing flashes of light or zigzag lines</td> </tr> <tr> <td>S</td> <td>Severe leg pains</td> </tr> </tbody> </table> <p>SEEK IMMEDIATE CONSULTATION</p>	J-A-C-H-E-S		J	Jaundice	A	Abdominal pain, severe	C	Chest pain, shortness of breath	H	Headache, severe	E	Eye problems, brief loss of vision, seeing flashes of light or zigzag lines	S	Severe leg pains	<p>Tell participants that the “warning” signs of the patch are the same as that of the COCs.</p> <p>Review with participants the “warning” signs.</p>
J-A-C-H-E-S															
J	Jaundice														
A	Abdominal pain, severe														
C	Chest pain, shortness of breath														
H	Headache, severe														
E	Eye problems, brief loss of vision, seeing flashes of light or zigzag lines														
S	Severe leg pains														
<p>The Combined Injectable</p> <p>The Combined Injectable</p> 	<p>Tell participants that:</p> <ul style="list-style-type: none"> • The combined injectable is another form of the combined contraceptive. 														
<p>Description</p> <ul style="list-style-type: none"> • The combined injectable (CIC) is a contraceptive containing a combination of estrogen and progestin in an injectable form. • The currently available CIC in the country contains: Norethisterone 50 mg Estradiol valerate 5 mg 	<p>Describe the combined injectable as presented on the slide.</p> <p>Tell participants that:</p> <ul style="list-style-type: none"> • Since the CIC is a combined contraceptive, its features are very much similar to that of the low dose COC. • Norifam is the brand that is available in the country, which is a combination of a natural estrogen and progestin. 														

Topics/Contents	Teaching-Learning Process
<p data-bbox="221 199 421 224">Mechanism of Action</p> <ul style="list-style-type: none"> <li data-bbox="242 365 405 385">• Inhibition of ovulation <li data-bbox="242 412 488 432">• Thickening of the cervical mucus <p data-bbox="242 461 767 481">Contraceptive effect is similar to that achieved by daily intake of the COC.</p>	<p data-bbox="847 221 1425 286">State the mechanism of action of the CIC as presented on the slide.</p>
<p data-bbox="403 734 600 772" style="text-align: center;">Group Work</p>	<p data-bbox="847 683 1425 790">Divide participants into two groups (four groups if there are more participants. there should not be more than five per group).</p> <p data-bbox="847 835 1425 943">One or two groups will work on the advantages of the CIC. The other group(s) will work on the disadvantages.</p> <p data-bbox="847 987 1425 1052">Each group discusses and lists their assigned topic.</p> <p data-bbox="847 1097 1425 1240">Instruct each group to assign a recorder to write down the items as discussed and a reporter to report the group's output during plenary.</p> <p data-bbox="847 1285 1425 1350">Plenary: Each group presents their output.</p> <p data-bbox="847 1395 1425 1460">Group(s) working on the advantages must have as additional inputs:</p> <ul style="list-style-type: none"> <li data-bbox="847 1471 1425 1536">• do not require daily action (no need to take a pill everyday) <li data-bbox="847 1547 954 1568">• private <li data-bbox="847 1579 1425 1610">• more regular monthly bleeding than DMPA <p data-bbox="847 1657 1425 1722">Group(s) working on the disadvantages must have the following additional inputs:</p> <ul style="list-style-type: none"> <li data-bbox="847 1733 1262 1765">• requires injection every month <li data-bbox="847 1776 1425 1877">• delayed return to fertility after the woman stops the method (average of one month longer than with the COCs) <li data-bbox="847 1888 1425 1919">• Does not protect against STIs, including HIV <p data-bbox="847 1964 1425 2029">Other groups should provide additional insights and ask questions for clarification.</p>

Topics/Contents

Teaching-Learning Process

Effectiveness

- Effectiveness in preventing pregnancy in the first year of use:
 - ✓ Correct use (no missed or late injections): 99%
 - ✓ Typical use (some missed or late injections): 97%

State the effectiveness of the CIC as presented on the slide.

Possible Side Effects

- Changes in monthly bleeding:
 - ✓ Lighter and fewer days of bleeding
 - ✓ Irregular
 - ✓ Infrequent or prolonged bleeding
 - ✓ No monthly bleeding
- Headaches
- Dizziness
- Breast tenderness

State the possible side effects of the CIC as presented on the slide.

Who Cannot Use

- Women with the following conditions are advised not to use the CIC:
 - ✓ Pregnancy
 - ✓ Breastfeeding an infant < six months old
 - ✓ Smoke cigarettes and > 35 years old
 - ✓ Hypertension
 - ✓ Migraine headaches
 - ✓ Breast cancer
 - ✓ Undiagnosed abnormal vaginal bleeding

Tell participants that:

- The WHO MEC is useful in identifying conditions of clients which may or may not use the method.
- The following are the more common conditions for which the CIC is not recommended.

How to Use

- **Schedule**
 - ✓ First injection is given on the first day of the menstrual cycle.
 - ✓ Succeeding injections are given every 30+/- 3 days
- **Administering the injection**
 - ✓ Follow infection prevention guidelines
 - ✓ Slow deep intramuscular injection preferably intragluteal or alternatively on the upper arm
 - ✓ Place plaster over the injection site after injection to prevent reflux of the solution

Present how to provide the CIC as written on the slide.

Topics/Contents	Teaching-Learning Process
<p>Client Instruction</p> <ul style="list-style-type: none"> • What to expect <ul style="list-style-type: none"> ✓ Vaginal bleeding episode is expected within one or two weeks after the first injection. This is normal. ✓ With continued use, bleeding episodes will occur at a 30-day interval. ✓ Visit the clinic if no bleeding occurs within 30 days after an injection to rule out pregnancy. • Follow-Up <ul style="list-style-type: none"> ✓ Return to the clinic every 30 days for the next injection. ✓ If injection has not been given after 30 days, abstain from sexual intercourse or use condom until the next injection. ✓ Come back to the clinic no matter how late you are for the next injection. You may still be able to use the injectable. • Return to the clinic at any time if: <ul style="list-style-type: none"> ✓ You develop any of the “warning signs”. ✓ You have any questions or problems. ✓ You think you are pregnant. 	<p>Present the client instructions as presented on the slides.</p>
<p>Warning Signs</p> <div style="border: 1px solid black; padding: 10px; margin: 10px 0;"> <p style="text-align: center;">J-A-C-H-E-S</p> <p>J Jaundice</p> <p>A Abdominal pain, severe</p> <p>C Chest pain, shortness of breath</p> <p>H Headache, severe</p> <p>E Eye problems, brief loss of vision, seeing flashes of light or zigzag lines</p> <p>S Severe leg pains</p> </div> <p style="text-align: center; background-color: #008000; color: white; padding: 5px;">SEEK IMMEDIATE CONSULTATION</p>	<p>Tell participants that the “warning” signs of the CIC are the same as that of the COCs.</p>



NARRATIVE

MODULE 6: HORMONAL CONTRACEPTIVE METHODS SESSION 2: OTHER COMBINED CONTRACEPTIVES

CONTRACEPTIVE PATCH



DESCRIPTION

The contraceptive patch is a form of contraceptive applied to the skin. It contains estrogen and progestin similar to the natural hormones in a woman's body and released slowly in the bloodstream.

MECHANISM OF ACTION

The contraceptive patch works by:

- inhibiting ovulation
- thickening of the cervical mucus

ADVANTAGES

Advantages include the following:

- effective (99%)
- no daily pill intake
- regulates menstrual flow such that monthly cycles are regular, lighter, with fewer days of bleeding
- can be stopped at any time by the client
- does not interrupt sex
- increased sexual enjoyment as there is no need to worry about getting pregnant
- convenient and simple to use
- safe
- Has significant non-contraceptive benefits similar to COCs
 - ✓ Monthly periods regular and predictable
 - ✓ Reduces symptoms of gynecologic conditions such as painful menses and endometriosis
 - ✓ Reduces the risk for ovarian and endometrial cancer
 - ✓ Decreases risk of iron-deficiency anemia
 - ✓ Can be used at any age from adolescence to menopause

DISADVANTAGES

There are disadvantages with the use of the contraceptive patch. These are:

- may be less effective in women with body weight greater than 90 kg
- affects quantity and quality of breastmilk
- has to replace patch weekly
- does not protect against sexually-transmitted infections
- Increased risk to users over 35 years old who smoke and have other health problems

WHO CANNOT USE THE PATCH

Women with the following conditions may not use the patch:

- pregnant
- smoking and are 35 years old or over
- 35 years old or over and stopped smoking less than a year ago
- breastfeeding
- overweight
- history of thrombosis
- heart disease

Being a combined contraceptive like the COC, the eligibility for use is the same as that of the COC.

POSSIBLE SIDE EFFECTS

There may be side effects with the use of the contraceptive patch. These are not signs of illness and not all women will experience them. These include:

- skin irritation or rashes at the site of the patch
- headache
- menstrual bleeding irregularities
- fluid retention
- nausea
- breast tenderness

HOW TO START

SITUATIONS	WHEN TO START
Having menses	<ul style="list-style-type: none">• Any day within the first five days of the menstrual cycle (first day is preferable).• Any time it is reasonably certain that she is not pregnant. If more than five days since menstrual bleeding started, she can start using the patch but should avoid unprotected sex for the next seven days. Condom use is advisable at this time.
Switching from non-hormonal methods or progestin-only pills	<ul style="list-style-type: none">• Same rule as for women having menses (see rule number 1).

- Disposing of the patch: used patches should be placed in the disposal sachet provided and put in a waste bin. They must not be flushed down the toilet.

MISSED PATCH CHANGES

Forgot to change the patch at the beginning of a monthly cycle: apply one as soon as remembered. Record this day of the week as the new patch change day and use a back-up method of birth control for the next seven days.

Forgot to change the patch by one or two days in the middle of a monthly cycle: change your patch as soon as you remember. Keep the same patch change day. A back-up method is not required.

Forgot to change the patch by more than two days in the middle of a cycle: put on a new patch as soon as possible. Begin a new four-week patch cycle with this patch. Record the day of the week and use a back-up method of birth control for the next seven days.

Forgot to remove the third patch in the cycle: remove it as soon as remembered. Apply a new patch as scheduled. No need to change the regular patch change day or use back up contraception.

WARNING SIGNS

The contraceptive patch has the following warning signs similar to the COCs. The client is advised to immediately return to the clinic or consult a physician when any of the following occurs:

- J** - Jaundice
- A** - Abdominal pain (severe)
- C** - Chest pain
- H** - Headaches (severe)
- E** - Eye problems such as brief loss of vision, seeing flashes of light or zigzag lines
- S** - Severe leg pains

The above signs may not be due to contraceptive use.

6.34

COMBINED INJECTABLE

Description

The combined injectable is a contraceptive containing estrogen and progestin in an injectable form.

The currently available combined injectable in the country contains Norethisterone 50 mg and Estradiol Valerate 5 mg in oily solution.

Mechanism of Action

The contraceptive effect is primarily on ovulation inhibition and thickening of the cervical mucus.

The contraceptive effect is similar to that achieved by daily intake of the COC.

Advantages

Advantages are similar to that of the COC with the following additional benefits:

- Does not require daily action. No need to take a pill daily.
- Private. No one else can tell that the woman is using a contraceptive.
- More regular monthly bleeding as compared to DMPA.

Disadvantages

- Requires injection every month.
- Delayed return to fertility after the woman stops the method. It takes an average of about one month longer than with the COC.
- Does not protect against sexually transmitted infections (STIs), including HIV.

Effectiveness

Effectiveness in preventing pregnancy in the first year of use is:

- Correct use (no missed or late injections): 99%
- Typical use (some missed or late injections): 97%

Possible Side Effects

- Changes in monthly bleeding, which lessen within three months of starting injections include:
 - ✓ Lighter and fewer days of bleeding
 - ✓ Irregular
 - ✓ Infrequent or prolonged bleeding
 - ✓ No monthly bleeding
- Headaches
- Dizziness
- Breast tenderness

Who Cannot Use

Women with the following conditions are advised not to use the CIC:

- Pregnancy
- Breastfeeding an infant that is less than six months old
- Smoke cigarettes and are 35 years old or older
- Hypertension
- Migraine headaches
- Serious diseases of the liver, heart, or blood vessels
- Breast cancer
- Undiagnosed abnormal vaginal bleeding

How to Use

- First injection is given on the first day of the menstrual cycle.
- Succeeding injections are given every 30 +/- 3 days.
- The injectable must be stored at controlled room temperature (15-30°C). Do not freeze.

- Administration:
 - ✓ Follow infection prevention measures for administering injections.
 - ✓ Slow deep intramuscular injection preferably intragluteal, alternatively into the upper arm.
 - ✓ Place a plaster over the injection site after injection to prevent any reflux of the solution.

- Client instructions
 - ✓ What to expect:

Vaginal bleeding episode will occur within one or two weeks after the first injection. This is normal and if use is continued, bleeding episodes will occur at a 30-day interval. Pregnancy should be ruled out if no withdrawal bleeding occurs within 30 days after an injection.
 - ✓ Follow-up
 - Return to the clinic every 30 days for your next injection. Try to come on time.
 - If, for some reason, the next injection was not given after 30 days, abstain from sexual intercourse or use a condom until you get the next injection.
 - Come back to the clinic no matter how late you are. You may still be able to use the injectable.
 - Return to the clinic at any time if:
 - s You develop any of the warning signs.
 - s You have any questions or problems.
 - s You think you are pregnant.

Warning Signs

The combined injectable contraceptive has the following warning signs similar to the COCs. The client is advised to immediately return to the clinic or consult a physician when any of the following occurs:

- J** - Jaundice
- A** - Abdominal pain (severe)
- C** - Chest pain
- H** - Headaches (severe)
- E** - Eye problems such as brief loss of vision in one eye, seeing flashes of light or zigzag lines
- S** - Severe leg pains

PROGESTIN ONLY PILLS (POPs)

LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Describe the POPs and commonly available preparations.
2. Relate the mechanism of action of the POP with the menstrual cycle.
3. State the effectiveness of the POP.
4. Enumerate the advantages and disadvantages of the POP.
5. Enumerate the possible side effects of the POP.
6. Explain the management of the possible side effects of the POP.
7. Identify conditions suitable for POPs based on the WHO MEC and checklist.
8. Explain the guidelines in providing the POPs including follow-up visits.
9. Correct myths and misconceptions.



METHODOLOGY

Illustrated Lecture-Discussion
Brainstorming



TIME ALLOTMENT

30 minutes






ADVANCE PREPARATION OF MATERIALS


Equipment:

- LCD or overhead projector
- Laptop computer (if using LCD)
- Whiteboard

Materials:

- Powerpoint presentation of Module 5
- Flipchart
- Manila paper
- Permanent markers, whiteboard markers
- Metacards, tape
- Handouts

Topics/Contents	Teaching-Learning Process
 <p>SESSION 3</p>  <p>PROGESTIN-ONLY PILLS (POPs)</p>	<p>Greet participants.</p> <p>Introduce the session by telling participants that:</p> <ul style="list-style-type: none"> • This session focuses on POPs as an alternative oral hormonal contraceptive. • POPs do not contain estrogen and are appropriate for breastfeeding women who prefer to use hormonal contraceptives.
<p> Learning Objectives</p> <ul style="list-style-type: none"> • Describe POPs and commonly available preparations. • Relate the mechanism of action of the POP with the menstrual cycle. • Enumerate the advantages and disadvantages of the POP. • Enumerate the possible side effects of the POP. • Explain the management of the possible side effects of the POP. • Identify conditions suitable for POPs based on the WHO MEC and checklist. • Identify conditions suitable for POPs based on the WHO MEC and checklist. • Explain the guidelines in providing the POPs including follow-up visits. • Correct myths and misconceptions. 	<p>State the objectives of the session as written on the slide.</p>
<p>What do you know about POPs???</p>	<p>Ask participants to write on metacards what they know or heard about the POPs. Write one idea for each metacard.</p> <p>Post metacards on the board/wall.</p> <p>Tell participants that at the end of the session, all of these information will be discussed.</p>
<p>Description</p> <p>Contains a small amount of only one kind of hormone (progestin)</p> <p>Does not contain estrogen</p>	<p>Describe the POP, including its types, as presented on the slides.</p>

Topics/Contents	Teaching-Learning Process
<p>Kinds of POPs Available</p> <p>Kinds of POPs Available</p> <p>.5 mg lynestrenol 75 ug desogestrol</p> <p>Both are available in a 28-tablet package.</p> 	<p>Greet participants.</p> <p>Introduce the session by telling participants that:</p> <ul style="list-style-type: none"> • This session focuses on POPs as an alternative oral hormonal contraceptive. • POPs do not contain estrogen and are appropriate for breastfeeding women who prefer to use hormonal contraceptives.
<p>Mechanism of Action</p> <p>Mechanism of Action</p> <ul style="list-style-type: none"> • Causes thickening of the cervical mucus, which makes it more difficult for sperm to pass through • Prevents ovulation in about half of menstrual cycles 	<p>Describe the mechanism of action as presented on the slide.</p> <p>Relate the mechanism of action to the menstrual cycle by asking participants:</p> <ul style="list-style-type: none"> • How does the POP act as a contraceptive? <p>Correct explanation is:</p> <ul style="list-style-type: none"> • Progestin, which is similar to progesterone causes thickening of the cervical mucus. • Due to the sustained high levels of progestin (as an effect of taking the POP), FSH secretion does not happen. • No FSH secretion means no follicles in the ovary are maturing. • There will be no matured ovum for ovulation. <p>Emphasize that POPs do not disrupt pregnancy.</p>
<p>Effectiveness</p> <p>Effectiveness</p> <ul style="list-style-type: none"> • For breastfeeding women, POPs are very effective: 99% when typically used, 99.5% when perfectly used. • POPs are less effective for women not breastfeeding. <p>(Source: Family Planning, A Global Handbook for Providers, 2007)</p>	<p>State the effectiveness of the POP as presented on the slide. Encourage participants to ask questions for clarification or share insights.</p>

Topics/Contents

Teaching-Learning Process

Advantages and Disadvantages

Ask participants what they think are the advantages of the POPs.

Responses should include but not be limited to:


- Can be used by nursing mothers starting at six weeks after childbirth. Quality and quantity of breast milk not affected; can be very effective during breastfeeding.
- No estrogen side effects.
- Women take one pill every day with no break. Easier to understand than taking 21-day combined pills.
- Lesser risk of progestin-related side effects, such as acne and weight gain, than with low-dose combined oral contraceptives.
- May help prevent:
 - ✓ Benign breast disease
 - ✓ Endometrial and ovarian cancer
 - ✓ Pelvic inflammatory disease

Ask participants what they think are the disadvantages of the POPs.

Responses should include but not be limited to:

- Experience changes in menstrual bleeding: irregular periods, spotting or bleeding between periods (common), amenorrhea possibly for several months (less common), prolonged or heavy menstrual bleeding.
- Less common: headache and breast tenderness
- For women who are not breastfeeding, taking the pill more than three hours late increases the risk of pregnancy. Missing two or more pills increases the risk greatly.
- Offers no protection against STIs/HIV.
- Effectiveness may be lowered when certain drugs for epilepsy (phenytoin and barbiturates) or tuberculosis (rifampicin) are taken.

Topics/Contents	Teaching-Learning Process										
<p>Possible Side Effects</p> <p>Possible Side Effects</p> <ul style="list-style-type: none"> • Common <ul style="list-style-type: none"> ✓ Changes in menstrual bleeding: irregular periods, inter-menstrual bleeding and spotting • Less common <ul style="list-style-type: none"> ✓ Amenorrhea for several months ✓ Prolonged or heavy menstrual periods ✓ Breast tenderness ✓ Headache 	<p>State the possible side effects of the POPs. Encourage participants to ask questions for clarification or share insights.</p>										
<p>Management of Side Effects</p> <p>Management of Side Effects</p> <p>Possible Side Effects</p> <ol style="list-style-type: none"> 1. Amenorrhea (No monthly bleeding) <ul style="list-style-type: none"> • Reassure that this is normal for breastfeeding women. It is not harmful. • For non-breastfeeding women, reassure that some women using POPs stop having monthly bleedings, but this is not harmful. 2. Irregular bleeding (bleeding at unexpected times that bothers the client) <ul style="list-style-type: none"> • Reassure that many women using POPs experience irregular bleeding, whether breastfeeding or not. • To reduce bleeding, teach her to make up for missed pills properly. • Consider other underlying conditions unrelated to method use and refer appropriately. 3. Ordinary headaches <ul style="list-style-type: none"> • Suggest pain relievers (Paracetamol, Aspirin, Ibuprofen). • If getting worse or occurs more often during POP use, warrants evaluation. 4. Nausea or dizziness <ul style="list-style-type: none"> • Suggest taking POPs at bedtime or with food. 	<p>Describe the management of side effects as presented on the slides.</p>										
<p style="text-align: center;">Who can use POPs</p> <p>Simplified MEC Categories for Temporary Methods including POPs</p> <table border="1" data-bbox="263 1711 746 2040"> <thead> <tr> <th>CATEGORY</th> <th>ELIGIBILITY CRITERIA</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Can use the method under any circumstance</td> </tr> <tr> <td>2</td> <td>Generally can use the method, advantages generally outweigh theoretical or proven risks</td> </tr> <tr> <td>3</td> <td>Should not use the method, unless other, more appropriate methods are not available or acceptable</td> </tr> <tr> <td>4</td> <td>Should not use the method, condition represents unacceptable health risk if method is used</td> </tr> </tbody> </table>	CATEGORY	ELIGIBILITY CRITERIA	1	Can use the method under any circumstance	2	Generally can use the method, advantages generally outweigh theoretical or proven risks	3	Should not use the method, unless other, more appropriate methods are not available or acceptable	4	Should not use the method, condition represents unacceptable health risk if method is used	<p>Review the WHO MEC with participants.</p> <p>State conditions and ask participants at random on the WHO category and whether the POP can be used, given the condition.</p> <p>Encourage participants to use the WHO MEC wheel or the WHO MEC Summary Table (whichever is available).</p> <p>Choose from conditions below.</p> <p>Category 1: Use the method without restriction</p> <p>POPs can be used by women in any of the following circumstances:</p> <ul style="list-style-type: none"> • Breastfeeding six weeks after childbirth • Smoke cigarettes • Have no children • Adolescents and over 40 years old • Have just had an abortion or miscarriage
CATEGORY	ELIGIBILITY CRITERIA										
1	Can use the method under any circumstance										
2	Generally can use the method, advantages generally outweigh theoretical or proven risks										
3	Should not use the method, unless other, more appropriate methods are not available or acceptable										
4	Should not use the method, condition represents unacceptable health risk if method is used										

Topics/Contents	Teaching-Learning Process
<p data-bbox="185 248 228 271">MEC</p> 	<ul style="list-style-type: none"> • Have breast disease • Experiencing heavy painful menstruation, irregular periods • Have thyroid diseases • Have benign ovarian tumors, uterine fibroids • Have valvular heart disease • Suffering from STIs and PID <p data-bbox="785 568 1329 636">Category 2: Generally use the method but with more than the usual follow-up</p> <ul style="list-style-type: none"> • Current history of ischaemic heart disease or stroke (if either develops during POP use, it becomes Category 3) • History of hypertension where blood pressure cannot be evaluated • Elevated blood pressure (systolic >160 or diastolic >100 mmHg) • Hypertension with vascular disease • Diabetes with or without complications • History of DVT/PE • Major surgery with prolonged immobilization • Mild compensated cirrhosis • Gall bladder disease • Undiagnosed breast mass • Previous ectopic pregnancy • Known hyperlipidemia • Irregular, heavy, or prolonged vaginal bleeding or unexpected vaginal bleeding • Treatment with griseofulvin • Antiretroviral therapy <p data-bbox="785 1576 1357 1688">Category 3: Do not use the method unless no other appropriate method is available under close supervision</p> <ul style="list-style-type: none"> • Current DVT/PE • Active viral hepatitis • Liver tumor (benign or malignant) • Severe decompensated cirrhosis • History of breast cancer with no evidence of disease for the last five years • Breastfeeding and less than six weeks postpartum

Topics/Contents

Medical Eligibility Checklist for Combined Oral Contraceptives (COCs)

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use combined oral contraceptives (COCs). If she answers YES to a question below, follow the instructions. No conditions restrict use of these methods, but some conditions can make them harder to use effectively.

- Do you smoke cigarettes and are you 35 or older?
 No YES
 Urge her to stop smoking. If she is 35 or older and will not stop smoking, do not provide COCs. Help her to choose a method without estrogen.
 - Do you have high blood pressure?
 No YES
 If you cannot check blood pressure (BP) and she reports high BP, do not provide COCs. Refer for BP check if possible or help her choose a method without estrogen. If there is no report of high BP, it is okay to provide COCs.
- Check if feasible:**
 If BP is below 140/90, it is okay to give COCs without further BP readings. If systolic BP is 140 or higher or diastolic BP is 90 or higher, do not provide COCs. Help her choose another method. (One BP reading in the range of 140-159/90-99 is not enough to diagnose high BP. Offer condoms or spermicide for use until she can return for another BP check, or help her choose another method if she prefers. If BP reading at next check is below 140/90, she can use COCs and further BP readings are not necessary.) If systolic BP is below 160 or higher or diastolic BP is 100 or higher, she also should not use DMPA or NET-EN.
- Are you breastfeeding a baby less than 6 months old?
 No YES
 Can provide COCs now with instruction to start when she stops breastfeeding or 6 months after childbirth – whichever comes first. If she is not fully or almost fully breastfeeding, also give her condoms or spermicide to use until her baby is 6 months old. Other effective methods are better choices than COCs when a woman is breastfeeding whatever her baby's age.
 - Do you have serious problems with your heart or blood vessels? Have you ever had such problems? If so, what problems?
 No YES
 Do not provide COCs if she reports heart attack or heart disease due to blocked arteries, stroke, blood clots (except superficial clots), severe chest pain with unusual shortness of breath, diabetes for more than 20 years, or damage to vision, kidneys, or nervous system caused by diabetes. Help her choose another effective method.
 - Do you have or have you ever had breast cancer?
 No YES
 Do not provide COCs. Help her choose a method without hormones.
 - Do you have jaundice, cirrhosis of the liver, a liver infection or tumor? (Are her eyes or skin unusually yellow?)
 No YES
 Perform physical exam or refer. If she has serious active liver disease (jaundice, painful or enlarged liver, active viral hepatitis, liver tumor), do not provide COCs. Refer for care as appropriate. Help her choose a method without hormones.
 - Do you often get severe headaches, perhaps on one side or pulsating, that cause nausea and are made worse by light and noise or moving about (migraine headaches)?
 No YES
 If she is 35 or older, do not provide COCs. Help her choose another method. If she is under age 35, but her vision is distorted or she has trouble speaking or moving before or during these headaches, do not use COCs. Help her choose another method. If she is under age 35 and has migraine headaches without distortion of vision or trouble or moving, she can use COCs.
 - Are you taking medicines for seizures? Are you taking rifampin (rifampicin) or griseofulvin?
 No YES
 Taking phenytoin, carbamazepine, barbiturates, or primidone for seizures or rifampin or griseofulvin, provide condoms or spermicide to use along with COCs or, if she prefers, help her choose another effective method if she is on long-term treatment.
 - Do you think you are pregnant?
 No YES
 Assess whether pregnant (see How to tell if a woman is not pregnant). If she might be pregnant, also give her condoms or spermicide to use until it is reasonably certain that she is not pregnant. Then she can start COCs.
 - Do you have gall bladder disease? Ever had jaundice while taking COCs? Planning surgery that will keep you from walking for a week or more? Had a baby in the past 21 days?
 No YES
 If she has gall bladder disease now or takes medicine for gall bladder disease, or if she has had jaundice while using COCs, do not provide COCs. Help her choose a method without estrogen. If she is planning surgery or she just had a baby, can provide COCs with instruction on when to start them later.

Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.

Teaching-Learning Process

- Migraine with an aura or development of migraine without an aura at any age that develops during POP use
- Drug treatment affecting liver enzymes: rifampicin and certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidine, topiramate, oxcarbazepine)

Category 4: Do not use the method

- Breast cancer within the past five years

Provide participants with a copy of the Medical Eligibility Checklist for Progestin-Only Pills (POPs).

Review the content of the checklist with participants, including the steps when the client answers “yes” to any of the questions.

Starting use of the POP

Menstruating

- Start within the first five days of menstrual cycle, preferably on the first day
 - At any time during the menstrual cycle, if reasonably sure that the woman is not pregnant
- If not within the first five days of the menstrual cycle = abstain from sex or use a back-up method for the next two days

Postpartum

- If breastfeeding, start after six weeks postpartum
- If not breastfeeding, can start immediately or at any time within the six weeks postpartum.

Present the information on how to start the POP as presented on the slide. Encourage participants to ask questions for clarification or share insights.

Topics/Contents	Teaching-Learning Process
<p>Taking the POP</p> <ul style="list-style-type: none"> • Take one pill each day at the same time until the packet is finished. • Start a new packet the day after she finishes the previous packet without break. • No pill-free days. 	<p>Present the information on what to do for missed pills as presented on the slides. Encourage participants to ask questions for clarification or share insights.</p>
<p>Missed Pills</p> <ul style="list-style-type: none"> • If client missed taking the pills by more than three hours: abstain from sexual intercourse or use a back-up method during the next 48 hours after re-starting the pills. • If client is breastfeeding and amenorrheic and missed pills more than three hours: take one pill as soon as possible and continue taking pills as usual. • If client is still covered by LAM: no back-up is needed. 	<p>Present the information on how to start the POP as presented on the slide. Encourage participants to ask questions for clarification or share insights.</p>
<p>Follow-Up</p>	<p>Ask participants:</p> <ul style="list-style-type: none"> • When should a client using POPs come for follow up? <p>Write responses on the board.</p> <p>Present the slide. Acknowledge responses given by participants earlier. Add those that are not in the slides, as appropriate.</p>
<p>Reasons for Follow-Up</p> <ul style="list-style-type: none"> • For questions or problems • For warning signs of possible complications <ul style="list-style-type: none"> ◦ Extremely heavy bleeding (twice as much and/or twice as long previous menses) ◦ Headaches that start or become worse after she started POP ◦ Skin or eyes becoming yellow ◦ Abdominal pain, tenderness or fainting ◦ Symptoms of pregnancy 	

Topics/Contents	Teaching-Learning Process
<p style="text-align: center;">Correcting Myths and Misconceptions</p>	<p>Review with participants the metacards containing the information on what they know about the POPs.</p> <p>For each information, ask participants whether this is a fact or a misconception. For the misconceptions, ask participants for the correct information based on what they have learned on the POPs.</p> <p>Below are some responses to possible misconceptions on the POP:</p> <ul style="list-style-type: none"> • POPs do not affect milk production. • POPs do not cause birth defects and will not otherwise harm the fetus if a woman becomes pregnant while taking POPs or accidentally takes POPs when she is already pregnant. • Women who stop using POPs can become pregnant as quickly as women who stop non-hormonal methods. • POPs do not cause cancer. • POPs do not affect the woman’s sexual behavior nor cause mood change. • POPs reduce the risk of ectopic pregnancy.
<p style="text-align: center;">SUMMARY</p>	<p>Present the session objectives and ask questions based on these objectives.</p>



NARRATIVE

MODULE 6: HORMONAL CONTRACEPTIVE METHODS

SESSION 3: PROGESTIN-ONLY PILLS (POPs)

There are two kinds of POPs available:

1. 0.5 mg lynestrenol
2. 75 ug desogestrel

Both are available in a 28-tablet package.



MECHANISM OF ACTION

1. Prevents ovulation in about half of the menstrual cycle.
2. Causes thickening of the cervical mucus, which make it more difficult for sperm to pass through.

EFFECTIVENESS

For breastfeeding women, POPs are very effective:

99% for typical use

99.5% for perfect use

POPs are less effective for women not breastfeeding.

It is particularly important that POPs be taken at the same time every day. When taken even a few hours late, they lose their effectiveness.

ADVANTAGES

- Can be used by nursing mothers starting at six weeks after childbirth. Quality and quantity of breastmilk not affected.
- No estrogen side effects.
- Women take one pill every day with no break. Easier to understand than taking 21- day combined pills.
- Can be very effective during breastfeeding.
- Lesser risk of progestin-related side effects, such as acne and weight gain, than with low-dose combined oral contraceptives.
- May help prevent:
 - Benign breast disease
 - Endometrial and ovarian cancer
 - Pelvic inflammatory disease

DISADVANTAGES

- Women who are not breastfeeding experience changes in menstrual bleeding. This includes irregular periods, spotting or bleeding between periods (common), and amenorrhea possibly for several months (less common). A few women may have prolonged or heavy menstrual bleeding.
- Less common side effects include headaches and breast tenderness.
- Must be taken at about the same time each day to be effective. For women who are not breastfeeding, taking a pill more than three hours late increases the risk of pregnancy and missing two or more pills increases the risk greatly.
- Does not protect against STIs/HIV.
- Effectiveness is lowered when certain drugs for epilepsy (phenytoin and barbiturates) or tuberculosis (rifampicin) are taken.

WHO CAN USE POPs

Category 1: Use the method without restriction

POPs can be used by women in any of the following circumstances:

- Breastfeeding six weeks after childbirth
- Smoke cigarettes
- Have no children
- Adolescents and women over 40 years old
- Have just had an abortion or miscarriage
- Have breast disease
- Experiencing heavy painful menstruation, irregular periods
- Have thyroid diseases
- Have benign ovarian tumors, uterine fibroids
- Have valvular heart disease
- Suffering from STIs and PID

Category 2: Generally use the method but with more than the usual follow-up

- Current history of ischaemic heart disease or stroke (if either develops during POP use, it becomes Category 3)
- History of hypertension where blood pressure cannot be evaluated
- Elevated blood pressure (systolic >160 or diastolic >100 mmHg)
- Hypertension with vascular disease
- Diabetes with or without complications
- History of DVT/PE
- Major surgery with prolonged immobilization
- Mild compensated cirrhosis
- Gall bladder disease
- Undiagnosed breast mass
- Previous ectopic pregnancy
- Known hyperlipidemia
- Irregular, heavy, or prolonged vaginal bleeding or unexpected vaginal bleeding
- Treatment with griseofulvin
- Antiretroviral therapy

WHO CANNOT USE THE METHOD

Category 3: Do not use the method

- Breast cancer within the past five years

Category 4: Do not use the method unless no other appropriate method is available under close supervision

- Current DVT/PE
- Active viral hepatitis
- Liver tumor (benign or malignant)
- Severe decompensated cirrhosis
- History of breast cancer with no evidence of disease for the last five years
- Breastfeeding and less than six weeks postpartum
- Migraine with an aura or development of migraine without an aura at any age that develops during POP use
- Drug treatment affecting liver enzymes: rifampicin and certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)

Management of Possible Side Effects

1. Amenorrhea (No monthly bleeding)

- Reassure that this is normal for breastfeeding women. It is not harmful.
- For non-breastfeeding women, reassure that some women using POPs stop having monthly bleeding and is not harmful. There is no need to lose blood monthly and woman is not fertile. Blood is not building up inside her (some women are happy to be free from monthly bleeding).

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

- Reassure that many women using POPs experience irregular bleeding, whether breastfeeding or not. It is not harmful and it lessens or stops after several months of use. However, other possible causes are vomiting/diarrhea and taking anticonvulsants or rifampicin.
- To reduce bleeding, teach her to make up for missed pills properly.
- Consider other underlying conditions unrelated to method use and refer appropriately

3. Ordinary headaches

- Suggest pain relievers (Paracetamol, Aspirin, Ibuprofen)
- Getting worse or occurring more often during POP use, warrants evaluation

4. Nausea or dizziness

- Suggest taking POPs at bedtime or with food

Starting POPs

Menstruating

- Start within the first five days of the menstrual cycle, preferably on the first day
- At any time during the menstrual cycle if reasonably sure that the woman is not pregnant
 - If not within the first five days of the menstrual cycle = abstain from sex or use a back-up method for the next two days

Postpartum

- If breastfeeding, start after six weeks postpartum
- If not breastfeeding, can start immediately or at any time within the six weeks postpartum

Instructions on Use

Once the client has chosen POPs as her preferred contraceptive method, the health provider should:

- Briefly explain how POPs work to prevent pregnancy.
- Show and let client handle a package of pills
 - Explain how to take the pills:
 - Take the first pill on the first day of your period or on any of the next four days.
 - Take one pill everyday, at the same time each day (e.g. between 6pm and 8pm- after an evening meal may be a good time to take the pills).
 - Take the pills non-stop, from one packet to another.
 - Do not miss a day.
 - Have a backup method of contraception (condoms) especially:
 - When you are waiting to start POPs
 - If you miss a pill, until you restart or until your next period
 - If you may be at risk of infection from STIs
- How to manage missed pills
 - Remember to emphasize the importance of not forgetting any pill, even just for a few hours.
 - Advise the client that if she misses one or more pills, she may have spotting or breakthrough bleeding. More importantly, she will be at a greater risk of becoming pregnant.
 - She needs to restart taking the pills as soon as possible.
 - If she missed taking the pills by more than three hours, advise her to abstain from sexual intercourse or use a barrier method of contraception during the first 48 hours after restarting the pills.
 - If the client is breastfeeding and amenorrheic and has missed one or more pills by more than three hours, she needs to take one pill as soon as possible and continue to take the pills as usual.
 - If she is less than six months postpartum, no additional contraceptive protection is needed.
- Keep track of your periods while you take POPs. If you have more than 45 days with no period, see your care provider for an examination and pregnancy test.
- If you have spotting or bleeding between periods, keep taking the pills on schedule. If your bleeding is very heavy, or if you have pain, fever or cramps, return to the clinic. In most cases, the bleeding is not serious and will stop in a few days. Bleeding is especially likely if you have missed a pill. Bleeding will be more common in the first months that you take the pill.

- If you decide to become pregnant, plan to stop your pills two months before you want to get pregnant and use another method like condoms. This gives time for your normal cycle to re-establish itself and makes it easier for your care provider to determine your pregnancy due date.

Guidelines and instructions for follow-up

- See your health care provider regularly for routine checkups. Feel free to come to the clinic if you have any questions.
- If you have any problems or questions you may come back to the clinic anytime.
- If you have any of the following symptoms or problems, come to the clinic:
 - Abdominal pain, tenderness, or fainting (this could be due to an ovarian cyst or ectopic pregnancy). Don't stop the pills, but come to the clinic right away.
 - Extremely heavy bleeding (twice as long or twice as much as usual).
 - Any very bad headaches (that start or become worse after taking POPs).
 - Skin or eyes become yellow.
 - If you think you might be pregnant.

Correct Myths and Misconceptions about POPs:

- POPs do not affect milk production.
- POPs do not cause birth defects and will not otherwise harm the fetus if a woman becomes pregnant while taking POPs or accidentally takes POPs when she is already pregnant.
- Women who stop using POPs can become pregnant as quickly as women who stop non-hormonal methods.
- POPs do not cause cancer.
- POPs do not affect women's sexual behavior nor cause mood changes.
- POPs reduce the risk of ectopic pregnancy.

PROGESTIN-ONLY INJECTABLES (POIs)

LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Describe the POIs and available preparations.
2. Relate the mechanism of action of the POI with the menstrual cycle.
3. Discuss the effectiveness of POIs.
4. Enumerate the advantages and disadvantages of DMPA.
5. Identify clients who can and cannot use the DMPA using the MEC wheel and checklist.
6. Enumerate the possible side effects of the DMPA.
7. Explain the management of possible side effects of the DMPA.
8. Discuss the guidelines on DMPA provision.
9. Demonstrate how to use the auto-disabled syringe.
10. Demonstrate how to administer the DMPA.
11. Explain the guidelines on return visits and follow-up.
12. Correct myths and misconceptions on the POIs.

METHODOLOGY

- Illustrated Lecture-Discussion
- Brainstorming
- Group Discussion
- Demonstration/Return Demonstration of DMPA injection

TIME ALLOTMENT

1 hour and 30 minutes

ADVANCE PREPARATION OF MATERIALS

- LCD/laptop computer/screen
- Metacards/marker/adhesives
- DMPA and other supplies for injection
- Auto-disabled syringe (number of participants and for demonstration)
- FP Form 1/WHO-MEC/ME Checklist/MEC Wheel

Topics/Contents

Teaching-Learning Process



SESSION 4



**PROGESTIN-ONLY
INJECTABLE
CONTRACEPTIVE (DMPA)**

Greet participants.

Introduce this session by telling that:

- In the previous two sessions, we have learned about hormonal contraceptives in pill form taken orally.
- This session discusses another hormonal contraceptive, but an injectable that is administered parenterally.

Learning Objectives

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

- Describe the POIs and available preparations.
- Relate the mechanism of action of the POI with the menstrual cycle.
- Discuss the effectiveness of POIs.
- Enumerate the advantages and disadvantages of DMPA.
- Identify clients who can and cannot use the DMPA using the MEC wheel and checklist.

State the objectives of the session as presented on the slide.

Learning Objectives

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

- Enumerate the possible side effects of the DMPA.
- Explain the management of possible side effects.
- Discuss the guidelines on DMPA provision.
- Demonstrate how to use the auto-disabled syringe.
- Demonstrate how to administer the DMPA.
- Explain the guidelines on return visits and follow-up.
- Correct myths and misconceptions on the POIs.

Progestin-only Injectable

**What do you know about
Progestin-Only Injectables?**


Ask participants to write on metacards what they know or heard about the progestin-only injectable (POI). Write one idea for each metacard.

Post metacards on the board/wall.

Tell participants that at the end of the session, all of these information shall be discussed.

Topics/Contents	Teaching-Learning Process
<p>Description</p> <ul style="list-style-type: none"> • An injectable contraceptive containing a synthetic progestin, which resembles the female hormone, progesterone. • Available preparations: <ul style="list-style-type: none"> ✓ DMPA (depot-medroxyprogesterone acetate) 150 mg given every three months ✓ Norethisterone enanthate 200 mg given every two months 	<p>Describe the POI as presented on the slide.</p>
<p>Mechanism of Action</p> <ul style="list-style-type: none"> • Inhibits Ovulation <ul style="list-style-type: none"> ✓ After a 150 mg injection of DMPA, ovulation does not occur for at least 14 weeks. ✓ Levels of the follicle stimulating hormone (FSH) and luteinizing hormone (LH) are lowered and an LH surge does not occur. • Thickens the Cervical Mucus <ul style="list-style-type: none"> ✓ The cervical mucus becomes thick, making sperm penetration difficult. 	<p>State the mechanism of action of the POI:</p> <ul style="list-style-type: none"> • Inhibits ovulation • Thickens the cervical mucus <p>Before showing additional information under each of these mechanisms, ask participants:</p> <ul style="list-style-type: none"> • How does the POI inhibit ovulation? • Why is the cervical mucus thickened? <p>Show responses on the slide.</p> <p>Acknowledge correct responses.</p>
<p>Effectiveness</p> <p>Highly effective</p> <ul style="list-style-type: none"> • Perfect use: 99.7% • Common/typical use: 97.0% <p>Effectiveness is dependent on having injections on time</p>	<p>Explain the effectiveness of the POI as presented on the slide.</p>
<p>Advantages and Disadvantages</p> <p style="text-align: center;">Advantages and Disadvantages</p>	<p>Ask participants the advantages and disadvantages of the POI. Write responses on whiteboard or easel sheet. Responses should include but not be limited to:</p> <p>Advantages:</p> <ul style="list-style-type: none"> • Reversible • No need for daily intake • Does not interfere with sexual intercourse • Perceived as culturally acceptable by some women

Topics/Contents	Teaching-Learning Process
	<ul style="list-style-type: none"> • Private since it is not coitally dependent • Has no estrogen-related side effects such as nausea, dizziness, nor serious complications such as thrombophlebitis or pulmonary embolism • Does not affect breastfeeding - quantity and quality of breastmilk not affected • Has beneficial non-contraceptive effects: <ul style="list-style-type: none"> - Helps prevent iron-deficiency anemia because of the scanty menses and the consequent amenorrhea - May make seizures less frequent in women with epilepsy - Reduces the risk of ectopic pregnancies - Prevents endometrial cancer <p>Disadvantages:</p> <ul style="list-style-type: none"> • Return to fertility is delayed - average is about 10 months from the last injection. • Requires an injection every two or three months to continue its effects • Does not protect against STIs/HIV/AIDS • Menstrual irregularity during the first few months of use • Amenorrhea; some women get anxious if they do not have menses • Not possible to discontinue immediately, until DMPA is cleared from the woman's body. • There may be a decrease in bone density for long-term users but study shows that this is reversible. Bone density loss is greater during pregnancy.
<p>Suitability for DMPA</p>	<p>Tell participants that:</p> <ul style="list-style-type: none"> • It is important to do a thorough medical history-taking using the FP Service Record 1 to detect conditions which may disqualify a client for DMPA use. • A physical examination is not necessary for DMPA provision unless an abnormal finding needs to be confirmed.

Topics/Contents	Teaching-Learning Process										
<p>DMPA is appropriate for...</p> <p>Women who:</p> <ul style="list-style-type: none"> • Do not want others to know that she is using a contraceptive. • Have problems of compliance with oral contraceptive intake. • Cannot use an estrogen-containing contraceptive. • Have completed her desired family size, but does not want sterilization. • Desire an effective long-acting, reversible contraceptive. • Prefer a method that does not require any preparation before intercourse. • Want a convenient method. • Are breastfeeding and wants to use a hormonal method. 	<p>Enumerate for whom the POI will be a suitable method as presented on the slides.</p>										
<p>Simplified MEC Categories for Temporary Methods including DMPA</p> <table border="1" data-bbox="252 768 718 1088"> <thead> <tr> <th>CATEGORY</th> <th>ELIGIBILITY CRITERIA</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Can use the method under any circumstance</td> </tr> <tr> <td>2</td> <td>Generally can use the method, advantages generally outweigh theoretical or proven risks</td> </tr> <tr> <td>3</td> <td>Should not use the method, unless other, more appropriate methods are not available or acceptable</td> </tr> <tr> <td>4</td> <td>Should not use the method, condition represents unacceptable health risk if method is used</td> </tr> </tbody> </table> <p>MEC Wheel</p> 	CATEGORY	ELIGIBILITY CRITERIA	1	Can use the method under any circumstance	2	Generally can use the method, advantages generally outweigh theoretical or proven risks	3	Should not use the method, unless other, more appropriate methods are not available or acceptable	4	Should not use the method, condition represents unacceptable health risk if method is used	<p>Tell participants that:</p> <ul style="list-style-type: none"> • The WHO MEC wheel and checklist are evidence-based tools that determine the suitability of clients for DMPA use. <p>To review participants' skills on using the MEC wheel, state conditions and ask participants at random on the WHO category and whether the client can use the POI given the condition.</p> <p>Choose from conditions below.</p> <p>Category 1: Use the method without restriction</p> <ul style="list-style-type: none"> • 18-45 years old • Nulliparous or parous • Breastfeeding (starting as soon as six weeks after childbirth) • Smoke cigarettes • With varicose veins <p>Category 2: Generally use the method but with more than the usual follow up</p> <ul style="list-style-type: none"> • Menarche to less than 18 years old • More than 45 years old • Mild to moderate hypertension (less than 160/100) • Migraine with or without aura • Cervical cancer awaiting treatment <p>Category 4: DO NOT USE THE METHOD</p> <ul style="list-style-type: none"> • Breast cancer within the past five years <p>Category 3: DO NOT USE THE METHOD unless no other appropriate method is available under close supervision</p>
CATEGORY	ELIGIBILITY CRITERIA										
1	Can use the method under any circumstance										
2	Generally can use the method, advantages generally outweigh theoretical or proven risks										
3	Should not use the method, unless other, more appropriate methods are not available or acceptable										
4	Should not use the method, condition represents unacceptable health risk if method is used										

Topics/Contents

Teaching-Learning Process

- Current DVT/PE
- Unexplained vaginal bleeding
- Acute viral hepatitis

WHO MEC Checklist for DMPA

Medical Eligibility Checklist for DMPA Injections

Ask the client the questions below. If she answers YES to ALL of the questions, then she CAN use any highly effective brand method she wants. If she answers YES to a question below, follow the instructions. No conditional method use of these methods, but some conditions can make them harder to use effectively.

1. Are you breastfeeding a baby less than 6 weeks old?
 NO She can start using DMPA beginning 6 weeks after delivery. If she is not fully or almost fully breastfeeding, however, she is protected from pregnancy for 6 months after initiation or until her menstrual period returns, whichever comes first. There are no contraindications to avoid breastfeeding. YES Change her to another breastfeeding method.

2. Do you have problems with your heart or blood vessels? Have you ever had chest pain or stroke?
 NO Do not provide DMPA if she reports heart attack or stroke, stroke, blood clots, deep vein thrombosis, severe chest pain with unusual shortness of breath, chest pain for more than 20 years, or changes in color, numbness, or tingling in fingers or toes, or any other condition that suggests a blood vessel problem.
 YES If you cannot check blood pressure (BP) and she reports high BP, you can provide DMPA. Refer to BP check.

Check if feasible
 If possible, BP is not considered BP is below 160. If it is above 160, do not provide DMPA. If possible, BP is over 160 and diastolic BP is over 100, do not provide DMPA. Help her choose another method except IUDs.

3. Do you have or have you ever had breast cancer?
 NO Do not provide DMPA. Help her choose a method without hormones.
 YES If you have breast cancer, whether of the breast, a liver infection or tumor? (Ask her eyes or skin or usually yellow?)
 NO Perform physical exam or refer. If she has serious liver disease, do not provide DMPA.
 YES If you cannot check blood pressure (BP) and she reports high BP, you can provide DMPA. Refer to BP check.

4. Do you think you are pregnant?
 NO Advise whether pregnant (see How to tell if a woman is pregnant). Advise her conditions or symptoms to use until reasonable certain that she is not pregnant. There are no contraindications to use until reasonable certain that she is not pregnant.
 YES Advise whether pregnant (see How to tell if a woman is pregnant). Advise her conditions or symptoms to use until reasonable certain that she is not pregnant. There are no contraindications to use until reasonable certain that she is not pregnant.

Review the WHO MEC Checklist for DMPA with the participants.

The DMPA screening checklist should be filled up prior to provision of DMPA.

Possible Side Effects

- Menstrual irregularities: breakthrough bleeding or spotting
- Amenorrhea
- Increased appetite

Present the possible side effects of the DMPA as written on the slide.

Management of Side Effects

- Amenorrhea: Reassure the client that amenorrhea is an expected side effect, and that she can expect menstrual cycles to return to normal within six months of discontinuing the POI.
- Menstrual irregularity: Reassure the client that breakthrough bleeding and spotting are common.

Explain how to manage the possible side effects as presented on the slide.

Topics/Contents	Teaching-Learning Process
<p data-bbox="225 271 442 293">Special Considerations</p> <ul data-bbox="205 353 785 495" style="list-style-type: none"> • Administering DMPA requires a sterile syringe and a 21-23 gauge needle. Ample supplies of both must be available. • Syringes and needles are manufactured for single use only and must be safely disposed of (in a sharps container, for example) following DMPA administration. • Storage conditions are critical to product stability. Follow manufacturer's storage recommendations. 	<p data-bbox="827 253 1398 320">Present the guidelines on the administration of the DMPA as presented on the slides.</p>
<p data-bbox="225 622 446 645">Timing of First Injection</p> <p data-bbox="205 719 354 741">For Interval Clients</p> <ul data-bbox="205 741 777 835" style="list-style-type: none"> • Preferably within seven days of the menstrual cycle. • Any time it is reasonably certain that the woman is not pregnant. • After seven days of the menstrual cycle, advise client to use a backup method or to exercise abstinence for the next seven days. <p data-bbox="205 864 401 887">For Breastfeeding Clients</p> <ul data-bbox="205 887 777 958" style="list-style-type: none"> • As early as six weeks after delivery. • If menses have resumed, the woman can start injectables at any time and it is reasonably certain that the woman is not pregnant. 	
<p data-bbox="225 1144 446 1167">Timing of First Injection</p> <p data-bbox="205 1240 475 1263">For Postpartum, Not Breastfeeding</p> <ul data-bbox="205 1263 777 1379" style="list-style-type: none"> • Immediately or at any time in the first six weeks after childbirth; no need to wait for menses • After six weeks, any time it is reasonably certain that client is not pregnant • If not reasonably certain that client is not pregnant, avoid sex or use condoms until her menses occur. <p data-bbox="205 1408 401 1431">For post-abortion Clients</p> <ul data-bbox="205 1431 762 1525" style="list-style-type: none"> • Immediately or within seven days after an abortion. • Any time it is reasonably certain that the client is not pregnant. • If administered later than seven days, avoid sex or use condoms for the next seven days. 	
<p data-bbox="225 1641 435 1664">Supplies and Materials</p> <p data-bbox="205 1742 471 1765">Prepare the following for injection:</p> <ul data-bbox="299 1794 762 1955" style="list-style-type: none"> • Progestin-only injectable vial • Sterile syringe and needle or auto-disabled syringe • Cotton balls • Locally available antiseptic to clean the skin (70% ethyl alcohol) 	

Topics/Contents

Teaching-Learning Process

The Auto-Disabled Syringe (ADS)

- Is a single dose, disposable syringe
- Has a locking mechanism that locks the plunger after a single dose
- Comes with a detachable needle, which cannot be attached to other types of syringe
- Is designed to prevent re-use

Steps in Using the Auto-Disabled Syringe

- Check that package seals are not damaged or changed. This ensures that sterility of the syringe is maintained.
- Do not touch the needle or syringe hub. This contaminates the ADS.
- Do not pull the piston, unless you are drawing a DMPA solution.
- Hold the DMPA vial upright when drawing up dose.
- Keep the needle in solution when drawing up the dose.
- Gently pull piston slightly past the 1.0 ml mark when drawing up the dose. Give space for air bubbles while maintaining full dose.
- After drawing up the dose and removing needle from vial, gently push piston to remove excess air.
- Stop when you reach 1.0 ml mark.

Preparing the Client

- Provide comprehensive counseling to each client.
- Ensure that the client understands method advantages, as well as the side effects of irregular bleeding, amenorrhea, and possible delayed return of ovulation.
- Explain the procedure to the client.
- Encourage the client to ask questions.
- Show supplies and materials that will be used.
- Reassure client before and after injection.

Steps

1. Wash hands thoroughly with soap and water and air dry them or use a clean towel.
2. Check vial for contents/dosage. If contents are less than indicated volume, do not use the vial.
3. Roll the vial back and forth between the palms of your hands to mix the solution or shake it lightly.
4. Gently shake the vial. Vigorous shaking will make the solution foamy.
5. Disinfect/clean the skin at the site of the injection with alcohol or other antiseptics, removing any visible dirt or soil. Allow the antiseptic to dry before giving the injection.
6. Put vial in a flat surface and slight tilt the vial while aspirating the solution to be sure that all of the solution is taken out from the vial.
7. Administer the injection. Aspirate first to ensure that the needle is not in a vein. Inject DMPA deep into the deltoid or gluteal muscle, without massaging the site.
8. Dispose the syringe with its needle in a sharps container.
9. Instruct the client not to massage the area after the injection. Massaging may speed the release of progestin and thus shorten the period of efficacy. It may also disperse the DMPA so that it is not properly absorbed.
10. Wash hands again.

Topics/Contents	Teaching-Learning Process
<p style="text-align: center;">Demonstration/ Return Demonstration</p>	<p>Demonstrate the steps in administering DMPA using the auto-disabled syringe. Ensure that all participants are able to see the demonstration.</p> <p>Encourage participants to ask questions to clarify particular steps.</p> <p>Divide participants into groups (depending on the number of facilitators).</p> <p>Group facilitators:</p> <ul style="list-style-type: none"> • Review the checklist on DMPA administration. • Ask participants to practice in pairs how to use the auto-disabled syringe and administer the DMPA.
<p style="text-align: center;">Return Visits and Follow-up</p> <ul style="list-style-type: none"> • Clients return to the clinic for next injection: <ul style="list-style-type: none"> → every three months for DMPA → every two months for Noristerat • Advise every client during counseling and during post-injection instructions about the importance of returning to the clinic on her scheduled date. • Come back no matter how late she is for the next injection. The injection may be administered two weeks early or two weeks late. • Give her an appointment card or slip. 	<p>Present the guidelines on return visits and follow-up as presented on the slide.</p>
<p style="text-align: center;">Warning Signs</p> <ul style="list-style-type: none"> • Severe headaches • Heavy bleeding = twice as much and twice as long • Severe lower abdominal pain • Signs of pregnancy • Swelling or prolonged bleeding at injection site 	<p>Present the warning signs as written on the slide.</p>

Topics/Contents	Teaching-Learning Process
<p>Myths and Misconceptions</p>	<p>Review with participants the metacards containing the information on what they know about the POIs.</p> <p>For each information, ask participants whether this is a fact or a misconception. For the misconceptions, ask participants for the correct information based on what they have learned on the POIs.</p> <p>Below are some responses to possible misconceptions on the POI:</p> <ol style="list-style-type: none"> 1. POIs do not cause birth defects and will not harm the fetus if a woman becomes pregnant while using them or accidentally starts POIs when she is already pregnant. 2. POIs do not disrupt an existing pregnancy nor can they be used to cause an abortion. 3. Bleeding episodes should not be used as a guide for the injection schedule; rather should be given every three months whether a woman has bleeding or not. 4. POIs are not used to regulate monthly periods especially for those with irregular cycles. 5. Women younger than 35 who smoke any number of cigarettes and women 35 and older who smoke less than 15 cigarettes a day CAN safely use POIs. 6. Generally, POIs do not cause change in a woman's mood or sexual drive. 7. POIs are safe for women with varicose veins. Women with DVT/PE should not use POIs. 8. POIs do not cause a woman to be infertile but there may be a delay in regaining fertility after stopping POIs; usually it takes around 10 months.



NARRATIVE

MODULE 6: HORMONAL CONTRACEPTIVE METHODS

SESSION 4: PROGESTIN-ONLY INJECTABLES(POI)

It is important that health service providers understand the nature, safety, characteristics, and mechanism of action, side effects, and management of side effects of progestin-only injectable.

The progestin-only injectable is a three-month injectable contraceptive. POI contains a synthetic progestin, which resembles the female hormone progesterone. Each standard dose contains 150 mg of the hormone, which is released slowly into the blood stream from the site of intramuscular injection, providing the client/user with a safe and highly effective form of contraception.

POIs commercially available in the Philippines.

1. Depot-medroxyprogesterone acetate (DMPA) (part of the Philippine FP program) is given every three months
2. Norethisterone enanthate is given every two months

Mechanism of Action

- **Inhibits Ovulation** - After a 150-mg injection of DMPA, ovulation does not occur for at least 14 weeks. Levels of the follicle stimulating hormone (FSH) and luteinizing hormone (LH) are lowered and an LH surge does not occur.
- **Thickens the Cervical Mucus** - The cervical mucus becomes thick, making sperm penetration difficult.

Effectiveness

Progestin-only injectable is a highly effective contraceptive method. Effectiveness if perfectly used is **99.7%**, if typically used **97.0%**.

6.62

Safety

Progestin-only injectable is a very safe contraceptive. Like other progestin-only contraceptives, it can be used by women who want a highly effective contraceptive. This includes those who are breastfeeding or who are not eligible to use estrogen-containing low-dose combined oral contraceptives.

Studies by the World Health Organization (WHO) reassure us that DMPA presents no overall risks for cancer, congenital malformations, or infertility. This research has evaluated more than three million woman-months of DMPA use.

The research found that:

- DMPA, like oral contraceptives, exerts a strong protective effect against endometrial cancer.

- Its use does not increase the risk of breast cancer overall.
- There is no relationship between ovarian cancer and the use of DMPA. Researchers expect that DMPA, like oral contraceptives, will protect women against ovarian cancer.
- DMPA does not affect the risk of developing liver cancer in areas where hepatitis is endemic.

Advantages

- Reversible
- No need for daily intake
- Does not interfere with sexual intercourse
- Perceived as culturally acceptable by some women
- Private since it is not coitally dependent
- Has no estrogen-related side effects such as nausea, dizziness, nor serious complications such as thrombophlebitis or pulmonary embolism
- Does not affect breastfeeding - quantity and quality of breast milk do not seem to be affected
- Has beneficial non-contraceptive effects:
 - Helps prevent iron-deficiency anemia because of the scanty menses and the consequent amenorrhea
 - May make seizures less frequent in women with epilepsy
 - Reduces the risk of ectopic pregnancies
 - Prevents endometrial cancer

Disadvantages

- Return to fertility is delayed - average is about 10 months from the last injection
- Requires an injection every two or three months to continue its effects
- Does not protect against STI/HIV/AIDS
- Menstrual irregularity during the first few months of use
- Amenorrhea; some women get anxious if they do not have menses
- Not possible to discontinue immediately, until DMPA is cleared from the woman's body
- There may be a decrease in bone density for long-term users. However, studies show that this condition is reversible after discontinuation and that bone density loss is greater during pregnancy.

SUITABILITY FOR DMPA

DMPA is an appropriate method for women with the following needs:

- Do not want others to know that she is using a contraceptive.
- Have problems of compliance with oral contraceptive intake.
- Cannot use an estrogen-containing contraceptive.
- Have completed her desired family size, but does not want sterilization.
- Desire an effective long-acting, reversible contraceptive.
- Prefer a method that does not require any preparation before intercourse.
- Want a convenient method.
- Are breastfeeding and wants to use a hormonal method.

Who can use DMPA?

Category 1: Use the method without restriction

- 18-45 years old
- Nulliparous or parous
- Breastfeeding (starting as soon as six weeks after childbirth)
- Smoke cigarettes
- Just had an abortion
- History of high blood pressure during pregnancy
- With endometriosis
- With benign trophoblastic disease
- With benign breast disease
- With uterine fibroids/thyroid disease
- Mild headaches
- With Iron deficiency anemia
- With varicose veins
- With ovarian/endometrial cancer
- With malaria

Category 2: Generally use the method but with more than the usual follow up

- Menarche to less than 18 years old
- More than 45 years old
- History of hypertension where BP cannot be evaluated
- Mild to moderate hypertension (less than 160/100)
- History of DVT/PE
- Migraine with or without aura
- With Valvular heart disease
- Irregular menstrual periods
- With cervical cancer awaiting treatment

Who cannot use DMPA?

Category 3: DO NOT USE THE METHOD

- Breast cancer within the past five years

Category 4: DO NOT USE THE METHOD unless no other appropriate method is available under close supervision by a physician

- Current DVT/PE
- Unexplained vaginal bleeding
- Breastfeeding and less than six weeks after childbirth
- Severe hypertension (more than 160/100 mm Hg)
- Diabetes with vascular disease or for more than 20 years
- Current or history of ischaemic heart disease or stroke
- History of breast cancer with no evidence of disease for the last five years
- Acute viral hepatitis
- Benign and malignant liver tumor

MANAGEMENT OF POSSIBLE SIDE EFFECTS

Your success in helping your client understand the cause/nature of side effects and complications related to progestin-only injectable and how well you manage such cases will largely determine the client's satisfaction and continuing use of the method.

When side effects are not well managed, many women stop using progestin-only injectable due to fear and misunderstanding.

On very rare occasions, allergic reactions immediately follow an injection of progestin-only injectable.

The possibility of change in menstrual bleeding patterns, include:

- Amenorrhea: reassure the client that amenorrhea is an expected side effect, and that she can expect menstrual cycles to return to normal within six months of discontinuing the POI.
- Menstrual irregularity: breakthrough bleeding and spotting are common.

GUIDELINES IN THE PROVISION OF DMPA

SPECIAL CONSIDERATIONS

- Administering DMPA requires a sterile syringe and a 21-23 gauge needle. Ample supplies of both must be available. Be sure syringes and needles are not removed from DMPA stocks for the administration of other drugs.
- Syringes and needles are manufactured for single use only and must be safely disposed of (in a sharps container, for example) following DMPA administration. Re-sterilizing needles and syringes may diminish their integrity, resulting in potentially unsafe or ineffective administration.
- Storage conditions are critical to product stability. Particle size in aqueous suspensions like DMPA can change with temperature fluctuations. These changes can affect drug efficacy. Follow manufacturer's storage recommendations.
- Because DMPA is a suspension, the colloid may separate. Shake the vial to return the suspension to a milky white color.
- Apply the normal visual indicators for quality control of injectable drugs, e.g. physical damage to carton or product; broken seals; foreign matter inside vial or syringe package; leakage or caking of ingredients.

TIMING OF THE FIRST INJECTION

For “Interval” clients

- Any time it is reasonably certain that the woman is not pregnant.
- Within seven days of the menstrual cycle, the client needs no backup method.
- After seven days of the menstrual cycle, advise the client to use a backup method or to exercise abstinence for the next seven days.

For Breastfeeding clients

- As early as six weeks after delivery
- If menses have resumed, the woman can start injectables any time it is reasonably certain that she is not pregnant.

For Postpartum, not breastfeeding

- Immediately or at any time in the first six weeks after childbirth; the client does not need to wait for her menstrual period.
- After six weeks, any time she is reasonably certain that she is not pregnant. If she is not certain, she should avoid sex or use condoms until her first menstrual period.

For Postabortion

- Immediately or within seven days after an abortion
- If later than seven days, any time it is reasonably certain that she is not pregnant. She should avoid sex or use condoms for the next seven days.

PREPARING EQUIPMENT, SUPPLIES, AND MATERIALS

Prepare the following supplies and materials needed for the injection.

- Progestin-only injectable vial
- Sterile syringe and needle or auto-disabled syringe
- Cotton balls
- Locally available antiseptic to clean the skin (70% ethyl alcohol)

If needles and syringes are to be used more than once, decontaminate, clean and sterilize them after each use. Presently available are disposable syringes, needles intended for single use.

PREPARING THE CLIENT

- Provide comprehensive counseling to each client.
- Ensure that the client understands method advantages, as well as the side effects of irregular bleeding, amenorrhea, and possible delayed return of ovulation.
- Explain the procedure to the client.
- Encourage the client to ask questions to reduce apprehension and anxiety.
- Show her the supplies and materials that will be used.
- Explain that the syringes and needles are sterile.
- Reassure the client before and after the injection.

STEPS IN ADMINISTERING DMPA

The following steps need to be followed in giving a DMPA injection:

1. Wash hands thoroughly with soap and water and air dry them or use a clean towel.
2. Check vial for contents/dosage. If contents are less than indicated volume, do not use the vial.
3. Roll the vial back and forth between the palms of your hands to mix the solution or shake it lightly.
Gently shake the vial as vigorous shaking will make the solution foamy. Failure to mix the solution will permit some of the drug to remain as sediment in the vial, resulting in an inadequate dose and lower contraceptive effectiveness.
4. Open the sterile packet of the syringe with needle.
Use a 21-23 gauge needle, 1-1.5 inches in length, with a 2-5 ml syringe.
5. Swab the skin at the site of the injection with alcohols or other antiseptics, removing any visible dirt or soil. Allow the antiseptic to dry before giving the injection.
6. Put vial in a flat surface and slightly tilt the vial or hold the vial upside down at eye level while aspirating the solution to be sure that all of the solution is taken out from the vial.

7. Inject deep into the deltoid or gluteal muscle.
If administering on the gluteal muscles (buttocks), inject on the upper outer quadrant of the buttocks to prevent hitting the sciatic nerve, which may cause paralysis of the legs.
8. Aspirate first to ensure that the needle is not in a vein.
9. Administer the DMPA.
10. Instruct the client not to massage the area after the injection.
Massaging may speed the release of progestin and thus shorten the period of efficacy. It may also disperse the DMPA so that it is not properly absorbed.
11. Dispose of needles and syringe in a puncture proof container.
12. Wash hands and dry.

THE AUTO-DISABLED SYRINGE

The auto-disabled syringe:

- Is a single dose, disposable syringe
- Has a locking mechanism that locks the plunger after a single dose
- Comes with a detachable needle, which cannot be attached to other types of syringe
- Is designed to prevent re-use

Steps on how to use the auto-disabled syringe:

- Check that package seals are not damaged or changed. This ensures that sterility of the syringe is maintained.
- Do not touch the needle or syringe hub. This contaminates the ADS.
- Do not pull the piston, unless you are drawing the DMPA solution.
- Hold the DMPA vial upright when drawing up the dose.
- Keep the needle in solution when drawing up the dose.
- Gently pull piston slightly past the 1.0 ml mark when drawing up the dose. Give space for air bubbles while maintaining full dose.
- After drawing up the dose and removing needle from vial, gently push piston to remove excess air.
- Stop when you reach 1.0 ml mark.

RETURN VISITS

Using progestin-only injectable as a method requires that clients return to the clinic every three months (90 days) for DMPA and every two months (60 days) for Noristerat for the next injection.

Advise every client during counseling and during post-injection instructions about the importance of returning to the clinic on her scheduled date. Give her an appointment card or slip of paper with the date of the appointment written on it.

Instruct the client that if she is more than two weeks late, she should abstain from sexual intercourse or reliably use an additional method until she returns. If you are reasonably assured that she is not at risk of pregnancy, you may give her the next injection. If you are unsure, do a sensitive pregnancy test or ask her to use another method of contraception, and have her return in one month. After one month, you may determine if she is not pregnant, and if not, you may give her the next injection.

The next injection may be given up to four weeks early, if the woman cannot return at the scheduled time. Giving the next injection early is also one form of managing prolonged bleeding or spotting, when this occurs within four weeks of the next scheduled visit.

Clients should be instructed to report back to the clinic for any of the following warning signals:

- repeated very painful headaches
- heavy bleeding
- depression
- severe, lower abdominal pain may be a sign of pregnancy
- pus, prolonged pain, or bleeding at injection site.

STEPS PERFORMED DURING FOLLOW-UP

During each follow up visit, the service provider should perform the following procedures or steps:

1. Interviewing the client:
 - Ask the client whether or not both she and her partner are satisfied with the method.
 - Ask if they have any questions, problems, or concerns.
 - Ask if the client has encountered any side effects, such as menstrual irregularities.
2. Take and record BP and weight.

Satisfied client:

- If the client is satisfied with the method and has no contraindications or precautions to continued use, give the client her next injection.
- Give supportive counseling and continued reassurance to help ensure a high tolerance for menstrual irregularities.
- Remind client to return to the clinic on the scheduled date, or any time she has problems (e.g. side effects) or any condition that may cause dissatisfaction with the method.
- Plan for return or next visit.

If the client has experienced a complication or side effect:

- If client has developed a complication or troublesome side effect, examine her and gather information about what she experienced.
- Reassure and provide further counseling.
- If it is beyond your capability to manage, refer client to the physician or to the appropriate health service center.
- If the next scheduled injection can be given after the management of the condition or as per physician's advice, then give the injection. If not, advise client to use a temporary back-up method and return after she has fully managed/recovered from the side effects or precautions.
- If the client finds the method unacceptable due to the developed condition, then help her choose another method.

CORRECT INFORMATION ABOUT MYTHS AND MISCONCEPTIONS

- a. POIs do not cause birth defects and will not harm fetus if a woman becomes pregnant while using them or accidentally starts POIs when she is already pregnant.
- b. POIs do not disrupt an existing pregnancy nor can they be used to cause an abortion.
- c. Bleeding episodes should not be used as a guide for the injection schedule. DMPA should be given every three months whether a woman has bleeding or not.
- d. POIs are not used to regulate monthly periods especially for those with irregular cycles.
- e. Women younger than 35 who smoke any number of cigarettes and women 35 and older who smoke more than 15 cigarettes a day CAN safely use POIs.
- f. Generally, POIs do not cause change in a woman's mood or sexual drive.
- g. POIs are safe for women with varicose veins. Women with history of DVT/PE should not use POIs.
- h. POIs do not cause a woman to be permanently infertile but there may be a delay in regaining fertility after stopping them; usually it takes around 10 months before they become pregnant.

SUMMARY:

- Bleeding changes are common but not harmful. Typically, irregular bleeding for the first several months then no monthly bleeding.
- Return for injections regularly. Every three months for DMPA.
- Injections can be as much as two weeks early or late. The client should come back even if she comes in late.
- Gradual weight gain is common.
- Return of fertility is often delayed. It takes several months longer on average to become pregnant after stopping POIs than after other methods.

SKILLS CHECKLIST ON PROGESTIN-ONLY INJECTABLE ADMINISTRATION

PARTICIPANT _____ Course Date _____

Instruction: Check the appropriate column for each of the tasks.

Key: 2= Yes 0= No	1= Yes, but needs improvement NA= Not applicable	1	2	3	4
PRE-INJECTION TASKS					
1. Conducts counseling.					
2. Ensures that the client understands and accepts the possible side effects of the POI.					
3. Explains the injection procedure to the client.					
4. Encourages the client to ask questions and responds to her questions.					
5. Listens attentively to client's response and concerns.					
6. Reassures the client that the needle and syringe used for injection are sterile.					
7. Washes hands thoroughly with soap and water.					
8. Checks vial for contents, dosage, and expiration.					
9. Disperses the suspension by rolling the vial back and forth between the palms of the hands or by gently shaking the vial, so that no bubbles are formed in the solution.					
Using the auto-disabled syringe					
10. Checks that package seals of the syringe are not damaged or changed to ensure that sterility of the syringe is maintained.					
11. Takes care that the sterility of the needle is maintained by not touching contaminated surfaces with it.					
12. Holds the DMPA vial upright.					
13. Inserts the needle into the vial and pulls the piston of the syringe to draw the solution.					
14. Keeps the needle in solution when drawing up the dose.					
15. Gently pulls the piston slightly past the 1.0 ml mark when drawing up the dose.					
16. Gives space for air bubbles while maintaining full dose.					

6.70

Key: 2= Yes 0= No	1= Yes, but needs improvement NA= Not applicable	1	2	3	4
17. After drawing up the dose and removing needle from vial, gently pushes the piston to remove excess air.					
18. Stops upon reaching the 1.0 ml mark.					
INJECTION TASKS					
19. Swabs the skin at the site of the injection with alcohol or other antiseptic.					
20. Allows the antiseptic to dry before giving the injection.					
21. Injects deep into the muscle.					
22. Administers the POI.					
23. Instructs the client not to massage the area after the injection.					
24. Disposes of needle and syringe in a puncture proof container.					
25. Washes hands and dry.					

COMMENTS/RECOMMENDATIONS:

Trainer's Signature: _____

Medical Eligibility Checklist for Progestin-Only Contraceptives (POPs,POIs)

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use the progestin-only contraceptives.. If she answers YES to a question below, follow the instructions. No conditions restrict use of these methods, but some conditions can make them harder to use effectively.

1. Do you have or have you ever had breast cancer?
No YES Do not provide POCs. Help her choose a method without hormones.
2. Do you have jaundice, cirrhosis of the liver, a liver infection, or tumor? (Are her eyes or skin unusually yellow?)
No YES Perform physical exam or refer. If she has serious active liver disease (jaundice, painful or enlarged liver, active viral hepatitis, live tumor), do not provide POCs. Refer for care. Help her choose a method without hormones.
3. Are you breastfeeding a baby less than six months old?
No YES Can give her POCs now with instruction on when to start – when the baby is six weeks old.
4. Do you have serious problems with your heart or blood vessels? If so, what problems?
No YES Do not provide POCs if she reports blood clots (except superficial clots). Help her choose another effective method.
5. Do you have jaundice, cirrhosis of the liver, a liver infection, or tumor? (Are her eyes or skin unusually yellow?)
No YES Perform physical exam or refer. If she has serious active liver disease (jaundice, painful or enlarged liver, active viral hepatitis, live tumor), do not provide POCs. Refer for care as appropriate. Help her choose a method without hormones.
6. Are you taking medicine for seizures? Are you taking rifampin (rifampicin) or griseofulvin?
No YES If she is taking phenytoin, carbamezaphine, barbiturates, or primidone for seizures or rifampin or griseofulvin, provide condoms to use along with POCs. If she prefers, or if she is on long treatment, help her choose another effective method.
7. Do you think you are pregnant?
No YES Assess whether pregnant (see How to tell if a woman is not pregnant). If she might be pregnant, also give her condoms or spermicide to use until reasonably certain that she is not pregnant. Then she can start POCs.

Be sure to explain the health benefits, risks and side effects of the method that the client will use.

Also, point out any conditions that would make the method inadvisable when relevant to the client.



MODULE 7



Male condoms

Session 1: Male condoms

MODULE 7: MALE CONDOMS



MODULE OVERVIEW

This module will cover the male condom as one of the barrier methods. Barrier methods include the male condoms, female condoms, diaphragm, cervical caps, and spermicides that mechanically or chemically prevent fertilization or the union of the egg and sperm cell. The male condom is the only barrier method widely available and included in the Philippine FP Program. This will be discussed in more detail in this module.

Condoms are one of the effective family planning methods when used consistently and correctly. It is also an effective method of preventing transmission of HIV and other sexually transmitted infections (STIs).




MODULE OBJECTIVES

At the end of the module, participants must be able to provide male condoms as an effective contraceptive method as well as a means of protection against the transmission of STIs, including HIV.



MODULE SESSION

Session 1:	Male condom
-------------------	-------------

Topics/Contents	Teaching-Learning Process
<div style="display: flex; align-items: center;">  <div style="margin-left: 20px;"> <h2 style="margin: 0;">MODULE 7</h2> <hr style="border: 0.5px solid #008000;"/> <h3 style="margin: 0;">MALE CONDOMS</h3> </div> </div>	<p>Greet the participants and introduce the module by stating the Module Overview, Objectives, and Sessions using the prepared slides.</p>
<div style="background-color: #008000; color: white; padding: 5px; margin-bottom: 10px;"> 🔍 MODULE OVERVIEW </div> <div style="background-color: #008000; color: white; padding: 5px; margin-bottom: 10px;"> 🔍 OVERVIEW </div> <ul style="list-style-type: none"> • This module will provide information about the male condom as an effective modern contraceptive method. • To enable service providers to provide counseling on the use of the male condom. 	
<div style="background-color: #008000; color: white; padding: 5px; margin-bottom: 10px;"> 🎓 MODULE OBJECTIVE </div> <div style="background-color: #008000; color: white; padding: 5px; margin-bottom: 10px;"> 🎓 OBJECTIVE </div> <p>To provide information on male condoms as an effective contraceptive method as well as a method of protection against the transmission of STIs, including HIV.</p>	

SESSION 1

MALE CONDOM

LEARNING OBJECTIVES

At the end of this module, the participants must be able to:

1. Describe the male condom in terms of its:
 - Features
 - Mechanism of Action
 - Advantages and Disadvantages
2. Discuss the effectiveness of the condom and the factors that influence this.
3. State client conditions for which the condom is suitable or not based on the WHO Medical Eligibility Criteria.
4. Discuss the guidelines for providing condoms.
5. Demonstrate putting on the condom on a penile model.
6. Correct misconceptions on the condom.



METHODOLOGY

Illustrated Lecturette-Discussion
Demonstration and Return Demonstration
Brainstorming






TIME ALLOTMENT

1 hour



ADVANCE PREPARATION OF MATERIALS

- Powerpoint presentation
- Computer and LCD
- Metacards
- Metacards with the headings: CATEGORY 1 and CATEGORY 4
- Marker pens, masking tapes,
- Whiteboard and whiteboard marker
- WHO Medical Eligibility Criteria Table or MEC Wheel
- Penile models
- Condoms for demonstration and practice

Topics/Contents	Teaching-Learning Process
<div style="text-align: center;">  <h2 style="margin: 0;">SESSION 1</h2> <hr style="width: 30%; margin: 10px auto;"/>  <h2 style="margin: 0;">MALE CONDOM</h2> </div>	<p>Introduce the session by telling participants that:</p> <ul style="list-style-type: none"> • The previous methods that we have studied are effective in preventing pregnancy. • However, we have noticed that not one of them prevents transmission of STIs. • The male condom, which is the subject of this session is the only contraceptive method available in the country that also prevents STI transmission.
<div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: flex; align-items: center;"> Learning Objectives </div> <p>At the end of this module, the participants will be able to:</p> <ol style="list-style-type: none"> 1. Describe the male condoms in terms of its: <ul style="list-style-type: none"> • Features • Mechanism of Action • Advantages and Disadvantages 2. Discuss the effectiveness of the condom and the factors that influence this. 3. State client conditions for which the condom is suitable or not based on the WHO Medical Eligibility Criteria. 4. Discuss the guidelines for providing condoms. 5. Demonstrate application of the condom on a penile model. 6. Correct misconceptions about the condom. 	<p>State the objectives of the session as presented on the slides.</p>
<p style="text-align: center; color: #008000;">WHAT DO YOU KNOW ABOUT MALE CONDOMS?</p>	<p>Ask participants to write on metacards what they know or heard about the condom. Write one idea for each metacard.</p> <p>Post metacards on the board/wall.</p> <p>Tell participants that at the end of the session, all of these information will be discussed.</p>
<div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: flex; align-items: center;"> What is the Male Condom </div> <div style="text-align: center; margin: 10px 0;">  </div> <ul style="list-style-type: none"> • Thin sheath of latex rubber made to fit a man's erect penis. • Condoms are often times lubricated and some have spermicidal components. 	<p>Describe the condom as presented on the slide.</p>
<div style="background-color: #008000; color: white; padding: 5px; border-radius: 10px; display: flex; align-items: center;"> Mechanism of Action </div> <ul style="list-style-type: none"> • Acts as barrier that prevents the sperm from getting into the vagina • Helps prevent both pregnancy and STIs • Stops disease organisms in the vagina from entering the penis 	<p>Present the mechanism of action of the male condom as presented on the slide.</p> <p>Emphasize that:</p> <ul style="list-style-type: none"> • Of the program contraceptive methods, it is only the condom that also prevents STIs, including HIV/AIDS.

Topics/Contents	Teaching-Learning Process
<p>Effectiveness</p> <ul style="list-style-type: none"> • Condoms, in order to be effective must be used correctly and consistently every time one is engaging in sex. • If perfectly used 98%; as typically used 85%. 	<p>Present the effectiveness of the condom and the factors that affect these as presented on the slides.</p>
<p>Factors that influence Effectiveness</p> <p>Incorrect use of the condom</p> <ul style="list-style-type: none"> • Unrolling a condom before putting it on. • Not "pressing the tip" of the condom. • Tearing caused by jewelry (ring) and fingernails. • Putting a condom on with the rolled rim toward the penis instead of away from it. • Failure to hold on to the rim of condom when withdrawing, resulting in spills/leaks. • Having intercourse first, then stopping to put condom on. 	
<p>Factors that influence Effectiveness</p> <p>Condom Breakage can occur due to:</p> <ul style="list-style-type: none"> • Expiration (used after expiration date) • Broken package • Inadequate vaginal lubrication • Defects in the condom • Poor or improper storage with exposure to heat, ultraviolet light, and/or humidity • Weakening of the latex due to application of mineral and vegetable oils as lubricants 	
<p style="text-align: center;">ADVANTAGES</p>	<p>Ask participants on the Advantages and Disadvantages of the Condom. Responses should include but not be limited to:</p> <p>Advantages</p> <ul style="list-style-type: none"> • Protects against sexually transmitted infections, including HIV • Easy to use • Usually easy to obtain • Usually inexpensive • Safe, effective, and portable • Helps protect against cervical cancer • Allows men to share more responsibility for family planning • Helps some men with premature ejaculation or to maintain erection • Convenient for short-term contraception
<p style="text-align: center;">DISADVANTAGES</p>	<p>Disadvantages</p> <ul style="list-style-type: none"> • Coitus-related (must be used during sexual intercourse) • Some men complain of decreased sensitivity • Interrupts the sexual act • Slipping off, tearing, spillage of sperm can occur, especially among inexperienced users • Allergy to latex (rare)

Topics/Contents	Teaching-Learning Process
	<ul style="list-style-type: none"> • Requires high motivation for consistent and correct use • Deteriorates quickly when storage conditions are poor • Causes some men difficulty in maintaining erection
<p style="text-align: center;">Who Can and Cannot Use the Condom</p> <p>Category 1: Use the method without restriction</p> <ul style="list-style-type: none"> • Couples who are reliable users and who ask for it • Couples who wish to use a backup method when the use of another method is interrupted e.g. missed pills • Couples with high risk of STIs • Couples who use it as a temporary method until another method is used or becomes effective (e.g. three months post-vasectomy) <p>Category 1: Use the method without restriction</p> <ul style="list-style-type: none"> • A woman who is unwilling to use contraceptive methods with systemic effects • A woman who is breastfeeding and needs contraception • When other methods are medically contraindicated to either of the couple or for their personal reasons. • Men who have problems with premature ejaculation <p>Category 4: Do not use the method</p> <p>Either or both of the sex partners have severe allergy to latex rubber (severe redness, itching, swelling after condom use)</p>	<p>Review the WHO MEC Categories for the use of FP methods.</p> <p>Present the categories for condom use as presented on slides.</p>
<p>Putting on the Condom</p> <p>Steps</p> <ol style="list-style-type: none"> 1. Check the pack for the expiry date and perforations. 2. Push condom to one side and carefully tear the pack on the opposite side. 3. Squeeze the tip of the condom between the thumb and index finger on one hand, while the other hand places the condom over the erect penis. 4. Unroll the condom a short distance to make sure that the rolled ring is directed outward. 5. Unroll the condom all the way down to the base of the penis. 6. Soon after ejaculation, withdraw the still erect penis from the vagina while holding the rim of the condom at the base of the penis. 7. Take off the condom once it is outside the vagina. 8. Knot the condom, wrap it with paper, and dispose properly. 	<p>Present the steps on putting on the condom as written on the slide.</p> <p>Demonstrate how to put on the condom on a penile model.</p> <p>Call a participant to demonstrate how to put on the condom on a penile model.</p>
<p style="text-align: center;">GUIDELINES</p>	<p>Present the guidelines on the provision of the male condom as presented on slides.</p>
<p>Client Education</p> <ul style="list-style-type: none"> • Demonstrate to the client putting on the condom using a penile model. • Ask client to practice putting on a condom using a penis model. • Instruct the client on what lubricants to use or not to use. • Provide client with enough supply. • Advise client on how to dispose of condoms. • Reassure client s/he may return at any time for advice, additional supplies, or when s/he wants to use another method. 	<p>Ask participants to practice putting on the condom on a penile model.</p>

Topics/Contents	Teaching-Learning Process
<p>Client Education</p> <ul style="list-style-type: none"> • Reiterate key messages to clients: <ul style="list-style-type: none"> • Be sure to have a condom before you need it. • Use a condom with every act of intercourse. • Do not use the same condom more than once. • Do not use a condom that is outdated, dry and brittle, or very sticky. 	
<p>Lubrication for latex condoms</p> <ul style="list-style-type: none"> • Use only water-based lubricants • Avoid oil-based lubricants like cold cream, mineral oil, cooking oil, petroleum jelly, body lotions, massage oil, or baby oil that can damage latex condoms • For polyurethane condoms, any type of lubricant can be used. 	
<p>Condom Storage</p> <ul style="list-style-type: none"> • Store condoms in a cool and dry place out of direct sunlight (heat may weaken latex). • Check the expiration or manufacture date on the box or individual package of condoms. • Condoms in damaged packages or obvious signs of deterioration (e.g. brittleness, stickiness, or discoloration) should not be used regardless of their expiration date. • Latex condoms should not be used beyond their expiration date or more than five years after the manufacturing date. 	
<p style="text-align: center;">CORRECTING MISCONCEPTIONS</p>	<p>Review with participants the metacards containing the information on what they know about condoms.</p> <p>For each information, ask participants whether this is a fact or a misconception. For the misconceptions, ask participants for the correct information based on what they have learned on the male condom.</p> <p>Below are some responses to possible misconceptions on the condom:</p> <ul style="list-style-type: none"> • Do not make men sterile, impotent, or weak. • Do not decrease men’s sex drive. • Cannot get lost in the woman’s body. • Do not have holes that HIV can pass through. • Are not laced with HIV. • Do not cause illness in a woman because they prevent semen or sperm from entering her body. • Do not cause illness in men because sperm “back up.”
<p style="text-align: center;">DO YOU HAVE ANY QUESTIONS?</p>	<p>Encourage participants to ask questions for clarification.</p> <p>Thank participants for their active participation.</p>



NARRATIVE

MODULE 7: MALE CONDOM SESSION 1: MALE CONDOM

The condom is one of the barrier methods. Barrier methods mechanically or chemically prevent fertilization or the union of the egg and sperm cell. The male condom is the only FP method included in the Philippine FP Program that prevents both pregnancy and sexually transmitted infections (STIs).

DESCRIPTION

The condom is a sheath made of thin, latex rubber made to fit over a man's erect penis.

MECHANISM OF ACTION

- Prevents entry of sperm into the vagina.
- Sperm and disease-causing organisms including HIV do not pass through intact latex rubber or polyurethane condoms.
- Some condoms have a spermicidal coating, which adds to its effectiveness.

EFFECTIVENESS

- Condoms in order to be effective must be used correctly and consistently. If correctly and consistently used, it is **98%** effective; as typically used, **85%**.

Condoms

- Offer dual protection from STIs, HIV and also prevent pregnancy.
- Prevent sexually transmitted infections which include HIV, gonorrhea, syphilis, chlamydia, trichomoniasis, herpes, genital wart virus (HPV). However, condoms cannot prevent sores and warts caused by STIs on the skin not covered by it.
- Reduce the risk of HIV infection by 80%-90%. They can reduce the risk of STIs to a very low level, if used correctly and consistently.

The most common condom failures that result in pregnancy or STI transmission are due to user-related causes. Below is the list of the use-related causes for condom failures;

1. **Inconsistent use**- inconsistent use means condoms are not used in every sexual intercourse.
2. **Incorrect use**

Common mistakes encountered when using condoms:

- Unrolling a condom before putting it on (this causes tears or breaks)
- Not "pressing the tip" of the condom
- Tearing caused by wearing of jewelry (ring) and fingernails
- Putting a condom on with the rolled rim inward toward the penis instead of away from it
- Stretching/pulling on the condom which weakens the thin rubber

3. **Other causes:**

- Failure to hold on to the rim of condom when withdrawing, resulting in spills/leaks
- Having intercourse first, then stopping to put condom on
- Condom Breakage - Condom breaks can occur due to:
 - Inadequate vaginal lubrication
 - Defects in the condom itself
 - Poor or improper storage with exposure to heat, ultraviolet light, and/or humidity
 - Application of certain mineral and vegetable oils as lubricants, which can weaken the latex

Condoms are more likely to break if:

- Used after the expiration date on package
- The seal on the package is broken
- Not produced by a reliable manufacturer
- Stored in high temperatures or exposed to sunlight

Inexperienced users tend to report more condom breaks than those who know how to use condoms correctly.

ADVANTAGES

- Protects against sexually transmitted infections, including HIV
- Easy to use
- Usually easy to obtain
- Usually inexpensive
- Safe, effective, and portable
- Helps protect against cervical cancer through prevention of HPV infection
- Allows men to share more responsibility in family planning
- Helps some men with premature ejaculation or to maintain erection
- Convenient for short-term contraception

DISADVANTAGES

- Coitus-related (must be used during sexual intercourse)
- Some men complain of decreased sensitivity
- Interrupts the sexual act
- Slipping off, tearing, spillage of sperm can occur, especially among inexperienced users
- Allergy to latex (rare)
- Requires high motivation for consistent and correct use
- Deteriorates quickly when storage conditions are poor
- Causes difficulty in maintaining erection

THE WHO MEDICAL ELIGIBILITY CRITERIA FOR CONDOM USE

Category 1: Use the method without restriction

- Couples who are reliable users and who ask for it
- Couples who wish to use a backup method when the use of another method is interrupted; e.g. missed pills
- Couples with high risk of STIs
- Couples who use it as a temporary method until another method is used or becomes effective (e.g. three months post-vasectomy)
- A woman who is at high risk for or is unwilling to use other contraceptive methods (there are no systemic effects from condom use)
- A woman who is breastfeeding and needs contraception (condoms have no effect on lactation and are a complementary FP method for lactating women who no longer meet LAM criteria)
- When other methods are medically contraindicated to either of the couple or for personal reasons.
- The male condom can help men who have problems with premature ejaculation; it can aid them in postponing ejaculation

Category 4: Do not use the method.

- In general, anyone CAN use condoms safely and effectively if not allergic to latex

- Only one medical condition prevents use of condoms and this is if either or both of the sex partners have severe allergy to latex rubber (severe redness, itching, swelling after condom use). The service provider can know this condition by asking the client. No test or examination need to be performed.

If the client is at risk of STIs, including HIV, he/she may want to keep using condoms despite the allergy.

CONDOM STORAGE

1. Store condoms in a cool and dry place out of direct sunlight (heat may weaken latex).
2. Don't use a bad condom.
 - Check the expiration or manufacture date on the box or individual package of condoms. Expiration dates are marked as "Exp."; otherwise, the date is the manufactured date (MFG). Latex condoms should not be used beyond their expiration date or more than five years after the manufactured date. Latex condoms with spermicide should be used within two years of the manufactured date.
3. Condoms in damaged packages or show obvious signs of deterioration (e.g. brittleness, stickiness, or discoloration) should not be used regardless of their expiration date.

HOW TO USE THE CONDOM TIPS

- Do not use condoms that are expired or when the package is perforated.
- Use the condom before the penis comes in contact with the partner's mouth, anus, or vagina.
- If the penis is uncircumcised, pull the foreskin back before putting on the condom. Keep the condom on the penis until after intercourse or ejaculation.
- If the condom breaks or falls off during intercourse but before ejaculation, stop and put on a new condom. A new condom can also be used when you have prolonged intercourse or different types of intercourse within a single session (e.g. vaginal and anal).
- Use a new condom from "start to finish" with each act of vaginal, oral, or anal intercourse. Do not reuse condoms.
- Take off the condom without spilling semen on the vaginal opening by holding the rim of the condom while withdrawing the penis.
- Adequate lubrication is important in condom use and there are lubricants which can and cannot be used with latex condoms. If lubrication is needed:
 - For latex condoms, use only water-based lubricants like water, lubricants or spermicidal creams, jellies, foam, or suppositories.
 - Avoid oil-based lubricants like cold cream, mineral oil, cooking oil, petroleum jelly, body lotions, massage oil, or baby oil that can damage latex condoms.
 - For polyurethane condoms, any type of lubricant can be used.

STEPS

1. Check package for manufactured or expiration date and perforation.
2. Slide condom to one side of the package and tear the opposite side.
Hint: Do not use teeth or sharp object to open the package.
3. Remove condom from the package.
4. Unroll condom slightly to make sure it unrolls properly with the rolled ring outward.
5. Place condom on the tip of the erect penis.
6. Pinch the tip of the condom while unrolling condom down to the base of the penis. This will squeeze air out of the tip of the condom and allow space for the ejaculation.

7. After ejaculation, hold on to the condom at the base of the penis, while withdrawing penis from the vagina.
8. Withdraw penis while still erect.
9. Remove condom from the penis.
10. Tie and wrap the condom to prevent spills or leaks.
11. Dispose of condom properly.

Correcting Misconceptions

The use of male condoms:

- Do not make men sterile, impotent, or weak
- Do not decrease men's sex drive
- Cannot get lost in the woman's body
- Do not have holes that HIV can pass through
- Are not laced with HIV
- Do not cause illness in a woman because they prevent semen or sperm from entering her body
- Do not cause illness in men because sperm "backs up"
- Are only for married couples. They are not only for use outside marriage

Key Learning points

1. Use of condoms encourages men's participation in contraception.
2. When used consistently and correctly, condoms provide effective protection from pregnancy and from sexually transmitted infections.
3. Correct and consistent condom usage protects against HIV and other STIs.
4. Only one medical condition prevents use of condoms and this is if either or both of the sex partners have severe allergy to latex rubber (severe redness, itching, swelling after condom use).
5. Condoms help to protect women from cervical cancer and pelvic inflammatory disease (PID).
6. Condoms should always be provided along with another method to any client:
 - Who might be at risk for sexually transmitted infections;
 - Who uses oral contraceptives (in case she forgets to take a pill);
 - Who had a vasectomy (condoms should be used for at least three months after vasectomy and until zero sperm is noted on examination of the semen);
 - Who might need condoms for any reason.



MODULE 8



Long-Acting and Permanent Methods

Session 1: Intrauterine Device
Session 2: Permanent Methods

MODULE 8: LONG-ACTING AND PERMANENT METHODS

MODULE OVERVIEW

This module will cover both long-acting and permanent methods. There are four contraceptive methods that are categorized as long acting and/or permanent: IUDs, implants, female sterilization, and vasectomy. IUDs and implants are long-acting and temporary. When they are removed, return to fertility is prompt. Female sterilization and vasectomy are permanent methods. In the Philippines, implants are not available so this module will only cover the other three methods.

Session1 of the module will tackle the knowledge portion of the Intrauterine Device and Session 2 will provide an overview of the permanent methods by describing both male and female voluntary surgical contraception (VSC): vasectomy and bilateral tubal ligation (BTL), respectively.

The Intrauterine Device (IUD) is one of the family planning methods provided by the Philippine Family Planning Program. Used by 4.1%¹ of women in the Philippines, it is one of the most effective child spacing methods available to women in the country. This method, because it is long-acting, can be used by women who do not want any more children.

Permanent methods next to COCs are the most commonly availed FP methods used by a total of 10.5% married Filipino men and women.

MODULE OBJECTIVES

At the end of the module, the participants will be able to:









- Understand the long-acting and permanent methods (i.e., IUD, BTL, and vasectomy).
- Identify clients suitable for each of the long-acting and permanent methods.

MODULE SESSIONS

The module contains the following sessions:

Session 1	Intrauterine Device
Session 2	Permanent Methods

¹ 2006 Family Planning Survey, National Statistics Office 2 Ibid.

Topics/Contents	Teaching-Learning Process
 <h2 data-bbox="377 322 597 360">MODULE 8</h2>  <h3 data-bbox="377 421 735 495">LONG-ACTING AND PERMANENT METHODS</h3>	
<p data-bbox="169 629 404 656"> MODULE OVERVIEW</p> <p data-bbox="169 701 330 728"> OVERVIEW</p> <ul data-bbox="178 801 727 943" style="list-style-type: none"> • Builds the knowledge of service providers on the long-acting and permanent FP methods available in the Philippines. • The knowledge acquired from this module will enable service providers to inform clients on the long-acting and permanent methods and provide effective FP counseling. 	<p data-bbox="793 658 1028 689">Greet participants.</p> <p data-bbox="793 732 1362 801">Present an overview of the module as written on the slide.</p>
<p data-bbox="169 1055 420 1081"> MODULE OBJECTIVES</p> <p data-bbox="169 1126 349 1153"> OBJECTIVES</p> <ul data-bbox="178 1223 727 1317" style="list-style-type: none"> • Understand the long-acting and permanent methods (i.e., IUD, BTL, and vasectomy). • Identify clients suitable for each of the long-acting and permanent methods. 	<p data-bbox="793 1084 1310 1153">State the module objectives as written on the slide.</p>
<p data-bbox="169 1471 398 1498"> MODULE SESSIONS</p> <p data-bbox="169 1543 326 1570"> SESSIONS</p> <p data-bbox="304 1648 526 1668">Session 1 - Intrauterine Device</p> <p data-bbox="304 1695 536 1715">Session 2 - Permanent Methods</p>	<p data-bbox="793 1503 1298 1534">Enumerate the sessions of the module.</p>

INTRAUTERINE DEVICE (IUD)

LEARNING OBJECTIVES

At the end of the session, the participants must be able to:

1. Describe the types of IUD available in the Philippines.
2. Describe the TCu380A in terms of its:
 - Features
 - Mechanism of Action
 - Effectiveness
 - Advantages and Disadvantages
3. Explain the possible side effects of IUD use.
4. Explain the WHO Medical Criteria for initiating IUD use.
5. Screen suitability of clients for IUD use employing the Medical Eligibility Checklist for Copper IUD.
6. Explain when the IUD can be inserted.
7. Enumerate the warning signs that indicate complications of IUD.
8. Correct misconceptions on the IUD based on the knowledge acquired on the method.

METHODOLOGY






Illustrated Lecture-Discussion
Brainstorming
Exercise


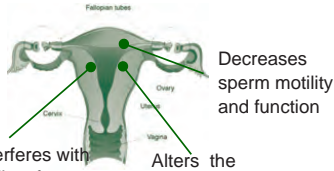
TIME ALLOTMENT

30 minutes

ADVANCE PREPARATION OF MATERIALS

- Powerpoint presentation
- Laptop and LCD
- Metacards
- Marker pens, tapes
- Whiteboard and whiteboard marker
- WHO Medical Eligibility Criteria Table or MEC Wheel
- Copies of the Medical Eligibility Checklist for Copper IUD

Topics/Contents	Teaching-Learning Process
 <h2 data-bbox="320 271 544 315">SESSION 1</h2>  <h3 data-bbox="320 371 584 405">Intrauterine Device</h3>	
<p data-bbox="161 577 440 607"> LEARNING OBJECTIVES</p> <p data-bbox="177 663 419 692"> Learning Objectives</p> <ul data-bbox="177 741 655 931" style="list-style-type: none"> • Describe the types of IUDs available. • Describe the TCu380A in terms of its: <ul style="list-style-type: none"> • Features • Mechanism of Action • Effectiveness • Advantages and Disadvantages • Explain the possible side effects. • Explain the WHO Medical Eligibility Criteria for Initiating IUD use. <p data-bbox="177 999 419 1028"> Learning Objectives</p> <ul data-bbox="177 1093 743 1256" style="list-style-type: none"> • Screen clients suitability for IUD use utilizing the Medical Eligibility Checklist for Copper IUD. • Explain when the IUD can be inserted. • Enumerate the warning signs that indicate complications of IUD use for which clients must be referred. • Correct misconceptions on the IUD based on the knowledge acquired on the method. 	<p data-bbox="802 600 1382 707">Introduce the session by stating the objectives while flashing the appropriate presentation slides.</p>
<p data-bbox="288 1447 612 1476">What Do you Know About the IUD???</p>	<p data-bbox="802 1368 1370 1514">Ask participants to write on metacards what they know or heard about the IUD. Write one information per metacard. Post the metacards on the board.</p>
<p data-bbox="172 1682 308 1711">Types of IUDs</p> <p data-bbox="188 1738 414 1767">Types of IUDs Available</p> <ol data-bbox="177 1854 732 1951" style="list-style-type: none"> 1.Copper bearing (TCu380A)- commonly available 2.Hormone releasing intrauterine system - steadily releases small amounts of levonorgestrel daily 	<p data-bbox="802 1697 1342 1771">State the two types of IUDs available in the Philippines as presented on the slide.</p> <p data-bbox="802 1816 1074 1845">Tell participants that:</p> <ul data-bbox="802 1850 1318 1957" style="list-style-type: none"> • The TCu380A is effective for 12 years • The hormone releasing intrauterine system is effective for five years

Topics/Contents	Teaching-Learning Process
<p data-bbox="216 203 448 230">Description the TCU380A</p> <p data-bbox="228 264 381 291">What is an IUD?</p>  <ul data-bbox="208 580 788 698" style="list-style-type: none"> • A small device made of plastic and copper. • It is placed in the uterus through the vagina and the cervix using a small applicator. • It has two thin strings attached, which hang down into the vagina. 	<p data-bbox="832 226 1397 333">Describe the TCU380A by flashing the slide which describes the TCU380A and its packaging.</p>
<p data-bbox="228 777 487 804">TCu380A Insertion Package</p> <ul data-bbox="216 844 591 1059" style="list-style-type: none"> • Pre-sterilized package containing : <ul data-bbox="315 893 591 1059" style="list-style-type: none"> • Inserter tube with a blue-depth-gauge • White plastic rod • Measurement insert • TCU380A laden with barium sulfate 	<p data-bbox="832 768 1404 878">Show the TCU380A in its package and its contents while being named. Supplement the presentation by flashing the appropriate slide.</p> <p data-bbox="832 918 969 949">State that:</p> <ul data-bbox="832 992 1404 1288" style="list-style-type: none"> • The shelf life of each pre-sterilized TCU380A insertion package is seven years. • The expiration date refers only to the shelf life of the sterility of the package. This means that if an IUD is inserted on the day before the expiration date (provided the package is not torn or damaged), its effectiveness is for a full 12 years from the time of insertion.
<p data-bbox="228 1393 428 1420">Mechanism of Action</p> <p data-bbox="233 1473 343 1496">Copper ions...</p>  <ul data-bbox="346 1496 707 1688" style="list-style-type: none"> Decreases sperm motility and function Alters the uterine and tubal environment Interferes with ability of sperm to pass through uterine cavity 	<p data-bbox="832 1384 1337 1453">Further describe the IUD by stating the IUD's primary mechanism of action as:</p> <p data-bbox="832 1496 1169 1529">Preventing fertilization by:</p> <ul data-bbox="867 1572 1404 1718" style="list-style-type: none"> • Altering the uterine and tubal environment • Interfering with the ability of sperm to pass through the uterine cavity • Decreasing sperm motility and function
<p data-bbox="228 1776 357 1803">Effectiveness</p> <ul data-bbox="216 1836 548 1928" style="list-style-type: none"> • One of the most effective long-acting method • Effective for 12 years • Perfect use: 99.4% • Common used: 99.2% 	<p data-bbox="832 1758 969 1792">State that:</p> <ul data-bbox="832 1834 1389 2013" style="list-style-type: none"> • The IUD is one of the most effective contraceptive methods. • The TCU380A is effective for 12 years. • When perfectly used, 99.4% effective, and as commonly used, 99.2% effective.

Topics/Contents	Teaching-Learning Process
<p>Advantages</p> <ul style="list-style-type: none"> • Highly effective and very safe • Immediate return of fertility • May be safely used immediately postpartum and by lactating women • Long duration of use and economical • Provides worry-free, continuous protection for 12 years • Allows privacy • Does not interact with medications client may be taking 	<p>State the advantages of the IUD as presented on the slide.</p>
<p>Disadvantages</p> <ul style="list-style-type: none"> • Requires a pelvic examination to insert the IUD • Requires a trained health service provider for insertion and removal • Does not protect against STIs • Increases the risk of PID for women with STIs • Device may be expelled 	<p>Tell the disadvantages of the IUD as presented on the slide.</p>
<p>Timing of IUD Insertion</p> <p>Timing of IUD Insertion</p> <ul style="list-style-type: none"> • Postpartum Insertion <ul style="list-style-type: none"> • Within 10 minutes after delivery of the placenta for immediate postpartum insertion • Within 48 hours after delivery • Not recommended after 48 hours to less than four weeks unless no other method available • Caesarean delivery: eight weeks postpartum 	<p>Tell that:</p> <ul style="list-style-type: none"> • IUD insertion can be: <ul style="list-style-type: none"> • Postpartum • Interval • Post abortion <p>Expound on the above information as presented on the slides.</p>
<p>Timing of IUD Insertion</p> <ul style="list-style-type: none"> • Interval Insertion <ul style="list-style-type: none"> • Any time during menstrual bleeding • Any other time within the menstrual cycle at the client's convenience, provided that it is reasonably certain that the woman is not pregnant • Post abortion <ul style="list-style-type: none"> • Immediately after evacuation, if no infection 	<p>Tell the participants that since they have not undergone the skills training in IUD insertion and removal, clients who express desire to have an IUD should be referred to a facility or service provider who has been trained in IUD insertion.</p>
<p>IUD and Infection</p> <ul style="list-style-type: none"> • The risk of upper reproductive tract infections among IUD users is low (less than 1%). • Risk is highest within the first 20 days (three weeks) after IUD insertion due to lack of proper infection prevention practices. • After the first 20 days, the risk of infection among IUD users appears to be comparable to that among non-IUD users. 	<p>On the issue of infection, say that:</p> <ul style="list-style-type: none"> • The risk of upper reproductive tract infections among IUD users is low (less than 1%). • The risk of these infections is highest within the first three weeks after IUD insertion, and is thought to be related to lack of proper infection prevention practices, rather than to the IUD itself. • After the first three weeks, the risk of infection among IUD users appears to be comparable to that among non-IUD users. This means that it is not the IUD that causes the infection.

Topics/Contents	Teaching-Learning Process
<p>IUD and Ectopic Pregnancy Risks</p> <ul style="list-style-type: none"> • Less than 1% of IUD users become pregnant. • IUDs do not increase the risk of ectopic pregnancy. • IUD users are 50% less likely to have an ectopic pregnancy than are women using no contraception (WHO multi-center study). • If an IUD user becomes pregnant, rule out the possibility of an ectopic pregnancy, just as for all pregnancies. 	<p>Emphasize that the IUD does not increase the risk of ectopic pregnancy. Flash the slide that states this information.</p> <p>Ask a participant to read the information.</p> <p>Ask participants at random on their understanding of the information on IUD. Expound as needed.</p>
<p>Possible Side Effects</p> <p>Possible Side Effects (not harmful and will subside in a few weeks)</p> <ul style="list-style-type: none"> • Menstrual changes: increase in duration and amount of bleeding • Changes in bleeding pattern: spotting or light bleeding in between menstrual periods • Discomfort and cramping 	<p>Tell participants that:</p> <ul style="list-style-type: none"> • Not all clients using the IUD will experience side effects. • If any of these possible side effects occur, the client is reassured that this does not require treatment. <p>Enumerate the possible side effects as written on the slide.</p> <p>Tell participants that:</p> <ul style="list-style-type: none"> • For these possible side effects, the service provider should reassure the client that these will diminish within three months. • If the client cannot tolerate the side effect, help her choose another method.
<p>The WHO MEC for IUD</p>	<p>Ask participants to refer to the WHO Medical Eligibility Criteria for Starting Contraceptive Methods summary table or the MEC Wheel (if available).</p> <p>Reiterate the interpretation of the categories of the WHO eligibility criteria as:</p> <ul style="list-style-type: none"> • Categories 1 and 2 “CAN USE”, and Categories 3 and 4 “CANNOT USE”. <p>Exercise:</p> <p>Give examples of conditions. For each condition, ask participants at random to state the WHO category of the condition and the recommendation (can or cannot use). Participants are asked to use either the MEC wheel or the WHO MEC Summary Table.</p>

Topics/Contents	Teaching-Learning Process
<p>Using the MEC Checklist for Copper IUD</p> <p>Medical Eligibility Checklist for Copper IUDs</p> <p>Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use an IUD if she wants. If she answers YES to a question below, follow the instructions.</p> <ol style="list-style-type: none"> Do you think you are pregnant? <input type="checkbox"/> No <input type="checkbox"/> YES Assess whether pregnant (see How to tell if a woman is not pregnant). Do not insert IUD. Give her condoms or spermicide to use until reasonably sure that she is not pregnant. In the last 3 months have you had vaginal bleeding that is unusual for you, particularly between periods or after sex? <input type="checkbox"/> No <input type="checkbox"/> YES If she has unexplained vaginal bleeding that suggest an underlying medical condition, do not insert IUD until the problem is diagnosed. Evaluate by history and during pelvic exam. Diagnose and treat as appropriate, or refer. Did you give birth more than 48 hours but less than four weeks ago? <input type="checkbox"/> No <input type="checkbox"/> YES Delay inserting an IUD until four or more weeks after childbirth. If needed, give her condoms or spermicide to use until then. Do you have infection following childbirth? <input type="checkbox"/> No <input type="checkbox"/> YES If she has puerperal sepsis (genital tract infection during the first 42 days after childbirth), do not insert IUD. Refer for care. Help her choose another effective method. <p>Note: Assure confidentiality before asking remaining questions.</p> <ol style="list-style-type: none"> Have you had a sexually transmitted infections (STI) or pelvic inflammatory disease (PID) in the last three months? Do you have an STI, PID or any other infection in the female organs now? (Signs and symptoms of PID: severe pelvic infection in the female organs) <input type="checkbox"/> No <input type="checkbox"/> YES Do not insert IUD now. Urge her to use condoms for STD protection. Refer or treat client and partner(s). IUD can be inserted three months after use unless reinfection is likely. Do you have an infection following childbirth? <input type="checkbox"/> No <input type="checkbox"/> YES If she has AIDS, is infected with HIV, or is being treated with medicines that make her body less able to fight infections, careful clinical judgment should be made. In general, do not insert IUD unless other methods are not available or acceptable. Whatever methods she chooses, urge her to use condoms. Give her condoms. Do you think you might get an STI in the future? Do you or your partner have more than one sex partner? <input type="checkbox"/> No <input type="checkbox"/> YES If she is at risk of STIs, explain that STIs can lead to infertility. Urge her to use condoms for STI protection. Do not insert IUD. Help her choose another method. Do you have any cancer in the female organs or pelvic tuberculosis? <input type="checkbox"/> No <input type="checkbox"/> Yes Known cervical, endometrial, or ovarian cancer; benign or malignant trophoblast disease; pelvic tuberculosis: Do not insert IUD. Treat or refer for care as appropriate. Help her choose another effective method. <p>Be sure to explain the health benefits and risks and the side effect of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.</p>	<p>Give copies of the MEC Checklist for Copper IUD to participants.</p> <p>Tell participants that:</p> <ul style="list-style-type: none"> The WHO MEC Wheel or the WHO Medical Eligibility Criteria for Starting Contraceptive Methods (summary table) is used to determine appropriate methods for a client based on the findings using the FP Form 1. The MEC Checklist for Copper IUD is used by the IUD service provider prior to IUD insertion to determine whether the IUD is a suitable method for a client who has chosen it. <p>Orient the participants on the use of the checklist.</p> <p>Review each of the items on the checklist.</p>
<p>WARNING SIGNS</p> <p>WARNING SIGNS (for immediate consultation/referral)</p> <ul style="list-style-type: none"> Client thinks that she may be pregnant (missed menstrual period) Client thinks that the IUD might be out of place (strings missing, hard plastic felt) Client has symptoms of infection (increasing severe lower abdominal pain, pain during sex, unusual vaginal discharge, fever, chills, nausea and/or vomiting) <p>WARNING SIGNS (for immediate consultation/referral)</p> <p>Period late Abdominal pain Infection Not feeling well String problems (missing or longer)</p>	<p>State that:</p> <ul style="list-style-type: none"> The service provider should instruct the client to immediately seek consultation when any of the signs occur. <p>List the warning signs while flashing the slides.</p> <ul style="list-style-type: none"> To facilitate recall of the warning signs, think of PAINS.
<p>Counteracting Misconceptions</p>	<p>Refer to the metacards earlier posted by participants on what they know and have heard about the IUD. For each of the information, get the consensus of participants, whether this is a fact or a misconception. For each misconception, call a participant at random to correct the misconception.</p>
<p>Conclusion</p>	<p>Flash the slides on the session objectives. Ask participants if these objectives have been attained during the session.</p>



NARRATIVE

MODULE 8: LONG-ACTING AND PERMANENT METHODS SESSION 1: INTRAUTERINE DEVICE

BASIC INFORMATION ABOUT THE IUD

The TCu380A

TYPES OF IUD

Common types of IUDs available worldwide are as follows:

- Copper-bearing, which includes the TCu380A (TCu380A, TCu380A with safe load; and TCU 200), the Multiload (MLCu 250 and Cu375), and the Nova T
- Medicated with a steroid hormone, such as Mirena®, the levonorgestrel-releasing intrauterine system (LNG-IUS)

The main IUD featured in this learning package is the TCu380A (or Copper T), which is:

- widely used
- well known for its effectiveness, ease of insertion and removal, wide margin of safety, acceptability to clients, and low cost
- effective for at least 12 years

The TCu380A Insertion package

- Each TCu380A comes in a pre-sterilized package that contains the equipment needed to insert the IUD.
- The package includes a clear plastic *inserter tube* with a *blue-depth-gauge*, which can be moved along the length of the tube and functions as a cervical stop.
- A white *plastic rod* is used in conjunction with the inserter tube to place the *TCu380A* in the uterus. The strings and stem of the T will already be inside the inserter tube.
- The package also contains an *identification card*, which also serves as a measurement insert.

The TCu380A looks like the letter "T" and contains barium sulfate so that it can be seen on X-ray.

There are small copper bands on each "arm" of the T, which ensure that copper is lodged high in the fundus of the uterus. The "stem" is also wound with copper wire. A thin polyethylene string is attached to the bottom of the stem to determine correct positioning of the IUD and for easy removal.



Copper T 380A IUD



Copper T 380A IUD inside the Uterus

Mechanism of Action

Copper-bearing IUDs, such as the Copper T, act primarily by preventing fertilization (Rivera et al., 1999). Copper ions decrease sperm motility and function by altering the uterine and tubal fluid environment, thus preventing sperm from reaching the fallopian tube and fertilizing the egg.

Effectiveness

The IUD is a highly effective form of long-term, reversible contraception, with an associated failure (pregnancy) rate of less than 1 % (0.8%) in the first year of use (Trussell, 2004a). In a long-term, international study sponsored by the WHO, the average annual failure rate was 0.4% or less, and the average cumulative failure rate over the course of 12 years was 2.2%, which is comparable to that of tubal sterilization (United Nations Development Programme et al., 1997). Service providers can tell their family planning clients that the IUD is the most effective, reversible contraceptive currently available.

Effective Life

The latest scientific evidence shows that the TCU380A is effective for at least 12 years (United Nations Development Programme et al., 1997), although the US Food and Drug Administration (USFDA) has approved it for only 10 years (as of this printing). Clients who have had a Copper T inserted should be advised that it should be replaced or removed 12 years from the date of insertion.

Shelf Life

According to the USFDA, the shelf life of each presterilized Copper T 380A insertion package is seven years. It is important to note that the expiration date on the IUD package refers only to the shelf life of the sterility of the package, and not to the contraceptive effectiveness of the IUD itself. This means that even if an IUD is inserted on the day before the expiration date (provided the package is not torn or damaged), it is still effective for the full lifespan of contraceptive efficacy. In other words, the Copper T 380A would be effective for a full 12 years from that date. On the expiration date, the IUD should be discarded.

Advantages

The IUD has the following advantages:

- Highly effective and very safe
- Reversible and economical
- May be safely used by lactating and immediate postpartum women
- Good choice for women who cannot use other methods
- Long duration of use (up to 12 years for TCU380A)
- Once inserted they are convenient and extremely easy to use, providing worry-free continuous protection
- Allows privacy and control over her fertility (client does not have to use anything at the time of sexual intercourse)
- Does not interact with medications client may use
- No systemic side effects as its effects are confined to the uterus

Disadvantages

- Requires a pelvic exam to insert the IUD
- Requires a trained health service provider to insert/remove the IUD
- Does not protect against STIs
- Increases the risk for PID for women with STIs
- Device may be expelled, possibly without the woman knowing it (especially for postpartum insertions)

Return to Fertility

A client's fertility returns immediately after an IUD is removed (Andersson et al., 1992). This message should be made very clear to clients having an IUD removed. Unless they want to get pregnant, they should have another IUD inserted immediately after removal (if desired and appropriate) or start another contraceptive method.

Health Benefits and Potential Health Risks

Non-hormonal IUDs, such as the Copper T, may protect against endometrial and cervical cancer (Hubacher and Grimes, 2002). Potential health risks associated with the IUD, which are uncommon or rare, are discussed below:

• Uterine perforation

Perforation of the uterus during IUD insertion has been shown to be rare, with fewer than 1.5 perforations per 1,000 insertions occurring in large clinical trials (United Nations Development Programme et al., 1997; Trieman et al., 1995). This minimal risk is associated with the level of provider skill and experience (Harrison-Woolrych et al., 2003). When the IUD is inserted by a skilled provider, the risk has been shown to be as low as 1 per 1,000 insertions (WHO, 1987) and 1 per 770-1,600 insertions (Nelson, 2000). If perforation occurs, the risk of serious complications is low and the need for surgical intervention rare (Penney et al., 2004).

• Expulsion

Although IUD failure is rare, expulsion is the most common cause (ARHP, 2004). In the first year of IUD use, 2-8% of women spontaneously expel their IUDs (Trieman et al., 1995). There are several factors that increase the risk of expulsion:

- ✓ Skill and experience of the provider is the most common factor (Chi, 1993).
Correct insertion, with the IUD placed high in the uterine fundus, is thought to reduce the chances of expulsion.
- ✓ Timing
Expulsion is most likely to occur within the first three months post-insertion and is more common in women who are nulliparous, have severe dysmenorrhea, or have heavy menstrual flow (Zhang et al., 1992).

The risk of expulsion is higher (11-25% after 12 months of use) when the IUD is inserted immediately after childbirth (more than 10 minutes but less than 48 hours after delivery of the placenta) (Trieman et al., 1995), and when inserted immediately after a second-trimester abortion (Grimes, Schulz, and Stanwood, 2002).

• Infection

According to the latest research, the risk of upper genital tract infection among IUD users is less than 1%, which is much lower than previously thought. This minimal risk is highest within the first 20 days after IUD insertion, and is related to insertion technique (due to lack of proper infection prevention practices) rather than to the IUD itself (Hatcher et al., 2004). After the first 20 days, the risk of infection among IUD users appears to be comparable to that among non-IUD users (Hatcher et al., 2004).

Possible Side Effects

A common side effect of copper-bearing IUDs is menstrual changes. Use of the Copper T has been associated with an increase of up to about 50% in the duration/amount of menstrual bleeding, and this is the most common reason for removal (Penney et al., 2004). Changes in bleeding patterns, such as spotting/light bleeding (between periods), may also occur in the first few weeks.

Finally, some women may experience discomfort or cramping during IUD insertion (Grimes, 2004) that could last for the next several days. Cramping/pain and changes in bleeding amount/patterns usually are not harmful for the client and often subside within the first few months after IUD insertion. Women should be advised of these common side effects before IUD insertion, and assessed for and counseled about it afterward. Non-steroidal anti-inflammatory drugs (NSAID) can lessen symptoms (WHO, 2004b), and good counseling can encourage continued use of the method (Backman et al., 2002).

Warning Signs

The service provider should instruct the client to immediately seek consultation when:

- She thinks that she may be pregnant. This is when she has missed a menstrual period and has signs of pregnancy.
- She thinks that the IUD might be out of place. For example, when the strings are missing or the hard plastic of the IUD is felt.
- She has symptoms of infection like increasing or severe pain in the lower abdomen, pain during sexual intercourse, unusual vaginal discharge, fever, chills, nausea and/or vomiting.

The signs of complication can be easily remembered: **PAINS**

Period late

Abdominal pain

Infection

Not feeling well

Strings missing or longer

Addressing Common Misconceptions About the IUD

Many misconceptions about the IUD remain despite scientific evidence to the contrary. The following section presents recent research to refute some of these misconceptions, while providing a basis for new recommendations and practices related to IUD.

8.12

<p>The IUD does not act as an abortifacient.</p>	<p>Studies suggest that the IUD prevents pregnancy primarily by preventing fertilization rather than inhibiting implantation of the fertilized egg (Rivera et al. 1999; Alvarez et al. 1988). This is particularly true of the copper-bearing IUDs.</p>
<p>The IUD does not increase a client's risk of ectopic pregnancy.</p> <p>The absolute number of ectopic pregnancies among IUD users is much lower than that among the general population.</p>	<p>The IUD reduces the risk of ectopic pregnancy by preventing pregnancy. Because IUDs are so effective at preventing pregnancy, they also offer excellent protection against ectopic pregnancy. Women who use copper-bearing IUDs are 91% less likely than women using no contraception to have an ectopic pregnancy (Sivin, 1991).</p> <p>The following points should be considered:</p> <ul style="list-style-type: none"> • Less than 1% of IUD users become pregnant, which reduces a woman's risk for ectopic pregnancy. • IUD users are 50% less likely to have an ectopic pregnancy than are women using no contraception.

	<ul style="list-style-type: none"> ⦿ However, in the unlikely event that an IUD user becomes pregnant, she has equal chances of having an ectopic pregnancy as non-users. Since ectopic pregnancy is a serious condition that requires emergency care, this condition must be considered. ⦿ Among IUDs, the TCU380A and Multiload Cu375 have the lowest rates of ectopic pregnancy (WHO, 1987). A long-term study of women using the TCU380A found the rate to be less than 1 (0.09%) per 100 women at one year, and less than 1 (0.89%) per 100 women at 10 years (Ganacharya, Bhattoa, and Batar, 2003). ⦿ Women with a history of ectopic pregnancy can use the IUD with no restrictions.
<p>The IUD does not cause PID, nor does the IUD need to be removed to treat PID.</p>	<p>Strict randomized controlled trials and literature reviews reveal that PID among IUD users is rare (ARHP, 2004; Grimes, 2000). Early studies that reported a link between PID and IUD use were flawed and poorly designed. Inappropriate groups were used for comparison, infection in IUD users was over-diagnosed, and there was a lack of control for confounding factors (Buchan et al., 1990).</p> <p>Here are some important points about PID and the IUD based on recent research:</p> <ul style="list-style-type: none"> ⦿ During the first three to four weeks after IUD insertion, there is a slight increase in the risk of PID among IUD users compared to non-IUD users, but it is still rare (less than 7/1,000 cases). After that, an IUD user appears to be no more likely to develop PID than a non-IUD user (Farley et al., 1992). ⦿ PID in IUD users is caused by the STIs, gonorrhea and chlamydia, not the IUD itself (Darney, 2001; Grimes, 2000). However, the risk is still very low, with an estimated three cases per 1,000 insertions in settings with a high prevalence (10%) of these STIs (Shelton, 2001). ⦿ If PID occurs, the infection can be treated while the IUD is kept in place, if the client so desires. Studies have shown that removing the IUD does not have an impact on the clinical course of the infection. If the infection responds to treatment within 72 hours, the IUD does not need to be removed (WHO, 2004b). ⦿ Randomized controlled trials and cohort studies reveal that the monofilament string does not increase the risk of PID (Grimes, 2000). ⦿ Women who have a history of PID can generally use the IUD (the advantages generally outweigh the risks), provided their current risk for STIs is low.

<p>The IUD does not cause infertility.</p>	<p>Infertility caused by tubal damage is associated not with IUD use, but with chlamydia (current infection or - as indicated by the presence of antibodies - past infection) (Hubacher et al., 2001). Moreover, there is an immediate return to fertility after an IUD has been removed (Belhadj et al., 1986). In one study, 100% of women who desired pregnancy (97 of 97) conceived within 39 months of IUD removal (Skjeldestad and Bratt, 1988).</p>
<p>The IUD is suitable for use in nulliparous women.</p>	<p>Nulliparous women can generally use the IUD (the advantages generally outweigh the risks). In theory, the smaller size of a nulligravid uterus may increase the risk of expulsion, whereas uterine enlargement, even if due to an abortion, may promote successful IUD use (Hatcher et al., 2004). Expulsion rates tend to be slightly higher in nulliparous women compared to parous women (Grimes, 2004).</p>
<p>The IUD can be safely used by HIV-infected women who are clinically well.</p>	<p>HIV-infected women who are clinically well can generally use the IUD (the advantages generally outweigh the risks). A large study in Nairobi showed that HIV-infected women had no significant increase in the risk of complications, including infection in early months, than HIV negative women (Sinei et al., 2001). In another study of HIV-infected and HIV-negative IUD users with a low risk of STI, no differences were found in overall or infection-related complications between the two groups (Sinei et al., 1998).</p>
<p>The IUD does not increase the risk of HIV transmission.</p>	<p>There is no current evidence that use of the IUD in HIV-infected women leads to increased risk of HIV transmission. Studies have shown that among HIV infected women using the IUD, there is no increase in viral shedding and no statistically significant increase in HIV transmission to male partners (ARHP, 2004; Richardson et al., 1999).</p>
<p>The IUD does not interfere with ARV therapy.</p>	<p>Women who have AIDS, are on ARV therapy, and are clinically well can generally use the IUD (advantages generally outweigh the risks). Because it is a non-hormonal family planning method, the IUD is not affected by liver enzymes and will not interfere with or be affected by ARV therapy (ARHP, 2004; Hatcher et al., 2004).</p>

Medical Eligibility Checklist for Copper IUDs

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use an IUD if she wants. If she answers YES to a question below, follow the instructions.

1. Do you think you are pregnant?
 No YES Assess whether pregnant (see How to tell if a woman is not pregnant). Do not insert IUD. Give her condoms or spermicide to use until reasonably sure that she is not pregnant.
2. In the last three months have you had vaginal bleeding that is unusual for you, particularly between periods or after sex?
 No YES If she has unexplained vaginal bleeding that suggest an underlying medical condition, do not insert IUD until the problem is diagnosed. Evaluate by history and during pelvic exam. Diagnose and treat as appropriate, or refer.
3. Have you given birth more than 48 hours but less than four weeks ago?
 No YES Delay inserting an IUD until four or more weeks after childbirth. If needed, give her condoms or spermicide to use until then.
4. Do you have infection following childbirth?
 No YES If she has puerperal sepsis (genital tract infection during the first 42 days after childbirth), do not insert IUD. Refer for care. Help her choose another effective method.

Note: Assure confidentiality before asking remaining questions.

5. Have you had a sexually transmitted infection (STI) or pelvic inflammatory disease (PID) in the last three months? Do you have an STI, PID or any other infection in the female organs now?
(Signs and symptoms of PID: severe pelvic infection in the female organs)
 No YES Do not insert IUD now. Urge her to use condoms for STI protection. Refer or treat client and partner(s). IUD can be inserted three months after use, unless re-infection is likely.
6. Do you have an infection following childbirth?
 No YES If she has AIDS, is infected with HIV, or is being treated with medicines that make her body less able to fight infections, careful clinical judgment should be made. In general, do not insert IUD unless other methods are not available or acceptable. Whatever methods she chooses, urge her to use condoms. Give her condoms.
7. Do you think you might get an STI in the future? Do you or your partner have more than one sex partner?
 No YES If she is at risk of STIs, explain that STIs can lead to infertility. Urge her to use condoms for STI protection. Do not insert IUD. Help her choose another method.

8. Do you have any cancer in the female organs or pelvic tuberculosis?
 No YES Known cervical, endometrial, or ovarian cancer; benign or malignant trophoblast disease; pelvic tuberculosis: Do not insert IUD. Treat or refer for care as appropriate. Help her choose another effective method.

Be sure to explain the health benefits, risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.

PERMANENT METHODS

LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Describe bilateral tubal ligation (BTL) as a method for female sterilization in terms of:
 - What it is
 - Mechanism of Action
 - Effectiveness
 - Advantages and Disadvantages
2. Explain the possible side effects BTL.
3. Explain when BTL can be performed.
4. Enumerate the warning signs of complications of BTL.
5. Counteract misconceptions on BTL based on the knowledge acquired on the method.
6. Describe vasectomy as a method of male sterilization.
7. Describe vasectomy in terms of its:
 - Mechanism of Action
 - Effectiveness
 - Advantages and Disadvantages
8. Explain the possible side effects of vasectomy.
9. Enumerate the warning signs of complications of vasectomy.
10. Counteract misconceptions on vasectomy based on the knowledge acquired on the method.



METHODOLOGY

Lecture-Discussion
Brainstorming









TIME ALLOTMENT

1 hour



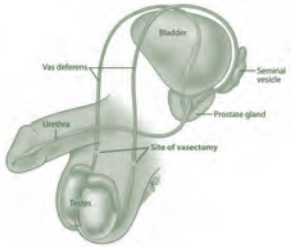
ADVANCE PREPARATION OF MATERIALS

- Powerpoint presentation
- Laptop and LCD
- Metacards
- Marker pens, tapes
- Whiteboard and whiteboard marker
- WHO Medical Eligibility Criteria Table

Topics/Contents	Teaching-Learning Process
 <h2 style="color: #008000;">SESSION 2</h2>  <h3 style="color: #008000;">Permanent Methods</h3>	
<p> LEARNING OBJECTIVES</p>	<p>Introduce the session by stating the objectives while flashing the appropriate slides.</p>
<p> Learning Objectives</p> <ul style="list-style-type: none"> • Describe BTL in terms of its: <ul style="list-style-type: none"> • Mechanism of Action • Effectiveness • Advantages and Disadvantages • Explain the possible side effects of BTL. • Explain when BTL can be performed. • Enumerate the warning signs of complications of BTL. • Counteract misconceptions on BTL based on the knowledge acquired on the method. • Describe vasectomy as a method for male sterilization. 	
<p> Learning Objectives</p> <ul style="list-style-type: none"> • Describe vasectomy in terms of its: <ul style="list-style-type: none"> • Mechanism of Action • Effectiveness • Advantages and Disadvantages • Explain the possible side effects of vasectomy. • Enumerate the warning signs of the complications of vasectomy. • Counteract misconceptions on vasectomy based on the knowledge acquired on the method. 	
<h2 style="color: #008000;">What do you know about BTL???</h2>	<p>Ask participants to write on metacards what they know or hear about BTL. Write one idea per metacard.</p>
<p>What is Bilateral Tubal Ligation (BTL)</p>	<p>Flash the slide. Describe BTL as it is stated on the slide:</p> <ul style="list-style-type: none"> • Minilaparotomy using local anesthesia and light sedation is the DOH-approved standard procedure for BTL.
<p>What is BTL</p> <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • A safe and simple surgical procedure that provides permanent contraception for women who do not want any more children. • Involves cutting or blocking the two fallopian tubes. 	
<p>Mechanism of Action</p>	<p>Tell about the mechanism of action of BTL in preventing pregnancy as written on the slide.</p>
<p>No fertilization occurs</p> <p>The fallopian tubes that carry the eggs from the ovaries are cut off and blocked. Eggs released from the ovaries cannot move down the fallopian tubes to meet the sperm.</p>	

Topics/Contents	Teaching-Learning Process
<p>Effectiveness</p> <ul style="list-style-type: none"> • 99.5% effective • Varies slightly depending on how the tubes are blocked, but pregnancy rates are still low with all techniques. 	<p>Tell that:</p> <ul style="list-style-type: none"> • BTL is one of the most effective methods of contraception but carries a small risk of failure. • It is 99.5% effective, which means that the failure rate of the method is five pregnancies per 1,000.
<p>Advantages</p> <ul style="list-style-type: none"> • Permanent method of contraception • Nothing to remember, no supplies needed, and no repeated clinic visits required • Does not interfere with sex • Does not affect a woman's ability to have sex • Results in increased sexual enjoyment - no need to worry about pregnancy • No effect on breastfeeding • No known long-term side effects or health risks • Can be performed immediately after delivery 	<p>Ask participants what they think are the advantages of BTL. Ask participants to explain responses that are unclear.</p> <p>Write their responses on the board. Supplement as presented on the slide.</p>
<p>Disadvantages</p> <ul style="list-style-type: none"> • Requires minor surgery by a specially trained physician • Requires an operating room set-up • Considered to be permanent • Does not protect against STIs and HIV • Limitation of physical activities for about one week 	<p>Ask participants what they think are the disadvantages of BTL. Ask participants to explain responses that are unclear.</p> <p>State the disadvantages of BTL as presented on the slide.</p>
<p>Possible Side Effects of BTL</p> <p>Possible Side Effects</p> <ul style="list-style-type: none"> • Related to surgical procedure: <ul style="list-style-type: none"> • Pain and swelling over the operative site (diminishes in a day or two) • Superficial bleeding 	<p>Tell participants that:</p> <ul style="list-style-type: none"> • BTL does not have any long-term side effects. • Side effects are related to the surgical procedure. • The service provider reassures the client that her complaints can be decreased by taking paracetamol every four hours, and will diminish in a day or two.
<p>Timing of BTL</p> <p>Timing of BTL</p> <p>Postpartum</p> <ul style="list-style-type: none"> • Immediately or within seven days after giving birth 	<p>Tell participants that:</p> <p>– A woman can undergo female sterilization procedure almost any time that it is reasonably certain that she is NOT pregnant.</p>

Topics/Contents	Teaching-Learning Process
<p>Interval</p> <ul style="list-style-type: none"> • From six weeks after childbirth if it is reasonably certain that the woman is not pregnant • Within seven days after the start of the woman's menstrual cycle • At any time if it is reasonably certain that the woman is not pregnant <p>Post abortion</p> <ul style="list-style-type: none"> • Within 48 hours after an uncomplicated abortion 	<p>Flash the slide and tell participants about the different times when BTL can be performed.</p> <p>Tell the participants that since they cannot perform BTL, clients who express desire to have the procedure should be referred to a facility where such services are available.</p>
<p>Warning signs</p> <p>Warning Signs</p> <ul style="list-style-type: none"> • Bleeding, pain, pus, heat, swelling or redness of the wound that becomes worse or does not heal/resolve • High grade fever • Fainting, persistent light-headedness, or extreme dizziness in the first week • Missed period 	<p>Tell participants that:</p> <ul style="list-style-type: none"> • Although they do not perform BTL and that they are not expected to manage complications, it is important that they know the signs of complications. This is to ensure that they can alert clients to seek immediate consultation when any of these complications occur or immediately refer these clients to facilities that can manage these complications. <p>Enumerate the warning signs as presented.</p>
<p style="text-align: center;">Counteracting Misconceptions on BTL</p>	<p>Refer to the metacards earlier posted by participants on what they know and have heard about BTL.</p> <p>For each of the information, get the consensus of participants whether this is a fact or a misconception.</p> <p>For each of the misconceptions, call any participant at random to correct/counter the misconception.</p>
<p>Key Messages for BTL</p> <p>Key Messages for BTL</p> <ul style="list-style-type: none"> • Safe for all women, has no long-term side effects. • No need to worry about contraception again. • Is easy to use, nothing to do or remember. • The procedure is intended to be permanent. 	<p>Tell the key messages for BTL while flashing the slide.</p> <p>Ask if participants have any questions on the information provided on BTL.</p>
<p style="text-align: center;">What do you know about Vasectomy???</p>	<p>Ask participants to write on metacards what they know or heard about vasectomy. Write one information per metacard. Post the metacards on the board or wall.</p>

Topics/Contents	Teaching-Learning Process
<p>What is Vasectomy</p> <p>What is Vasectomy</p> <ul style="list-style-type: none"> • Known as male sterilization, as it provides permanent contraception for men who decide they will not want any more children. • Safe, simple, and quick surgical procedure • Procedure involves tying and cutting a segment of the vas which carries sperm • No scalpel vasectomy (NSV) is the DOH-approved procedure • NSV is a small puncture on the scrotum to get the vas 	<p>Describe vasectomy as presented on the succeeding slides in terms of:</p> <ul style="list-style-type: none"> • What it is • Mechanism of Action • Effectiveness • Advantages • Disadvantages
<p>Mechanism of Action</p>  <ul style="list-style-type: none"> • Works by closing off each vas deferens, keeping sperm out of semen. • Semen without sperm is ejaculated, but it cannot cause pregnancy. 	
<p>Effectiveness</p> <ul style="list-style-type: none"> • Correctly used: 99.9% • Commonly used: 99.8% • More effective when used correctly <ul style="list-style-type: none"> • Use of a reliable method of contraception for three months after the procedure • Semen is checked after three months to ensure that it does not have any more sperm 	
<p>Advantages</p> <ul style="list-style-type: none"> • Safe, easy to perform • Permanent • Nothing to remember except to use condoms or another effective method for at least three months after the procedure • No supplies to get, and no repeated clinic visits required after no sperm is seen in the semen • Can be tested for effectiveness at any time • Does not affect the man's ability to have sex • Increased sexual enjoyment because there is no need to worry about pregnancy • No known long-term side effects or health risks • If pregnancy occurs in the man's partner, less likely to be ectopic 	<p>Tell the advantages of vasectomy as presented on the slide.</p>
<p>Disadvantages</p> <ul style="list-style-type: none"> • Requires minor surgery by a specially trained health care provider • Not immediately effective • Must be considered as permanent • Does not protect against STIs, including HIV/AIDS 	<p>Tell the disadvantages of vasectomy as presented on the slide.</p>

Topics/Contents	Teaching-Learning Process
<p data-bbox="158 203 487 226">Possible Side Effects of Vasectomy</p> <p data-bbox="181 264 377 286">Possible Side Effects</p> <ul data-bbox="169 383 711 524" style="list-style-type: none"> • Discomfort for two to three days • Pain in the scrotum, swelling, and bruising which decreases in about two to three days • Brief feeling of faintness after the procedure 	<p data-bbox="788 226 1056 248">Tell participants that:</p> <ul data-bbox="788 300 1357 553" style="list-style-type: none"> • There are no long-term side effects of vasectomy. • Not all men who undergo vasectomy will experience these side effects. • If side effects occur, the service provider assures the client that this is very temporary and will disappear in a few days.
<p data-bbox="158 584 294 607">Warning Signs</p> <p data-bbox="181 645 318 667">Warning Signs</p> <ul data-bbox="169 719 534 882" style="list-style-type: none"> • Severe bleeding or blood clots after the procedure • Redness, heat, swelling, pain at the incision site • Pus at the incision site • Pain lasting for months 	<p data-bbox="788 595 1056 618">Tell participants that:</p> <ul data-bbox="788 674 1365 994" style="list-style-type: none"> • Although they do not perform vasectomy and that they are not expected to manage complications, it is important that they know the signs of complications. This is to ensure that they can alert clients to seek immediate consultation when any of these complications occur or immediately refer these clients to facilities that can manage these complications. <p data-bbox="788 1043 1354 1066">Enumerate the warning signs as presented.</p>
<p data-bbox="244 1227 671 1301" style="text-align: center;">Counteracting Misconceptions on Vasectomy</p>	<p data-bbox="788 1122 1357 1218">Refer to the metacards earlier posted by participants on the information they know and heard about vasectomy.</p> <p data-bbox="788 1267 1357 1368">For each of the information, get the consensus of participants whether this is a fact or a misconception.</p> <p data-bbox="788 1417 1350 1518">For each of the misconceptions, call a participant at random to correct/counter the misconception.</p>
<p data-bbox="244 1630 671 1659" style="text-align: center;">Key Messages for Vasectomy</p>	<p data-bbox="788 1581 1357 1715">Tell the participants that since they cannot perform vasectomy, clients who express desire to have the procedure should be referred to a facility where such services are available.</p>



NARRATIVE

MODULE 8: LONG-ACTING AND PERMANENT METHODS

SESSION 2: PERMANENT METHODS

BILATERAL TUBAL LIGATION

DESCRIPTION

- Bilateral tubal ligation (BTL) is known as female sterilization as it provides permanent contraception for women who do not want any more children.
- It is a safe and simple surgical procedure to tie and cut the two fallopian tubes located on both sides of the uterus.

MECHANISM OF ACTION

- The service provider makes a small incision in the woman's abdomen and ties and cuts the two fallopian tubes on each side of the uterus. These tubes carry eggs from the ovaries to the uterus.
- With the tubes blocked, the woman's egg cannot meet the man's sperm. The woman continues to have menstrual periods after BTL.

EFFECTIVENESS

- BTL is very effective with an effectiveness rate of 99.5%.
- Effectiveness depends partly on how the tubes are blocked, but pregnancy rates are low.

ADVANTAGES

- Very effective
- Permanent. A single decision leads to lifelong, safe prevention of pregnancy
- Nothing to remember, no supplies needed, and no repeated clinic visits required
- No interference with sex, does not affect the woman's ability to have sex.
- Increased sexual enjoyment because no need to worry about pregnancy.
- Has no hormonal side effects.
- No effect on breast milk.
- No known long-term side effects or health risks.
- Can be performed just after a woman gives birth (immediately and within seven days after childbirth)
- For interval cases, can be done six weeks after delivery.
- Can be performed at any day of the menstrual cycle provided that the service provide is reasonably sure that the woman is not pregnant.

DISADVANTAGES

- Requires minor surgery
- Compared with vasectomy, BTL is:
 - ✓ Slightly more risky
 - ✓ Often more expensive
- Considered to be permanent as reversal surgery is difficult, expensive, and success cannot be guaranteed
- If pregnancy happens (very rare), there is a greater risk for ectopic pregnancy compared to women who have not undergone the procedure
- Does not protect against STIs including HIV/AIDS

POSSIBLE SIDE EFFECTS

There are no long-term side effects of BTL.

- Common side effect: pain over the operative site, which diminishes in a day or two

- Complications of surgery, which include the following, are uncommon:
 - ✓ Infection or bleeding at the incision
 - ✓ Internal infection or bleeding
 - ✓ Injury to internal organs
 - ✓ Anesthesia risk:
 - With local anesthesia alone or with sedation, rare risk of allergic reaction or overdose
 - With general anesthesia, occasional delayed recovery and side effects. Complications are more severe than with local anesthesia

TIMING OF BTL

Timing of performing BTL can either be:

- Postpartum
- Interval, or
- Post abortion

Postpartum BTL

BTL can be performed immediately or within seven days after childbirth. The procedure is not recommended between eight days to six weeks postpartum due to difficulty in accessing the tubes at this time and greater risk for infection.

Interval

When not associated with a recent pregnancy, BTL can be performed:

- From six weeks after childbirth, if it is reasonably certain that the woman is not pregnant.
- Within seven days after the start of the woman's menstrual cycle.
- At any time convenient for the woman, if it is reasonably certain that she is not pregnant

Postabortion

After a miscarriage, BTL can be performed after 48 hours after an uncomplicated miscarriage (i.e., no signs of infection, no heavy bleeding).

WARNING SIGNS

Problems affect women's satisfaction with BTL. It is, therefore, important that the health service provider attends to clients complaining of the following warning signs of complications and refer her to a facility or health service provider who can assess and manage her complaint. These warning signs are:

- Bleeding, pain, pus, heat, swelling or redness of the wound that becomes worse or is persistent. These are signs of infection of the incision site.
- High grade fever is a sign of more severe infection.
- Fainting, persistent light-headedness, or extreme dizziness
- Missed period which signifies pregnancy

VASECTOMY

DESCRIPTION

- Vasectomy is known as male sterilization as it provides permanent contraception for men who decide they will not want any more children.
- It is a safe, simple, and quick surgical procedure. The procedure can be done in a clinic or office with proper infection prevention practices.
- The procedure involves tying and cutting a segment of the two vas which carries the sperm.
- No Scalpel Vasectomy involves a small puncture on the scrotum (not using a scalpel) to get the vas. This is the DOH-approved procedure for vasectomy.

MECHANISM OF ACTION

- The service provider makes a puncture in the man's scrotum and ties and cuts the two vas. The vas carries sperm from the testicles.
- Semen is still produced and found in the tubes after the blocked vas.
- With the two vas blocked, there will be no sperm in the semen.

The man continues to have erections and ejaculate semen.

EFFECTIVENESS

- Vasectomy is very effective at 99.9% for correct use but slightly lower with typical use at 99.8%.
- More effective when used correctly. This means using condoms or his woman partner using another effective family planning method (e.g. pills, injectable) consistently for at least three months after the procedure and after a semen check showing no sperm has been performed.

ADVANTAGES

- Very effective
- Permanent. A single decision leads to lifelong, safe and effective contraception
- Nothing to remember except to use condoms or another effective method for at least three months after the procedure
- No interference with sex. Does not affect the man's ability to have sex
- Increased sexual enjoyment because there is no need to worry about pregnancy
- No supplies to get, and no repeated clinic visits required
- No known long-term side effects or health risks
- Compared to BTL, vasectomy is:
 - ◉ More effective
 - ◉ Safer
 - ◉ Easier to perform
 - ◉ Less expensive
 - ◉ Able to be tested for effectiveness at any time
 - ◉ If pregnancy occurs in the man's partner, less likely to be ectopic

DISADVANTAGES

- Requires minor surgery by a specially trained health care provider
- Not immediately effective. The couple should use another effective family planning method for at least three months after the procedure
- Must be considered as permanent. Reversal surgery is more difficult, expensive, may not be available in some areas, and success is not guaranteed. Men who may want to have more children in the future should choose a different method
- Does not protect against STIs including HIV/AIDS

POSSIBLE SIDE EFFECTS

Common side effects of vasectomy are:

- ✓ Discomfort for two to three days
- ✓ Pain in the scrotum, swelling and bruising, which decreases for about two to three days

WARNING SIGNS

Problems affect men's satisfaction with vasectomy. It is, therefore, important that the service provider attends to clients complaining of the following warning signs of complications and refer him to a facility or health service provider who can assess and manage his complaint.

These warning signs are:

- Severe bleeding or blood clots after the procedure
- Redness, heat, swelling, pain at the incision site
- Pus at the incision site
- Pain lasting for months



MODULE 9



FP for Special Populations

MODULE 9: FP FOR SPECIAL POPULATIONS



MODULE OVERVIEW

Providing FP services to special groups that would have specific needs apart from the general population cannot be overemphasized. The unique characteristics of these special populations imply that their family planning methods must be appropriate and responsive to these special needs.



MODULE OBJECTIVES

At the end of the module the participants will be able to identify appropriate contraceptive methods to meet the specific needs of special populations like:

- Adolescents
- Women over 40 years old
- Obese women
- Smokers
- Postpartum and breastfeeding women

These women may be in situations that require different contraceptive methods. Likewise, women with conditions that may make pregnancy an unacceptable health risk should be advised that because of their relatively higher typical-use failure rates, sole use of barrier methods for contraception and behavior-based methods of contraception may not be an appropriate choice for them.



LEARNING OBJECTIVES

At the end of the module, participants will be able to:

1. Describe the reproductive health concerns/conditions of each of the special populations.
2. Discuss the recommended FP methods/practices for each of the special populations.



METHODOLOGY

Lecture-discussion
Group work
Plenary presentations





TIME ALLOTMENT

1 Hour



ADVANCE PREPARATION

- LCD/laptop computer/screen
- Powerpoint presentation
- Whiteboard, Manila paper, Tape
- Permanent markers, whiteboard markers
- WHO MEC Checklist/ MEC Wheel

Topics/Contents	Teaching-Learning Process
 <h2 data-bbox="341 360 558 405">MODULE 9</h2>  <h3 data-bbox="341 461 577 528">FP FOR SPECIAL POPULATIONS</h3>	<p data-bbox="788 244 1263 315">Link with previous modules by telling participants that:</p> <ul data-bbox="788 356 1345 647" style="list-style-type: none"> <li data-bbox="788 356 1345 465">• The Modules Six to Eight have discussed FP methods applicable to the general population. <li data-bbox="788 506 1345 647">• This module considers the unique characteristics of special populations as a basis for identifying their family planning need.
<p data-bbox="153 685 432 712">LEARNING OBJECTIVES</p> <p data-bbox="174 770 349 797">OBJECTIVES</p> <p data-bbox="181 904 581 927">At the end of this module, the participants will be able to:</p> <ul data-bbox="181 954 699 1043" style="list-style-type: none"> <li data-bbox="181 954 699 976">• Describe the RH concerns/conditions of each of the special populations. <li data-bbox="181 1003 699 1043">• Discuss the recommended FP methods/practices for each of the special populations. 	<p data-bbox="788 707 1271 779">State the objectives of the session as presented in the slides.</p>
<p data-bbox="185 1263 333 1290">ADOLESCENTS</p> <ul data-bbox="185 1346 730 1536" style="list-style-type: none"> <li data-bbox="185 1346 730 1368">• Adolescence is the period between the ages 10 to 19 years (WHO). <li data-bbox="185 1395 730 1536">• Due to lack of knowledge on sexual and reproductive health, adolescents are exposed to: <ul data-bbox="208 1469 667 1536" style="list-style-type: none"> <li data-bbox="208 1469 667 1491">✓ Unplanned pregnancy, that may result in unsafe abortion <li data-bbox="208 1496 667 1518">✓ Pregnancy risks due to "too young" pregnancy <li data-bbox="208 1523 667 1536">✓ High risk of STIs as a result of unprotected sexual intercourse <p data-bbox="185 1675 467 1702">WOMEN OVER 40 YEARS OLD</p> <ul data-bbox="185 1771 699 1962" style="list-style-type: none"> <li data-bbox="185 1771 699 1816">• Delayed pregnancy after age 35 is associated with an increased risk for maternal morbidity and mortality. <ul data-bbox="208 1843 401 1962" style="list-style-type: none"> <li data-bbox="208 1843 401 1865">• Spontaneous abortion <li data-bbox="208 1870 401 1892">• Ectopic pregnancy <li data-bbox="208 1897 401 1919">• Hyperemesis <li data-bbox="208 1924 401 1946">• Diabetes <li data-bbox="208 1951 401 1962">• Hemorrhage and infection 	<p data-bbox="788 1267 1298 1377">Describe the reproductive health characteristics and needs of the special population.</p>

Topics/Contents	Teaching-Learning Process
<p>OBESE WOMEN</p> <ul style="list-style-type: none"> • Obese women are those who have a body mass index of more than 30kg/m³. • Obese women are at risk for medical illnesses like cardiovascular disease, diabetes, gallbladder disease, some forms of arthritis, and certain cancers, which puts them at high risk for pregnancy. <p>SMOKERS</p> <p>Women who smoke during PREGNANCY have increased risks of:</p> <ul style="list-style-type: none"> • delivering low-birth weight infants • miscarriages • stillbirths • infant deaths <p>POSTPARTUM AND BREASTFEEDING WOMEN</p> <ul style="list-style-type: none"> • Postpartum women are strongly encouraged to breastfeed their infant. • FP method choice and practice must be compatible with breastfeeding. <ul style="list-style-type: none"> • Estrogen affects the quantity and quality of breastmilk adversely. • Estrogen-containing contraceptives are not the best choice for breastfeeding women. • Pregnancy is a hypercoagulable state. <ul style="list-style-type: none"> • Estrogen increases the risk for venous thrombosis and embolism. • Estrogen-containing preparations must be avoided until one month postpartum. 	
<p style="text-align: center;">Recommendations for FP practice and methods</p>	<p>Divide participants into five groups representing each of the special populations.</p> <p>Each group:</p> <ul style="list-style-type: none"> • Assigns a recorder to write the group's output and a rapporteur to present the output in plenary. • Discusses FP method options for their assigned special population given the above information on their assigned special population group. <p>Participants are encouraged to use the MEC Wheel or the WHO MEC listing of conditions with recommendations. Provide 20 minutes for the group work. Each group's rapporteur presents the group's output.</p>

Topics/Contents	Teaching-Learning Process
<p>SUMMARY</p> <p>Summary</p> <ul style="list-style-type: none"> • Special populations have particular family planning needs that should be considered when providing them with services. • Adolescents are primarily advised to practice ABSTINENCE, but once they become sexually active, the following methods are recommended for them namely: fertility awareness-based methods, condoms and low-dose COCs. <p>Summary</p> <ul style="list-style-type: none"> • Women over 40 years of age have an increased risk of pregnancy-related morbidity and mortality. Taking into consideration the related risks, the recommended methods for family planning are low-dose COCs, POPs, progestin injectables, IUDs or sterilization (if limiting family size is desired). • Obese women are at risk for other diseases that may be affected by some family planning methods. The recommended FP methods for this group are POPs, progestin-only injectables and IUDs. <p>Summary</p> <ul style="list-style-type: none"> • Smokers must be encouraged to quit smoking. For three to 12 months after quitting, the risks will be similar to nonsmokers in terms of selecting a method best for them. However, low-dose estrogen contraceptives may be provided to smokers who are less than 35 years old. 	<p>Ask participants at random to state in one sentence what they have learned.</p> <p>Supplement by showing the slides on the key messages.</p>



NARRATIVE

MODULE 9: FP FOR SPECIAL POPULATIONS

Providing FP services to special groups that would have specific needs apart from the general population cannot be over-emphasized. The unique characteristics of these special populations imply that their family planning methods must be appropriate and responsive to these special needs.

The special populations included in the module are the following:

- **Adolescents**
- **Women over 40 years old**
- **Obese women**
- **Smokers**
- **Postpartum and breastfeeding women (as discussed with LAM and progestin-only pills/injectables)**

These women may be in situations that require different contraceptive methods. Likewise, women with conditions that may make pregnancy an unacceptable health risk should be advised that, because of their relatively higher typical-use failure rates, sole use of barrier methods for contraception and behavior-based methods of contraception may not be the most appropriate choice for them.

ADOLESCENTS

Characteristics of Adolescents:

- Adolescence is defined by WHO as the period between the ages 10 to 19 years.
- Adolescents attain biological maturity earlier than in previous generations, but not necessarily accompanied by psychosocial maturity or economic independence.
- Adolescents face several potential problems in relation to their sexual and reproductive health:
 - The consequence of unsafe abortion due to unplanned pregnancy is a serious concern.
 - ✓ An estimated number of abortions in the Philippines is 400,000/year. Thirty-three (33%) are contributed by teens (Allan Guttmacher studies in 2003).
 - ✓ High risks of early (under age 16) childbearing for the mother, infant, and child.
 - ✓ About 30 out of 100 deliveries occur among young people. Three out of four pregnancies in young people result to maternal deaths.
 - Diminished opportunities for education and employment, which affect social and cultural development, especially for females.
 - Unprotected sexual intercourse exposes adolescents to a high risk of STIs, including HIV infection.
- DOH reported that 62 out of 100 reported cases of STIs and 29 out of 100 cases of HIV involved young people.
- Sex Education
 - Develops the adolescents' knowledge and confidence to make decisions related to their sexual behavior, including the decision not to engage in sexual intercourse until they are ready to do so.
 - Should include an orientation on fertility awareness, which is a comprehensive understanding of how one's reproductive system functions and the biological and sociological facts about human fertility. The peer approach (youth-to-youth) is effective in delivering these information.

- Parents should be assisted to understand and encourage participation in the sex education of their children.
- Emphasis on responsible sexual behavior is very important among the youth, particularly male adolescents who need to share such a responsibility for responsible sexual behavior with their female partners.

OPTIONS

ALL CONTRACEPTIVES ARE SAFE FOR USE OF YOUNG PEOPLE

Generally all adolescents are advised to practice ABSTINENCE until they reach the proper age to start a family.

- Fertility awareness-based methods
 - For those adolescents who can effectively monitor body changes to determine the woman's fertile period and able to follow the rules as to when to abstain from sex. If not able, consider other FP methods.
- Oral contraceptives
 - ⊙ Low dose COC is a good choice because of high efficacy and low frequency of side effects.
 - ⊙ Emphasis is needed for consistent and proper use of the methods during counseling along with COC side effects.
- Male condoms
 - One main advantage is its safety. Since they are readily available and accessible in different places and set up. Education and counseling are important to ensure correct and consistent condom use.
- Progestin-only injectables
 - For those adolescents having difficulty in using COCs, progestin-only injectables are suitable alternatives.
- IUD
 - Not a good choice for young women who are at high risk for STIs. IUD can be an option for parous adolescents who require long-term protection against pregnancy and have a low risk of STIs.

9.6

WOMEN OVER 40 YEARS OLD

Characteristics

Fertility decreases after age 35, but many women in this age group are delaying pregnancy or avoiding pregnancy because of career demands or choice. Hence, there is a need to provide FP information to this population.

Half of pregnancies in this age group are unintentional and international epidemiologic studies show that about two-thirds of these pregnancies are terminated. Pregnancy in this age group is associated with an increased risk for morbidity and mortality.

Most common causes of maternal morbidity are:

- Spontaneous abortion
- Ectopic pregnancy
- Hyperemesis
- Diabetes
- Hemorrhage and infection

There is no contraceptive method that is contraindicated merely by age. Contraceptive needs of women in this age group may be influenced by a desire to stop fertility, frequency of intercourse, need for protection from STI, or a desire for non-contraceptive benefits, such as control of menstrual cycle irregularities or hot flushes, and prevention of gynecologic cancers, and osteoporosis.

OPTIONS

In the absence of other adverse clinical conditions, combined hormonal contraceptives can be used until menopause.

- **Low dose estrogen oral contraceptives** can be taken by women in this age group. Low-dose estrogen (less 50 ug estrogen) formulations may be used by healthy non-smoking women until menopause sets in.
 - Non-contraceptive effects which women of this age group benefit from are:
 - reduction of the risk for ovarian cancer
 - possible reduction of the risk for colorectal cancer
 - decreased rate of PID
 - reduced effects in functional ovarian cysts
 - prevention of uterine myoma and endometriosis
 - decreased episodes of hot flushes, and others
- **Progestin-only injectable contraceptives** can be used by women, especially those who cannot take oral contraceptives for medical reasons.
- **IUDs** are useful for older women with a completed family size in a monogamous relationship and who prefer not to have surgical sterilization.
- **Surgical sterilization** is an option if the desired family size is met.
- Typical menstrual pattern of a woman nearing the perimenopausal period is unpredictable. Shorter cycles, irregular bleeding, and other variations may render predicting ovulation very difficult for the woman. However, these women can still use FAB methods like the BBT, Billings Ovulation Method and the Sympto-thermal method may be practiced.

OBESE WOMEN

Characteristics

Obese women are those who have a body mass index of more than 30kg/m³. Obesity is an emerging problem because a bigger percentage of the population is becoming obese as a result of:

- over-nutrition
- poor eating habits
- inadequate exercise
- inappropriate lifestyle habits

Obese women are also at risk for cardiovascular disease, diabetes, gall bladder disease, some forms of arthritis and certain cancers. Although over-nourished, some obese women are also found to be deficient in calcium, iron, vitamin B, and folic acid.

Obese women are also found to be anovulatory because of higher levels of estrogen stored in their fat cells. Episodes of anovulation tend to increase as women get older and near menopause. However, many obese women still menstruate regularly, are ovulatory, and can become pregnant.

OPTIONS:

- WHO MEC category 1 for obese women:
 - POP
 - Progestin-only injectable
 - Levonorgestrel IUD/Copper IUD
- WHO MEC category 2 for obese women:
 - COC
 - CIC

NOTE: Obese women who use COCs are at an increased risk of venous thrombosis and embolism (VTE) compared with non-users. HOWEVER, the absolute risk of VTE remains small.

Women who weigh 70.5 kg or more had a 1.6-fold increased risk of pregnancy while using pills, and a four to five fold increased pregnancy rate if they used low-dose oral contraceptives. Obese women may have difficulty when undergoing surgical ligation. The surgeon should exercise extra caution to prevent complications due to difficulty in accessing the fallopian tubes.

SMOKERS

Characteristics

Smoking for women is associated with many health risks as with men. The increasing rate of lung cancer in women has been associated with the corresponding increase in smoking. Women smokers HAVE INCREASED RISK for:

- cervical cancer
- premature menopause
- impaired fertility
- cardio-vascular disease (myocardial infarction) when age is >35 years so that an estrogen-containing method is not recommended

Women who smoke during PREGNANCY have increased risks of :

- delivering low-birth weight infants
- miscarriages
- still births
- infant deaths

OPTIONS:

- COCs may be taken by women younger than 35 and who are not heavy smokers. If the pill is chosen, the best option will be that with the lowest estrogen content to reduce the risk of arterial thrombosis and the lowest androgenicity (to minimize any adverse effects of lipids).
- Other methods which do not contain high estrogenic levels may be recommended to women who smoke.
- Advise women smokers and who ask for advice on any FP method to quit smoking. Three to 12 months after quitting, past smokers will have the same oral contraceptive cardiovascular risk as non-smokers.
- Cigarette smokers OVER AGE 40 face a higher mortality risk with ongoing oral contraceptive use than they would experience by getting pregnant.

- Heavy smokers (more than 15 cigarettes/ day) and smokers who are more than 35 years old with an increasing number of cigarettes used per day are at a high risk for cardiovascular disease, especially myocardial infarction and thrombotic and hemorrhagic stroke.
- Smokers who are more than 35 years old CANNOT use COC and CICs. They should avoid estrogen-containing methods.

POSTPARTUM AND BREASTFEEDING WOMEN

Characteristics

Pregnancy is a hypercoagulable state. Estrogen increases the risk of venous thrombosis and embolism. As a result, it is generally recommended that postpartum women delay use of estrogen-containing contraceptive until about a month postpartum, when those changes induced by pregnancy would have been resolved. Additionally, estrogen should be avoided by breastfeeding mothers, because it decreases the quality and quantity of breast milk.

Counseling for postpartum contraception should begin during the pre-natal period. Proper understanding and adequate preparation for certain methods will make the provision of these methods easier soon after delivery.

OPTIONS:

- Lactational amenorrhea method provides effective protection against pregnancy for up to six months postpartum. If continued protection is desired, recommend another method of contraception, when the LAM criteria indicate a return to fertility.
- Tubal ligation may be performed immediately postpartum, although there are some concerns about the disruption of lactation because of the effects of general anesthesia. However, with local anesthesia, this is not a problem.
- Copper IUDs are also useful since copper does not affect the quality and quantity of breastmilk.
- Spermicides and barrier methods have no effect on the ability to breastfeed. The vaginal dryness associated with the postpartum condition may be relieved by some of the lubricating action of some barrier methods.
- DMPA or progestin-only pills may be used. These do not have adverse effects on lactation, and may even increase milk volume. They also do not have an effect on child growth and development. However, these should be started six weeks postpartum by breastfeeding women.
- Estrogen-containing contraceptives can be used if the mother is more than six months postpartum.
- Fertility awareness-based methods may be difficult to use during the return to fertility, which can extend for many cycles during lactation. The changing fertility symptoms after the first postpartum menses may be especially difficult for new users to identify, and may lead to an increased risk for unplanned pregnancy.
- As with other progestin-only methods, the progesterone IUD and the levonorgestrel IUDs are not recommended for use by breastfeeding women until six weeks postpartum.
- Combined hormonal contraceptives (combined pill, patch, injectables) should generally not be used by breastfeeding mothers.

Six weeks postpartum:

- Estrogen containing contraceptives are not advised.
- There is some theoretical concern that the neonate may be at risk due to exposure to steroid hormones during the first six weeks postpartum.

• Six weeks to less than six months (primarily breastfeeding):

- Estrogen containing contraceptives are not advised. Use of combined hormonal contraceptives during breastfeeding diminishes the quantity of breast milk, decreases the duration of lactation, and may thus adversely affect the infant's growth.

• Less than 21 days or three weeks:

- There is some theoretical concern regarding the association between combined hormonal contraceptive use up to three weeks postpartum and risk of thrombosis for the mother. Blood coagulation and fibrinolysis are essentially normalized at three weeks postpartum.

Key Messages:

- a) Special populations have particular family planning needs that should be considered when providing them with FP services.
- b) Evidence-based tools (WHO MEC, Medical Eligibility Checklist and MEC Wheel) are useful in determining client's eligibility for using a method especially among populations with special concerns or needs.

FEMALE SURGICAL STERILIZATION		Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.
CONDITION	CATEGORY	CLARIFICATIONS/EVIDENCE
NEUROLOGIC CONDITIONS		
HEADACHES		
a) Non-migrainous (mild or severe)	A	
b) Migraine		
(i) without aura		
Age < 35	A	
Age ≥ 35	A	
(ii) with aura (at any age)	A	
EPILEPSY	C	
DEPRESSIVE DISORDERS		
DEPRESSIVE DISORDERS	C	
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS		
VAGINAL BLEEDING PATTERNS		
a) Irregular pattern <i>without</i> heavy bleeding	A	
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	A	
UNEXPLAINED VAGINAL BLEEDING (suspicious for serious condition)		
Before evaluation	D	Clarification: The condition must be evaluated before the procedure is performed.
ENDOMETRIOSIS	S	
BENIGN OVARIAN TUMOURS (including cysts)	A	
SEVERE DYSMENORRHOEA	A	

* See also additional comments at end of table

FEMALE SURGICAL STERILIZATION		Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	CATEGORY	CLARIFICATIONS/EVIDENCE	
TROPHOBLAST DISEASE			
a) Benign gestational trophoblastic disease	A		
b) Malignant gestational trophoblastic disease	D		
CERVICAL ECTROPION	A		
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	A		
CERVICAL CANCER* (awaiting treatment)	D		
BREAST DISEASE			
a) Undiagnosed mass	A		
b) Benign breast disease	A		
c) Family history of cancer	A		
d) Breast cancer			
(i) current	C		
(ii) past and no evidence of current disease for 5 years	A		
ENDOMETRIAL CANCER*	D		
OVARIAN CANCER*	D		
UTERINE FIBROIDS*			
a) Without distortion of the uterine cavity	C		
b) With distortion of the uterine cavity	C		
PELVIC INFLAMMATORY DISEASE (PID)*			
a) Past PID (assuming no current risk factors for STIs)			Clarification: A careful pelvic examination must be performed to rule out recurrent or persistent infection and to determine the mobility of the uterus.
(i) with subsequent pregnancy	A		
(ii) without subsequent pregnancy	C		
b) PID - current	D		

* See also additional comments at end of table

FEMALE SURGICAL STERILIZATION		Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	CATEGORY	CLARIFICATIONS/EVIDENCE	
STIs*			
a) Current purulent cervicitis or chlamydial infection or gonorrhoea	D	Clarification: If no symptoms persist following treatment, sterilization may be performed.	
b) Other STIs (excluding HIV and hepatitis)	A		
c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	A		
d) Increased risk of STIs	A		
HIV/AIDS			
HIGH RISK OF HIV	A	Clarification: No routine screening is needed. Appropriate infection prevention procedures, including universal precautions, must be carefully observed with all surgical procedures. The use of condoms is recommended following sterilization.	
HIV-INFECTED	A		
AIDS	S	Clarification: The presence of an AIDS-related illness may require that the procedure be delayed.	
OTHER INFECTIONS			
SCHISTOSOMIASIS			
a) Uncomplicated	A	Clarification: Liver function may need to be evaluated.	
b) Fibrosis of liver	C		
TUBERCULOSIS			
a) Non-pelvic	A		
b) Known pelvic	S		
MALARIA			
ENDOCRINE CONDITIONS			
DIABETES*			
a) History of gestational disease	A	Clarification: If blood glucose is not well controlled, referral to a higher-level facility is recommended. Clarification: There is a possible decrease in healing and an increased risk of wound infection. Use of prophylactic antibiotics is recommended. Evidence: Diabetic women were more likely to have complications when undergoing sterilization. ²²	
b) Non-vascular disease:			
(i) non-insulin dependent	C		
(ii) insulin dependent	C		
c) Nephropathy/retinopathy/neuropathy	S		

* See also additional comments at end of table

FEMALE SURGICAL STERILIZATION		Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	CATEGORY	CLARIFICATIONS/EVIDENCE	
DIABETES (Cont'd)			
d) Other vascular disease or diabetes of > 20 years' duration	S		
THYROID DISORDERS*			
a) Simple goitre	A		
b) Hyperthyroid	S		
c) Hypothyroid	C		
GASTROINTESTINAL CONDITIONS			
GALL-BLADDER DISEASE			
a) Symptomatic	A		
(i) treated by cholecystectomy			
(ii) medically treated			
(iii) current	D		
b) Asymptomatic	A		
HISTORY OF CHOLESTASIS			
a) Pregnancy-related	A		
b) Past COC-related	A		
VIRAL HEPATITIS*			
a) Active	D	Clarification: Appropriate infection prevention procedures, including universal precautions, must be carefully observed with all surgical procedures.	
b) Carrier	A		
CIRRHOSIS			
a) Mild (compensated)	C	Clarification: Liver function and clotting might be altered. Liver function should be evaluated.	
b) Severe (decompensated)	S		
LIVER TUMOURS			
a) Benign (adenoma)	C	Clarification: Liver function and clotting might be altered. Liver function should be evaluated.	
b) Malignant (hepatoma)	C		
ANAEMIAS			
THALASSAEMIA			
	C		
SICKLE-CELL DISEASE*			
	C		

* See also additional comments at end of table

FEMALE SURGICAL STERILIZATION		Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	CATEGORY	CLARIFICATIONS/EVIDENCE	
IRON-DEFICIENCY ANAEMIA a) Hb < 7g/dl b) Hb ≥ 7 to < 10g/dl	D C	Clarification: The underlying disease should be identified. Both preoperative Hb level and operative blood loss are important factors in women with anaemia. If peripheral perfusion is inadequate, this may decrease wound healing.	
OTHER CONDITIONS RELEVANT ONLY FOR FEMALE SURGICAL STERILIZATION			
LOCAL INFECTION Abdominal skin infection	D	Clarification: There is an increased risk of postoperative infection.	
COAGULATION DISORDERS*	S		
RESPIRATORY DISEASES* a) Acute (bronchitis, pneumonia) b) Chronic (i) asthma (ii) bronchitis (iii) emphysema (iv) lung infection	D S S S S	Clarification: The procedure should be delayed until the condition is corrected. There are increases in anaesthesia-related and other perioperative risks.	
SYSTEMIC INFECTION OR GASTROENTERITIS*	D		
FIXED UTERUS DUE TO PREVIOUS SURGERY OR INFECTION*	S		
ABDOMINAL WALL OR UMBILICAL HERNIA	S	Clarification: Hernia repair and tubal sterilization should be performed concurrently, if possible.	
DIAPHRAGMATIC HERNIA*	C		
KIDNEY DISEASE*	C		
SEVERE NUTRITIONAL DEFICIENCIES*	C		
PREVIOUS ABDOMINAL OR PELVIC SURGERY	C	Evidence: Women with previous abdominal or pelvic surgery were more likely to have complications when undergoing sterilization. ^{21, 22, 24-26}	

* See also additional comments at end of table

FEMALE SURGICAL STERILIZATION	Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	CATEGORY	CLARIFICATIONS/EVIDENCE
STERILIZATION CONCURRENT WITH ABDOMINAL SURGERY		
a) Elective	C	
b) Emergency (without previous counselling)	D	
c) Infectious condition	D	
STERILIZATION CONCURRENT WITH CAESAREAN SECTION*	A	

* See also additional comments at end of table

Medical Eligibility Checklist for Fertility Awareness-Based (FAB) Methods

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use any fertility awareness-based method she wants. If she answers YES to a question below, follow the instructions. No conditions restrict use of these methods, but some conditions can make them harder to use effectively.

1. Do you have a medical condition that would make pregnancy especially dangerous?
(Medical Conditions and Method Choice).
 No YES She may want to choose a more effective method. If not, stress careful use of fertility awareness-based methods to avoid pregnancy.
2. Do you have irregular menstrual cycles? Vaginal bleeding between periods? Heavy or long monthly bleeding? For younger women: Are your periods just starting? For older women: Have your periods become irregular, or have they stopped?
 No YES Predicting her fertile time with only the calendar method may be hard or impossible. She can use basal body temperature (BBT) and/or cervical mucus, or she may prefer another method.
3. Did you recently give birth or have an abortion? Are you breastfeeding? Do you have any other condition that affects the ovaries or menstrual bleeding, such as stroke, serious liver disease, hyperthyroid, or cervical cancer?
 No YES These conditions do not restrict use of fertility awareness-based methods. But these conditions may affect fertility signs, making fertility awareness-based methods hard to use. For this reason, a woman or couple may prefer a different method. If not, they may need more counseling and follow-up to use the method effectively.
4. Have you had any infections or diseases that may change cervical mucus, basal body temperature, or menstrual bleeding, such as vaginal infections or sexually transmitted infections (STI), pelvic inflammatory disease (PID) in the last three months?
 No YES These conditions may affect fertility signs, making fertility awareness-based methods hard to use. Once an infection is treated and reinfection is avoided, however, a woman can use fertility awareness-based methods more easily.
5. Do you take any drugs that affect cervical mucus, such as mood-altering drugs, lithium, tricyclic antidepressants, or anti-anxiety therapies?
 No YES Predicting her fertile time correctly may be difficult or impossible using only the cervical mucus method. She may use BBT and/or the SDM, or she may prefer another method.

Be sure to explain the health benefits, risks, and side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable pertaining to the client.

Medical Eligibility Checklist for Lactational Amenorrhea Method (LAM)

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use LAM. If she answers YES to a question below, follow the instructions.

1. Is your baby six months old or older?
 No YES She cannot use LAM. Help her choose another method. If she is breastfeeding, a non-hormonal method is best.
2. Has your menstrual period returned? (Bleeding in the first eight weeks after childbirth does not count.)
 No YES After eight weeks since childbirth, if a woman has two straight days of menstrual bleeding, or her menstrual period has returned, she cannot use LAM. Help her choose another method. If she is breastfeeding, a non-hormonal method is best.
3. Have you begun to breastfeed less often? Do you regularly give the baby other food or liquid?
 No YES If the baby's feeding pattern has just changed, explain that she must fully or nearly fully breastfeed – day and night – to protect against pregnancy. At least 85% of her baby's feedings should be breastfeeds. If she is not fully or nearly fully breastfeeding, she cannot use LAM as effectively. Help her choose another non-hormonal method.
4. Has a health care provider told you not to breastfeed your baby?
 No YES If she is not breastfeeding, she cannot use LAM. Help her choose another method. A woman should not breastfeed if she is taking mood-altering drugs - reserpine, ergotamine, antimetabolites, cyclosporine, cortisone, bromocriptine, radioactive drugs, lithium, or certain anticoagulants, if her baby has a specific infant metabolic disorder, or if she has active viral hepatitis, breastfeeding is also inadvisable. All others can and should breastfeed for the health benefits.
5. Do you have AIDS? Are you infected with HIV, the virus that causes AIDS?
 No YES Where infectious diseases kill many babies, she could be encouraged to breastfeed. However, HIV may be passed to the baby in breast milk. When infectious diseases are low risk and safe, affordable food for the baby is available, advise her to feed her baby other food. Help her choose a family planning method other than LAM (some other infectious conditions, such as active viral hepatitis can also be transmitted during breastfeeding.)

Be sure to explain the health benefits, risks, and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.

Medical Eligibility Checklist for Combined Oral Contraceptives (COCs)

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use combined oral contraceptives (COCs). If she answers YES to a question below, follow the instructions.

1. Do you smoke cigarettes and are you 35 or older?

- No YES Urge her to stop smoking. If she is 35 or older and will not stop smoking, do not provide COCs. Help her to choose a method without estrogen.

2. Do you have high blood pressure?

- No YES If you cannot check blood pressure (BP) and she reports high BP, do not provide COCs. Refer for BP check if possible or help her choose a method without estrogen. If there is no report of high BP, it is okay to provide COCs.

Check if feasible:

If BP is below 140/90, it is okay to give COCs without further BP readings. If systolic BP is 140 or higher or diastolic BP is 90 or higher, do not provide COCs. Help her choose another method. (One BP reading in the range of 140-159/90-99 is not enough to diagnose high BP. Offer condoms or spermicide for use until she can return for another BP check, or help her choose another method she prefers. If BP reading at next check is below 140/90, she can use COCs and further BP readings are not necessary.) If systolic BP is below 160 or higher or diastolic BP is 100 or higher, she also should not use DMPA or NET-EN.

3. Are you breastfeeding a baby less than six months old?

- No YES Can provide COCs now with instruction to start when she stops breastfeeding or six months after childbirth – whichever comes first. If she is not fully or almost fully breastfeeding, also give her condoms or spermicide to use until her baby is six months old. Other effective methods are better choices than COCs when a woman is breastfeeding whatever her baby's age.

4. Do you have serious problems with your heart or blood vessels? Have you ever had such problems? If so, what problems?

- No YES Do not provide COCs if she reports heart attack or heart disease due to blocked arteries, stroke, blood clots (except superficial clots), severe chest pain with unusual shortness of breath, diabetes for more than 20 years, or damage to vision, kidneys, or nervous system caused by diabetes. Help her choose another effective method.

5. Do you have or have you ever had breast cancer?

- No YES Do not provide COCs. Help her choose a method without hormones.

6. Do you have jaundice, cirrhosis of the liver, a liver infection or tumor? (Are her eyes or skin unusually yellow?)

- No YES Perform physical exam or refer. If she has serious active liver disease (jaundice, painful or enlarged liver, active viral hepatitis, liver tumor), do not provide COCs. Refer for care as appropriate. Help her choose a method without hormones.

7. Do you often get severe headaches, perhaps on one side or pulsating, that cause nausea and are made worse by light and noise or moving about (migraine headaches)?
 No YES If she is 35 or older, do not provide COCs. Help her choose another method. If she is under age 35, but her vision is distorted or she has trouble speaking or moving before or during these headaches, do not use COCs. Help her choose another method. If she is under age 35 and has migraine headaches without distortion of vision or trouble or moving, she can use COCs.
8. Are you taking medicines for seizures? Are you taking rifampin (rifampicin) or griseofulvin?
 No YES If taking phenytoin, carbamazepine, barbiturates, or primidone for seizures or rifampin or griseofulvin, provide condoms to use along with COCs or, if she prefers, help her choose another effective method if she is on long-term treatment.
9. Do you think you are pregnant?
 No YES Assess whether pregnant (see How to tell if a woman is not pregnant). If she might be pregnant, also give her condoms or spermicide to use until it is reasonably certain that she is not pregnant. Then she can start COCs.
10. Do you have gall bladder disease? Ever had jaundice while taking COCs? Planning surgery that will keep you from walking for a week or more? Had a baby in the past 21 days?
 No YES If she has gall bladder disease now or takes medicine for gall bladder disease, or if she has had jaundice while using COCs, do not provide COCs. Help her choose a method without estrogen. If she is planning surgery or she just had a baby, can provide COCs with instruction on when to start them later.

Be sure to explain the health benefits, risks, and side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.

Medical Eligibility Checklist for Progestin-Only Contraceptives (POPs,POIs)

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use the progestin-only contraceptives. If she answers YES to a question below, follow the instructions. No conditions restrict use of these methods, but some conditions can make them harder to use effectively.

1. Do you have or have you ever had breast cancer?
No YES Do not provide POCs. Help her choose a method without hormones.
2. Do you have jaundice, cirrhosis of the liver, a liver infection, or tumor? (Are her eyes or skin unusually yellow?)
No YES Perform physical exam or refer. If she has serious active liver disease (jaundice, painful or enlarged liver, active viral hepatitis, live tumor), do not provide POCs. Refer for care. Help her choose a method without hormones.
3. Are you breastfeeding a baby less than six months old?
No YES Can give her POCs now with instruction on when to start – when the baby is six weeks old.
4. Do you have serious problems with your heart or blood vessels? If so, what problems?
No YES Do not provide POCs if she reports blood clots (except superficial clots). Help her choose another effective method.
5. Do you have jaundice, cirrhosis of the liver, a liver infection, or tumor? (Are her eyes or skin unusually yellow?)
No YES Perform physical exam or refer. If she has serious active liver disease (jaundice, painful or enlarged liver, active viral hepatitis, live tumor), do not provide POCs. Refer for care as appropriate. Help her choose a method without hormones.
6. Are you taking medicine for seizures? Are you taking rifampin (rifampicin) or griseofulvin?
No YES If she is taking phenytoin, carbamazepine, barbiturates, or primidone for seizures or rifampin or griseofulvin, provide condoms to use along with POCs. If she prefers, or if she is on long treatment, help her choose another effective method.
7. Do you think you are pregnant?
No YES Assess whether pregnant (see How to tell if a woman is not pregnant). If she might be pregnant, also give her condoms or spermicide to use until reasonably certain that she is not pregnant. Then she can start POCs.

Be sure to explain the health benefits, risks, and the side effects of the method that the client will use.

Also, point out any conditions that would make the method inadvisable when relevant to the client.

Medical Eligibility Checklist for Copper IUDs

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use an IUD if she wants. If she answers YES to a question below, follow the instructions.

1. Do you think you are pregnant?
 No YES Assess whether pregnant (see How to tell if a woman is not pregnant). Do not insert IUD. Give her condoms or spermicide to use until reasonably sure that she is not pregnant.
2. In the last three months have you had vaginal bleeding that is unusual for you, particularly between periods or after sex?
 No YES If she has unexplained vaginal bleeding that suggest an underlying medical condition, do not insert IUD until the problem is diagnosed. Evaluate by history and during pelvic exam. Diagnose and treat as appropriate, or refer.
3. Have you given birth more than 48 hours but less than four weeks ago?
 No YES Delay inserting an IUD until four or more weeks after childbirth. If needed, give her condoms or spermicide to use until then.
4. Do you have infection following childbirth?
 No YES If she has puerperal sepsis (genital tract infection during the first 42 days after childbirth), do not insert IUD. Refer for care. Help her choose another effective method.

Note: Assure confidentiality before asking the remaining questions.

5. Have you had a sexually transmitted infection (STI) or pelvic inflammatory disease (PID) in the last three months? Do you have an STI, PID or any other infection in the female organs now?
(Signs and symptoms of PID: severe pelvic infection in the female organs)
 No YES Do not insert IUD now. Urge her to use condoms for STI protection. Refer or treat client and partner(s). IUD can be inserted three months after use unless re-infection is likely.
6. Do you have an infection following childbirth?
 No YES If she has AIDS, is infected with HIV, or is being treated with medicines that make her body less able to fight infections, careful clinical judgment should be made. In general, do not insert IUD unless other methods are not available or acceptable. Whatever methods she chooses, urge her to use condoms. Give her condoms.
7. Do you think you might get an STI in the future? Do you or your partner have more than one sex partner?
 No YES If she is at risk of STIs, explain that STIs can lead to infertility. Urge her to use condoms for STI protection. Do not insert IUD. Help her choose another method.

8. Do you have any cancer in the female organs or pelvic tuberculosis?
 No YES Known cervical, endometrial, or ovarian cancer; benign or malignant trophoblast disease; pelvic tuberculosis: Do not insert IUD. Treat or refer for care as appropriate. Help her choose another effective method.

Be sure to explain the health benefits, risks, and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.

CHECKLIST for PROVISION of the SDM

NAME OF COURSE: _____ Dates: _____

Instructions: Put a (v) in the space provided for if the trainee performed the task “satisfactorily”, (x) if the task was performed “unsatisfactorily”, and (NO) if the task was “not observed”.

TASKS	PRACTICES						
	1	2	3	4	5	6	7
1. Once the client has chosen to use the SDM, determines the length of the client’s menstrual cycle by reviewing her last and past menstrual periods and asking when she expects her next menses.							
2. Determines the client’s cycle length by reviewing her menstrual history.							
3. If the cycle meets the criteria, provides the client with a SDM card and cycle beads.							
4. If the cycle length is less than 26 days or more than 32 days, explains to the client that she cannot use the SDM and helps her choose another method.							
5. If woman has recently used another FP method, determines whether she has the following criteria. <ul style="list-style-type: none"> • If recently used the pills, her last two cycles after stopping the pills were within 26-32 days. • If recently used the injectable, her last injection was at least three months ago and that her cycles were within 26-32 days prior to use of the injectable. • If recently used an IUD, her IUD has been removed and her menstrual cycles are within 26-32 days. 							
6. Describes the SDM CycleBeads while showing the client the beads and telling her that: <ul style="list-style-type: none"> • The red bead represents the first day of menstrual bleeding. 							
<ul style="list-style-type: none"> • The brown beads represent the “infertile” days. 							
<ul style="list-style-type: none"> • The white beads (days 8-19) represent the “fertile” days. 							
7. Instructs the client on the use of the SDM by telling her to: <ul style="list-style-type: none"> • Put the ring on the red bead on the first day 							

TASKS	PRACTICES						
	1	2	3	4	5	6	7
of her menses and mark with an “x” this date on the SDM card/calendar.							
<ul style="list-style-type: none"> • Move the ring to a bead each day every morning. 							
8. Tells the client that she should abstain from sexual intercourse on white-bead days if she wants to avoid pregnancy.							
9. Draws the client’s attention to the dark brown and black beads and tells her that: <ul style="list-style-type: none"> • If she experiences menstrual bleeding before the dark brown bead, her cycle is short and less than 26 days. 							
<ul style="list-style-type: none"> • If the ring reaches the black bead and she has not experienced menstrual bleeding, then her cycle is long and more than 32 days. 							
10. Warns the client that if either of the above events happens at least twice in a year, she cannot reliably use the SDM as her FP method.							
11. Asks the client to repeat the instructions on SDM use in her own words.							
12. Corrects or clarifies instructions, as needed.							
13. Asks client what issues or difficulties might arise during fertile days (during white bead days).							
14. Asks client about possible ways she can handle the fertile days.							
15. Asks client for questions and concerns and responds to these.							
16. Tells the client to come to the clinic: <ul style="list-style-type: none"> • Within seven days of her next menstrual period bringing with her the CycleBeads, client card, and if possible, her partner. 							

TASKS	PRACTICES						
	1	2	3	4	5	6	7
<ul style="list-style-type: none"> Menses occur before the dark brown bead or has not occurred upon reaching the black bead. 							
<ul style="list-style-type: none"> After menses for the next three menstrual periods. 							
17. Refers the client for methods or services not offered at the counselor's site, if use of the CycleBeads is not appropriate.							
18. Fills up information in the Client Register and record client as New Acceptor.							
19. Provide information materials on the method.							

SKILLS CHECKLIST on PROGESTIN-ONLY INJECTABLE ADMINISTRATION

PARTICIPANT: _____ Course Date: _____

Instruction: Check the appropriate column for each of the tasks.

Key: 2= Yes 0= No	1= Yes, but needs improvement NA= Not applicable	1	2	3	4
PRE-INJECTION TASKS					
1. Conducts counseling.					
2. Ensures that the client understands and accepts the possible side effects of the POI.					
3. Explains the injection procedure to the client.					
4. Encourages the client to ask questions and responds to her questions.					
5. Listens attentively to client's response and concerns.					
6. Reassures the client that the needle and syringe used for injection are sterile.					
7. Washes hands thoroughly with soap and water.					
8. Checks vial for contents, dosage, and expiration.					
9. Disperses the suspension by rolling the vial back and forth between the palms of the hands or by gently shaking the vial so that no bubbles are formed in the solution.					
Using the auto-disabled syringe					
10. Checks that package seals of the syringe are not damaged or changed to ensure that sterility of the syringe is maintained.					
11. Takes care that the sterility of the needle is maintained by not touching contaminated surfaces with it.					
12. Holds the DMPA vial upright.					
13. Inserts the needle into the vial. and pulls the piston of the syringe to draw the solution.					
14. Keeps the needle in solution when drawing up the dose.					
15. Gently pulls the piston slightly past the 1.0 ml mark when drawing up the dose.					
16. Gives space for air bubbles while maintaining full dose.					

Key: 2= Yes 0= No	1= Yes, but needs improvement NA= Not applicable	1	2	3	4
17. After drawing up the dose and removing needle from vial, gently pushes the piston to remove excess air.					
18. Stops upon reaching the 1.0 ml mark.					
INJECTION TASKS					
19. Swabs the skin at the site of the injection with alcohol or other antiseptic.					
20. Allows the antiseptic to dry before giving the injection.					
21. Injects deep into the muscle.					
22. Administers the POI.					
23. Instructs the client not to massage the area after the injection.					
24. Disposes of needle and syringe in a puncture proof container.					
25. Washes hands and dry.					

COMMENTS/RECOMMENDATIONS:

Trainer's Signature: _____

COUNSELING SKILLS PRACTICE CHECKLIST

PARTICIPANT: _____ COURSE DATE: _____

Instruction: Check the appropriate column for each of the tasks.

Key: 2= Yes 1= Yes, but needs improvement 0= No NA= Not applicable	2	1	0	NA
Interpersonal Communication				
1. Maintains eye contact with the client.				
2. Uses simple language that the client understands.				
3. Uses appropriate tone of voice.				
4. Exhibits positive non-verbal communication.				
5. Uses the cue card effectively.				
6. Asks open-ended, closed and probing questions effectively.				
7. Listens attentively to client's response and concerns.				
Counseling Process				
1. Greets client and introduces self.				
2. Offers the client a seat.				
3. Asks reason for client's visit.				
4. Respects clients' right by:				
– Ensuring confidentiality				
– Providing privacy				
5. Invites client to speak freely.				
New Clients				
6. Uses the FP Form 1 to obtain relevant information.				
7. Assesses the client's reproductive needs (short-term, long-term, permanent)				
8. Asks client if s/he has a method in mind and what s/he knows about the method.				
9. Assesses what the client knows about FP methods.				
10. Asks if client has previously used an FP method and reason for discontinuing.				
11. If postpartum, assesses the client's willingness to breastfeed.				
12. Assesses reproductive health needs of clients				
• Risk for STIs				
• Gender-based violence				
13. Checks what possible methods client can use by using the WHO Medical Eligibility Criteria (i.e., wheel or summary table).				
14. Corrects rumors and misconceptions.				

Key: 2= Yes 1= Yes, but needs improvement 0= No NA= Not applicable	2	1	0	NA
15. Tells the client about available methods based on the client's knowledge and reproductive needs. <ul style="list-style-type: none"> • Mode of action • Advantages and disadvantages • STI and HIV prevention • Possible side effects 				
16. Allows the client to choose a method among those previously presented to her/him.				
17. Determines suitability of the chosen method using the method specific MEC checklist.				
18. Helps the client make a decision by asking her how s/he will cope with potential side effects of the chosen method.				
19. Correctly explains to the client how to use the chosen method.				
20. Offers condoms to clients with risk for STIs for dual protection and/or back-up.				
21. Correctly explains the warning signs and what s/he should do if any of these occurs.				
22. Checks at appropriate times if client has understood the information or instructions given.				
23. Asks the client to repeat all instructions in her/his own words.				
24. Tells the client when to return for routine follow-up, if needed.				
25. Refers the client for methods or services not offered at counselor's site.				

SUMMARY TABLE FOR BARANGAY HEALTH STATIONS

FAMILY PLANNING (Part 1 of 2)

INDICATORS	TARGET	JAN	FEB	MAR	1st Q	APR	MAY	JUNE	2nd Q	JULY	AUG	SEPT	3rd Q	OCT	NOV	DEC	4th Q	TOTAL
1. Total New Acceptors																		
▶ Female Sterilization																		
▶ Male Sterilization																		
▶ Pills																		
▶ IUD																		
▶ Injectables (DMPA)																		
▶ NFP-CM																		
▶ NFP-BBT																		
▶ NFP-LAM																		
▶ NFP-SDM																		
▶ NFP-STM																		
▶ Condom																		
▶ LAM																		
2. Total Other Acceptors																		
▶ Female Sterilization																		
▶ Male Sterilization																		
▶ Pills																		
▶ IUD																		
▶ Injectables (DMPA)																		
▶ NFP-CM																		
▶ NFP-BBT																		
▶ NFP-LAM																		
▶ NFP-SDM																		
▶ NFP-STM																		
▶ Condom																		
▶ LAM																		

FAMILY PLANNING (Part 2 of 2)

INDICATORS	TARGET	JAN	FEB	MAR	1st Q	APR	MAY	JUNE	2nd Q	JULY	AUG	SEPT	3rd Q	OCT	NOV	DEC	4th Q	TOTAL
3. Total Drop-out																		
▶ Female Sterilization																		
▶ Male Sterilization																		
▶ Pills																		
▶ IUD																		
▶ Injectables (DMPA)																		
▶ NFP-CM																		
▶ NFP-BBT																		
▶ NFP-LAM																		
▶ NFP-SDM																		
▶ NFP-STM																		
▶ Condom																		
▶ LAM																		
4. Total Current Users																		
▶ Female Sterilization																		
▶ Male Sterilization																		
▶ Pills																		
▶ IUD																		
▶ Injectables (DMPA)																		
▶ NFP-CM																		
▶ NFP-BBT																		
▶ NFP-LAM																		
▶ NFP-SDM																		
▶ NFP-STM																		
▶ LAM																		
▶ Condom																		

MONTHLY CONSOLIDATION TABLE FOR RURAL HEALTH UNITS

FAMILY PLANNING (Part 1 of 4)

Month: _____ Year: _____

INDICATORS	NAME OF BHS														
1. Total New Acceptors															
▶ Female Ster/BTL															
▶ Male Ster/Vasectomy															
▶ Pills															
▶ IUD															
▶ Injectables (DMPA)															
▶ NFP-CM															
▶ NFP-BBT															
▶ NFP-STM															
▶ NFP-SDM															
▶ NFP-LAM															
▶ Condom															

FAMILY PLANNING (Part 2 of 4)

Month: _____ Year: _____

INDICATORS	NAME OF BHS														
2. Total Other Acceptors															
▶ Female Ster/BTL															
▶ Male Ster/Vasectomy															
▶ Pills															
▶ IUD															
▶ Injectables (DMPA)															
▶ NFP-CM															
▶ NFP-BBT															
▶ NFP-STM															
▶ NFP-SDM															
▶ NFP-LAM															
▶ Condom															

FAMILY PLANNING (Part 3 of 4)

Month: _____ Year: _____




INDICATORS	NAME OF BHS											
3. Drop-out												
▶ Female Ster/BTL												
▶ Male Ster/Vasectomy												
▶ Pills												
▶ IUD												
▶ Injectables (DMPA)												
▶ NFP-CM												
▶ NFP-BBT												
▶ NFP-STM												
▶ NFP-SDM												
▶ NFP-LAM												
▶ Condom												

FAMILY PLANNING (Part 4 of 4)

Month: _____ Year: _____

INDICATORS	NAME OF BHS											
4. Total Current Users												
▶ Female Ster/BTL												
▶ Male Ster/Vasectomy												
▶ Pills												
▶ IUD												
▶ Injectables (DMPA)												
▶ NFP-CM												
▶ NFP-BBT												
▶ NFP-STM												
▶ NFP-SDM												
▶ NFP-LAM												
▶ Condom												

M1/FHSIS Report Form

 	FHSIS REPORT for the MONTH _____ YEAR: _____ Name of BHS: _____ Municipality/City of: _____ Province: _____ Projected Population of the Year: _____ <i>For submission to RHU</i>	FHSIS version 2008 		
MATERNAL CARE		No.		
Pregnant women with 4 or more Prenatal visits				
Pregnant women given 2 doses of Tetanus Toxoid				
Pregnant women given TT2 plus				
Preg.women given complete iron w/folic acid supplementation				
Preg.women given Vitamin A supplementation				
Postpartum women with at least 2 postpartum visits				
Postpartum women given complete iron supplementation				
Postpartum women given Vitamin A supplementation				
PP women initiated breastfeeding w/in 1 hr.after delivery				
FAMILY PLANNING	Current User (Begin Mo.)	Acceptors New Other	Dropout	Current User (End Mo.)
a. Female Sterilization/BTL				
b. Male Sterilization/Vasectomy				
c. Pills				
d. IUD				
e. Injectables (DMPA)				
f. NFP-CM				
g. NFP-BBT				
h. NFP-STM				
i. NFP-Standard Days Method				
j. NFP-LAM				
k. Condom				

Q1 FORM FOR FP

FHSIS Report for the Quarter: _____ Year: _____
 Municipality/City: _____
 Province: _____ Projected Population of the Year: _____



FHSIS v. 2008 - Q Form

<i>FAMILY PLANNING</i>								
Indicators	Current Users (beginning of the quarter)	Acceptors		Drop-Out	Current Users (End Qtr.)	CPR Col.6/TP x 14.5%	Interpretation	Recommendations/ Actions Taken
		New	Others*					
Col.1	Col.2	Col.3	Col.4	Col.5	Col.6	Col.7	Col.8	Col.9
a. Female Ster/BTL								
b. Male Ster/ Vasectomy								
c. Pills								
d. IUD								
e. Injectables (DMPA)								
f. NFP-CM								
g. NFP-BBT								
h. NFP-STM								
i. NFP-SDM								
j. NFP-LAM								
k. Condom								

* Others include CM, CC and RS

ACTION PLAN on FAMILY PLANNING

CHD: _____ Province: _____ Municipality/City: _____

Barangay: _____ Date: _____

Prepared by: _____

OBJECTIVES	ACTIVITIES	PERFORMANCE INDICATORS	TARGET	TIME FRAME	RESOURCE REQUIREMENT		RESPONSIBLE PERSON
					Items	Cost	
A. Service Delivery							
B. Logistics Management							
C. Information, Education and Communication (IEC)							
D. Advocacy and Resource Mobilization							
E. Monitoring and Evaluation							

GUIDELINES ON POST-TRAINING FOLLOW-UP AND MONITORING OF FPCBT BASIC COURSE TRAINEES

Preparatory Activities

1. One month prior to visit

Ensure that communication (i.e., letter followed by phone call, if possible) with the head of the trainee's facility, the trainee's supervisor, and the trainee to inform them of:

- Purpose of the visit which may be but not be limited to:
 - ✓ determine if the trainee-service provider is able to competently perform the skills taught during the FPCBT Basic Course.
 - ✓ provide trainee with technical assistance, as necessary.
 - ✓ identify problems the trainee may have in applying the knowledge and skills learned.
 - ✓ assist the trainee in finding solutions to these problems.
- Date of the visit
- What the trainee needs to prepare: FP Form 1 of FP clients provided services after the course, Target Client List, CDLMIS Inventory Report, Referral slips, BHS Summary Table (green book), and the RHU Summary Table (blue book).
- Arrange for availability of client(s) during the visit.

2. Two weeks prior to visit

Obtain confirmation of the scheduled visit

Prepare materials you will need, such as:

- ✓ Performance monitoring checklist (two copies/midwife: a copy to be left with the midwife and another for the monitoring agency)
- ✓ Copy of the letter previously sent informing the midwife of your visit
- ✓ Copy of the action plan (developed during the course)

3. Immediately prior to the visit

- Prepare for travel arrangements

4. Plan to be on time for the site visit

During the Follow-up

1. Conduct a courtesy call on the head of the facility.

- Explain the purposes of the follow-up visit which are:
 - o To determine if the trainee-service provider is able to competently perform the skills taught during the FPCBT Basic Course.
 - o To provide trainee with technical assistance, as necessary.
 - o To identify problems the trainee may have in applying the knowledge and skills learned.
 - o To assist the trainee in finding solutions to these problems.

2. Arrange to interview the trainee's immediate supervisor.

The following are some informal interview questions the trainer can ask the supervisor:

- Did training improve the trainee's work attitude and performance?
- Is the trainee able to effectively provide FP services (e.g. counseling, provision of SDM, pills, DMPA, and condoms)?
- Has there been an increase in the FP client load of the clinic after the trainee's training?
- Has there been an improvement in the quality of services provided by the trainee? In what way?

- Has there been a change in the infection prevention practices in the clinic and as practiced by the trainee? In what way?
- Has the trainee been involved in activities to improve the quality of FP services in the facility (e.g. work planning activities, forecasting and allocation of commodity needs, accomplishment of reports, resource mobilization)?
- Were the changes in the trainee's performance and attitude worth the time invested in training?
- Based on observations in the trainee's change of behavior, knowledge, and attitude, what suggestions would the midwife have towards improvement of the course?
- Did training correct the problem or meet the need for which the training program was designed?
- What recommendations does the midwife have for future trainees of the course?

3. Interview the trainee and observe performance

- Review the action plan developed during the course. Determine the extent to which the trainee has implemented the action plan.
- Find out whether the midwife is able to apply the concepts (e.g. infection prevention, informed consent and voluntarism, managing for quality) and provide FP services as learned in the course.
- Validate performance with records: FP Form 1 of FP clients provided services after the course, Target Client List, CDLMIS Inventory Report (DTUR, *Barangay* Inventory Worksheet), Referral slips, BHS Summary Table (green book) and the RHU Summary Table (blue book).
- If trainee expresses not being able to apply fully the concepts and skills learned in the course, ask for the constraints encountered. Include these as part of the "Issues" that need to be addressed.
- COACH the midwife to reinforce the critical skills learned during training by:
 - o Reviewing the performance monitoring checklist as the basis of the evaluation. Ask if there are any tasks in the checklist the midwife finds difficult to perform.
 - o Observing performance on counseling and infection prevention practices.
Note: Do a role play if no client is available during the visit.
 - o Checking and assisting the midwife, on the accomplishment of appropriate forms, as needed.
 - o Providing feedback by commending on tasks that were performed well followed by recommendations for improvement.
 - o Asking additional assistance needed to improve performance.
 - o Arrange for schedule of return visit if trainee has not performed satisfactorily and to check if recommendations are implemented.
- Provide feedback on the comments of the supervisor.
- Process the observations by listing items rated as "2" in the "Good Points" portion. Those rated as "1" and "0" under the "Issues" heading. For each of the issues, discuss recommendations for improvement and the agreed time frame for completion of the recommended activities.
- Thank the trainee for her/his cooperation.

4. Conduct an exit conference with the supervisor/head of facility.

- Present a summary of the results of the trainee observation and assistance they can provide in improving the trainee's performance.

After the follow-up visit

Prepare the report.

Send copies of the report to appropriate agencies.

POST-TRAINING MONITORING AND FOLLOW-UP CHECKLIST OF FPCBT BASIC COURSE GRADUATES

Name of Service Provider: _____ Course Dates: _____
 Address: _____
 Visited by: _____ Date of Visit: _____

OBSERVATION CHECKLIST

Instruction: Check the appropriate column for each of the items.

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
PHYSICAL ENVIRONMENT					
THE FACILITY IS ADEQUATELY EQUIPPED AND SUPPLIED AS IT HAS THE FOLLOWING:					
1. Signage that informs clients of services, including FP provided at the clinic and clinic hours.					
2. Clean and well ventilated client areas free from garbage, pests, and insects.					
3. Waiting area with seats for clients.					
4. All-methods poster displayed in an area where clients can see.					
5. An area for consultation and counseling that:					
– has a table and chairs.					
– provides auditory and visual privacy.					
– has an examination table with Kelly pad.					
– has gooseneck lamp and alternate source for light (i.e., emergency light, flashlight).					
– has sink with running water, liquid or bar soap, and clean, dry towel for washing and drying hands.					
– has locked storage for medicines and supplies.					
– has locked filing cabinet to keep clients' records.					
6. Clean toilet with running water accessible to clients and staff.					
7. Has provisions for infection prevention such as:					
– boiler or sterilizer					

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
– gloves (i.e., utility, examination, and sterile)					
– antiseptics (i.e., isopropyl 70% alcohol, betadine)					
– bleach for preparing 0.5% decontaminating solution					
– detergent					
– plastic containers for soaking and cleaning used instruments.					
– covered waste baskets lined with appropriate color coded plastic bags in client areas (i.e., waiting area, consultation room)					
– work area for cleaning instruments, Kelly pad, and mop.					
– access to potable water.					
– color-coded garbage containers for different types of wastes ✓ Black plastic lining for general, dry, non-infectious waste ✓ Green plastic lining for general, wet, non-infectious waste ✓ Yellow for infectious/pathological waste					
– container for sharps.					
– mops and rags					
8. Has an area for interim storage of waste that is minimally accessible to staff, clients, and visitors.					
9. Has the following supplies: – cotton					
– gauze					
– pregnancy test					
– family planning supplies: cycle beads, pills (COC, POP), DMPA with syringe, condoms					
TECHNICAL COMPETENCE					
INTERPERSONAL COMMUNICATION					
1. Uses simple language that client understands.					

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
2. Exhibits positive non-verbal communication.					
3. Uses appropriate tone of voice.					
4. Asks open-ended, closed, and probing questions effectively.					
5. Ensures that clients understand information given by asking follow-up questions.					
6. Listens attentively to client's response and concerns.					
7. Responds to all client's questions and concerns.					
8. Treats the client with respect by informing the client of procedures to be performed and asking about how she/he feels.					
COUNSELING PROCESS					
1. Greets client and introduces self, if needed.					
2. Offers the client a seat.					
3. Asks reason for client's visit.					
4. Respects clients right by: a. Ensuring confidentiality					
b. Providing privacy					
5. Invites client to speak freely.					
NEW CLIENTS					
6. Uses the FP Form 1 to obtain relevant information.					
7. Assesses the client's reproductive needs (short-term, long-term, permanent)					
8. Asks client if s/he has a method in mind and what s/he knows about the method.					
9. Assesses what the client knows about FP methods.					
10. Asks if client has previously used an FP method and reason for discontinuing.					
11. If postpartum, assesses the client's willingness to breastfeed.					

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
12. Assesses reproductive health needs of clients					
• Risk for STIs					
• Gender-based violence (VAW)					
13. Checks what possible methods client can use by using the WHO Medical Eligibility Criteria (i.e., wheel or summary table).					
14. Corrects rumors and misconceptions.					
15. Tells the client about available methods based on knowledge and reproductive needs.					
• Mode of action					
• Advantages and disadvantages					
• STI and HIV prevention					
• Possible side effects					
16. Allows the client to choose a method among those previously presented to her/him.					
17. Determines suitability of the chosen method using the method specific MEC checklist.					
18. Helps the client make a decision by asking how s/he will cope with potential side effects of the chosen method.					
19. Correctly explains to the client how to use the chosen method.					
20. Offers condoms to clients with risk for STIs for dual protection and/or back-up.					
21. Correctly explains the warning signs and what s/he should do if any of these occurs.					
22. Checks at appropriate times if client has understood the information or instructions given.					
23. Asks the client to repeat all instructions in her/his own words.					
24. Tells the client when to return for routine follow-up, if needed.					
25. Refers the client for methods or services not offered at counselor's site.					

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
RETURN CLIENTS					
6. Greets the client and introduces self, if needed.					
7. Offers the client a seat.					
8. Asks if the client's situation, including reproductive needs, had changed since the last visit.					
9. Asks the client if s/he has problems with the method s/he is using.					
10. If client is satisfied with the present method:					
• Asks the client to repeat how s/he uses the method.					
• Asks the client to repeat warning signs of the method s/he is using and emphasizes that immediate consultation should be sought if any of these occurs.					
• Gives client re-supply of the method s/he is using.					
• Tells the client when to return for follow-up, if needed.					
11. If client is not satisfied with the method:					
• Tells the client that there are other methods that s/he can use to meet her/his needs					
• Tells the client about appropriate methods for her/his reproductive need.					
• Helps the client make a decision by determining how s/he will cope with potential side effects.					
• Explains how to use the chosen method, including what to do for warning signs.					
12. Refers the client for methods or services not offered at the clinic.					
CLINIC MANAGEMENT					
WORK PLANNING					
1. Reviews the CBMIS regularly to identify clients with FP unmet needs for planning alternative service delivery interventions in the community.					
2. Reviews the target client list regularly to plan and carry out FP client care and service delivery.					
3. Contributes to the clinic's workplan by developing a plan					

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
for the provision of FP services in the community and clinic.					
PROMOTIONAL ACTIVITIES					
4. Uses the opportunity of a clinic visit with a woman to discuss additional issues like FP.					
5. Makes women/couples realize the relationship of FP to their health concerns.					
6. Conducts community education on FP.					
7. Conducts “ <i>Buntis</i> ” parties for pregnant women which includes FP and discussing the possibility of practicing postpartum FP.					
8. Discusses family planning to women of reproductive age in the clinic or community by telling: <ul style="list-style-type: none"> – that the ideal gap between pregnancies is three years – that there are options depending on her/their situation and needs. – of FP services available in the clinic. 					
REFERRAL					
9. Refers client to other facilities or service providers for services not available in the clinic.					
10. Has identified facilities for referral of specific services not available in the clinic					
11. Accomplishes referral slips accurately when appropriate.					
12. Follows-up outcome of referrals.					
13. Keeps record of clients referred for FP and other RH services.					
14. Compiles returned referral slips.					
RESOURCE MOBILIZATION					
15. Partners with companies, NGOs, local government executives, and other stakeholders in the community for support and delivery of services.					
16. Networks with other facilities, including private sector delivery points (private birthing homes), for continuation of services and referral.					

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
MANAGEMENT INFORMATION SYSTEM					
17. Ensures that all FP users have an FP Form 1.					
18. Updates the TCL every time a client comes to the clinic for FP services.					
19. Accomplishes the BHS summary table (green book) and/or the RHU summary table (blue book).					
20. Accomplishes the RHU summary table (blue book)					
21. Supervises BHWs in updating the family profile (part of the CBMIS) to determine FP unmet needs in the community.					
22. Completes the FHSIS by accomplishing the: <ul style="list-style-type: none"> - FP Form 1 - TCL - Summary Table for FP Program (i.e., green and blue books) 					
23. Consolidates/lists all clients with FP unmet needs.					
24. Has a system for the submission of reports.					
INFECTION PREVENTION					
25. Keeps the clinic and its surroundings clean.					
26. Washes hands properly and at appropriate times.					
27. Uses gloves correctly and appropriately.					
28. Uses antiseptics and disinfectants correctly.					
29. Follows the three steps for processing equipment/instruments that has contact with body fluids. The steps, in proper order, are: <ul style="list-style-type: none"> - decontamination - washing/cleaning - high-level disinfection 					
30. Maintains single-use injection practice.					
31. Disposes used needles/sharps in a sharps container.					
32. Segregates wastes properly. <ul style="list-style-type: none"> - Black trash bag = general, non-infectious, dry - Green trash bag = general, non-infectious, wet - Yellow trash bag = infectious, pathological 					

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
- Sharps container = sharps					
33. Properly disposes contaminated materials, pathological, and other medical wastes.					
LOGISTICS MANAGEMENT SYSTEM					
34. Estimates FP commodity requirements of the clinic.					
35. Ensures proper storage of FP commodities.					
36. Follows the FEFO principle in using up stocks of commodities.					
37. Returns expired and damaged contraceptives and other supplies to the delivery team.					
38. Reviews/prepares records like the following to determine logistical requirements for FP commodities: – CDLMIS Inventory Report					
– Dispensed to User Report					
– Target Client List					
– Supplies Ledger Card					
– Contraceptive Order Form					
39. Monitors stock levels of FP commodities by maintaining the authorized stock level and ensures availability of these commodities at all times.					
40. Checks availability of essential clinic equipment and supplies and reports if any of these are not available or functional.					
41. Submits requirements for commodities and equipment to the procuring level.					
INFORMED CHOICE AND VOLUNTARISM					
42. Ensures that the six elements of informed choice and voluntarism are complied with in the facility. – Availability of a broad range of modern contraceptive methods. – No quota and targets are imposed on the BHWs. – No financial rewards or incentives. – No denial of rights and benefits. – Comprehensible information given to clients. – Informed consent for BTL and NSV are signed.					

DOH ICV ADMINISTRATIVE ORDER



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

JUN 23 2011

ADMINISTRATIVE ORDER
No. 2011- 0005

SUBJECT: Guidelines on Ensuring Quality Standards in the Delivery of Family Planning Program and Services through Compliance to Informed Choice and Voluntarism

I. BACKGROUND and RATIONALE

In 2001, the Administrative Order- 50-A s.2001, National Family Planning Policy (NFPP) which embodies the Philippines FP program policies has refocused FP as a health intervention that will promote the overall health of all Filipinos by: preventing high-risk and unplanned pregnancies thus reducing maternal deaths, and preventing abortions, responding to the reproductive rights of women with unmet FP needs and promoting responsible parenthood. As such, the management and implementation of the program are specifically guided by the "Four Principles/Pillars of Family Planning" namely: 1) Respect for the sanctity of life; 2) Respect for human rights; 3) The freedom of choice and voluntary decisions (Informed Choice and Voluntarism - ICV); and 4) Respect for the rights of clients to determine their desired family size. These principles uphold the rights of the Filipino people to have access to quality health services, promote the will and abilities of couples and individuals to freely choose which method to use according to their religious beliefs and ethical values and cultural background to enable them to respond to their needs and aspirations in pursuit of a better life

In a memorandum to all regional directors of Centers for Health Development issued on June 29, 2006, the Department of Health (DOH) reiterated its order for national and local health managers and FP service providers to observe, comply and adhere to four FP guiding principles. However, through the years, ICV compliance has not been sustained reflecting the need to strengthen monitoring of implementation and the issuance of guidelines on establishing ICV compliance monitoring and reporting system.

This Order is issued to reiterate observance, compliance and adherence to the prescribed principles in the delivery of accessible quality family planning services.

CERTIFIED TRUE COPY

JUN 23 2011

MAYREEN AGUIRRE
Chief, Records Section - IMS
Department of Health

II. GOAL and OBJECTIVES

Goal

To provide universal access to quality FP information and services to men and women whenever and wherever needed and enable them to make informed choice and voluntary decision to use modern FP method best suited to his/her needs.

Objectives

1. To provide policy and program directions on FP service delivery that support informed choice and voluntary decision making;
2. To ensure that health service providers are providing accurate and complete information on family planning methods and services, crucial to informed choice and voluntary decision-making;
3. To increase awareness among men and women of reproductive age of their individual rights to access quality FP services and make choices for themselves; and
4. To establish and implement an effective and efficient monitoring and reporting system on informed choice and voluntary decision making.

III. COVERAGE and SCOPE

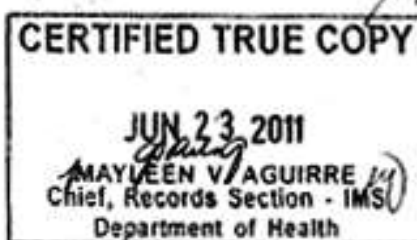
This policy applies to all DOH units and attached agencies such as the Commission on Population (POPCOM) and Philippine Health Insurance Corporation (PHIC), non-government organizations and the private sector.

Compliance to ICV policy requirements shall cover the operations of both public and private health facilities providing FP services under the local government units, and other government agencies in so far as their health service operations are governed by technical guidelines, standards, and policies mandated by DOH.

IV. DEFINITION of TERMS

1. Informed Choice

Effective access to information on a wide range of family planning options and to counseling, services and supplies needed to help individuals choose to obtain or decline services, to seek, obtain and follow up on a referral, or simply to consider the matter further. ICV is when clients freely make their own decision based on accurate and complete information on a broad range of available modern FP methods.



2. Voluntarism

Decision-making on the choice of FP method is based upon the exercise of free choice and not obtained by any special inducements or forms of coercion or misrepresentation.

3. FP Target

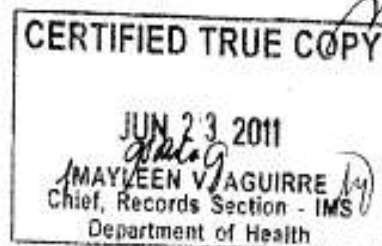
FP target is a quantitative estimate used for determining logistics and budget requirements for planning purposes;

4. Incentives

An incentive is a form of payment in cash or material transferred or provided in order to influence or coerce the acceptance of any family planning method by a client or in recruiting clients to achieve set targets or quota by service providers.

V. GENERAL GUIDELINES

1. The delivery of the family planning program services shall strictly adhere to the principles of:
 - a) Respect for the sanctity of life. Family Planning is aimed at preventing abortions thus saving the lives of women and children
 - b) Respect for human rights. Family Planning services are provided using only medically and legally acceptable methods appropriate to the health status/needs of the client and shall be provided regardless of gender, number of children, religion, sexual orientation, moral background, occupation, socio-economic status, cultural and political affiliation.
 - c) The freedom of choice and voluntary decisions. The Family Planning program enable couples and individuals to make family planning decisions based on informed choice through the provision of complete and accurate information.
 - d) Respect for the right of clients to determine their desired family size. The Family Planning program respects the basic rights of couples and individuals to freely and responsibly decide on the number and spacing of their children.
2. FP services shall adhere to quality standards and shall be part of an integrated core of service package across the continuum of care for men and women of reproductive age, so that missed opportunities in serving the unmet needs of clients will be reduced.
3. Informed choice and voluntarism shall be promoted in all facilities rendering FP services, public or private. Sustained regular quarterly monitoring coupled with facilitative supervision and periodic evaluation of service delivery procedures shall be established to ensure that clients are satisfied and able to make informed choices thus an informed choice and voluntary compliance monitoring system shall be installed at the central, regional and provincial, city/municipal levels of the health care delivery system.

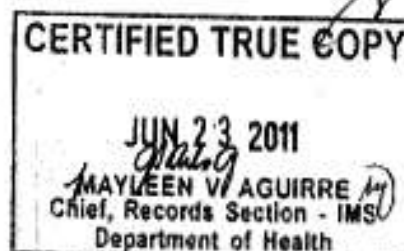


VI. SPECIFIC GUIDELINES

1. To ensure adherence to the principles of the Family Planning Program and ensure delivery of quality services the following shall be implemented:
 - a) Clients will be provided with correct, evidence-based and comprehensible information on the benefits of the chosen method, including contraindications, and possible side effects. Clients will further be provided clear, unbiased information on the advantages and disadvantages of the various family planning methods and explain correct use of the chosen method.
 - b) Incentives and financial rewards, gratuities, and bribes shall not be provided in exchange of or to influence client's decision for becoming a FP acceptor, or for service provider to achieve a target or quota.
 - c) Clients shall not be denied any right or benefit including the right of access to participate in any program of general welfare or the right of access to health care, as a consequence of client's decision **not to accept** family planning services.
 - d) Clients shall be assured of the availability, accessibility and affordability of a broad range of FP methods to enable them to choose the suitable method they like and to switch when they decide to do so.
 - e) Proper referral systems shall be ensured by creating links with the concerned health facilities (both in the public and private clinics/ hospitals) and other agencies to meet the range of clients' family planning needs.
 - f) Service providers shall not be subjected to target/quota, or other numerical targets of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning that may run contrary to clients' decision. This provision shall not include FP program targets used as quantitative estimates or indicators for planning and budgeting of logistics requirements.
 - g) Service providers shall ensure that informed consent have been secured from every voluntary sterilization (VS) potential acceptor prior to the performance of the procedure.
2. To promote informed choice and voluntary decision making, three types of measures or approaches shall be adopted for implementation. These are:

A. Measures to promote compliance to ICV

The first approach is creating awareness among potential FP clients, FP public and private service providers including NGOs and local chief executives to strengthen their knowledge, attitude and skills in ensuring compliance to these policies and enable potential clients to have access to



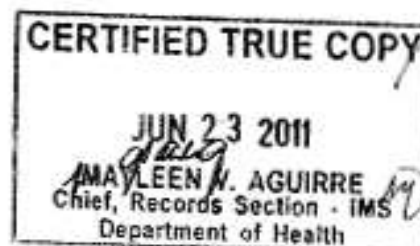
broad range of choice of FP services. The awareness raising activities for particular targeted groups are as follows:

1. Effective dissemination of information on ICV principles to potential clients especially regarding their rights to choose from and access a broad range of FP services. Public and private service providers including NGOs shall ensure that the counseling process reflects the principle of informed choice and leads to family planning decisions that clients make for themselves.
2. Effective dissemination of information on ICV principles to public and private FP service providers and NGOs including Barangay Health Workers (BHWs) as referral agents through:
 - The conduct of orientation training on ICV principles and policy requirements and Compliance Monitoring and Reporting among frontline public and private service providers, NGOs and BHWs on a regular basis;
 - The implementation of the revised Family Planning Competency-Based Training (FPCBT) Level 1 and Level 2 which also contain a comprehensive discussion on ICV thereby increasing the knowledge and improve the skills of frontline service providers in providing quality FP services.
 - Use of FP wall charts which explain all the FP methods. These shall be posted on the most visible area of the facility for the clients to read. Likewise, other IEC materials on the different FP methods shall also be available for the clients to read or take home.
3. Advocacy to Local Chief Executives (LCEs), leader, organizations of private sector providing FP services and NGOs on ICV principles to prevent the provision of incentives among their constituents/clients as this may influence informed choice and voluntary decision making of potential FP clients. Likewise, LCEs should support and ensure the availability of broad range of FP methods by providing logistics and budgetary support to the implementation of the FP program.

B. Compliance Monitoring and Reporting Measures

Monitoring Compliance shall also be implemented to ensure strict adherence to the ICV requirements in the delivery of FP services. These shall include the following:

1. Periodic ICV compliance monitoring and reporting



The Department of Health-National Center for Disease Prevention and Control (DOH-NCDPC) shall install a functional ICV compliance monitoring and reporting system at all levels: from the DOH-Center for Health Development (DOH-CHD) to the Provincial/City Health Office (PHO/CHO) to ensure ICV compliance at the city/municipal level health service delivery facilities.

ICV compliance monitoring shall be integrated into existing regular field visits. ICV compliance monitoring may also be incorporated during meetings and discussions with provincial, city and municipal health personnel to identify and address potential issues and concerns.

Compliance monitoring results shall be consolidated and reported to appropriate levels quarterly, while monitoring results indicating possible non-compliance shall be immediately reported to the Regional ICV Compliance Committee (Annex A. ICV Compliance Monitoring and Reporting Flow) using the narrative report form for non-compliance (Annex D)

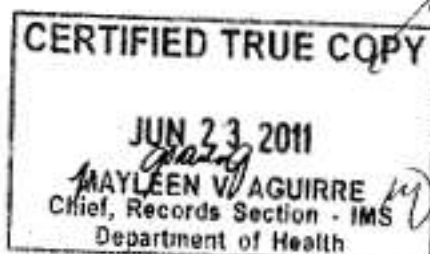
2. Use of standard ICV Compliance Monitoring Questionnaires and Reporting Forms

ICV compliance monitoring tool for service providers/service delivery sites and clients [Annex B1 and B2, ICV Compliance Monitoring Questionnaires] and Summary Matrix (Part B) were developed to facilitate the gathering of information pertaining to compliance with the National Family Planning policies of the Department of Health. The service provider and client questionnaires serve as rapid assessment tools.

The results of the service provider and client compliance monitoring shall be reported jointly using the standard reporting forms [Annex C. ICV Reporting Forms]. For instance, where the results from the two tools do not match, cross-checking and validation shall be conducted. In facilities where interviews of clients revealed possible non-compliance but interviews of service providers of the same facility did not reveal any possible non-compliance, there is a need to conduct a validation of the report.

C. Implementing Corrective Measures

If, during monitoring visits, any service provider or any relevant person (program managers, policy-makers, or the local chief executives) is identified as not compliant to the ICV policy requirement, the following steps shall be undertaken:



1. A report of the non-compliance shall be immediately submitted to the Regional ICV Compliance Committee which upon receiving the report shall immediately mobilize the Regional Validation Team to conduct in-depth investigation.

2. In cases that non-compliance is confirmed, the Validation Team shall propose immediate corrective actions (e.g., ensure that the non-compliant practice ceases, formulation/issuance of appropriate local policies/guidelines addressing the compliance problem and reporting requirements are complied with) and shall immediately prepare and submit the report on the in-depth investigation together with the proposed corrective action to the CHD Director/Regional ICV Compliance Committee who shall in turn immediately submit the report with recommendations to the NCDPC Director IV for information and possible recommendation of additional corrective action.

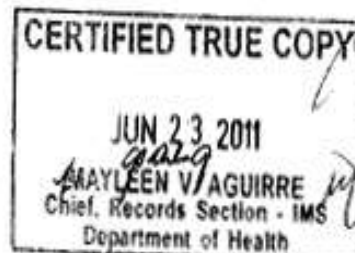
3. In instances where corrective actions for ICV non-compliance require national mandate (e.g., systems strengthening, training, policy changes), the CHD Director through the Regional ICV Compliance Committee shall submit an in-depth investigation report and recommendations to the DOH National ICV Compliance Committee through the DOH-NCDPC Director for immediate action.

4. Proper feedback on the findings of non-compliance with the appropriate recommendations/corrective actions are relayed to, applied and implemented by the health facility concerned. The DOH National ICV Compliance Committee through the FP program manager may conduct further investigation if necessary and/or shall ensure that the committee recommendations for further corrective actions are relayed to the CHD Director for implementation and monitoring.

VII. IMPLEMENTATION ARRANGEMENT

1. At the National Level:

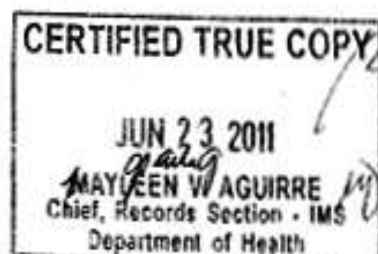
- a. The DOH-NCDPC-Family Health Office (FHO) shall create a National ICV Compliance Committee that shall be responsible for the overall implementation of the FP ICV Compliance Monitoring and Reporting Policy.
- b. The DOH-National ICV Compliance Committee shall strictly monitor the implementation and establishment of ICV compliance monitoring and reporting at the regional, provincial/city levels and shall ensure the regions that essential logistics requirements including the availability of monitoring tools/ instruments are set in place to support the implementation of the ICV compliance monitoring



- c. The DOH National ICV Compliance Committee shall be chaired by the DOH-NCPDC Director and shall be composed of representatives from the
 - 1. DOH-NCDPC Family Health Office
 - 2. DOH-BHFS (Bureau of Health Facilities and Services)
 - 3. DOH-BLHD (Bureau of Local Health Development)
- d. DOH-NCDPC-FHO through the FP program manager shall ensure that National ICV Compliance Committee recommended corrective measures are relayed to and implemented by the concerned health facility found to be non compliant to ICV policy standards

2. At the Regional Level:

- a. The CHD Director IV shall constitute a Regional ICV Compliance Committee composed of the following:
 - i. Director IV or III as Chair
 - ii. Local Health Assistance Chief as member
 - iii. Family Health Cluster Head as member
- b. The CHD Director IV through Regional ICV Compliance Committee shall be responsible for the strict implementation and adherence of FP service providers and facilities to the FP informed choice and voluntary decision making policy.
- c. The Regional ICV Compliance Committee shall ensure that the CHD and its provinces have installed a functional ICV compliance monitoring and reporting system
- d. The Regional ICV Compliance Committee through the regional FP coordinator shall be responsible for the conduct of orientation training and use of the monitoring tools and reporting forms for the DOH-Representatives and the Provincial/City FP coordinators and technical staff.
- e. The regional FP coordinator shall consolidate all field monitoring reports and shall prepare and submit a semi-annual monitoring report to the Regional ICV Compliance Committee, and the National FP program manager (end of July and end of January of each year). Copies of the semi-annual report shall be provided to the P/CHO.
- f. The CHD Director IV shall create a Validation Team composed of the Regional Family Planning Coordinator and the members of the provincial/city monitoring team which reported the non-compliance. The Validation Team shall review and/or conduct in-depth investigation on reported non-compliance and recommend corrective actions.
- g. The Regional FP coordinator through the Provincial/City Monitoring Team shall regularly monitor and report the status of implementation of the recommended corrective measures where appropriate.
- h. The CHD Director shall ensure that LGUs have the essential logistics requirements including the availability of monitoring tools/ instruments to support the implementation of the ICV compliance monitoring



3. At the LGU Level:

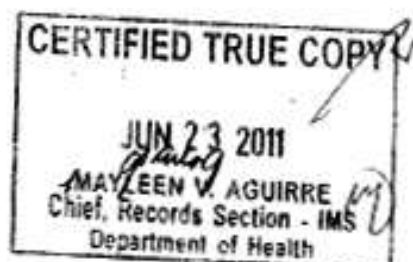
- a. The PHO/CHO through their respective FP coordinator shall be responsible for the functional operation of the provincial/city ICV compliance monitoring and reporting system and the strict adherence and compliance to the Informed Choice and Voluntary decision making policy
- b. The PHO/CHO shall ensure essential logistics requirements including the availability of monitoring tools/ instruments are set in place to support the implementation of the ICV compliance monitoring
- c. The DOH-Representatives with the PHO/CHO FP coordinators/technical staff shall orient all health service providers on compliance monitoring in their respective areas of responsibility.
- d. The PHO/CHO shall designate the Provincial/City Family Planning coordinator as the chair of the Provincial/City ICV Monitoring Team with the DOH-Provincial Team Leader and DOH-Representatives as members
- e. The Provincial/City ICV Compliance Monitoring Team shall monitor ICV compliance in all government and private health facilities providing FP services within their respective territorial jurisdiction (City Health Office, Main Health Centers, Rural Health Units, Barangay Health Stations, and hospitals, private clinics, NGOs providing FP services). ICV compliance monitoring shall be conducted as part of regular monitoring (quarterly) visits or as a separate ICV monitoring visit.
- f. The Provincial/City ICV Compliance Monitoring Team through the Provincial/City FP Coordinator shall consolidate and submit the report to the PHO/CHO and to the Regional ICV Compliance Committee.
- g. FP service delivery facilities' (CHOs, MHCs/RHUs, BHS, and hospitals) head, or the public health nurse/rural health midwife shall ensure that ICV components/elements are strictly implemented by ensuring that FP wall charts are displayed, information are disseminated and pertinent materials and counseling services are provided.

4. DOH Attached Agencies (POPCOM and PhilHealth)

- a. Support and advocate compliance to FP informed choice and voluntary decision making policy of the Department of Health
- b. Support CHDs in monitoring and reporting ICV compliance within their respective areas of responsibilities

5. NGO/Private Sector

- a. Support and advocate compliance to FP informed choice and voluntary decision making policy of the Department of Health
- b. Support ICV compliance monitoring and reporting within their respective areas of responsibilities



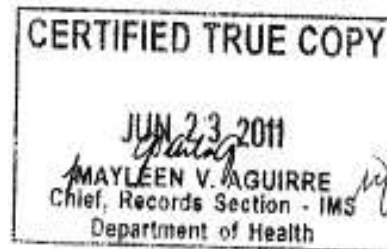
VIII. REPEALING CLAUSE

Any provisions of existing policies or issuances found inconsistent with this Order shall be deemed repealed.

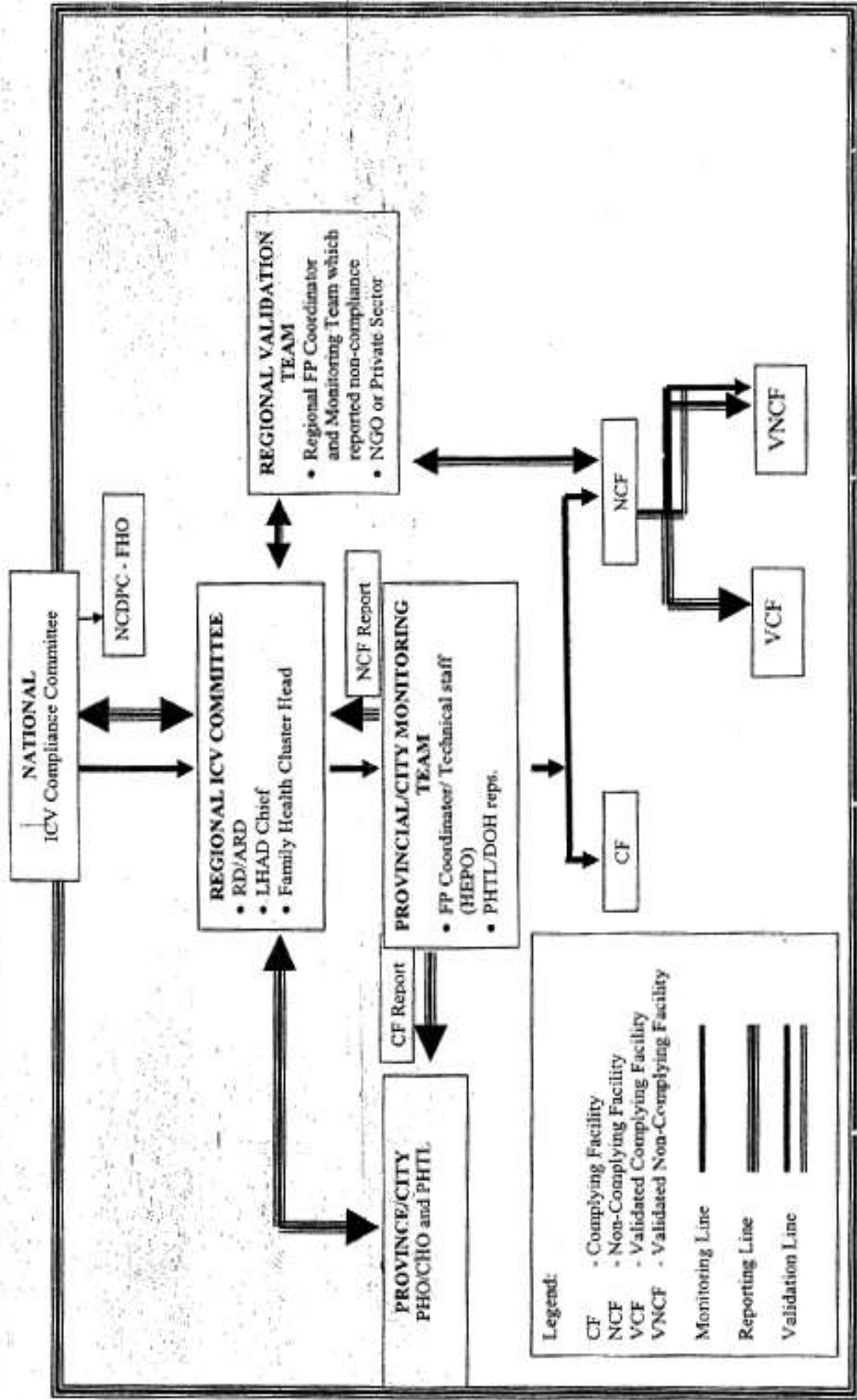
IX. EFFECTIVITY

This Order shall take effect after fifteen days of publication in a newspaper of national circulation.


ENRIQUE T. ONA, MD, FPCS, FACS
Secretary of Health



ICV Compliance Monitoring and Reporting Flow Chart



ICV Compliance Monitoring tool for Service Providers/Service Delivery Sites**Instructions to Interviewer:**

The purpose of this Assessment Tool is to facilitate the gathering of information related to compliance with the Department of Health legislative and policy requirements to ensure quality of care in family planning service delivery. This tool is intended to serve as a rapid assessment of compliance to the National Family Planning Program policies **by the service providers at service delivery sites or outlets** at the regional, provincial, city, municipal or barangay levels. It is not necessary to follow this tool verbatim, but rather during the course of conversation, to obtain the information requested below, it may be necessary to ask additional questions and probe deeper to obtain details about a given issue. It is the responsibility of the interviewer to continue the in-depth discussion to the point necessary to gather all the necessary information and provide a comprehensive report to the appropriate level of DOH office. If during the use of the tool there is a 'red flag' that indicates non-compliance, it is necessary to report this **immediately** to the appropriate level of DOH office to initiate in-depth investigation. The results of this tool must be reported jointly with the results of the Assessment Tool for Family Planning Clients. If the results obtained by the two tools do not match, further investigation will be required.

When all pertinent questions in the interview have been asked and answered, all feedback and comments have been taken, **BE SURE** to address the service provider's questions, issues or concerns. **DO NOT** leave without addressing issues that you had picked up during the interview.

How to use this instrument:

The instrument is divided into 10 sections that examine different aspects of family planning and abortion-related issues and concerns. Each section has several questions which are designed to elicit the information necessary to determine whether there is cause for concern related to that particular issue. Each section contains a space to record answers to the specific questions and a space for additional comments based on the information provided.

This tool is intended to serve as a guide to the interviewer. For record keeping purposes, please fill in the tool immediately following the interview and submit the form to the appropriate entity within your respective office.

ICV Compliance Monitoring Questionnaire for Service Providers/Service Delivery Sites

Date : _____
 Name of Interviewer : _____
 Position and Office : _____
 Name of Health Facility : _____
 Address of health facility : _____
 Name of individual interviewed : _____
 Position/Title : _____

Interviewees include: Doctors, nurses, midwives and barangay health workers.

Introduction:

My name is _____ and I work for _____ as a _____. I am here to collect some information about family planning services in this region/province/ city/ municipality/ barangay. I will ask you some questions about family planning services at this facility. Thank you for your assistance in helping us better understand the family planning services in this facility.

Do you have any questions? Yes No

1. Broad range of contraceptive methods available at the health facility

No.	Question		
1.1	What family planning (FP) methods are currently available and offered to clients in this health facility? <input type="checkbox"/> Pills <input type="checkbox"/> NFP (what method? _____) <input type="checkbox"/> Injectables <input type="checkbox"/> Bilateral Tubal Ligation (BTL) <input type="checkbox"/> Intra-Uterine Device (IUD) <input type="checkbox"/> Vasectomy <input type="checkbox"/> Condoms <input type="checkbox"/> Other (specify) _____		
1.2	If methods are not available, are clients referred elsewhere?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If yes, a) what methods _____ and b) where referred? _____		
Comments			

2. Numerical Targets

No.	Question	Answer	
		Yes	No
2.1	Do you have planned FP targets/goals?		
2.2	<p><i>If yes, for what purpose/s?</i></p> <p><input type="checkbox"/> Planning</p> <p><input type="checkbox"/> Logistics (forecasting, procurement and distribution)</p> <p><input type="checkbox"/> Performance evaluation</p> <p><input type="checkbox"/> Other, please specify:</p>		
2.3	<p>Are you required to achieve any assigned specific numbers of any of the following?</p> <p><i>If yes, please check all that apply:</i></p> <p>_____ total number of FP acceptors</p> <p>_____ number of acceptors of specific methods as follows:</p> <p>_____ for IUD</p> <p>_____ for injectables</p> <p>_____ for modern NFP (BBT, CM, ST, LAM, SDM)</p> <p>_____ for vasectomy</p> <p>_____ for pills</p> <p>_____ for condoms</p> <p>_____ for tubal ligation</p> <p>_____ for others, specify pls:</p>		
2.4	<p>What happens if you meet your targets?</p> <p>What if you fail to meet your targets?</p>		
<i>Comments</i>			

3. Incentives/Financial Rewards

No.	Question	Answer	
		Yes	No
	Incentives/Financial rewards for Service Providers/Clients		
3.1	<p>Aside from your salary, do you get paid (money or in kind) for FP services and/or referrals?</p> <p><i>If yes, how much and explain for what?</i></p>		
3.2	Are financial rewards/incentives provided when you achieved your individually assigned predetermined FP numerical targets?		

3.3	Does the facility offer anything to clients in exchange for accepting family planning (e.g., food, money)?		
	<i>If yes, how much and for what?</i>		
<i>Comments</i>			

4. Denial of Benefits

No.	Question	Answer	
		Yes	No
4.1	If a client decides not to use family planning, are any benefits or rights withheld from the client or their family?		
4.2	<i>If yes, what is withheld?</i>		
<i>Comments</i>			

5. Comprehensible Information

No.	Question
5.1	What information do you give to clients about the FP method he/she has chosen (check) <input type="checkbox"/> Risks and benefits <input type="checkbox"/> Side effects <input type="checkbox"/> Advantages/Disadvantages <input type="checkbox"/> How to use the methods/procedures <input type="checkbox"/> Conditions that would render method inadvisable?

6. Family Planning IEC Materials Available

No.	Question	Answer	
		Yes	No
6.1	Is there a wall chart with all FP methods visible? (<i>where is/are posted and in what language?</i>)		
6.2	Are other family planning IEC materials available- flipcharts, brochures, leaflets, etc)		
<i>Comments</i>			

7. Abortion

No.	Question	Answer	
		Yes	No
7.1	Have there been times when you were consulted for missed or delayed menstruation?		
7.2	What do you do when such clients ask you to help them regain menstruation?		
7.3	What do you do if pregnancy is confirmed?		
Comments			

8. Voluntary Surgical Sterilization (VSS)

No.	Question	Answer	
		Yes	No
8.1	VSS Information Giving		
8.2	Do you provide counseling to clients who want VSS services (BTL/Vasectomy)?		
8.3	Does this health facility have informed consent forms for VSS?		
8.4	Are informed consent forms signed prior to any VSS procedure?		
8.5	Compensation to Clients/Providers services		
8.6	If VSS is provided at this health facility, do VSS clients receive any type of compensation? <i>If so, how much?</i>		
8.7	If VSS is provided at this health facility, are referral agents or service providers paid on a per case basis related to VSS?		
Comments			

9. Document Review

No.	Question	Answer	
		Yes	No
<i>Request for permission to review the service provider's service records/statistics (3-6 months) and referral records (ex. FP Form 1, FP clients' logbook; target client list; FHSIS monthly/quarterly reports; O.R. logbook; others). Use the guide</i>			

<i>questions below to determine compliance with FP policies.</i>		
9.1	Are there any sharp increases that might indicate more emphasis on increasing number of acceptors/users of any one particular method (note or record any observations)?	
9.2	Are there any kind of inconsistency in the data (ex. Anything that looks unusual; supply vs. utilization reports)?	

10. Coercion

No.	Question	Answer	
		Yes	No
10.1	<p>Is there any evidence of coercion in the family planning program?</p> <p>If yes, please describe and explain.</p>		

ICV Compliance Monitoring Tool for FP Clients**Instructions to Interviewer:**

The purpose of this Assessment Tool is to facilitate the gathering of information related to compliance with the Department of Health legislative and policy requirements to ensure quality of care in family planning service delivery. This tool is intended to serve as a rapid assessment of compliance to the National Family Planning Program policies from *family planning clients*. It is not necessary to follow this tool verbatim, but rather during the course of conversation, to obtain the information requested below, it may be necessary to ask additional questions and probe deeper to obtain details about a given issue. It is the responsibility of the interviewer to continue the in-depth discussion to the point necessary to gather all the necessary information and provide a comprehensive report to the appropriate level of office of the DOH. If during the use of the tool there is a 'red flag' that indicates non-compliance, it is necessary to report this *immediately* to the appropriate level of office of the DOH to initiate in-depth investigation. The results of this tool must be reported jointly with the results of the Assessment Tool for Service Providers. If the results obtained by the two tools do not match, further investigation will be required.

When all pertinent questions in the interview have been asked and answered, all feedback and comments have been taken, BE SURE to address the FP clients' issues or concerns. DO NOT leave without addressing issues that you had picked up during the interview.

This tool is intended to serve as a guide to the interviewer. For record keeping purposes, please fill in the tool immediately following the interview and submit the form to the appropriate entity within your respective office.

ICV Compliance Monitoring Questionnaire for Family Planning Clients

Date _____

Name of Interviewer _____

Position and Office _____

Place of Interview/address _____

Client (circle one) : Male Female

Introduction

My name is _____ and I work for _____ as a _____. I am here to collect some information about the family planning services in this area. I will ask you some questions about the family planning services you have received and your impressions about family planning services in general. The results of our interview and data collection will be used to better understand the current situation in this LGU and to identify areas that might be strengthened or improved. I am not recording your name or any other information that could be linked to you. The responses you give me are confidential and will be summarized with the responses of other clients from different sites around the country. In addition to our discussions with clients, we will also be gathering information from health facility staff.

Do you have any questions? Yes No

Do you agree to participate in this interview? Yes No

1. Client Feedback on the Quality of FP Services

No.	Question	Answer
1.1	What family planning method are you currently using?	
1.2	Where do you get family planning supplies and/or services?	
	<i>If no, explain?</i>	

2. Voluntary decision making

2.1	How did you decide/choose the FP method that you are using now?
-----	---

2.2	Who decided/chose the family planning method that you are using now? <input type="checkbox"/> A. Myself <input type="checkbox"/> B. My husband/partner <input type="checkbox"/> C. My in-laws/parents <input type="checkbox"/> D. Others: (pls. specify) _____
-----	--

3. Knowledge of complete and accurate information on FP method

No.	Question	Answer	
		Yes	No
3.1	Did the service provider share with you the information about the method you selected. <input type="checkbox"/> advantages/disadvantages <input type="checkbox"/> possible side effects <input type="checkbox"/> how to use the method/procedures <input type="checkbox"/> conditions that made method inadvisable		
3.2	Did the service provider explain what to do and where to go if you experienced side effects?		
3.3	Do you think that you received all of the information necessary to make a decision about your family planning needs?		

4. Coercion/Denial of Benefits

No.	Question	Answer	
		Yes	No
4.1	Did you feel any pressure from anyone to use family planning, or to use a particular method?		

5. Incentives/Financial Rewards

No.	Question	Answer	
		Yes	No
5.1	Did someone give you anything, in exchange for using family planning or using a particular method (i.e. food, money, gift, access to a particular program)?		
	<i>If yes, what or how much?</i>		

1. Voluntary Sterilization (for BTL/NSV Clients only)

No.	Question	Answer	
		Yes	No
6.1	Before you had the procedure, did you sign a form saying you understand what bilateral tubal ligation (BTL)/vasectomy is about?		
6.2	Did you receive anything (money, food, gift, etc.) for having BTL/vasectomy done?		
	<i>If yes, what or how much?</i>		

Part B. Summary Matrix of Service Providers/Facilities Monitored and Family Planning Clients Interviewed

Date Monitored	Name of Facilities	Location of Facilities	Name/Designation of Service Providers	No. of FP Clients Interviewed	Monitored by	Results/Findings (Please be as detailed as possible and indicate separately for service providers and FP Clients)	Steps Taken/Recommendations (Please be as detailed as possible and indicate separately for service providers and FP Clients)

Total number of Facilities Monitored: _____

Total number of Service Providers Monitored: _____

Total number of FP clients interviewed: _____

Number of facilities noted to be compliant to policies: _____

Number of facilities noted to not compliant: _____

Part C. General Recommendations and Next Steps

Good points determined during this monitoring:

Points to improve on and recommendations/next steps:

Prepared by: _____ (Signature over printed name) Designation _____ Contact Number _____

Date: _____

Form 3: ICV Reporting Form for Service Provider/Service Delivery Sites and Clients Monitoring Results

Center for Health Development: _____
 Province/City: _____
 Date Submitted: _____
 Report for the Month of: _____

Part A: Technical Assistance, Inputs and Other Activities

Specific Activity (Topic or Content)	Date of Activity	Place of activity	Conducted By Whom	Number of Participants		Remarks
				M	F	

Total Number of Orientation/Training Activities conducted: _____
 Total Number of Participants Trained or Oriented: _____
 Males: _____
 Females: _____

Narrative Report of Non-compliance with FP Policies

Date of monitoring:

Name of Unit (RHU/Hospital/private clinic, etc)

Location/Exact Address of Unit:

Reported by:

Witnessed by:

Complete Name/s of Service Providers or Source of Info:

Nature of the incident/possible non-compliance:

Specific FP Policy possibly not complied with:

Evidence/result or outcome of the possible non-compliance committed, if any:

Action taken by reporter/eyewitness:

Printed name and signature of eyewitness or reporter:

Printed name and signature of the FP Compliance Focal Person:

Noted by (Signature of) the Reporter's immediate superior:



Annexes



Facilitator's Guide

CODE

FAMILY PLANNING COMPETENCY-BASED TRAINING Pre-Test

NAME: _____ Date: _____

HUMAN REPRODUCTIVE ANATOMY and PHYSIOLOGY

Instructions: Identify the lettered parts and write on the corresponding letters below.

A -

D -

G -

B -

E -

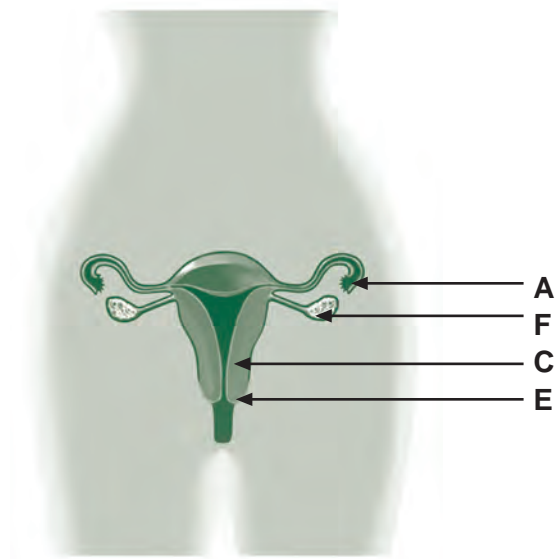
H -

C -

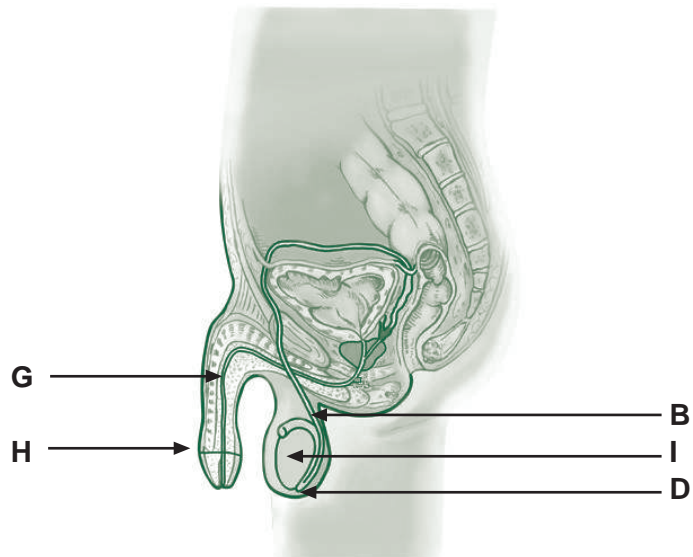
F -

I -

FEMALE REPRODUCTIVE SYSTEM



MALE REPRODUCTIVE SYSTEM



Instructions: Write T on the space provided for if the answer is TRUE and F if FALSE.

PFPP

- ___10. The approach of the National Population Program has been reoriented from a population reduction to a health intervention program.
- ___11. The four pillars of the Family Planning Program are: a) informed choice b) birth spacing at least three years c) respect for life and d) responsible parenthood.
- ___12. Gender responsiveness, culturally oriented, and rights-based approaches are the overall guiding principles in designing and implementing RH-related programs/activities.
- ___13. Family planning services shall be provided regardless of the client's age, sex, number of children, marital status, religious beliefs, and cultural values.
- ___14. One of the major strategies of the Family Planning Program is the promotion and implementation of Contraceptive Self-Reliance Initiative.

FERTILITY AWARENESS

- ___15. A woman can get pregnant on any day of her cycle.
- ___16. A man after puberty is fertile all the time until death.
- ___17. A breastfeeding woman who has no menses can get pregnant.

FP CLIENT ASSESSMENT

- ___18. According to WHO MEC, all clients wanting to use a family planning method should undergo a physical examination.
- ___19. It is mandatory that clients choosing bilateral tubal ligation (BTL) have laboratory examinations like hemoglobin determination and complete blood count.
- ___20. The WHO Medical Eligibility Criteria is an available reference tool for assessing clients on their eligibility for initiating and continuing the use of a specific contraceptive method based on a certain criteria.

INFECTION PREVENTION

- ___21. During client interaction, handwashing is necessary even if the client does not require an examination or treatment.
- ___22. Used instruments that have been decontaminated and thoroughly cleaned can be sterilized by boiling them in water for 20 minutes.
- ___23. Wiping the skin with an antiseptic before an injection has no added benefit.

FERTILITY AWARENESS-BASED METHODS

- ___24. Fertility awareness-based methods can be used only to avoid pregnancy.
- ___25. Any woman, regardless of the length of her cycle, can use SDM.
- ___26. The three conditions necessary to practice Lactational Amenorrhea Method are: breastfeeding on demand without supplementation, no return of menses, and a seven-month old child.

HORMONAL METHODS

- ___27. Women who are 40 years old and older cannot use the low dose COCs.
- ___28. COCs are safe for women with superficial varicose veins.
- ___29. All the pills in the 28-day POP package contain hormones.

LONG-ACTING and PERMANENT METHODS

- ___30. The IUD is inserted only during menstruation.
- ___31. After vasectomy, the couple needs to use another reliable FP method for at least the next three months.
- ___32. Tubal ligation can be performed immediately after delivery.

BARRIER METHODS

- ___ 33. Condoms prevent sexually transmitted infections to include HIV, gonorrhea, syphilis, chlamydia, and trichomoniasis.
- ___ 34. The condom is a barrier method that prevents entry of sperm into the vagina.

SPECIAL POPULATIONS

- ___ 35. Sex education among adolescents is not recommended as this may give them a distorted knowledge and attitude on sexual behavior.
- ___ 36. Counseling for postpartum contraception should be performed during labor and reinforced after delivery.

CLINIC MANAGEMENT

- ___ 37. Monitoring can be done at any period of time to determine if a health program is being implemented.
- ___ 38. Evaluation links particular outputs and outcomes directly to an intervention as mandated by the objectives of the program.
- ___ 39. Setting targets for the purpose of determining logistical requirements is a violation of informed choice and voluntarism.
- ___ 40. Provision of a broad range of FP methods means that all the methods are available in the facility, including voluntary surgical services.

CODE

FAMILY PLANNING COMPETENCY-BASED TRAINING Post-Test

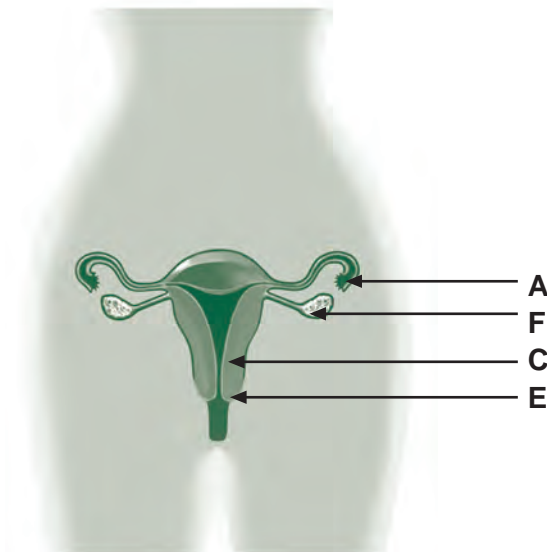
NAME: _____ Date: _____

HUMAN REPRODUCTIVE ANATOMY and PHYSIOLOGY

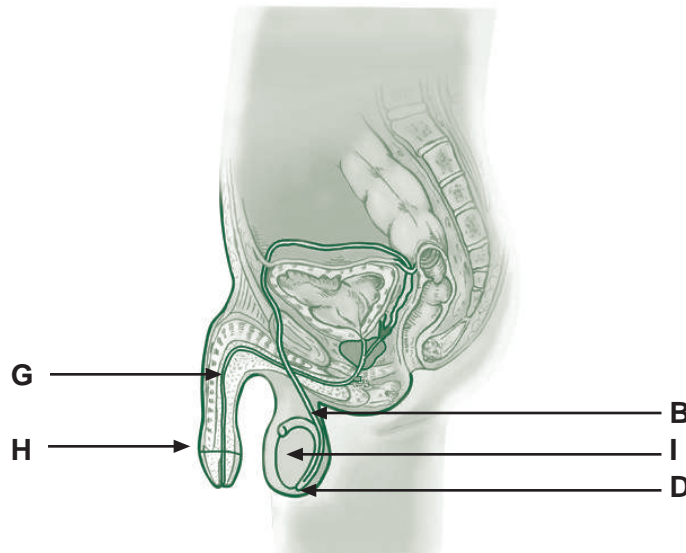
Instructions: Identify the lettered parts and write on the corresponding letters below.

- | | | |
|-----|-----|-----|
| A - | D - | G - |
| B - | E - | H - |
| C - | F - | I - |

FEMALE REPRODUCTIVE SYSTEM



MALE REPRODUCTIVE SYSTEM



Instructions: Write T on the space provided for if the answer is TRUE and F if FALSE.

PFPP

- ___ 10. The approach of the National Population Program has been reoriented from a population reduction to a health intervention program.
- ___ 11. The four pillars of the Family Planning Program are: a) informed choice b) birth spacing at least three years c) respect for life, and d) responsible parenthood.
- ___ 12. Gender responsiveness, culturally oriented, and rights-based approaches are the overall guiding principles in designing and implementing RH-related programs/activities.
- ___ 13. Family planning services shall be provided regardless of the client's age, sex, number of children, marital status, religious beliefs, and cultural values.
- ___ 14. One of the major strategies of the Family Planning Program is the promotion and implementation of Contraceptive Self-Reliance Initiative.

FERTILITY AWARENESS

- ___ 15. A woman can get pregnant on any day of her cycle.
- ___ 16. A man after puberty is fertile all the time until death.
- ___ 17. A breastfeeding woman who has no menses can get pregnant.

FP CLIENT ASSESSMENT

- ___ 18. According to the WHO MEC, all clients wanting to use a family planning method should undergo a physical examination.
- ___ 19. It is mandatory that clients choosing bilateral tubal ligation (BTL) have laboratory examinations like hemoglobin determination and complete blood count.
- ___ 20. The WHO Medical Eligibility Criteria is an available reference tool for assessing clients on their eligibility for initiating and continuing the use of a specific contraceptive method based on certain criteria.

INFECTION PREVENTION

- ___ 21. During client interaction, handwashing is necessary even if the client does not require an examination or treatment.
- ___ 22. Used instruments that have been decontaminated and thoroughly cleaned can be sterilized by boiling them in water for 20 minutes.
- ___ 23. Wiping the skin with an antiseptic before an injection has no added benefit.

FERTILITY AWARENESS-BASED METHODS

- ___ 24. Fertility awareness based methods can be used only to avoid pregnancy.
- ___ 25. Any woman, regardless of the length of her cycle, can use SDM.
- ___ 26. The three conditions necessary to practice Lactational Amenorrhea Method are: breastfeeding on demand without supplementation, no return of menses, and a seven-month old child.

HORMONAL METHODS

- ___ 27. Women who are 40 years old and older cannot use the low dose COCs.
- ___ 28. COCs are safe for women with superficial varicose veins.
- ___ 29. All the pills in the 28-day POP package contain hormones.

LONG-ACTING and PERMANENT METHODS

- ___ 30. The IUD is inserted only during menstruation.
- ___ 31. After vasectomy, the couple needs to use another reliable FP method for at least the next three months.
- ___ 32. Tubal ligation can be performed immediately after delivery.

BARRIER METHODS

- ___ 33. Condoms prevent sexually transmitted infections to include HIV, gonorrhea, syphilis, chlamydia, and trichomoniasis.
- ___ 34. The condom is a barrier method that prevents entry of sperm into the vagina.

SPECIAL POPULATIONS

- ___ 35. Sex education among the adolescents is not recommended as this may give them a distorted knowledge and attitude on sexual behavior.
- ___ 36. Counseling for postpartum contraception should be performed during labor and reinforced after delivery.

CLINIC MANAGEMENT

- ___ 37. Monitoring can be done at any period of time to determine if a health program is being implemented.
- ___ 38. Evaluation links particular outputs and outcomes directly to an intervention as mandated by the objectives of the program.
- ___ 39. Setting targets for the purpose of determining logistical requirements is a violation of informed choice and voluntarism.
- ___ 40. Provision of a broad range of FP methods means that all the methods are available in the facility, including voluntary surgical services.

CODE

FAMILY PLANNING COMPETENCY-BASED TRAINING Answer Key

NAME: _____

Date: _____

HUMAN REPRODUCTIVE ANATOMY and PHYSIOLOGY

Instructions: Identify the lettered parts and write on the corresponding letters below.

A -

D -

G -

B -

E -

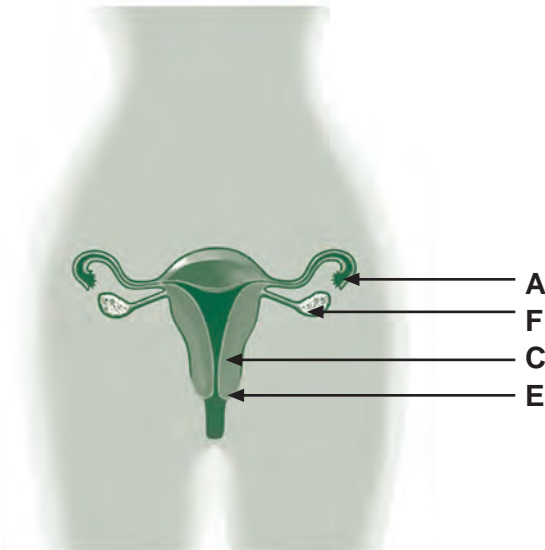
H -

C -

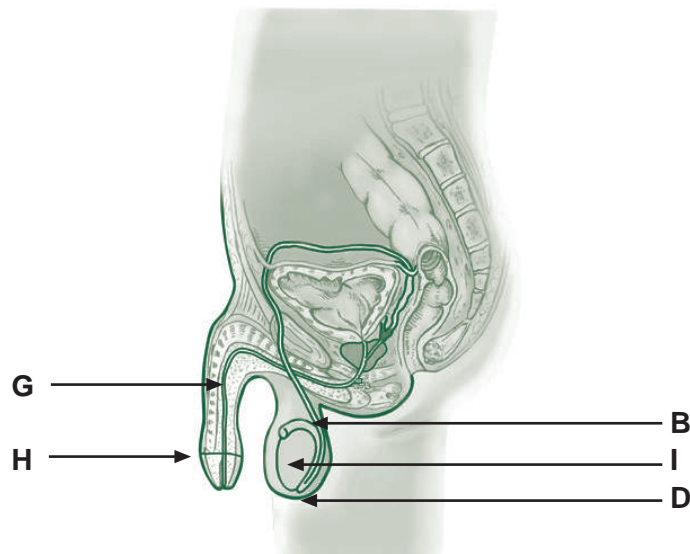
F -

I -

FEMALE REPRODUCTIVE SYSTEM



MALE REPRODUCTIVE SYSTEM



A- fallopian tube B- vas deferens C- uterus D- scrotum E- cervix F- ovary G- urethra H- penis I- testes

Instructions: Write T on the space provided for if the answer is TRUE and F if FALSE.

PFPP

- T 10. The approach of the National Population Program has been reoriented from a population reduction to a health intervention program.
- T 11. The four pillars of the Family Planning Program are: a) informed choice b) birth spacing at least three years c) respect for life, and d) responsible parenthood.
- T 12. Gender responsiveness, culturally oriented, and rights-based approaches are the overall guiding principles in designing and implementing RH-related programs/activities.
- T 13. Family planning services shall be provided regardless of the client's age, sex, number of children, marital status, religious beliefs and cultural values.
- T 14. One of the major strategies of the Family Planning Program is the promotion and implementation of Contraceptive Self-Reliance Initiative.

FERTILITY AWARENESS

- F 15. A woman can get pregnant on any day of her cycle.
- T 16. A man after puberty is fertile all the time until death.
- T 17. A breastfeeding woman who has no menses can get pregnant.

FP CLIENT ASSESSMENT

- F 18. According to WHO MEC all clients wanting to use a family planning method should undergo a physical examination.
- F 19. It is mandatory that clients choosing bilateral tubal ligation (BTL) have laboratory examinations like hemoglobin determination and complete blood count.
- T 20. The WHO Medical Eligibility Criteria is a tool for assessing clients on their eligibility for initiating and continuing the use of a specific contraceptive method based on certain criteria.

INFECTION PREVENTION

- T 21. During client interaction, handwashing is not necessary if the client does not require an examination or treatment.
- F 22. Used instruments that have been decontaminated and thoroughly cleaned can be sterilized by boiling them in water for 20 minutes.
- T 23. In using alcohol as skin antiseptic prior to injection, wait for the alcohol to dry prior to administration of the injection.

FERTILITY AWARENESS-BASED METHODS

- F 24. Fertility awareness based methods can be used only to avoid pregnancy.
- F 25. Any woman, regardless of the length of her cycle, can use SDM.
- F 26. The three conditions necessary to practice Lactational Amenorrhea Method are: breastfeeding on demand without supplementation, no return of menses, and a seven-month old child.

HORMONAL METHODS

- F 27. Women who are over 40 years old cannot use the low dose COCs.
- T 28. COCs are safe for women with superficial varicose veins.
- T 29. All the pills in the 28-day progestin-only pills pack contain hormones.

LONG-ACTING and PERMANENT METHODS

- F 30. The IUD is inserted only during menstruation.
- T 31. After vasectomy, the couple needs to use another reliable FP method for at least the next three months.
- T 32. Tubal ligation can be performed immediately after delivery.

BARRIER METHODS

- T 33. Condoms prevent sexually transmitted infections including HIV, gonorrhea, syphilis, chlamydia, and trichomoniasis.
- T 34. The condom is a barrier method that prevents entry of sperm into the vagina.

SPECIAL POPULATIONS

- F 35. Sex education among the adolescents is not recommended as this may give them a distorted knowledge and attitude on sexual behavior.
- F 36. Counseling for postpartum contraception is ideally performed during labor and reinforced after delivery.

CLINIC MANAGEMENT

- F 37. Monitoring can be done at any period of time to determine if a health program is being implemented.
- T 38. Evaluation links particular outputs and outcomes directly to an intervention as mandated by the objectives of the program.
- F 39. Setting targets for the purpose of determining logistical requirements is a violation of informed choice and voluntarism.
- F 40. Provision of a broad range of FP methods means that all the methods are available in the facility, including voluntary surgical services.

POST-COURSE EVALUATION

Please give your rating by putting a check on the box using the following scale:

1. Strongly Agree 2. Agree 3. Not Sure 4. Disagree 5. Strongly Disagree

A. Objectives are:

	1	2	3	4	5
a. Relevant to the course					
b. Relevant to my work setting					
c. Specific and reasonable					
d. Attained					

B. Content was:

	1	2	3	4	5
a. Consistent with objectives					
b. Properly organized/sequenced					
c. Adequately discussed					

C. Workshops/Exercises were

	1	2	3	4	5
a. Consistent with objectives					
b. Properly organized/sequenced					
c. Adequately discussed					

Please give your rating by putting a check on the box using the following scale:

1 - Excellent 2 - Very Good 3 - Good 4 - Fair 5 - Poor

D. Administration

	1	2	3	4	5
1. The quality of the accommodation.					
2. The quality of food.					
3. The quality of food service.					
4. The overall rating for the venue staff.					

	1	2	3	4	5
5. The facilitation of handouts/exercise materials.					
6. The degree of service by the administrative staff (registration, facilitation of participants needs)					

E. What aspects of the course did you? (use back for more space)

- a. Like best
- b. Like least

F. What did the teacher or training team do that were? (use back for more space)

- a. Most helpful
- b. Least helpful

G. What suggestions can you give to improve this training program? (use back for more space)

WHO MEC Summary Table

SUMMARY TABLES								
CONDITION	COC	CIC	P/R	POP	DMPA NET-EN	LNG/ ETG Implants	Cu-IUD	LNG-IUD
I = Initiation, C = Continuation								
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY								
PREGNANCY	NA*	NA*	NA*	NA*	NA*	NA*	4*	4*
AGE	Menarche to <40=1 ≥40=2	Menarche to <40=1 ≥40=2		Menarche to <18=1 18-45=1 >45=1	Menarche to <18=2 18-45=1 >45=2	Menarche to <18=1 18-45=1 >45=1	Menarche to <20=2 ≥20=1	Menarche to <20=2 ≥20=1
PARITY								
a) Nulliparous	1	1	1	1	1	1	2	2
b) Parous	1	1	1	1	1	1	1	1
BREASTFEEDING								
a) < 6 weeks postpartum	4	4	4	3*	3*	3*		
b) 6 weeks to < 6 months (primarily breastfeeding)	3	3	3	1	1	1		
c) ≥ 6 months postpartum	2	2	2	1	1	1		
POSTPARTUM (non-breastfeeding women)								
a) < 21 days	3	3	3	1	1	1		
b) ≥ 21 days	1	1	1	1	1	1		
POSTPARTUM (breastfeeding or non-breastfeeding women, including post-caesarean section)								
a) < 48 hours							2	3
b) ≥ 48 hours to <4 weeks							3	3
c) ≥ 4 weeks							1	1
d) Puerperal sepsis							4	4
POST-ABORTION								
a) First trimester	1*	1*	1*	1*	1*	1*	1*	1*
b) Second trimester	1	1	1	1	1	1	2	2
c) Immediate post-septic abortion	1	1	1	1	1	1	4	4
PAST ECTOPIC PREGNANCY	1	1	1	2	1	1	1	1

* Please consult the tables in the text for a clarification to this classification

SUMMARY TABLES								
CONDITION	COC	CIC	P/R	POP	DMPA NET-EN	LNG/ ETG Implants	Cu-IUD	LNG-IUD
I = Initiation, C = Continuation								
HISTORY OF PELVIC SURGERY (including caesarean section) (see also postpartum section)	1	1	1	1	1	1	1	1
SMOKING								
a) Age < 35	2*	2	2	1	1	1	1	1
b) Age ≥ 35								
(i) <15 cigarettes/day	3*	2	3	1	1	1	1	1
(ii) ≥15 cigarettes/day	4*	3	4	1	1	1	1	1
OBESITY ≥30 kg/m ² body mass index (BMI)	2	2	2	1	1	1	1	1
BLOOD PRESSURE MEASUREMENT UNAVAILABLE	NA*	NA*	NA*	NA*	NA*	NA*	NA*	NA*
CARDIOVASCULAR DISEASE								
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (such as older age, smoking, diabetes and hypertension)	3/4*	3/4*	3/4*	2*	3*	2*	1	2
HYPERTENSION								
a) History of hypertension where blood pressure CANNOT be evaluated (including hypertension during pregnancy)	3*	3*	3*	2*	2*	2*	1	2
b) Adequately controlled hypertension, where blood pressure CAN be evaluated	3*	3*	3*	1*	2*	1*	1	1
c) Elevated blood pressure levels (properly taken measurements)								
(i) systolic 140-159 or diastolic 90-99	3	3	3	1	2	1	1	1
(ii) systolic >160 or diastolic >100	4	4	4	2	3	2	1	2
d) Vascular disease	4	4	4	2	3	2	1	2

* Please consult the tables in the text for a clarification to this classification

SUMMARY TABLES								
CONDITION	COC	CIC	P/R	POP	DMPA NET-EN	LNG/ ETG Implants	Cu-IUD	LNG-IUD
I = Initiation, C = Continuation								
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is measurable and normal)	2	2	2	1	1	1	1	1
DEEP VEIN THROMBOSIS (DVT)/ PULMONARY EMBOLISM (PE)								
a) History of DVT/PE	4	4	4	2	2	2	1	2
b) Current DVT/PE	4	4	4	3	3	3	1	3
c) Family history (first-degree relatives)	2	2	2	1	1	1	1	1
d) Major surgery								
(i) with prolonged immobilization	4	4	4	2	2	2	1	2
(ii) without prolonged immobilization	2	2	2	1	1	1	1	1
e) Minor surgery without immobilization	1	1	1	1	1	1	1	1
KNOWN THROMBOGENIC MUTATIONS (e.g. Factor V Leiden; Prothrombin mutation; Protein S, Protein C and Antithrombin deficiencies)	4*	4*	4*	2*	2*	2*	1*	2*
SUPERFICIAL VEIN THROMBOSIS								
a) Varicose veins	1	1	1	1	1	1	1	1
b) Superficial thrombophlebitis	2	2	2	1	1	1	1	1
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE				I C		I C		I C
	4	4	4	2 3	3	2 3	1	2 3
STROKE (history of cerebrovascular accident)				I C		I C		
	4	4	4	2 3	3	2 3	1	2
KNOWN HYPERLIPIDAEMIAS (screening is NOT necessary for safe use of contraceptive methods)	2/3*	2/3*	2/3*	2*	2*	2*	1*	2*

* Please consult the tables in the text for a clarification to this classification

SUMMARY TABLES																
CONDITION	COC		CIC		P/R		POP		DMPA NET-EN		LNG/ ETG Implants		Cu-IUD	LNG-IUD		
I = Initiation, C = Continuation																
VALVULAR HEART DISEASE																
a) Uncomplicated	2		2		2		1		1		1		1	1		
b) Complicated (pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis)	4		4		4		1		1		1		2*	2*		
NEUROLOGIC CONDITIONS																
HEADACHES																
	I	C	I	C	I	C	I	C	I	C	I	C		I	C	
a) Non-migrainous (mild or severe)	1*	2*	1*	2*	1*	2*	1*	1*	1*	1*	1*	1*	1*	1*	1*	
b) Migraine																
(i) without aura																
Age <35	2*	3*	2*	3*	2*	3*	1*	2*	2*	2*	2*	2*	1*	2*	2*	
Age ≥35	3*	4*	3*	4*	3*	4*	1*	2*	2*	2*	2*	2*	1*	2*	2*	
(ii) with aura (at any age)	4*	4*	4*	4*	4*	4*	2*	3*	2*	3*	2*	3*	1*	2*	3*	
EPILEPSY																
	1*		1*		1*		1*		1*		1*		1	1		
DEPRESSIVE DISORDERS																
DEPRESSIVE DISORDERS																
	1*		1*		1*		1*		1*		1*		1*	1*		
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS																
VAGINAL BLEEDING PATTERNS																
													I	C		
a) Irregular pattern without heavy bleeding	1		1		1		2		2		2		1	1	1	
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	1*		1*		1*		2*		2*		2*		2*	1*	2*	
UNEXPLAINED VAGINAL BLEEDING (suspicious for serious condition)																
													I	C	I	C
Before evaluation	2*		2*		2*		2*		3*		3*		4*	2*	4*	2*
ENDOMETRIOSIS																
	1		1		1		1		1		1		2	1		
BENIGN OVARIAN TUMOURS (including cysts)																
	1		1		1		1		1		1		1	1		

* Please consult the tables in the text for a clarification to this classification

SUMMARY TABLES

CONDITION	COC	CIC	P/R	POP	DMPA NET-EN	LNG/ ETG Implants	Cu-IUD	LNG-IUD
I = Initiation, C = Continuation								
SEVERE DYSMENORRHOEA	1	1	1	1	1	1	2	1
TROPHOBLAST DISEASE								
a) Benign gestational trophoblastic disease	1	1	1	1	1	1	3	3
b) Malignant gestational trophoblastic disease	1	1	1	1	1	1	4	4
CERVICAL ECTROPION	1	1	1	1	1	1	1	1
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)	2	2	2	1	2	2	1	2
CERVICAL CANCER (awaiting treatment)							I : C	I : C
	2	2	2	1	2	2	4 : 2	4 : 2
BREAST DISEASE								
a) Undiagnosed mass	2*	2*	2*	2*	2*	2*	1	2
b) Benign breast disease	1	1	1	1	1	1	1	1
c) Family history of cancer	1	1	1	1	1	1	1	1
d) Cancer								
(i) current	4	4	4	4	4	4	1	4
(ii) past and no evidence of current disease for 5 years	3	3	3	3	3	3	1	3
ENDOMETRIAL CANCER							I : C	I : C
	1	1	1	1	1	1	4 : 2	4 : 2
OVARIAN CANCER							I : C	I : C
	1	1	1	1	1	1	3 : 2	3 : 2
UTERINE FIBROIDS								
a) Without distortion of the uterine cavity	1	1	1	1	1	1	1	1
b) With distortion of the uterine cavity	1	1	1	1	1	1	4	4
ANATOMICAL ABNORMALITIES								
a) That distort the uterine cavity							4	4
b) That do not distort the uterine cavity							2	2

* Please consult the tables in the text for a clarification to this classification

SUMMARY TABLES											
CONDITION	COC	CIC	P/R	POP	DMPA NET-EN	LNG/ ETG Implants	Cu-IUD		LNG-IUD		
I = Initiation, C = Continuation											
PELVIC INFLAMMATORY DISEASE (PID)											
a) Past PID (assuming no current risk factors of STIs)							I	C	I	C	
(i) with subsequent pregnancy	1	1	1	1	1	1	1	1	1	1	
ii) without subsequent pregnancy	1	1	1	1	1	1	2	2	2	2	
b) PID - current	1	1	1	1	1	1	4	2*	4	2*	
STIs											
a) Current purulent cervicitis or chlamydial infection or gonorrhoea	1	1	1	1	1	1	4	2*	4	2*	
b) Other STIs (excluding HIV and hepatitis)	1	1	1	1	1	1	2	2	2	2	
c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	1	1	1	1	1	1	2	2	2	2	
d) Increased risk of STIs	1	1	1	1	1	1	2/3*	2	2/3*	2	
HIV/AIDS											
HIGH RISK OF HIV											
	1	1	1	1	1	1	I	C	I	C	
							2	2	2	2	
HIV-INFECTED	1	1	1	1	1	1	2	2	2	2	
AIDS	1*	1*	1*	1*	1*	1*	3	2*	3	2*	
Clinically well on ARV therapy	See ANTIRETROVIRAL THERAPY below							2	2	2	2
OTHER INFECTIONS											
SCHISTOSOMIASIS											
a) Uncomplicated	1	1	1	1	1	1	1		1		
b) Fibrosis of the liver	1	1	1	1	1	1	1		1		
TUBERCULOSIS											
a) Non-pelvic	1*	1*	1*	1*	1*	1*	I	C	I	C	
b) Known pelvic	1*	1*	1*	1	1	1	4	3	4	3	
MALARIA	1	1	1	1	1	1	1		1		

* Please consult the tables in the text for a clarification to this classification

SUMMARY TABLES								
CONDITION	COC	CIC	P/R	POP	DMPA NET-EN	LNG/ ETG Implants	Cu-IUD	LNG-IUD
I = Initiation, C = Continuation								
ENDOCRINE CONDITIONS								
DIABETES								
a) History of gestational disease	1	1	1	1	1	1	1	1
b) Non-vascular disease								
(i) non-insulin dependent	2	2	2	2	2	2	1	2
(ii) insulin dependent	2	2	2	2	2	2	1	2
c) Nephropathy/ retinopathy/ neuropathy	3/4*	3/4*	3/4*	2	3	2	1	2
d) Other vascular disease or diabetes of >20 years' duration	3/4*	3/4*	3/4*	2	3	2	1	2
THYROID DISORDERS								
a) Simple goitre	1	1	1	1	1	1	1	1
b) Hyperthyroid	1	1	1	1	1	1	1	1
c) Hypothyroid	1	1	1	1	1	1	1	1
GASTROINTESTINAL CONDITIONS								
GALL-BLADDER DISEASE								
a) Symptomatic								
(i) treated by cholecystectomy	2	2	2	2	2	2	1	2
(ii) medically treated	3	2	3	2	2	2	1	2
(iii) current	3	2	3	2	2	2	1	2
b) Asymptomatic	2	2	2	2	2	2	1	2
HISTORY OF CHOLESTASIS								
a) Pregnancy-related	2	2	2	1	1	1	1	1
b) Past COC-related	3	2	3	2	2	2	1	2
VIRAL HEPATITIS								
a) Active	4	3/4*	4*	3	3	3	1	3
c) Carrier	1	1	1	1	1	1	1	1
CIRRHOSIS								
a) Mild (compensated)	3	2	3	2	2	2	1	2
b) Severe (decompensated)	4	3	4	3	3	3	1	3

* Please consult the tables in the text for a clarification to this classification

A. Female surgical sterilization

FEMALE SURGICAL STERILIZATION		Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.
CONDITION	CATEGORY	CLARIFICATIONS/EVIDENCE
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY		
PREGNANCY	D	
YOUNG AGE*	C	<p>Clarification: Young women, like all women, should be counselled about the permanency of sterilization and the availability of alternative, long-term, highly effective methods.</p> <p>Evidence: Studies show that up to 20% of women sterilized at a young age later regret this decision, and that young age is one of the strongest predictors of regret (including request for reversal information and obtaining reversal) that can be identified before sterilization.¹⁻¹⁹</p>
PARITY*		
a) Nulliparous	A	
b) Parous	A	
BREASTFEEDING	A	
POSTPARTUM*		
a) < 7 days	A	
7 to < 42 days	D	
≥ 42 days	A	
b) Pre-eclampsia/ eclampsia		
(i) mild pre-eclampsia	A	
(ii) severe pre-eclampsia/ eclampsia	D	
c) Prolonged rupture of membranes: 24 hours or more	D	
d) Puerperal sepsis, intrapartum or puerperal fever	D	
e) Severe antepartum or postpartum haemorrhage	D	
f) Severe trauma to the genital tract: cervical or vaginal tear at time of delivery	D	

* See also additional comments at end of table

FEMALE SURGICAL STERILIZATION		Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.
CONDITION	CATEGORY	CLARIFICATIONS/EVIDENCE
POSTPARTUM (Cont'd)		
g) Uterine rupture or perforation	S	Clarification: If exploratory surgery or laparoscopy is conducted and the patient is stable, repair of the problem and tubal sterilization may be performed concurrently if no additional risk is involved.
POST-ABORTION*		
a) Uncomplicated	A	
b) Post-abortal sepsis or fever	D	
c) Severe post-abortal haemorrhage	D	
d) Severe trauma to the genital tract: cervical or vaginal tear at time of abortion	D	
e) Uterine perforation	S	Clarification: If exploratory surgery or laparoscopy is conducted, repair of the problem and tubal sterilization may be performed concurrently if no additional risk is involved.
f) Acute haematometra	D	
PAST ECTOPIC PREGNANCY	A	
SMOKING		
a) Age < 35 years	A	
b) Age ≥ 35 years		
(i) <15 cigarettes/day	A	
(ii) ≥15 cigarettes/day	A	
OBESITY ≥ 30 kg/m ² body mass index (BMI)	C	Clarification: The procedure may be more difficult. There is an increased risk of wound infection and disruption. Obese women may have limited respiratory function and may be more likely to require general anaesthesia. Evidence: Women who were obese were more likely to have complications when undergoing sterilization. ²⁰⁻²³

* See also additional comments at end of table

FEMALE SURGICAL STERILIZATION	Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	CATEGORY	CLARIFICATIONS/EVIDENCE
CARDIOVASCULAR DISEASE		
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE* (such as older age, smoking, diabetes and hypertension)	S	
HYPERTENSION		
For all categories of hypertension, classifications are based on the assumption that no other risk factors for cardiovascular disease exist. When multiple risk factors do exist, risk of cardiovascular disease may increase substantially. A single reading of blood pressure level is not sufficient to classify a woman as hypertensive.		
a) Hypertension, adequately controlled	C	Clarification: Elevated blood pressure should be controlled before surgery. There are increased anaesthesia-related risks and an increased risk of cardiac arrhythmia with uncontrolled hypertension. Careful monitoring of blood pressure intraoperatively is particularly necessary in this situation.
b) Elevated blood pressure levels (properly taken measurements)		
(i) systolic 140-159 or diastolic 90-99	C	
(ii) systolic \geq 160 or diastolic \geq 100	S	
c) Vascular disease	S	
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is measurable and normal)	A	
DEEP VENOUS THROMBOSIS (DVT)/ PULMONARY EMBOLISM (PE)		
a) History of DVT/PE	A	Clarification: To reduce the risk of DVT/PE, early ambulation is recommended.
b) Current DVT/PE	D	
c) Family history of DVT/PE (first-degree relatives)	A	

* See also additional comments at end of table

FEMALE SURGICAL STERILIZATION		Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	CATEGORY	CLARIFICATIONS/EVIDENCE	
DEEP VEIN THROMBOSIS (DVT)/PULMONARY EMBOLISM (PE) (Cont'd)			
d) Major surgery (i) with prolonged immobilization (ii) without prolonged immobilization e) Minor surgery without immobilization	D A A		
KNOWN THROMBOGENIC MUTATIONS (e.g., Factor V Leiden; Prothrombin mutation; Protein S, Protein C, and Antithrombin deficiencies)	A	Clarification: Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening.	
SUPERFICIAL VEIN THROMBOSIS a) Varicose veins b) Superficial thrombophlebitis	A A		
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE* a) Current ischaemic heart disease b) History of ischaemic heart disease	D C		
STROKE (history of cerebrovascular accident)	C		
KNOWN HYPERLIPIDAEMIAS	A	Clarification: Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening.	
VALVULAR HEART DISEASE a) Uncomplicated b) Complicated (pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis)	C S	Clarification: The woman requires prophylactic antibiotics. Clarification: The woman is at high risk for complications associated with anaesthesia and surgery. If the woman has atrial fibrillation that has not been successfully managed or current subacute bacterial endocarditis, the procedure should be delayed.	

* See also additional comments at end of table