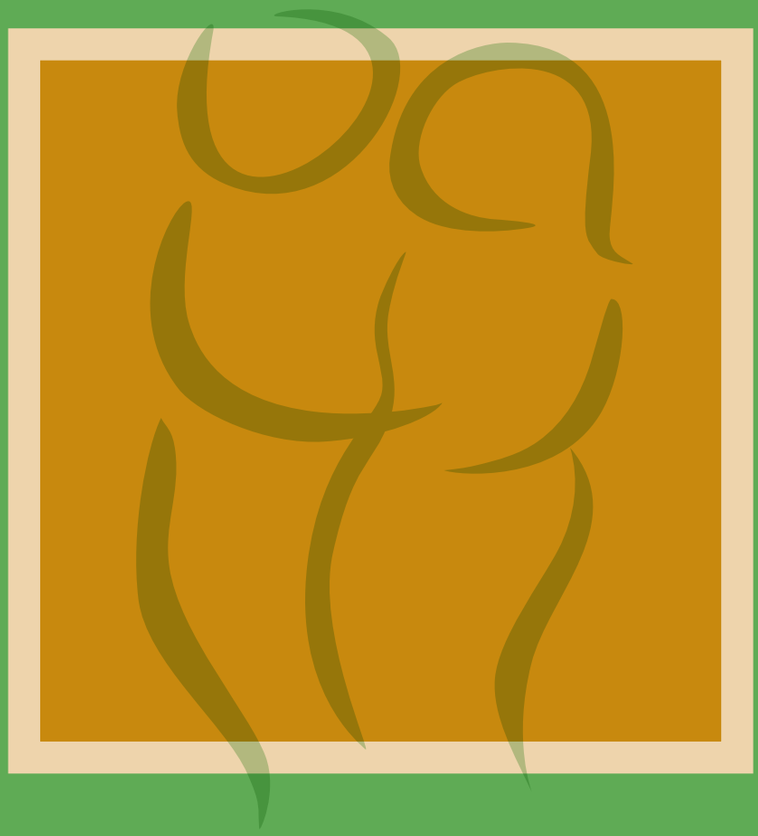
CLINICAL TRAINING *for*
REPRODUCTIVE HEALTH
in EMERGENCIES

Family Planning



PARTICIPANT GUIDE

RAISE
Reproductive Health Access, Information and Services in Emergencies

CLINICAL TRAINING *for*
REPRODUCTIVE HEALTH
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Family Planning

PARTICIPANT GUIDE

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The Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative has developed a Family Planning Learning Resource Package for training service providers in emergency settings with contributions from many key individuals, without whom these manuals would not have been possible. RAISE would like to acknowledge with gratitude the many skilled professionals who developed this package including: Dr. Fred Akonde, Dr. Grace Kodindo, Pamela Ochieng, Louise Lee-Jones, Emma Simpson, Dr. Kathleen Mitchell and the Medical Development Team of Marie Stopes International.

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ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ANC	Ante-natal care
ART	Anti-retroviral therapy
ARV	Anti-retroviral
CBT	Competency-based training
CDC	Centers for Disease Control and Prevention
CIC	Combined injectable contraceptive
COC	Combined oral contraceptive
CVA	Cardiovascular accident
DMPA	Depo-Provera, Depo, Megestron and Petogen
DVT	Deep-vein thrombosis
EC	Emergency contraception
ECP	Emergency contraception pill
FGM	Female genital mutilation
FP	Family planning
HGC	Human chorionic gonadotrophin
HIV	Human immunodeficiency virus
HLD	High-level disinfection
IDP	Internally displaced person
IEC	Information, education and communication
IHD	Ischaemic heartdisease
IP	Infection prevention
IPCC	Interpersonal communication and counselling
IUD	Intra-uterine device
LAM	Lactational amenorrhoea method
LNG	Levonorgestrel
MCH	Maternal and child health
MVA	Manual vacuum aspiration
NET-EN	Noristerat and syngestal
PAC	Post-abortion care
PE	Pulmonary embolism
PIC	Progestin-only injectable contraceptive
PITC	Provider-initiated counselling and testing
PNC	Post-natal care
POP	Progestin-only pill
PPE	Personal protective equipment
RH	Reproductive health
RTI	Respiratory tract infection
SDP	Service delivery point
STI	Sexually-transmitted infection
TL	Tubal ligation
VCT	Voluntary counselling and testing
VSC	Voluntary surgical contraception
WHO	World Health Organisation

INTRODUCTION

The rights of displaced people to reproductive health (RH) were recognised at the International Conference on Population and Development in 1994. Since then, RH service provision has progressed, but substantial gaps remain in services, institutional capacity, policy and funding. It has been shown that provision of emergency obstetric care, clinical family planning methods, care for survivors of gender-based violence and management of sexually-transmitted infections (STIs) is lacking in most conflict-affected settings.

One of the key barriers to the provision of comprehensive RH services is the lack of skilled providers. In order to address this, RAISE has developed a comprehensive training package, including training centres and course manuals. The clinical training teams provide theoretical and practical training to RH service providers at the training centres, as well as on-site supervision at the participants' workplace and on-going technical assistance. Providing clinical training to humanitarian agency and ministry of health staff from a range of conflict settings, the RAISE training team aims to improve the quality of care of RH services in conflict settings.

The resources in the Clinical Training for Reproductive Health in Emergencies series are based on existing materials and have been updated and adapted for use in emergency settings. All manuals have been pre-tested at the RAISE Training Centre at Eastleigh Maternity Home in Nairobi. Many procedures and protocols remain unchanged from non-emergency settings. However, in some instances it is necessary to adapt a protocol to recognise the particular challenges faced in emergency settings.

The Family Planning (FP) learning resource package comprises materials and supervised clinical practise. The materials are:

- **trainer guide and reference manual (for the trainer)**
- **participant guide and reference manual (for the training participant)**

INTRODUCTION *to this* TRAINING COURSE

OVERVIEW

This clinical training course will be conducted in a way that is different from traditional training courses. First of all, it is based on the assumption that people participate in training courses because they:

- are interested in the topic
- wish to improve their knowledge or skills, and thus their job performance
- desire to be actively involved in course activities.

For these reasons, all of the course materials focus on the participant. For example, the course content and activities are intended to promote learning, and the participant is expected to be actively involved in all aspects of that learning.

Second, in this training course, the clinical trainer and the participant are provided with a similar set of educational materials. The clinical trainer by virtue of her/his previous training and experiences works with the participants as an expert on the topic and guides the learning activities. In addition, the clinical trainer helps create a comfortable learning environment and promotes those activities that assist the participant in acquiring the new knowledge, attitudes and skills.

Finally, the training approach used in this course stresses the importance of the cost-effective use of resources and application of relevant educational technologies including humanistic training techniques. The latter encompasses the use of anatomic models, to minimise client risk and facilitate learning.

LEARNING APPROACH

Mastery learning

The mastery learning approach assumes that all participants can master (learn) the required knowledge, attitudes or skills provided sufficient time is allowed and appropriate learning methods are used. The goal of mastery learning is that 100% of the participants will "master" the knowledge and skills on which the learning is based. Mastery learning is used extensively in in-service training where the number of participants, who may be practising clinicians, is often low. Although the principles of mastery learning can be applied in pre-service education, the larger number of participants presents some challenges.

Although some participants are able to acquire new knowledge or new skills immediately, others may require additional time or alternative learning methods before they are able to demonstrate mastery. Not only do people vary in their abilities to absorb new material, but they also learn best in different ways—through written, spoken or visual means. Effective learning strategies, such as mastery learning, take these differences into account and use a variety of teaching methods.

The mastery learning approach also enables the participant to have a self-directed learning experience. This is achieved by having the trainer serve as facilitator and by changing the concept of testing and how test results are used. Moreover, the philosophy underlying the mastery learning approach is one of continual assessment of learning in which the trainer regularly informs participants of their progress in learning new information and skills.

With the mastery learning approach, assessment of learning is:

- competency-based, which means assessment is keyed to the learning objectives and emphasises acquiring the essential skills and attitudinal concepts needed to perform a job, not just acquiring new knowledge
- dynamic, because it enables participants to receive continual feedback on how successful they are in meeting the course objectives
- less stressful, because from the outset participants, both individually and as a group, know what they are expected to learn, know where to find the information and have ample opportunity for discussion with the trainer.

Mastery learning is based on principles of adult learning. This means that learning is participatory, relevant and practical. It builds on what the participant already knows or has experienced and provides opportunities for practising skills. Key features of mastery learning are as follows:

- behaviour modelling
- competency-based
- humanistic learning techniques.

Behaviour modelling

Social learning theory states that when conditions are ideal, a person learns most rapidly and effectively from watching someone perform (model) a skill or activity. For modelling to be successful, however, the trainer must clearly demonstrate the skill or activity so that participants have a clear picture of the performance expected of them. Behaviour modelling, or observational learning, takes place in three stages. In the first stage, skill acquisition, the participant sees others perform the procedure and acquires a mental picture of the required steps. Once the mental image is acquired, the participant attempts to perform the procedure, usually with supervision. Next, the participant practises until skill competency is achieved, and s/he feels confident performing the procedure. The final stage, skill proficiency, occurs with repeated practise over time.

Skill acquisition	Knows the steps and their sequence (if necessary) to perform the required skill or activity but **needs assistance**
Skill competency	Knows the steps and their sequence (if necessary) and **can perform** the required skill or activity
Skill proficiency	Knows the steps and their sequence (if necessary) and **effectively performs** the required skill or activity

Competency-based training

Competency-based training (CBT) is learning by doing. It focuses on the specific knowledge, attitudes and skills needed to carry out the procedure or activity. How the participant performs (i.e. a combination of knowledge, attitudes and, most important, skills) is emphasised rather than just the information learned. Competency in the new skill or activity is assessed objectively by evaluating overall performance.

To successfully accomplish CBT, the clinical skill or activity to be taught must be broken down into its essential steps. Each step is then analysed to determine the most efficient and safe way to perform and learn it. The process is called standardisation. An essential component of CBT is coaching, in which the classroom or clinical trainer first explains a skill or activity and then demonstrates it using an anatomic model or other training aid, such as a video. Once the procedure has been demonstrated and discussed, the trainer then observes and interacts with participants to guide them in learning the skill or activity, monitoring their progress and helping them overcome problems. The coaching process ensures that the participant receives feedback regarding performance:

- before practise—the trainer and participants meet briefly before each practise session to review the skill/activity, including the steps/tasks that will be emphasised during the session
- during practise—the trainer observes, coaches and provides feedback to the participant as s/he performs the steps/tasks outlined in the learning guide
- after practise—immediately after practise, the trainer uses the learning guide to discuss the strengths of the participant's performance and to offer specific suggestions for improvement.

Humanistic training techniques

The use of humanistic techniques also contributes to better clinical learning. A major component of humanistic training is the use of anatomic models, which closely simulate the human body, and other learning aids. Initially working with models rather than with clients allows participants to learn and practise new skills in a simulated setting. This reduces stress for the participant as well as risk of injury and discomfort to the client. Thus, effective use of models (humanistic approach) is an important factor in improving the quality of clinical training and, ultimately, service provision. Before a participant performs a clinical procedure with a client, two learning activities should occur:

- the clinical trainer should demonstrate the required skills and client interactions several times using an anatomic model, role-plays or simulations
- under the guidance of the trainer, the participant should practise the required skills and client interactions using the model, role-plays or simulations and actual instruments in a setting that is as similar as possible to the real situation.

Only when skill competency has been demonstrated should participants have their first contact with a client. This often presents challenges in a pre-service education setting when there are large numbers of participants. Before any participant provides services to a client, however, it is important that the participant demonstrate skill competency using models, role-plays or simulations, especially for core skills. When mastery learning, which is based on adult learning principles and behaviour modelling, is integrated with CBT, the result is a powerful and extremely effective method for providing clinical training. And when humanistic training techniques, such as using anatomic models and other learning aids, are incorporated, training time and costs can be significantly reduced.

LEARNING METHODS

A variety of learning methods, which complement the learning approach described in the previous section, are included in the learning resource package. A description of each learning method is provided below.

Illustrated lectures

Lectures should be used to present information about specific topics. During lectures, the trainer should direct questions to participants and also encourage them to ask questions at any point during the lecture. Another strategy that encourages interaction involves stopping at predetermined points during the lecture to discuss issues and information of particular importance.

Group activities

Group activities provide opportunities for participants to interact with each other and learn together. The main group activities cover three important topics: clinical decision-making, interpersonal communication and infection prevention (IP). The group activities associated with these topics are important because they provide a foundation for learning the skills required for clinical decision-making, interpersonal communication and IP. All of these skills are essential for family planning (FP) provision.

Case studies

The purpose of the case studies included in the learning resource package is to help participants develop and practise clinical decision-making skills. The case studies can be completed in small groups or individually, in the classroom, at the clinical site or as homework assignments. The case studies follow a clinical decision-making framework. Each case study has a key that contains the expected responses. The trainer should be thoroughly familiar with these responses before introducing the case studies to participants. Although the key contains "likely" answers, other answers provided by participants during the discussion may be equally acceptable.

Learning guides and checklists

The learning guides and checklists used in this course are designed to help the participant learn to provide FP short and long term methods. Voluntary surgical sterilisation, lactational amenorrhoea method and natural family planning are not included in the skills practise sessions. Please refer to the reference manual for details on these methods. The participant guide contains learning guides, whilst the trainer guide contains both learning guides and checklists. There are seven learning guides and seven checklists:

1. Learning Guide and Checklist for Family Planning Counselling
2. Learning Guide and Checklist for History Taking
3. Learning Guide and Checklist for Physical Examination
4. Learning Guide and Checklist for Male and Female Condoms
5. Learning Guide and Checklist for Combined Oral Contraceptives
6. Learning Guide and Checklist for Progestin-only Pill
7. Learning Guide and Checklist for Progestin-injectable Contraceptives

8a. Learning Guide and Checklist for Implant Contraception Insertion

8b. Learning Guide and Checklist for Implant Contraception Removal

9a. Learning Guide and Checklist for Intra-uterine Device (IUD) Insertion

9b. Learning Guide and Checklist for Intra-uterine Device (IUD) Removal

Each learning guide contains the steps or tasks performed by the provider for the specific procedure. These tasks correspond to the information presented in relevant chapters of the resource materials. This facilitates participant review of essential information.

The participant is not expected to perform all of the steps or tasks correctly the first time s/he practises them. Instead the learning guides are intended to:

- help the participant in learning the correct steps and the order in which they should be performed (skill acquisition)
- measure progressive learning in small steps as the participant gains confidence and skills (skill competency).

Before using the learning guides for FP, the clinical trainer will review each procedure with the participants using the relevant learning materials. In addition, participants will be able to watch each procedure during demonstration sessions with the appropriate model and/or to observe the activity being performed in the clinic with a client. Used consistently, the learning guides and checklists for practise enable each participant to chart her/his progress and to identify areas for improvement.

Furthermore, the learning guides are designed to facilitate communication (coaching and feedback) between the participant and clinical trainer. When using the learning guides, it is important that the participant and clinical trainer work together as a team. For example, before the participant attempts a skill or activity for the first time, the clinical trainer should briefly review the steps involved and discuss the expected outcome. The trainer should ask the participant if s/he feels comfortable continuing. In addition, immediately after the skill or activity has been completed, the clinical trainer should debrief with the participant. The purpose of the debriefing is to provide positive feedback about the participant's progress and to define the areas (knowledge, attitude or practise) where improvement is needed in later practise sessions.

Using the learning guides

The learning guides for FP methods are designed to be used primarily during the early phases of learning (i.e. skill acquisition) when the participant is practising with models.

In the beginning, the participant can use the learning guides to follow the steps as the clinical trainer demonstrates the procedures with a training model or role-plays counselling a woman. Later, during the classroom practise sessions, they serve as step-by-step guides for the participant as s/he performs the skill using the models or counsels a volunteer "client."

Because the learning guides are used to help in developing skills, it is important that the rating (scoring) be done carefully and as objectively as possible. The participant's performance of each step is rated on a three-point scale as follows:

Needs improvement	Step or task not performed correctly or out of sequence (if necessary) or is omitted
Competently performed	Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently
Proficiently performed	Step or task efficiently and precisely performed in the proper sequence (if necessary).

Using the checklists for practise

The checklists for FP methods are based on the information provided in the learning guides. As the participant progresses through the course and gains experience, dependence on the detailed learning guides decreases and the checklists may be used in their place. The checklists focus only on the key steps in the entire procedure and can be used by the participant when providing services in a clinical situation to rate her/his own performance. These checklists that the participant uses for practise are the same as the checklists that the clinical trainer will use to evaluate the participant's performance at the end of the course. The rating scale used is described below:

Satisfactory	Performs the step or task according to the standard procedure or guidelines
Unsatisfactory	Unable to perform the step or task according to the standard procedure or guidelines
Not observed	Step or task not performed by participant during evaluation by trainer.

Skills practise sessions

Skills practise sessions provide participants with opportunities to observe and practise clinical skills, usually in a simulated setting. The outline for each skills practise session includes the purpose of the particular session, instructions for the trainer, and the resources needed to conduct the practise session, such as models, supplies, equipment, learning guides and checklists.

Before conducting a skills practise session, the trainer should review the session and ensure that s/he can perform the relevant skill or activity proficiently. The trainer should also ensure that the necessary resources are available and that an appropriate site has been reserved. Although the ideal site for conducting skills practise sessions may be a learning resource centre or clinical laboratory, a classroom may also be used, provided that the models and other resources for the session can be conveniently placed for demonstration and practise.

The first step in a skills practise session requires that participants review the relevant learning guide, which contains the individual steps or tasks, in sequence (if necessary), required to perform a skill or activity in a standardised way. The learning guides are designed to help learn the correct steps and the sequence in which they should be performed (skill acquisition) and measure progressive learning in small steps as the participant gains confidence and skills (skill competency).

Next, the trainer demonstrates the steps/tasks, several times if necessary, for the particular skill or activity and then has participants work in pairs or small groups to practise the steps/tasks and observe each other's performance, using the relevant learning guide. The trainer should be available throughout the session to observe the performance of participants and provide guidance. Participants should be able to perform all of the steps/tasks in the learning guide before the trainer assesses skill competency, in the simulated setting, using the relevant checklist.

Supervised practise should then be undertaken at a clinical site before the trainer assesses skill competency with clients, using the same checklist. The time required to practise and achieve competency may vary from hours to weeks or months, depending on the complexity of the skill, the individual abilities of participants and access to appropriate models and equipment. Therefore, numerous practise sessions will usually be required to ensure achievement of competency before moving into the clinical skills practise area.

COMPONENTS *of the* FAMILY PLANNING (FP) LEARNING RESOURCE PACKAGE

USING THE FP LEARNING RESOURCE PACKAGE TO TRAIN SERVICE PROVIDERS IN EMERGENCY SETTINGS

In designing the training materials for this course, particular attention has been paid to making them "user-friendly" and to permit the course participants and clinical trainer the widest possible latitude in adapting the training to the participants' (group and individual) learning needs. For example, at the beginning of each course an assessment is made of each participant's knowledge. The results of this pre-course assessment are then used jointly by the participants and the advanced or master trainer to adapt the course content as needed so that the training focuses on acquisition of new information and skills.

A second feature relates to the use of the **reference manual** and guides. The reference manual is designed to provide all of the essential information needed to conduct the course in a logical manner. Because it serves as the "text" for the participants and the "reference source" for the trainer, special handouts or supplemental materials are not needed. In addition, because the manual contains **only** information that is consistent with the course goals and objectives, it becomes an integral part of all classroom exercises, such as giving an illustrated lecture or providing problem-solving information.

The **participant guide**, on the other hand, serves a dual function. First, and foremost, it is the road map that guides the participant through each phase of the course. It contains the course syllabus and course schedule, as well as all supplemental printed materials (pre-course questionnaire, individual and group assessment matrix, case studies, protocols, learning guides and course evaluation) needed during the course.

The **trainer guide** contains the same material as the participant guide as well as material for the trainer. This includes the course outline, pre-course questionnaire answer key, midcourse questionnaire and answer key and competency-based qualification checklists.

In keeping with the training philosophy on which this course is based, all training activities will be conducted in an interactive, participatory manner. To accomplish this requires that the role of the trainer continually change throughout the course. For example, the trainer is an **instructor** when presenting a classroom demonstration; a **facilitator** when conducting small group discussions or using role-plays; and a **coach** when helping participants practise a procedure. Finally, when objectively assessing performance, the trainer serves as an **evaluator**.

In summary, the CBT approach used in this course incorporates a number of key features.

- **First**, it is based on adult learning principles, which means that it is interactive, relevant and practical. Moreover, it requires that the trainer facilitate the learning experience rather than serve in the more traditional role of an instructor or lecturer.
- **Second**, it involves use of behaviour modelling to facilitate learning a standardised way of performing a skill or activity.
- **Third**, it is competency-based. This means that evaluation is based on **how well** the participant performs the procedure or activity, not just on **how much** has been learned.
- **Fourth**, where possible, it relies heavily on the use of anatomic models and other training aids (i.e. it is humanistic) to enable participants to practise repeatedly the standardised way of performing the skill or activity **before** working with clients. Thus by the time the trainer evaluates each participant's performance, using the checklist, **every** participant should be able to perform **every** skill or activity competently.

This is the ultimate measure of training.

COURSE DESIGN

The course builds on each participant's past knowledge and takes advantage of her/his high motivation to accomplish the learning tasks in the minimum time. Training emphasises doing, not just knowing, and uses competency-based evaluation of performance.

Specific characteristics of this course are as follows:

- during the morning of the first day, participants demonstrate their knowledge of FP by completing the Pre-Course Questionnaire
- classroom and clinical sessions focus on key aspects of FP
- progress in knowledge-based learning is measured during the course using a standardised written assessment (Mid-Course Questionnaire)
- clinical skills training builds on the participant's previous experience relevant to FP. For many of the skills, participants practise first with anatomic models, using learning guides that list the key steps in performing the skills/procedures for managing obstetric emergencies. In this way, they learn the standardised skills more quickly
- progress in learning new skills is documented using the clinical skills learning guides
- a clinical trainer uses competency-based skills checklists to evaluate each participant's performance
- clinical decision-making is learned and evaluated through case studies and simulated exercises and during clinical skills practise with clients
- appropriate interpersonal skills are learned through behaviour modelling, role-play and evaluation during clinical skills practise with clients.

Successful completion of the course is based on mastery of the knowledge and skills components, as well as satisfactory overall performance in providing care for women who experience obstetric emergencies.

EVALUATION

This clinical training course is designed to produce healthcare providers (i.e. doctors, clinical officers, midwives and/or nurses with midwifery skills) who are qualified to provide FP, as team members, at health facilities and hospitals. Qualification is a statement by the training institution(s) that the participant has met the requirements of the course in knowledge, skills and practise. Qualification does not imply certification. Only an authorised organisation or agency can certify personnel. Qualification is based on the participant's achievement in three areas:

- knowledge: a score of at least 85% on the Mid-Course Questionnaire
- skills: satisfactory performance of clinical skills for managing obstetric emergencies
- practise: demonstrated ability to provide care in the clinical setting for women who experience obstetric emergencies.

The participant and the trainer share responsibility for the participant becoming qualified. The evaluation methods used in the course are described briefly below:

- Mid-Course Questionnaire. Knowledge will be assessed at the end of the second week of the course. A score of 85% or more correct indicates knowledge-based mastery of the material presented during classroom sessions. For those participants scoring less than 85% on their first attempt, the clinical trainer should review the results with the participant individually and guide her/him on using the reference manual to learn the required information. Participants scoring less than 85% may take the Mid-Course Questionnaire again at any time during the remainder of the course.
- Clinical skills. Evaluation of clinical skills will occur in three settings—during the first three weeks of the course, with models in a simulated setting and with clients at the clinical training site; and during the six-week to three-month self-directed practicum, at the time of the mentoring visit at the participant's hospital. In each setting, the clinical trainer will use skills checklists to evaluate each participant as they perform the skills and procedures needed to manage obstetric emergencies and interact with clients.

  Case studies will be used to assess problem-solving and decision-making skills. Evaluation of the interpersonal communication skills of each participant may take place at any point during this period through observation of participants during role-plays.

  Participants should be competent in performing the steps/tasks for a particular skill or procedure in a simulated setting before undertaking supervised practise at a clinical site. Although it is desirable that all of the skills/procedures included in the training course are learned and assessed in this manner, it may not be possible. For example, because obstetric emergencies are not common, opportunities to practise particular skills with

clients may be limited; therefore, practise and assessment of skill competency should take place in a simulated setting.

- Clinical skills practise. It is the clinical trainer's responsibility to observe each participant's overall performance in providing FP during the group-based course and during the self-directed practicum. This includes observing the participant's attitude—a critical component of quality service provision—towards women who experience obstetric emergencies and towards other members of the FP team. By doing this, the clinical trainer assesses how the participant uses what s/he has learned. Further evaluation is provided during the six week to three-month self-directed practicum (see below) and is important for several reasons. First, it not only provides the participant direct feedback on her/his performance, but also provides an opportunity to discuss any problems or constraints related to the provision of FP (e.g., lack of instruments, drugs and other supplies). Second, and equally important, it provides the clinical service/training centre, via the clinical trainer, key information on the adequacy of the training and its appropriateness to local conditions.

COURSE SYLLABUS

Course description

This clinical training course is designed to equip participants with the skills to offer comprehensive family planning counselling and safely provide short and long term family planning methods of choice and work effectively as members of a team. The course begins with a two-week block at a designated training site and focuses on the development, application and evaluation of knowledge and skills; the first week takes place in the classroom and the second week in designated clinical sites. The first two weeks are followed immediately by a six-week to three-month self-directed practicum at the participant's worksite, during which the clinical trainers for the course provide at least one follow-up visit for mentoring and further evaluation. See page 16 for participant guidelines for the self-directed practicum.

Course goals

- influence in a positive way the attitudes of the participant towards teamwork and her/his abilities to manage and provide FP services
- provide the participant with the interpersonal communication skills needed to respect the rights of women to life, health, privacy and dignity.

Participant learning objectives

By the end of the training course, participants should be able to:

- apply effective counselling techniques for the provision of FP methods
- discuss latest advances in all FP methods, including in the context of HIV/AIDS epidemic
- provide short- and long-term methods to clients
- have knowledge of and apply the latest WHO Eligibility Criteria for contraceptive use
- apply best IP practices
- manage the logistic of FP commodities
- monitor and evaluate the FP services delivery system.

Training and learning methods

- classroom presentations and demonstrations
- group discussions
- individual and group exercises
- role-plays
- case studies
- guided clinical activities
- simulated practise (demonstrations, coaching and evaluation using anatomic models).

Training materials

- trainer guide
- participant guide
- reference manual
- PowerPoint Presentations and resources
- Anatomic models (arm, breast, pelvis, penis).

Reference material

- Family Planning: A Global Handbook for Providers/ Essentials of Contraceptive Technology (2007)
- WHO Medical Eligibility Criteria (including wall chart and wheel).

Selection criteria for participants

It is advisable to ensure a mix of different cadres of healthcare providers for each course. Selected participants should include healthcare providers working in emergency settings (doctors, nurses, and community health workers). Participants may be drawn from a variety of service areas that deal with FP especially maternal and child health (MCH) and community health services.

Course duration

The course is composed of 10 classroom sessions (five days), followed by one week of supervised clinical skills practise and a six-week to three-month self-directed practicum. It is important to note that course duration may need to be revised depending on participants' experience and progress in learning new knowledge and skills. For example, if participants do not develop skill competency by the end of the course, it may be necessary to extend supervised clinical skills practise and/or the self-directed practicum. Alternatively, it may also be necessary to extend the classroom component of the course.

Course Schedule
FP for Service Providers – 10-day Schedule (Week One)

TIME	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
8:30-10:30AM	Opening and Welcome Course Overview Expectations and Norms Pre-course Questionnaire Course Materials Administrative Issues	Module III: Infection Prevention	Module IV continued Implants	Emergency Contraception	Skills Assessment on Models
10:30-11:00AM	TEA BREAK				
11:00-1:00PM	Session II Family Planning Counselling	Infection Prevention	IUD	Barrier Methods	Skills Assessment on Models
1:00-2:00PM	LUNCH BREAK				
2:00-3:30PM	Family Planning Counselling	Module IV: Modern Contraceptive Methods COC POP	Practise: IUD Implants	Natural FP Methods LAM Newer Methods	Skills Assessment on Models
3:30-4:00PM	TEA BREAK				
4:00-5:00PM	Session III Client Assessment	Injectables	Practise: IUD Implants	Permanent Methods Overview	Skills Assessment on Models Forming Groups for Clinical Placements
5:00-5:30PM	End-of-day Summary and Evaluation	End-of-day Summary and Evaluation	End-of-day Summary and Evaluation	End-of-day Summary and Evaluation	End-of-day Summary and Evaluation

Course Schedule
FP for Service Providers – 10-day Schedule (Week Two)

TIME	DAY 6	DAY 7	DAY 8	DAY 9	DAY 10
8:00-10:00AM	Clinical Practise	Pre-clinical Conference	Pre-clinical Conference	Pre-clinical Conference	Pre-clinical Conference
10:00-10:30AM	TEA BREAK				
10:30-1:00PM	Clinical Practise	Clinical Practise	Clinical Practise	Clinical Practise	Clinical Practise
1:00-2:00PM	LUNCH BREAK				
2:00-3:30PM	Clinical Practise	Clinical Practise	Clinical Practise	Clinical Practise	Action Plans Course Evaluation
3:30-4:00PM	TEA BREAK				
4:00-5:00PM	Post-clinical Conference	Post-clinical Conference	Post-clinical Conference Post/Mid-course questionnaire	Post-clinical Conference	Course Summary Closing

PARTICIPANT GUIDELINES FOR SELF-DIRECTED PRACTICUM

The purpose of the six-week to three-month self-directed practicum is to provide participants with an opportunity to apply the knowledge and skills learned during the first five weeks of the FP training course, at their worksites. During the self-directed practicum, trainers will visit participants' worksites towards the end of the first and third months of the practicum to provide individual and team guidance, support and evaluation. Additional visits will be scheduled, if necessary, based on the individual and team needs of participants. The dates for mentoring visits can be agreed upon before the practicum begins.

Participant responsibilities

During the self-directed practicum, participants will be expected to apply their knowledge and skills while providing FP. The participant must record the experience in her/his Clinical Experience Log Book, including the client's unit/hospital number, presenting symptom(s), diagnosis, treatment and outcome. Participants should, in particular, seek learning opportunities that will help meet the specific learning needs noted at the end of the week-long clinical skills practise period that preceded the self-directed practicum. In conjunction with skills practise, participants will be expected to:

- demonstrate accountability for their actions
- demonstrate recognition of and respect for the rights of women to life, health, privacy and dignity
- use appropriate interpersonal communication skills when providing care, with particular emphasis on FP
- apply recommended IP practices.

Team responsibilities

As team members, participants will be responsible for implementing the Action Plan developed at the end of the week-long clinical practise period. At a minimum, this should include mobilising the communities that they serve, ensuring all supplies and equipment are available, ensuring IP practices are of an acceptable standard and that adequate support from supervisors and team members is in place.

Team members should meet twice weekly (e.g., Mondays and Fridays) to discuss the following:

Start of week meetings:

- plan for the week
- availability of equipment, supplies and drugs

End of week meetings:

- clinical cases
- factors that facilitated clinical skills development
- factors that made clinical skills development difficult
- overcoming difficulties
- individual and team strengths with respect to clinical skills practise
- aspects of individual and team work that need to be strengthened and how to accomplish this.

Documenting activities

Participants will be expected to use their Clinical Experience Log Book and their Action Plan Worksheets to document the activities undertaken during the self-directed practicum.

Clinical experience log book

Participants must record activities/experience in the relevant section of their Clinical Experience Log Book on a daily basis. This will include information on clients for whom a FP method has been provided, notes on perceptions of their individual progress and notes on team meetings/progress.

Action plan worksheets

Participants will annotate their Action Plans with the dates the steps were accomplished or make revisions to any aspects of the overall plan. During mentoring visits and subsequent supervisory visits, the trainer/supervisor will assess the degree to which these steps have been achieved.

KNOWLEDGE QUESTIONNAIRES

How the results will be used

The main objective of the Pre-Course Knowledge Questionnaire is to assist both the trainer and the participant as they begin their work together in the course by assessing what the participants, individually and as a group, know about the course topics. This allows the trainer to identify topics that may need additional emphasis during the course. Providing the results of the pre-course assessment to the participants enables them to focus on their individual learning needs. In addition, the questions alert participants to the content that will be presented in the course.

The questions are presented in the multiple choice format. A special form, the Individual and Group Assessment Matrix, is provided to record the scores of all course participants. Using this form, the trainer and participants can quickly chart the number of correct answers for each of the questions. By examining the data in the Matrix, the group members can easily determine their collective strengths and weaknesses and jointly plan with the trainer how to best use the course time to achieve the desired learning objectives.

For the trainer, the questionnaire results will identify particular topics that may need additional emphasis during the learning sessions. Conversely, for those categories where 85% or more of participants answer the questions correctly, the trainer may elect to use some of the allotted time for other purposes.

Using the questionnaire

This knowledge assessment is designed to help participants monitor their progress during the course. By the end of the course, all participants are expected to achieve a score of 85% or better. The questionnaire should be given at the time in the course when all subject areas have been presented. A score of 85% or more indicates knowledge-based mastery of the material presented in the reference manual(s). For those scoring less than 85% on their first attempt, the clinical trainer should review the results with the participant individually and guide her/him on using the reference manual(s) to learn the required information. Participants scoring less than 85% can retake the questionnaire at any time during the remainder of the course. Repeat testing should be done only after the participant has had sufficient time to study the reference manual(s).

FAMILY PLANNING KNOWLEDGE QUESTIONNAIRE

Participant No: _____

Instructions:
Please read the statement and consider which is the correct answer. Circle or mark the answer you have chosen.

COUNSELLING

1. The person responsible for making the choice of a family planning method is the

   A. healthcare provider
   B. client
   C. client's partner
   D. village elder

2. When a client returns to the clinic for her follow-up visit, the health worker should

   A. ask whether she is happy with her method of choice and offer her more supplies (depending on the method)
   B. change the method of family planning
   C. leave supplies at the reception desk for returning clients to collect
   D. none of the above

3. The most important part of counselling is

   A. informing the client about all available methods and answering her concerns and questions about using contraceptives
   B. making a good decision for the client
   C. using up all surplus supplies in the health facility
   D. making friends with the client

4. Initial family planning counselling should be done

   A. if the client does not know which method to use
   B. with every client to ensure that they are aware of all methods and make an informed choice
   C. by a doctor
   D. only with married couples

MALE CONDOMS

5. Condoms

   A. should be used only once and then be discarded appropriately
   B. should be inflated with water or air before use to check for holes
   C. are not affected by being stored in a warm place
   D. can be lubricated with cooking oils or petroleum jelly

6. For a male condom to be effective it is important that

   A. the penis be withdrawn from the vagina just before ejaculation
   B. the penis should be withdrawn while still moderately erect
   C. the man puts the condom on himself
   D. all of the above

7. An advantage of the female condom is

   A. they last longer
   B. they are cheaper
   C. they have greater protection against HIV
   D. they can be inserted ahead of time so do not interrupt sex

8. Which of the following is true of spermicides:

   A. they may cause vaginal burning and itching in the woman
   B. they are very effective at preventing pregnancy
   C. they can be used by women who are HIV positive
   D. they can be insterted into the vagina several hours before sex

ORAL CONRACEPTIVES

9. A woman who is taking combined oral contraceptives should return to her service provider immediately if she has

   A. menstrual cramps
   B. headache
   C. severe leg pain or visual problems such as blurring
   D. increase in weight

Family Planning Knowledge Questionnaire – (cont'd)

10. Before giving a woman her first pack of combined oral contraceptives, the service provider should

A. be sure that the woman does not want any more children
B. explain all possible side effects and when to return to the clinic
C. make sure that the woman is breastfeeding
D. do a pelvic examination

11. When a client comes to the clinic with spotting while taking oral contraceptives, the immediate care is

A. to establish rapport and discuss with her how she is taking the pill
B. make an emergency referral
C. change the method of contraception
D. all of the above

INJECTABLE CONTRACEPTIVES (DEPO-PROVERA)

12. The most common side effect of Depo-Provera is

A. jaundice and liver damage
B. increased facial hair
C. reduced sexual desire
D. changes in the menstrual cycle

13. In the post-partum period, a breastfeeding mother should receive her first Depo-Provera injection

A. immediately
B. after one week
C. within 48 hours
D. any time after six weeks post-partum when it is certain she is not pregnant

IMPLANTS

14. Contraceptive Implants are inserted

A. by a doctor
B. just under the skin of the upper arm
C. when the client doesn't want anymore children
D. all of the above

15. One advantage of implants is that the capsules can be removed

A. by the woman herself
B. by a trained nurse, midwife or doctor
C. in a non-sterile environment
D. easily with the fingers

IUD

16. An IUD can be inserted at any time

A. if the client does not want anymore children
B. if you are certain that the client is not pregnant
C. if the client is married
D. to protect against STI

17. Most women experience changes in their menstrual periods following the insertion of an IUD. You should explain to new IUD users that they can have

A. less bleeding than usual but more menstrual cramping during the first few periods following insertion
B. more bleeding than usual and less menstrual cramping during the first few periods following insertion
C. less bleeding than usual and no menstrual cramping during the first few periods following insertion
D. more bleeding than usual and more menstrual cramping and pain during the first few periods following insertion

18. The IUD is a contraceptive method highly effective in

A. preventing the transmission of HIV
B. preventing pregnancies
C. preventing syphilis
D. increasing sexual pleasure

Family Planning Knowledge Questionnaire – (cont'd)

PERMANENT METHODS
19. A side effect of vasectomy is
A. loss of interest in sex B. decrease in erection C. premature ejaculation D. none of the above
20. Female sterilisation can be performed
A. within 48 hours after a miscarriage or abortion with voluntary informed choice B. on a woman who would like to have more children C. only by a doctor D. in a non-sterile environment
LACTATIONAL AMENORRHOEA METHOD (LAM)
21. A mother who is less than six months post-partum and amenorrhoeic (her menses have not returned after delivery) is protected from pregnancy as long as she
A. breastfeeds her baby during the day and the baby sleeps at night B. breastfeeds the baby on demand day and night C. bottle feeds the baby D. breastfeeds the baby at night and bottle feeds during the day
EMERGENCY CONTRACEPTION
22. Potential users of emergency contraception include
A. unmarried women B. young women C. women who smoke under the age of 35 D. any woman who has had an episode of unprotected sex
23. When the COC is used as emergency contraceptive it should be taken
A. within 24 hours of unprotected sex B. up to 72 hours after unprotected sex C. after 48 hours of unprotected sex D. within a week of unprotected sex
INFECTION PREVENTION
24. Decontamination of surgical instruments by soaking in 0.5% chlorine for 10 minutes will:
A. completely kill all micro-organisms including bacterial endospores B. kill viruses such as HIV and Hepatitis B C. remove organic material, dirt and other matter D. make the instruments shinier
25. When using boiling water for HLD, you should always boil instruments for
A. 20 minutes, starting the timing when the water reaches a rolling boil B. 10 minutes, starting the timing as soon as you put the water in the pot C. 20 minutes, starting the timing as soon as you put the water in the pot D. 10 minutes, starting the timing when the water reaches a rolling boil
26. Ideally sharps should be disposed of by
A. burning in a small fire B. industrial incineration C. throwing into a bush D. carefully placing into the rubbish bin

FAMILY PLANNING COURSE INDIVIDUAL AND GROUP ASSESSMENT MATRIX

Correct – ✓ Incorrect – ✗

Dates: _____ Clinical trainer(s): _____

CATEGORIES	QUESTION NUMBER	CORRECT ANSWERS (PARTICIPANTS)																		
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Total	Class %	Remarks
COUNSELLING	1																		
	2																		
	3																		
	4																		
MALE CONDOM	5																		
	6																		
	7																		
	8																		
ORAL CONTRACEPTIVES	9																		
	10																		
	11																		
INJECTABLES	12																		
	13																		
IMPLANTS	14																		
	15																		
IUD	16																		
	17																		
	18																		

Family Planning Course Individual and Group Assessment Matrix (cont'd)

CATEGORIES	QUESTION NUMBER	CORRECT ANSWERS (PARTICIPANTS)																	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Total	Class %	Remarks
PERMANENT METHODS	19																		
	20																		
LAM	21																		
EMERGENCY CONTRACEPTION	22																		
	23																		
INFECTION PREVENTION	24																		
	25																		
	26																		
Total Individual																			
% Individual																			
Class Average																			

SKILLS PRACTISE SESSION: LEARNING GUIDES

SKILLS PRACTISE SESSION: LEARNING GUIDES

SKILLS PRACTISE SESSION: FAMILY PLANNING COUNSELLING

Purpose

The purpose of this activity is to enable participants to practise family planning counselling of the client and achieving competency in the skills required.

Instructions

This activity should be conducted in a simulated setting, with a fellow participant playing the role of a client.

Participants should review the Learning Guide for Family Planning Counselling before beginning the activity.

The trainer should demonstrate the preliminary steps of counselling a client. Under the guidance of the trainer, participants should then work in pairs to practise the steps/tasks and observe each other's performance, using the Learning Guide for Family Planning Counselling.

Participants should be able to perform the steps/tasks in the Learning Guide for Family Planning Counselling before skill competency is assessed by the trainer in the simulated setting, using the Checklist for Family Planning Counselling.

Finally, following supervised practise at a clinical site, the trainer should assess the skill competency of each participant, using the Checklist for Family Planning Counselling.

Resources

The following equipment or representations thereof:

- family planning job aids
- examples of methods

Learning Guide for Family Planning Counselling

Learning Guide for Family Planning Counselling

Checklist for Family Planning Counselling

Checklist for Family Planning Counselling

1. LEARNING GUIDE FOR FAMILY PLANNING COUNSELLING

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale (Write 1, 2 or 3 as the case may be in the box provided):

1. **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed:** Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently
3. **Proficiently Performed:** Step or task efficiently and precisely performed in the proper sequence (if necessary)

(Many of the following steps/tasks should be performed simultaneously)

STEP/TASK	CASES				
	1	2	3	4	5
PREPARATION FOR COUNSELLING					
1. Ensure room is well lit and ventilated.					
2. Ensure availability of chairs and tables.					
3. Assemble teaching aids (e.g., posters, diagrams, pamphlets).					
4. Ensure availability of writing materials (e.g., client file, daily activity register, and follow-up cards).					
5. Ensure privacy.					
INITIAL COUNSELLING (GROUPS OR INDIVIDUALS). USE GATHER.					
1. **GREET** Greet the client(s) respectfully and with kindness; make them comfortable.					
2. Offer the client(s) a seat near you.					
3. Introduce yourself to the client(s) and ask their name(s).					
4. **ASK** Ask the client(s) what you can do for them.					
5. Ask the client what s/he knows about FP and whether s/he has ever used a method; if so, how s/he used the method and whether s/he has any concerns about it.					
6. Ask the client(s) about their reproductive goals: ■ How many children do they want? ■ Are they interested in spacing pregnancies or preventing them completely? ■ How long a time do the client(s) want between pregnancies?					
7. Take a personal reproductive and basic medical history of the client: ■ name ■ date of birth ■ possibility of pregnancy (date of last menstrual period) ■ number of pregnancies ■ number of births ■ any family planning methods they may have used in the past, for how long, why stopped and any problems with the method(s) ■ family planning method used at this time ■ any medical conditions that may be a contraindication for the methods the client(s) are interested in using ■ history of RTIs.					

1. LEARNING GUIDE FOR FAMILY PLANNING COUNSELLING (cont'd)

STEP/TASK	CASES				
	1	2	3	4	5
8. **TELL** Briefly provide general information about all FP methods available including: ■ effectiveness ■ possible problems or complications ■ side effects and their management ■ advantages and disadvantages ■ possible needs for protection against STIs/HIV ■ the difference between reversible and permanent contraception.					
9. Ask which method interests the client(s).					
10. **HELP** Help the client(s) choose an appropriate method. Make sure there are no medical conditions that contraindicate the use of the method. If there are, suggest alternatives.					
METHOD – SPECIFIC COUNSELLING					
1. Once the client(s) choose a method, **ASK** whether they have any more questions about that method.					
2. **TELL** Explain in detail the chosen method(s): ■ types ■ how they work ■ advantages and non-contraceptive benefits ■ disadvantages ■ indications ■ contraindications ■ common side effects and warning signs ■ protection against STIs/HIV.					
3. Conduct client assessment that is necessary for the method chosen; if indicated refer the client for evaluation.					
4. **HELP** Help the client(s) choose a different method if the chosen method is found unsuitable after additional evaluation.					
5. Provide the method of choice, if available, or refer to the nearest health facility where it is available.					
6. **EXPLAIN** Give the client(s) instructions again on: ■ how to use this method ■ its side effects and their management ■ possible problems or complications for which the client(s) should return to the health facility right away; where to go ■ any other relevant information.					
7. Ask the client(s) to repeat the instructions to be sure they understand.					
8. Ask whether the client(s) have any questions or concerns.					
9. **RETURN FOR FOLLOW-UP** Discuss return visits and follow-up with the client(s): ■ where to go for more supplies (if applicable) ■ when to return to the health facility.					

1. LEARNING GUIDE FOR FAMILY PLANNING COUNSELLING (cont'd)

STEP/TASK	CASES				
	1	2	3	4	5
10. Reassure the client(s) that they can return to the same clinic at any time to receive advice or ask a question, or if they have a problem or need medical attention.					
11. Record the information in the client's file and daily activity register.					
12. Thank the client, politely say goodbye.					
FOLLOW-UP COUNSELLING					
1. **GREET** Greet the client(s) respectfully and with kindness; make them feel comfortable.					
2. Offer the client(s) a seat near you.					
3. Introduce yourself to the client(s) and ask their names.					
4. **ASK** Ask the client(s) what you can do for them.					
5. Check whether the client(s) are satisfied with the method and still using it.					
6. **TELL/HELP** Explore changes in the client's current health status or life style that may mean s/he needs a different method; or whether s/he is using it correctly, and if appropriate have the client(s) repeat the instructions.					
7. Ask the client(s) about any problems they may be having with the method.					
8. **EXPLAIN** Reassure the client(s) about any minor side effects they may have and treat them if necessary.					
9. Consider whether an alternative method needs to be considered and counsel the client(s) again for other methods.					
10. Ask for questions from the client(s) and answer them correctly.					
11. Provide supplies if necessary.					
12. **RETURN VISIT** Schedule return visit.					
13. Record the information in the client's file and daily activity register.					
14. Thank the client(s), politely say goodbye and invite them to return to the clinic.					

SKILLS PRACTISE SESSION: HISTORY TAKING

Purpose

The purpose of this activity is to enable participants to practise history taking of the client and achieving competency in the skills required.

Instructions

This activity should be conducted in a simulated setting, with a fellow participant playing the role of a client.

Participants should review the Learning Guide for History Taking before beginning the activity.

The trainer should demonstrate the preliminary steps of History Taking. Under the guidance of the trainer, participants should then work in pairs to practise the steps/tasks and observe each other's performance, using the Learning Guide for History Taking.

Participants should be able to perform the steps/tasks in the Learning Guide for History Taking before skill competency is assessed by the trainer in the simulated setting, using the Checklist for History Taking.

Finally, following supervised practise at a clinical site, the trainer should assess the skill competency of each participant, using the Checklist for History Taking.

Resources

The following equipment or representations thereof:

- client records

Learning Guide for History Taking

Learning Guide for History Taking

Checklist for History Taking

Checklist for History Taking

2. LEARNING GUIDE FOR HISTORY TAKING

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale (Write 1, 2 or 3 as the case may be in the box provided):

1. **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed:** Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently
3. **Proficiently Performed:** Step or task efficiently and precisely performed in the proper sequence (if necessary)

(Many of the following steps/tasks should be performed simultaneously)

STEP/TASK	CASES				
	1	2	3	4	5
1. Prepare the environment for history taking: ■ adequate light ■ chairs ■ tables ■ client file and card ■ privacy ■ daily activity register.					
2. Greet the client respectfully and with kindness, make them comfortable.					
3. Introduce yourself to the client and ask their names.					
4. Take a personal/social history from the client: ■ name ■ age ■ postal address/residential address ■ nationality.					
5. Take a medical history from the client: ■ migraine headache with aura ■ respiratory system ■ tuberculosis ■ cardiovascular ■ diabetes ■ digestive system ■ liver disease ■ kidney disease ■ gall bladder disease ■ general considerations: □ surgery □ smoking □ current medications □ allergies.					

2. LEARNING GUIDE FOR HISTORY TAKING (cont'd)

STEP/TASK	CASES				
	1	2	3	4	5
REPRODUCTIVE HISTORY					
1. Take a menstrual and gynaecological history from the client: ■ last menstrual period ■ duration of menses ■ amount of menses ■ interval days ■ associated symptoms: □ cramps □ headaches □ nausea □ vomiting ■ history of abnormal genital bleeding ■ surgery of the reproductive organs ■ history of RTIs □ vaginal discharge □ dysuria □ itching of genitalia □ sores/ulcers on genitalia.					
2. Take an obstetrical history from the client: ■ pregnancies □ gravida □ parity □ outcome of the pregnancies □ mode of the delivery ■ complication of any pregnancy/delivery/post-partum period ■ health status of nuclear family ■ number of living children ■ date of last delivery/abortion ■ breastfeeding □ duration □ frequency.					
3. Take a family planning history from the client: ■ previous use of family planning methods ■ type of methods used ■ duration of use of the methods ■ place where the method is/was obtained ■ reasons for discontinuation or switching to another method ■ any side effects/complications of the methods ■ last time the method was used ■ method used consistently and correctly.					
4. Take the sexual history from the client: ■ number of current sexual partners ■ any pain during or after sex ■ any bleeding during or after intercourse ■ screened for RTI ■ previous pelvic examination.					

2. LEARNING GUIDE FOR HISTORY TAKING (cont'd)

STEP/TASK	CASES				
	1	2	3	4	5
5. Ensure all history taken is recorded in client's file and daily activity register.					
6. Prepare area and materials necessary for physical examination: ■ room/screen ■ adequate light ■ chairs ■ table ■ weighing scale ■ blood pressure cuff ■ examination couch ■ clients files and cards ■ daily activity register ■ linen.					
7. Ensure privacy.					
8. Communicate with the client throughout the procedure.					
GENERAL EXAM					
1. Take: ■ blood pressure ■ weight of client.					
POST-HISTORY TAKING					
1. Give client feedback on findings of history taking and general examination.					
2. Record the findings in the client's file and daily activity register if no further exam is needed.					
3. Ask client whether they have any further questions.					
4. If indicated by history or by choice of method, prepare the client for physical examination.					
5. Proceed with family planning counselling.					

SKILLS PRACTISE SESSION: PHYSICAL EXAMINATION

Purpose

The purpose of this activity is to enable participants to practise physical examination of the client and achieving competency in the skills required.

Instructions

This activity should be conducted in a simulated setting, with a fellow participant playing the role of a client.

Participants should review the Learning Guide for Physical Examination before beginning the activity.

The trainer should demonstrate the preliminary steps for Physical Examination. Under the guidance of the trainer, participants should then work in pairs to practise the steps/tasks and observe each other's performance, using the Learning Guide for Physical Examination.

Participants should be able to perform the steps/tasks in the Learning Guide for Physical Examination before skill competency is assessed by the trainer in the simulated setting, using the Checklist for Physical Examination.

Finally, following supervised practise at a clinical site, the trainer should assess the skill competency of each participant, using the Checklist for Physical Examination.

Resources

The following equipment or representations thereof:

- anatomic model
- sterile equipment and materials

Learning Guide for Physical Examination

Learning Guide for Physical Examination

Checklist for Physical Examination

Checklist for Physical Examination

3. LEARNING GUIDE FOR PHYSICAL EXAMINATION

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale (Write 1, 2 or 3 as the case may be in the box provided):

1. **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed:** Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently
3. **Proficiently Performed:** Step or task efficiently and precisely performed in the proper sequence (if necessary)

(Many of the following steps/tasks should be performed simultaneously)

STEP/TASK	CASES				
	1	2	3	4	5
PELVIC EXAMINATION					
1. Prepare area and materials necessary for physical examination: ■ room/screen ■ adequate light ■ chairs ■ table ■ weighing scale ■ blood pressure cuff ■ examination couch ■ clients files and cards ■ daily activity register ■ equipment and supplies ■ linen.					
2. Ensure privacy.					
3. Greet the client respectfully and with kindness, make them comfortable.					
4. If you have not met already, introduce yourself to the client and ask their names.					
5. Communicate with the client throughout the procedure.					
6. Prepare client for pelvic examination ■ explain procedure and each step as it is performed throughout ■ reassure client that they can ask questions at any time and that the examination can stop at any point if they feel uncomfortable. ■ ensure clients(s) empty bladder ■ ask client to remove clothing from the waist down and cover themselves with a drape (if appropriate leave room while they are doing so) ■ position client in lithotomy position ■ cover client to avoid exposure.					
7. Maintain IP throughout the pelvic exam ■ wash hands with soap and water and dry them ■ wear clean gloves ■ use only high-level disinfected/sterilised instruments.					

3. LEARNING GUIDE FOR PHYSICAL EXAMINATION (cont'd)

STEP/TASK	CASES				
	1	2	3	4	5
8. (A) Inspect the external genitalia (STI screening) for: □ warts □ abnormal discharge □ ulcer □ bleeding from the vagina □ sores □ scars □ swellings. (B) Palpate for: □ inguinal glands using left hand □ Bartholin gland and milk skenes glands using right hand.					
9. ■ Place one or two (lubricated) fingers just inside the vaginal opening and gently press downward to relax the muscles. ■ Ask the client to relax the muscles as much as possible. ■ Introduce the closed speculum into the vagina with the blades rotated about 45°. ■ Slide the speculum over your fingers while directing it downward (posteriorly). ■ Insert the blades fully and rotate the speculum so that the blades are horizontal and the handle is pointing downward. ■ Open the blades and manoeuvre the speculum so that the cervix comes into full view. ■ Tighten the thumb screws to maintain the blades open. ■ Using a focused light inspect the cervix for abnormal discharge, lesions and friability. ■ Check for abnormal discharge and obtain a specimen for microscopic examination or culture if necessary. ■ When finished with the examination, loosen the thumb screws and withdraw the speculum gently.					
BI-MANUAL PELVIC EXAMINATION					
1. Wearing gloves on both hands, wet the index and middle fingers of one hand.					
2. With the other hand, separate the labia with two fingers so that the vaginal opening is easily seen.					
3. Introduce the lubricated index and middle finger of the pelvic hand slowly into the vagina.					
4. Exert downward pressure and locate the cervix.					
5. Move the cervix side to side between the fingers and ask whether the client feel pain.					
6. Place the fingers of the pelvic hand in the space between the cervix and the posterior vaginal wall with the palm up.					
7. Place the other hand flat on the abdomen, midway between the umbilicus and the pubic bone.					
8. Exert slight upward pressure on the fingers of the vaginal hand.					
9. Slowly slide the abdominal hand towards the pubic symphysis.					
10. Palpate the uterus gently between two hands, checking for size, shape, location, consistency, mobility and tenderness.					
11. Move the fingers of the vaginal hand and the abdominal hand slightly to one side of the uterus and palpate the ovary.					

3. LEARNING GUIDE FOR PHYSICAL EXAMINATION (cont'd)

STEP/TASK	CASES				
	1	2	3	4	5
12. Do the same on the opposite side. Check for location, size, consistency and tenderness.					
13. Gently remove the fingers.					
14. Tell the client the examination is complete.					
POST-EXAM					
1. Unless IUD insertion is the next step, ask client to get off the couch and dress.					
2. Thank client for their cooperation.					
3. Follow IP procedures.					
4. Wash hands with soap and water.					
5. Share findings of the examination with client ■ Tell client reassuringly what has been seen on examination ■ Tell client of any abnormalities discovered ■ Explain possible causes of the abnormalities discovered ■ Prepare client for the next step.					
6. Record all the findings in the client's file, noting any abnormalities discovered (if IUD is method of choice then follow steps for IUD insertion).					
7. If nothing further is required on current visit, politely say goodbye to the client and invite them to return for any concerns or questions.					

SKILLS PRACTISE SESSION: MALE *and* FEMALE CONDOMS

Purpose

The purpose of this activity is to enable participants to practise advising on and demonstrating male and female condoms to the client and achieving competency in the skills required.

Instructions

This activity should be conducted in a simulated setting, with a fellow participant playing the role of a client.

Participants should review the Learning Guide for Male and Female Condoms before beginning the activity.

The trainer should demonstrate the preliminary steps advising on and demonstrating male and female condoms. Under the guidance of the trainer, participants should then work in pairs to practise the steps/tasks and observe each other's performance, using the Learning Guide for Male and Female Condoms.

Participants should be able to perform the steps/tasks in the Learning Guide for Male and Female Condoms before skill competency is assessed by the trainer in the simulated setting, using the Checklist for Male and Female Condoms.

Finally, following supervised practise at a clinical site, the trainer should assess the skill competency of each participant, using the Checklist for Male and Female Condoms.

Resources

The following equipment or representations thereof:

- anatomic models
- male and female condoms

Learning Guide for
Male and Female Condoms

Learning Guide for
Male and Female Condoms

Checklist for
Male and Female Condoms

Checklist for
Male and Female Condoms

4. LEARNING GUIDE FOR MALE AND FEMALE CONDOMS

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale (Write 1, 2 or 3 as the case may be in the box provided):

1. **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed:** Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently
3. **Proficiently Performed:** Step or task efficiently and precisely performed in the proper sequence (if necessary)

(Many of the following steps/tasks should be performed simultaneously)

STEP/TASK	CASES				
	1	2	3	4	5
1. Client has been greeted and has received general counselling on all FP methods; personal and basic medical history have been taken and documented, reproductive goals discussed and methods of choice explored in more detail.					
2. Ask the client(s) what they already know about condoms and correct any misinformation.					
3. ■ Discuss risk factors for STIs. ■ Ask whether the client(s) have a known latex allergy. ■ Counsel client(s) on correct and consistent use to avoid pregnancy. If this is not possible, counsel on additional methods					
4. Briefly, giving only the most important information, tell the client(s) about male and female condoms: ■ **effectiveness:** 89%-98% effective when used correctly every time a couple has sex; but failure rate is high when not used correctly ■ **how condoms prevent pregnancy:** by blocking and catching the sperm so that they cannot get into the vagina and uterus ■ **advantages:** effective immediately, very effective if used correctly and with every intercourse, free or low cost, few side effects, easy to use, encourages male participation in contraception, protects against STIs ■ **disadvantages:** requires practise, may dull sensation of sex for some men. Must be issued correctly with every act of sex to achieve greatest effectiveness ■ **side effects:** rare, local irritation to penis, vulva or vagina.					
5. Demonstrate on a penis model, encouraging the client(s) to also demonstrate using the model. Give client(s) instructions on how to use a male condom: ■ For maximum effectiveness use a condom every time you have intercourse. ■ Do not use mineral oil, cooking oils, baby oil or petroleum jelly; if lubrication is required, use saliva or vaginal secretions. ■ Do not use teeth, knife, scissors or other sharp utensils to open the package. ■ Check for tears and expiry date. Do not use if the package is damaged. ■ The condom should be unrolled onto the erect penis before the penis enters the vagina, because the pre-ejaculatory semen contains active sperm. ■ If the condom does not have an enlarged end (reservoirs tip), about 1-2cm should be left at the tip for the ejaculate. ■ After intercourse, while holding the base (ring) of the condom, withdraw the penis before losing the erection. This prevents the condom from slipping off and spilling semen. ■ Each condom should be used only once. ■ Dispose of used condoms by placing in a waste container, in the latrine or burying. ■ For extra protection against pregnancy, spermicides can be usedwith condoms. ■ Condoms may be available free at health facilities and FP clinics and can be purchased from shops or chemists. ■ Encourage clients and their partners to practise at home.					

4. LEARNING GUIDE FOR MALE AND FEMALE CONDOMS (cont'd)

STEP/TASK	CASES				
	1	2	3	4	5
6. Explain and demonstrate female condoms: ■ Use a new condom for each sex act. ■ The female condom can be inserted up to eight hours before having sex. ■ Check the package and the expiry date and carefully open it. ■ Rub the sides of the condom together to spread lubricant. ■ Squeeze the inner ring (at the closed end of the condom) between your thumb and middle finger. ■ With the other hand, open the labia and locate the opening of the vagina. ■ Insert the inner ring of the condom as far as it will go into the vagina. ■ Insert your index finger into the condom and push it into place. ■ Ensure that the condom is not twisted and that the outer ring remains outside the vagina. ■ During sexual intercourse, ensure that the penis enters the condom and that it does not come out during sex. ■ If the condom comes out or is pushed into the vagina during sex, carefully replace it. ■ After sex, remove the condom before standing up. ■ Squeeze and twist the outer ring to avoid spilling semen. ■ Dispose of the used condom correctly.					
7. Explain what to do when the condom breaks or leaks during intercourse: ■ Replace the condom with a new one immediately. ■ Use spermicides with the condom. ■ The woman should go to the health facility or clinic as soon as possible for emergency contraception.					
8. Ask the client(s) to repeat the instructions to be sure they understand.					
9. Ask the client(s) whether they have any questions or concerns.					
10. Provide condoms to the client(s).					
11. Encourage the client(s) to return any time they have a question/problem.					
12. Record the information in the client's file and daily activity register.					
13. Politely say goodbye to the client(s) and invite them to return for supplies.					

NOTES

SKILLS PRACTISE SESSION: COMBINED ORAL CONTRACEPTIVES

Purpose

The purpose of this activity is to enable participants to practise advising on and demonstrating combined oral contraceptives to the client and achieving competency in the skills required.

Instructions

This activity should be conducted in a simulated setting, with a fellow participant playing the role of a client.

Participants should review the Learning Guide for Combined Oral Contraceptives before beginning the activity.

The trainer should demonstrate the preliminary steps advising on and demonstrating combined oral contraceptives. Under the guidance of the trainer, participants should then work in pairs to practise the steps/tasks and observe each other's performance, using the Learning Guide for Combined Oral Contraceptives.

Participants should be able to perform the steps/tasks in the Learning Guide for Combined Oral Contraceptives before skill competency is assessed by the trainer in the simulated setting, using the Checklist for Combined Oral Contraceptives.

Finally, following supervised practise at a clinical site, the trainer should assess the skill competency of each participant, using the Checklist for Combined Oral Contraceptives.

Resources

The following equipment or representations thereof:

- job aids
- combined oral contraceptives

Learning Guide for Combined Oral Contraceptives

Learning Guide for Combined Oral Contraceptives

Checklist for Combined Oral Contraceptives

Checklist for Combined Oral Contraceptives

5. LEARNING GUIDE FOR COMBINED ORAL CONTRACEPTIVES

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale (Write 1, 2 or 3 as the case may be in the box provided):

1. **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed:** Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently
3. **Proficiently Performed:** Step or task efficiently and precisely performed in the proper sequence (if necessary)

(Many of the following steps/tasks should be performed simultaneously)

STEP/TASK	CASES				
	1	2	3	4	5
1. Client has been greeted and has received general counselling on all FP methods; personal and basic medical history have been taken and documented; reproductive goals discussed and methods of choice explored in more detail.					
2. Ask the client what they already know about pills and correct any misinformation.					
3. Briefly, giving only the most important information, tell the client about pills: ■ **effectiveness:** 99.7% when taken correctly and 92% as commonly used ■ **how the pill prevents pregnancy:** thickens cervical mucus and suppresses release of eggs; prevents fertilisation ■ **how the pill is used:** one pill taken daily; one pack taken continuously depending on the type of pill ■ **advantages:** effective, free or low cost, few side effects, easy to discontinue ■ **disadvantages:** must be taken daily, does not provide protection against STIs, some drug interactions (rifampin, anticonvulsants), minor side effects.					
4. Emphasise that the client may discontinue the method any time, for any reason.					
5. Give the client instructions and demonstrate with job aids: **How to take combined oral contraceptives:** ■ one pill a day ■ take at same time each day ■ start the first pack the first seven days of the menstrual cycle ■ take all the pills in the pack ■ menstrual bleeding will occur during the resting days (21-day pack) ■ a new pack should be started immediately after the resting period. **Side effects and their management:** ■ mild nausea ■ breast tenderness ■ light bleeding ■ mild headache ■ slight weight gain. **Problems or complications for which the client should return to health facility right away:** ■ suspicion of pregnancy ■ severe lower abdominal or pelvic pain ■ severe chest pain, cough or shortness of breath ■ severe headache ■ eye problems (loss of vision, blurring) ■ severe leg pain (calf and thigh).					

5. LEARNING GUIDE FOR COMBINED ORAL CONTRACEPTIVES (cont'd)

STEP/TASK	CASES				
	1	2	3	4	5
5. *continued* **What to do for missed pills:** ■ If she missed one pill, she should take the pill as soon as she remembers and continue with the pack as usual. ■ If she misses three or more pills in a row, she should follow the special instructions, use a back-up method for seven days and then finish the pack as usual. ■ If she has had sex in the past five days after missing the pills, she should consider emergency contraception.					
6. Provide at least three months supply of oral contraceptives to the client, considering the starting criteria.					
7. Ask the client to repeat the instructions to be sure they understand.					
8. Ask the client whether they have any questions or concerns.					
9. Discuss return visits and follow-up with the client: ■ First return visit should be in three months.					
10. Encourage the client to return any time they have a question or a problem.					
11. Record the information in the client's file and daily activity register.					
12. Politely say goodbye to the client and encourage their return for a follow-up visit.					

NOTES

6

SKILLS PRACTISE SESSION: PROGESTIN-ONLY PILLS

Purpose

The purpose of this activity is to enable participants to practise advising on and demonstrating progestin-only pills to the client and achieving competency in the skills required.

Instructions

This activity should be conducted in a simulated setting, with a fellow participant playing the role of a client.

Resources

The following equipment or representations thereof:

- job aids
- progestin-only pills

Participants should review the Learning Guide for Progestin-only Pills before beginning the activity.

Learning Guide for Progestin-only Pills

The trainer should demonstrate the preliminary steps advising on and demonstrating progestin only pills. Under the guidance of the trainer, participants should then work in pairs to practise the steps/tasks and observe each other's performance, using the Learning Guide for Progestin-only Pills.

Learning Guide for Progestin-only Pills

Participants should be able to perform the steps/tasks in the Learning Guide for Progestin-only Pills before skill competency is assessed by the trainer in the simulated setting, using the Checklist for Progestin-only Pills.

Checklist for Progestin-only Pills

Finally, following supervised practise at a clinical site, the trainer should assess the skill competency of each participant, using the Checklist for Progestin-only Pills.

Checklist for Progestin-only Pills

6. LEARNING GUIDE FOR PROGESTIN-ONLY PILLS

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale (Write 1, 2 or 3 as the case may be in the box provided):

1. **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed:** Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently
3. **Proficiently Performed:** Step or task efficiently and precisely performed in the proper sequence (if necessary)

(Many of the following steps/tasks should be performed simultaneously)

STEP/TASK	CASES				
	1	2	3	4	5
1. Client has been greeted and has received general counselling on all FP methods; personal and basic medical history have been taken and documented, reproductive goals discussed and methods of choice explored in more detail.					
2. Introduce yourself to the client.					
3. Ask the client what they already know about progestin-only pills and appropriately correct any misinformation.					
4. Briefly, giving only the most important information, tell the client about pills: ■ **effectiveness:** 99.7% if consistently and correctly used, 97% as commonly used ■ **how the pill prevents pregnancy:** thickens cervical mucus and sometimes suppresses release of eggs; prevents fertilisation ■ **how the pill is used:** one pill taken at the same time every day, taken continuously without a break ■ **advantages:** effective when used correctly, few side effects, easy to discontinue, does not affect breastfeeding ■ **disadvantages:** must be taken at the same time every day, does not provide protection against STIs/HIV, minor side effects ■ **side effects:** nausea, breast tenderness, bleeding or spotting between periods, dizziness, headache, weight gain or weight loss, mood changes.					
5. Emphasise that the client may discontinue the method any time they want, for any reason.					
6. Give the client: **Instructions on how to take progestin-only pills:** ■ one pill a day ■ take at the same time every day, within three hours ■ start the first pack on the first day of the menstrual cycle ■ take all the pills without stopping ■ starting and possible back-up method if required ■ a new pack should be started immediately after finishing the previous pack; no rest period is necessary ■ side effects: headache, bleeding changes, mood changes, breast tenderness, mild nausea, weight gain ■ if spotting or light bleeding between periods, discontinue taking pills, spotting may occur if pill is missed or taken late. **Instructions about warning signs that indicate immediate return to the clinic:** ■ symptoms of pregnancy ■ severe lower abdominal, pelvic, chest or leg pain ■ missing pills or taking pills late.					

6. LEARNING GUIDE FOR PROGESTIN-ONLY PILLS (cont'd)

STEP/TASK		CASES				
		1	2	3	4	5
6.	*continued* **Instructions for missed pills:** ■ If they miss one pill, they should use a back-up method for two days ■ If they miss two pills, take both pills as soon as they remember and use a back-up method for the next 48 hours.					
7.	Provide minimum three-month supply of progestin-only pills to client.					
8.	Ask client to repeat the instructions to be sure they understand.					
9.	Ask the client whether they have any questions or concerns.					
10.	Discuss return visits and follow-up with the client: ■ First return visit should be in three months.					
11.	Encourage the client to return any time they have a question or problem.					
12.	Politely say goodbye to the client and encourage them to return for a follow-up visit.					

NOTES

SKILLS PRACTISE SESSION: PROGESTIN-INJECTABLE CONTRACEPTIVES DMPA (DEPO-PROVERA), NET-EN (NORISTERAT)

Purpose

The purpose of this activity is to enable participants to practise advising on and demonstrating progestin-injectable contraceptives to the client and achieving competency in the skills required.

Instructions

This activity should be conducted in a simulated setting, with a fellow participant playing the role of a client.

Participants should review the Learning Guide for Progestin-injectable Contraceptives before beginning the activity.

The trainer should demonstrate the preliminary steps advising on and demonstrating progestin-injectable contraceptives. Under the guidance of the trainer, participants should then work in pairs to practise the steps/tasks and observe each other's performance, using the Learning Guide for Progestin-injectable Contraceptives.

Participants should be able to perform the steps/tasks in the Learning Guide for progestin injectable contraceptives before skill competency is assessed by the trainer in the simulated setting, using the Checklist for Progestin-injectable Contraceptives.

Finally, following supervised practise at a clinical site, the trainer should assess the skill competency of each participant, using the Checklist for Progestin-injectable Contraceptives.

Resources

The following equipment or representations thereof:

- job aids
- progestin-injectable contraceptives

Learning Guide for Progestin-injectable Contraceptives

Learning Guide for Progestin-injectable Contraceptives

Checklist for Progestin-injectable Contraceptives

Checklist for Progestin-injectable Contraceptives

7. LEARNING GUIDE FOR PROGESTIN-INJECTABLE CONTRACEPTIVES DMPA (DEPO-PROVERA), NET-EN (NORISTERAT)

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale (Write 1, 2 or 3 as the case may be in the box provided):

1. **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed:** Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently
3. **Proficiently Performed:** Step or task efficiently and precisely performed in the proper sequence (if necessary)

(Many of the following steps/tasks should be performed simultaneously)

STEP/TASK	CASES				
	1	2	3	4	5
1. Client has been greeted and has received general counselling on all FP methods; personal and basic medical history have been taken and documented, reproductive goals discussed and methods of choice explored in more detail.					
2. Introduce yourself to the client.					
3. Ask client what they already know about injectables and correct any misinformation.					
4. Briefly, giving only the most important information, tell the client about DMPA/NET-EN: ■ **effectiveness:** 99.7% if used consistently and correctly and 97% as commonly used ■ **how injectables prevent pregnancy:** thicken cervical mucus, prevent release of eggs ■ **advantages:** highly effective, rapidly effective, easy to use, convenient, few side effects, do not adversely affect breast feeding, reversible. Reduce or completely halt menstruation ■ **disadvantages:** do not protect against STIs ,cause menstrual changes in most users, possible delay in return of fertility after stopped ■ **side effects:** change in menstrual pattern, headaches/dizziness, weight gain, changes in sexual drive ■ **warning signs to indicate immediate return to the clinic:** severe lower abdominal pain, heavy bleeding, depression, severe headache or blurred vision.					
5. Emphasise that client may discontinue the method any time they want, for any reason.					
6. **Describe schedule of injections-** DMPA every 12 weeks; NET-EN every 8 weeks (back-up contraception needed if injection delayed > 2 weeks past appointment date).					
7. Explain the difference in progestin injectable contraceptives and (if more than one product is available) allow the client to decide which they would prefer.					
8. Asses the woman's knowledge about major and minor side effects of injectables.					
9. Be responsive to the client's needs and concerns about injectables and address any rumours and misconceptions.					
10. Describe how the injections will be given and what to expect.					
PROCEDURE					
1. Wash hand thoroughly with soap and water dry them with a clean towel. Put on clean gloves.					
2. Check expiry date on DMPA/NET-E single dose vial.					
3. Shake the via well.					
4. Draw the drug into a syringe.					

7. LEARNING GUIDE FOR PROGESTIN-INJECTABLE CONTRACEPTIVES (DMPA/NET-EN) (cont'd)

STEP/TASK		CASES				
		1	2	3	4	5
5.	Cleanse skin with antiseptic solution.					
6.	Insert the needle deep into the muscle (deltoid in arm or upper, outer quadrant of gluteal area) and withdraw the piston to check for blood.					
7.	Inject DMPA/NET-EN.					
8.	Apply pressure to injection site with cotton, but do not rub. Apply spot dressing if needed.					
9.	Discard used syringe and needles by placing them in a puncture-proof container.					
10.	Wash hands thoroughly with soap and water and dry them with a clean towel.					
CLIENT INSTRUCTION AFTER INJECTION						
1.	Instruct client to return for another injection in 12 weeks for DMPA and 8 weeks for NET-EN; give return appointment date.					
2.	Remind client about what to expect, warning signs and when to return to clinic.					
3.	Ask the client to repeat the instructions to be sure they understand.					
4.	Ask client whether they have any questions or concerns.					
5.	Discuss return visits and follow-up with client.					
6.	Encourage the client to return any time they have a question or problem.					
7.	Politely say goodbye to the client and encourage them to return for follow-up visit.					

NOTES

8

SKILLS PRACTISE SESSION: IMPLANT CONTRACEPTION

Purpose

The purpose of this activity is to enable participants to practise advising on and demonstrating implant contraception and implant contraception removal to the client and achieving competency in the skills required.

Instructions

This activity should be conducted in a simulated setting, with a fellow participant playing the role of a client.

Participants should review the Learning Guide for Implant Contraception and Implant Contraception Removal before beginning the activity.

The trainer should demonstrate the preliminary steps advising on and demonstrating implant contraception and implant contraception removal. Under the guidance of the trainer, participants should then work in pairs to practise the steps/tasks and observe each other's performance, using the Learning Guide for Implant Contraception and Implant Contraception Removal.

Participants should be able to perform the steps/tasks in the Learning Guide for Implant Contraception and Implant Contraception Removal before skill competency is assessed by the trainer in the simulated setting, using the Checklist for Implant Contraception and Implant Contraception Removal.

Finally, following supervised practise at a clinical site, the trainer should assess the skill competency of each participant, using the Checklist for Implant Contraception and Implant Contraception Removal.

Resources

The following equipment or representations thereof:

- anatomic model
- implant contraception and implant contraception removal
- sterile equipment and materials for procedure

Learning Guide for Implant Contraception and Implant Contraception Removal

Learning Guide for Implant Contraception and Implant Contraception Removal

Checklist for Implant Contraception and Implant Contraception Removal

Checklist for Implant Contraception and Implant Contraception Removal

8a. LEARNING GUIDE FOR IMPLANT CONTRACEPTION INSERTION (JADELLE AND IMPLANON)

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale (Write 1, 2 or 3 as the case may be in the box provided):

1. **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed:** Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently
3. **Proficiently Performed:** Step or task efficiently and precisely performed in the proper sequence (if necessary)

(Many of the following steps/tasks should be performed simultaneously)

STEP/TASK	CASES				
	1	2	3	4	5
1. Client has been greeted and has received general counselling on all FP methods; personal and basic medical history have been taken and documented, reproductive goals discussed and methods of choice explored in more detail.					
2. Ask the client what they already know about implants (Jadelle or Implanon) and correct any misinformation.					
3. Briefly, giving only the most important information, tell the client about implants: ■ **effectiveness:** greater than 99.9% ■ **how implants prevent pregnancy:** thicken cervical mucus so sperm cannot enter the uterus; prevent the release of eggs ■ **advantages:** highly effective, long-term protection, reversible, few side effects, easy to use, effective 24 hours after insertion and fertility returns 24 hours after removal, suitable for breastfeeding women, no menstruation ■ **disadvantages:** do not provide protection against STIs, changes in user's menstrual pattern (prolonged bleeding, bleeding or spotting between periods, amenorrhoea), weight loss or gain, require minor surgical procedure for insertion and removal by trained healthcare workers under sterile conditions ■ **side effects:** menstrual change (irregular bleeding or spotting, prolonged or heavy vaginal bleeding, amenorrhoea, or some combination of these), headache, dizziness, blurred vision, changes in weight, depression ■ **warning signs to indicate return to clinic:** severe lower abdominal pains; heavy vaginal bleeding, pus or bleeding at insertion site, expulsion of capsule, new episodes of migraine with aura, repeated bad headaches or blurred vision, suspicion of pregnancy, severe arm pain.					
4. Emphasise that the client may discontinue the method any time they want, for any reason.					
5. Give the client instructions on the insertion procedure.					
PRE-INSERTION TASKS					
1. ■ Wash hands with soap and running water. ■ Use aseptic technique throughout. ■ Prepare the area and sterile packs to be used.					
2. Clean the client's upper arm with antiseptic solution, and cover the arm with either sterile cloth or a sterile fenestrated drape.					
3. Open the sterile implant pouch by pulling apart the films of the pouch and let the rods or the rod and applicator drop onto a sterile cloth.					
4. Put on a pair of sterile gloves.					
5. Draw 2ml of Lidocaine 1% using a sterile needle and syringe.					
6. Inject the local anaesthetic at the incision site and along the sub-dermal tracks (media aspect of the upper arm about 6-8cm above the fold of the elbow) first checking that a blood vessel is not being injected by drawing back on the syringe.					

8a. LEARNING GUIDE FOR IMPLANT CONTRACEPTION INSERTION (cont'd)

STEP/TASK		CASES				
		1	2	3	4	5
7.	Check for anaesthetic effect before making skin incision by asking whether client can feel pinprick.					
INSERTION - JADELLE						
1.	Make an incision of about 2mm with the scalpel through the skin.					
2.	Insert the tip of the trocar through the incision with the bevel facing upwards and keep it that way throughout the insertion procedure.					
3.	Keep the trocar sub-dermal by tensing the skin with the trocar.					
4.	Advance the trocar beneath the skin about 5.5cm from the incision to correct mark near the handle of the trocar.					
5.	Remove the plunger when the trocar is advanced to the correct mark and load a Jadelle into the trocar either with tweezers or fingers.					
6.	Push the Jadelle gently with the plunger to the tip of the trocar.					
7.	Hold the plunger steady and pull the trocar back along it until it touches the handle of the plunger.					
8.	Withdraw the trocar only to the mark closest to its tip (before inserting subsequent Jadelle(s)).					
9.	Insert the second Jadelle at the side of the first one, to form a V shape.					
10.	Withdraw the trocar and plunger after completing the insertion.					
11.	Press the edge of the incision together and close the incision with a sterile skin closure.					
12.	Cover the incision area with a compress and wrap enough gauze around the arm to ensure haemostasis.					
13.	Observe the client at the clinic for a few minutes in case of complications.					
INSERTION – IMPLANON						
1.	Carefully remove the sterile disposable applicator carrying the Implanon rod from its blister.					
2.	Hold the blister with the tip of the needle facing upwards to prevent Implanon from dropping out.					
3.	Align applicator with the arm.					
4.	Mark the insertion site where the Implanon will be inserted.					
5.	Stretch the skin around the insertion site with thumb and index finger.					
6.	Insert the tip of the cannula (needle) slightly angled about 20°					
7.	Lower the applicator to a horizontal position.					
8.	Lift the skin with the tip of the needle, but keep the needle in the sub-dermal connective tissue.					
9.	Gently insert, while lifting skin, the needle to its full length, and keep the applicator parallel to the surface of the skin.					
10.	Break the seal of the applicator.					
11.	Turn the obturator (the rounded end of the applicator) a quarter turn to 90°					
12.	Fix the obturator with one hand against the arm, and with the other hand slowly drawing the cannula (needle) out of the arm.					
13.	Press the edges of the incision together and close the incision with a sterile skin closure.					
14.	Cover the incision area with a compress and wrap enough gauze around the arm to ensure haemostasis.					
15.	Observe the client at the clinic for a few minutes in case of complications before discharging them.					

8a. LEARNING GUIDE FOR IMPLANT CONTRACEPTION INSERTION (cont'd)

STEP/TASK	CASES				
	1	2	3	4	5
POST-INSERTION PROCEDURE					
1. Follow normal IP procedures with all clinical equipment, instruments and waste.					
2. Wash hands thoroughly with soap and running water and dry them.					
3. Record information in client file and daily activity register.					
POST-INSERTION INFORMATION					
1. Instruct client regarding wound care.					
2. Discuss what to do if any problems occur. Answer any questions or concerns client may have.					
3. Observe client in the clinic for 10-15 minutes for any signs of immediate complications before sending themr home.					
4. Give return date for follow-up visit.					
5. Thank the client and say goodbye.					

8b. LEARNING GUIDE FOR IMPLANT CONTRACEPTION REMOVAL (JADELLE AND IMPLANON)

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale (Write 1, 2 or 3 as the case may be in the box provided):

1. **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed:** Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently
3. **Proficiently Performed:** Step or task efficiently and precisely performed in the proper sequence (if necessary)

(Many of the following steps/tasks should be performed simultaneously)

STEP/TASK	CASES				
	1	2	3	4	5
1. Greet client and welcome to the clinic.					
2. Offer client a seat.					
3. Ask client for reason for removal.					
4. Review client's reproductive goals.					
5. Counsel client on fertility preferences and desire for ongoing or alternative FP.					
6. Describe the removal procedure and ask client whether there are any questions.					
GETTING READY					
1. Prepare the environment, ensure privacy, lighting.					
2. Gather required materials: ■ local anaesthetic 1% ■ 5cc syringe and needles ■ sterile drapes ■ sterile gauze ■ sterile mosquito artery forceps: curved and straight ■ surgical blade on a bard Parker handle ■ sterile gloves of correct size (surgical gloves).					
3. Ask the client to lie on the couch with arm extended exposing the implant site.					
4. Palpate capsule(s) to determine point for removal incision.					
PRE-REMOVAL TASKS					
1. Wash hands with soap and running water and dry.					
2. Wear sterile gloves on both hands.					
3. Put a sterile towel/drape under the client's arm.					
4. Swab removal site with antiseptic.					
5. Place a sterile towel/drape (with a hole in the centre) over the client's arm.					
6. Draw up Lidocaine 1%.					
7. Inject small amount (1ml) of local anaesthetic (at the incision site under the end of the capsule(s)).					
8. Check for anaesthetic effect before making skin incision.					

8b. LEARNING GUIDE FOR IMPLANT CONTRACEPTION REMOVAL (JADELLE AND IMPLANON) (cont'd)

STEP/TASK	CASES				
	1	2	3	4	5
REMOVAL OF JADELLE: "U" TECHNIQUE					
1. Make a small (4mm) skin incision vertically between capsules one and two, about 5mm above the capsule end near the elbow fold.					
2. While stabilising the capsule with index finger: ■ grasp capsule at right angle with forceps ■ gently pull capsule towards the incision site ■ flip handle of forceps at 180° to expose capsule					
3. Clean off any exposed fibrous tissue with sterile gauze (or scalpel if necessary).					
4. Grasp exposed end of capsule with curved forceps.					
5. Remove capsule and place in a bowl containing 0.5% of chlorine solution for ten minutes for decontamination.					
6. Repeat the same technique to remove the remaining capsule injecting more anaesthetic if required.					
7. After removal of both capsules, show to client to reassure them that they have all been removed.					
REMOVAL OF IMPLANON					
1. Make an incision 2mm with the scalpel close to the proximal end of the implant (do not make a large incision).					
2. Push implant gently towards the incision with the finger.					
3. When the tip of the rod is visible, grasp it with forceps and gently pull out the rod with the forceps.					
4. After removal of capsule, show client to reassure them it has been removed.					
POST-REMOVAL TASKS					
1. Wipe client's skin with antiseptic solution (Povidone Iodine or Betadine).					
2. Bring edges of incision together. Use a butterfly bandage to cover the incision site.					
3. Place a piece of sterile gauze over the butterfly bandage and apply a pressure dressing around the arm to ensure haemostasis.					
4. Follow IP procedures with all clinical equipment, instruments and waste.					
5. Wash hands thoroughly with soap and running water and dry them.					
6. Record information in client file and daily activity register.					
POST-REMOVAL INFORMATION					
1. Instruct client regarding wound care and what to do if there are any problems.					
2. Counsel the client regarding a new contraceptive method, if required.					
3. Provide new method of FP if required.					
4. Counsel on pre-pregnancy health and nutrition if pregnant.					
5. Observe client in the clinic for 10-15 minutes for any signs of complications before sending home.					
6. Give client appointment for follow-up visit.					
7. Thank the client and say goodbye.					

SKILLS PRACTISE SESSION: INTRA-UTERINE DEVICE (IUD)

Purpose

The purpose of this activity is to enable participants to practise advising on and demonstrating IUD to the client and achieving competency in the skills required.

Instructions

This activity should be conducted in a simulated setting, with a fellow participant playing the role of a client.

Participants should review the Learning Guide for IUD before beginning the activity.

The trainer should demonstrate the preliminary steps advising on and demonstrating IUD. Under the guidance of the trainer, participants should then work in pairs to practise the steps/tasks and observe each other's performance, using the Learning Guide for IUD.

Participants should be able to perform the steps/tasks in the Learning Guide for IUD before skill competency is assessed by the trainer in the simulated setting, using the Checklist for IUD.

Finally, following supervised practise at a clinical site, the trainer should assess the skill competency of each participant, using the Checklist for IUD.

Resources

The following equipment or representations thereof:

- IUD
- sterile materials and equipment for procedure

Learning Guide for IUD

Learning Guide for IUD

Checklist for IUD

Checklist for IUD

9a. LEARNING GUIDE FOR IUD INSERTION

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale (Write 1, 2 or 3 as the case may be in the box provided):

1. **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed:** Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently
3. **Proficiently Performed:** Step or task efficiently and precisely performed in the proper sequence (if necessary)

(Many of the following steps/tasks should be performed simultaneously)

STEP/TASK	CASES				
	1	2	3	4	5
INITIAL INTERVIEW					
1. Client has been greeted and has received general counselling on all FP methods; personal and basic medical history have been taken and documented, reproductive goals discussed and methods of choice explored in more detail.					
2. Ask the client what they already know about IUDs and correct any misinformation.					
3. Briefly give the client the most important information on IUDs: ■ mode of action: the device works by causing a chemical change that damages sperm and egg before they meet ■ effectiveness: 99.4% effective if used correctly and consistently and 99.2% as commonly used ■ advantages: convenience, long-term protection against pregnancy (12 years copper bearing and 5 years Mirena) and immediate return to fertility after removal ■ side effects: changes in bleeding patterns ■ demonstrate how the IUD is used and explain the procedure					
4. Determine whether the following apply to the client which would contraindicate the use of IUD: ■ multiple sexual partners (either partner) ■ pregnant or suspected pregnancy ■ current, recent, (within three months) or recurrent PID severe ■ abnormal uterine bleeding ■ risk of STI exposure ■ cancer of reproductive tract ■ recent septic abortion (past three months) ■ congenital uterine abnormalities ■ history of ectopic pregnancy.					
5. Take a history of STIs ■ vaginal discharge ■ lower abdominal pain ■ dyspareunia ■ genital lesions ■ dysuria ■ genital warts.					
6. Ask about current medications, including: ■ anticoagulant therapy ■ corticosteroid (long term, high dose) ■ immunosuppressive drugs ■ antibiotics.					

9a. LEARNING GUIDE FOR IUD INSERTION (cont'd)

STEP/TASK	CASES				
	1	2	3	4	5
PRE-INSERTION COUNSELLING					
1. Inform client about required physical and pelvic examination and careful screening to ensure there is no medical or STI condition that is a precaution for IUD.					
2. Inform client about the need to collect vaginal/cervical specimens if necessary (and depending on location).					
3. Explain procedure to client and encourage them to ask questions.					
4. Advise client that they may feel some cramping or pressure during the procedure but that it should not be painful. Tell them to let you know if they feel pain at any time during the procedure.					
5. Ask client to empty their bladder.					
INSERTING THE IUD					
1. Prepare all of the instruments and supplies before beginning the procedure.					
2. Wash hands thoroughly and dry them. Wear clean gloves.					
3. Perform an external genitalia and bi-manual pelvic examination (look for discharge, masses or abnormalities of the vagina and cervix).					
4. Assess the size, position and consistency of the uterus.					
5. Assess for cervical motion tenderness, suggestive of PID.					
6. Put on sterile gloves and insert a sterile or high-level disinfected speculum into the vagina and visualise the cervix.					
7. Tighten the thumb screws when the cervix is in view.					
8. Clean the vagina and cervix with antiseptic solution.					
9. Clean the cervix using a circular motion and starting from the os and moving outward.					
10. Pass the tenaculum through the speculum and gently grasp the cervix to stabilise the cervix and uterus.					
11. Slowly pass the uterine sound through the cervical os to assess the uterine position and to measure the depth of the uterine cavity.					
12. Without opening the sterile packaging load the IUD onto the inserter.					
13. Remove the IUD and inserter from the sterile packaging without allowing them to touch any un-sterile surfaces.					
14. Slowly and gently insert the IUD through the cervix and to the indicated depth in the uterus. Remove the inserter.					
15. Cut the strings of the IUD, leaving 3-4cm in the vagina.					
16. Gently release and remove the tenaculum.					
17. If there is any bleeding of the cervix, apply pressure.					
18. Remove the speculum and place in decontaminant.					
19. Clean and dry the client's genital area.					
20. Inform the client when the procedure is complete.					
21. Allow the client to rest on the couch/table until they feel ready to get up.					
22. Maintain clients' dignity and allow them time to get dressed.					
23. Ask client whether they have any questions or concerns.					
24. Follow IP procedures with all clinical equipment, instruments and waste.					
25. Wash hands thoroughly with soap and running water and dry them.					
26. Record information in client file and daily activity register.					

9a. LEARNING GUIDE FOR IUD INSERTION (cont'd)

STEP/TASK	CASES				
	1	2	3	4	5
POST-INSERTION INSTRUCTIONS					
1. Teach client how and when to check for threads.					
2. Explain IUD warning signs to client.					
3. Discuss what to do if the client experience any side effects or problems.					
4. Assure client they can return to the same clinic at any time to receive advice, medical attention, and if desired, to have the IUD removed.					
5. Ask the client to repeat the instructions and answer any questions.					
6. Record information in the client's file and daily activity register.					
7. Politely say goodbye to the client.					

9b. LEARNING GUIDE FOR IUD REMOVAL

(To be completed by **Participants**)

Rate the performance of each step or task observed using the following rating scale (Write 1, 2 or 3 as the case may be in the box provided):

1. **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
2. **Competently Performed:** Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently
3. **Proficiently Performed:** Step or task efficiently and precisely performed in the proper sequence (if necessary)

(Many of the following steps/tasks should be performed simultaneously)

STEP/TASK		CASES				
		1	2	3	4	5
PRE-REMOVAL AND REMOVAL TASKS						
1.	Greet client and welcome to the clinic.					
2.	Ask client the reason for removal.					
3.	Review client's reproductive goals.					
4.	Ask whether client want another IUD or a change to another method.					
5.	Describe the removal procedure and what the client should expect during and after removal.					
6.	Advise the client that they may feel some mild discomfort or cramping.					
7.	Ask the client to let you know whether they experience any pain during the procedure.					
8.	Prepare the client and the procedure room.					
9.	Wash hands and put on gloves.					
10.	Insert a speculum into the vagina to visualise the cervix.					
11.	Tighten the thumb screws when the cervix is in place.					
12.	Clean the cervix with an antiseptic solution.					
13.	Using narrow forceps, grasp the strings close to the cervix and pull slowly and gently until the IUD is completely removed.					
14.	Show the IUD to the client.					
15.	If the IUD is to be replaced, the new IUD can be inserted immediately.					
POST-REMOVAL COUNSELLING						
1.	Discuss what to do if client experience any problems (e.g., prolonged bleeding or abdominal or pelvic pain).					
2.	Ask client to repeat instructions.					
3.	Answer any questions correctly.					
4.	Counsel the client regarding a new contraceptive method, if required.					
5.	Provide new method of FP if required.					
6.	Counsel on pre-pregnancy health and nutrition if pregnant.					
7.	Observe client in the clinic for 10-15 minutes for any signs of immediate complications before sending home.					
8.	Give client card for a follow-up visit.					
9.	Thank the client and say goodbye.					

CASE STUDIES

CASE STUDY 1:

Sara is a 37-year old woman who has come to a health centre in a refugee camp, requesting family planning. She has seven living children. The oldest is eighteen and the youngest is nine months old. She and her husband have discussed their family and agree they do not want any more children. She does not know much about family planning, but she has heard that there are things that she can do to prevent pregnancy. In the past she has tried to use local herbs, but she thinks these did not work as she became pregnant again.

How would you help the client choose an appropriate method?

What additional information/tests are needed?

Which methods are appropriate for this client?

CASE STUDY 2:

Amina brings her six-week old baby for immunisation and goes for her post-partum check-up at the health centre. She is 21 years old and this is her first baby. She is breastfeeding and supplementing with water, and the baby is thriving. Amina has experienced no post-partum complications. She would like to have another baby sometime in the future. She lives in a small village a short distance from the health centre.

How would you help the client choose an appropriate method?

What additional information/tests are needed?

Which methods are appropriate for this client?

CASE STUDY 3:

Rose is a nineteen-year old student. She is staying with her aunt and family while she studies at college in the state capital. When she is not studying, she enjoys spending time with her new boyfriend. During discussions, you discover that she is not sure whether he has another girlfriend but she has heard that her boyfriend has a wife in another town.

How would you help the client choose an appropriate method?

What additional information/tests are needed?

Which methods are appropriate for this client?

CASE STUDY 4:

Judith is 27, has two children and has come to the health centre with heavy bleeding and cramping. Her last menstrual period was more than eight weeks ago, and she thinks she is pregnant. You diagnose incomplete abortion and, after discussion with Judith, agree to perform MVA to ensure removal of all retained products of conception. During your discussions with Judith, she has implied that the pregnancy was unplanned and that she does not currently want to have a baby.

How would you help the client choose an appropriate method?

What additional information/tests are needed?

Which methods are appropriate for this client?

REFERENCE GUIDE

REFERENCE GUIDE

CLINICAL TRAINING *for*
REPRODUCTIVE HEALTH
in EMERGENCIES

Family Planning

REFERENCE GUIDE

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RAISE Initiative. *Family Planning: Reference Guide. Clinical Training for Reproductive Health in Emergencies*. Reproductive Health Access Information and Services in Emergencies Initiative. London, Nairobi and New York, 2009.

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ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ANC	Ante-natal care
ART	Anti-retroviral therapy
ARV	Anti-retroviral
CBT	Competency-based training
CDC	Centers for Disease Control and Prevention
CIC	Combined injectable contraceptives
COC	Combined oral contraceptives
CVA	Cardiovascular accident
DMPA	Depo-Provera, Depo, Megestron and Petogen
DVT	Deep-vein thrombosis
EC	Emergency contraception
ECP	Emergency contraception pill
FGM	Female genital mutilation
FP	Family planning
HGC	Human chorionic gonadotrophin
HIV	Human immunodeficiency virus
HLD	High-level disinfection
IDP	Internally displaced persons
IEC	Information, education and communication
IHD	Ischaemic heart disease
IP	Infection prevention
IPCC	Interpersonal communication and counselling
IUD	Intra-uterine device
LAM	Lactational amenorrhoea method
LNG	Levonorgestrel
MCH	Maternal and child health
MVA	Manual vacuum aspiration
NET-EN	Noristerat and syngestal
PAC	Post-abortion care
PE	Pulmonary embolism
PIC	Progestin-only injectable contraceptive
PID	Pelvic inflammatory disease
PITC	Provider-initiated counselling and testing
PNC	Post-natal care
POP	Progestin-only pill
PPE	Personal protective equipment
RH	Reproductive health
RTI	Respiratory tract infection
SDP	Service delivery point
STI	Sexually-transmitted infection
TL	Tubal ligation
VCT	Voluntary counselling and testing
VSC	Voluntary surgical contraception
WHO	World Health Organisation

INTRODUCTION

Planning families and spacing births can preserve the health and save the lives of women and children by preventing untimely and unwanted pregnancies, reducing women's exposure to the health risks of childbirth and abortion, and giving women more time to care for their children and for themselves. The rights of refugees and displaced people to family planning (FP) were recognised at the International Conference on Population and Development held in Cairo in 1994. Specifically, the Cairo Conference recognised the rights of all couples to decide freely and responsibly the number and spacing of their children and to have access to the information, education and means necessary to do so.

In emergency situations, the provision of FP services poses special challenges:

- the disruption of health infrastructure may limit access to reproductive health (RH) services, including FP services
- clients who are displaced or mobile may have difficulty adhering to methods that require daily dosing, and they may not have access to health facilities for injections or replenishment of pill supplies
- supply chain issues may limit the availability of certain methods
- providers who are affected by high client volumes and limited resources may de-prioritise FP

Despite these and other challenges, it is important that clients who are already using FP can continue to have access to methods during an acute emergency and that once the situation stabilises, FP methods and services are available to all clients who request them.

This manual serves as a reference guide for FP service providers working in emergency and crisis-affected settings. It is meant to be a companion to the WHO "Green Book," *Family Planning: A Global Handbook for Providers*.

The quality of RH services and the uptake of FP services can be increased by linking FP with other RH services, including:

- ante-natal care (ANC)
- post-natal care (PNC)
- post-abortion care (PAC)
- diagnosis and treatment of sexually-transmitted infections (STIs) including HIV/AIDS
- voluntary counselling and testing (VCT) or provider-initiated counselling and testing (PITC) for HIV
- clinical care for survivors of sexual violence
- adolescent reproductive health.
- FP counselling should be provided to clients when any of these services are provided and referral to FP services should be made, if the client desires.

Conception normally results from vaginal sexual intercourse, and four things are necessary for conception to occur:

The female hormone system must be functional:

- each month, the ovaries release at least one egg around 14 days after the start of the menstrual period
- changes take place in the mucus of the vagina and cervix, which help the sperm reach the egg
- changes take place in the lining of the uterus so that a fertilised egg can implant.

The male hormone system must be functional and must allow:

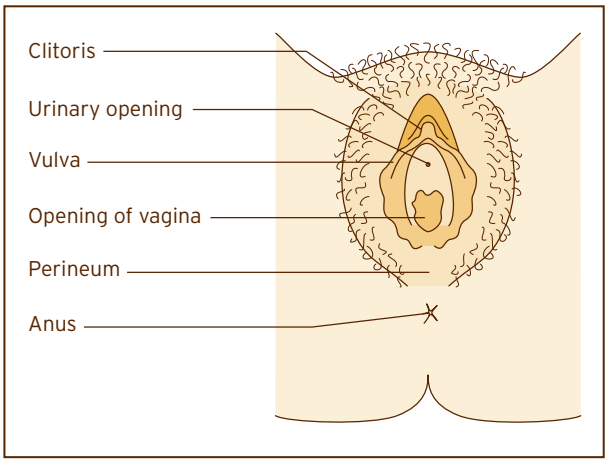
- sperm production and effective sperm
- the desire for sex
- eggs and sperm to pass freely through the fallopian tubes
- contact between egg and sperm must occur at the time that is most favourable for conception, usually within 12 hours of the release of the egg from the ovaries.

SEXUAL AND REPRODUCTIVE ANATOMY

It is important that FP service providers understand the sexual anatomy and physiology of conception, so that they understand how modern contraceptives work and provide quality counselling to clients.

Female Reproductive Organs

Female external genitalia

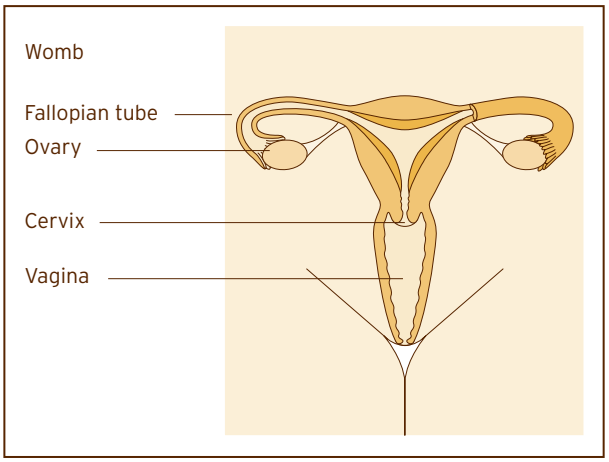


© Illustration 2009 copyright: Annabel Milne sourced from the MSI Family Planning Counselling Flipchart

The external female genitalia or the vulva is made up of four parts:

- Mons pubis: a pad of fatty tissue which lies over the pubic bone. This is covered with hair at puberty.
- Labia majora: two folds of spongy tissue on either side of the vaginal opening, which protect the genital structures.
- Labia minora: two smaller folds of skin that extend from the clitoris on both sides of the urethra (opening to the bladder) and the vagina. The labia minora swell with sexual arousal.
- Clitoris: a sensitive organ at the upper joining of the labia, which provides sexual pleasure for women.

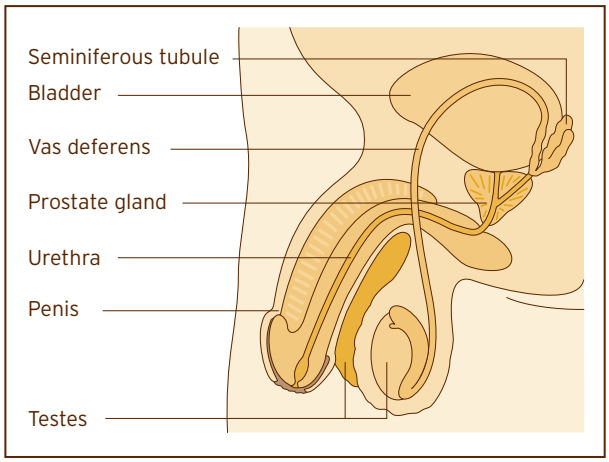
Female internal genitalia



The female internal genitalia are made up of six parts, which are affected by the hormonal system that secretes oestrogen, progesterone and testosterone (in smaller quantities than in men):

1. The vagina: a muscular passageway leading to the uterus; the vaginal opening *(introitus)* lies between the urethra and the anus. The vagina allows for the passage of menstrual blood and allows the passage of the newborn during childbirth. The penis enters the vagina during sexual intercourse. The vagina is lubricated with mucus, which is usually slightly acidic and damaging to sperm. During the fertile phase of the menstrual cycle, oestrogen makes the mucus more receptive to sperm. When a woman is sexually aroused, glands around the vaginal opening and cervix secrete a lubricating fluid, which helps protect the vaginal tissues from being damaged during sexual intercourse.
2. The cervix (or neck of the womb): the entrance of the uterus that projects into the vagina. The cervix has a rubbery texture (similar to the end of a nose) and can be felt at the top of the vagina. The opening of the cervix (the "os") allows the passage of sperm into the uterus and allows the flow of blood out. Oestrogen produced by the ovaries around the time of ovulation makes the mucus of the cervix more receptive to sperm, allowing them to pass more easily into the uterus and fallopian tubes for fertilisation.
3. The uterus ("womb"): a hollow, thick-walled muscular organ, lying between the bladder and the rectum. In most women the uterus tilts forward, although in some women it tilts backwards. The lining of the uterus *(endometrium)* changes during the menstrual cycle to prepare for implantation of the fertilised egg. If conception occurs, the fertilised egg normally implants in the uterus and the foetus develops there. Each month, if conception does not occur, the endometrium is shed during menstruation. During pregnancy, the uterus stretches from its original size (3-4 inches) to a size which can hold a baby. One week after the baby is born, the uterus shrinks back to one-half its fully pregnant size and by the time the baby is one month old, the uterus returns to its original size.
4. The fallopian tubes extend from the upper part of the uterus towards the ovaries and allow the egg to pass towards the uterus. Finger-like projections ("fimbriae") at the ends of the tubes draw in eggs released by the ovaries. Normally, fertilisation of the egg takes place in one of the fallopian tubes and the fertilised egg goes on to implant in the uterus. Sometimes the fertilised egg implants in the fallopian tube, a dangerous situation known as an *ectopic pregnancy*. After a fertilised egg implants in a fallopian tube, the multiplying cells stretch the tube and can eventually cause the tube to burst (rupture), leading to internal haemorrhage and even death of the woman.
5. The ovaries: two organs at the end of each fallopian tube containing *follicles* that house the eggs. At birth, a woman's ovaries contain all of the eggs that she will have available for reproduction during her life time. Once a woman reaches reproductive age, a few follicles are stimulated by hormones each month. After stimulation, one of the mature follicles releases an egg, usually on or around Day 14 of the menstrual cycle. The egg can be fertilised for 12-24 hours after it is released; if it is not fertilised, it dies. The ovaries produce oestrogen and progesterone, which promote the development of sexual characteristics and increase the elasticity of genitalia and lubrication of the vagina.
6. The perineum: a network of muscles around the vagina and anus that support the pelvic cavity and keep the pelvic organs in place.

Male Reproductive Organs



The male external genitalia are made up of the penis and scrotum:

The **penis**: the sexual organ through which urine and seminal fluid pass. The penis is usually flaccid (limp) and becomes stiff (erect) during sexual arousal to facilitate vaginal intercourse. The head of the penis *(glans)* is highly sensitive. The head of the penis is covered by *foreskin*, which in some societies, may be removed by circumcision.

The **scrotum**: a pouch of thick skin that hangs under the base of the penis. The scrotum contains and protects the testicles and helps to keep them at a temperature that is cooler than the body temperature, which is important for sperm production.

Male internal genitalia

The male internal genitalia include the testes (testicles), epididymides, vas deferens, seminal vesicles, prostate gland and Cowper's glands:

The **testes**: two oval-shaped organs, which produce sperm and the male hormone testosterone, responsible for the development of male sexual characteristics and sex drive.

The **epidydimides**: coiled tubes that lie against the side of the testicles closest to the body. Sperm mature and are stored here until they are expelled during ejaculation.

The **vas deferens**: tubes that carry mature sperm from the epidydimides to the urethra.

The **seminal vesicles**: glandular sacs that produce around 60% of the fluid making up the semen that carries the sperm.

The **prostate gland**: a walnut-sized structure that lies behind the bladder and secretes around 30% of seminal fluid. The alkaline quality of the fluid neutralises the acid environment of both the male and female reproductive tracts and protects the sperm. A muscle at the base of the prostate gland shuts sperm out of the urethra until ejaculation, although some may find their way into the pre-ejaculatory fluid (it is important for clients to understand why pulling the penis out of the vagina before ejaculation (withdrawal) is an unreliable FP method).

The Cowper's glands: two pea-sized glands, located at the base of the penis under the prostate that secrete clear alkaline fluid into the urethra during sexual arousal and before orgasm and ejaculation. The Cowper's glands also produce a pre-ejaculatory fluid in the urethra that lubricates the sperm and coats the urethra as sperm flow out of the penis.

Some facts about sperm

- Sperm are the tiniest cells in the human body, less than half the width of a white blood cell. The egg is 30 times as wide and can be seen with the naked eye.
- Sperm are produced by the testes from puberty onwards at the rate of around four million new sperm per hour. Men produce sperm throughout their life.
- There can be 350 million sperm in the 3–5ml of ejaculate. The sperm account for only about 1% of the semen.
- Sperm normally survive no more than six hours in the vagina but have been found up to 16 hours after intercourse and in certain cases, where the woman's mucus remains receptive, sperm can survive for five to seven days.
- Small amounts of sperm may be present in pre-ejaculatory fluid.

MENSTRUATION

The menstrual cycle is a process that prepares a woman's body for pregnancy. FP service providers need to have a clear understanding of the menstrual cycle, so that they are able to explain it to clients. Menstruation is a very important part of women's lives, but is complicated to understand, can be unpredictable, and is surrounded by beliefs, myths and taboos. This section explains some key facts about menstruation and goes on to look at how it affects the choice of FP method.

Phases of the Menstrual Cycle

On average, the menstrual cycle is 28 days long, but it varies from woman to woman and in some women, there may be variations each month. Regardless of the length of her "normal" menstrual cycle, an individual woman's cycles generally do not vary by more than four days.

Among adolescent girls, menstrual cycles can be variable during the first two or three years, ranging from 21 to 45 days. Missing a period is also common among girls who have recently started to menstruate and among women who are nearing menopause.

Days 1 – 5 Menstrual bleeding

These are the days of menstrual bleeding. The first day of menstrual bleeding is counted as Day 1 of the menstrual cycle. Bleeding usually lasts from two to seven days, with five days being common. Menstrual bleeding does not occur during pregnancy.

Days 5 – 13 Follicular phase

Each month, five to seven ovarian follicles develop, although only one or two go on to mature. The follicles secrete increasing amounts of oestrogen, which encourages new endometrial growth and stimulates the cervix to produce a thinner cervical mucus that allows easier passage of sperm.

Day 14 Ovulation

On or around Day 14, a mature egg is released from a follicle and moves down the fallopian tube. If fertilised within the next 12 – 24 hours, it will proceed to the uterus, where it implants. If it is not fertilised, the egg disintegrates in the uterus. Some women experience pain lasting a few hours at the time of ovulation. The change in hormones at this time can also cause light mid-cycle bleeding, or spotting, in some women.

Days 15 – 28 Luteal phase

For two weeks after the egg is released, the remaining follicle, or the corpus luteum, produces large amounts of progesterone as well as oestrogen. The progesterone causes the endometrium to thicken, in preparation for pregnancy.

If fertilisation takes place, the egg implants in the uterus 6 – 12 days after ovulation. The hormone human chorionic gonadotrophin (HGC) is produced, maintaining the corpus luteum and enabling it to continue to produce progesterone. If implantation does not occur within around two weeks of ovulation, the corpus luteum dies, resulting in a sharp drop in progesterone and oestrogen. These hormonal changes cause the uterine lining (endometrium) to be shed, resulting in menstrual bleeding.

Fertile days

Days 8-19 of the menstrual cycle are considered a woman's "fertile days," although these days vary from woman to woman, based on their menstrual cycles. Pregnancy is *most likely* to occur if a woman has intercourse from two to three days before ovulation to two days after ovulation. Although ovulation normally takes place on Day 14, it is possible to conceive earlier or later than this for several reasons:

- the egg can survive 12-24 hours after it is released, but if more than one egg is released, this window may be extended
- ovulation may occur earlier or later than Day 14
- sperm may live in the fallopian tubes for up to five days.

Menstruation

Menstruation ("menses" or "menstrual period") is the monthly shedding of tissue and blood from the lining of the uterus that occurs when conception has not taken place. Menstrual periods normally last from two to seven days and the amount of blood and tissue lost during a menstrual period is normally between 10 to 35ml (about 3 – 8 teaspoons). In addition to the normal period, some women have a small amount of bleeding ("spotting") at the midpoint of their menstrual cycle, when the egg is released; this is also completely normal.

The occurrence of menstruation each month is usually an indication that a woman is not pregnant (although there can be some bleeding or spotting in early pregnancy). Menstruation stops during pregnancy and, in many women, continues to be suppressed for several months post-partum, particularly if the woman is exclusively breastfeeding.

Some menstrual disorders include:

Menorrhagia: very heavy bleeding that can cause anaemia. Menorrhagia is more common amongst very young or pre-menopausal women. Unusual bleeding problems that have no apparent cause should be investigated.

Dysmenorrhoea: menstrual cramps caused by contraction of the uterus to expel the menstrual blood. Moderate exercise or non-steroidal anti-inflammatory drugs can help ease the symptoms.

Amenorrhoea: the absence of menstrual periods. Other than pregnancy, lactation and menopause, menses may stop temporarily because of stress, illness, poor nutrition, weight loss or sometimes for no apparent reason. Pregnancy should always be considered.

Menarche

The onset of menstruation can happen anywhere between 8 and 16 years of age. It is not possible to tell exactly when a girl will start her periods and it is possible for a girl to become pregnant without having ever had a menstrual period.

Menopause

Menopause is the end of menstruation, and once complete, signals the end of a woman's ability to reproduce. This commonly occurs between the ages of 45 and 55, but can occur at any time in a woman's life, after 40 years of age. The process of menopause takes an average of four years. Hormonal changes cause irregular menstrual cycles, changed cycle lengths and sometimes other symptoms such as hot flushes. Eventually, the ovaries stop producing eggs and menstruation stops. A woman should continue to use contraception and be considered fertile until she has not had a menstrual period for at least one year.

INFECTION PREVENTION

The following pages are a useful review of basic infection prevention (IP) methods and procedures. Infection Prevention has several different components, we have included a few key areas below for your revision.

For more comprehensive information or training, we recommend Engender Health Infection Prevention Online Course http://www.engenderhealth.org/ip or Marie Stopes Infection Prevention Training Pack, available from Marie Stopes International, Medical Development Team, 1 Conway Street, Fitzroy Square, London, W1T 6LP.

Why is it so important to prevent the spread of infection?

Over recent years, we have seen increased outbreaks of infections that were once better controlled, like measles and tuberculosis (TB). Now there are new incurable illnesses, such as those caused by HIV and Hepatitis B and C, viruses which have become a significant cause of serious illness and death in many parts of the world.

Health facilities are 'ideal' places for infections to spread because:

- we perform invasive procedures involving contact bloodstream and tissues under the skin
- unseen microorganisms can get into parts of the body where they cause infections
- service providers and the centre team are constantly exposed to infectious materials
- some clients may be infected already or be susceptible to infection
- some clients have infections that can be passed onto others; we may not know whether our clients are infected or not
- we often have many clients during a day, close together in a small space.

Also, we may not know how many of our clients pick up infections, such as HIV, Hepatitis B or C, as a result of using health services. Clients may go elsewhere for treatment and it can be difficult to trace an infection to its source. The absence of this information can lead us to think that our IP measures are acceptable when in fact they could be improved. We need to be confident that **all IP measures are performed, by all members of the team, with all clients all the time.**

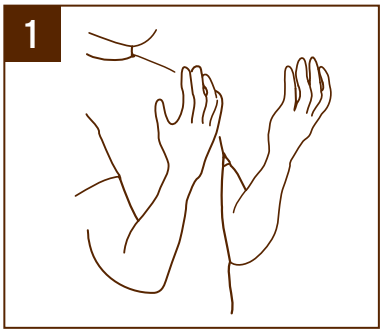
GLOVES AND GLOVING

Gloves protect both clients and team members by acting as a barrier against microorganisms. There are three kinds of gloves:

- sterile—for use when there is contact with bloodstream or tissues under the skin (surgical procedures, bilateral tubal ligation etc.)
- clean examination gloves—for when there is contact with intact mucous membranes, or when you want to reduce the risk of exposure
- utility—for handling contaminated items, medical or chemical waste, and for housekeeping.

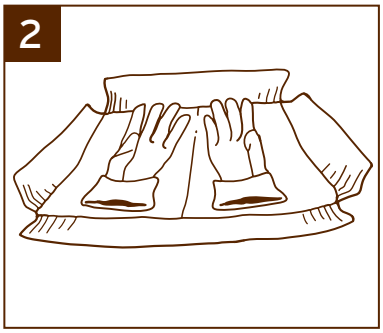
Steps of Putting on Surgical Gloves

1



Prepare a large, clean, dry area for opening the package of gloves. Either open the outer glove package and then perform a surgical scrub, or perform a surgical scrub and ask someone else to open the package of gloves for you.

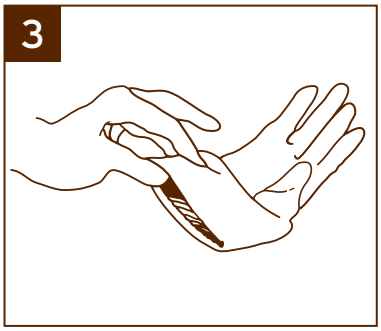
2



Open the inner glove wrapper, exposing the cuffed gloves with the palms up.

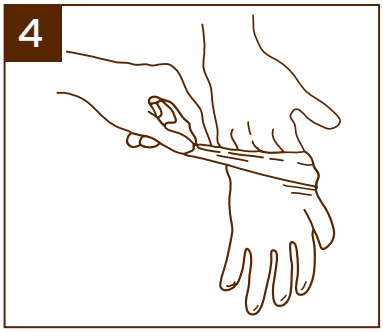
Gloves are cuffed to make it easier to put them on without contaminating them. When putting on sterile gloves, remember that the first glove should be picked up by the cuff only. The second glove should then be touched only by the other sterile glove.

3



Pick up the first glove by the cuff, touching only the inside portion of the cuff (the inside is the side that will be touching your skin when the glove is on).

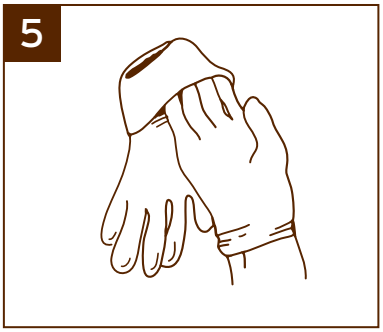
4



While holding the cuff in one hand, slip your other hand into the glove. (Pointing the fingers of the glove toward the floor will keep the fingers open.) **Be careful not to touch anything, and hold the gloves above your waist level.**

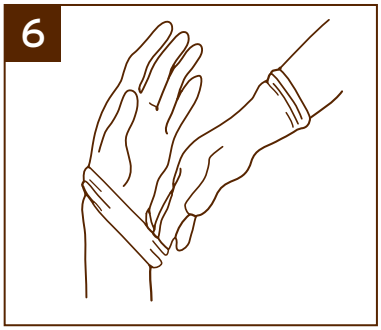
N.B.: *If the first glove is not fitted correctly, wait until the second glove is on before making any adjustments. Then use the sterile fingers of one glove to adjust the sterile portion of the other glove.*

5



Pick up the second glove by sliding the fingers of the gloved hand under the cuff of the second glove. Be careful not to contaminate the gloved hand with the ungloved hand as the second glove is being put on.

6



Put the second glove on the ungloved hand by maintaining a steady pull through the cuff. Adjust the glove fingers and cuffs until the gloves fit comfortably.

Injuries from needles and other sharps are the number one cause of infections for team members from blood-borne infectious microorganisms such as HIV, Hepatitis B and C. All team members who use sharps are at risk. Careful handling of sharps is an essential way to avoid complications in delivering services.

Injuries can occur when:

- team members recap, bend or break needles
- someone carrying an unprotected sharp accidentally sticks another team member or client
- sharps are left in linens
- service providers are working in confined spaces and cannot easily see what is going on
- handling and disposing of waste containing sharps
- clients move suddenly during injections.

ASEPTIC TECHNIQUE

This section describes the practices carried out before or during a **surgical procedure** to reduce the client's risk of post-procedure infection. Aseptic technique prevents infection-causing microorganisms from entering the body.

The key features of aseptic technique are:

- the use of barriers such as gowns and masks (where necessary)
- surgical scrub and gloving
- proper preparation of the client
  - cleaning the surgical site with soap and water if visibly dirty
  - preparing the incision site by wiping with antiseptic, working in a circular motion from the centre of the site outwards
  - properly preparing the vagina, cervix and other mucous membranes.
- the set up and maintenance of a sterile field (for invasive procedures)
  - place only sterile items within the sterile field
  - open or transfer sterile items without contaminating them
  - recognise what is and is not sterile
  - act in ways that do not contaminate the sterile field
  - recognise and maintain the service provider's sterile area
  - do not place sterile items near open windows or doors.
- the use of good surgical technique
  - gentle tissue handling and minimal incisions reduce the risk of post-procedure infection in the client.
- creating a clean surgical/procedure area, for example:
  - restricting the numbers of people who come in and out of the space
  - setting up the space to reduce potential for infection; do not set up a sterile field near an open door or window
  - when in doubt about whether an item is sterile, consider it contaminated
  - cleaning and disinfecting all surfaces that may have been contaminated before a new client enters.

REMEMBER:

- only authorised people should be allowed to enter the procedure room
- keep doors and curtains closed
- enclose the space to minimise dust and keep out insects
- disinfect and clean all surfaces that may have been contaminated before a new client enters.

PROCESSING INSTRUMENTS

Proper processing is vital for reducing infection transmission during clinical or surgical procedures. Correct handling and processing also reduces the centre team's risk of infection.

There are four steps:

Step 1 - Decontamination

Step 2 - Cleaning

Step 3 - Sterilisation or HLD

Step 4 - Storage.

Step 1 - Decontamination

This step:

- kills viruses (including Hepatitis B virus, other viruses which cause hepatitis, HIV and many other microorganisms)
- makes instruments and other items safer to handle by the team members who do the cleaning and further processing
- makes items easier to clean by preventing blood, other body fluids and tissue from drying on them (although cleaning is still needed because decontamination does not remove the blood and tissue on the items).

How to decontaminate

Use a 0.5% chlorine solution. Chlorine is usually the cheapest, most available disinfectant.

See the box below about how to prepare a 0.5% solution. Use a plastic bucket with a lid and mark the bucket 0.5% chlorine solution.

All instruments must be decontaminated immediately after use.

Soak for 10 minutes, using a timer which sounds when the time is up (longer soaking will corrode metal instruments).

Making up a 0.5% chlorine solution

Chlorine in bleach comes in different concentrations. You can use any type of bleach, no matter what the concentration, to make a 0.5% solution, using the formula below. Look on the bleach container to find the concentration.

(% active chlorine in liquid bleach divided by 0.5) – 1 = parts of water for each part of bleach.

[Handy tip: dividing by 0.5 is the same as multiplying by 2]

A 'part' can be any unit of measure – for example a jug or bowl may be used. (see box with formula below)

The person responsible for ordering supplies should tell the team member if the product has been changed.

Too weak a solution will not kill the microorganisms; too strong a solution will damage or corrode the items put in the solution.

The decontamination solution should be changed daily, or earlier if it is cloudy (see *Tips about decontamination* on next page).

Step 2 - Cleaning

Cleaning means scrubbing with a soft sponge or brush, detergent and water. It is essential because it:

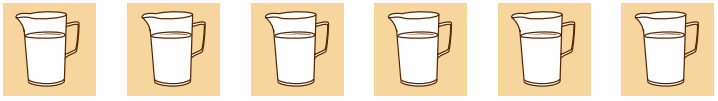
- removes organic material, dirt and other matter that can interfere with sterilisation or HLD
- reduces the number of microorganisms including bacterial endospores on instruments and other items.

Without cleaning:

- microorganisms trapped in blood clots and other organic material may be protected and survive sterilisation
- organic material and dirt can reduce the effectiveness of chemicals used in some instrument processing techniques.

Any instrument with old blood still on it after instrument processing cannot be considered sterile or HLD.

Formula for making a 0.5% chlorine solution using 3.5% active chlorine bleach



[water] + [chlorine] = 0.5% chlorine

Handy guide to making up a chlorine solution

To mix a **0.5% chlorine solution** using the formula (% of active chlorine in original bleach bottle divided by 0.5) – 1 = number of parts of water used to dilute the bleach, then:

- if the concentration of bleach is 3.5% then one part of bleach is mixed with six parts of water
- if the concentration of bleach is 4% then one part of bleach is mixed with seven parts of water
- if the concentration of bleach is 4.5% then one part of bleach is mixed with eight parts of water
- if the concentration of bleach is 5% then one part of bleach is mixed with nine parts of water
- if the concentration of bleach is 5.5% then one part of bleach is mixed with 10 parts of water
- if the concentration of bleach is 6% then one part of bleach is mixed with 11 parts of water. Team members responsible for mixing the 0.5% chlorine solution should understand that bleach concentrations can differ between products. Doing the calculations or following the manufacturer's instructions if using bleach powder or chlorine releasing tablets is essential.

Tips about decontamination

- use a plastic bucket with a lid for the decontamination solution; chlorine corrodes metals
- use a marker pen to write '0.5% chlorine solution' on the bucket
- place used instruments in the decontamination bucket without splashing
- always rinse procedure gloves in the decontamination bucket before removing them
- never leave instruments in the decontamination bucket for more than 10 minutes as this will damage them
- change the decontamination solution daily (because chlorine evaporates) or when it becomes contaminated with blood or becomes cloudy
- never use the decontamination solution on the skin or mucous membranes
- set up a bucket of tap water next to the decontamination bucket so that, when the items are ready to come out of the disinfectant solution, they can be placed in the water until the staff member is ready to clean them
- utility gloves should always be used when removing items from the decontamination bucket.

Cleaning steps

1. Using a soft brush or old toothbrush, water and enough **detergent** to make the water frothy or sudsy (do not use soap, which leaves an oily residue that microorganisms flourish in):
    a. scrub instruments and other items vigorously to remove blood, body fluids, tissue and other organic matter
    b. use utility gloves with long cuffs when cleaning
    c. carry out the cleaning in a bowl or basin near a sink to rinse the cleaned items in
    d. hold the instruments under the water to avoid splashing
    e. disassemble instruments and brush in the grooves, teeth and joints where organic material can collect and stick
    f. do not use abrasives in instrument cleaning as these can cause tiny scratches on metal instruments where microorganisms can hide.
2. Rinse items thoroughly with clean water to remove all detergent. Detergent residue can reduce the effectiveness of chemical processing.
3. Allow items to air dry or dry them with a clean towel. Instruments which will be processed with chemical solutions must be completely dry, otherwise the solution will be diluted; items that will be high-level disinfected by being boiled or steamed do not need to be dried first.

Step 3 - Sterilisation and HLD

Sterilisation or HLD: what are the differences and when should each be used?

Sterilisation kills all microorganisms that can cause infection: bacteria, viruses, fungi, parasites and bacterial endospores which cause diseases like tetanus and gas gangrene.

HLD kills bacteria, viruses, fungi and parasites but does not reliably kill all bacterial endospores.

Sterilisation is preferred and should be used wherever possible.

HLD should be available for instruments which have a low risk of carrying bacterial endospores such as MVA cannulae. Because MVA cannulae are flexible plastic, heat sterilisation is not possible and extensive international research supports the recommendation that HLD is suitable for MVA cannulae.

The following notes summarise the most common sterilisation and HLD methods. They may not all be in use in your centre. As you read through the notes, compare what is recommended with what happens in your centre.

Methods of sterilisation

There are three methods. For each method it is essential that items are decontaminated and properly cleaned before they are sterilised. Clots of blood can harbour harmful microorganisms even after sterilisation.

1. Steam sterilisation or autoclaving

    Destroys microorganisms on clean items by applying moist heat under pressure.

Autoclave should be used for sterilising:

- liquids (sterile water)
- metal instruments and other items
- gowns and surgical drapes. These can only be sterilised in an autoclave and they are essential to create a sterile field where instruments enter tissues under the skin.

2. Dry heat sterilisation (electric oven)

   Destroys microorganisms on clean items by applying dry heat for a given period of time The lower the heat, the longer the time needed for sterilisation.

Dry heat should be used for sterilising:

- glass or metal objects (other items may melt or burn).

3. Chemical sterilisation

   Destroys microorganisms on clean items (which should also be dry as water dilutes the chemicals) by soaking them in a chemical disinfectant solution (e.g., cidex) and rinsing them with sterile water.

Chemical sterilisation should be used for:

- heat sensitive items.

What is the purpose of wrapping items before autoclaving, steam or dry heat sterilisation?

Wrapping helps to prevent contamination after sterilisation but before use. Where storage conditions are good and the items are handled as little as possible, properly wrapped items can be considered sterile as long as they remain intact and dry, for up to seven days.

When wrapping for steam sterilisation, use muslin or cotton fabric. Do not use canvas because the steam cannot penetrate the material.

When wrapping for dry heat sterilisation, use foil, double-layered cotton or muslin fabric.

Steps of steam sterilisation (autoclave)

1. Decontaminate and clean items.
2. Disassemble items with sliding or multiple parts to allow steam to reach all parts.
3. Wrap, using muslin or cotton fabric (do not use canvas because steam cannot penetrate the material).
4. Arrange packages or items in autoclave so that the steam can circulate freely.
5. Follow the manufacturer's instructions for how long and at what pressure to autoclave.
6. Shut off the autoclave (unless automatic) after the desired time and leave items until they dry completely (could be 30 minutes).
7. Remove sterile packs using sterile pickups for unwrapped items, place on a surface padded with paper or fabric to prevent condensation until they reach room temperature.
8. Store properly:
   - wrapped: for best results store in closed cabinets in low-trafficked areas at moderate temperatures and zero or low humidity for up to seven days
   - unwrapped: use immediately on removal from autoclave or keep covered in a dry, unopened, sterile container, and use within seven days.
9. Timings– always check with the manufacturer. Typical timings are:
   - wrapped items – 30 minutes
   - unwrapped items – 20 minutes.

Steps of dry heat sterilisation

1. Decontaminate, clean and dry all items.
2. Either wrap, using foil, double layered cotton or muslin, or put unwrapped items on a tray or shelf, or put items in a metal lidded container (it is not necessary to unlock or disassemble because dry heat raises the temperature of the entire item).
3. Put items in the oven and heat to the correct temperature. Do not begin timing until the required temperature has been reached (and then use a timer or record the time).

Temperature	Time at required temperature
170° C (340°F)	1 hour
160° C (320°F)	2 hours
150° C (300°F)	2.5 hours
140° C (285°F)	3 hours

   The total time for sterilisation is likely to be twice as long as above because of the time taken during heating up and cooling.

   REMEMBER, do not sterilise sharps at temperatures above 160° because dry heat dulls them.

4. Leave items in the oven to cool, then remove and use or store immediately, using sterile pickups to remove unwrapped items.

5. Store properly:
    - wrapped: for best results store in closed cabinets in low-trafficked areas with moderate temperatures and dry or low humidity
    - unwrapped: use immediately on removal from autoclave or keep covered in dry sterile container, and use within seven days.

Steps of chemical sterilisation

1. Decontaminate, clean and dry (water from wet instruments dilutes chemical solution and makes it less effective).
2. Prepare the solution according to the manufacturer's instructions or use a solution prepared earlier, provided it is not cloudy and has not expired.
3. Open all instruments so the solution can contact all the parts. Submerge them in the solution and place bowls and containers upright so they can fill with solution.
4. Follow the manufacturer's instructions for soaking time. If the solution contains glutaraldehyde (cidex), cover the container and allow to soak for at least 10 hours (remembering not to add anything else once soaking has begun).
5. Remove sterilised instruments using sterile pickups (lifters, Cheatle forceps) and rinse thoroughly with **sterile water** to remove solution residue which is toxic to skin and tissues **(remember that boiled water is not sterile and rinsing with boiled water can contaminate sterile instruments)**.
6. Store properly:
    - place items on a sterile tray or in a sterile container and allow to air dry before use or storage
    - use immediately or keep in a covered, dry, sterile container to use within seven days.

What methods are there for HLD?

1. **HLD by boiling**
    - this can be done anywhere provided there is clean water and a heat source
    - instruments are placed in a pot or boiler, covered with water and boiled for 20 minutes.

Tips for HLD by boiling

- cover with a lid; make sure that boiling water can reach all parts of the instrument by disassembling items with multiple parts and opening hinged instruments
- always boil for 20 minutes, start timing when water reaches a rolling boil
- do not add or remove anything once boiling begins; this contaminates the water
- remove items using sterile pick-ups/Cheatle forceps and place in a sterile tray or container.

2. **Chemical HLD**
    - soak in glutaraldehyde or chlorine for 20 minutes
    - rinse with **sterile** water
    - some chemicals should NOT be used for chemical HLD; for example, antiseptics (like betadine or savlon), formaldehyde (which can be cancer forming), alcohol (which does not kill all viruses).

Tips for chemical HLD

- make sure items are completely covered with chemical solution, disassembling or unhinging items with multiple parts
- soak for 20 minutes
- do not add or remove anything once timing begins
- remove items from the solution using dry, sterile pick-ups (lifters, Cheatle forceps)
- thoroughly rinse items with **sterile** water to remove the chemicals as these are toxic to skin and tissues
- place items on a sterile tray or container and allow to air dry before storage.

3. **HLD by steaming**
    - in a tiered steamer for 20 minutes
    - useful for PAC cannulae and surgical gloves.

Tips for HLD by steaming

- do not pack equipment too tightly in the trays; allow steam to circulate
- when steam comes out between the trays, water is boiling and timing can star
- steam for 20 minutes; use a timer or record the start time
- lift out with sterile lifters and place on a sterile tray or container.

Special considerations when using HLD

- reusable needles and syringes:
  - do not reuse needles and syringes
  - disposable needles and syringes are preferred as reusables are difficult to process properly.
- gowns and surgical drapes:
  - only steam sterilisation is appropriate.
- MVA instruments:
  - MVA cannulae – sterilisation or HLD
  - MVA syringe – requires decontamination and proper cleaning but because it does not come into contact with the client, does not need sterilisation or HLD.

Step 4 - Storage

Proper storage is as important as proper decontamination, cleaning, sterilisation and HLD. If instruments and other items are not stored properly, all the efforts made to follow the correct processing of supplies will be wasted.

NEVER store instruments or other items in solutions. ALWAYS store them dry. Microorganisms can live and multiply in both disinfectant and antiseptic solutions and items left in contaminated solutions can lead to infections in clients.

NEVER use antiseptic solutions to process objects. REMEMBER, antiseptics are for use on people; disinfectants are for use on objects.

REMEMBER:

- if a sterile item comes into contact with anything or anybody not considered to be sterile/HLD, then that item is contaminated
- unwrapped sterile or HLD items should be used immediately or kept in a covered sterile container for no longer than 24 hours. Unwrapped items are at increased risk of contamination
- once a pack or container is opened its contents must be used or reprocessed within 24 hours
- **the maximum storage time for wrapped sterile items is seven days.**

The shelf life of a wrapped item is influenced by:

- the type of packing material
- how many times the pack is handled
- the number of people who handle the pack
- cleanliness, humidity and temperature of handling area; damp items must be considered contaminated
- whether or not packs are stored on open or closed shelves
- whether or not dust covers are used.

It is best to place sterile packs in closed cupboards in areas which are not heavily trafficked, have moderate temperatures and are dry and of low humidity. In these conditions, with limited handling, properly wrapped items can be considered sterile as long as they are intact and dry. If a pack of instruments is wet it must be considered unsterile.

Storage and handling time should be kept to a minimum because the likelihood of contamination increases over time and with increased handling.

If in doubt, re-sterilise before use.

WASTE DISPOSAL

This is often the most neglected part of IP.

All team members who handle waste are at risk of waste-related injuries. Sharps pose the greatest risk and can cause transmission of serious infections, including HIV and Hepatitis B.

Anyone who handles contaminated waste from the time it is disposed of by the service provider until it reaches the site for final disposal is at risk of infection and injury. Poor disposal of waste is a great threat in communities where waste dumps are open to children and scavengers. Every step in waste disposal should be carefully considered.

Proper disposal of waste:

- minimises the spread of infection and reduces the risk of accidental injury to service providers and the local community
- helps to create a pleasant centre environment
- reduces unpleasant smells
- helps keep down the numbers of insects and animals
- reduces the risk of contamination of local soil or ground water by microorganisms or chemicals.

There are three kinds of waste:

1. **General waste**
    - waste that presents no risk of injury or infection – paper, boxes, bottles, plastic containers, food-related waste.
2. **Medical waste**
    - waste generated in client treatment
    - blood, blood products and other body fluids as well as bandages, surgical sponges and other materials containing fresh or dried blood or other body fluids
    - organic waste: tissue, POC
    - sharps, used or unused, including hypodermic and suture needles, blades, IV tubes, glass slides, cover slips.
3. **Chemical waste**
    - cleaning products and disinfectants.

Developing a waste management plan

Every centre should have a waste management plan and a named person whose responsibility it is to look after the management of medical waste, which is potentially the most harmful waste generated.

There are four parts to a waste management plan:

1. Sorting waste by type where it is generated
2. Handling – collecting and transporting waste within the centre
3. Interim storage in the centre until the waste can be disposed of
4. Final disposal – removing or transporting dangerous waste from the centre.

Sorting

Sorting saves energy and resources by reducing the amount of waste that needs special handling:

- locate containers, clearly marked for either general or medical waste, conveniently close to where the waste is generated
- distinguish the containers by colour and easily readable labels
- sharps containers should be in convenient places so team members do not have to walk carrying used sharps.

Handling

- waste containers should be emptied before they become too full, at least once a day
- dispose of sharps containers when they are ¾ full
- never put your hands into a container of medical waste
- always use utility gloves when handling waste.

Interim storage

- make sure this is short term, ideally only a few hours before disposal
- store waste in a closed area that is inaccessible to staff, clients and visitors; the number of people who come into contact with medical waste should be kept to a minimum
- make sure all containers have lids and seal tops of plastic bags with tape to prevent spills and smells
- never store medical waste in open containers and never throw it into an open pit.

Final disposal

Solid medical waste should be disposed of on the premises. Options include:

- burning – this is the best option. Use an incinerator or oil drum to prevent scattering
- burying – in a pit big enough for all the waste generated at the site, with a fence or wall surrounding the pit, to prevent access to it
- transporting waste – this can be considered if neither burning nor burial at the site is possible. Ensure that the people transporting the waste are aware of the risks and take proper precautions. If transporting waste, it is vital that you know where the waste can be disposed of correctly.

Liquid medical and chemical waste

Always wear utility gloves and closed footwear when handling liquid medical waste.

Cleaning solutions and disinfectants should be handled in the same way as liquid medical waste:

- carefully pour liquid waste down a sink, drain, flushable toilet or latrine, remembering, before doing this, to make sure you know where the drain empties, checking that it does not run through an open gutter and drain into the ground locally
- rinse the sink, drain or toilet thoroughly with water, avoiding splashing. Clean these areas with a disinfectant solution at the end of each day or more frequently if they become heavily soiled
- decontaminate the container that held the liquid waste by soaking it for 10 minutes in a 0.5% chlorine solution before washing it and washing your hands.

Disposing of sharps

- sharps are not destroyed by burning except in large, industrial incinerators
- place needles, plastic syringes and scalpels in a puncture resistant, sealable container and, when the container is ¾ full, pour in fuel, ignite and allow to burn until the fire goes out. The plastic syringes will melt and when cool become a solid block of plastic with the sharps embedded in it and this can then be buried in the burial pit
- always wash your hands after handling sharps containers.

Disposing of foetal waste and POC

Foetal waste and POC should be disposed of in a sympathetic and appropriate manner. As with other medical waste, foetal waste may be poured into a sink, drain, functioning sewage system or maintained pit latrine. You must consider where the drain empties. The drain must not run through open gutters or empty onto ground. Rinse and disinfect any drain that is used with a 0.5% chlorine solution. Alternatively, products should be placed into containers, which can then be sealed and burnt.

FAMILY PLANNING COUNSELLING

In emergency and non-emergency situations alike, it is important that clients seeking family planning (FP) receive quality FP counselling, to enable them to make informed decisions about whether to use FP and to help them select the methods that best suit their needs.

All FP clients have the right to complete, correct and current information about the FP methods available and they have the right to make informed choices, based on this information. FP clients also have the right to services that are safe, private and confidential; that respect their dignity and comfort; and that allow them to express their opinions. Quality FP counselling ensures that clients understand how to use the methods they select, that they are informed of the possible side effects and that they know when and where to seek help. It can also help to dispel myths and misconceptions about FP that may exist in the community.

FP counsellors discuss the health implications of sexual behaviour and how to prevent STIs as well as how to avoid unwanted pregnancy. This is known as *integrated family planning counselling* and responds to the global need for women and men to have clear information and advice on STIs, including HIV.

Providing FP counselling during emergency situations can be particularly challenging: providers may feel pressured because of high client volumes, the methods available may be limited because of disruption of health systems, and space limitations in the health facility may make it difficult to ensure the privacy and confidentiality of clients. Although it may be difficult to provide FP counselling under these circumstances, counselling is crucial, not only because it allows clients to make informed choices, but also because it promotes the correct use of methods, better birth spacing, increased client satisfaction, longer continuation of FP method use, and improved client RH in general.

What is FP Counselling?

FP counselling is not like a procedure in which the provider performs a sequence of clinical steps. It is an exchange of information in which the client and the provider are equal partners, a conversation with several stages:

- Together, client and counsellor discuss the client's situation and what she needs from a contraceptive method. Discussion includes partner's needs and desires, but the client needs are key.
- The counsellor asks about the client's health to rule out possible medical contraindications. The provider describes methods to suit the client's needs, including side effects.
- The client chooses a method. The provider describes and demonstrates how to use the chosen method, possible side effects and complications and what to do if these occur.
- The method is provided and supplies are given. It is important that FP counsellors are skilled, as unskilled counsellors can decrease the effectiveness of FP counselling by making the client feel uncomfortable, nervous, embarrassed, or unsafe. FP counsellors should be empathetic towards their clients' needs, non-judgemental, and able to treat all clients with respect.

FP counselling relies on interpersonal communication and counselling (IPCC) skills and techniques, including both verbal and non-verbal communication and counselling skills.

Verbal communication refers to what is said and how it is said. Good verbal communication skills include active listening, clarifying, paraphrasing, summarising, repeating and reflecting.

Non-verbal communication refers to the messages that are conveyed by eye contact, body language, tone of voice and demeanour.

Good FP counsellors do not only have strong IPCC skills, they also have highly developed skills in describing and demonstrating contraceptive methods and in determining whether a client is already pregnant. Counsellors must feel comfortable, and should be able

to make the client feel comfortable, discussing sexuality and other sensitive topics. Counsellors who are FP service providers must be skilled in conducting a physical examination (needed for some methods) and in insertion and removal of IUDs and implants.

Both FP providers and FP counsellors need a sound knowledge of:

- factors influencing a client's choice and use of method
- the reproductive system and how pregnancy happens
- STIs, including HIV/AIDS, how they are transmitted, diagnosed, treated and prevented
- modern contraceptive methods, how they work, their effectiveness, potential side effects and complications.

What are the Phases of the Counselling Session?

Counselling is not a fixed set of steps; rather, it is a conversation with some important moments. There are several frameworks for FP counselling. The GATHER approach is one model that takes providers and clients through connected and overlapping steps as they discuss FP needs and options. Using this approach will help the client make informed decisions about FP methods.

The following briefly outlines the steps of the GATHER approach[1]:

Greet the client in a culturally acceptable way and make her/him feel welcome. Treat the client with respect. This is an important step in building confidence and opening the channels of communication.

Ask about the client and her FP needs. Ask questions in a friendly, respectful tone. Ask simple, open-ended, effective questions that do not limit the client's responses. Use active listening skills.

Tell the client about the FP methods that are available to her/him. Use clear, simple language that is easily understandable. The client has the right to receive full information about the methods available, but some methods may be contraindicated or less desirable to certain clients. Provide complete information, but tailor and personalise it, based on what the client told you during the "Ask" step.

Help the client select a method. Ask the client what s/he has decided to do. Discuss the method that is mentioned and help the client decide whether this is the best method for her/him. Unless there is a medical contraindication to a particular method, the client should receive the method of her/his choice. Explain how to use the method, including possible side effects and how to deal with them.

Return or refer. Tell the client when to return for more medication, a repeat dose, or for check-up. Let the client know that s/he may return to the health facility at any time, if s/he has questions or if any problems related to the method arise. Provide a referral for further care, as appropriate. The counselling session will not always follow this logical pattern, but all of these issues should be covered at some point. As you become more experienced, you will find your own effective and efficient ways of covering all of these points.

What Topics are Covered in FP Counselling?

FP counselling strives to answer the following questions, which will help the provider assist the client in making an informed choice:

What is the client's sexual history?

What are the client's reproductive goals?

Do the clients want children? When? How many? At what birth intervals?

If the client is in a relationship is there an agreement on reproductive goals? Is there an agreement on FP methods and responsibilities for making sure the method is effective? Is one partner acting secretly to prevent fertility?

What role does sex have in the client's relationship?

Is the relationship equitable, or does the woman have to give in to the demands of her partner?

Does the client experience pain or difficulty during sexual activities?

Is the client or the client's partner in other sexual relationships? Should the client be concerned about preventing STIs, including HIV?

What contraceptive methods has the client used before or is using now? What is her/his experience with these?

What is the client's relevant surgical and medical history?

[1] Rinehart W, Rudy S. and Drennan, M. GATHER *Guide to Counselling*. Population Reports, Series J, No. 48. Baltimore, Johns Hopkins University School of Public Health, Population Information Program, December 1998.

Influences on Client Choice and Use of FP Methods

In the many social, cultural and religious settings throughout the world, the status of women varies widely. It is essential for FP counsellors to understand the status of women and the other various factors that influence a client's decision-making process, in the setting where they work, in order to help her choose a method that best suits her needs. By asking the following questions during FP counselling, the counsellor and the client are able to assess each of these factors and use the client's responses to choose the method that best suits her needs:

Value of Children
What is the client's attitude to having children? Does she want children, or more children? When? How many?

Is she under pressure from family members to have children?

Are there medical or other reasons for her not to have more children?

What is the value of children in her society? (One client might say, "I won't have children until I have established my career." While another says, "We need many sons to work on the farm.")

Religious Beliefs
Do these influence her attitudes to sex, family and children?

Do they mean that for her only certain methods are acceptable?

Relationship
At what stage of any relationship is she?

What does this mean for contraceptive use?

Does her partner support her views on having children?

Does she need to use a method secretly?

Does she or her partner have other relationships and if so, is she at risk of disease?

Identity Including Attitudes to Sex
Does she have sex voluntarily? Is she coerced?

Does she offer sex in return for money or food?

Is she able to touch her own body?

Does she find some methods messy or unpleasant?

Does she have spontaneous or planned intercourse?

Education, Knowledge, Beliefs, Myths
Does she have a clear understanding of reproduction and sexual health?

Can she understand how methods work, how to use them and the side effects to expect?

Is she likely to be influenced by misinformation about contraceptive methods, for example, that IUDs can travel around the body?

Do her social circumstances mitigate the use of certain methods?

Family, Peer Group
Is she under pressure from family members to produce children as soon as possible?

Does the family see producing sons as more important than producing daughters?

Does the family try to make her decisions for her?

Do young women in your locality experience pressure to have sex when they do not want to?

Age and Life Stage
How old is the client?

Has she used contraceptives before?

What reproductive life stage has she reached?

Experience of Contraceptive Methods and Services
Has she been satisfied or dissatisfied with previous methods?

How easy was it to get the method?

Was it difficult to get supplies?

Was the method too expensive?

Was there back up if she had questions?

Did providers put restrictions on who could have the method?

Did she feel unable to ask questions because the provider was her social superior? "

TALKING *about* SEXUAL MATTERS

"I felt embarrassed when the counsellor asked me what my boyfriend and I do when we have sex."
(Client interviewed when leaving a health facility).

Every person has a right to receive sexual information and to consider sexual relationships for pleasure as well as for procreation. (WHO Technical Reports Series # 572).

Just as social and cultural factors influence a woman's choice of FP method, social norms and rules about sex influence a client's ability to discuss the intimate details of her life and sexuality. When discussing sexual matters with a client, it is important to consider the social norms and rules about sex, including:

What are the values and beliefs about men's and women's roles in society?

What is expected or allowed, in terms of sexual behaviour?

What is considered "right" and what is considered "wrong?"

Are expectations different for men and women?

How does society view marriage? Sex outside of marriage? Polygamy?

How does society view prostitution? Homosexuality?

Who does the society feel should have access to RH services? To RH information?

Although social norms and rules exist, not everyone obeys them. For example, some societies forbid or stigmatise homosexuality but people still have homosexual relationships. Some people regard themselves as heterosexual whilst also having sex with someone of the same sex. Sex outside marriage may be seen as shameful but some married people have sex with other partners. Women are coerced into doing things they do not like because of their lack of power or sense of duty.

A client who engages in activities that society forbids, frowns upon or sees as "unnatural" may feel guilty or ashamed. She may find it difficult to discuss sexual behaviour if she does not understand it or how the body works. She may feel inhibited because she does not know the "right" words to use. She may feel inferior to the FP counsellor or provider, especially if she is a different age, gender or from a different sector of society. Any of these feelings can make it difficult for her to talk about her sexual activities and those of her partner.

It is the role of the counsellor to put the client at ease and encourage her to speak openly. In order to do this, the counsellor must feel comfortable discussing subjects such as anatomy, menstruation and sexual behaviours. Nervousness, anxiety or embarrassment on the counsellor's part can make the client feel uncomfortable and will make the counselling session less productive.

FP counsellors (and providers) must never be judgemental. Regardless of what the client says, and regardless of the counsellor's personal beliefs or opinions, the client should never see that the counsellor or provider is shocked, upset or amused by what a client says. Showing these emotions will cause a loss of trust and will break the rapport that has been established during the counselling session.

Using Plain Language

FP counselling requires that both the counsellor and the client understand the words that the other is using. When describing anatomy, procedures or even sexual practices, FP counsellors may use technical terms that the client does not understand. On the other hand, a client may use local terms or "slang" or she may take a roundabout route to say what she means. FP counsellors can help by using everyday, plain words and by avoiding the use of medical terms. It is important that the FP counsellor be familiar with the local words used for body parts and sexual practices so that s/he understands what the client intends to say when she uses them and so that the s/he can use them to help the client understand, if necessary.

Male involvement in family planning

Men play a crucial role in reproduction and in many cultures, they are the decision-makers on health and reproductive matters. Service providers must recognise the importance of male involvement in FP and they must be skilled in engaging men so that they understand the benefits of FP and participate actively in the decision-making related to the timing and spacing of children.

CLIENT ASSESSMENT *and* HISTORY TAKING

The primary objectives of assessing clients prior to providing FP services are to determine whether:

- the client is not pregnant
- any conditions exist that might make a particular method inadvisable
- there are any special problems that require further assessment, treatment or regular follow-up.

This may seem like a time-consuming process, but experienced providers and counsellors can usually obtain the necessary information by asking a few well-directed questions.

Because sensitive information is discussed during the client history, it is important to ensure privacy and confidentiality at all times. The service provider must make the client feel comfortable by:

- ensuring privacy
- ensuring confidentiality
- establishing a rapport
- treating the client with respect.

THE CLIENT HISTORY

A history should be taken with all new clients to obtain baseline information that can help to guide the selection of a contraceptive method. The client's record should include all information relevant to decision-making about contraceptive use.

The following information should be collected in a client history:

- presenting information
- personal/social history
- past medical and surgical history (including history of STIs)
- menstrual history
- obstetric history
- sexual history
- FP history.

A brief client history (update) should be taken with the continuing user, to determine whether:

- s/he has experienced any side effects with the current method
- s/he has had any difficulties using the method correctly
- there is a need to change to a different contraceptive method.

ASSESSING FOR PREGNANCY

Most contraceptive methods can be provided as long as the client and provider are reasonably certain that the client is not pregnant. If a client has no signs or symptoms of pregnancy and meets any one of the following criteria, it is *reasonably certain* that she is not pregnant:

- is less than six months post-partum, exclusively (or near-exclusively) breastfeeding, and menses have not resumed
- has not had sexual intercourse since delivery or since her last menstrual period
- is less than four weeks post-partum
- began her last menstrual period less than seven days ago
- is less than seven days post-abortion
- has been using a modern method of contracepti on consistently and correctly.

PHYSICAL EXAMINATION

Unless specific problems are identified in the client history, most contraceptive methods (except IUDs and voluntary sterilisation) can be provided without performing a physical or pelvic examination.

If physical problems are indicated/suspected after assessment, a focused physical examination should be performed, to identify the source of the problems so that treatment or referral to a higher level of care can be provided (if possible in the context). If the client chooses IUD or sterilisation, a pelvic examination should be conducted prior to performing the procedure to evaluate for any physical condition that might affect the procedure, STI or PID, which would require a delay in performing the procedure, or the presence of fibroids that might make IUD insertion more difficult.

Pelvic Examination

If necessary, introduce yourself to the client. Explain what will be done during the examination and why the exam is necessary. Reassure her that her privacy will be protected during the examination. Tell her that she may ask questions at any time during the examination and that if she feels uncomfortable at any time, she may ask you to stop for a moment or to end the examination completely. Be sure that the client has emptied her bladder prior to the examination.

Ask the client to undress completely from the waist down and cover herself from the waist down with a cloth or drape. (If the client does not need assistance, step out of the room while she undresses to protect her modesty.) Ask the client to lie on the examination couch (or table) in the lithotomy position.

Before you begin the examination, check to see that you have all of the items that you will need for the examination and to collect specimens for any lab tests. Wash and dry your hands thoroughly and put on clean gloves. Explain each step of the procedure as you go along and let the client know that she can ask questions or ask you to stop the examination at any time. Special care should be taken when examining a woman who has never had a pelvic examination before, as the procedure may cause anxiety or discomfort.

External Genitalia Examination

With a gloved hand, separate the labia and inspect the external genitalia looking for any swelling, inflammation, lesions, discharge or abnormal bleeding. During the external genital examination, inspect the:

- labia minora
- clitoris
- urethral orifice
- vaginal opening.

If a woman has undergone female genital cutting/circumcision, the clitoris and all or part of the labia will be absent. If she has been infibulated, it may not be possible to inspect the urethral or vaginal openings.

Speculum Examination

(This assumes that a bi-valve speculum is used. If a different type of speculum is used, the technique will vary slightly).

Warm the speculum with your hand and lubricate the ends of the blades with water or vaginal secretions.

Place one or two fingers just inside the vaginal opening and gently press downward to relax the muscles. Ask the client to relax the muscles as much as possible. It may be helpful to ask her to take a couple of deep breaths as she relaxes the muscles.

With the other hand, introduce the closed speculum into the vagina with the blades rotated about 45º. Slide the speculum over your fingers while directing it downward (posteriorly). Exert slight pressure downward, towards the posterior wall of the vagina, in order to avoid injuring the anterior vaginal wall and the urethra. Be careful not to pull the client's pubic hair or pinch the labia with the speculum. Insert the blades fully and rotate the speculum so that the blades are horizontal and the handle is pointing downward, maintaining slight posterior pressure.

Open the blades and manoeuvre the speculum so that the cervix comes into full view. You may need to pull back on the speculum very slightly so that the cervix "pops" into view. Once the cervix is in view, tighten the thumb screws to maintain the blades open.

Using a focused light directed into the vagina, inspect the cervix for abnormal discharge, lesions and friability (easy bleeding of the cervical tissue).

If abnormal discharge is present, obtain a specimen for microscopic examination, culture, or Pap smear (when indicated). (If the appropriate tests cannot be performed in your setting, treat the client syndromically or refer, as appropriate).

After examining the cervix and taking specimens, loosen the thumb screws to release the blades. Withdraw the speculum slowly and gently, inspecting the walls of the vagina by rotating the speculum slightly in each direction. Remove the speculum from the vagina gently, taking care not to pinch the client's labia or pull her pubic hair.

Bi-manual Pelvic Examination

Wearing gloves on both hands, wet the index and middle fingers of one hand with clean water, water-based lubricant or a small amount of vaginal secretions.

Using the other hand, separate the labia with two fingers so that the vaginal opening is easily seen. Introduce the lubricated index and middle finger of the pelvic hand slowly into the vagina, exerting downward pressure until you touch the cervix. Move the cervix side to side between your fingers. The cervix should easily move 1-2 cms in each direction without any pain.

To feel the body of the uterus, place the fingers of your pelvic hand in the space between the cervix and the posterior vaginal wall with the palm up. Next, place your other hand flat on the abdomen, midway between the umbilicus and the pubic bone. Exert slight upward pressure on the fingers of the vaginal hand as you slowly slide the abdominal hand towards the pubic symphysis until you feel the uterine fundus (the top of the uterus).

Palpate the uterus gently between your two hands, checking for size, shape, location, consistency, mobility and tenderness.

Move the fingers of the vaginal hand and the abdominal hand slightly to one side of the uterus and palpate the ovary. (The ovaries are usually located behind and to either side of the uterus.) Do the same on the opposite side. Check for location, size, consistency and tenderness.

Before removing the fingers gently push posteriorly to check for tenderness or masses in the cul-de-sac (the space at the top of the vagina, between the cervix and the posterior vaginal wall).-

MODERN CONTRACEPTIVE METHODS

GENERAL INFORMATION

Modern contraceptive methods are hormonal, non-hormonal, barrier and permanent methods that, when used consistently and correctly, allow women and couples to plan the number of pregnancies they have, determine the interval between births, and avoid unwanted pregnancies. All modern contraceptive methods (with the exception of vasectomy) can be used by all women of reproductive age, including adolescents and women over 40. All modern methods can be used by women, regardless of their marital status and regardless of whether they have had children.

Most modern contraceptive methods can be provided by mid-level health workers and do not require physical or pelvic examinations or laboratory testing—very important factors when providing services in emergency settings, where health infrastructure and human resources may be limited.

Hormonal, barrier and permanent methods of contraception will be covered in the sections that follow. Further details regarding both modern and natural family contraceptive methods can be found in the corresponding sections of *Family Planning: A Global Handbook for Providers*.

Please refer to Annex B of this manual for a table on the effectiveness of contraceptive methods.

HORMONAL CONTRACEPTIVES

Hormonal contraceptives are methods containing synthetic hormones (oestrogen, progesterone, or a combination of both), similar to the hormones that occur naturally in a woman's body. These methods work primarily by preventing ovulation, fertilisation or implantation. Common hormonal contraceptives include:

- combined oral contraceptives (COCs)
- progestin-only pills (POPs)
- progestin-only injectable contraceptives (PICs)
- combined injectable contraceptives (CICs)
- implants
- hormone-releasing IUDs.

Combined Oral Contraceptive Pills

Combined oral contraceptive pills (COCs) contain synthetic oestrogen and progesterone, similar to the hormones that are naturally present in a woman's body. COCs work through several mechanisms to prevent pregnancy from occurring:

- prevention of ovulation (primary mechanism)
- thickening of the cervical mucus, which prevents sperm from penetrating into the upper female reproductive tract
- thinning of the endometrial lining, which decreases the likelihood of implantation.

Who can use COCs?

COCs are a highly-effective method of contraception, which can be safely used by most women, including:

- women who can adhere to a daily dosing schedule
- exclusively breastfeeding mothers more than six months post-partum
- partially breastfeeding mothers more than six weeks post-partum
- women who are more than three weeks post-partum and are NOT breastfeeding
- women who have recently had a miscarriage or abortion (should begin within seven days)
- women who smoke cigarettes and are under 35 years old
- women with anaemia from heavy menstrual bleeding
- women who have a history of ovarian cysts or endometriosis
- women with severe menstrual pains
- women with a history of ectopic pregnancy

Table 1: BENEFITS OF COCs		
Contraceptive Benefits	**Non-contraceptive Benefits**	**Limitations**
■ highly effective ■ effective immediately ■ easy to use ■ safe ■ can be provided by trained, nonclinical service provider ■ does not require pelvic examination ■ reversible: return to fertility is immediate after discontinuation ■ can be used as EC.	■ reduces menstrual cramps and pain ■ decreases menstrual flow, hence may protect against anaemia ■ improves hirsuitism (excess body and facial hair) ■ protects against ovarian and endometrial cancer ■ may help protect against ovarian cysts ■ decreases the risk of benign breast disease ■ protects against ectopic pregnancy by preventing ovulation ■ improves acne ■ enhances sexual enjoyment.	■ requires strict adherence to daily dosing ■ does not protect against STI/HIV ■ may decrease the quantity of breast milk produced ■ effectiveness may be lowered with gastroenteritis, vomiting or diarrhoea ■ effectiveness may be lowered when taken with certain other drugs ■ serious side effects are rare and include: myocardial infarction, stroke, venous thrombosis/embolism and benign tumours (adenomas) of the liver.

- women who have varicose veins
- women who are HIV+, regardless of whether they are on ART (HIV+ women should be counselled to also use condoms for dual protection).

Who should not use COCs?

- women who are unable to adhere to a daily dosing regimen for any reason
- mothers who are less than six months post-partum and exclusively breastfeeding
- women with unexplained or suspicious abnormal vaginal bleeding
- women with a history of blood clotting disorders
- women with a history of heart disease
- women with high blood pressure (BP over 140/90 mmHg, which is confirmed on more than one occasion)
- women with active liver disease (jaundice, viral hepatitis, mild to severe cirrhosis, benign or malignant tumours)
- women with diabetes mellitus for over 20 years, or complications involving circulation, eyes, kidneys or nervous system
- women with a history of breast cancer
- women taking medications for seizures or rifampicin for TB (many commonly-used seizure medications make COCs less effective)
- women who smoke and are older than 35 years
- women with symptomatic gall bladder disease including those on medical treatment
- women who are over 35 and have migraine with aura (women under 35 with migraine and aura may take COCs; women with migraine and no aura may also take COCs).

Backup Methods provide additional protection at times when the primary contraceptive method may not yet be effective or may be temporarily less effective.

The most reliable backup methods are *male or female condoms and abstinence*. Spermicides or withdrawal may also be used, but these methods are less reliable and are more likely to result in unwanted pregnancy.

If the client chooses condoms or spermicide as her backup method, it is good practice to provide these whenever COCs are provided so that she has them available in case of need.

Client instructions for taking COCs

COCs come in 21-day packs and 28-day packs.

- If you are taking pills from a 21-day pack, all of the pills contain hormones. Take one pill at the same time each day. When you reach the end of the pack, wait one week (seven days) and then start a new pack.
- If you are taking pills from a 28-day pack, the first 21 pills contain hormones and the last seven pills in the pack are inert (contain no hormones); these pills are often a different colour. Take one pill at the same time each day. When you reach the end of the pack, start a new pack at the same time the following day. DO NOT TAKE A REST BETWEEN 28-DAY PACKS.

Special instructions
■ If you vomit within 30 minutes of taking a pill, take another pill or use a backup method if you have sex during the next seven days.
■ If you forget to take a pill, but remember it later the same day, take the pill as soon as possible and then continue taking one pill each day, as usual.
■ If you forget to take a pill for one or two days, take a pill as soon as possible (you may take two pills in one day) and then continue taking one pill each day, as usual.
■ **Missing three or more pills in a row requires special instructions:** □ If you miss three or more consecutive pills during the first two weeks of your menstrual cycle, OR if you start a new pack of pills more than two days late: take a *hormonal* pill as soon as you remember (you may take two pills in one day if necessary). Use a backup method for the next seven days. You are at increased risk of pregnancy, so if you have had sex in the last five days, you should consider taking EC. □ If you miss three or more consecutive pills during the third week of your cycle, take a *hormonal* pill as soon as you remember (you may take more than one pill day, if necessary). If you are using the 21-day pack, take all of the pills remaining in the current pack at the usual time of day, but DO NOT TAKE A REST. Start a new pack immediately and use a backup method for seven days. If you are using the 28-day pack, take the remaining *hormonal* pills at the usual time of day AND THROW AWAY THE SEVEN HORMONAL PILLS. Start a new pack immediately, without taking a rest and use a backup method for seven days. □ If you miss menstrual periods after missing several pill doses, or if you develop symptoms of early pregnancy, go to the health facility for evaluation.

It is good practice to give the client several pill packs at one time so that she is not required to return to the health facility each month and so that she has a new pack available to start when she finishes the current one.

Client instructions for starting COCs

In general, COCs may be started at any time during the menstrual cycle, as long as you are reasonably certain that the client is not pregnant. The following table provides guidelines for starting COCs. It assumes reasonable certainty that the client is not pregnant.

Table 2: CLIENT INSTRUCTIONS FOR STARTING COCs

Criteria	Start	Backup Method	Comments
Menstruating women	Any time	7 days	Start on days 1-5 of cycle does not require backup
Amenorrhoeic women	Any time	7 days	
Post-partum women			
Exclusively breastfeeding (no menses)*	6 months post-partum	7 days	
Partially breastfeeding (no menses)*	6 weeks post-partum	7 days	
Not breastfeeding	21 days post-partum	7 days	Start on days 21-28 post-partum does not require backup
Post-abortion women			
≤ 7 days post-abortion	Immediately	NO	
> 7 days post-abortion	Any time	7 days	
Women switching from modern method			
Switching from a hormonal method	Immediately	NO	Assumes correct and consistent use of the method
Switching from injectable	When injection is due	NO	
Switching from non-hormonal method	Any time	7 days	Also applies to incorrect or inconsistent use of hormonal method.
Switching from IUD	Immediately	NO	
Women who have taken ECP	1 day after taking ECP	7 days	

*If menses have resumed post-partum, follow the instructions for menstruating women.

Side effects of COCs

Most side effects of COCs are minor and subside after the first few months of using the method. Women should be counselled about the possible side effects and advised that if they experience mild symptoms, they should continue taking the COC to avoid becoming pregnant. If the side effects are very bothersome or do not decrease after the first few months, the client should return to the clinic for evaluation and to discuss alternative methods. The most common side effects are:

- **Bleeding changes:** are very common, usually occurring during the first few months and may include irregular periods, amenorrhoea (missed periods) or bleeding/spotting between periods. Any bleeding that persists or that begins after the client has been taking COCs for several months requires gynaecological evaluation to assess for non-method-related causes.
- **Breast tenderness, mild nausea, mild headaches and weight changes** are also common and are not usually indications for discontinuing COCs. If they are very bothersome to the client, or if she develops severe headaches, with or without aura, she should return to the clinic for evaluation. Treatment is mostly symptomatic.
- **Mood changes or changes in sex drive (libido)** may occur. *If serious mood changes (such as major depression) occur, switch methods and refer for mental health and psycho-social support, if available.* Local remedies may also be helpful.

Progestin-only pills (POPs)

Progestin-only pills (POPs) are also called "mini-pills." They work primarily by causing thickening of the cervical mucus, making it more difficult for the sperm to penetrate, and thinning of the endometrium, making implantation less likely. POPs may also suppress ovulation.

Who can use POPs?

POPs are a highly effective form of contraception for women who are breastfeeding. They are also very effective (although slightly less) for women who are not breast-feeding. POPs are safe for nearly all women, including:

- women who are able/willing to adhere to a daily dosing schedule (able to take pill at exactly the same time each day)
- women who are post-partum and are breastfeeding (after six weeks) or not breastfeeding
- smokers of any age
- women who cannot use COCs, due to oestrogen-related contraindications
- women with anaemia or history of anaemia
- women with varicose veins
- women who have had abortion or miscarriage
- women with mild hypertension (BP <160/100mmHg)
- women who are HIV+, regardless of whether they are on ART (HIV+ women should be counselled to also use condoms for dual protection).

Who should not use POPs?

- breastfeeding women who are less than six weeks post-partum
- women with unexplained abnormal vaginal bleeding
- women who have breast cancer or history of breast cancer
- women with active liver disease (jaundice, viral hepatitis, severe cirrhosis, benign or malignant liver tumours)
- women with hypertension (BP ≥160/100 mmHg)
- women who are currently taking certain drugs for seizures or rifampicin for tuberculosis (TB)
- women who currently have deep-vein thrombosis (DVT) or pulmonary embolism (PE).

Table 3: BENEFITS OF POPs

Contraceptive Benefits	Non-contraceptive Benefits	Limitations
■ highly effective ■ easy to use ■ safe ■ no rest period ■ pelvic examination is not required ■ reversible: return to fertility is immediate after discontinuation ■ can be provided by non-medical staff.	■ does not affect breastfeeding ■ menstrual periods are lighter and shorter ■ less breast tenderness ■ does not increase risk of clotting or thrombo-embolism ■ decreases menstrual pain ■ protects against endometrial cancer, PID, benign breast disease.	■ requires strict adherence to daily dosing at the same time each day ■ contraceptive protection is slightly lower than COCs ■ effectiveness may be decreased by certain drugs ■ does not protect against STI/HIV ■ risk of pregnancy with missed pill dose.

Table 4: CLIENT INSTRUCTIONS FOR STARTING POPs

Criteria	Start	Backup Method	Comments
Menstruating women	Any time	2 days	Start on days 1-5 of cycle does not require backup
Amenorrhoeic women	Any time	2 days	
Post-partum women			
Exclusively breastfeeding (no menses)*	6 weeks post-partum	2 days if ≥ 6 months	No backup required before 6 months
Partially breastfeeding (no menses)*	6 weeks post-partum	2 days	
Not breastfeeding	Immediately	2 days if > 4 weeks	Start 0-4 weeks post-partum does not require backup
Post-abortion women			
≤ 7 days post-abortion	Immediately	NO	
> 7 days post-abortion	Any time	2 days	
Women switching from modern method			
Switching from a hormonal method	Immediately	NO	Assumes correct and consistent use of the method
Switching from injectable	When injection is due	NO	
Non-hormonal method (or inconsistent use of hormonal method)	Any time	2 days	
Switching from IUD	Immediately	NO	
Women who have taken ECP	The day after taking ECP	2 days	

*If menses have resumed post-partum, follow the instructions for menstruating women.

Client instructions for starting POPs

In general, POPs can be started at any time during the menstrual cycle, as long as you are reasonably certain that the client is not pregnant. The following table provides guidelines for starting POPs and assumes reasonable certainty that the client is not pregnant.

Client instructions for taking POPs

POPs are taken every day without stopping, including during the menstrual period.

- Take one pill a day (within a three-hour time frame), preferably after the evening meal, until the pack is finished (28-35 days). As soon as you finish the pack, start a new pack at the same time the following day. NEVER MISS A PILL AND NEVER TAKE A BREAK in between the packs.

Special instructions
■ If you take a pill more than three hours after the normal time or if you forget to take a pill one day, take the pill as soon as you remember and continue to take one pill each day, at the usual time. (It may be necessary to take two pills in one day, depending on when you remember) You must use a backup contraceptive method for the next two days and if you have had sex in the five days before missing a pill or taking a late dose, you might consider emergency contraception (EC).
■ If you forget to take two pills, take one pill twice a day for two days, and then go back to taking one pill daily, at the usual time. Use a backup method for the next two days. If you vomit less than two hours after taking your pill, take another pill immediately and continue to take the pills every day at the same time each day, as usual.
■ If you do not have a menstrual period within 45 days of your last period, you should go to the health facility for a pregnancy test.
■ If you occasionally forget to take pills for two days, this is probably not the best method of contraception for you.

Side effects of POPs

Most side effects of POPs are minor and may subside after a few months. Clients should be counselled about the side effects of POPs and advised that they should continue taking the pills as instructed to avoid pregnancy. They should return to the health facility if the side effects become very bothersome or if they continue after the first few months. The most common side effects experienced with POPs include:

- **Bleeding changes** including spotting or bleeding between menses (very common), bleeding that is heavier or lasts longer than normal usually resolving or improving after a few months. Any bleeding that persists or that begins after the client has been taking POPs for several months requires gynaecological evaluation to assess for non-method-related causes. Amenorrhoea that is not due to pregnancy may be method-related or may be due to breastfeeding.
- **Headaches:** *Mild headaches or migraine headaches without aura* can be treated symptomatically and are not necessarily an indication to discontinue the method. *Migraine headaches with aura* are an indication to discontinue POPs. Counsel the client and help her to select a non-hormonal method.
- **Ovarian cysts and enlarged ovarian follicles** may develop in women taking POPs. These usually do not require treatment.
- **Breast tenderness, mild nausea, weight changes** are usually not indications to discontinue the method. Management is mostly symptomatic.
- **Mood changes, depression, change in sex drive** may or may not be related to the method. *If the client develops major depression, discontinue the POPs and refer for mental health and psycho-social support, if available.* Local remedies may also be helpful.

Injectables

Progestin-only injectable contraceptives (PICs)

Progestin-only injectable contraceptives (PICs) contain a long-lasting synthetic formulation of the hormone progesterone. PICs are injected into a woman's body every two or three months (depending on the formulation) to prevent pregnancy from occurring. PICs work primarily by suppressing ovulation. Other contraceptive effects include thickening of the cervical mucus, which prevents sperm from penetrating into the upper reproductive tract and thinning of the endometrium, which interferes with implantation.

PICs come in different formulations with different dosing intervals:

- *DMPA* (also known as *Depo-Provera, Depo, Megestron* and *Petogen*) is given as a deep intra-muscular injection once every three months.
- In some regions, DMPA is also available in a formulation for sub-cutaneous injection, which is also given every three months. Sub-cutaneous DMPA has lower hormone concentrations and may be associated with fewer side-effects. It is important to note that the sub-cutaneous formulation should not be administered intra-muscularly, nor should the intra-muscular formulation be administered sub-cutaneously.
- *NET-EN* (also known as *Noristerat* and *Syngestal*) is also given as a deep intra-muscular injection once every two months.

Table 5: BENEFITS OF PROGESTIN-ONLY INJECTABLES

Contraceptive Benefits	Non-contraceptive Benefits	Limitations
■ highly effective ■ easy to use ■ safe ■ discreet ■ effective immediately (within 24 hours) ■ reversible ■ no pelvic examination required ■ no oestrogen-related side effects.	■ protects against endometrial cancer ■ protects against uterine fibroids ■ reduces monthly menstrual flow ■ protects against iron-deficiency anaemia ■ reduces symptoms of endometriosis and uterine fibroids ■ decreases sickle cell crises.	■ does not protect against STI or HIV ■ return to fertility may be delayed several months after discontinuing (average of 10 months with DMPA and six months with NET-EN) ■ may cause bleeding irregularities ■ may cause headaches or decreased libido ■ may cause weight gain.

Who can use PICs?

- women who want a highly-effective, long-acting and discreet form of contraception
- women who or prefer not to (or are unable to) adhere to a daily dosing schedule
- women who are post-partum who are breastfeeding (after six weeks) or not breastfeeding
- women who have had miscarriage or abortion
- women who smoke, regardless of age or the number of cigarettes smoked per day
- women with obesity, anaemia, sickle cell disease, thyroid disease, valvular heart disease or mild hypertension (<160/100 mmHg)
- women with varicose veins
- women who are HIV+, regardless of whether they are on ART (HIV+ women should be counselled to also use condoms for dual protection).

Who should not use PICs?

- breastfeeding women less than six weeks post-partum
- women with active liver disease (jaundice, viral hepatitis, severe cirrhosis, benign or malignant liver tumours)
- women with unexplained abnormal vaginal bleeding
- women with breast cancer or a history of breast cancer
- women with current or history of ischaemic cardiovascular disease or CVA
- women with current DVT or PE
- women with diabetes mellitus complicated by vascular disease
- women with high blood pressure >160/100mmHg.

Client instructions for using PICs

If using DMPA, return to the health facility every three months for an injection. You may receive the injection from two weeks before to two weeks after the scheduled date for repeat injection.

If using NET-EN, return to the health facility every two months for an injection. You may receive the injection from two weeks before to two weeks after the scheduled date for repeat injection.

Special instructions: Missed or late for injection date

Within two weeks of missing an injection:
If you forget to return or are unable to receive the next injection for any reason, remember that you can still receive the injection up to two weeks after the scheduled date and there is no need to use a backup method.

More than two weeks after missing an injection:
You may still receive the injection more than two weeks after the scheduled date, if you are reasonably certain that you are not pregnant. *You will need to use a backup method for the first seven days after the injection*.

Client instructions for starting PICs

In general, PICs can be started at any time during the menstrual cycle, as long as you are reasonably certain that the client is not pregnant. The following table provides guidelines for starting PICs and assumes reasonable certainty that the client is not pregnant.

Table 6: CLIENT INSTRUCTIONS FOR USING PICs			
Criteria	**Start**	**Backup Method**	**Comments**
Menstruating women	Any time	7 days	Start on days 1-7 of cycle does not require backup
Amenorrhoeic women	Any time	7 days	
Post-partum women			
Exclusively breastfeeding (no menses)*	6 months post-partum	7 days if ≥ 6 months	No backup required before 6 months
Partially breastfeeding (no menses)*	6 weeks post-partum	7 days	
Not breastfeeding	Immediately	7 days if > 4 weeks	Start 0-4 weeks post-partum does not require backup
Post-abortion women			
≤ 7 days post-abortion	Immediately	NO	
> 7 days post-abortion	Any time	7 days	
Women switching from modern method			
Switching from a hormonal method	Immediately	NO	Assumes correct and consistent use of the method and no break between methods.
Switching from another injectable	When injection is due	NO	
Non-hormonal method	Any time	7 days	
Switching from IUD	Immediately	NO	
Women who have taken ECP	Immediately OR days 1-7 of menstrual cycle	7 days	

*If menses have resumed post-partum, follow the instructions for menstruating women.

Side effects of PICs

Bleeding changes, including spotting, heavy or prolonged bleeding and amenorrhoea may be seen with PICs and are not usually an indication to discontinue the method. Re-assure clients that these changes are common and are usually not harmful. Any bleeding that persists or that begins after the client has been taking POPs for several months requires gynaecological evaluation to assess for non-method-related causes.

Headaches that are mild or migraine headaches without aura can be treated symptomatically and are not an absolute indication to discontinue the method. Migraine headaches with aura or headaches that become more frequent or more severe while receiving injections are indications to discontinue the method and switch to a non-hormonal method.

Weight gain *may average 1-2 kg per year. Review the client's diet with her and discuss weight loss with her.*

Mood changes, depression, change in sex drive may or may not be related to injections. *If the client develops major depression, discontinue the injections and refer for mental health and psycho-social support, if available.* Local remedies may also be helpful.

Infection or inflammation at the injection site is not common.

Combined injectable contraceptives (CICs, monthly injectables)

Combined injectable contraceptives (CICs) contain oestrogen and progestin and are administered intra-muscularly once per month. The mechanism of action of CIC is similar to that of COCs: prevention of ovulation and thickening of cervical mucus. CICs are highly effective when injections are received on schedule.

Table 7: BENEFITS OF CICs		
Contraceptive Benefits	**Non-contraceptive Benefits**	**Limitations**
▪ highly effective when repeat doses are received on time.	▪ discreet ▪ does not require pelvic examination, breast examination or lab tests.	▪ return to fertility is slightly longer than other methods.

Who can use CICs?

Most women can use monthly injections safely, including;

- women who are willing/able to comply with a monthly dosing schedule
- women who have recently had an abortion or miscarriage
- women who smoke and are under 35 years old
- women who smoke <15 cigarettes a day and are over 35
- women with current or history of anaemia
- women with varicose veins
- HIV+ women, regardless of whether they are on ART (HIV+ women should be counselled to also use condoms for dual protection).

Who should not use CICs?

- exclusively breastfeeding mothers before six months post-partum
- women who are over 35 years of age and smoke >15 cigarettes per day
- women with active liver disease
- women with hypertension (BP ≥ 160/100 mmHg)
- women with current or a history of ischaemic heart disease, DVT, PE or stroke
- women with unexplained or suspicious vaginal bleeding
- women with a history of clotting disorder
- women with current or history of breast cancer
- women with migraine headaches with aura.

Client instructions for starting CIC

In general, CICs can be started at any time during the menstrual cycle, as long as you are reasonably certain that the client is not pregnant. The following outlines the client instructions for starting CIC, assuming reasonable certainty that the client is not pregnant.

Table 8: CLIENT INSTRUCTIONS FOR STARTING CIC

Criteria	Start	Backup Method	Comments
Menstruating women	Any time	7 days	Start on days 1-7 of cycle does not require backup
Amenorrhoeic women	Any time	7 days	
Post-partum women			
Exclusively breastfeeding (no menses)*	6 months post-partum	7 days	No backup required before 6 months
Partially breastfeeding (no menses)*	6 weeks post-partum	7 days	
Not breastfeeding	21 days post-partum	7 days if ≥ 4 weeks	Start at 21-28 days does not require backup
Post-abortion women			
≤ 7 days post-abortion	Immediately	NO	
> 7 days post-abortion	Any time	7 days	
Women switching from modern method			
Switching from a hormonal method	Immediately	NO	Assumes correct and consistent use of the method and no break between methods.
Switching from another injectable	When injection is due	NO	
Non-hormonal method	Any time	7 days	
Switching from IUD	Immediately	NO	
Women who have taken ECP	Immediately	7 days	

*If menses have resumed post-partum, follow the instructions for menstruating women.

Side effects of CIC

Most side effects are temporary and do not require discontinuation or changing of methods. Counsel the client thoroughly about possible side effects before providing the CIC and advise her that it is important to continue using the method in order to avoid unwanted pregnancy. If the side effects are severe, if they persist after several months, or if they appear suddenly after several months of using the method, alternative methods should be considered.

Bleeding changes, especially spotting and heavy or prolonged bleeding are common side effects of CIC. If the spotting or heavy bleeding continues or if it causes other health issues, discontinue CICs and offer an alternative contraceptive method. If bleeding begins suddenly after the client has been receiving the injections for some time with normal periods or no bleeding, a gynaecological evaluation is indicated to assess for non-method-related causes of bleeding.

Weight gain, breast tenderness, mild headaches and dizziness are usually not indications to discontinue the method. Management is symptomatic. Local remedies may be helpful.

Migraine headaches with or without aura are an indication to discontinue CIC if the client develops them or if they become worse after starting the method. Counsel the client on other methods and help her select one that does not contain oestrogen.

Procedure for giving injectable contraceptives

1. Prepare supplies:
    - vial of contraceptive or pre-filled syringe (it is best to use single-dose vials, if possible)
    - 2ml disposable syringe (unused)
    - 21 - 23 gauge sterile needle
2. Wash your hands with soap and water.
3. Clean the injection site if it is dirty (it is not necessary to use antiseptic).
4. Warm the vial to room temperature if it is cold. Gently shake DMPA-containing formula before drawing up the medication (NET-EN containing preparations do not require shaking).
5. Draw the dose of medication into the syringe.
6. Inject the medication:
    - PICs (DMPA, NET-EN) are given by deep intra-muscular injection to the hip, buttock, or arm, depending on the client's preference.
    - CICs are given by deep intra-muscular injection to the hip, buttock, arm, or thigh, depending on the client's preference.
7. Do not rub the site after injecting (instruct the client not to rub the site as well).
8. Dispose of needles and syringes safely.
9. Advise the client when she should return for her next injection (providing a reminder card with the date of the next injection may be helpful).

CONTRACEPTIVE IMPLANTS

General Information

Implants are small hormone-bearing capsules or rods, which when inserted under the skin of a woman's upper arm, slowly release the hormone progestin to prevent pregnancy over a long period of time. They work primarily by thickening the cervical mucus, thus preventing sperm from penetrating into the female upper reproductive tract, and by suppressing ovulation. Implants also cause thinning of the endometrium, which makes implantation less likely.

There are several different types of implants available, with varying numbers of rods and durations of effectiveness. Jadelle and Implanon are two implants that are widely available:

- Jadelle uses two rods and is effective for five years
- Implanon uses one rod and is effective for three years.

Table 9: BENEFITS OF IMPLANTS

Contraceptive Benefits	Non-contraceptive Benefits	Limitations
■ highly effective ■ safe ■ easy to use ■ protection is continuous and long-term ■ effective 24 hours after insertion ■ immediate return to fertility ■ pelvic examination not required.	■ discreet ■ reduces the risk of symptomatic PID ■ reduces the risk of ectopic pregnancy ■ does not affect breastfeeding ■ may protect against anaemia ■ no oestrogen-related effects ■ may reduce menstrual flow.	■ must be inserted and removed by trained providers ■ IP measures must be followed during insertion and removal ■ removal may be difficult (especially if not properly inserted or provider is not skilled at removal) ■ expulsion may rarely occur ■ may cause menstrual changes (spotting, prolonged bleeding, amenorrhoea) ■ does not protect against STI or HIV ■ may cause ovarian cysts.

Who can use implants?

- women who want a discreet, long-lasting, highly-effective method of contraception
- women with sickle cell disease
- women who are post-partum, whether they are breastfeeding (after six weeks) or not breastfeeding
- women who have just had an abortion, miscarriage or ectopic pregnancy
- women who smoke, regardless of their age or the number of cigarettes they smoke per day
- women with varicose veins
- women who are HIV+, regardless of whether they are on ART (HIV+ women should be counselled to also use condoms for dual protection).

Who should not use implants?

- breastfeeding women less than six weeks post partum
- women with active liver disease (jaundice, viral hepatitis, severe cirrhosis, benign or malignant liver tumours)
- women who have undiagnosed abnormal vaginal bleeding
- women with breast cancer or history of breast cancer
- women with migraine headaches with aura
- women with current DVT or PE
- women with current or history of ischaemic heart disease or stroke
- women receiving treatment with rifampicin, seizure medications or ARVs that affect liver enzymes.

Client instructions for starting implants

In general, implants can be inserted at any time during the menstrual cycle, as long as you are reasonably certain that the client is not pregnant. The following table provides guidelines for starting implants and assumes reasonable certainty that the client is not pregnant.

Table 10: CLIENT INSTRUCTIONS FOR STARTING IMPLANTS

Criteria	Start	Backup Method	Comments
Menstruating women	Any time	7 days	Start on days 1-5 (Implanon) or 1-7 (Jadelle) of cycle does not require backup
Amenorrhoeic women	Any time	7 days	
Post-partum women			
Exclusively breastfeeding (no menses)*	6 months post-partum	7 days if > 6 months	Start 6 weeks to 6 months does not require backup
Partially breastfeeding (no menses)*	6 weeks post-partum	7 days	
Not breastfeeding	Immediately	7 days if ≥ 4 weeks	Start at 0-4 weeks does not require backup
Post-abortion women			
≤ 7 days post-abortion	Immediately	NO	
> 7 days post-abortion	Any time	7 days	
Women switching from modern method			
Switching from a hormonal method	Immediately	NO	Assumes correct and consistent use of the method and no break between methods.
Switching from another injectable	When injection due	NO	
Non-hormonal method	Any time	7 days	
Switching from IUD	Immediately	NO	
Women who have taken ECP	Immediately	7 days	

*If menses have resumed post-partum, follow the instructions for menstruating women.

Side effects and complications of implants

- **Bleeding changes**, including spotting, prolonged or heavy bleeding and amenorrhoea are very common and are usually not an indication for changing methods. Bleeding changes may decrease after the first few months. If spotting or heavy bleeding persists for several months, if a client with implants and either normal periods or no bleeding suddenly begins to have unusual bleeding, a gynaecological evaluation is indicated to evaluate for non-method-related causes of bleeding before removing the implants.
- **Headaches** that are mild or migraine headaches without aura can be treated symptomatically. Migraine headaches with aura or headaches that become more frequent or more severe after implants are inserted are indications to discontinue the method and switch to a non-hormonal method.
- **Local pain after implant insertion or removal** that is not associated with infection may be treated symptomatically with paracetamol or ibuprofen.
- **Infection or inflammation at the implant site** should be treated for 7-10 days with oral antibiotics. DO NOT remove the implants unless the infection persists after antibiotic treatment.
- **Abscess at the implant site** should be incised and drained and treated with antibiotics for 7-10 days. DO NOT remove the implants unless the infection persists.
- **Expulsion of implants** is not common, but may occur with or without previous infection.
- **Weight gain, breast tenderness, nausea or dizziness** may occur. Management is symptomatic. Local remedies may be helpful.
- Mood changes, depression, change in sex drive may or may not be method-related. *If the client develops major depression, refer for mental health and psycho-social support, if available.* Locally available remedies may also be helpful.

Implant insertion procedure

Implants should only be inserted by trained providers who are familiar with the procedure. The insertion technique will vary slightly, depending on the type of implants used. For example, some implants (such as Implanon) are supplied in pre-loaded applicators, which do not require the use of a trochar for insertion.

1. Introduce yourself to the client if necessary and explain the procedure to her. Explain that she may feel some pressure or tugging during the procedure, but that it should not be painful. Answer any questions that she has prior to beginning the procedure.
2. Position the client and ensure that she is comfortable. Usually, the procedure is performed with the client lying on her back with the arm in which the implant will be inserted (usually the non-dominant arm) supported. If the client or the provider prefers, the procedure can be performed with the client sitting up and the arm supported.
3. Ensure that the insertion site (inner aspect of the upper arm) is clean.
4. Before beginning the procedure, arrange the materials and instruments on a sterile tray or trolley so that they are easily accessible. (Aseptic technique should be used during the procedure).
5. Using aseptic technique, prep and drape the insertion site.
6. Anaesthetise the area where the implants will be inserted (at the trochar entry point and along the sub-dermal tracts for implants) with 1% local anaesthetic without adrenaline (epinephrine). Ensure that anaesthetic is not being injected into a blood vessel by drawing back on the syringe slightly before injecting.
7. Make a small incision at the trochar entry point with a scalpel blade tip and insert the trochar and plunger into the incision until the distal mark on the trochar is at the level of the incision.
8. Remove the plunger and place it on the sterile tray, but do NOT remove the trochar.
9. Load the implant capsule into the trochar and re-insert the plunger until you feel some resistance.
10. Gently slide the trochar back (but do not remove it) while holding the plunger in place, leaving the implant in the sub-dermal tract.
11. Withdraw the trochar and plunger until the proximal mark on the trochar is at the skin incision. **Do not remove the trochar from the incision.**
12. Repeat the procedure until all implants are inserted (two for Jadelle).
13. Apply pressure with two fingers at the incision site to prevent bleeding.
14. Palpate the implants to ensure that they are in place and not protruding from the incision site.
15. Apply an adhesive bandage to the incision site, cover with sterile gauze and wrap with gauze dressing.
16. Observe the client for bleeding prior to discharge.

Client instructions after insertion of implants

Keep insertion site dry for four to five days. Remove the gauze dressing after one to two days, but leave the adhesive bandage in place for five days. It is normal to feel some soreness in the arm after the anaesthetic wears off. Return to the health facility if the implants start to come out, if soreness in the arm lasts more than a week or at any time if the area becomes red, hot, swollen, very painful or you notice pus. See a health provider to have the implants replaced or removed before they lose their effectiveness (give the client a card with the date for removal or replacement).

Implant removal procedure

1. Explain the procedure to the client. Advise her that she will feel some pressure or pulling but that procedure should not be painful.
2. Position the client and her arm. Palpate the arm to locate the implants and mark the skin.
3. Use aseptic technique. Prep the area. Put on sterile gloves and drape the area.
4. Anaesthetise the area (incision site and sub-dermal tracts) with 1% local anaesthetic without adrenaline (epinephrine). Ensure that anaesthetic is not injected into a blood vessel by drawing back slightly on the plunger of the syringe before injecting.
5. Make a small incision with a scalpel blade tip.
6. Insert a mosquito forceps into the incision and grasp the nearest implant. Rotate the forceps until the end of the implant pops into the incision.
7. Rotate the forceps 1/2 turn. Using the tip of the scalpel, scrape off any fibrous tissue from the implant.
8. Gently remove the implant.
9. Repeat this procedure for each implant.
10. Hold pressure over the incision site to prevent bleeding. Apply an adhesive bandage and a gentle pressure dressing to the site.
11. Advise the client to keep the pressure dressing in place for two to three days to minimise swelling.
12. If implants are to be replaced, insert the new implants either above or below the previous site, or in the other arm.
13. Observe the client for bleeding prior to discharge.

INTRA-UTERINE DEVICES (IUDs)

General Information

An intra-uterine contraceptive device (IUD) is a small plastic device containing copper or a steroid hormone (levonorgestrel or progesterone) that is placed high in the uterus (at the uterine fundus) to prevent pregnancy. IUDs work primarily by preventing fertilisation and by causing changes to the endometrium that prevent implantation.

There are several different types of IUDs with varying lengths of effectiveness. The Copper T380A IUD has a duration of effect of 12 years. Mirena, a levonorgestrel-containing IUD (LNG-IUD), has a duration of effect of five years.

Table 11: BENEFITS OF IUDs

Contraceptive Benefits	Non-contraceptive Benefits	Limitations
■ highly-effective, long-term protection against pregnancy ■ safe ■ immediate return to fertility after removal.	■ protects against ectopic pregnancy ■ may increase sexual enjoyment ■ does not interfere with sexual intercourse ■ does not interfere with breastfeeding. *Copper-bearing IUD:* ■ does not affect breast milk and can be inserted immediately post-partum ■ no hormonal side effects ■ no drug interactions ■ may protect against endometrial cancer. *Hormone-releasing IUD:* ■ reduces menstrual flow and cramps ■ reduces symptoms of endometriosis ■ protects against anaemia ■ may protect against PID ■ reduces need for hysterectomy in up to 85% of women with bleeding related problems.	■ insertion and removal require trained providers ■ uterine perforation may occur ■ IP measures must be followed during insertion and removal ■ client cannot discontinue method on her own ■ IUD may be expelled or migrate ■ does not protect against STI/HIV ■ copper-bearing IUD may increase menstrual bleeding and cramping during the first few months.

Who can use IUDs?

- women who want long-term, highly-effective protection against pregnancy
- women who are post-partum (four weeks for hormonal IUD and between 0 and 48 hours for copper-bearing IUD)
- women who have had a first trimester abortion (if there is no evidence of infection)
- women who have had an ectopic pregnancy
- women who have delivered by caesarean section
- women with irregular menstrual cycles
- women with history of PID
- women with anaemia
- women with diabetes with or without complications
- women who are HIV+ or women who have AIDS and are on ART and clinically well (HIV+ women should be counselled to also use condoms for dual protection).

Copper-bearing IUDs can be used in:

- women with multiple risk factors for cardiovascular disease (smoking, diabetes, hypertension)
- women of any age
- women with current ischaemic heart disease, DVT or PE, stroke and uncomplicated valvular heart disease
- women with current or history of breast cancer
- women with liver and gall bladder diseases.

Who should not use IUDs?

- women who are between 48 hours and five weeks post-partum
- women with PID, purulent cervicitis, puerperal sepsis or immediately after a septic abortion
- women who are at high risk of gonorrhoea and/or chlamydia infection
- women with unexplained vaginal bleeding that has not been evaluated
- women with pelvic cancer (cervical, endometrial or ovarian)
- women with congenital uterine abnormalities or tumours of the uterus which distort the cavity
- women known to have pelvic tuberculosis

Women should not use hormone-containing IUDs if they:

- are less than four weeks post-partum
- have current DVT or PE
- have active liver disease
- have current or history of breast cancer.

When to insert IUD?

In general, IUDs can be inserted at any time, as long as you are reasonably certain that the client is not pregnant, although in some circumstances, it is necessary to confirm that the client is not pregnant prior to inserting the IUD. The tables below provide guidelines for when copper-bearing IUDs and LNG-IUDs can be inserted.

Table 12: WHEN TO INSERT COPPER-BEARING IUDs?

Criteria	Start	Pregnancy Test	Backup Method	Comments
Menstruating women	Any time	NO	NO	
Amenorrhoeic women	Any time	YES	NO	
Post-partum women				
Immediately post-partum	0-48 hours post-partum	NO	NO	If not inserted within 48 hours, wait until at least 4 weeks
Exclusively breastfeeding (no menses)*	4 weeks post-partum	NO	NO	
Partially breastfeeding (no menses)*	4 weeks post-partum	YES	NO	
Not breastfeeding	4 weeks post-partum	YES	NO	
Post-abortion women				
≤ 12 days post-abortion (1st/2nd trimester only)	Immediately	NO	NO	If infection present, must treat infection before inserting IUD
> 12 days post-abortion (1st/2nd trimester only)	Any time	NO	NO	

Table 12: When to Insert Copper-bearing IUDs? (cont'd)

Criteria	Start	Pregnancy Test	Backup Method	Comments
Women switching from modern method				
Switching from a hormonal method	Immediately	NO	NO	Assumes correct and consistent use of the method and no break between methods.
Switching from injectable	When injection due	NO	NO	
Non-hormonal method	Any time	NO	NO	
Women who have taken ECP	Immediately	NO	NO	

*If menses have resumed post-partum, follow the instructions for menstruating women.

Table 13: WHEN TO INSERT LNG-IUDs?

Criteria	Start	Pregnancy Test	Backup Method	Comments
Menstruating women	Any time	NO	7 days	No backup required if start on days 1-7
Amenorrhoeic women	Any time	YES	7 days	
Post-partum women				
Immediately post-partum	NO			
Exclusively breastfeeding (no menses)*	4 weeks post-partum	NO	7 days if > 6 months post-partum	No backup required from 4 weeks to 6 months post-partum
Partially breastfeeding (no menses)*	4 weeks post-partum	YES	7 days	
Not breastfeeding	4 weeks post-partum	YES	7 days	
Post-abortion women				
≤ 7 days post-abortion (1st/2nd trimester only)	Immediately	NO	NO	If infection present, must treat infection before inserting IUD
> 7 days post-abortion (1st/2nd trimester only)	Any time	NO	7 days	
Women switching from modern method				
Switching from a hormonal method	Immediately	NO	NO	Assumes correct and consistent use of the method and no break between methods.
Switching from injectable	When injection due	NO	7 days	
Non-hormonal method	Any time	NO	7 days	
Women who have taken ECP	Immediately	NO	NO	

*If menses have resumed post-partum, follow the instructions for menstruating women.

Side effects and complications of IUDs

- **Bleeding changes** are very common with both copper-bearing and hormonal IUDs. Amenorrhoea is most common with LNG-IUD. Heavy vaginal bleeding is most common with the copper-bearing IUDs. Irregular vaginal bleeding is common with both copper-bearing and hormonal IUDs. A gynaecological examination is indicated if the bleeding persists, or if a client develops heavy or irregular vaginal bleeding long after the IUD was inserted to assess for a non-method-related cause.
- **Cramping** commonly occurs immediately after IUD insertion and is also very common during the first three to six months of IUD use. It may also be associated with menstrual periods, PID, partial expulsion of the IUD, uterine perforation or ectopic pregnancy.
- **Missing strings** could be a sign of expulsion or uterine perforation. If the client knows that the IUD fell out, rule out pregnancy, provide a backup method and insert a new IUD during her next menstrual period.
- **Severe abdominal pain** may suggest uterine perforation, PID or ectopic pregnancy.

Client instructions for use of IUDs

- The IUD has been inserted into your uterus and once it is there you are not likely to become pregnant.
- The Copper T380A can remain in the uterus for 12 years. The Mirena can remain for five years.
- Each month after your menstrual period, you should check the placement of your IUD by inserting one finger into your vagina to feel for the strings (your partner may also help you to do this). If you do not feel the strings, the IUD may have become dislodged. Come to the health facility immediately for evaluation.
- Check your sanitary pads after every month before throwing them away because sometimes IUDs may come out. If this happens, go to the health facility immediately for evaluation. If the IUD has fallen out, you are not protected from pregnancy. You must use a backup method to prevent pregnancy until the IUD is re-inserted or you start another method.
- Return to the clinic if you notice any danger signs, such as severe abdominal pain, pain during sex, unusual vaginal discharge, nausea/vomiting, fever or chills or if you think that you might be pregnant.
- You should have a check-up once per year at the health facility.

IUD insertion procedure

1. Introduce yourself to the client, if you have not done so already. Show her an IUD and explain the procedure to her. Advise her that she may feel some cramping or pressure during the procedure but that it should not be painful. Tell her to let you know whether she feels pain at any time during the procedure.
2. Have all of the instruments and supplies prepared before beginning the procedure.
3. Wearing clean gloves, perform an external genitalia and bi-manual pelvic examination, assessing for discharge, masses or abnormalities of the vagina and cervix. Assess the size, position and consistency of the uterus. Assess for cervical motion tenderness, suggestive of PID (if you suspect that the client has PID, do NOT insert the IUD at this time).
4. Wearing sterile gloves, insert a sterile or high-level disinfected speculum into the vagina and visualise the cervix. Tighten the thumb screws when the cervix is in view.
5. Clean the vagina and cervix with antiseptic solution, such as povidone-iodine or chlorhexidine. Clean the cervix using a circular motion, starting from the os and moving outward.
6. Pass the tenaculum through the speculum and gently grasp the cervix to stabilise the cervix and uterus (the client may feel a pinching sensation or discomfort at this point).
7. Slowly pass the uterine sound through the cervical os to assess the uterine position and to measure the depth of the uterine cavity.
8. Without opening the sterile packaging, load the IUD onto the inserter. Remove the IUD and inserter from the sterile packaging without allowing them to touch any un-sterile surfaces.
9. Slowly and gently insert the IUD through the cervix and to the indicated depth in the uterus. Remove the inserter.
10. Cut the strings of the IUD, leaving 3-4 cm in the vagina.
11. Gently release and remove the tenaculum. If there is any bleeding of the cervix, apply pressure. Remove the speculum.
12. Allow the client to rest on the couch/table until she feels ready to get up.

IUD removal procedure

IUD removal is a simple procedure that can be done at any time of the month, although removal may be easier during menstrual bleeding.

1. Explain the procedure to the client. Advise her that she might feel some mild discomfort or cramping, but that it should not be painful. Ask her to let you know whether she experiences any pain during the procedure.
2. Insert a speculum into the vagina to visualise the cervix. Tighten the thumb screws when the cervix is in place.
3. Clean the cervix with an antiseptic solution such as povidone-iodine or chlorhexidine.
4. Using a hemostat or other narrow forceps, grasp the strings close to the cervix and pull slowly and gently until the IUD is completely removed. Do not use force.
5. Show the IUD to the client. If the IUD is to be replaced, the new IUD can be inserted immediately.

BARRIER METHODS

Barrier methods prevent the sperm from gaining access to the upper reproductive tract, thus preventing fertilisation from occurring. There are several types of barrier methods, including:

- male condoms
- female condoms
- diaphragm and cervical cap
- spermicides, such as foaming tablets, creams, suppositories, jellies and film.

Male and female condoms will be covered in this manual.

Male Condoms

A male condom is a thin sheath, usually made of latex rubber, which is put over the erect penis before sex and is removed immediately after ejaculation. The male condom acts as a barrier, preventing sperm from entering the vagina and cervix. It also protects against transmission of STI/HIV from one partner to the other.

Who should use male condoms?

Male condoms are safe and can be used by almost all men and women.

Who should not use male condoms?

- People with severe allergies to latex rubber (men and women).

Using a male condom

1. Check the condom package to ensure that it is intact. Check the expiry date.
2. Carefully open the package so that the condom does not tear (do not use your teeth or any sharp instrument to open the package). Inspect the tip of the condom and position the condom so that it will roll down the shaft of the penis.
3. Squeeze the tip of the condom and put it on the end of the erect penis.
4. Unroll the condom carefully down the shaft to the base of the erect penis. If the condom does not unroll easily or if it tears, it may be too old or it may be on backward. Discard the condom and start the process again with a new one.
5. After ejaculation (coming) and while the penis is still erect, grasp the condom at the base of the penis and hold it in place as you withdraw the penis. Be careful not to spill the contents as you withdraw the penis.
6. Remove the condom carefully to prevent spilling the semen and dispose of it by wrapping and putting it in the rubbish bin or down a latrine (not in a flush toilet).

Side effects of male condoms

- **Allergy or Irritation:** Latex allergies do occur, but are very uncommon. If local irritation occurs on the penis or vagina, first try changing to a different brand of condom. Using lubrication (water or a water-based lubricant) may also help by reducing rubbing that can cause irritation. If the irritation persists, evaluate for infection.

Table 14: BENEFITS OF MALE CONDOMS

Contraceptive Benefits	Non-contraceptive Benefits	Limitations
■ 98% effective if used consistently and correctly (85% effective as commonly used) ■ immediately effective ■ no hormonal side effects ■ easy to obtain.	■ protects against STI/HIV with consistent and correct use ■ may prevent premature ejaculation ■ can be used without the help of a health provider.	■ a new condom must be used for each act of sex ■ must be used consistently and correctly for maximum effectiveness ■ can be damaged by oil-based lubricants, excessive heat, humidity or light ■ requires co-operation of both partners to use.

Table 15: BENEFITS OF FEMALE CONDOMS		
Contraceptive Benefits	**Non-contraceptive Benefits**	**Limitations**
■ 95% effective if used consistently and correctly ■ 79% effective as commonly used ■ effective immediately ■ female-controlled method ■ easy to use ■ no associated health risks.	■ provides protection against STI/HIV with consistent and proper use ■ outer ring provides additional sexual stimulation for some women ■ can be inserted before sex so it does not interrupt sex ■ does not have to be removed immediately after ejaculation.	■ must be inserted before sexual intercourse ■ insertion may be cumbersome ■ may be noisy during sexual intercourse ■ expensive; single-use only.

Female Condoms

The female condom is a soft, loosely-fitting sheath made of plastic or latex that fits inside of the vagina to protect against pregnancy and STI/HIV. The female condom has flexible rings at each end. The ring at the closed end of the sheath fits into the vagina and serves as an anchor over the cervix. The outer ring forms the external edge of the device and remains outside the vagina after insertion, providing protection to the base of the labia and the base of the penis during intercourse. The female condom works by acting as a barrier, preventing sperm from entering the vagina and the cervix. It also provides protection from transmission of STI/HIV between partners.

Who should use the female condom?

- all women, regardless of age, marital status or parity
- women of reproductive age, including adolescents and women over 40
- women who have had children and women who have not had children
- women needing a backup method
- women needing a temporary method of contraception
- women with contraindications to hormonal methods
- women who are breastfeeding.

Who should not use the female condom?

- there are no medical conditions that restrict its use
- women who are allergic to latex *(see the section above under Male condoms, for information about allergy to latex female condoms)*.

Using the female condom

1. Use a new condom for each sex act. The female condom can be inserted up to eight hours before having sex.
2. Check the condom package to ensure that it is not damaged. Check the expiry date.
3. Wash your hands if possible and choose a comfortable position for inserting the condom (lying, squatting, sitting, standing with one leg raised).
4. Carefully open the package and remove the condom.
5. Rub the sides of the condom together to spread lubricant.
6. Squeeze the inner ring (at the closed end of the condom) between your thumb and middle finger.
7. With the other hand, open the labia and locate the opening of the vagina.
8. Insert the inner ring of the condom as far as it will go into the vagina. Insert your index finger into the condom and push it into place.
9. Ensure that the condom is not twisted and that the outer ring remains outside the vagina.
10. During sexual intercourse, ensure that the penis enters the condom and that it does not come out during sex.
11. If the condom comes out or is pushed into the vagina during sex, carefully replace it.
12. After sex, remove the condom before standing up.
13. Squeeze and twist the outer ring to avoid spilling semen.
14. Dispose of the used condom correctly (wrap it in its package and dispose in latrine or rubbish; do not flush down the toilet, as it can block the plumbing).

Special instructions for female condom users

- use a new condom for each sex act
- use each condom only once
- do not use condoms that may be old or damaged
- dispose of used condoms correctly.

Table 16: BENEFITS OF ECPs		
Contraceptive Benefits	**Non-contraceptive Benefits**	**Limitations**
■ 98-99% effective in preventing pregnancies if taken correctly (depending on formulation).	■ no tests or examinations required before taking pills ■ controlled by the woman ■ client may have them on hand in case of emergency ■ reduces unwanted pregnancy and subsequent seeking of abortion.	■ undesirable hormonal side effects ■ limited timeframe for effectiveness ■ does not protect against STI/HIV ■ does not protect against pregnancy with future sexual intercourse ■ should not be used as a regular contraceptive method.

EMERGENCY CONTRACEPTION

Emergency contraception (EC) refers to contraceptive methods used to prevent pregnancy after unprotected sex. Emergency contraceptive pills (ECPs), sometimes called "morning after" pills or "post-coital" contraception, work primarily by preventing or delaying ovulation.

Several contraceptive formulations can be used for EC. Tablets containing levonorgestrel and combinations of levonorgestrel and ethinyl estradiol are marketed specifically as ECPs. If those formulations are not available, both high-dose and low-dose COCs can also be used (see Table below). It is possible to use POPs for EC, but their use requires taking extremely large numbers of pills, which is not practical in most emergency settings due to supply issues.

Who can use ECPs?

- all women of reproductive age, including women who have contra-indications to hormonal contraceptive methods
- women who have had unprotected sexual intercourse within the last 120 hours, such as:
  - consensual or forced sex
  - condom broke, IUD expelled
  - ran out of oral contraceptives
  - missed three or more POPs
  - is more than two weeks late for PICs.

Who should not use ECPs?

- clients who are already consistently using a reliable contraceptive method
- clients who are known to be pregnant (although ECPs are not known to cause any harm to the woman, her foetus or the course of the pregnancy).

Client instructions for using ECPs

ECPs are effective when taken within five days (120 hours) of unprotected sexual intercourse, but they are more effective the earlier they are taken. Take the pills as instructed (see Table 17 below for examples).

Side effects of ECPs

The most common side effects of ECPs are nausea and vomiting, slight irregular bleeding and changes in the timing of the menstrual period. Re-assure the client that this is expected and is temporary. If menses are delayed, pregnancy should be suspected.

IUD for EC

In addition to ECPs, IUDs can be used for emergency contraception in those women who desire a long-term contraceptive method. More information on this can be found in *Family Planning: A Global Handbook for Providers*.

Table 17: CLIENT INSTRUCTIONS FOR USING ECPs		
Contraceptive Type	**Content**	**Dose**
Progestin-only ECP	Levonorgestrel 0.75mg Levonorgestrel 1.5 mg	2 tabs as single dose 1 tab as single dose
Combined ECP	Ethinyl estradiol 0.05 mg + Levonorgestrel 0.25mg	2 pills now and 2 pills in 12 hours
Low-dose COC	Ethinyl estradiol 0.03mg + Levonorgestrel 0.15mg	4 pills now and 4 pills in 12 hours
High-dose COC	Ethinyl estradiol 0.05mg + Norgestrel 0.50mg	2 pills now and 2 pills in 12 hours

PERMANENT FAMILY PLANNING METHODS

Voluntary Surgical Sterilisation

Voluntary surgical sterilisation, also referred to as voluntary surgical contraception (VSC), is a method of creating permanent sterility by surgical means that must be performed on a voluntary basis. In females, sterilisation is achieved through tubal ligation or tubal occlusion, which prevents fertilisation by cutting or occluding the fallopian tubes. In males, vasectomy is performed to cut the vas deferens, thus preventing the passage of sperm (and preventing fertilisation).

Counselling for voluntary surgical sterilisation

Prior to performing surgical sterilisation, it is important to counsel the client and obtain informed consent for the procedure. Clients must be aware:

- that sterilisation is permanent (irreversible)
- that sterilisation is >99.5% effective
- that alternative, temporary methods (including long-term methods) are available
- of the surgical procedure involved and the possible complications
- of the risks and benefits of and alternatives to surgical sterilisation
- that s/he can change her/his mind at any time before the surgery.

Tubal Ligation (TL)

Who can use TL?

- any women of reproductive age, including young women and women over 40, who have been properly counselled and have given informed consent
- women who are certain they have achieved the desired family size
- women who want a permanent contraceptive method
- clients in whom pregnancy could pose a serious health risk
- women who are post-partum
- women who are breastfeeding
- women who are HIV+, whether or not they are on ART (HIV+ women should be counselled to also use condoms for dual protection).

Who should not use TL?

- clients who are uncertain of their desire for future fertility
- clients who do not give voluntary informed consent
- clients who are currently pregnant.

When should TL be provided with caution?

- women aged <18 years
- women with no living children
- women with history of previous PID
- fixed uterus due to any cause.

Procedures for TL

- *Laparoscopic tubal ligation:* After obtaining informed consent, and ensuring IP procedures, the provider performs a physical and pelvic examination. Laparoscopic TL is performed under light sedation and local anaesthetic. A laparoscope is inserted through a small incision in the woman's abdominal wall and each fallopian tube is occluded, using a clip, a ring or electro-coagulation. After the procedure, the incision is closed with sutures. The client is able to return home after a few hours.
- *Mini laparotomy:* After obtaining informed consent and ensuring IP procedures, the provider performs a physical and pelvic examination. TL by mini laparotomy is performed under light sedation and local anaesthetic. A small incision is made in the woman's abdominal wall. A uterine elevator is inserted into the vagina, through the cervix and into the uterus to raise the fallopian tubes closer

Table 18: BENEFITS OF TUBAL LIGATION

Contraceptive Benefits	Non-contraceptive Benefits	Limitations
■ highly effective ■ immediately effective ■ permanent ■ no side effects ■ does not affect breastfeeding.	■ does not change sexual function ■ does not interfere with intercourse ■ may decrease the risk of ovarian cancer ■ decreases the risk of PID ■ does not require blood tests ■ does not require cervical cancer screening.	■ irreversible ■ risks associated with surgical procedures ■ does not protect against STI/HIV ■ painful in the short term ■ pregnancy risk is low, but if pregnancy occurs, it is more likely to be ectopic ■ can only be provided by a trained provider.

to the incision. Each of the tubes is tied and cut or occluded, using a ring or clip. After the procedure, the incision is closed with sutures. The client is able to return home after a few hours.

Complications associated with TL

Abdominal pain and swelling are common after TL and are most often relieved with analgesics, such as paracetamol or ibuprofen. Clients should also be advised of other post-operative complications, such as bleeding, infection at the wound site and instructed to return to the health facility if these occur.

Vasectomy

Who can use vasectomy?

- men of reproductive age, regardless of age or whether they have had children, if they have received counselling and have given informed consent
- men who have achieved desired family size
- men who have sickle cell disease
- men who are HIV+, regardless of whether they are on ART (HIV+ men should be advised to use also condoms for dual protection).

Who should not use vasectomy?

- clients who are uncertain of their desire for future fertility
- clients who do not give voluntary informed consent.

For whom should vasectomy be provided with caution?

- men with scrotal or testicular abnormalities or men with undescended testicle(s)
- men who have diabetes, depression or are very young.

Procedure for vasectomy (scalpel-less)

No scalpel method: After obtaining informed consent and ensuring IP procedures, the provider palpates and secures one vas deferens with his fingers. Local anaesthetic is used to anaesthetise the scrotal skin. The vas is clamped through the skin at the anaesthetised spot, and the skin is punctured to expose the vas. The vas is cut and ligated with absorbable suture and returned to the scrotum. The procedure is repeated for the other vas. After both vasa have been cut and ligated, pinch the puncture site and apply pressure for a few minutes. There is no need for suture. The client can resume having sex within two to three days, but must use condoms or another FP method for the next 20 ejaculations or for three months after the procedure.

Conventional method: The procedure is the same as above, except one or two small incisions are made in the scrotal skin with a scalpel, in order to expose the vasa.

Complications associated with vasectomy

Complications of vasectomy are uncommon, but may include wound infection, haematoma formation and chronic scrotal or testicular pain.

NEWER CONTRACEPTIVE METHODS

There are several contraceptive methods that have recently emerged, which are not covered in detail in this manual. Service providers should be aware of these methods, in case clients raise questions or in case these methods become available in the areas in which they work.

Contraceptive Patch (OrthoEvra, Evra)

This is a trans-dermal combined hormonal contraceptive patch that is applied to the skin once per week, with one free week every month, i.e. three patches are used every four weeks. Its primary mechanism of action is inhibition of ovulation.

Vaginal Ring (NuvaRing)

This is a flexible ring containing combined hormonal contraceptives that is inserted into the vagina, where the hormones are slowly absorbed through the vaginal mucosa. The ring is left in the vagina for three weeks, followed by one ring-free week. Its primary mechanism of action is inhibition of ovulation.

Table 19: BENEFITS OF VASECTOMY

Contraceptive Benefits	Non-contraceptive Benefits	Limitations
■ highly effective ■ permanent.	■ does not change sexual function ■ does not interfere with sexual intercourse ■ takes the contraceptive burden off of the woman.	■ irreversible ■ not immediately effective: backup method required for first 12 weeks after procedure ■ does not protect against STI/HIV ■ surgical risks ■ can only be offered by a trained provider.

NATURAL FAMILY PLANNING METHODS

Natural family planning (also called "fertility awareness") allows partners to either become pregnant or avoid pregnancy by planning their sexual activity according to the fertile and infertile phases of the woman's menstrual cycle. Abstinence from vaginal sexual intercourse is practised or barrier methods are used during the woman's fertile phase, so that fertilisation does not occur. As commonly used, natural FP methods are about 75% effective in preventing pregnancy. When used consistently and correctly, however, natural methods can be very effective (effectiveness varies by method).

Natural FP methods are classified as *calendar-based* or *symptoms-based*. The table below summarises several natural family planning methods.

Table 20: NATURAL FAMILY PLANNING METHODS

Method	Description	Effectiveness *
Calendar-based Methods		
Calendar rhythm method	The couple keeps track of the woman's menstrual cycles for six months before beginning to calculate the first and last days of her fertile phase. The couple either abstains from vaginal sex or uses a barrier method on the fertile days. The fertile day calculation must be updated every month.	91%
Standard days method	The couple keeps track of the woman's menstrual cycle and either abstains from vaginal sex or uses a barrier method on Days 8-19. May use memory aides, such as CycleBeads to assist with counting days.	95%
Symptoms-based Methods		
Billings (ovulation) method	The woman checks for cervical secretions every day. As soon as she notices secretions, she is considered fertile. The couple abstains from vaginal sex or uses a barrier method until three days after the "peak" day of secretions. After this, the couple resumes unprotected sex until menstrual bleeding begins. After menstrual bleeding has ended, the couple can resume unprotected sex until secretions appear (but should not have sex on two consecutive days).	97%
Two-day method	The woman checks for cervical secretions every afternoon or evening. When she detects secretions, she considers herself fertile on that day and the following day. The couple either abstains from vaginal sex or uses a barrier method on fertile days. The couple may resume unprotected sex as soon as she has had two dry days in a row.	96%
Basal body temperature method (BBT)	The woman monitors her body temperature each morning before she gets out of bed, eats or drinks. The couple abstains from vaginal sex or uses a barrier method from the first day of the menstrual cycle (first day of bleeding) until three days after she notices an increase in her body temperature. After three days of elevated body temperature, the couple may resume unprotected sex.	99%
Sympto-thermal method	The woman monitors basal body temperature and ovulation (using the Billings method). The woman may also monitor other physical signs (breast tenderness, cramping). The couple abstains or uses a barrier method from the first day of the menstrual cycle (first day of bleeding) until the fourth day of cervical secretions or after three full days of elevated body temperature (whichever occurs later).	98%

* Effectiveness assumes correct and consistent use of the method; these rates are not 'as commonly used' rates.

Table 21: BENEFITS OF NATURAL FAMILY PLANNING METHODS		
Contraceptive Benefits	**Non-contraceptive Benefits**	**Limitations**
■ no side effects ■ does not require procedures or supplies.	■ allows women to be aware of their fertility ■ allows some couples to adhere to cultural or religious norms ■ requires male involvement.	■ clients must abstain from sex or use barrier method during fertile phase ■ clients with irregular menstrual cycles should not use calendar-based methods.

LACTATIONAL AMENORRHOEA METHOD (LAM)

The lactational amenorrhoea method (LAM) is a temporary FP method that relies on the natural hormonal suppression of ovulation during exclusive or near-exclusive breastfeeding.

This method is only effective for clients who meet the following three criteria:

- less than six months post-partum
- exclusively (or near-exclusively) breastfeeding an infant frequently during both the day and night
- menstrual periods have not resumed post-partum.

LAM is 99% effective when used correctly during the first six months post-partum.

COITUS INTERRUPTUS (WITHDRAWAL)

Coitus interruptus (withdrawal) is a method by which the man pulls his penis out of the woman's vagina before he ejaculates so that his semen does not enter the vagina or touch her external genitalia. This method is one of the least effective methods: 73% effective as commonly used. This low rate of effectiveness is mostly due to premature ejaculation and to difficulty in consistently sensing ejaculation is about to occur.

ANNEXES

ANNEX A: ESSENTIAL READING LIST

Family Planning: A Global Handbook for Providers. (WHO, JHUCCP/INFO Project, USAID).

Decision-making Tool for Family Planning Clients and Providers (WHO, JHUCCP/INFO Project).

Medical Eligibility Criteria for Contraceptive Use. Third edition. (WHO) Pocket Guide for Family Planning Service Providers (Jhpiego). Available at http://www.reproline.jhu.edu/english/6read/6multi/pg/index.htm

Reproductive Health in Humanitarian Settings: An Inter-agency Field Manual

GATHER Guide to Counselling (Rinehart W, et al) Emergency Contraception in Conflict-Affected Settings (Reproductive Health in Conflict Consortium)

ANNEX B: EFFECTIVENESS OF CONTRACEPTIVE METHODS

The table below lists modern contraceptive methods and their effectiveness

* Correct and consistent use means according to exact instruction of use.

** Commonly used refers to average client compliance.

Table 22: EFFECTIVENESS OF CONTRACEPTIVE METHODS

Method	Description	Effectiveness *	
		Correct consistent use	Common use
Hormonal Methods			
Combined oral contraceptive pills (COC)	One tablet containing oestrogen and progestin taken daily. Suppresses ovulation.	99.7%	92%
Progestin-only pills (POP)	One progestin-containing tablet taken daily. Causes thickening of cervical mucus (inhibiting sperm penetration) and thinning of endometrium (inhibiting implantation)	99.7%	92%
Combined injectable contraceptives	Intra-muscular injection containing oestrogen and progestin received monthly. Suppresses ovulation.	99.7%	97%
Implants	Sub-dermal capsules or rods with variable duration of effectiveness (Jadelle, five years; Implanon, three years). Causes thickening of cervical mucus and suppression of ovulation.	99.95%	99.95%
Intra-uterine Contraceptive Devices			
Copper-bearing IUD	Intra-uterine device with duration of effectiveness of 12 years. Prevents fertilisation and implantation.	99.4%	99.2%
LNG-IUD	Intra-uterine device with duration of effectiveness of 5 years. Prevents fertilisation and implantation	99.8%	99.8%
Barrier Methods			
Male condom	Single use latex (or plastic) sheath that covers penis and prevents fertilisation by blocking the entry of sperm into female reproductive tract during sexual intercourse.	98%	85%
Female condom	Single use plastic (or latex) sheath that fits into vagina and prevents fertilisation by blocking entry of sperm into female reproductive tract during sexual intercourse.	95%	79%
Permanent Methods			
Tubal ligation	Voluntary surgical procedure that cuts or occludes the fallopian tubes, preventing fertilisation.	99.5%	99.5%
Vasectomy	Voluntary surgical procedure that cuts or occludes vas deferens yielding sterile ejaculate.	99.9%	99.85%

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Ref for diagrams of repro organs etc.

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