NURHI

Family Planning
On-the-Job Training Curriculum

Course 2: CLINICAL SERVICE PROVISION TRAINING

FACILITATOR'S MANUAL

NOVEMBER 2012

Produced by Nigerian Urban Reproductive Health Initiative (NURHI), a Bill and Melinda Gates Foundation funded project in Nigeria.

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List of Abbreviations/Acronyms

Abbreviations/Acronyms

ARV	Anti-Retroviral
ASK	Attitudes, Skills and Knowledge
BBT	Basal Body Temperature
CIC	Combined Injectable Contraceptives
COC	Combined Oral Contraceptive
CPR	Contraceptive Prevalence Rate
DMPA	Depot Medroxyprogesterone Acetate
ECP	Emergency Contraceptive Pills
ECS	Endocervical Swab
ELC	Experiential Learning Cycle
FAM	Fertility Awareness-based Methods
FMOH	Federal Ministry of Health
FP	Family Planning
Hb	Haemoglobin
HLD	High Level Disinfectant
HVS	High Vaginal Swab
IDSRS	Integrated Disease Surveillance and Response Strategy
IEC	Information, Education and Communication
IMNCH	Integrated Maternal, Newborn and Child Health
IPPC	Interpersonal Communication
IUD	Intra Uterine Device
LAM	Lactational Amenorrhea Method
LGA	Local Government Area
LMIS	Logistics Management Information Systems
LNG-IUD	Levonorgestrel Intrauterine Device
MDG	Millennium Development Goal
MEC	Medical Eligibility Criteria
Minilap	Minilaparotomy
MNCH	Maternal, Newborn and Child Health
NET-EN	Norethisterone Enanthate
NSF	National Strategic Framework
NURHI	Nigeria Urban Reproductive Health Initiative
OC	Oral Contraceptives
OCP	Oral Contraceptive Pills
OJT	On the Job Training
Pap	Papanicolaou
PCV	Packed Cell Volume
PID	Pelvic inflammatory disease
POP	Progestin Only Pill
SARI	Severe acute respiratory Infection
SARS	Severe acute respiratory syndrome
SEM	Social Ecology Model
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development
VIA	Visual Inspection with Acetic acid
WHO	World Health Organization

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The development of the On-the- Job Training curriculum has been recognised as another milestone in building the technical competence of the health workers in the provision of quality Family Planning service. This achievement has been through the concerted effort of the Ministry and its technical partners.

The Federal Ministry of Health would like to extend its gratitude to individuals and organizations who contributed to the development of On-the-Job Training (OJT) curriculum for health workers in the provision of Family Planning services through **clinical services.** The curriculum will continually strengthen the skills and capacity of health workers, most especially the Nurses/Midwives, who are key health providers at the grass root level.

I commend the support of our esteemed partners particularly Nigerian Urban Reproductive Health Initiative (NURHI) who provided technical support to Federal Ministry of Health in the development of the OJT Curriculum in line with the global concept of continuum of care.

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FOREWORD

The Goal of achieving the health related Millennium Development Goals (MDGs 4, 5 & 6) may not be realized without family planning. Family planning plays a vital role in the health of the individual, family and also contributes significantly to the socio-economic development of a nation. In view of this, there is need to strengthen the health care system to ensure the provision of quality reproductive and family planning health care services across Nigeria. This is in tandem with the new global trends in family planning and reproductive health practice.

Providing quality family planning services to women, men and young people while ensuring that there are no barriers to assessing care is no doubt critical to reduction in maternal and child mortality, unplanned pregnancy, STDs and increasing awareness for child spacing. Thus, it is important that evidence-based information is given to family planning users to enable them make informed choices. Similarly, health providers need current information to facilitate provision of quality family planning services.

In response to this and in recognition of new global trends in family planning, the Federal Ministry of Health in collaboration with the Nigerian Urban Reproductive Health Initiative (NURHI), other development partners and NGOs developed On-the-Job training (OJT) curriculum for training the health workers on **clinical skills services.** The document is developed in line with the recently updated National Training Manual on Family Planning for Physicians and Nurses/Midwives, the service protocols, the Performance Standards for family Planning services in Nigerian Hospitals and 2008 WHO Medical Eligibility Criteria (MEC) and the Performance Standards for Family Planning services in Nigeria.

This approach provides learning through classroom teaching integrated with practical demonstrations of skills by trainees through group exercises and practical experience at the service delivery points. Throughout the duration of the training, participants will be trained to acquire the knowledge, skills and attitudes that are needed to provide quality FP services.

This curriculum will improve the technical competence and confidence of health workers, contribute to increase access to quality family planning service provision and which ultimately will lead to increase contraceptive prevalence rate (CPR) within the country so as to achieve the health related MDGs 4, 5 & 6 by year 2015.

Prof. C. O. Onyebuchi Chukwu
Honourable Minister of Health
November, 2012

AKNOWLEDGED LIST OF CONTRIBUTORS

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INTRODUCTION TO THIS CURRICULUM

1. PROJECT OUTLINE

The Nigeria Urban Reproductive Health Initiative (NURHI) is a five-year project (2009-2014) funded by the Bill and Melinda Gates Foundation to reduce barriers to family planning (FP)/child spacing use and increase the Contraceptive Prevalence Rate (CPR) in selected urban areas of Nigeria. The program brings together private and public sector resources to strengthen the delivery of family health services. NURHI aims to eliminate the supply and demand barriers to contraceptive use in order to significantly increase the CPR over the five-year life of the project in six selected urban cities in Nigeria. NURHI envisions a Nigeria where supply and demand barriers to contraceptive use are eliminated, particularly among the marginalized urban poor.

NURHI has five objectives:

1. Develop cost-effective interventions for integrating quality FP with maternal and newborn health, HIV and AIDS, post-partum and post-abortion care programs.
2. Improve the quality of FP services for the urban poor with emphasis on high volume clinical settings.
3. Test novel public-private partnerships and innovative private-sector approaches to increase access to and use of FP by the urban poor.
4. Develop interventions for creating demand for and sustaining use of contraceptives among marginalized urban populations.
5. Increase funding and financial mechanisms and a supportive policy environment for ensuring access to FP supplies and services for the urban poor.

1.1 The situation of family planning in Nigeria

Data from the 2008 edition of the Nigeria Demographic Health Survey provides a context to situate the need for focusing on-the-job-training (OJT) as an important strategy to reduce barriers to access to and utilization of FP services. Nigeria has a population of over 150 million with over half of these being in the reproductive age group of 15 to 49. The total fertility rate is 5.7% with unwanted pregnancy at 4%, and mistimed pregnancies at 7%. Although there are high levels of knowledge about FP (90% among men and 72% among women), 29% of the population has ever used a method. Current use for FP is 15% for all methods and 10% for modern methods. Nigeria currently has an unmet need of 20%. The role of the private sector in providing FP services is significant: 61% of the population source FP from the private sector of which patent medicine vendors and pharmacies account for about half of this figure. Public sector participation accounts for 23% of FP service provision.

The reality behind these statistics is about the many missed opportunities to help clients access and utilize FP services. Often, providers' attitudes to clients' informed voluntary choices still act as barriers to FP, and gender-inequitable social and cultural norms create further obstacles. The strategic role that FP and maternal, newborn and child health (MNCH) services play towards the Millennium Development Goals (MDGs) is often still not fully understood by heath providers and the community at large, and this weakens efforts to address misconceptions and biases about FP.

OJT can play a very important role to address these issues and increase capacity of FP/MNCH services to minimize missed opportunities to access and use FP.

1.2 Addressing the national strategy and policy context

NURHI works in close collaboration with the Federal Ministry of Health (FMOH) and with State Health Ministries. Therefore this curriculum was designed to support and build on the strengths of existing service protocols and standards. In particular, the following documents were used to guide the design of the curriculum:

- The National Training Manual on Family Planning for Physicians and Nurses/Midwives.
- The National Family Planning/Reproductive Health Service Protocols.
- The Performance Standards for Family Planning Services in Nigerian Hospitals.
- The National Family Planning /Reproductive Health Policy Guidelines and Standards of Practice.
- The Streamlined Contraceptive Logistics Management System (CLMS, 2009) Participant's and Trainer's Guides.
- The USAID | DELIVER PROJECT, Task Order 1. 2009. *The Logistics Handbook: A Practical Guide for Supply Chain Managers in Family Planning and Health Programs.* Arlington, Va.: USAID | DELIVER PROJECT.)
- The Integrated Maternal Newborn and Child Health (IMNCH) Strategy.
- The National Strategic Framework 2010-2015. Policy context and considerations for the development of the National Strategic Framework II (NSF II) 2010-2015.
- The Global HIV/AIDS Initiative Nigeria Technical Strategies.

2. CONCEPTUAL AND METHODOLOGICAL DESIGN OF THE OJT CURRICULUM

2.1 Overall goals of the curriculum

These are to contribute to:

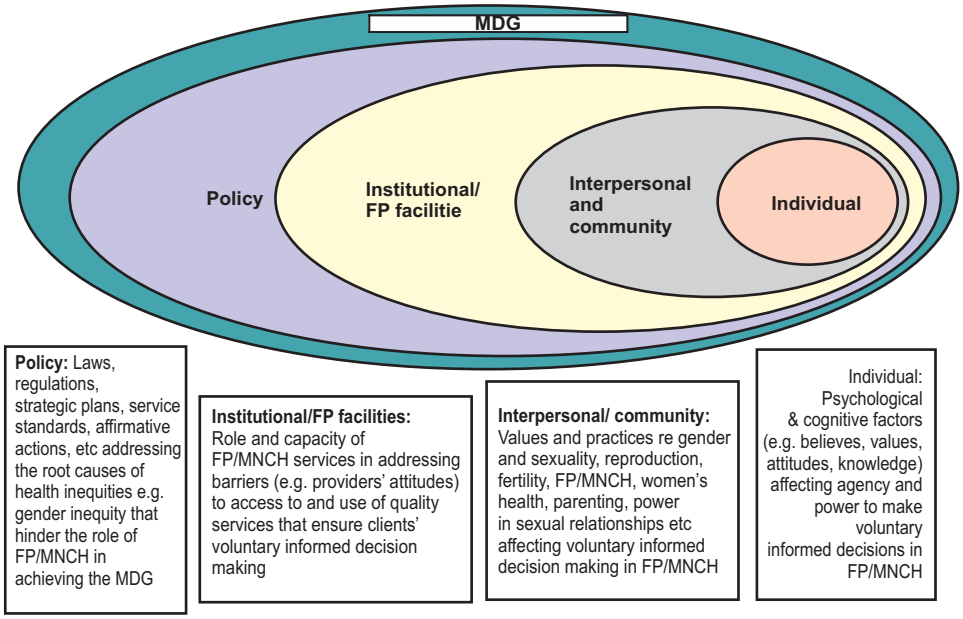
- Strengthening the strategic role of FP/MNCH service provision in achieving the MDG, and especially goals 3, 4, 5, 6, and 7.
- Strengthening quality of FP/MNCH service provision in Nigeria, and especially in high volume sites in urban areas.
- Advancing provision of client-centred integrated FP/MNCH services, and especially in high volume sites in urban areas.
- Removing barriers to access to and use of FP and child-birth spacing methods.
- Increasing the contraceptive prevalence rate in Nigeria.

2.2 The Social Ecology Model as a design framework

This curriculum was designed mirroring the conceptual approach of NURHI, namely the social ecology model (SEM):

- The SEM provides a framework to analyse *the big picture* in various disciplines, including health.
- The SEM looks at how structural and individual factors inter-relate across key spheres of influence to influence health issues. These spheres of influence are: **individual, interpersonal, institutional and policy.** In the case of FP/MNCH services and programs in urban areas of Nigeria, NURHI applied the SEM to analyse how the inter-relations of these spheres of influence affect the strategic role of FP/MNCH services and programs to achieve the MDGs.

Social Ecology of FP/MNCH in the context of achieving MDG in Nigeria



- **Individual sphere of influence**: In order to be able to access and use FP/MNCH services and make voluntary and informed decisions, individuals and couples need to develop an understanding of the issues that affect their lives and an ability to take action on those issues. In other words, they need to have **agency**. But the development and use of agency requires self-reflection, self-esteem, self-assurance, and a sense of self-worth as human beings regardless of any other label. These psychological and cognitive factors shape our perceptions and our individual identities, and impact the power we have (or perceive we have) to make informed and voluntary decisions that we can carry out and sustain without fear of negative repercussions, e.g. deciding how many children to have and their spacing.

- **Interpersonal and community sphere of influence**: Individual agency is developed in and affected by the social context in which people live. The interpersonal and community sphere is the primary social context that we get exposed to from very early on in our lives. Clearly, this sphere has a huge impact on how we develop self-reflection, self-esteem, self-assurance, and a sense of self-worth as human beings. This is the sphere of influence in which as individuals we have a first experience of what society expects of us as women and men, and the roles and opportunities that come with those expectations and norms. For example, beliefs that women should not have access to decision-making around their reproductive health or that "real men" should not be involved in caring for children may very negatively affect access to and use of FP/MNCH services for individual and couples and, in turn, undermine achieving the MDGs. The detrimental impact of such beliefs on the psychological and cognitive factors needed to develop agency for voluntary informed decision-making and health seeking is very significant and very pervasive because it precludes access to a wide range of opportunities for human and social development. Unless the institutional and policy spheres acts to redress this situation – for example through education and training of providers to support clients in making voluntary informed decisions and choices - inequities may become entrenched and turn into cultural features of a society. Thus any attempt to change such inequities may be easily labelled as an attack on "our culture" and inequities may be masked as moral righteousness. At the same time, those who face the brunt of inequity may find other ways to cope with their issues and needs, for example by turning to unqualified practitioners or to unsafe practices, or having to pay more (if they can afford it) to access services. Again and again, inequity breeds inequity and affects the most vulnerable.

- **Institutional/FP facilities sphere of influence**: This sphere of influence is connected to all the others by many interwoven threads. The family is perhaps the most obvious institution showing the impact of this sphere. Values, beliefs, attitudes, and social norms that affect the psychological and cognitive factors for voluntary informed decision-making and health seeking are first and foremost experienced in this context. From this perspective, the family really functions as the cornerstone of social ecology and plays a huge role in enhancing or hindering a supportive environment for equitable social development. Similarly, other institutions such as police, schools, media organizations, NGOs, religious groups, unions, political parties etc. all play an important role in shaping the social environment. The values and practices of these institutions greatly affect root causes of inequity, such as gender discrimination, denial of human rights, and stigma and discrimination, one way or the other. However, when change happens in one of these institutions, often there is a ripple effect over time especially if these institutions are elements of broader networks (such as in FP/MNCH) and if they can model change from within effectively, for example by championing and realizing equity. In health, this sphere of influence is paramount. Unless health institutions realize that they have a very significant effect on root causes of health problems simply by the values that they model (e.g. equity, respect of human rights and first and foremost the right to health, do no harm, ethical conduct, and accountability) they may continue to exclude many people from accessing life- saving information and services, and hindering the MDG.

- **Policy sphere of influence**: This sphere of influence is greatly affected by all the others and in turn affects the social ecology as a whole. In public health, we have come to realize the importance of informing policy development through research and evidence. However, in order to affect the social ecology of health problems, health policy must also be the result of meaningful engagement of the communities and groups that it aims to benefit (e.g. women and families). Most important, health policy should aim to address root causes of problems, i.e. the social determinants (factors) that contribute to create specific health patterns or unfair and avoidable difference among socially defined population groups, such as women of reproductive age. Therefore, health policy development and its implementation cannot be divorced from an equity and rights-based perspective, because these are the fundamental issues that determine access to information, services, research, resources (including decision-making for health seeking behaviours). In the SEM, effective policy development and implementation (intended as a broad term encompassing normative and guiding principles and actions) is one of the most important strategies for equitable social development and for promoting social inclusion and cohesiveness because it focuses on addressing the social and system factors that undermine attaining the highest possible level of health and well-being, which is a human right as well as a social and individual outcome. At social level, this outcome requires the elimination of inequities in order to foster and maximize the development and sustainable use of agency and power for voluntary informed decisions for health seeking behaviours at individual level.

2.3 Contribution to strengthening the role of FP/MNCH in support of the MDGs

1. End poverty and hunger.
2. Achieve universal primary education.
3. **Promote gender equality and empower women.**
4. **Reduce child mortality.**
5. **Improve maternal health.**
6. **Combat HIV/AIDS, malaria and other diseases.**
7. **Ensure environmental sustainability.**
8. Develop a global partnership for development.

By developing the curriculum through an analysis of the social ecology in which FP/MNCH services operate, this curriculum aims to contribute to strengthen the role of such services toward structural change, and specifically in achieving MDGs 3, 4, 5, 6, and 7:

Many married women report having mistimed or unintended pregnancies or a desire to space or limit future pregnancies, but are not using modern contraceptive methods. Satisfying existing unmet FP need would help families achieve their desired family size, reduce total fertility, and, ultimately, slow population growth.

In fact, to accelerate progress in achieving the MDGs, a new target was added under the maternal health goal (MDG 5) in 2007. The new target, 5b, calls for providing universal access to reproductive health services and includes the contraceptive prevalence rate and unmet need for family planning as key indicators for meeting this target. Source: USAID | HEALTH POLICY INITIATIVE, Task Order 1, 2009: Family Planning and the MDGs: Saving Lives, Saving Resources

In order to contribute to strengthening the role of FP/MNCH in achieving the MDGs and broader social development aims, this curriculum focuses on strengthening providers' A-S-K to contribute to overcome health inequity and its causes, especially gender inequity and the inadequate empowerment of women.

2.4 Focus on competencies and performance improvement

This curriculum is structured in three courses, namely:

1. OJT for FP counselling service provision.
2. OJT for FP clinical service provision.
3. OJT for contraceptive logistics management for FP service provision.

In the approach used in this curriculum, a core competency is defined as:

> *Core competency: Units of attitudes-skills-and knowledge (ASK), which are essential to be achieved by a person (e.g. a FP/MNCH service provider) in order to provide quality services.*

The curriculum revolves around four cross-cutting core competencies, which are realized through clusters or units or A-S-K. These A-S-K clusters create synergy of the four competencies across the three courses:

CORE COMPETENCIES	SPECIFIC CLUSTERS OF A-S-K FOR EACH COURSE		
	ILLUSTRATIVE COUNSELING COURSE A-S-K	**ILLUSTRATIVE CLINICAL COURSE A-S-K**	**ILLUSTRATEIVE LOGISTICS COURSE A-S-K**
1. Effectively ensure client's voluntary informed decisions	Value and ensure clients' rights Effectively enable clients to assess their reproductive goals and needs Enable clients to choose most appropriate option for their circumstances Develop clients skills to implement choices and decisions	Value and ensure clients' rights Effectively provide accurate and complete information in language that clients can understand Provide services with privacy, dignity, and safety for clients	Value and ensure clients' rights Value and ensure the six rights of CLMS Effectively implement the key principles of CLMS
2. Effectively enable access to and use of quality FP/MNCH services	Perform effective IPCC skills Value and promote gender equity Manage attitudes effectively Assess clients' additional reproductive and MNCH needs and refer appropriately	Demonstrate and effectively use technical knowledge Address misconceptions effectively Assess clients' additional reproductive and MNCH needs and refer appropriately Value and ensure reproductive rights	Collect and compile quality LMIS data Effectively maintain the inventory control system Ensure no stock-outs Ensure no over-supply

CORE COMPETENCIES	SPECIFIC CLUSTERS OF A-S-K FOR EACH COURSE		
	ILLUSTRATIVE COUNSELING COURSE A-S-K	**ILLUSTRATIVE CLINICAL COURSE A-S-K**	**ILLUSTRATEIVE LOGISTICS COURSE A-S-K**
3. Effectively provide quality reproductive care	Provide accurate and complete information in a language that clients can understand Provide effective client-centred FP/MNCH integrated counselling Address rumours and misconceptions effectively	Perform effectively and safely client assessment and screening Effectively implement medical eligibility criteria Effectively Address side effects Perform effective infection prevention	Effectively determine when to order supplies Effectively use different types of LMIS forms Effectively implement proper storage procedures Effectively conduct visual inspections for proper storage
4. Effectively provide referral and follow-up	Implement protocols effectively Enable clients to identify and plan follow-up Provide effective follow-up as necessary	Implement standards effectively Assess clients' additional reproductive and MNCH needs and refer appropriately	Implement standards effectively Effectively support contraceptive and non-contraceptive forecasting

In each course, the key A-S-K clusters are defined through the objectives of each session.

The core competencies and the A-S-K are aligned to the National Training Manual on Family Planning for Physicians and Nurses/Midwives, the National Family Planning/Reproductive Health Service Protocols, the Performance Standards for Family Planning Services in Nigerian Hospitals, and the Streamlined Contraceptive Logistics Management System (CLMS, 2009) Participant's and Trainer's Guides.

2.5 Focus on addressing gender inequity as a key barrier to ensuring the strategic role of FP/MNCH in achieving the MDGs

The four cross-cutting competencies that this curriculum focuses on are essential to strengthen the strategic role of FP/MNCH services in achieving the MDGs because each of the competencies and their synergy through the A-S-K clusters address key social ecology factors that impede access to and utilization of FP/MNCH.

The curriculum places particular emphasis on enabling health providers to explore in depth the role of gender inequity in undermining access to and utilization of FP/MNCH services, and how they can use

this enhanced understanding to facilitate clients' problem-solving for informed voluntary decision making. Through this approach, health providers can identify real life impacts of gender inequity on access to and utilization of FP/MNCH services and on quality of care. An important aspect of this learning process consists of enabling providers to explore how their own attitudes to gender and sexuality may reinforce barriers to FP/MNCH access and use, and how to re-orient their attitudes in support of clients' informed voluntary decision making.

The emphasis on addressing gender inequity runs across the three manuals of this curriculum:

- In the **counselling** training manual, it is realized through a focus on addressing the impact of gender inequity on quality of counselling as an essential pre-requisite to enable optimal access to and utilization of FP/MNCH services.
- In the **clinical** service provision training manual, it is realised through a focus on ensuring clients' reproductive goals, reproductive rights, and provision of client-centred quality care.
- In the **logistics** management training manual, it is addressed through a focus on skills for effective logistics management to ensure the strategic role of FP/MNCH services towards the MDGs.

In this way, the three manuals connect and reinforce learning opportunities to develop A-S-K clusters (i.e. the four cross-cutting competencies) in order to address gender inequity-related barriers to access to and utilization of FP/MNCH services.

2.6 Focus on FP/MNCH Integration

This curriculum emphasizes the development of A-S-K clusters that enable health providers to minimize missed opportunities thus helping clients access services and make voluntary informed decisions at any entry point of the FP/MNCH spectrum of services.

It is worth noting that the Master Trainers involved in the design of this curriculum developed a FP/MNCH Integration Framework through their knowledge and experience of the Nigerian clinical setting. This framework is used in the curriculum and applied to scenarios and case studies during the training to enhance skills for integrated service provisions and improved referrals. These analyses are in turn used to enable the participants to further reflect on the strategic role of FP/MNCH towards the MDGs.

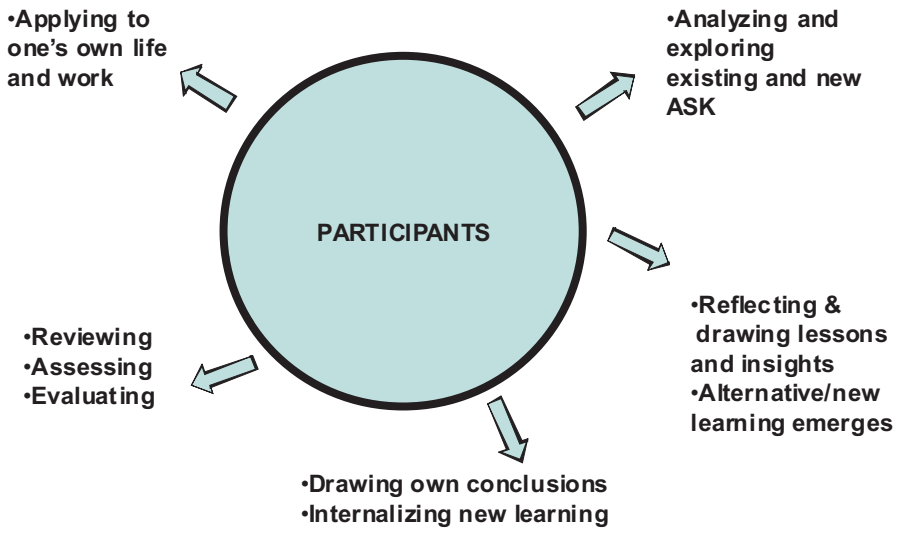
2.7 Focus on effective clinical skills

One of the important contributions to this curriculum to improve quality of care consists of its emphasis on developing effective skills to apply the Medical Eligibility Criteria (MEC) of the World Health Organisation. Both the counselling and the clinical service provision training manual contain sessions and materials to strengthen and apply knowledge and skills to use the MEC to facilitate clients' problem-solving and ensure their safe informed voluntary decisions.

2.8 Learner centred experiential focus

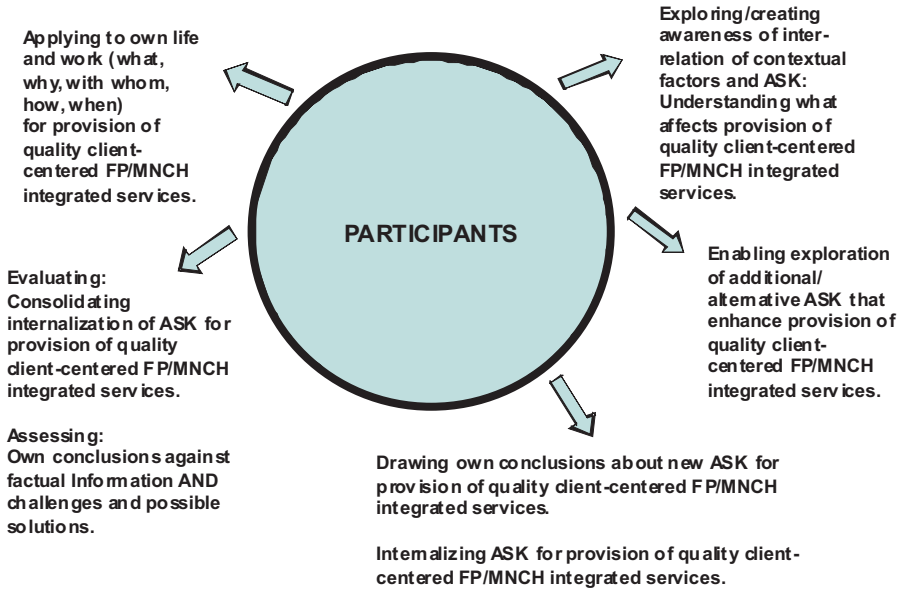
This curriculum adapts contemporary good practice models for learner-centred training, and namely the Experiential Learning Cycle (ELC). This model recognizes that participants and learners bring psychological and cognitive assets i.e. their existing attitudes-skills-knowledge (A-S-K) to the process. These assets, often informed by the participants' own experience of the issues being explored, are highly valued and contribute to the wealth of knowledge from which the activities in the curriculum will draw:

Experiential Learning Cycle: Theory Outline



In this curriculum, the application of the ELC focuses on developing assets that support effective counselling for client-centred FP/MNCH integrated service provision:

Experiential Learning Cycle in this curriculum



The approach aims to foster the development of participants' insight, reflective thinking, problem-solving skills, and ownership of learning. In most activities, participants are encouraged to reflect on their own experiences and to draw from their real life issues either as a context for their reflection and problem-solving and/or to apply new insight and knowledge.

The curriculum creates connections and linkages across session topics by exploring key attitudes, skills, and knowledge (ASK) in different ways and perspectives by using a range of methodologies such as:

* story telling	* case studies	*role plays
*group work	*buzz groups	*structured discussions
* brainstorms	*presentations	* values clarification

Teachable moments are created throughout the curriculum and are used to reinforce internalization of learning. Substantial time is allocated to skill-building through role plays.

The exploration of how individual and social factors interconnect in affecting both FP/MNCH and **provision of quality client-centred FP/MNCH integrated services** is a prominent theme in this curriculum and it is linked to developing ASK that support quality in service provision in order to contribute to address the structural factors of poor FP/MNCH.

The curriculum deliberately limits the use of power point presentations in order to focus on learner-centred experiential methodologies. Therefore a key aspect of this course is the active engagement of participants.

1. CURRICULUM DEVELOPMENT PROCESS

3.1 How the conceptual and methodological approach led to identifying, testing, and finalizing competencies and A-S-K of the curriculum

The development process of this curriculum drew from the facility assessments and performance improvement plans previously conducted by NURHI. The facility assessments confirmed that a major challenge for both the public and the private sectors was to manage a situation characterized by countless training programs offered by many development partners. As a consequence, health providers from health facilities were often absent from work for relatively substantial periods of time.

Therefore, NURHI set out to design a curriculum that would help to overcome this situation by providing materials that could be used flexibly and in a tailored way to address specific capacity gaps identified at local level.

Through a capacity strengthening process for curriculum design, NURHI engaged a group of Nigerian master trainers, national experts, and external expert technical assistance to use the SEM as a planning framework to identify core competencies for this course.

This process was realized through the following activities:

The participants conducted a social ecology analysis of FP/MNCH to identify issues that may function as barriers for access to, and use of, these services. This analysis was placed in the context of the role of FP/MNCH in contributing to achieve relevant MDGs, especially goals 3 to 7. This enabled the participants to connect to the broader population and development discourse, which is acknowledged in the existing policy and service provision rationale, for example in the National Training Manual on Family Planning for Physicians and Nurses/Midwives. The participants were able to examine how the social ecology issues that they had identified can create inequities affecting access to and use of FP/MNCH, and the potential detrimental effect on achieving the MDGs. In particular, the workshop focused on examining gender issues and their inter-relations with other social ecology factors to identify the impact on people's decision making and their lives, particularly FP/MNCH clients.

Using these analyses, the workshop identified key Attitudes-Skills-Knowledge (A-S-K) that should act as the building blocks for competencies developed using OJT. Participants explored how the concepts of competency and skill work in synergy to inform a training approach that aims to contribute to system strengthening and the achievement of strategic goals, such as the MDGs. Participants made these connections by exploring the role of competency-based OJT in achieving client-centred service provision in an integrated FP/MNCH approach. Through this analysis, the participants produced a tentative framework for provision of integrated FP/MNCH services in Nigeria. This framework has been incorporated in the counselling training manual of this curriculum.

The next step in curriculum design consisted of connecting the analysis about competencies and A-S-K to the National Training Manual on Family Planning for Physicians and Nurses/Midwives, the National Family Planning/Reproductive Health Service Protocols, the Performance Standards for

Family Planning Services in Nigerian Hospitals, and the National Handbook Contraceptive Logistics Management System. The last step consisted of linking the technical content to training approaches and methodologies best suited to ensure effective transferring and retaining of A-S-K and, ultimately, core competencies. For this purpose, the participants explored learner-centred experiential training, its conceptual overview, and its application to training. The workshop also reviewed good practice materials used in Nigeria and internationally to prevent re-inventing the wheel and to ensure harmonization with Nigerian national standards.

The result of the workshop was the production of outlines for three FP training manuals:1) Counselling; 2) Clinical; and, 3) Logistics Management.

July 18-22, 2011: Curriculum review workshop and field test preparation with NURHI Master Trainers
NURHI master trainers were invited to review the three draft manuals to assess the extent to which the materials addressed the outlines produced during the May 2011 curriculum design workshop. The master trainers contributed to address gaps and made additional recommendations for improving the materials. The trainers worked in teams (counselling, clinical, and logistics) and each team was responsible for organizing and conducting the field test of one of the manuals.

Ilorin, July 23-31, 2011: Field test of the three manuals
The field test was structured as three concurrent training workshops conducted by the same three teams of trainers who had reviewed the draft manuals. Each course had about 20 participants. The three concurrent workshops took place in Ilorin and the participants included FP providers from Ibadan and Ilorin health facilities. After the completion of the field test, the trainers participated in a final debriefing and identified the changes to be made to the manuals as a result of the field test.

August-October 2011: Roll-out of draft curriculum
This period was used to continue to test the draft manuals in order to gather more input from trainers and providers for the final revisions.

October-November 2011: Updating draft curriculum
This period was used to continue to update the draft manuals based on feedback from the field testing, preliminary roll-out of the first draft versions and other input gathered from trainers and providers.

Abuja, 6-9 December 2011: Curriculum review with NURHI Master Trainers
The three manuals were further revised during this workshop in which NURHI Master Trainers identified their final recommendations for changes to the manuals.

12 December 2011: Stakeholders' meeting
This was the final curriculum development activity in which key stakeholders provided their input and recommendations to finalize the materials.

2. MONITORING AND EVALUATION

This curriculum does not require any parallel monitoring and evaluation system outside of what already exists. The curriculum has been designed to build on the strengths of existing standards and protocols and all the A-S-K clusters, i.e. the four core cross-cutting competencies, were identified as contributing to achieve existing performance standards. However, it is recommended to train supervisors in this curriculum in order to enable them to effectively monitor and evaluate the impact of this training on service provision.

3. TAKING RESPONSIBILITY FOR ONE'S OWN LEARNING

This curriculum aims to achieve a balance of factual knowledge and knowledge for problem-solving in order to foster acquisition and retention of knowledge and skills. Therefore the activities focus on enabling participants to:

- Reflect critically on what they may already know e.g. How technically correct is their current knowledge? How well have they been applying it? How are their attitudes supporting or hindering them in ensuring optimal access to and use of FP/MNCH services?
- Analyse the important points of new knowledge being presented.
- Share reflections and insights to learn from each other and internalize (absorb) new or expanded knowledge and skills through the learning interactions.
- Apply their expanded or new knowledge to what they do, i.e. strengthening skills.
- Evaluate their learning through constructive peer-feedback.

Therefore the facilitators are not “knowledge banks” or the “know it all” experts. Facilitators, as the term suggests, have the fundamental role of enabling the participants' own learning, but the participants are expected to take full responsibility of their learning by actively contributing their thinking, reflections, analyses, practice and constructive feedback to each other.

4. ISSUES FOR FURTHER CONSIDERATION

We acknowledge that there are important issues that require additional attention in OJT and sensitivity to specific socio-cultural factors. For example: providing services to clients with mental health conditions; addressing the specific needs of under-age wives; addressing specific legal aspects of FP provisions; etc. At the time of developing this curriculum, efforts were being undertaken by other development partners to produce resources specifically focused on these issues. Therefore NURHI decided to prevent duplications by focusing this curriculum on key issues identified during the facility assessments.

LETTER TO FACILITATORS

1. Duration and scheduling of the OJT courses

NURHI identified the challenge associated with pulling out providers for the stipulated statutory periods for FP trainings, including the refresher training, especially in the private sector. NURHI decided to address these issues in partnership with the Family Health Department of the Federal Ministry of Health. As a result, NURHI is proud to present the three courses contained in this curriculum, namely:

1. OJT Family Planning Counselling Training Manual
2. OJT Clinical Service Provision
3. OJT Contraceptive Logistics Management Training Manual

Based on the experience and recommendations of the curriculum design and field test process, it is recommended to schedule the three courses in the same order as they are listed above.

The Counselling and Clinical Service Provision courses run for six days each while the Contraceptive Logistics Management Course runs for four days. Thus the total time needed to implement the whole curriculum is16 days as opposed to the time frames of six weeks or three weeks usually implemented in Nigeria in the past.

Although each course provides a sample training schedule organized by day, each of the three

courses can be implemented flexibly as: 1) a program covering the entire duration of the course; 2) by scheduling the course in modules over a few weeks; or, 3) by selecting the sessions that address specific capacity gaps and organizing a training schedule accordingly.

The structure of the courses also allows choosing selectively which topics to focus on if managers and trainers assess that providers only require training on certain topics.

In order to ensure the effectiveness of the training methodology, it is recommended to ensure a minimum of six to eight participants during each course. Therefore facility managers are encouraged to plan cooperatively within their Local Government Area (LGA), and facilitators are encouraged to support these efforts.

2. How to use this curriculum effectively: before starting the courses

2.1 Selecting facilitators

This curriculum requires facilitators who are conversant with the SEM and skilled in applying a learner-centred experiential cycle. The effective implementation of this curriculum also requires facilitators with knowledge and skills to address the topics in the three courses and their inter-relations. The pool of Master Trainers that participated in the development process of this curriculum can provide technical assistance and function as key resources to implement the curriculum as well as to train others as trainers.

2.2 Selecting participants and using the curriculum with different types of providers

To ensure the effectiveness of the training methodology, a minimum of six to eight participants are required during each course. This is important to ensure the effectiveness of the methodology, which focuses on fostering the participants' reflective thinking and problem-solving skills. These skills are developed and internalized through activities that require learning interactions and practice of skills with others. Hence, it is recommended that facilitators and facility managers plan cooperatively within their LGA to ensure a minimum of six to eight participants for the learning interactions to be meaningful and effective.

This curriculum can be used flexibly with all the categories of providers identified in the National Family Planning /Reproductive Health Policy Guidelines and Standards of Practice. For example, it can be used to address gaps in capacity of Midwives/Family Planning Nurses CHOs who are newly qualified or who are experienced but require support around specific aspects of their capacity. Similarly, **the curriculum can be used with all types of service providers identified by the National Family Planning /Reproductive Health Policy Guidelines and Standards of Practice as long as facilitators and mangers identify which specific capacity gaps they want to address for which specific types of providers in relation to the functions of those providers.** Once they know which capacity gaps they aim to address vis-à-vis the functions of the different types of providers, facilitators and their counterparts can select the sessions that best help address these issues and create a suitable training agenda.

2.3 Deciding how to use these materials with public and private sector providers

These materials have been designed to help address the challenges that services and clients in both the public and private sectors face when health providers spend long periods of time to participate in training programs. The sessions in each of these manuals can be packaged flexibly in training agendas that can be delivered with minimal disruptions to the service schedules of public or private sector facilities. For example, the courses can be conducted either following the sample agendas provided in each manual or by focusing only on the specific sessions that address the capacity gaps identified. As previously explained, facilitators and managers need to work closely to identify which capacity gaps they want to address in order to select the most appropriate sessions and materials and develop their own training agenda.

2.4 A few essentials preparation tips

- Read the facilitator's manual and all reference materials carefully, including the participant's handouts and the knowledge pack of each course. Consider the flow of topics, the structure of each course, and the training methodology of each activity so that you will know how to conduct the sessions, what you need for each activity, the key messages to convey, etc.
- Make sure that the training venue is appropriate for learner-centred experiential training activities, i.e. most of the sessions require the participants to move around the room to interact. Space is an important consideration. Noise is also an important consideration. Therefore whenever possible ensure that the training will not be disrupted by excessive outside noises.
- Make sure that the sessions are adapted to the local context if necessary.
- Prepare all handouts, flipcharts, cards, and other materials and supplies in advance. Each session of each manual identifies the materials that facilitators should prepare in advance. Read the sessions carefully as part of your preparation and identify any additional materials you may want to prepare. **Please note: the methodology used in this curriculum requires facilitators to distribute handouts at the appropriate time during sessions in order to avoid pre-empting participants' learning. This in turn requires effective planning by facilitators to ensure that all printing and photocopying is completed in advance of starting the sessions.**
- If co-facilitation is involved, facilitators should determine how the course will be managed with their co-facilitators. Be sure to discuss potentially disruptive situations. For example:
    - How to intervene if a facilitator forgets an important point during an exercise, presentation, or discussion.
    - How to manage participants who dominate discussions.
    - How to respond to participants who upset others by making negative comments.
    - How to alert each other if the pace of training is too fast or too slow.
    - How to alert each other when a presentation or exercise is running longer than its scheduled time.

3. How to use the curriculum effectively: during the courses

3.1 Create a supportive learning environment

Many factors contribute to and affect the learning process. The facilitator's understanding of her/his role is a key factor. A learner-centred training requires facilitators to:

- Consider themselves equal to participants.
- Focus on enabling participants to use reflective thinking to develop insight, draw conclusions, and integrate new knowledge and skills into their lives.
- Understand that a facilitator's fundamental role is to ask useful questions at the right time and in the right way to foster creative thinking and problem-solving.

The manual provides sample questions for each activity that facilitators can use to achieve these purposes. Facilitators should also use participants' comments/observations/insights to formulate additional questions and expand reflection, analysis, and constructive feedback. Facilitators are encouraged to use their groups as a resource by inviting questions, enabling participants to answer each other's questions, and using participants' observations to link topics and issues.

Through behaviour and communication style, facilitators can create a positive, non-threatening, and inclusive environment. Facilitators are encouraged to apply learner-centred principles in adapting and implementing the curriculum materials to ensure a successful learning process.

In order to build trust and create a learner-centred environment, facilitators are encouraged to (see 3.2 to 3.17 below):

3.2 Create and maintain a nonthreatening environment

- Treat the participants with **respect** and **as equals**, and make sure that the participants treat each other with respect and equality.
- Maintain **confidentiality** if the participants share private information with you or each other.
- Make sure that **the physical environment helps to create a positive learning environment** (e.g. thoughtful seating arrangements, comfortable temperature, ventilation and light in the room, scheduling of breaks, and other arrangements as feasible).

3.3 Pay careful attention to communication

The flow of **information** during this course is important. When people are informed, they feel valued and an integral part of the team. When there is secrecy, they feel excluded or threatened. Communication should be as complete as possible and should convey messages of trust and mutual respect. Other suggestions:

- Use icebreaker activities at the beginning of the course and warm-up exercises after breaks to increase comfort.
- Read body language of the participants and listen to all ideas, and help participants reflect on whether their suggestions are relevant to the learning objectives that are to be achieved.
- Acknowledge and praise participants' ideas, and help them reflect on their relevance to the learning objectives.
- Avoid judging participants and their comments, and enable constructive peer feedback.
- Acknowledge that it is normal to feel nervous, anxious, or uncomfortable in new and unfamiliar situations.
- Show the group that you enjoy working with them.
- If possible, spend time with the participants during breaks and meals so that you are able to communicate with them informally.
- Learn and use the participants' names.

3.4 Pay attention to the formulation of useful contracts

It is often standard practice to agree a set of “ground rules” with the participants at the beginning of the course to ensure useful and fair interactions. This curriculum suggests calling these agreements *contracts* in order to stress their importance in ensuring successful learning outcomes. Contracts play a very useful role if they are phrased in ways that help pre-empt or manage issues that may become potentially controversial or disruptive during the program.
Facilitators often feel that only the participants are entitled to suggest contracts. However, in a participatory learning process based on mutual respect, facilitators can also suggest contracts. For this course, facilitators may want to consider including the following:

- Mutual respect, including of diversity among participants e.g. ethnic, religious, geographic origin, marital status, seniority in the work place, etc.
- Taking responsibility for one's own learning, i.e. recognizing that a learner-centred experiential process requires the active contribution of each person.
- Recognizing that facilitators are not the source of all possible knowledge, i.e. accepting to be referred to other sources if the need arises.
- Committing to constructive feedback during interactions and throughout the course, and avoiding “blame games”.

3.5 Model correct behaviour

By showing trust in others and being reliable yourself. Remember that your actions are as important as your words. Make sure that there is consistency between the two.

3.6 Avoid "I'm right/you're wrong" debates

Unless it is necessary to provide correct factual and technical information, facilitators should not engage in "right/wrong" discussions and should help participants to avoid such situations. In fact, "right/wrong" deadlocks will undermine the methodology and the learning aims of this curriculum, which is primarily focused on developing participants' reflective thinking in order to internalize and retain learning.

3.7 Use definitions flexibly to foster reflective and "out of the box" thinking

Some sessions provide definitions of concepts or approaches, and facilitators are encouraged to be flexible in how they use them. Use definitions to encourage reflections and insight. Don't waste time dissecting words, but do use words in definitions to help participants reflect on the key issues that the definitions focus on.

3.8 Involve participants in course management if possible

In order to foster participation and ownership of learning, consider introducing a "task roster." Invite participants to volunteer to manage some aspect of the course by rotating responsibilities for tasks such as time keeping, energizers, ice-breakers, and daily feedback.

3.9 Practice appropriate self-disclosure

When you share what you are thinking, people are more likely to trust you. However, revealing too much can be problematic, particularly in cultures in which it is not common to share feelings or inner thoughts. Keep the cultural context in mind when considering self-disclosure of opinions. Also always remember that you need to maintain a professional role and relationship with each participant. Excessive or inappropriate self-disclosure may jeopardize your professional role and relationship with the group and/or individual participants and may also create a conflict of interest.

3.10 Conduct daily debriefings of co-facilitators

If co-facilitation is involved, it is recommended to hold daily debriefings with your co-facilitators. Debriefings provide you and your colleagues with an opportunity to discuss aspects of the training that need improvement and to make adjustments to the training agenda or style.

Review the participants' daily evaluation to understand the opinions of participants (Appendix 3). Below you will find sample questions for debrief discussions among facilitators (select only the most appropriate/useful for your team, or create your own):

- How well did we meet the objectives of our sessions today?
- What did we do today that promoted learning?
- What do we want to do differently tomorrow?
- How well did we handle problems that arose during the sessions today?
- How well are we working together? What do we need to improve?
- Which feedback issues from participants are the most important to address tomorrow?
- How thoroughly have we planned tomorrow's sessions? What are our roles in delivering the sessions? What needs clarification? Are all the supplies and logistics organized?

3.11 Address gender and sexual stereotyping

This curriculum focuses on strengthening performance improvement to ensure the strategic role of FP/MNCH services in achieving the MDG. In order to achieve this aim, reducing barriers to access to and use of such services is fundamental. Therefore helping to address gender inequity is of

paramount importance because gender inequity is both a structural barrier to FP/MNCH optimal access and use as well as a social determinant of under-development.

This curriculum, and especially the counselling training course, addresses these issues as thoroughly as possible within the time limitations of OJT. The curriculum focuses specially on the inter-relations of gender, sexuality, power in relationships and FP/MNCH. Therefore, it is extremely important that facilitators are aware of their attitudes about these key content areas and ensure that their own personal values do not hinder participants' own reflective thinking.

Equally important, facilitators should be aware of participants' attitudes and beliefs and ensure that nobody attempts to impose their views on others.

Sometimes, agreeing to disagree is a strategy that facilitators may use if a discussion around these issues becomes too divisive. However, a more effective way is to help the participants reflect on how providers' attitudes to these issues may become barriers to access to and use of FP/MNCH services. Facilitators and participants are encouraged to put themselves in the shoes of clients who might experience judgmental or hostile attitudes because of gender or sexuality issues: how would they feel if they were those clients? What difficulty to access and use FP/MNCH services would they face as a result of providers' attitudes? How would such attitudes undermine achieving the MDGs? What can providers do to separate their own values from their professional and ethical duty to do no harm and to provide quality services to all clients? These questions may be more useful than agree to disagree in order to advance self-reflection and useful insights to improve performance. In addition, facilitators are encouraged to formulate and use contracts strategically, for example by having contracts that commit the participants to respect diversity in the group, including diversity of views and opinions.

Also, facilitators are encouraged to be sensitive to how gender and sexual stereotypes may be influenced by specific cultural beliefs and norms. It is never useful to blame “culture” as a whole for creating barriers to access to and use of FP/MNCH. This is why the curriculum places such an emphasis on the inter-connections of gender and sexuality issues, because these are specific aspects of social and cultural systems, and not the systems as wholes.

In some socio-cultural contexts, facilitators or participants may tell jokes as energizers. It is fundamental that facilitators assess whether such jokes and stories may perpetuate sexual, gender, or ethnic stereotypes that may offend or alienate some of the participants or potential clients of FP/MNCH services. For example, some jokes may generate or perpetuate stigmatizing and discriminatory attitudes about unmarried women who are sexually active, reinforce stigma and discrimination against commercial sex workers, or perpetuate perceptions of women as inferior to men. Particularly in the context of this curriculum, it is critical that facilitators pay attention to group dynamics that may reinforce inequitable power imbalances based on gender/sexual stereotypes and norms. This does not mean that facilitators bar or censure such jokes or stories. Rather, facilitators are encouraged to use them as materials to enable a reflection on the gender and sexual stereotypes that such jokes and stories communicate, and what attitudes they may contribute to perpetuate that hinder access to and use of FP/MNCH.

3.12 Conduct icebreakers and energizers

Facilitators are encouraged to use icebreakers and energizers that they are familiar with as well as to encourage the participants to volunteer what they have used in other workshops.
Icebreakers and energizers should aim not only to help participants maintain or revitalize their energy levels, but to build participants' confidence to interact openly. Facilitators are encouraged to use icebreakers and energizers that will make participants move around the room, use the space, and do things that require collaboration or team effort. Please be mindful of the recommendations about avoiding gender and sexual stereotyping discussed in the above sections.

3.13 Monitor participant progress during the training

It is important that the facilitators monitor the learning process and how/if participants learn and strengthen their skills. Facilitators are encouraged to:

- **Conduct** pre- and post- training assessments of participants in order to assess results at the end of the course. Use the pre-test and post-test questionnaires and answers provided in each manual.
- Evaluate participants' knowledge and skills during brainstorming, small group work, exercises, role-play, and discussions while the training is in progress. Correct misconception and provide correct factual information when necessary, and use the group as a resource to do this.
- Enable the participants to reflect on their learning. What questions you ask, how, and when, is the critical way of enabling participants to evaluate their learning. Also, reserve a few minutes before the end of each session to ask participants what they have learnt that is useful to improve their work.
- Conduct a formal evaluation at the end of each course to assess participants' perceptions of their learning through the training. This will help you identify changes to be made both to the training materials and your facilitation. The end-of-course evaluation allows participants to provide feedback about the usefulness of the training, the learning materials, the training methodologies used, the logistics of the training, and to assess facilitators' performance. Use the end-of-course evaluation guide provided for each course.

3.14 Use participant handouts

Participant's handouts are provided in most sessions of each of the manuals. **Please ensure that the distribution of these materials does not pre-empt participants' learning and reflective thinking.** Therefore it is important to acknowledge and discuss with the participants the following key points:

- Some participants may expect to receive all handouts at the beginning of the course, but if this happened the methodology of this curriculum would be undermined.
- The aim of the methodology is to foster participants' reflective thinking for problem-solving. Therefore this methodology is undermined by having access to knowledge for problem-solving before such problems are experienced during the training sessions.
- In this curriculum, handouts are resources to help participants consolidate their learning in their own time, and not to pre-empt it.
- When appropriate and useful, handouts will be distributed during training activities.
- Each session in each manual provides instructions as to when the distribution of each handout should happen. However, facilitators will use their own judgment to decide the most useful time to distribute these materials during training sessions.
- The title of each handout includes the session number and the activity in the session to which the handout refers to in order to help participants collate these materials in chronological order.

It is also important to emphasize the following messages:

- Most of the handouts in the three manuals can be used as job aids. Participants should take responsibility for collecting and collating the handouts they receive during the training in order to continue to use them as job aids or reference materials once they go back to their work places.
- Participants are also encouraged to use the handouts to share and explain to their peers and managers their learning from this curriculum.

Please also note that participants' handouts are useful materials for facilitators in preparing their sessions to review key points.

3.15 Use participant Knowledge Packs

Each manual is accompanied by a participant's Knowledge Pack. The information contained in each Knowledge Pack is tailored to support the participants' learning during the courses, and not to pre-empt it, and this is why the Knowledge Packs are small and contain only essential information necessary prior to attending each course.

The purpose of the Knowledge Packs is not to duplicate what is contained in the handouts that participants receive during the training sessions. This is another reason why the knowledge packs are small.

The knowledge pack of each manual should be sent to the participants with the invitation letter to attend that specific course. Participants should be encouraged to read the Knowledge Pack before the course begins. It may be useful to explain in the invitation letter that the purpose of the knowledge pack is to provide essential additional information about the topics addressed in the training. However, as the course uses a learner-centred experiential approach, most of the information will be provided during the sessions through handouts.

3.16 Enable participants to collate and keep knowledge packs and handouts

It is recommended to provide participants with a folder for each course to collect and collate the Knowledge Pack and the handouts. Ideally, the Knowledge Pack will also contain the introduction to the curriculum. A practical way to help participants collate and organize these materials is to provide a folder with plastic sleeves in which the participants can insert the handouts session by session.

3.17 Limit use of projectors and slides

This curriculum has been designed to minimize the need to use projectors and slides in order to avoid transforming the methodology into lecturing. However, facilitators are encouraged to use their judgment as to when additional visuals, such as power point presentations, may be useful. In any case, facilitators should avoid lecturing as much as possible because it will defy the skill transfer aim of the methodology used in this curriculum.

OJT FP CLINICAL SERVICE PROVISION COURSE

COURSE OBJECTIVES

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

- Demonstrate effective attitudes, knowledge, and skills in all four core competencies addressed in this course, namely:
  - Effectively ensure client's voluntary informed decisions
  - Effectively enable access to and use of quality FP/MNCH services
  - Effectively provide quality reproductive care
  - Effectively provide referral and follow-up
- Explain the role of family planning in ensuring comprehensive quality reproductive health care.
- Demonstrate effective skills to apply the Medical Eligibility Criteria developed by the World Health Organisation for FP service provision.

IMPORTANT MESSAGE TO FACILITATORS

In the conceptual and methodological approach of this curriculum, this course follows the OJT FP Counselling Training Course. Counselling is an essential component of quality client-centred FP service provision as a whole, and therefore the distinction of “counselling” and “clinical” in two separate courses is only due to practical considerations to ensure that providers are not absent from work for too many days at a time to attend training.

The effective facilitation of the clinical course depends on ensuring that participants continue to apply what they learnt in the counselling training course. This course, therefore, includes many activities to strengthen skills – such as role-plays and demonstrations – in which participants are expected to use their counselling skills to deliver quality clinical services.

SUGGESTED SAMPLE COURSE SCHEDULE

Please note: Although a sample training schedule organized by day is provided below, this course can be implemented flexibly either as a program covering the entire duration of the course, or by scheduling the course in modules over a few weeks, or by selecting the sessions that address specific capacity gaps and organizing a training schedule accordingly.

DAY 1

Time	Session	Activity/Notes
15 minutes	Registration and official opening remarks	
1 hour and 45 minutes	SESSION 1: climate setting and course overview	
30 minutes	**BREAK**	
2 hours	SESSION 2: Family planning in the socio - economic context of Nigeria and the role of family planning as a key component and a pillar of reproductive health	
1 hour	**LUNCH**	
15 minutes	Energizer	
1 hour	SESSION 3: Reviewing key issues about quality of care	
1 hour and 15 minutes	SESSION 4: Anatomy and physiology of the male and female reproductive systems	
15 minutes	Participants' daily reflections	
	BREAK	

SUGGESTED COURSE SCHEDULE DAY 2

Time	Session	Activity/Notes
30 minutes	Day 1 Recap	
1 hour and 15 minutes	SESSION 5: Client assessment. Part I: Being sure that a client is not pregnant	
30 minutes	**BREAK**	
2 hours	SESSION 6: Client assessment. Part II: Strengthening skills for effective history taking and assessing potential method contraindications	
1 hour	**LUNCH**	
15 minutes	Energizer	
2 hours	SESSION 7: Client assessment. Part III: Physical examination	
15 minutes	Participants' daily reflections	
	BREAK	

SUGGESTED COURSE SCHEDULE DAY 3

Time	Session	Activity/Notes
30 minutes	Day 2 Recap	
1 hour and 30 minutes	SESSION 8: Laboratory tests	
30 minutes	**BREAK**	
2 hours	SESSION 9: Modern methods of contraception. Overview.	
1 hour	**LUNCH**	
15 minutes	Energizer	
2 hours	SESSION 10: Applying the medical eligibility criteria to help clients make safe informed and voluntary decisions (Part I).	
15 minutes	Participants' daily reflections	
	BREAK	

SUGGESTED COURSE SCHEDULE
DAY 5

Time	Session	Activity/Notes
30 minutes	Day 4 Recap	
1 hour and 30 minutes	SESSION 14: Providing information effectively to clients about Fertility Awareness-based Methods (FAM)	
30 minutes	**BREAK**	
1 hour	SESSION 15: Using effectively the medical eligibility criteria for Fertility-based Awareness Methods (FAM)	
40 minutes	SESSION 16 (**Optional**): Essential information about the Withdrawal method	
1 hour and 15 minutes	SESSION 17: Providing information effectively to clients about Lactational Amenorrhea Method (LAM)	
1 hour	**LUNCH**	
15 minutes	Energizer	
2 hours	SESSION 18: Helping effectively clients to deal with side effects	
15 minutes	Participants' daily reflections	
	BREAK	

SUGGESTED COURSE SCHEDULE
DAY 6

Time	Session	Activity/Notes
30 minutes	Day 5 Recap	
2 hours	SESSION 19: Ensuring clients understand how modern methods of contraception work	
30 minutes	**BREAK**	
2 hours	SESSION 20: Infection prevention in health care facilities	
1 hour	**LUNCH**	
15 minutes	Energizer	
1 hour and 15 minutes	SESSION 21: The role of health providers in ensuring sound infection prevention practices in health care facilities	
1 hour and 15 minutes	SESSION 22: Concluding the course	
	BREAK	

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SESSION 1: Climate Setting and Course Overview

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

- Explain how the course is organized and the approach that it is based on.
- Explain the objectives of the course.
- Self-assess their pre-course knowledge.

Total Session Time
105 minutes (one hour and 45 minutes)

Materials

- Flipcharts, markers, tape, name tags
- Flipchart "Session objectives"
- Flipchart "Course objectives"
- Flipchart "Task roster"
- Pre-titled flipcharts for the structured brainstorm in Activity 4
- Copies of course schedule /training agenda
- Copies of pre course self-assessment questionnaire
- LCD projector if available/necessary

Facilitator's Resources

- Activity 4: Amina's case scenario.

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide).
This session welcomes the participants and provides them with an overview of the course methodological approach, its objectives and content. Participants will be able to get to know each other and to self-assess their pre-course knowledge.

Activity 1: Welcome, opening remarks, and self-introductions (25 minutes)

1.1 After the initial brief welcome and opening remarks (five minutes maximum), explain that as in any workshop, introductions come first. This will be done in a game that will allow us to build a relaxed atmosphere and become more comfortable with the participatory and interactive approach of this course.

1.2 Ask the participants to organize their chairs in a circle. The facilitator stands in the middle and explains the rules of the game called "fruit salad". In this game, each participant will be a fruit. There should be at least two people who will have the same fruit name. For example, if there are six participants, the group may choose three fruits with two people named after each of the fruits.

1.3 The facilitator also chooses to be one of the fruits, e.g., banana, and starts walking inside the circle. As the facilitator walks, she/he says the following things about herself/himself:

- Name, and where from.
- Current job, and how long been doing it.
- Favourite food.

At this point, the facilitator says "*And I like*..." completing the statement by calling out one of the other fruits used in the game, e.g. *mango*.

All the people who picked the fruit name *mango* have to get up from their chairs and run around the circle to find a new seat. The facilitator at this point can step outside and remove her/his chair. The person who is left without a seat will introduce herself/himself and call a new fruit name as the facilitator did, and so on, until everyone has introduced herself/himself.

Explain that:

- Participants cannot simply shift to the next chair. If someone does this, s/he will automatically become the one standing in the middle.
- If someone who has already been introduced ends up standing again, she/he will choose a person with the same fruit name, and that person will stand in the middle and continue the game.

1.4 After the introduction, give each person a piece of card or a name tag, and ask her/him to put his/her name on it and either fold the card in half and place it on the table or floor in front of him/her or pin it on his/her chest.

Activity 2: Establish the contracts for the course, and create a task roster (10 minutes)

2.1 Explain that the group will agree on few ground rules – which we will call *contracts* in order to stress their binding role to guide the interactions during the whole course. We will use a brainstorm to generate an initial list of contracts. Encourage participants to suggest helpful rules.

2.2 Write participant responses on a flipchart.

> ***Facilitator's Tip***
>
> In alternating colours, write down participants' suggestions. Consider rewriting in positive terms as needed. For example, if a participant suggests "Do not be late," consider rephrasing this as "Be on time."
>
> Some examples of useful contracts :
>
> - Participate actively
> - Respect each other's opinions/ideas
> - Speak one at a time
> - No session within session
> - Put cell phone on vibrator mode/turn off
> - Limit to minimum the use of cell phones during sessions, even if on vibrator mode
> - Be supportive, not judgmental

2.3 After all of the suggestions are written down on the flipchart, ask the participants to commit to those contracts.

2.4 Post the flipchart with the contracts on the wall so that all of the participants can see it during the course. **Please note:** In order to enhance the effectiveness of contracts, facilitators are encouraged to type and print out the list of agreed contracts and distribute to participants.

2.5 Explain that you would like the participants to be actively involved in running the workshop. For this purpose you would like the participants to rotate responsibility for the following tasks every day:

- Time keeping/Information: Ensure that everyone is on time at the beginning of each day and after breaks.
- Energizers/ Icebreakers /Social welfare: Help maintain energy, especially at the start of

each day, after lunch breaks and/or whenever energy levels appear to decrease.

- Daily evaluation and daily recap: At the end of each day the participants will be asked to fill in a simple feedback form to assess how useful the sessions were (see Appendix 3). One person or a pair will use the daily evaluation to prepare a 30-minute participatory activity that they will conduct the next morning. This 30-minute activity will aim to identify the key learning from the previous day and present a summary of the participants' feedback/evaluation.

Post a flipchart on the wall with a roster for these four groups and ask the participants to write their names on one of the task for each day of the course:

COURSE DAY	TASK AND VOLUNTEERS		
	TIME KEEPING	ENERGIZERS & ICEBREAKERS	DAILY EVALUATIONS & DAILY RECAP
Day 1			
Day 2			
Day 3			
Day 4			
Day 5			
Day 6			Not required

If necessary, suggest simple icebreakers and energizers and offer to work at the end of the day with the person/pair who will prepare the recap activity for the next day.

Activity 3: Participant expectations and course objectives (10 minutes)

3.1 Ask participants to write their expectations on cards and to post them onto the expectation flipchart.

3.2 Gather and summarize participant responses on the flipchart.

3.3 Show the objectives of this course on flipchart and discuss how participants' expectations relate to the objectives. Help participants to identify which expectations are realistic and relevant to the objectives, and which ones may not be. Reach agreement on which expectations may have to be placed in brackets or erased because they are not directly relevant to the objectives of this course.

Activity 4: Approach and methodology of the course (25 minutes)

4.1 Ask the participants if they have read the sections in the introduction to their knowledge pack that explain the course approach, i.e. its focus on addressing the social ecology of FP/MNCH, and on developing core competencies through learner-centred methodologies and reflective thinking. Briefly discuss:

- What did you find new or useful about the social ecology model?
- What did you find new or useful about the focus on four core cross-cutting competencies?
- What did you find new or useful about the learner-centred experiential cycle?

> ***Note for Facilitators***
>
> There is no need to write down responses on flipchart. These questions serve only an ice-breaking purpose to introduce the case study that you will use next. At this stage, spend only little time to elicit a few responses without delving into any in-depth discussion of these issues. However, make sure to review thoroughly the relevant sections in the participants' knowledge pack before the beginning of the course. Also please note that the same issues are addressed in the Introduction section in the Facilitator's manual.

4.2 Build on relevant participants' responses to explain that this course focuses on developing problem-solving skills to help clients make voluntary informed decisions about their reproductive needs and goals. Developing problem-solving skills requires that we put ourselves in clients' shoes to fully understand what factors can hinder their ability to overcome barriers for informed voluntary decision making. In this course, we do this by using learning methodologies that foster our reflective thinking, insight, and analyses that we then apply to our work. For example, we use case studies.

4.3 Distribute copies of the case study provided in the **Facilitator's Resources** section below. Review the case study with the group. Explain that we are going to explore this question (show on flipchart if necessary):

- What factors hindered Amina's access to and utilization of FP/MNCH services?

Explain that we are going to explore these factors at four different levels (post four flipcharts as follows):

Individual/personal	**Interpersonal & community**	**Institutional**	**Policy**

Rapidly brainstorm factors for each of these dimensions.

4.4 When you have several factors on each flipchart, help the participants draw connections across the four levels. Pick a factor from the Individual level and one from another level e.g. Institutional, and ask:

- How do these factors interconnect to affect Amina's access to and use of FP/MNCH services?

Repeat the same process a few times by selecting factors from different levels, e.g. one from Interpersonal & Community and another from Institutional or Policy, and discuss the same question.

Note for Facilitators

At the end of the discussion, please remember to highlight the following key messages:

- By identifying key factors and their connections across the four levels, the participants have conducted a rapid analysis of how the social environment affect a person's ability to access and utilize FP/MNCH services.
- The four levels that the participants analysed make up what we call the Social Ecology of FP service provision, i.e. the social environment in which FP services are situated.

(At this point you may want to refer the participants to the relevant section of the introduction to their knowledge pack in which the diagram of the Social Ecology Model is provided).

- Each of the levels is a sphere of influence, i.e. it both influences and is influenced by all the other spheres to create, maintain, or change such a social environment.
- This course is based on understanding the social ecology in which FP services are provided because the social ecology (the social environment) influences in many ways clients' ability to make voluntary informed decisions. As providers, we need to understand these factors in order to put ourselves in clients' shoes and help them develop solutions that meet their needs.

4.5 Ask the participants to work in pairs for five minutes. Give to each pair one of the following questions to discuss:

- How can the social ecology that you analysed in Amina's case study undermine the role of FP/MNCH service provision in contributing to the MDGs?
- How can an understanding of the social ecology factors help health providers reduce barriers to access to and utilization of FP/MNCH services for clients like Amina?

Invite the pairs to share and discuss.

4.6 Finally, help the participants reflect on the methodology that was used in this activity to foster their reflective thinking and insight. Discuss:

- In which ways did the methodology foster your own analysis and drawing conclusions?
- Now that you have begun to experience this methodology, what are the key differences with lecturing?

4.7 Conclude by emphasizing that this activity enabled the participants to define the Social Ecology Model that informs this course as well as identify key features of the learner-centred experiential methodology that will continue to be used in all the sessions.

Activity 5: Pre-course self-assessment (20 minutes)

5.1 Briefly explain that the purpose of the pre-course self-assessment is to help participants and facilitators assess the usefulness of the course and which areas or topics may require more attention during the training.

5.2 Distribute the pre-test self-assessment questionnaires to participants and allow 20 minutes for completion. Let them know when five minutes remain.

5.3 Inform the participants that they will be asked to complete a formal evaluation of the course at the end of the program.

Activity 6: Review of course schedule (15 minutes)

6.1 Distribute and clarify the training schedule/agenda. Invite questions for clarification.

6.2 Explain any logistics for the course.

6.3 Thank participants for their active participation in this session and transition to Session 2.

Facilitator's Resources

Activity 4: Amina's case scenario

Amina, a 34 year old housewife, married to 55 year old Zacharia, who is a petty trader. At the time when we want you to imagine this story is unfolding, they already had six children (five girls and a boy) and were living in a one-room apartment with their children. Amina's last baby was three months old but her husband kept pressuring her to have sex. Amina felt that it was too early to start having sex again, but she was also afraid of saying no to sex with her husband for fear of possible consequences she may suffer, for example denial of domestic allowance and violence.

Amina had heard of family planning, but had no specific knowledge of any method. She had also heard people complain about family planning saying that the methods had many side effects that could cause death. She was also afraid of how family planning providers might judge her if she told them about the problems with her husband.

Although Amina really didn't want any more pregnancies, she was afraid to talk about it with her husband for fear of his reaction. She was very worried that he might accuse her of infidelity just because she could not face another pregnancy. And so she felt that she had no choice and started having sex with her husband again.

Just four months after the delivery of her last baby, she became pregnant again. Amina could not consider abortion even though her family did not have enough food and there was no money for health care. Six months into her pregnancy, Amina started to bleed and her husband took her to see a traditionalist herbalist who gave her some herbs. The bleeding did not stop and by the time Amina was eight months pregnant it had become severe. Zacharia borrowed some money from his neighbours to take Amina to a nearby health post since a general hospital was too far and they could not afford the expenses. The health worker at the health post had no knowledge to provide emergency obstetric care, and Amina died while they were trying to sort out what to do.

SESSION 2: Family Planning in the Socio-Economic Context of Nigeria and the Role of Family Planning as a Key Component and a Pillar of Reproductive Health

Objectives

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

- Explain the role of family planning as a key component and a pillar of reproductive health.
- Explain how family planning contributes to health and development in Nigeria.

Total Session Time

120 minutes (two hours)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- LCD projector if available/necessary

Handouts

- Handout 1 – Definition of Reproductive Health and key implications. Definition of Family Planning.
- Handout 2 – Reproductive Health Care
- Handout 3 – Key components of reproductive health as outlined in the Revised National Reproductive Health Policy
- Handout 4 – Family Planning as a core component and pillar of reproductive health in the context of socio-economic development

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide).
Drawing from the information provided in the knowledge pack of this course, this session provides an opportunity for the participants to reflect on and share their knowledge and insights about the socio-economic context of family planning in Nigeria. This session will enable the participants to deepen their understanding of the social ecology of family planning in Nigeria and expand their understanding of the role of family planning as a critically important component of reproductive health and how it contributes to the social development of the country.

Activity 1: Values clarification about family planning in Nigeria (25 minutes)

1.1 Begin the session with a fun activity to trigger initial reflections on the role of family planning for socio-economic development.

- Ask the participants to arrange their chairs in a line or in a semi-circle in an area of the room that you cleared before the session began. Explain that you will read out a statement at a time. Those who agree with the statement will choose one or more of the following ways to show it:
  - Say "Yes!" loudly, and/or
  - Jump out of their chairs waving their arms, and/or
  - Stamp the ground with their feet

Those who do not agree with the statement will remain seated and silent.

Please note: facilitators are encouraged to choose other ways that they consider culturally appropriate to make the activity fun and active.

- After each statement, spend only a few minutes to debrief the group. First, ask those in agreement with the statement to provide a rationale for agreeing with it. Ask those who

disagreed to also explain their views. Please note: do not allow the debriefing to become a "I'm right/you're wrong" debate. Participants may change their views if they are convinced by what their peers say, but the purpose is not to challenge directly anyone's opinions.

- Once the activity is completed, ask the participants to mingle in the group and spend five minutes maximum to share with one or two people what useful reflections they take away from this activity. Finally, invite randomly a few participants to share with the large group.

Sample statements to use in the above exercise (please note: it is not necessary to use all the statements. Facilitators are encouraged to adapt the statements or develop additional ones according to the issues and needs of their groups):

- Access to family planning is important to decrease and eliminate maternal mortality.
- Family planning is beneficial for the whole family and for the whole country.
- Family planning and child spacing is very important in Nigeria, which is already the most populous country in Africa.
- Without good family planning services, reproductive health care is incomplete.
- Family planning is important because it provides a key entry point to other reproductive and health services for many people.
- Family planning empowers people to make decisions about their options and their lives.
- Family planning is an effective way of supporting planned social development.

Note for Facilitators

In debriefing the participants after each statement, the following talking points may be useful to highlight the benefits of family planning:

- FP is beneficial to prevent pregnancy-related health risks in women.
- FP contributes to reduce infant mortality (children of surviving healthy mothers stand a better chance of survival).
- Integration of FP and HIV services is essential to maximize HIV prevention, and provide effective access to the continuum of care to those who need it.
- FP is very important to reduce unsafe abortion.
- FP is essential to reduce adolescent pregnancies.

Activity 2: The role of family planning in the context of reproductive health and reproductive health care (30 minutes)

2.1 The exercises in this activity will enable the participants to expand on their knowledge and experience to reflect on the role of family planning as a fundamental element of reproductive health. Divide the participants in two teams or two pairs depending on the total number in the group (if you have a large group, you may divide them in more than two teams or in several pairs) and explain the instructions:

- Each person receives a copy of Handout 1, which provides the definition of reproductive health and family planning. The handout also includes four potential key implications of the definition of reproductive health.
- The teams will have 10 minutes maximum to decide if all four implications are relevant to the definition of reproductive health or if any is not relevant, and why. They will also discuss how family planning can contribute to achieve the goals expressed in the definition of reproductive health.
- After discussing this matter for 10 minutes, each team will share their decisions and their reasons for it. Finally the facilitator will present the solution and discuss it.

Note for Facilitators

All the implications are relevant to the definition. If participants question the relevance of any of the implications, a useful way to help them reflect on these issues is by discussing in pairs or in the large group questions such as:

- In which ways each of these implications is important to achieve a state of complete physical, mental, and social wellbeing and not merely the absence of disease?
- Why is it necessary to have the freedom to decide if, when, and how to have children in order to achieve a state of complete physical, mental, and social wellbeing? (Facilitator can ask the same questions for each of the implications)

2.2 Participants continue to work in the same teams. Distribute Handout 2 with the definition of reproductive health care and ask the teams/pairs to discuss for five minutes the questions in the handout. Stop the discussion after five minutes and facilitate sharing of responses.

Activity 3: Family planning, reproductive health, reproductive health care and their role for social development (60 minutes)

3.1 This activity aims to enable the participants to further explore the role of family planning both as a key component of reproductive health as outlined in the revised National Reproductive Health Policy as well as one of the pillars of reproductive health recognized at international level.

3.2 Distribute Handout 3 and briefly review with the teams the components and pillars of reproductive health:

- Draw the participants' attention to the similarities between the national components and pillars.
- Remind them that an explanation of most of these components and pillars is provided in their knowledge pack, which they were expected to read in preparation for the course.
- Ask the participants to explain in their own words each of the components and pillars. If necessary, refer the participants to the relevant section of the knowledge pack.

3.3 Divide the participants in pairs or groups of three people, and distribute Handout 4 to each person. Review with the group and explain the diagram in Handout 4 as follows:

- The oval represents socio-economic development. At the center we have individuals, couples, and families, which should both contribute to and benefit from development.
- However, the ways in which they can both contribute to and benefit from development is greatly influenced by how population and demography of a country evolve. (Read and clarify the definitions of population and demography). For example, rapid or explosive population growth may affect what resources are available, how resources can be shared, which resources may become depleted or totally consumed, which opportunities are available and how they can be accessed, etc.
- The changes in population and demography are significantly influenced by many factors, including access to reproductive health and reproductive health care.
- In turn, access to reproductive health and reproductive health care is influenced by which components and pillars of reproductive health are available and work well.

Once you have briefly discussed the above points, assign to each pair or group one of the scenarios in Handout 4. The pairs/group will have 10 minutes to discuss the questions for their scenario and a few minutes to present. They should refer to Handout 3 as well.

- Facilitate a brief discussion after each presentation.

3.4 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Participant's Handout

Session 2: Handout 1, Activity 2 – Definition of Reproductive Health (RH) and key implications.

"**Reproductive health** is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes." (*WHO, 1994*)

Discuss in your team for five minutes:

- Which of the implications below would you consider relevant to the definition, and why?
- Which, if any, would you consider not relevant, and why?

Potential implications of the definition of reproductive health

- That people are able to have a satisfying and safe sex life.
- That they have the capability to reproduce and the freedom to decide if, when, and how to do so.
- The right to be informed and have safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility that are not against the law;
- The right to access appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Definition of Family Planning (World Health Organisation)

It is "a way of thinking and living that is adopted voluntarily upon the basis of knowledge, attitudes and responsible decisions by individuals and couples in order to promote health and welfare of the family group and thus contribute effectively to the social development of the country."

Also discuss:

- How does family planning contribute to achieve RH?

Participant's Handout

Session 2: Handout 2, Activity 2 – Reproductive Health Care

Definition of Reproductive Health Care

"Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproductive and sexually transmitted diseases." (*United Nations, 1994*)

Discuss (5 minutes total):

- Why this definition implies that women have special needs before, during, and beyond child-bearing age?
- Why this definition also implies that men too have reproductive health care needs as adolescents and as adults?
- Why is family planning important in achieving reproductive health care as per above definition?

Participant's Handout

Session 2: Handout 3, Activity 2 – Key components of reproductive health as outlined in the revised National Reproductive Health Policy

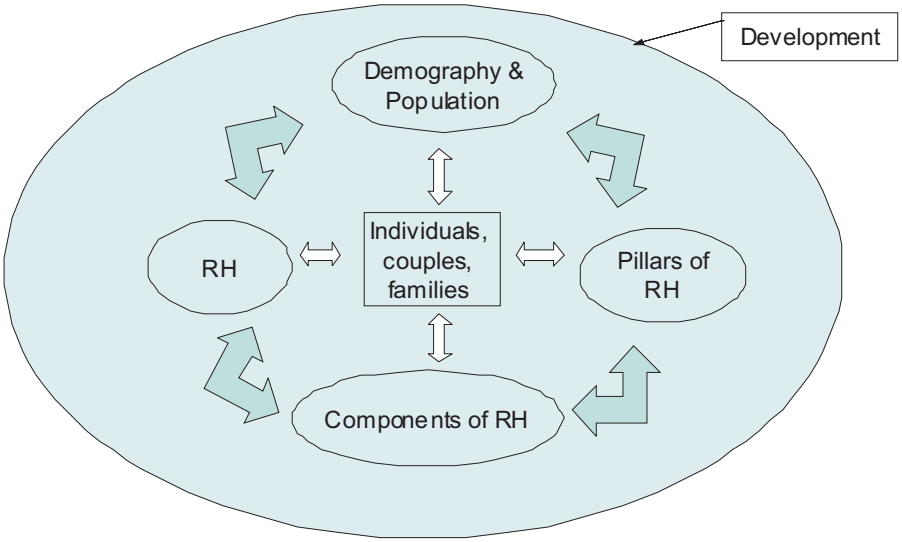
- Family Planning and Fertility Management.
- Safe Motherhood.
- HIV and other sexually transmitted diseases.
- Adolescent sexuality and reproductive health.
- Infertility.
- Post abortion care.
- Reproductive cancers.
- Harmful traditional practices.

Twelve pillars of reproductive health (international framework):

1. Status of women.
2. Family planning.
3. Maternal care and safe motherhood.
4. Abortion.
5. Reproductive tract infections and HIV/AIDS.
6. Infertility.
7. Nutrition.
8. Infant and child health.
9. Adolescent reproductive health and sexuality.
10. Sexual behaviour and harmful sexual practices.
11. Environmental and occupational health.
12. Reproductive tract malignancies.

Participant's Handout

Session 2: Handout 4, Activity 2 – Family planning as a core component and pillar of reproductive health in the context of socio-economic development



Demography: The study of the characteristics of human populations, such as size, growth, density, distribution, and vital statistics (birth, deaths etc.).

Population: The number of inhabitants found within a given area. The UN estimates the population of Nigeria for 2011 at 166 million people. With this population, Nigeria is the most populous country in Africa. If the population growth continues unchecked, it will double in 25 years.

SCENARIOS

Scenario 1:
Amina is a 22 year old married woman with two daughters. She is a small trader and her husband is a daily labourer. He wants a son, but Amina is worried about how another child will impact their ability as a family to provide for their children.

Discuss:

- Which components of reproductive health should be available and work well in order to help Amina and her family in this situation?
- Which pillars of reproductive health are necessary to help Amina and her family in this situation? If these pillars were not available, what might be the impact on Amina and her family in terms of contributing to and benefiting from socio-economic development?

Scenario 2:
Dayo is a 17 year old boy who is still in school. He has a girl friend of the same age and they have started having sex. They use condoms when they have them, but sometimes he uses withdrawal. He wants his girlfriend to get family planning, but when she went to the family planning clinic she had a bad experience with the provider and doesn't want to try again.

Discuss:

- Which components of reproductive health should be available and work well in order to help Dayo and his girl friend in this situation?

- Which pillars of reproductive health are necessary to help Dayo and his girlfriend in this situation? If these pillars were not available, what might be the impact on Dayo and his girlfriend in terms of how they can contribute to and benefit from socio-economic development?

Scenario 3:
Mary is a 33 year old woman who recently re-married after the death of her first husband. She has four children, two sons and two daughters. She was a widow for four years, but she has had a steady job and has been able to support her children and herself. A year ago she met a man that she fell in love with and they got married. She is using contraception, but her new husband has started pressuring her to have a child. Mary does not want to have a child, but she is worried that her marriage may end if she continues to say no. She also suspects that her husband may have started having sex with other women.

Discuss:

- Which components of reproductive health should be available and work well in order to help Mary in this situation?
- Which pillars of reproductive health are necessary to help Mary in this situation? If these pillars were not available, what might be the impact on Mary and her family in terms of how they can contribute to and benefit from socio-economic development?

SESSION 3: Reviewing Key Issues about Quality of Care

Objectives

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

- Explain the concept of quality in health care, particularly in the context of family planning.
- Identify the role of different components of quality in health care and their inter-relations in ensuring optimal service delivery.

Total Session Time

60 minutes (one hour)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- Flipchart "**Quality of care: Some commonly used definitions"**
- LCD projector if available/necessary

Handouts

- Handout 1 – Definitions of quality of care
- Handout 2 – Dimensions of quality of care

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide).
Quality of care is a topic explored in depth in the Family Planning Counselling course of this curriculum. Therefore this session provides a succinct orientation to the topic.

Activity 1: An overview of quality of care (55 minutes)
Steps:

1.1 Brainstorm with the group ways of describing or defining quality of care in health. Spend only five minutes on this exercise.

1.2 Show the following flipchart and discuss similarities and differences with the group's brainstorm (make sure to leave some blank space where you will add one more definition later):

Quality of care: Some commonly used definitions
• Quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. • Meeting the needs, expectations, and requirements of clients and other customers with a minimum of effort, rework and waste. • Doing the right thing, right, right away. • Striving for and reaching agreed levels o f care that are accessible, equitable, affordable, acceptable, client centred, effective, efficient, and safe.

1.1 Now distribute Handout 1 and discuss the additional definition (# 5 in the list, in bold):

Quality of care: Some commonly used definitions
1. Quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
2. Meeting the needs, expectations, and requirements of clients and other customers with a minimum of effort, rework and waste.
3. Doing the right thing, right, right away.
4. Striving for and reaching agreed levels of care that are accessible, equitable, affordable, acceptable, client centred, effective, efficient, and safe.
5. The quality of technical care is the application of medical science and technology in a way that maximizes its benefits for health without increasing its risk.

Divide the participants in pairs and assign one or more of the following questions per pair to discuss for five minutes:

- What inter-relations can you identify between definitions 1 and 5?
- Between 2 and 5?
- Between 3 and 5?
- Between 4 and 5?

Debrief the pairs by inviting them to share their opinions and facilitate a short discussion inviting comments from the others.

1.4 Distribute Handout 2. Divide the participants in pairs or small groups. Each pair /group will have 10 minutes to discuss one of the scenarios in the handout and prepare a short presentation. Explain that all the dimensions of care are important. Each scenario examines the role of only a few dimensions of care to highlight how the absence of even just a few may have serious repercussions for clients and for quality of care.

1.5 Facilitate a discussion after each presentation to enable additional input, comments, and insights.

1.6 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Participant's Handout

Session 3: Handout 1, Activity 1 – Definitions of quality of care

Quality of care: Some commonly used definitions
1. Quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. 2. Meeting the needs, expectations, and requirements of clients and other customers with a minimum of effort, rework and waste. 3. Doing the right thing, right, right away. 4. Striving for and reaching agreed levels of care that are accessible, equitable, affordable, acceptable, client centred, effective, efficient, and safe. **5. The quality of technical care is the application of medical science and technology in a way that maximizes its benefits for health without increasing its risk.**

Participant's Handout

Session 3: Handout 2, Activity 1 – Dimensions of quality of care

Please refer to the knowledge pack of this course for an overview of these dimensions.

- Technical competence.
- Access to services.
- Effectiveness of services/standards.
- Efficiency of services.
- Clients' rights to ensure voluntary and informed decisions by clients.
- Interpersonal communication and counselling skills.
- Choices of services.
- Continuity of services and care.
- Safety of services.
- Amenities.
- Providers' needs (e.g. training and supportive supervision).

SCENARIOS

Scenario 1:

Client 1: married woman, 27 year old, three children. Tells the provider she wants a long-term family planning method.
Discuss: What would happen if technical competence, clients' rights, effectiveness of services/standards, and safety of services were lacking? In your settings, what could hinder the implementation of these dimensions of quality?

Scenario 2:

Client 2: adolescent unmarried girl. Tells the provider she needs emergency contraception.
Discuss: What would happen if technical competence, interpersonal communication and counselling skills, choices of services, and access to services were lacking? In your settings, what could hinder the implementation of these dimensions of quality?

Scenario 3:

Client 3: married woman, 34 year old, four children. Tells the provider she needs a method that she can use without discussing it with her husband.

Discuss: What would happen if client's rights, interpersonal communication and counselling skills, choices of services, and continuity of services/care were lacking? In your settings, what could hinder the implementation of these dimensions of quality?

Scenario 4:

Client 4: married woman, 23 year old, presents with complications of unsafe abortion.
Discuss: What would happen if clients' rights, technical competence, access to services, safety of services, and providers' needs were lacking? In your settings, what could hinder the implementation of these dimensions of quality?

Scenario 5:

Client 5: married man, 39 year old, says he can't use condoms anymore because they make him "feel nothing". In reality, he has problems with maintaining erection.

Discuss: What would happen if clients' rights, technical competence, amenities, interpersonal communication and counselling skills, and providers' needs were lacking? In your settings, what could hinder the implementation of these dimensions of quality?

SESSION 4: Anatomy and Physiology of the Male and Female Reproductive Systems

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

- Explain accurately and effectively human reproductive anatomy and physiology and sexual practices in relation to family planning using language that clients can understand.

Total Session Time
75 minutes (1 hour and 15 minutes)

Materials

- Flipcharts, markers, tape
- "Human reproductive anatomy and physiology and sexual practices" flipcharts
- Anatomical models
- Diagrams of female and male reproductive organs on news sprint
- LCD projector if available/necessary

Handouts

- Handout 1 – Male and female anatomy diagrams
- Handout 2 – Female anatomy and physiology
- Handout 3 – Male anatomy and physiology

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide).
The ability to explain complex terminology and concepts in language that clients can understand is essential to ensure effective interpersonal communication skills in a provider-client interaction. Most important, this ability is fundamental to enable clients' informed choices and decisions.

Activity 1: Identifying language that clients use to talk about reproductive anatomy and physiology, and developing the confidence to use such language (25 minutes)
1.1 In this exercise, the participants will work individually. Give to each participant a marker (color not important) and show them the flipcharts below that you will have pre-prepared and posted on different walls around the room:

Sample human reproductive anatomy and physiology and sexual practices flipcharts:
(Please note: Facilitators are encouraged to select different anatomy and physiology terms, which they feel more useful to discuss with their groups)

PENIS	**VAGINA**	**SCROTUM**	**UTERUS**
TESTICLES	**OVUM**	**SEMEN**	**CERVIX**
OVULATION	**EJACULATION**	**MENSTRUATION**	**SEXUAL PRACTICES**

1.2 The participants will take turns on each flipchart to write words that are commonly used by people in their communities to describe the topic. They will have 10 minutes maximum to complete this task.

1.3 Stop the participants after 10 minutes. Ask them to spend two-to-three minutes to read all the flipcharts. Explain that we are going to do a fun exercise designed to boost their confidence to use the words that they just wrote. However, first ask the participants to identify the words on each flipchart that **they feel more uncomfortable to use** and mark those words by drawing a smile next to them.

1.4 Ask the participants to stand in a line or semi-circle in the middle of the room. You will say some of the "smiling" words and the participants will have to repeat them loudly and clapping at the same time. They can also jump or stamp their feet when they say the word loudly, if they want. Repeat the exercise with as many words as time permits. Conclude the activity by congratulating the participants on their newly increased comfort level.

Activity 2: Explaining reproductive anatomy and physiology in relation to family planning using language that clients can understand. Mini role-plays
(45 minutes)

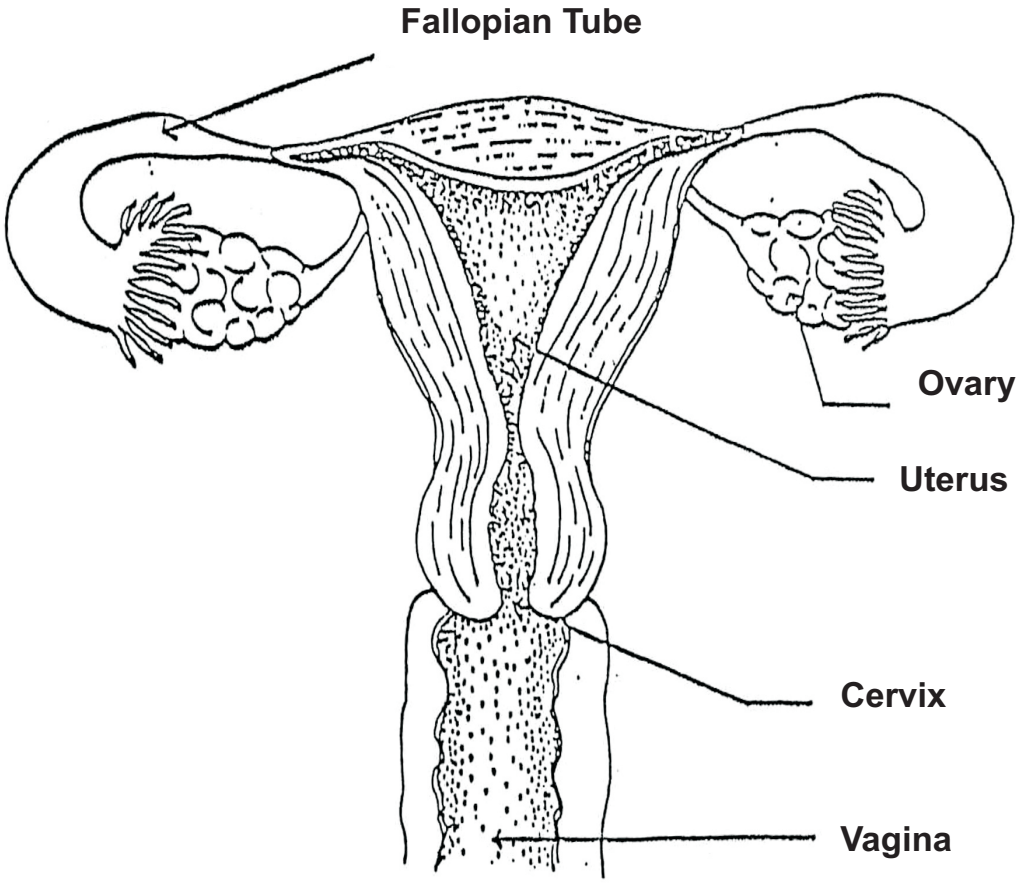
2.1 Distribute Handout 1, 2, and 3 to each participant. Divide the participants in pairs and assign a client scenario to each pair (you can use the client scenarios from Session 3, Handout 2 Activity 1 of this course, or you can develop your own scenarios).

- Pairs will have 15 minutes to review the handouts and prepare a five minute mini role-play for their scenarios. In their role-plays, they should demonstrate their ability to:
  - Explain the relevant human anatomy, physiology, and sexual practices (if applicable) in language that the client can understand.
  - Use an anatomical model and/or a diagram of human anatomy effectively.
  - Explain the relevance of family planning (and of specific family planning methods) to the anatomy and physiology issues as well as to the sexual practices that are being discussed.
  - Any other relevant information.
- In order to maximize time, the role-plays will not start from the beginning. The pairs should assume that the initial phase has already occurred and the client and the provider are now discussing the issue described in the scenario.

2.2 Stop the preparation after 15 minutes and begin the role-play demonstrations. Debrief the pairs after each role play in the following way:

- Remind the participants that we focus on constructive feedback. This means that we do not "point the finger" to highlight what was not done well. Instead, we focus first on what was useful and then we provide suggestions to improve.
- Start by debriefing the "provider" by asking what she/he did well and what she/he would do differently, and why.
- Next, debrief the "client" by asking what the "provider" did that was useful, and what the "provider" should have done better or differently to help the "client".
- Finally, ask the group to suggest **what, how**, and **why** the "provider" could have done differently in order to better help the "client".

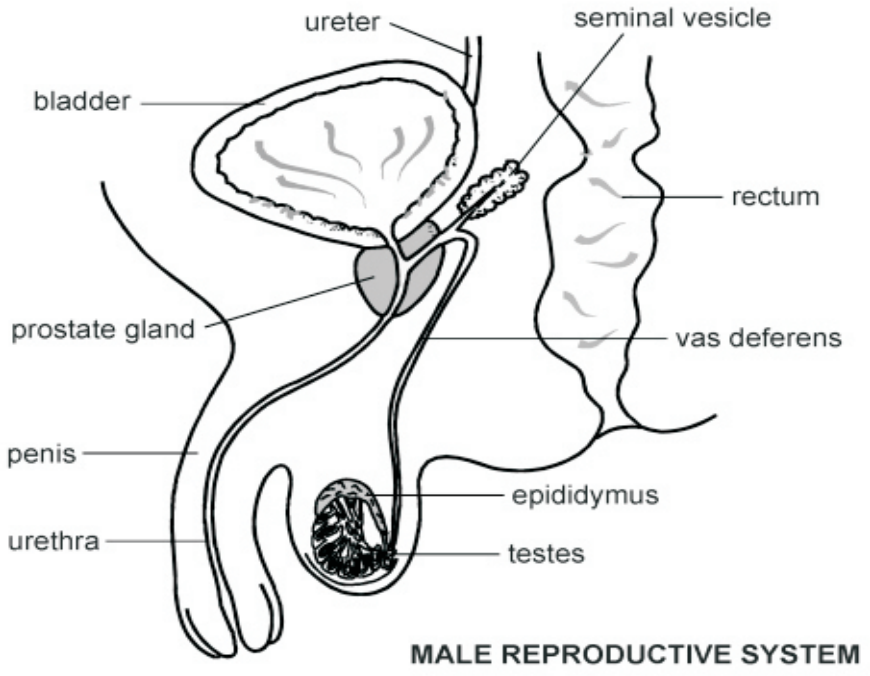
2.3 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.



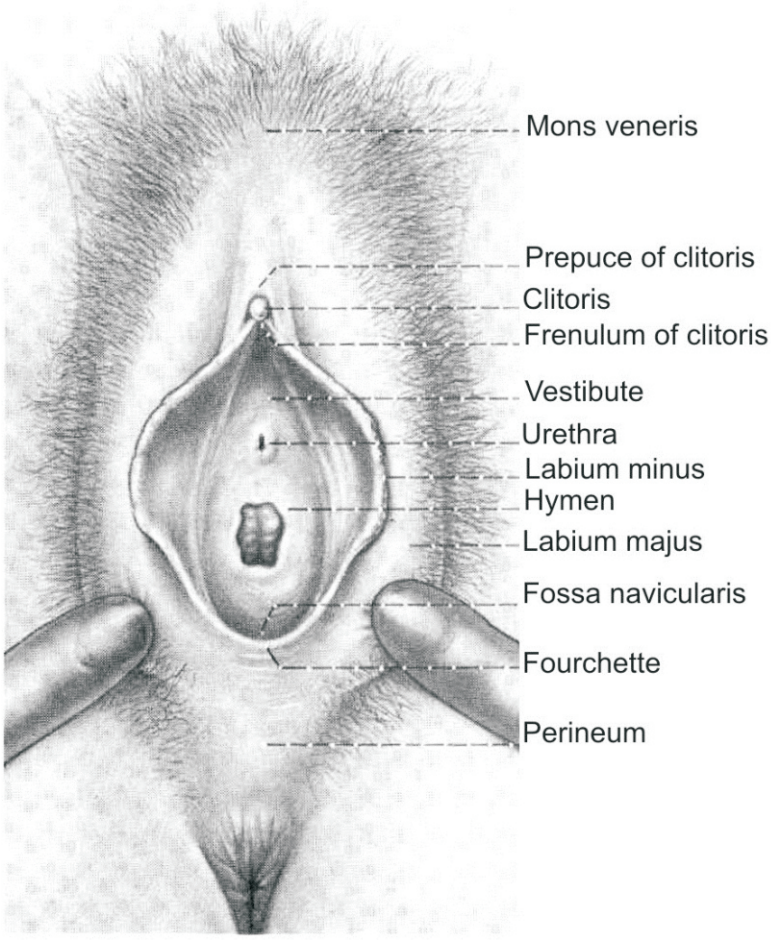
FEMALE REPRODUCTIVE SYSTEM

Participant's Handouts

Session 4: Handout 1, Activity 2 – Male and female anatomy diagrams



MALE REPRODUCTIVE SYSTEM



FEMALE REPRODUCTIVE SYSTEM

Participant's Handouts

Session 4: Handout 2, Activity 2 – Female anatomy and physiology

Women have two **ovaries**, which produce eggs and female hormones. Female hormones give women their female characteristics (e.g., breasts and the way their voices sound) and their sex drive. One of the ovaries releases one egg once a month (as the release of the egg is called **ovulation**).

Each ovary is connected by a **fallopian tube** to the **uterus** (or **womb**). When an egg is released from the ovary during ovulation, it travels through one of the fallopian tubes to the uterus.

The **cervix** is the narrow neck of the uterus that connects the uterus with the vagina. The **vagina** is the passage that connects the uterus with the outside of the body.

To start a pregnancy, a man and a woman have sexual intercourse, and the man ejaculates in the woman's vagina. The ejaculated **sperm** from the man then travels from the vagina through the cervix and the uterus until it reaches the fallopian tubes.

Fertilization (conception) happens when the man's sperm (“seed”) enters the egg; this usually happens in the fallopian tube. **Pregnancy** happens when a fertilized egg travels down the fallopian tube and attaches itself to the inside wall of the uterus. This is where the fertilized egg grows into a baby over the course of nine months.

When a woman of reproductive age is not pregnant, her uterus sheds its lining, which includes a lot of blood, every month. This is called **menstruation**. Menstrual blood is expelled from the woman's body through the vagina. When a pregnant woman goes into labor, the cervix widens out to let the baby out while the vagina is the passage (birth canal) through which the baby passes during delivery.

The **clitoris** is a small bud of tissue and nerve endings covered with a soft fold of skin. It is located above the urinary opening, which is just above the opening to the vagina. It is very sensitive to touch. During sexual arousal, the clitoris swells and becomes erect. It plays an important role in a woman's sexual pleasure and climax **(orgasm)**.

The **vulva** is the area around the opening of the vagina, including the folds of skin **(labia)**, the clitoris, the urinary opening, and the opening to the vagina itself. Many areas of the vulva are also sensitive to touch and play a role in female orgasm.

Source: USAID | the ACQUIRE Project, 2008: Counseling for Effective Use of FP—Participant Handbook

Participant's Handouts

Session 4: Handout 3, Activity 2 – Male anatomy and physiology

The **testicles** produce sperm and male hormones. Male hormones give men their masculine characteristics (e.g., facial hair and muscles) and their sex drive (desire for sexual intercourse).
The **scrotum** is the sack of skin that holds the two testicles.

Sperm are "seeds," the cells that enter a woman's egg during fertilization. After being produced in the testicles, the matured sperm are stored in the **epididymis**, a long, curled-up tube above each testicle. When the man's body is ready to release sperm, the sperm leave the epididymis and travel through the **vas deferens**. The vas deferens loop over the bladder and joins the **seminal vesicles**, two pouches located on either side of the prostate gland. (One vas deferens leads from each testicle to a seminal vesicle.) The seminal vesicles add fluid that energizes the sperm.

The **prostate gland** is located at the base of the bladder. It produces the majority of the fluid that makes up semen. The prostate fluid is alkaline (basic), which protects the sperm from the acid environment in the woman's vagina.

Semen is the liquid that comes out of the penis when a man climaxes and ejaculates. It contains sperm and fluids from the seminal vesicles and the prostate gland. Sperm make up only a tiny amount of the semen. After a man has a **vasectomy**, semen is still produced, but it will no longer contain sperm 3 months after vasectomy.

Semen passes from the prostate gland, through the **urethra**, and out through the **penis**. During **sexual intercourse**, the man puts his penis into the woman's vagina and semen is released during **ejaculation**.

Urine also passes through the urethra from the bladder when a man urinates. However, when a man ejaculates, a valve at the base of the bladder closes so that no urine can come out with the semen.

Cowper's glands are two small glands that release clear fluid into the penis just before ejaculation. Their purpose is probably to help clean out the acid in the urethra (from urine) before the sperm pass through. This fluid can also contain some sperm or infectious microorganisms. Because the man cannot feel or control this fluid when it comes out, it is important for him to use a condom for all contact between his partner and his penis, if there is any concern about pregnancy or disease.

Source: USAID | the ACQUIRE Project, 2008: Counseling for Effective Use of FP—Participant Handbook

SESSION 5: Client Assessment Part I: Being Sure that a Client is Not Pregnant

Objectives
By the end of the session, the participants will be able to:
- Explain what client assessment for family planning is.
- Demonstrate effective skills to establish if a client is pregnant during client assessment.

Total Session Time
75 minutes (1 hour and 15 minutes)

Materials
- Flipcharts, markers, tape, blank A4 size paper sheets
- "CLIENT ASSESSMENT" flipchart
- Post-it stickers
- LCD projector if available/necessary

Handouts
- Handout 1 - Overview of client assessment
- Handout 2 - How to be reasonably sure a client is not pregnant

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide).
Client assessment is a very important aspect of client-provider interaction that provides broad based information about the client. This information will assist the provider in supporting the client in making informed decisions about the most appropriate family and reproductive services. This session will begin by focusing on improving our skills for assessing that a client is not pregnant.

Activity 1: Reviewing the purpose of client assessment (35 minutes)

1.1 Divide the participants in two teams (or more than two, depending on the total number of participants). Give two or three blank A4 size paper sheets to each team and explain the instructions:
- ➢ Each team has five minutes to develop a simple definition of client assessment. After five minutes the team will post their definitions under the CLIENT ASSESSMENT sign that the trainer has pre-prepared on the wall.

1.2 Stop the exercise after five minutes. Show the following definition and discuss similarities and differences with those developed by the participants:

Client Assessment
Client assessment helps the client and healthcare provider determine: • That the client is not pregnant. • Whether there are any reasons that may make a particular method unsuita ble for the client. • Whether there are any problems that might require further assessment, treatment, or follow-up.

1.3 Divide the participants in pairs and give two-to-three post-it stickers to each pair. Different pairs will discuss only one of the following questions that you will assign and will write their answers on the stickers (one answer per sticker):

- How can providers be reasonably sure that the client is not pregnant without using laboratory tests?
- What are some of the reasons that may make a particular method unsuitable for a client?
- What problems may require further assessment, treatment, or follow-up?

The pairs have five minutes to discuss the question that they have been assigned and prepare their answers. They will place the stickers under the corresponding issues on the flipchart.

1.1 Allow a few minutes for the participants to read all the answers. Briefly discuss if there are any answers on the stickers that participants wish to clarify or further expand on. Distribute Handout 1 and review it with the group relating/comparing its content to the answers developed by the participants.

Activity 2: Practicing how to be reasonably sure that a client is not pregnant. Mini role-plays (35 minutes)

2.1 Distribute and review Handout 2 with the participants. Explain the exercise:

- The participants work in pairs. In each pair there will be a person playing the “provider” and one playing the “client”. The person playing “client” will decide what kind of client to be and will not tell the person playing the “provider”.
- They will have five minutes to rehearse their mini-role play using the checklist in Handout 2.
- They will pretend that they have already completed the initial greetings and bio-data collection, and will start from the point at which the provider wants to be sure that the client is not pregnant. In their role plays, the “provider” has to demonstrate to be able to:
  - Use simple language that the client can understand i.e. rephrase the questions if necessary.
  - Establish whether the client is not pregnant or if the client should wait for her menses or use a pregnancy test.

2.2 Select two pairs to perform their mini-role plays in front of the large group and facilitate feedback.

2.3 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Participant's Handouts

Session 5: Handout 1, Activity 1 – Overview of client assessment

Client assessment helps the client and healthcare provider determine:

- That the client is not pregnant

"Before initiating a medical regimen, health care providers often need to assess whether a woman is pregnant, because some medications may have side effects that are potentially harmful to the fetus. According to the World Health Organization (WHO), there is no known harm to the woman, the course of her pregnancy, or the fetus if COCs, DMPA (or NET-EN), combined injectable contraceptives, the contraceptive patch, or the contraceptive ring are accidentally used during pregnancy. However, it is recommended that family planning providers assess whether a woman seeking contraceptive services might already be pregnant, because women who are currently pregnant do not require contraception. In addition, the IUD should never be inserted in pregnant women because doing so might lead to septic miscarriage, a serious complication. Although pregnancy tests are reliable, in many areas such tests are unavailable or unaffordable. When providers lack recourse to pregnancy tests, they rely on the presence of menses as evidence that a woman is not pregnant. In these cases, clients who are not menstruating when they visit a health facility for contraception are turned away. These women are often required to wait for their menses to return before they can initiate use of a contraceptive method."
Source: Family Health International, 2008: How to Be Reasonably Sure a Client is Not Pregnant

- Whether there are any reasons that may make a particular method unsuitable for the client

It is very important to assess the safety of use of different methods for women and men with specific characteristics or known medical conditions. For example, a client may face challenges in negotiating the use of a certain method with her/his partner and such an issue may be a serious obstacle for the client to use that method even if it is suitable. For this reason, client assessment requires attention not only to clinical issues, but also to the social and relationship aspects of a client's life.

In order to help providers and clients assess the suitability of methods, the WHO has developed *Medical eligibility criteria for contraceptive use*. How to use these guidelines is practiced in the counselling training course of this curriculum. However, a separate session later on in this course will also refresh our knowledge and skills on using these recommendations.

- Whether there are any problems that might require further assessment, treatment, or follow-up

Such problems may include hypertension, malaria, STI, etc. With many of these conditions, it is possible to identify the suitable family planning method/s by applying the WHO medical eligibility criteria to help clients make informed choices. However, further assessment and follow-up may still be necessary to help the client deal with those conditions as well as prevent/minimize any potential complications or side effects.

Participant's Handouts

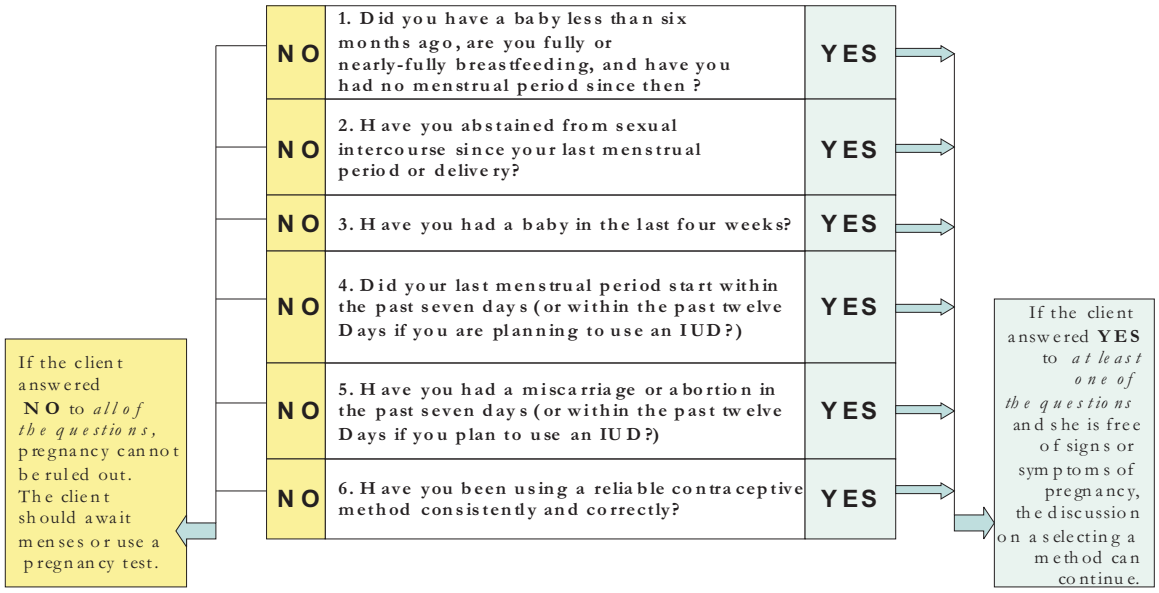
Session 5: Handout 2, Activity 2 – How to be reasonably sure a client is not pregnant.

Mini Role-plays - Pregnancy Assessment Checklist:

Source: Family Health International, 2008: How to Be Reasonably Sure a Client is Not Pregnant

If the client answered **NO** to ***all of the questions,*** pregnancy cannot be ruled out. The client should await menses or use a pregnancy test.

If the client answered **YES** to ***at least one of the questions*** and she is free of signs or symptoms of pregnancy, continue with the client toward identifying a suitable method.



"Explanation of the Questions
The checklist consists of six questions that providers ask clients while taking their medical history. If the client answers "yes" to any of these questions, and there are no signs or symptoms of pregnancy, then a provider can be reasonably sure that the woman is not pregnant. Women who are in the first seven days of their menstrual cycle, who have had a miscarriage/abortion in the past seven days, or who are in their first four weeks postpartum, are protected from unplanned pregnancy because the possibility of ovulation in each of these situations is extremely low. With the IUD, the possibility of pregnancy is very low before day 12 of the menstrual cycle because of the additional contraceptive effectiveness of the copper IUD. Women who satisfy the lactational amenorrhea method criteria (e.g., women who are in their first six months postpartum, are fully or nearly-fully breastfeeding, and are amenorrheic) are protected from unplanned pregnancy because of the effects of lactational amenorrhea on the reproductive cycle. Likewise, women who consistently and correctly use a reliable contraceptive method are effectively protected from pregnancy, as are those who have abstained from sexual intercourse since their last menstrual period."

Source: Family Health International, 2008: How to Be Reasonably Sure a Client is Not Pregnant

SESSION 6: Client Assessment Part II: Strengthening Skills for Effective History Taking and Assessing Potential Method Contraindications

Objectives

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

- Obtain relevant information during client assessment about the physical and psychological status of the client.
- Obtain relevant history that will be used to help the client make informed decisions about the most appropriate and safe family planning method.
- Verify and update the data collected at the first visit.
- Detect, during follow up visits, any side effects of the clients' chosen FP method.

Total Session Time

120 minutes (two hours)

Materials

- Flipcharts, markers, tape, blank A4 size paper sheets
- "CLIENT ASSESSMENT" flipchart from Session 5
- World Health Organisation medical eligibility criteria
- Sufficient copies of task cards for Activity 2
- LCD projector if available/necessary

Facilitator's Resources

- Activity 2: Task Cards

Handouts

- Handout 1 – History taking
- Handout 2 – Effective use of the WHO medical eligibility criteria in client assessment (COCs)
- Handout 3 – Effective use of the WHO medical eligibility criteria in client assessment (DMPA, NET-EN)
- Handout 4 – Effective use of the WHO medical eligibility criteria in client assessment (Copper IUD)
- Handout 5 – Effective use of the WHO medical eligibility criteria in client assessment (Implants)

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide).
In part II of *client assessment* we focus on history taking. Effective history taking skills play a very important role in enabling providers to help clients make informed choices about the most suitable family planning options. History taking is also very important to assess possible barriers or challenges that client may face in implementing their decisions and choices, and thus provides an opportunity to begin to help clients think of ways to overcome those problems.

Activity 1: Important elements of history taking (40 minutes)

1.1 Show the CLIENT ASSESSMENT flipchart that you used in Session 5, and put brackets around the first point, as shown below:

Client Assessment
Client assessment helps the client and healthcare provider determine: • (That the client is not pregnant). • Whether there are any reasons that may make a particular method unsuitable for the client • Whether there are any problems that might require further assessment, treatment, or follow-up.

Explain that in this and the next session the focus will be on the last two elements of client assessment.

1.2 In order to assess *whether there are any reasons that may make a particular method unsuitable for the client,* providers need to elicit broad base information about her/him. This happens during the counselling process, and in the counselling training course of this curriculum the participants practice skills to apply GATHER towards achieving this aim. In the next exercise we will continue to refresh these skills and at the same time we will aim to address this question:

- How do we ensure that we collect the essential information for history taking without overburdening the client and overstretching our resources? In other words: **What is the essential information for history taking?**

1.3 Divide the participants in two teams and explain the instructions:

- Each team receives seven blank A4-size paper sheets. They will have five minutes to write on each sheet the heading of one key element of history taking.
- When the five minutes expire, each team will post their A4s in a column under the HISTORY TAKING sign that the facilitator will have prepared on a wall. Therefore, there will be two columns, one per team.
- At this point in the exercise, it is <u>not</u> important to post the A4s in a "proper" logical or sequential order.

1.4 Ask the teams to gather around the wall and give a few minutes to each team to explain their list. Discuss:

- Why are these issues useful for history taking?
- In which ways would this information enable providers to assist a client in choosing the preferred method?

1.5 If necessary, re-arrange the lists and produce a final example as shown below (you may need additional A4 sheets if the participants have not identified some of the following items):

History Taking
Source of referral
Client's bio data/profile
Medical record (past and present)
Social and relations hip context (including family and social history)
Gynaecological History (Menstrual History, Sexual History)
Obstetrical history
Contraceptive history

1.6 Distribute Handout 1 and review and discuss it with the group. If time permits, it is useful to ask and discuss the questions in the handout before distributing it.

Activity 2: Using effectively the medical eligibility criteria of the World Health Organisation (55 minutes)

2.1 Even new clients may already have in mind a method that they want to use. They may have heard about it from other clients or from other sources. Returning clients may want to switch method whether because they have side effects with their current one or for other reasons. Clients who do not have a method in mind may develop their preference based on the information they receive from providers during the interaction. In any case, once clients indicate a preference for a method it is necessary to rule out that there are no reasons that may make that method clinically unsuitable or unsafe for that particular clients. For these reasons, use the medical eligibility criteria developed by the WHO. A copy of these criteria is enclosed in the knowledge pack of this manual that the participants were asked to read prior to the training. In this activity the participants will strengthen their skills to use these criteria effectively, building on the practice that they had during the counselling course.

2.2 Divide the participants in four pairs or small groups (or less, if the total number does not allow). Explain the instructions:

- In this exercise we are going to sharpen our skills to use effectively the medical eligibility criteria developed by the WHO, which are included in the knowledge pack of this course. In order to maximize time for practice, we are going to focus on four main types of contraceptives: COCs, DMPA (or NET-EN), Copper IUD, and Implants.
- Each pair/group will be assigned one of these types of contraceptives (if you do not have enough pairs/groups, assign more than one method per pair or group). Pairs/groups will receive a task card explaining what they have to do (please refer to the **Facilitator's Resources** section below). They will have 20 minutes to complete their task and five-to-seven minutes to present.

2.3 Stop the pair/group work after 20 minutes and facilitate the presentations and discussions. Distribute Handouts 2, 3, 4, and 5. **Do not** read with the participants the handouts in their entirety. Select only two questions from each handout for each task about issues that the pairs/groups did not identify and invite the participants to discuss:

- Why are these issues important for conducting effective client assessment for this method?

2.4 Encourage the participants to read the handouts in their own time. Explain that in the next session the participants will complete the exploration of client assessment and will expand on their practicing with the medical eligibility criteria.

Activity 3: Checking and updating a client's base line information at subsequent visits (20 minutes)

3.1 The steps in client assessment that we have explored so far take place at the first visit of the client. However, providers need to check and update a client's information at every subsequent visit.

3.2 Divide the participants in two pairs/groups. Each pair/group will conduct the following three minute brainstorm:

- Pair/group 1: What client's information is especially important to check and update at subsequent visits?
- Pair/group 2: Why is it important to check and update a client's base line information at subsequent visits?

3.3 Pairs/groups present their respective brainstorms and share comments and input.
Facilitators should stress the importance of using follow-up visits to find out about, check and help clients solve issues concerning:

- **Client's choices and decisions about reproductive goals:** what support, if any, does the client still need to carry out the choices and decisions she/he made? Are the client's

reproductive goals still the same or have they changed?

- **Using the method correctly and consistently:** has the client been able to do so? Has the client experienced any difficulty, e.g. pressure from partner?
- **Side effects of the method:** has the client experienced any? What these are, and if and how they can be resolved or whether a different method is a better option.
- **Outcome of referral/treatment**, if client was referred to other services or received treatment for a certain condition: What next steps are still needed, if any?

In addition, there are obvious elements of the client's base line that should be checked. For example:

- Any **changes to the client's bio** data (e.g. address or occupation?)
- Any **new physical or emotional problem**/issue requiring attention?
- Any **changes in the client's medical, gynaecological, and obstetric** history?
- Any **changes in the client's relationships** e.g. a new partner (casual or permanent)?

3.1 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Facilitator's Resources

Activity 2: Task Cards

Copy and distribute the following task cards according to the number of pairs/groups you will have.

Task Card 1: Assessing clients who want to initiate use of Combined Oral Contraceptives (COCs)

"Research findings have established that combined oral contraceptives (COCs) are safe and effective for use by most women, including those who are at risk of sexually transmitted infections (STIs) and those living with or at risk of HIV infection. For some women, COCs are not recommended because of the presence of certain medical conditions, such as ischemic heart disease, stroke, and breast cancer. For these reasons, women who desire to use COCs must be screened for certain medical conditions to determine if they are appropriate candidates for COCs."

Source: Family Health International, 2008: Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives

Consulting the WHO medical eligibility criteria from your knowledge pack, you have 20 minutes to:

- Develop on flipchart a few questions that you would use during the client assessment of a client who wants to start COCs in order to find out whether **there are any reasons that may make COCs unsuitable for the client.**

You will post your flipchart on the wall. Write in large letters to ensure that everyone can read it. You will have 5-7 minutes to present and explain the rationale for each question.

Task Card 2: Assessing clients who want to initiate use of DMPA (or NET-EN)

"Research findings have established that depot medroxyprogesterone acetate (DMPA) and norethisterone enanta te (NET-EN) are safe and effective for use by most women, including those who are at risk of sexually transmitted infections (STIs) and those living with, or at risk of, HIV infection. For some women, DMPA is usually not recommended because of the presence of certain medical conditions, such as breast cancer or most types of liver tumors. For these reasons, women who desire to use DMPA must be screened for certain medical conditions to determine if they are appropriate candidates."

Source: Family Health International, 2008: Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN)

Consulting the WHO medical eligibility criteria from your knowledge pack, you have 20 minutes to:

- Develop on flipchart a few questions that you would use during the client assessment of a client who wants to start DMPA in order to find out whether **there are any reasons that may make DMPA unsuitable for the client.**

You will post your flipchart on the wall. Write in large letters to ensure that everyone can read it. You will have 5-7 minutes to present and explain the rationale for each question.

Task Card 3: Assessing clients who want to initiate use of Copper IUD

"Research findings over the past 25 years have established that intrauterine devices (IUDs) are safe and effective for use by most women, including those who have not given birth, who want to space births, and those living with or at risk of HIV infection. For some women, IUDs are not recommended because of the presence of certain medical conditions, such as genital cancer and current cervical infection. For these reasons, women who desire to use an IUD must be screened for certain medical conditions to determine if they are appropriate candidates for the IUD."

Source: Family Health International, 2008: Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD

Consulting the WHO medical eligibility criteria from your knowledge pack, you have 20 minutes to:

- Develop on flipchart a few questions that you would use during the client assessment of a client who wants to start copper IUD in order to find out whether **there are any reasons that may make this method unsuitable for the client.**

You will post your flipchart on the wall. Write in large letters to ensure that everyone can read it. You will have 5-7 minutes to present and explain the rationale for each question.

Task Card 4: Assessing clients who want to initiate use of Contraceptive Implants

"Contraceptive implants, such as Norplant, Jadelle, Sinoplant, and Implanon, are safe and effective for use by most women, including those who are at risk of cardiovascular disease, sexually transmitted infections (STIs) and HIV infection, or those living with HIV. For some women, implants are generally not recommended because of the presence of certain medical conditions, such as breast cancer or most types of liver tumors. Women who desire to use implants must therefore be screened for certain medical conditions to determine if they are appropriate candidates."

Source: Family Health International, 2008: Checklist for Screening Clients Who Want to Initiate Contraceptive Implants

Consulting the WHO medical eligibility criteria from your knowledge pack, you have 20 minutes to:

- Develop on flipchart a few questions that you would use during the client assessment of a client who wants to start implants in order to find out whether **there are any reasons that may make this method unsuitable for the client.**

You will post your flipchart on the wall. Write in large letters to ensure that everyone can read it. You will have 5-7 minutes to present and explain the rationale for each question.

Participant's Handouts

Session 6: Handout 1, Activity 1 – History taking

History Taking
Source of referral
Client's bio data/profile
Medical record (past and present)
Social and relationship context (including family and social history)
Gynecological History (Menstrual History, Sexual History)
Obstetrical history
Contraceptive history

➢ **What should providers ensure and communicate to the client before starting history taking?**

- History taking usually happens at the beginning of the client's visit. Providers should ensure privacy and confidentiality and a non-threatening atmosphere, explain why they will ask personal questions, and inform that the client can decline to respond to any questions that she/he is not comfortable with.

➢ **Why begin with the source of referral and client's bio data?**

- These issues are less sensitive than discussing issues such as the sexual relationships of the client. By starting from these less sensitive issues, clients are gradually engaged in the interaction.

➢ **Why is medical history (past and present) important?**

- Some medical conditions may prevent or limit the use/effectiveness of certain family planning methods. This information is very important in the context of the WHO medical eligibility criteria. It is also important to help the client realize whether there are any issues that require further investigation, treatment, or follow-up.

➢ **Why is asking about the social and relationship context of a client, including family and social history important?**

- Some clients may face challenges in their social environment (e.g. the family) and in their relationships (e.g. lack of power to negotiate) and these issues may prevent them from carrying out their family planning choices and decisions. Furthermore, clients may face issues in their relationships that may put them at risk of other problems, e.g. sexually transmitted infection (STI). Therefore providers need to find out about these issues to help clients think through their options and make the most useful informed decisions for their lives.

➢ **Why is asking about a client's gynaecological history (menstrual history, sexual history) and obstetrical history important?**

- This information is important in the context of using the WHO medical eligibility criteria. It is also important to help the client realize whether there are any issues that require further investigation, treatment, follow-up, and/or referral to other services.

➢ **Why is asking about a client's contraceptive history important?**

- In order to help assess whether the client has any knowledge of and experience with using

contraception, what perceptions the client has about contraception, whether the client (if a user in the past) has had any negative experiences e.g. with side effects, whether the client has already a method in mind.

Please note: The order in which these aspects of history taking are presented is not set in stone. Providers must always remember that an interaction with a client is flexible. Some clients may be comfortable with discussing their sexual relationships, while others may be very shy and providers may need to re-build comfort and trust.

Participant's Handouts

Session 6: Handout 2, Activity 2 – Effective use of the WHO medical eligibility criteria in client assessment: COCs

Task 1: Assessing clients who want to use Combined Oral Contraceptives (COCs)

Sample useful questions to ask:
Source: Family Health International, 2008: Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives

1. Are you currently breastfeeding a baby less than six months of age?
Because COC use during breastfeeding diminishes the quantity of breast milk and can decrease the duration of lactation, a breastfeeding woman should delay COC use until her baby is at least six months old. If a client does not continue breastfeeding, she may be a candidate for COCs even before the baby reaches six months of age.

2. Have you given birth in the last three weeks?
Women who are within three weeks of giving birth may be at a higher risk of thrombosis if they take COCs. However she may start taking COCs at three weeks postpartum (if she is not planning to breastfeed).

3. Do you smoke cigarettes and are you more than 35 years of age?
Women who are over 35 years of age and smoke cigarettes may be at increased risk of cardiovascular disease (e.g., heart attack). This is a two-part question — both parts need to be asked together, and the answer "yes" must apply to both parts of the question for the woman to be ineligible. This is because a woman less than 35 years of age who smokes, as well as a woman over the age of 35 years who is a non-smoker, are not at increased risk for cardiovascular disease. The answer "no" to one or both parts of this question means a client may be eligible for COC use.

4. Do you have repeated severe headaches, often on one side, and/or pulsating, causing nausea, and which are made worse by light, noise, or movement?
The use of the words, "repeated severe headache, often on one side," and the occurrence of other problems during the headache are essential parts of this question. These words help the client distinguish between the types of headaches that make her ineligible for COC use (such as migraines) and the less severe (more common) mild headaches, which do not rule out COC use.

5. Have you ever been told you have breast cancer?
Women who have had or currently have breast cancer are not good candidates for COCs, because breast cancer is a hormone-sensitive tumour, and COC use may adversely affect the course of the disease.

6. Have you ever had a stroke, blood clot in your legs or lungs, or heart attack?
Women with these conditions may be at increased risk of blood clots if they take COCs.

7. Do you regularly take any pills for tuberculosis (TB), seizures (fits), or ritonavir for ARV therapy?
The following medications make COCs less effective; hence, women taking these medications should generally not use COCs: rifampicin or rifabutin (for tuberculosis), certain anticonvulsants including phenytoin, carbamazepine, primidone, topiramate, oxcarbazepine, lamotrigine, and barbiturates (for epilepsy/seizures), or ritonavir (as part of an antiretroviral regimen).

8. Do you have gall bladder disease or serious liver disease or jaundice (yellow skin or eyes)?

COC use may aggravate symptoms of gall bladder disease; or a serious liver disease such as severe cirrhosis; acute hepatitis; malignant liver tumours; or benign liver tumours, with the exception of focal nodular hyperplasia (a tumour that consists of scar tissue and normal liver cells). The hormones used in COCs are processed by the liver and may further compromise liver function. Women with other liver problems, such as chronic hepatitis, can use COCs safely.

9. Have you ever been told you have high blood pressure?
Women with high blood pressure should not use COCs because they may be at increased risk of stroke and heart attack. Women who do not know if they have high blood pressure should have it checked by a trained provider before receiving COCs.

10. Have you ever been told you have diabetes (high sugar in your blood)?
Among women with diabetes, those who have had the disease for 20 years or longer, or those with vascular complications, should not be using COCs because of the increased risk of blood clots. If these complications are absent, the woman may still be a good candidate for COCs once testing confirms it.

11. Have you ever been told that you have a rheumatic disease, such as lupus?
Women who have systemic lupus disease and who are not on immunosuppressive treatment should not use COCs, due to concerns about a possible increased risk of thrombosis.

Participant's Handouts

Session 6: Handout 3, Activity 2 – Effective use of the WHO medical eligibility criteria in client assessment: DMPA (or NET-EN)

Task 2: Assessing clients who want to use DMPA (or NET-EN)

Sample useful questions to ask:
Source: Family Health International, 2008: Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN)

1. Have you ever been told you have breast cancer?
Women who have had or currently have breast cancer are not good candidates for DMPA because breast cancer is a hormone-sensitive tumour, and DMPA use may adversely affect the course of the disease.

2. Have you ever had a stroke or heart attack, or do you currently have a blood clot in your legs or lungs?
Women with these conditions usually experience acute symptoms, which prompt them to seek health care. For this reason, they would likely be aware of the condition and would answer "yes." Because DMPA use may make these conditions worse, answering "yes" to the question means that the woman is not a good candidate for DMPA. However, women on established anticoagulant therapy generally can use DMPA.

3. Do you have a serious liver disease or jaundice (yellow skin or eyes)?
Women with conditions such as severe cirrhosis, malignant liver tumours, or benign liver tumours, with the exception of focal nodular hyperplasia (a tumour that consists of scar tissue and normal liver cells), should not use DMPA because the hormone used in DMPA is processed by the liver and may further compromise liver function. Women with other liver problems, such as acute or chronic hepatitis, can use DMPA safely.

4. Have you ever been told you have diabetes (high sugar in your blood)?
Women who have had diabetes for 20 years or longer, or those with vascular complications, should generally not use DMPA because of the increased risk of blood clots.

5. Have you ever been told you have high blood pressure?
Women who may have high blood pressure should be evaluated or referred for evaluation as appropriate. Based on evaluation, women with blood pressure levels of 160/100 Hg or more should not initiate DMPA.

6. Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)?
This question is intended to identify women who may have an underlying pathological condition. While these conditions are not directly affected by DMPA, changes in bleeding patterns, which are common among DMPA users, could make such conditions harder to diagnose. Unusual, unexplained bleeding changes may indicate infection or cancer that should be evaluated without delay or treated by a higher-level health care provider. DMPA use should be postponed until the condition can be evaluated. In contrast, women for whom heavy, prolonged, or irregular bleeding constitutes their usual bleeding pattern may initiate and use DMPA safely.

7. Have you ever been told that you have a rheumatic disease, such as lupus?
Women who have systemic lupus disease and who are not on immunosuppressive treatment should not use DMPA, due to concerns about a possible increased risk of thrombosis.

8. Are you currently breastfeeding a baby less than six weeks old?

This question is included because of the concern that hormones in breast milk can have an adverse effect on a newborn during the first six weeks after birth. A breastfeeding woman can initiate DMPA six weeks after her baby is born.

Participant's Handouts

Session 6: Handout 4, Activity 2 – Effective use of the WHO medical eligibility criteria in client assessment: COPPER IUD

Task 3: Assessing clients who want to use Copper IUD

Sample useful questions to ask:
Source: Family Health International, 2008: Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD

Do you have bleeding between menstrual periods that is unusual for you or bleeding after intercourse (sex)?

Unexplained vaginal bleeding may be a sign of conditions such as genital cancer or infection. All these possibilities must be ruled out before an IUD can be inserted. Counsel the client about other contraceptive options available, and provide condoms to use in the meantime.

1. Have you ever been told that you have a rheumatic disease, such as lupus?
Women with systemic lupus disease with severe thrombocytopenia. These women should not initiate use of an IUD.
Note: Questions 3-6 are intended to identify clients vulnerable to STIs because there is a possibility that they may currently have chlamydia and/or gonorrhoea infection. Unless these STIs can be reliably ruled out, these clients are not good candidates for IUD insertion because IUD insertion may increase risk of pelvic inflammatory disease (PID) in these clients.

2. Within the last 3 months, have you had more than one sexual partner?
Clients who have multiple sexual partners are more vulnerable to contracting STIs. Unless chlamydia and/or gonorrhoea infection can be reliably ruled out, these clients are not good candidates for IUD insertion.

3. Within the last 3 months, do you think your partner has had another sexual partner?
Clients whose partners have more than one sexual partner are more vulnerable to contracting STIs. Unless chlamydia and/or gonorrhoea infection can be reliably ruled out, IUD insertion is not recommended. In situations where polygamy is common, the provider should ask about sexual partners outside of the union.

4. Within the last 3 months, have you been told you have an STI?
These clients may currently have chlamydia and/or gonorrhoea infection. Unless these STIs can be reliably ruled out, these clients are not good candidates for IUD insertion.

5. Within the last 3 months, has your partner been told that he has an STI, or do you know if he has had any symptoms – for example, penile discharge?
There are two parts to this question. Answering "yes" to either part or both parts of the question restricts IUD insertion because clients whose partners have STIs may have these infections as well.

6. Are you HIV-positive, and have you developed AIDS?
If the woman is HIV-positive but has not developed AIDS, the IUD may generally be used. If the woman has developed AIDS, ask if she is taking ARVs and make sure she is doing clinically well. If she is doing clinically well, she may be a candidate for the IUD. If she is not, an IUD usually is not recommended unless other more appropriate methods are not available or not acceptable. There is concern that people who have developed AIDS and are not taking ARVs may be at increased risk of STIs and PID because of a suppressed immune system. IUD use may further increase that risk.

7. Is there any type of ulcer on the vulva, vagina, or cervix?
Genital ulcers/lesions may indicate a current STI. An ulcerative STI is not a contraindication for IUD insertion, but indicates risk of STIs, thus IUDs are not recommended. An IUD can still be inserted if co-infection with gonorrhoea and chlamydia are reliably ruled out.

8. Does the client feel pain in her lower abdomen when you move the cervix?
Cervical motion tenderness is a sign of PID. Clients with current PID should not use an IUD.

9. Is there purulent cervical discharge?
Purulent cervical discharge is a sign of cervicitis and possibly PID. Clients with current cervicitis or PID should not use an IUD.

10. Does the cervix bleed easily when touched?
If the cervix bleeds easily at contact, it may indicate that the client has cervicitis or cervical cancer. Clients with current cervicitis or cervical cancer should not have an IUD inserted.

11. Is there an anatomical abnormality of the uterine cavity that will not allow appropriate IUD insertion?
If there is an anatomical abnormality that distorts the uterine cavity, proper IUD placement may not be possible.

12. Were you unable to determine the size and/or position of the uterus?
Determining size and position of the uterus is essential before IUD insertion to ensure correct placement of the IUD, and to minimize the risk of perforation.

Participant's Handouts

Session 6: Handout 5, Activity 2 – Effective use of the WHO medical eligibility criteria in client assessment: IMPLANTS

Task 4: Assessing clients who want to use contraceptive implants

Sample useful questions to ask:
Source: Family Health International, 2008: Checklist for Screening Clients Who Want to Initiate Contraceptive Implants

1. Have you ever been told you have breast cancer?
Women who have had or currently have breast cancer are not good candidates for implants because breast cancer is a hormone-sensitive tumour, and implant use may adversely affect the course of the disease.

2. Do you currently have a blood clot in your legs or lungs?
Women with blood clots in their legs or lungs usually experience acute symptoms that prompt them to seek health care. For this reason, they would likely be aware of the condition and would answer "yes." Because implants use may make these conditions worse, answering "yes" to the question means that the woman is not a good candidate for contraceptive implants. However, women on established anticoagulant therapy generally can use implants.

3. Do you have a serious liver disease or jaundice (yellow skin or eyes)?
Women with conditions such as severe cirrhosis, malignant liver tumours, or benign liver tumours-with the exception of focal nodular hyperplasia (a tumour that consists of scar tissue and normal liver cells) should not use implants because the hormones used in implants are processed by the liver and may further compromise liver function. Women with other liver problems, such as acute or chronic hepatitis, can use implants safely.

4. Have you ever been told that you have a rheumatic disease, such as lupus?
Women who have systemic lupus disease and who are not on immunosuppressive treatment should not use implants, due to concerns about a possible increased risk of thrombosis.

5. Do you have bleeding between menstrual periods, which is unusual for you or bleeding after intercourse (sex)?
This question is intended to identify women who may have an underlying pathological condition. While these conditions are not directly affected by implants, changes in bleeding patterns (common among implant users) could make such conditions harder to diagnose. Unusual, unexplained bleeding changes may indicate infection or cancer that should be evaluated without delay or treated by a higher-level health care provider. Implant use should be postponed until the condition can be evaluated. In contrast, women for whom heavy, prolonged, or irregular bleeding constitutes their usual bleeding pattern may initiate and use implants safely.

6. Are you currently breastfeeding a baby less than six weeks old?
This question is included because of the concern that hormones in breast milk may have an adverse effect on a newborn during the first six weeks after birth. A breastfeeding woman can begin implant use six weeks after her baby is born.

SESSION 7: Client Assessment Part III: Physical Examination

Objectives
By the end of the session, the participants will be able to:
- Conduct an effective physical examination of clients.

Total Session Time
120 minutes (two hours)

Materials
- Flipcharts, markers, tape, blank A4 size paper sheets
- "CLIENT ASSESSMENT" flipchart from Session 5
- World Health Organisation medical eligibility criteria
- Sufficient copies of task cards for Activity 2
- LCD projector if available/necessary

Handouts
- Handout 1 – Physical examination in client assessment
- Handout 2 – Breast examination
- Handout 3 – Abdominal examination
- Handout 4 – Client preparation for pelvic examination
- Handout 5 – Conducting a pelvic examination
- Handout 6 – Pelvic examination using a speculum

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide).
In Part III of *Client Assessment* we focus on skills for effective physical examination. This is an important element of client assessment, especially at first visit.

Activity 1: The role of physical examination in client assessment (60 minutes)
1.1 Show the CLIENT ASSESSMENT flipchart that you used in Sessions 6:

Client Assessment
Client assessment helps the client and healthcare provider determine: • (That the client is not pregnant). • Whether there are any reasons that may make a particular method unsuitable for the client • Whether there are any problems that might require further assessment, treatment, or follow-up.

Explain that in this session we are going to complete the exploration of the last two elements of client assessment. In the previous sessions we focused on assessing potential contraindications of methods as per the medical eligibility criteria of the WHO. An effective physical examination of a client is also important in using the eligibility criteria. However:

➢ **Providers should avoid turning a physical examination into a barrier to access contraceptives. This is one of the key reasons why the WHO has created the medical eligibility criteria in order to help providers assist effectively clients in choosing the most appropriate method for their circumstances.**

Note for Facilitators

It is important at this stage to stress that the order of the steps of client assessment that we have explored so far is not set in stone. Client assessment happens during a provider-client interaction and therefore requires good technical knowledge as well as good counselling skills. The latter includes the ability to create a comfortable and non-threatening atmosphere for the client. Some clients may be comfortable with starting a physical examination almost immediately after the initial introduction, while others may first want to ask a few questions or discuss and clarify their reproductive goals or their concern in using contraception in general.

1.2 Brainstorm with the group:
- What is the purpose of conducting a physical examination in client assessment?

Discuss responses and emphasize that the main purpose of a physical examination is to assess the client's health status.

1.3 Distribute Handout 1 and review it with the participants. Stress that a general physical examination should precede the examination of the different systems and it can provide very useful information about the medical condition of the patient.

Explain that when conducting a physical examination, providers should record the information on the client's card. Distribute a sample client's card to each participant. Continue to review Handout 1 and relate it to the client's card at any relevant step.

1.4 The next step consists of conducting a **breast examination**:
- Show the anatomical model and distribute Handout 2.
- Demonstrate a breast examination correctly on the model.
- Next, demonstrate again a breast examination, but explain that you will perform one or two steps incorrectly or omit them completely. The participants should identify the incorrect or omitted steps without consulting Handout 2.
- Ask the participants to work in pairs: They will take turns in performing a breast examination, while the other person will observe and comment whether it is done completely and correctly using the handout.
- Finally, invite one or two participants to perform the breast examination in front of the large group.

1.5 Participants will now practice conducting an **abdominal examination** using models:
- Distribute and review Handout 3 with the participants.
- Demonstrate correctly an abdominal examination on the model.
- Next, demonstrate again an abdominal examination, but explain that you will perform one or two steps incorrectly or omit them completely. The participants should identify the incorrect or omitted steps without consulting Handout 3.
- Ask the participants to work in pairs. They will take turns in performing an abdominal examination, while the other person will observe and comment whether it is done completely and correctly using the handout.
- Finally, invite one or two participants to perform the examination in front of the large group.

Activity 2: Pelvic examination (60 minutes)

2.1 Explain in this activity, the participants will strengthen their skills to perform a pelvic examination correctly and effectively.

2.2 Distribute Handout 4 and review it with the participants. Discuss:
- Do you usually follow all these steps in **preparing a client for pelvic examination**?

- Which steps are new, if any?
- If you were a client who has never had a pelvic examination before, how would these steps help you to understand what is happening to you and feel comfortable and respected?

2.3 Distribute Handout 5:

- Using a model, demonstrate correctly a **bi-manual pelvic examination**.
- Next, demonstrate again the examination, but explain that you will perform one or two steps incorrectly or omit them completely. The participants should identify the incorrect or omitted steps without consulting Handout 5.
- Ask the participants to work in pairs. They will take turns in performing the examination on a model, while the other person will observe and comment whether it is done completely and correctly using the handout.
- Finally, invite one or two participants to perform the examination in front of the large group.

2.4 Distribute Handout 6. Review and discuss it with the participants:

- Do you usually follow all these steps when performing **a pelvic examination with speculum**?
- Which steps are new, if any?
- If you were a client who has never had a pelvic examination with speculum before, how would these steps help you to feel safe, comfortable, and respected? What else would you want?
- Explain that in the next session will review essential information about laboratory tests including steps for obtaining laboratory specimen e.g. pap smear and culture for gonorrhoea.

2.5 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective. *Participant's Handouts*

Session 7: Handout 1, Activity 1 – Physical examination in client assessment

- **The main purpose of a physical examination is to assess the client's health status.**
- Providers should gain useful insight into the health status of a client as soon as a client walks in. Observe:
  - Gait (walking) – shuffling, limping with or without pain
  - Facial expressions
  - Pronounced disability or obvious ill-health

Preparation of Client

- Ensure the client's comfort, privacy, and confidentiality
- Explain every procedure to the client in language that the client can understand
- Ask client to empty bladder and explain why it is necessary
- Wash hands with soap and water before and after examining the woman (or having any direct contact)

Vital Signs

- Check temperature, pulse, respiration rate, blood pressure, weight, and record on card.
- Check blood pressure at every visit and record findings.
- If there are any abnormalities such as hypertension or hypotension refer for management.

Note: If any abnormality is detected, put a circle or an asterisk in front of the client's card.

Head to Toe Examination

- Explain why it is necessary for the client to be in an appropriate position and help the client to take the most appropriate position for examination and check:
  - Head and neck for tinea capitis or corporis (ring worm), lumps, including thyroid enlargement and engorged veins.
  - Face for pimples, acne and chloasma.
  - Eyes for jaundice and anaemia.
  - Mouth for colour of tongue and mucus membrane, ulcers and fissures.

Participant's Handouts

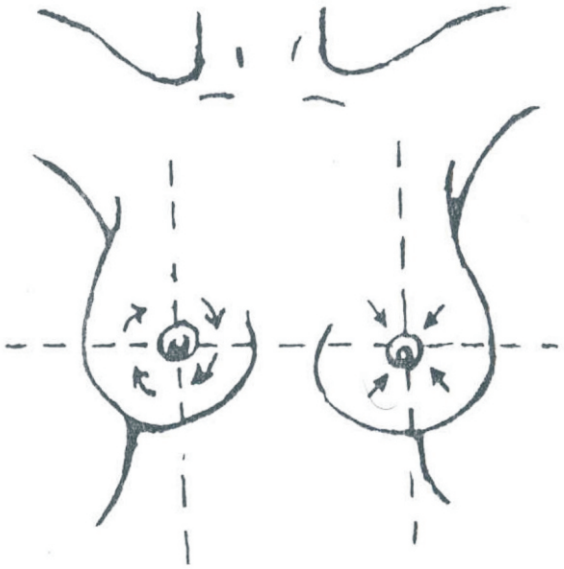
Session 7: Handout 2, Activity 1 – Breast examination

- Explain to the client why it is important to have a breast examination.

Note: There are two steps for breast examination – standing and lying, but lying is the commonly used method. Explain why lying is more commonly used, and ask the client what position she prefers.

First Step: Check for:

- The breast for size, shape, symmetry, scars, thickening of the skin, visible lumps, "peau d'orange" (skin looking like orange peel with little dimples).
- Engorgement; redness, colour of nipples, the size and shape, the direction of the nipples, ulceration.
- Dimpling and drawing in of the nipples by asking client to:
  - Lift both arms over the head, and check if both breasts rise equally.
  - Lean forward letting the breasts hanging loosely from the chest.



Second Step: Lying flat on the back with head on one pillow:

- Assist client to lie on her back.
- Position client's left arm under her head, make imaginary line, dividing the breast into four quadrants and go through these steps:
  - Palpate each quadrant, either clockwise round the breast or towards the nipple.
  - Express the nipple to demonstrate any discharge. (Note the discharge for colour and blood stain).
  - Examine the tail of the breast, axilla, and supra-clavicular regions for any enlarged lymph node.
  - Repeat with the other breast.
- If lump is present, ask client if she is aware of it.
- Ask her if the lump has been increasing in size, and whether it hurts.
- Instruct client on self-examination of breast, have her perform the self-examination while you observe and correct.
- Encourage the client to examine the breasts every month two-to-three days after her menstrual period, and report to the provider if there are changes.
- For menopausal women, encourage them to set a date to do the examination monthly.

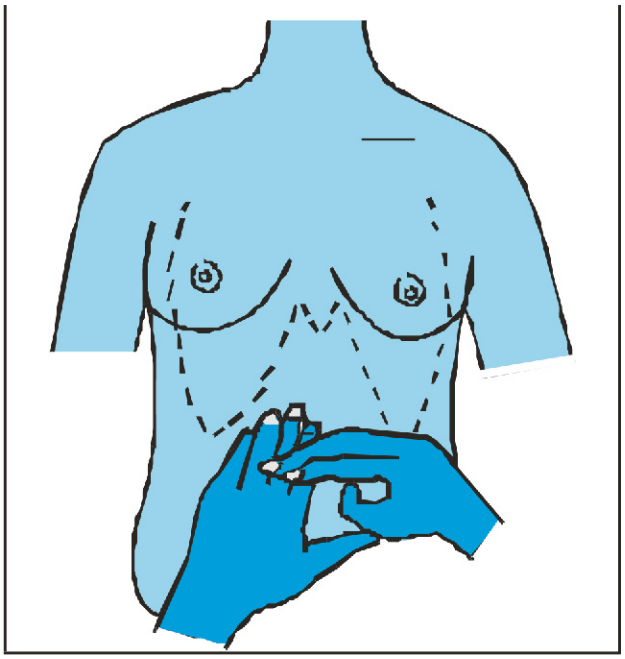
Participant's Handouts

Session 7: Handout 3, Activity 1 – Abdominal examination

Abdominal examination is used to identify deeper lying tenderness and enlargement of organs to obtain information on the size, consistency, tenderness and mobility of a mass and the position of organs such as liver and spleen.

Steps:

- Explain to the client why this examination is important in the context of family planning.
- Position client on her back with arms at sides and knees straight; cover the client properly and expose only the area for examination.
- **Inspect for:**
  - Scars of previous operations or traditional marks
  - Distension
  - Abnormal vascular patterns on the abdomen (distended abdominal veins)
  - Other abnormalities



Inspect using the "Palpation" method: This can be light or deep palpation

- **Light Palpation**
  - Using palmer surface of fingers, palpate lightly the entire abdominal wall.
  - Observe the client's facial expression, which may indicate pain.

- **Deep Palpation**
  - Place the right hand on the right lower abdomen with fingers pointed upwards.
  - With each deep breath, move the hand on the abdomen towards the edge of the rib to feel the edge of the liver.
  - Repeat for the left side to feel the spleen.
  - Leaving the palmar surface of the fingers on the abdomen, deeply palpate the rest of the abdomen, including the inguinal area feeling for masses, as well as the supra-pubic region.
  - If any enlargement is detected, percuss it for resonance or dullness/extent of enlargement.

Participant's Handouts

Session 7: Handout 4, Activity 2 – Client preparation for pelvic examination

Source: Royal College of Nursing, 2006: Vaginal and pelvic examination. Guidance for nurses and midwives

The following recommendations should be followed whenever possible and practicable, and the dignity of the woman and her consent should be ensured at all times. **Before starting, ensure**:

- The waiting area is comfortable, displaying appropriate posters and leaflets.
- Toilet facilities are situated close by.
- The woman is provided with privacy when undressing/changing clothes.
- If possible, a woman should be given the choice to remain in her own clothes.
- It should be easy for clothing and/or underwear to be laid aside and for the disposal of any sanitary or continence products.
- There is no undue delay prior to examination.
- The examination takes place in a closed room that cannot be entered while the examination is in progress.
- The room is stocked in advance with the necessary supplies to allow the examination to proceed as quickly as possible.
- A range of speculum sizes is on hand to choose from, to make the examination as physically comfortable as possible.
- Latex-free products are available, if possible.
- There is supply of sanitary products in case they are needed after the examination, if possible.
- The provision of a mirror may help during the examination; if a woman is able to see her external genitalia during inspection, it may lessen her anxiety.

Explain the reason for the examination, discuss with the woman if she wishes to have a chaperone and/or someone of her choice in the room while she is being examined. Exclude any relevant allergies, e.g. latex or iodine.

Explain the procedure for the examination, using language that the woman understands:

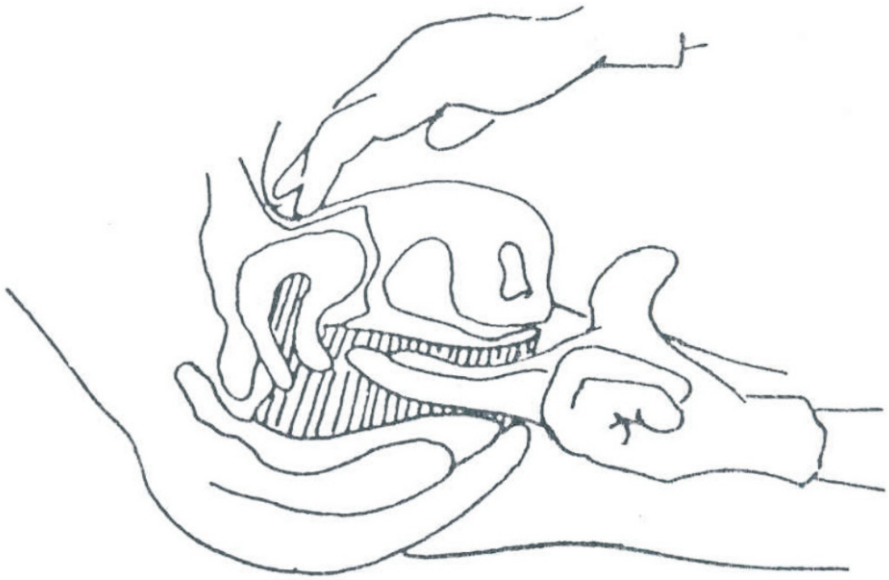
- Assure the woman that privacy and dignity will be maintained throughout the procedure.
- If you have not done it already, ensure that the woman has emptied her bladder (in some cases this may not be appropriate, e.g. where swabs are required for urethral gonorrhoea or chlamydia these will need to be taken before passing urine).
- Inform the woman that the examination should not be painful, but may be uncomfortable.
- Emphasize the importance of relaxation of the pelvic and/or abdominal muscles during the procedure.
- Explain that some women may get spotting after swabs and cervical sampling (if these are performed).
- Explain that she may stop the examination at any point with a request to do so, and agree how that request can be made, for example a key word, raising of the hand.
- Explain that examinations may be undertaken in the prone or left lateral position, depending upon the procedure. You should inform the woman of the position she will be in and if she can remain in that position for the anticipated length of the examination or procedure. It may be appropriate to offer a choice.
- The woman should be advised that it is usually only necessary to remove her lower garments.
- Ensure the woman has privacy if she needs to undress and show her where to put her clothes.
- Assistance to remove garments should only be given if required, and not in an attempt to hurry the woman.
- Provide enough tissue or a sheet to cover the pelvic area when the woman is undressed, if possible.
- Ask if she would like the procedure to be 'talked through' as it happens, and act accordingly.
- Ask the woman to let you know when she's ready.

Participant's Handouts

Session 7: Handout 5, Activity 2 – Conducting a pelvic examination

Equipment and preliminary steps:

- Position sources of light (angle poised lamp or torch) effectively.
- Wash hands with soap and water then dry.
- Wear sterile gloves.
- Place kidney dish containing Cusco's or Sim's speculum, sponge holding forceps, lubricant, spatula and swab on a trolley.



Bi-manual Examination for Anterior Position of the Uterus:

- Inspect external genitalia and note:
  - Distribution of pubic hair.
  - Presence of scars, lice, varicose vein, excoriation, bleeding, vaginal discharge, abrasions, rashes, warts and swelling.
- Separate labia majora from labia minora and note evidence of circumcision.
- Observe urethral opening for discharges and signs of inflammation.
- Instruct client to cough and observe closely urine leakage and bulging of vaginal wall indicating urethrocele, cystocele and or rectocele.
- Insert two fingers of the examining hand well inside the vagina and feel the vaginal walls.
- Using upward pressure, instruct client to cough and observe for bulge in the posterior vaginal wall which might indicate rectocele.
- With the palm up, using the fingers in the vagina, follow the anterior vaginal wall until you reach the end of it and locate the cervix.
- Feel the cervix with the vaginal fingers, noting the position, consistency and whether open or closed. Feel the shape of the external os, recognise any old lacerations and presence of cyst or polyp seen on speculum examination.
- Steady pelvic organs by placing the abdominal hand gently on the lower abdomen above the symphysis and exert steady downward pressure.
- With the fingers in front of the cervix, gently lift the fingers inside vagina toward the abdominal hand to discover if the uterus can be felt in between the two hands, indicating anterior position of uterus.
- If the uterus is not palpable in front, then place the vaginal fingers behind the cervix and gently lift the cervix and uterus, towards the abdominal hand.

- The mid position situation of the uterus may be determined by this movement.
- If the uterus is not felt between the two hands, it may be behind the cervix at the end of the posterior wall of the vagina.
- Feel the uterus with the tip of your vaginal fingers pointing downwards and backwards. The posterior position of the uterus may be determined by this movement.
- Immediately after the position of the uterus is identified, divide the vaginal fingers into a v-shape and with these fingers on either side of the cervix, outline the uterus, noting the size, shape, consistency and mobility of the uterus.
- Move the vaginal fingers into the lateral fornix (the side of the cervix) and simultaneously move the abdominal hand to the same side. While the abdominal hand presses towards the vaginal fingers identify the presence of swelling, tenderness and thickening.
- Repeat the other side of cervix.
- Gently remove your fingers from the vagina.

Participant's Handouts

Session 7: Handout 6, Activity 2 – Pelvic examination using a speculum

Steps:

- Inform the client that a lubricated speculum will be inserted.
- Offer to demonstrate the speculum.
- Inform and reassure about the noise associated with opening the Cusco speculum.
- Confirm that the woman is aware of her right to ask questions or indicate for the procedure to be stopped at any time.
- Ensure that the correct size and type of speculum is selected.
- Lubricate Cusco's or Grave's speculum (use water if specimen for cytology or culture is to be taken). Inform the client that the speculum may feel cold.
- Insert lubricated speculum into the vagina.
- Hold the speculum closed in the right hand and open the labia using the index and middle fingers of the left hand.
- Obliquely insert the blades of the speculum into the vaginal canal. Avoid pressure on the urethra and the clitoris. Do not catch the skin and the hair between the blades and hinges of the speculum.
- Halfway into the vaginal canal, turn the blades in the horizontal plane and slowly introduce the speculum further towards the cervix.
- Put a little downward pressure on the floor of the vagina and gently open the blades of the speculum and visualise the cervix.
- Inspect the following:
  - Cervix for contour, laceration, polyp, erosion, cysts, discharge or bleeding
  - Vaginal mucosa for colour, ulceration (consistency and colour).
  - (If there is a need for cervical acetic test, paint the cervix with acetic acid and observe any change in colour).
  - IUD strings for visibility and length.

Following the examination:

(Source: Royal College of Nursing, 2006: Vaginal and pelvic examination. Guidance for nurses and midwives)

- Switch off the examination light and provide privacy for the woman to get dressed or rearrange her clothing.
- Ensure the woman has tissue available to wipe away any lubricant or discharge and that there is access to washing facilities and sanitary pads, if needed.
- Ensure a full record is made of the examination performed, and that any tests taken and findings observed are all recorded clearly and timely in the client's notes.
- Provide correct information about the findings and results of the examination. If swabs have been taken or screening performed this should include:
  - How the results will be communicated.
  - When to expect results.
  - What to do if she does not get the expected results.
  - Possible outcomes.
  - Any further management.

SESSION 8: Laboratory Tests

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

- Identify the essential laboratory tests that a FP provider should be able to conduct.
- Identify the laboratory tests that a FP provider should refer for.
- Identify the equipment necessary for general laboratory tests.
- Identify the equipment necessary for specific laboratory tests.
- Explain the correct procedures for the laboratory tests that FP providers are expected to perform.

Total Session Time
90 minutes (1 hour and 30 minutes)

Materials

- Flipcharts, markers, tape
- "Session objectives" flipchart
- Flipchart *Equipment necessary to conduct general laboratory tests*, Activity 1
- LCD projector if available/necessary

Handouts

- Handout 1 – Equipment for specific laboratory tests in FP
- Handout 2 – Urinalysis (detailed examination of urine)
- Handout 3 – Alternative urine test for protein/albumin
- Handout 4 – Procedures for other laboratory tests

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide).
In this session, the participants will review essential laboratory tests that FP providers are expected to perform. They will review the equipment necessary and the correct procedures to follow for specific tests. The participants will also reflect on the importance of referring clients for other tests in order to enhance FP/MNCH integration and prevent missed opportunities to help clients address their health needs beyond the stated ones.

Activity 1: Identifying the essential laboratory tests, the necessary equipment, and the correct test procedures that FP providers are expected to perform (40 minutes)

1.1 Brainstorm with the group:

- What are the essential laboratory tests that a FP provider must be able to perform according to the National Family Planning/Reproductive Health Service Protocols?
- Record responses on flipchart. Confirm the following essential checklist (show on flipchart):
  - Urinalysis (hot and cold)- albumin, sugar and acetone.
  - Blood for haemoglobin (Hb), packed-cell volume (PCV), malaria parasites, sickling, HIV, Hepatitis B virus.
  - Pregnancy test.
  - Other tests such as Papanicolaou (pap) smear, visual inspection with acetic acid (VIA),

microscopy, culture and sensitivity for high vaginal swab (HVS), endocervical swab (ECS) and urine.

1.2 Ask the participants to work in pairs for five minutes to develop a list of equipment necessary to conduct general laboratory tests. Invite the pairs to share their results and discuss vis-à-vis the following checklist (show it on flipchart):

Equipment necessary to conduct general laboratory tests:•

- Methylated spirit lamp
- Blue/red Litmus paper
- Urinometer
- 20% salicylsulphonic acid
- Acetic acid
- Clinitest tablets
- Acetest reagent tablets
- Sterile swab stick
- Sterile urine container
- Transport medium
- Test tubes
- Test tube holder
- Test tube rack
- Waste Bin
- Blood sample bottles
- HIV rapid screening test kits
- HBV rapid test kits

Participants work in pairs:

- Assign one of the following laboratory tests to each pair:
  - Urinalysis.
  - Blood test.
  - Pregnancy test.
  - Pap smear and VIA.

- The pairs must identify the equipment necessary for the test they have been assigned (five minutes).
- Invite the pairs to present their results. Distribute Handout 1 and use it as a checklist during the discussion.

1.3 Brainstorm:

- Which of the tests discussed so far do you perform in your clinic and which do you refer for, and why?

Discuss the results of the brainstorm and ensure that the following tests are identified:

- Blood haemoglobin
- PCV
- Malaria parasites
- HBV
- Pap smear, HVS, and ECS they take samples and send to lab
- HIV for confirmation test

Stress the important role of effective history taking to prevent missed opportunities to address clients' needs beyond the stated ones. FP providers play a very important role in enabling and ensuring effective FP/MNCH integration and history taking is a very important stage in this process.

Activity 2: Procedures for laboratory tests (45 minutes)
Steps:

2.1 Participants work individually. Each participant receives one of the following laboratory tests and must identify the steps to follow to perform it correctly:

- Urinalysis (detailed examination of urine)
- Alternative urine test for protein/albumin

- Participants have five minutes to write down on their note pads the steps they would follow.
- Stop their brainstorm after five minutes. Now the participants will mingle and each person will discuss her/his steps with at least two other people to check if there are any incorrect or missing steps.
- Finally, distribute Handouts 2 and 3, and use them as a check lists.

2.2 Participants work individually. Each participant receives one of the following laboratory tests and must identify the steps to follow to perform it correctly:

- Pap smear
- HVS and ECS
- HIV rapid test
- Pregnancy test
- Visual inspection
  - Participants have five minutes to write down on their note pads the steps they would follow.
  - Stop their brainstorm after five minutes. Now the participants will mingle and each person will discuss her/his steps with at least two other people to check if there are any incorrect or missing steps.
  - Finally, distribute Handout 4 and use it as a check list.

2.3 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Participant's Handouts

Session 8: Handout 1, Activity 1 – Equipment for specific laboratory tests in FP

Source: Federal Ministry of Health, Nigeria. 2009: National Family Planning/Reproductive Health Service Protocols

Equipment for general laboratory tests:

- Methylated spirit lamp
- Blue/red Litmus paper
- Urinometer
- 20% salicylsulphonic acid
- Acetic acid
- Clinitest tablets
- Acetest reagent tablets
- Sterile swab stick
- Sterile urine container
- Transport medium
- Test tubes
- Test tube holder
- Test tube rack
- Waste Bin
- Blood sample bottles
- HIV rapid screening test kits
- HBV rapid test kits

Equipment for specific tests:

Urinalysis

- Urine
- Urine Dip stick (Multisticks/Combi – 9 or other test sticks)

Blood test

- Taliquist paper
- Cotton wool swab
- Needle or lancet
- Tourniquet
- Plaster

Pregnancy test

- Pregnancy test kits

Pap smear and VIA

- Speculum
- Sterile swab stick
- Glass slides
- Wooden spatula
- 95% alcohol
- Acetic acid 3-5%
- Clean gloves

Participant's Handouts

Session 8: Handout 2, Activity 2 – Urinalysis (detailed examination of urine)

Source: Federal Ministry of Health, Nigeria. 2009: National Family Planning/Reproductive Health Service Protocols

Urinalysis (detailed examination of urine): Use fresh urine specimen for all tests except pregnancy tests, which requires early morning urine. If the client has fever, allow urine to cool to room temperature before the reading is done.

Client Preparation: Instruct client to collect mid-stream sample of urine by passing initial urine out before collecting some into the specimen bottle.

Steps:

- Observe the following:
  - Colour
    - Normal colour is amber
    - Abnormal colours:
      - Wine or red indicates blood
      - Orange-brown indicates bile pigments
      - Various other colours are a result of drugs and other substances which have been ingested
  - Turbidity
    - Normal urine should be clear
    - Haziness indicates presence of protein, mucus or pus (suspect urinary tract infection)
  - Odour
    - Normal: it is aromatic
    - Sweet smell indicates presence of acetone
    - Fish odour indicates infection
  - Specific gravity
    - Normal range is 1.010-1.025
    - Place the urinometer into a cylinder containing urine
    - Allow the urinometer to float freely in the urine without touching the sides or bottom of the cylinder. If there is insufficient urine to allow the urinometer to float freely, then add an equal quantity of water and double the last two figures of the reading obtained.
    - Perform this after all other tests have been completed
    - Read the number on urinometer at the lower level of the meniscus of urine
  - pH
    - Normal urine (pH) is acidic
    - Dip litmus paper in the urine for 10-15 seconds (depends on manifacturer's instructions), remove and observe colour change
    - Blue litmus paper changed to red indicates acidic reactions
    - Red litmus paper changed to blue indicates alkaline reaction
    - Purplish colour change in both indicates neutral reaction (other indicator test papers show various pH ranges)
  - Albumin
    - Dip test end of albustix in urine
    - Remove immediately
    - Compare colour of dipped test end with colour scale on the container (this depends on the manufacturer's instructions)

Participant's Handouts

Session 8: Handout 3, Activity 2 – Alternative urine test for protein/albumin

Source: Federal Ministry of Health, Nigeria. 2009: National Family Planning/Reproductive Health Service Protocols

Alternative urine test for protein/albumin:

1. **Salicyl sulphonic acid test**

- Make the test tube three-quarter full with urine.
- Add 10-20 drops of 20% salicyl sulphonic acid.
- If the solution is cloudy, albumin is present. The degree of cloudiness varies with the amount of albumin present.

2. **Hot test for albumin**

- Make test tube three-quarter full with urine.
- Hold the tube at the bottom.
- Heat the top over a methylated spirit lamp and shake continuously.
- Add a few drops of acetic acid when boiling.
- Remove from the flame and read the results.
- Cloudiness indicates the presence of albumin.

3. **Sugar**

Use either of the following tests:

a. Clinistix (Ames test)
   - Dip the test end into the urine and withdraw.
   - Observe colour change and compare colour with scale on the container for the presence of glucose.

b. Clinitest tablets test
   - Place 5 drops of urine in test tube.
   - Add 10 drops of water.
   - Add one clinitest tablet.
   - Do not shake the mixture while it is bubbling.
   - Wait for 15 seconds after bubbling stops.
   - Shake and compare with the colour chart.

Note: Use the same dropper for urine and water.

Participant's Handouts

Session 8: Handout 4, Activity 2 – Procedures for other laboratory tests

Source: Federal Ministry of Health, Nigeria. 2009: National Family Planning/Reproductive Health Service Protocols

Blood tests

- Set up the tray.
- Ensure client is positioned comfortably.
- Explain the procedure to the client.
- With your thumb and index fingers, hold the client thumb firmly.
- Clean the tip of the finger with cotton wool swab dipped in methylated spirit and discard swab after use.
- Prick the fingertip once sharply with needle or lancet.
- Squeeze out the blood.
- Clean the first drop of blood.
- Blot the next drop of blood on a piece of taliquist paper.
- Compare the colour with the one on the taliquist scale.

Pregnancy test

Follow the manufacturer's instructions for the kit you have.

Routine pap smear

- Procedure for obtaining specimen for microscopy, culture and sensitivity for HVS and ECS:
  - Insert vaginal speculum (avoid using lubricant except water) and visualize the cervix.
  - Using a sterile swab, collect a sample of discharge from the cervical opening.
  - Stick the swab into the transport medium and break off the stick at the level of the bottle.
  - Screw on the cap immediately.
  - Label and send to the laboratory.

  Note: Culture and sensitivity should be done where laboratory facilities are available.

- Procedure for obtaining specimen for urine culture and sensitivity:
  - Give a sterile container to the client.
  - Instruct the client to collect mid-stream urine in the sterile container.
  - Label and send to the laboratory immediately.

- Visual inspection of the cervix:
  - The procedure and reason for the inspection should be carefully explained to the woman to be examined and she should be made as comfortable as possible.
  - Put patient in lithotomy position (if possible) or supine with legs bent at knees.
  - Good visualization is essential. Direct the light source to the genital area.
  - Observe and record any abnormal findings in the external genitalia.
  - Lubricate the speculum with warm water and insert into the vagina with the speculum closed.
  - Open the speculum and adjust the light source so as to get a clear view of the cervix.
  - If there is excess mucus of discharge, clean it with a cotton swab soaked in boiled water or normal saline solution.
  - Observe any abnormal findings.
  - Wash the cervix with acetic acid (3-5%) with the help of a syringe.
  - Wait for approximately one minute and inspect the cervix for acetowhite area(s).

  Note: 1) Do not perform the examination if the woman is having her menstrual period or is using

intra-vaginal medication. Advise her to come back when the menses or the treatment is over. 2) Do not apply acetic acid if there is a gross lesion suspicious of malignancy, refer patient directly to oncology/tertiary care facility.

Rapid screening for HIV

- Counsel client on HIV test.
- If client consents, take appropriate sample (blood) for rapid screening test for HIV (follow manufacturer's instructions for the kit available in your facility).

SESSION 9: Modern Methods of Contraception: Overview

Objectives

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

- Explain the types and characteristics of modern contraceptives, including their effectiveness.
- Identify key potential health benefits and health risks of each of these methods, including possible side effects.
- Identify key criteria defining who can use these methods and when their use can be initiated.

Total Session Time

120 minutes (two hours)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- Sufficient copies of Question Cards (Handout 1) based on number of participants

Handouts

- Handout 1 – Contraceptive modern methods question cards

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide).

In this session, the participants will strengthen their skills to effectively help clients make safe, voluntary and informed decisions about modern methods of contraception. The activities in this session draw from the relevant content in the knowledge pack of this manual and build on the participants' own professional experience.

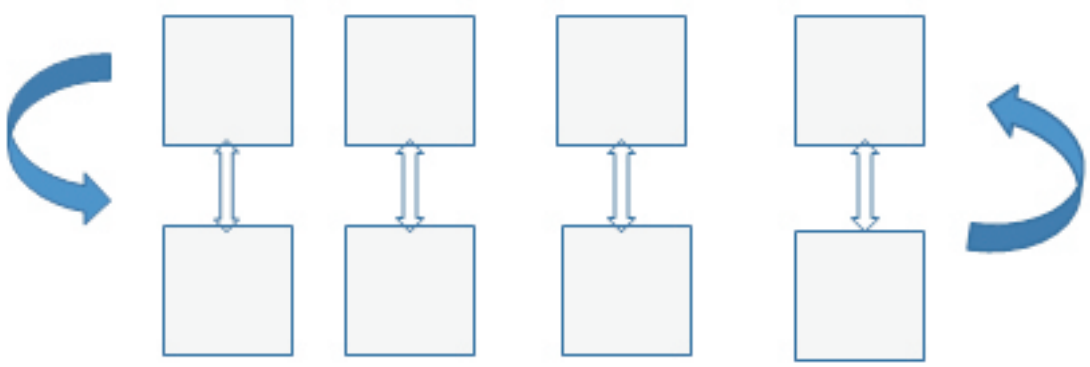
Activity 1: Reviewing key facts about modern methods of contraception. The mini role-play carousel (120 minutes)

1.1 In the next exercise, the participants will be engaged in a series of mini role-plays to help each other check their knowledge on essential information about modern contraceptive methods.

Instructions:

- The participants sit on two rows of chair facing each other. The activity has two parts: Part 1 is preparation, while Part 2 and Part 3 constitute the actual mini-role plays.
- **Part 1:** The facilitator gives one question card to each participant (cards are provided in the **Participant's Handout** section below. Please note: there are 17 questions cards. Unless you have 17 participants or more, do not use all the cards at once. For example, if you have eight participants, initially use the first eight cards).
- Each participant on both rows receives a different question card and will have five minutes maximum to read it without asking questions or comparing cards with other participants.

Once the participants have had five minutes to read their cards, the facilitator gives a signal. At the signal, the participants must exchange their cards with the person sitting opposite and then shift one seat sideways:



- Continue the process until they have exchanged all the cards, each time giving the participants five minutes for reading. For example, if there are eight participants, there will be eight of such exchanges, and Part 1 will be completed. Throughout Part 1, the participants cannot comment on the cards they are reading.
- **Part 2:** The facilitator assigns to the participants on one row the role of "providers", while the participants sitting on the opposite row will be the "clients". Each facing pair will role-play together, and all pairs will role-play at the same time.
- When the facilitator gives the signal to start, the mini role-plays will begin. The pairs will pretend that the "client" is seeking information on the method on her/his card. The "client" will ask the questions on the card she/he is holding without showing it to the "provider". For example, let's imagine that a "client" has got the *Combined Oral Contraceptive* card. The "client" will ask the "provider" the questions on the card, starting from the first i.e. *What are COCs? How do COCs work?* and then continuing with all the other questions on the card.
- The "provider" will have to answer all the questions in no more than five minutes. The "client" must not correct the "provider" at this stage.
- Stop the mini role-plays after five minutes. Now the pairs will swap roles (but not cards). The person who played "provider" before will now be the "client" and will ask the questions about her/his method, and the "provider" will have five minutes to answer all the questions.
- Stop the mini role-plays after five minutes and ask the people in each pair to swap cards. Next, everybody shifts of one seat sideways. Repeat Part 2 steps only one more time.
- Next, collect all the cards and distribute new ones, a different card per participant. Repeat Part 1 and Part 2 with the new set of cards, as time permits.

1.2 Stop the activity when you still have 20-25 minutes before the end of the session. Ask the participants to stay seated in the two rows and debrief them using questions such as:

- Which contraceptive methods can be relied on for STI prevention?
- Which methods may be less effective if women are over a certain weight?
- Which methods have an effectiveness rate in protecting from pregnancy of 97% or higher? Which factors affect effectiveness of each of these methods?

Please note: facilitators are encouraged to develop their own questions.

1.3 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Participant's Handouts

Session 9: Handout 1, Activity 1 – Contraceptive modern methods question cards

Question Card 1: Combined Oral Contraceptives (COCs) (Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers)			
What is it? What is its mode of action?	**Effectiveness? Who can use it, and when can they start?**	**Health benefits and advantages?**	**Side effects and health risks?**
COCs are also called "the Pill", low-dose combined pills, OCPs, and OCs. COCs contain low doses of a progestin and an estrogen - two hormones like the natural hormones progesterone and estrogen in a woman's body. COCs work primarily by preventing the release of eggs from the ovaries (ovulation).	**92%** (WHO). **Effectiveness depends on the user** : Risk of pregn ancy is greatest when a woman starts a new pill pack 3 or more days late, or misses 3 or more pills near the beginning or end of a pill pack. **Nearly all women can use COCs safely and effectively, including women who:** Have or have not had children; Are not married; Are of any age, including adolescents and women over 40 years old; Have just had an abortion or miscarriage; Smoke cigarettes—if under 35 years old; Have anaemia now or had in the past; Have varicose veins; Are infected with HIV, whether or not on antiretroviral therapy. **Women can start using COCs:** Without a pelvic examination; Without any blood tests or other routine laboratory tests; Without cervical cancer screening; Without a breast examination; Even when a woman is not having monthly bleeding at the time, if pregnancy has been reasonably ruled out.	**Return of fertility after COCs are stopped:** No delay. **Help protect against** : Risks of pregnancy; Cancer of the lining of the uterus (endometrial cancer); Cancer of the ovary; Symptomatic pelvic inflammatory disease. **<u>May</u> help protect against:** Ovarian cysts; Iron -deficiency anaemia. **Reduces:** Menstrual cramps; Menstrual bleeding problems; Ovulation pain; Excess hair on face or body; Symptoms of polycystic ovarian syndrome (irregular bleeding, acne, excess hair on face or body); Symptoms of endometriosis (pelvic pain, irregular bleeding). **Other advantages:** Are controlled by the woman; Can be stopped at any time without a provider's help; Do not interfere with sex.	**Protection against STI:** None. **Side effects may include:** – Changes in bleeding patterns (Lighter bleeding and fewer days of bleeding; Irregular bleeding; Infrequent bleeding; No monthly bleeding). – Blood pressure increases a few points (mm Hg). When increase is due to COCs, blood pressure decli nes quickly after use of COCs stops. – Other: Headaches; Dizziness; Nausea; Breast tenderness; Weight change; Mood changes; Acne. **Very rare health risk:** Blood clot in deep veins of legs or lungs (deep vein thrombosis or pulmonary embolism). **Extremely rare health risk:** Stroke; Heart attack.

Question Card 2: Progestin -only Pills (POPs) (Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook forProviders)			
What is it, and what is its mode of action?	**Effectiveness? Who can use it, and when can they start?**	**Health benefits and advantages?**	**Side effects and health risks?**
POPs have very low doses of a progestin like the natural hormone progesterone in a woman's body. Do not contain estrogen, and so can be used throughout breastfeeding and by women who cannot use methods with estrogen. Work primarily by: – Thickening cervical mucus (this blocks sperm from meeting an egg) – Disrupting the menstrual cycl e, including preventing the release of eggs from the ovaries (ovulation).	**Effectiveness depends on the user:** For – Women who have monthly bleeding: risk of pregnancy is greatest if pills are taken late or missed completely. – Breastfeeding women: As commonly used, 99% effective. – Less effective for women not breastfeeding: 90% to 97% effective. **Nearly all women can use POPs safely and effectively, including women who:** Are breastfeeding (starting as soon as 6 weeks after childbirth); Have or have not had children; Are not married; Are of any age, including adolescents and women over 40 years old; Have just had an abortion, miscarriage, or ectopic pregnancy; Smoke cigarettes, regardless of woman's age or number of cigarettes smoked; Have anaemia now or had in the past; Have varicose veins; Are infected with HIV, whether or not on antiretroviral therapy. **Women can start using POPs:** Without a pelvic examination; Without any blood tests or other routine laboratory tests; Without cervical cancer screening; Without a breast examination; Even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant.	**Return of fertility after POPs are stopped:** No delay. **Help protect against:** Risks of pregnancy **Other advantages:** Can be used while breastfeeding; Can be stopped at any time without a provider's help; Do not interfere with sex; Are controlled by the woman	**Protection against STI:** None. **Side effects may include:** – For breastfeeding women, longer delay in return of monthly bleeding after childbirth (lengthened postpartum amenorrhea); – Frequent bleeding; Irregular bleeding; Infrequent bleeding; Prolonged bleeding; No monthly bleeding. Breastfeeding also affects a woman's bleeding patterns. – Other: Headaches; Dizziness; Mood changes; Breast tenderness; Abdominal pain; Nausea. **Other possible physical changes:** For women not breastfeeding, enlarged ovarian follicles. **Known health risks**: None.

Question Card 3: Emergency Contraceptive Pills (ECPs) (Source: World Health Organizat ion, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers)			
What is it, and what is its mode of action?	**Effectiveness? Who can use it, and when can they start?**	**Health benefits and advantages?**	**Side effects and health risks?**
ECPs are also called "morning after" pills or postcoital contraceptives. ECPs prevent or delay the release of eggs from the ovaries (ovulation). **Pills that can be used as ECPs:** - A special EC P product with the progestin levonorgestrel - A special ECP product with estrogen and levonorgestrel - Progestin-only pills with levonorgestrel or norgestrel - Combined oral contraceptives with estrogen and a progestin e.g. levonorgestrel, norgestrel, or norethindrone (also called norethisterone).	**Progestin-only ECPs**: 99% effectiveness if used correctly. **Estrogen and progestin ECPs** : 98% effectiveness if used correctly. **Safe and suitable for all women:** Tests and examinations are not necessary for using ECPs. They may be appropriate for other reasons — e.g. in the case of rape or forced sex.	**Return of fertility after taking ECPs**: No delay. **Help protect against:** Risks of pregnancy **Other advantages:** Offer a second chance at preventing pregnancy; Are controlled by the woman; Reduce seeking out abortion in the case of contraceptive errors or if contraception is not used; Can have on hand in case an emergency arises.	ECPs prevent pregnancy only if they are taken within 72 hours from the time of having unprotected sex. They will not protect a woman from pregnancy from acts of sex *after* she takes ECPs—not even on the next day. To stay protected from pregnancy, women must begin to use another contraceptive method at once. **Protection against STI:** None. **Side effects may include:** – Changes in bleeding patterns e.g.1) Slight irregular bleeding for 1–2 days after taking ECPs; 2) Monthly bleeding that starts earlier or later than expected – In the week after taking ECPs: Nausea; Abdominal pain; Fatigue; Headaches; Breast tenderness; Dizziness; Vomiting (*Women using progestin-only ECP formulations are much less likely to experience nausea and vomiting than women using estrogen and progestin ECP formulations.)* **Known health risks**: None.

Question Card 4: Progestin Only Injectabl es (Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers)

What is it, and what is its mode of action?	Effectiveness? Who can use it, and when can they start?	Health benefits and advantages?	Side effects and health risks?
DMPA (Depot medroxyprogesterone acetate) and NET-EN (norethisterone enanthate) contain a progestin (like progesterone in a woman's body). DMPA is also known as Depo, Depo-Provera, Megestron, and Petogen. NET-EN is also known as norethindrone enanthate, Noristerat, and Syngestal. DMPA and NET - EN do not contain estrogen, and so can be used throughout breastfeeding and by women who cannot use methods with estrogen. Work by preventing the release of eggs from the ovaries (ovulation).	**Effectiveness depends on getting injections regularly:** Risk of pregnancy is greatest when a woman misses an injection. As commonly used: 97% effectiveness. When women have injections on time, less than 1 pregnancy per 100 women using progestin-only injectables over the first year. **Nearly all women can use progestin - only injectables safely and effectively,** **including women who:** Have or have not had children; Are not married; Are of any age, including adolescents and women over 40 years old; Have just had an abortion or miscarriage; Smoke cigarettes, regardless of woman's age or number of cigarettes smoked; Are breastfeeding (starting as soon as 6 weeks after childbirth); Are infected with HIV, whether or not on antiretroviral therapy; **Women can start using progestin-only injectables:** Without a pelvic examination; Without any blood tests or other routine laboratory tests; Without cervical cancer screening; Without a breast examination; Even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant.)	**Return of fertility after injections are stopped**: An average of about four months longer for DMPA and one month longer for NET-EN than with most other methods. **DMPA helps protect against**: Risks of pregnancy; Cancer of the lining of the uterus (endometrial cancer); Uterine fibroids. **<u>May</u> help protect against:** Symptomatic pelvic inflammatory disease; Iron-deficiency anaemia. **Reduces:** Sickle cell crises among women with sickle cell anaemia; Symptoms of endometriosis (pelvic pain, irregular bleeding). **NET-EN helps protect against:** Iron-deficiency anaemia. NET-EN may offer many of the same health benefits as DMPA, but currently there is not complete research evidence for all the benefits. **Other advantages of these injectables:** Do not require daily action; Do not interfere with sex; Are private: No one else can tell that a woman is using contraception; Cause no monthly bleeding (for many women); May help women to gain weight.	**Protection against STI:** None. **Side effects may include:** Changes in bleeding patterns including **DMPA**: First three months: – Irregular bleeding – Prolonged bleeding At one year: – No monthly bleeding – Infrequent bleeding – Irregular bleeding **NET-EN** affects bleeding patterns less than DMPA. NET-EN users have fewer days of bleeding in the first 6 months and are less likely to have no monthly bleeding after one year than DMPA users. **Other side effects may include:** Weight gain; Headaches; Dizziness; Abdominal bloating and discomfort; Mood changes; Less sex drive. **Other possible physical changes:** Loss of bone density **Known health risks for DMPA and NET-EN**: None.

Question Card 5: Monthly Injectables, also called combined injectable contraceptives (CICs). (Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planing. A Global Handbook for Providers)

What is it, and what is its mode of action?	**Effectiveness? Who can use it, and when can they start?**	**Health benefits and advantages?**	**Side effects and health risks?**
Contain two hormones (a progestin and an estrogen, like the natural hormones progesterone and estrogen in a woman's body.) Most common are **MPA/estradiol cypionate** and norethisterone enanthate **(NET-EN)/estradiol valerate**. MPA/estradiol cypionate is known as Ciclofem, Ciclofemina, Cyclofem, Cyclo-Provera, Feminena, Lunella, Lunelle, Novafem, and others. NET-EN/estradiol valerate is known as Mesigyna and Norigynon. Work primarily by preventing ovulation.	**Effectiveness depends on returning on time:** Risk of pregnancy is greatest when a woman is late for an injection or misses an injection. As commonly used: 97% effectiveness. When women have injections on time, less than 1 pregnancy per 100 women using monthly injectables over the first year. **Nearly all women can use monthly injectables safely and effectively, including women who:** Have or have not had children; Are not married; Are of any age, including adolescents and women over 40 years old; Have just had an abortion or miscarriage; Smoke any number of cigarettes daily *and* are under 35 years old; Smoke fewer than 15 cigarettes daily *and* are over 35 years old; Have anaemia now or had anaemia in the past; Have varicose veins; Are infected with HIV, whether or not on antiretroviral therapy. **Women can start using monthly injectables:** Without a pelvic examination; Without blood tests or other routine laboratory tests; Without cervical cancer screening; Without a breast examination; Even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant.	**Return of fertility after injections are stopped:** An average of about one month longer than with most other methods. **Monthly injectables help protect from:** Risk of pregnancy. **Known Health Benefits:** Long-term studies of monthly injectables are limited, but researchers expect that their health benefits are similar to those of combined oral contraceptives. **Other advantages of these injectables:** Do not require daily action; Are private: No one else can tell that a woman is using contraception; Injections can be stopped at any time. Are good for spacing births.	**Protection against STI:** None. **Side effects may include:** – Changes in bleeding patterns including: Lighter bleeding and fewer days of bleeding; Irregular bleeding; Infrequent bleeding; Prolonged bleeding; No monthly bleeding – Other: Weight gain; Headaches; Dizziness; Breast tenderness. **Known health risks:** Long-term studies of monthly injectables are limited, but researchers expect that their health benefits and health risks are similar to those of combined oral contraceptives. There may be some differences in the effects on the liver, however.

Question Card 6: Implants. (Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers)

What is it, and what is its mode of action?	**Effectiveness? Who can use it, and when can they start?**	**Health benefits and advantages?**	**Side effects and health risks?**
Small plastic rods/ capsules, about the size of a matchstick. Inserted under the skin on the inside of a woman's upper arm by a trained provider, release a progestin (like the natural hormone progesterone). Do not contain estrogen, and so can be used throughout breastfeeding and by women who cannot use methods with estrogen. Work primarily by: – Thickening cervical mucus (this blocks sperm from meeting an egg) – Disrupting the menstrual cycle, including preventing the release of eggs from the ovaries (ovulation).	- **Jadelle**: 2 rods, effective for 5 years - **Implanon**: 1 rod, effective for 3 years - **Norplant**: 6 capsules, labeled for 5 years of use (large studies have found it is effective for 7 years) - **Sinoplant**: 2 rods, effective for 5 years. Implants are over 99% effective. However: **For women weighing 80 kg or more**, Jadelle and Norplant become less effective after 4 years of use. **For women weighing 70–79 kg**, Norplant becomes less effective after 5 years of use. These users may want to replace their implants sooner. **Implants can be used safely and effectively by women who:** Have or have not had children; Are not married; Are of any age, including adolescents and women over 40 years old; Have just had an abortion, miscarriage, or ectopic pregnancy; Smoke cigarettes, regardless of woman's age or number of cigarettes smoked; Are breastfeeding (starting as soon as 6 weeks after childbirth); Have anaemia now or in the past; Have varicose veins; Are infected with HIV, whether or not on antiretroviral therapy. **Women can start using implants without:** a pelvic examination; blood tests or routine laboratory tests; cervical cancer screening; a breast examination. Even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant.	**Return of fertility after implants are removed:** No delay. **Help protect against:** Risks of pregnancy Symptomatic pelvic inflammatory disease **May help protect against:** Iron-deficiency anaemia **Other advantages:** Do not require the user to do anything once they are inserted. Prevent pregnancy very effectively. Are long-lasting. Do not interfere with sex.	**Protection against STI:** None **Side effects may include:** Changes in bleeding patterns including: First several months: – Lighter bleeding and fewer days of bleeding – Irregular bleeding that lasts more than 8 days – Infrequent bleeding – No monthly bleeding After about one year: – Lighter bleeding and fewer days of bleeding – Irregular bleeding – Infrequent bleeding **Implanon users** are more likely to have infrequent or no monthly bleeding than irregular bleeding lasting more than 8 days. **Other possible side effects:** Headaches; Abdominal pain; Acne (can improve or worsen); Weight change; Breast tenderness; Dizziness; Mood changes; Nausea. **Other possible physical changes:** Enlarged ovarian follicles **Known health risks:** None **Complications:** Infection at insertion site (often within the first 2 months after insertion). Difficult removal (rare if properly inserted and provider is skilled at removal). Rare: Expulsion of implant (most often occurs within the first 4 months).

Question Card 7: Copper Bearing Intra-uterine Device (IUD). (Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. AGlobal Handbook for Providers)			
What is it, and what is its mode of action?	**Effectiveness? Who can use it, and when can they start?**	**Health benefits and advantages?**	**Side effects and health risks?**
The IUD is a small, flexible plastic frame with copper sleeves or wire around it. A trained health provider inserts it into a woman's uterus through her vagina and cervix. Almost all types of IUDs have one or two strings (threads) tied to them. The strings hang through the cervix into the vagina. An IUD causes a chemical change that damages sperm and egg before they can meet.	One of the most effective and long-lasting methods: Over 99% effective. A small risk of pregnancy remains beyond the first year of use and continues as long as the woman is using the IUD. **Most women can use IUDs safely and effectively, including women who:** Have or have not had children; Are not married; Are of any age, including adolescents and women over 40 years old; Have just had an abortion or miscarriage (if no evidence of infection); Are breastfeeding; Do hard physical work; Have had ectopic pregnancy; Have had pelvic inflammatory disease (PID); Have vaginal infections; Have anaemia; Are infected with HIV or on antiretroviral therapy and doing well. **Women can start using IUDs:** Without STI testing; Without an HIV test; Without any blood tests or other routine laboratory tests; Without cervical cancer screening; Without a breast examination.	**Return of fertility after Copper Bearing IUDs are removed:** No delay. **Helps protect against:** Risks of pregnancy. **May help protect against:** Cancer of the lining of the uterus (endometrial cancer). **Other advantages:** It prevents pregnancy very effectively; It is long-lasting; It has no further costs after the IUD is inserted; It does not require the user to do anything once the IUD is inserted.	**Protection against STI:** None **Side effects may include:** Changes in bleeding patterns (especially in the first three-to-six months) including: – Prolonged and heavy monthly bleeding – Irregular bleeding – More cramps and pain during monthly bleeding **Known health risks:** Uncommon: May contribute to anaemia if a woman already has low iron blood stores before insertion and the IUD causes heavier monthly bleeding Rare: Pelvic inflammatory disease (PID) may occur if the woman has chlamydia or gonorrhea at the time of IUD insertion. **Complications** Rare: Puncturing (perforation) of the wall of the uterus by the IUD or an instrument used for insertion. Usually heals without treatment. Miscarriage, preterm birth, or infection in the rare case that the woman becomes pregnant with the IUD in place.

Question Card 8: Levonorgestrel Intrauterine Device. (Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers)			
What is it, and what is its mode of action?	**Effectiveness? Who can use it, and when can they start?**	**Health benefits and advantages?**	**Side effects and health risks?**
Also known as LNG-IUD, it is a T-shaped plastic device. Each day, it releases small amounts of levonorgestrel (a progestin widely used in implants and oral contraceptive pills.) A health care provider inserts it into a woman's uterus through her vagina and cervix. Also called the levonorgestrel-releasing intrauterine system, LNG-IUS, or hormonal IUD. Works primarily by suppressing the growth of the lining of uterus (endometrium).	Over 99% effective. A small risk of pregnancy remains beyond the first year of use and continues as long as the woman is using the LNG-IUD. Approved for up to 5 years of use. **Safe and suitable for nearly all women:** Nearly all women can use the LNG-IUD safely and effectively. **Women can start using a LNG-IUD:** In many cases a woman can start the LNG-IUD any time it is reasonably certain she is not pregnant.	**Return of fertility after use of Levonorgestrel Intrauterine Device is stopped:** No delay **Help protect against:** Risks of pregnancy; Iron-deficiency anaemia. **<u>May</u> help protect against:** Pelvic inflammatory disease. **Reduces:** Menstrual cramps; Symptoms of endometriosis (pelvic pain, irregular bleeding).	**Protection against STI:** None **Known health risks:** None **Side effects:** – Changes in bleeding patterns, including: Lighter bleeding and fewer days of bleeding; Infrequent bleeding; Irregular bleeding; No monthly bleeding; Prolonged bleeding. – Other: Acne; Headaches; Breast tenderness or pain; Nausea; Weight gain; Dizziness; Mood changes. **Other possible physical changes:** Ovarian cysts **Complications:** <u>Rare</u>: Puncturing (perforation) of the wall of the uterus by the LNG-IUD or an instrument used for insertion. Usually heals without treatment. <u>Very rare</u>: Miscarriage, preterm birth, or infection in the very rare case that the woman becomes pregnant with the LNG-IUD in place.

Question Card 9: Voluntary Surgical Contraception/Permanent Methods: Tubal Ligation . (Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers)

What is it, and what is its mode of action?	**Effectiveness? Who can use it, and when can they start?**	**Health benefits and advantages?**	**Side effects and health risks?**
Called tubal sterilization, tubectomy, bi-tubal ligation, and minilap. **Two most commonly used procedures**: - Minilaparotomy: making a small incision in the abdomen to reach and cut or block the fallopian tubes. Or - Laparoscopy: inserting a long thin tube with a lens in it (laparoscope) into the abdomen through a small incision. The laparoscope enables the doctor to see, block or cut the fallopian tubes. The eggs released from the ovaries cannot move down the tubes, and so do not meet sperm.	One of the most effective methods (99.5%) but carries a small risk of failure. A small risk of pregnancy remains beyond the first year of use and until the woman reaches menopause. The procedure is intended to be permanent. Reversal surgery is difficult, expensive, and not available in most areas. When performed, reversal surgery often does not lead to pregnancy. **With proper counselling and informed consent, any woman can have female sterilization safely, including women who:** Have no children or few children; Are not married; Do not have husband's permission; Are young; Just gave birth (within the last 7 days); Are breastfeeding; Are infected with HIV, whether or not on antiretroviral therapy. In some of these situations, especially careful counselling is important to make sure the woman will not regret her decision. **Women can have female sterilization:** Without any blood tests or routine laboratory tests; Without cervical cancer screening. Even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant.	**Helps protect against:** Risks of pregnancy; Pelvic inflammatory disease (PID). **May help protect against:** Ovarian cancer. **Other advantages:** It has no side effects; No need to worry about contraception again; It is easy to use, nothing to do or remember.	**Protection against STI:** None **Side effects:** None **Known health risks:** Uncommon to extremely rare: Complications of surgery and anaesthesia. **Complications of Surgery:** Uncommon to extremely rare: Female sterilization is a safe method of contraception. It requires surgery and anaesthesia, however, which carry some risks such as infection or abscess of the wound. Serious complications are uncommon. Death, due to the procedure or anaesthesia, is extremely rare. The risk of complications with local anaesthesia is significantly lower than with general anaesthesia. Complications can be kept to a minimum if appropriate techniques are used and if the procedure is performed in an appropriate setting.

Question Card 10: Voluntary Surgical Contraception/Permanent Methods: Vasectomy . (Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers)

What is it, and what is its mode of action?	**Effectiveness? Who can use it, and when can they start?**	**Health benefits and advantages?**	**Side effects and health risks?**
Permanent contraception for men who will not want more children. Through a puncture/ small incision in the scrotum, the provider locates each of the 2 tubes that carries sperm to the penis (vas deferens) and cuts or blocks it by cutting and tying it closed or by applying heat or electricity (cautery). Works by closing off each vas deferens, keeping sperm out of semen. Semen is ejaculated, but it cannot cause pregnancy.	Highly effective (97-98%) but carries a small risk of failure. Vasectomy is not fully effective until 3 months after the procedure. Some pregnancies occur within the first year if couple does not use condoms or another effective method consistently and correctly in the first 3 months, before the vasectomy is fully effective. Vasectomy might not be effective until sperm analysis confirms that spermatozoa have been excluded from all ejaculates post procedure. **With proper counselling and informed consent, any man can have a vasectomy safely, including men who:** Have no children or few children; Are not married; Do not have wife's permission; Are young; Have sickle cell disease; Are at high risk of infection with HIV or another STI; Are infected with HIV, whether or not on antiretroviral therapy. **Men can have a vasectomy:** Without any blood tests or routine laboratory tests; Without a blood pressure check; Without a haemoglobin test; Without a cholesterol or liver functionality check. Even if the semen cannot be examined by microscope later to see if it still contains sperm.	**Helps protect against:** Risks of pregnancy **Other advantages:** It is safe, permanent, and convenient; It has fewer side effects and complications than many methods for women; The man takes responsibility for contraception—takes burden off the woman. It increases enjoyment and frequency of sex.	**Protection against STI:** None **Side effects and known health risks:** None **Complications:** Uncommon to rare: Severe scrotal or testicular pain that lasts for months or years. Uncommon to very rare: Infection at the incision site or inside the incision (uncommon with conventional incision technique; very rare with no-scalpel technique). Rare: Bleeding under the skin that may cause swelling or bruising (hematoma). **Please note**: If the partner of a man who has had a vasectomy becomes pregnant, it may be because: - The couple did not always use another method during the first 3 months after the procedure - The provider made a mistake - The cut ends of the vas deferens grew back together. Good counselling is important to make sure the man will not regret his decision. Reversal surgery is difficult, expensive, and not available in most areas. When performed, reversal surgery often does not lead to pregnancy.

Question Card 11: Male condoms . (Source: World Health Organization, Johns Hopkins Bloomberg School of Publi c Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers)			
What is it, and what is its mode of action?	**Effectiveness? Who can use it, and when can they start?**	**Health benefits and advantages?**	**Side effects and health risks?**
Coverings usually made of thin latex rubber that fit over a man's erect penis. Also called rubbers, "raincoats," "umbrellas," skins, and prophylactics, condoms are known by many different brand names. Work by forming a barrier that keeps sperm out of the vagina, preventing both pregnancy and STI.	**Effectiveness depends on the user:** Risk of pregnancy or sexually transmitted infection (STI) is greatest when condoms are not used with every act of sex. Very few pregnancies or infections occur due to incorrect use, slips, or breaks. As commonly used, available data show that condom have an 85% effectiveness use in preventing pregnancies in the first year of use. However, if used correctly with every act of sex, condoms have an effectiveness rate of 98% in preventing pregnancies. **All men and women can safely use male condoms except people with:** Severe allergic reaction to latex rubber. **Men can start using condoms:** Any time they want.	**Return of fertility after use of condoms is stopped:** No delay **Help protect against:** Risk of pregnancy; HIV and other STI (Male condoms significantly reduce the risk of becoming infected with HIV when used correctly with every act of sex). **When used consistently and correctly,** condom use prevents 80% to 95% of HIV transmission that would have occurred without condoms. Condoms reduce the risk of becoming infected with many STIs when used consistently and correctly: – Protect best against STIs spread by discharge, such as HIV, gonorrhea, and chlamydia. – Also protect against STIs spread by skin-to-skin contact, such as herpes and human papillomavirus. **<u>May</u> help protect against:** Conditions caused by STIs: - Recurring pelvic inflammatory disease and chronic pelvic pain. - Cervical cancer. - Infertility (male and female). **Other advantages:** No hormonal side effects; Can be used as a temporary or backup method; Can be used without seeing a health provider; Are sold in many places and generally easy to obtain.	**Side effects:** None **Known health risks:** <u>Extremely rare</u>: Severe allergic reaction (among people with latex allergy).

Question Card 12: Female condoms . (Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook forProviders)			
What is it, and what is its mode of action?	**Effectiveness? Who can use it, and when can they start?**	**Health benefits and advantages?**	**Side effects and health risks?**
Linings that fit loosely inside a woman's vagina. Made of thin, soft plastic film. – Have flexible rings at both ends – One ring at the closed end helps to insert the condom – The ring at the open end holds part of the condom outside the vagina. Known by different brand names. Lubricated with a silicone-based lubricant on the inside and outside. Latex female condoms may be available in some countries. Work by forming a barrier that keeps sperm out of the vagina, preventing Pregnancy and infections.	**Effectiveness depends on the user:** Risk of pregnancy or STI is greatest when female condoms are not used with every act of sex. Few pregnancies or infections occur due to incorrect use, slips, or breaks. As commonly used, 79% effective in preventing pregnancies. When used correctly and consistently, effectiveness rate increases to 95%. **All women can use plastic female condoms:** No medical conditions prevent the use of this method. **Women can start using female condoms:** Any time they want.	**Return of fertility after use of female condom is stopped:** No delay **Help protect against:** Risk of pregnancy; HIV and other STI (Female condoms reduce the risk of infection with STI, including HIV, when used correctly with every act of sex). **Other advantages:** Women can initiate their use. Have a soft, moist texture that feels more natural than male latex condoms during sex. Help protect against both pregnancy and STI, including HIV. Outer ring provides added sexual stimulation for some women. Can be used without seeing a health care provider. Can be inserted ahead of time so do not interrupt sex. Are not tight or constricting like male condoms. Do not dull the sensation of sex like some men complain about male condoms. Do not have to be removed immediately after ejaculation.	**Side effects:** None **Known health risks:** None

Question Card 13: Spermicides . (Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers)			
What is it, and what is its mode of action?	**Effectiveness? Who can use it, and when can they start?**	**Health benefits and advantages?**	**Side effects and health risks?**
Sperm-killing substances inserted deep in the vagina, near the cervix, before sex. - Nonoxynol-9 is most widely used. - Others include. menfegol, octoxynol-9, and sodium docusate. **Jellies, creams, and foam** can be used alone, with a diaphragm, or with condoms. **Films, suppositories, foaming tablets, or foaming suppositories** can be used alone or with condoms. Work by causing the membrane of sperm cells to break, killing them or slowing their movement. This keeps sperm from meeting an egg.	**Effectiveness depends on the user:** Risk of pregnancy is greatest when spermicides are not used with every act of sex. One of the least effective family planning methods: 71% rate as commonly used. However, when used correctly with every act of sex, the effectiveness rate increases to 82%. **Safe and suitable for nearly all women except for those who:** Are at high risk for HIV infection; Have HIV infection; Have AIDS. **When to start using:** Any time the client wants.	**Return of fertility after use of spermicide is stopped:** No delay **Help protect against:** Risk of pregnancy. **Other advantages:** Are controlled by the woman; Have no hormonal side effects; Increase vaginal lubrication; Can be used without seeing a health care provider; Can be inserted ahead of time and so do not interrupt sex.	**Protection against STI:** None **Side effects:** Irritation in or around the vagina or penis. **Other possible physical changes:** Vaginal lesions. **Known health risks:** Uncommon: Urinary tract infection, especially when using spermicides 2 or more times a day. Rare: Frequent use of nonoxynol-9 may increase risk of HIV infection.

Question C ard 14: Diaphragms . (Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers)			
What is it, and what is its mode of action?	**Effectiveness? Who can use it, and when can they start?**	**Health benefits and advantages?**	**Side effects and health risks?**
A soft latex cup that covers the cervix. Plastic diaphragms also exist. The rim contains a firm, flexible spring that keeps the diaphragm in place. Used with spermicidal cream, jelly, or foam to improve effectiveness. Comes in different sizes and requires fitting by a trained provider. Works by blocking sperm from entering the cervix; spermicide kills or disables sperm. Both keep sperm from meeting an egg.	**Effectiveness depends on the user:** Risk of pregnancy is greatest when the diaphragm with spermicide is not used with every act of sex. As commonly used, effectiveness rate is 84%. When used correctly with every act of sex, effectiveness is 94%. **Nearly all women can use the diaphragm safely and effectively.** **When to start using a diaphragm:** At any time if she has had a full-term delivery or second trimester spontaneous or induced abortion less than 6 weeks ago, give her a backup method to use, if needed, until 6 weeks have passed. **If a woman is switching from another method:** Suggest that she try the diaphragm for a time while still using her other method so that she can safely gain confidence that she can use the diaphragm correctly.	**Return of fertility after use of diaphragms is stopped:** No delay **Help protect against:** Risk of pregnancy. **May help protect against:** May provide some protection against certain STI (chlamydia, gonorrhoea, pelvic inflammatory disease, trichomoniasis), but should not be relied on for STI prevention. May also protect against cervical pre-cancer and cancer. **Other advantages:** It is controlled by the woman; It has no hormonal side effects; It can be inserted ahead of time and so does not interrupt sex.	**Protection against STI:** it cannot be relied upon for STI prevention. **Side effects:** Irritation in or around the vagina or penis. **Known health risks:** Common to uncommon: Urinary tract infection. Uncommon: Bacterial vaginosis; Candidiasis. Rare: Frequent use of nonoxynol-9 may increase risk of HIV infection. Extremely rare: Toxic shock syndrome.

Question Card 15: Cervical caps . (Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning.A Global Handbook for Providers)			
What is it, and what is its mode of action?	**Effectiveness? Who can use it, and when can they start?**	**Health benefits and advantages?**	**Side effects and health risks?**
A soft, deep, latex or plastic rubber cup covering the cervix. Comes in different sizes; requires fitting by a trained provider. Works by blocking sperm from entering the cervix; spermicides kill or disable sperm. Both keep sperm from meeting an egg.	**Effectiveness depends on the user:** Risk of pregnancy is greatest when the cervical cap with spermicide is not used with every act of sex. **Women who have given birth:** One of the least effective methods, as commonly used effectiveness rate is 68%. However, if used correctly with every act of sex, the rate increases to 80%. **More effective among women who have <u>not</u> given birth:** as commonly used, effectiveness rate is 84%. However, if used correctly with every act of sex, the rate increases to 91%. **Nearly all women can use the cervical cap safely and effectively.**	**Return of fertility after use of cervical caps is stopped:** No delay **Help protect against:** Risk of pregnancy. **<u>May</u> help protect against:** May provide some protection against certain STI (chlamydia, gonorrhoea, pelvic inflammatory disease, trichomoniasis), but should not be relied on for STI prevention. May also protect against cervical pre-cancer and cancer. **Other advantages:** It is controlled by the woman; It has no hormonal side effects; It can be inserted ahead of time and so does not interrupt sex.	**Protection against STI:** it cannot be relied upon for STI prevention. **Side effects:** Irritation in or around the vagina or penis. **Known health risks:** <u>Common to uncommon</u>: Urinary tract infection. <u>Uncommon</u>: Bacterial vaginosis; Candidiasis. <u>Rare</u>: Frequent use of nonoxynol-9 may increase risk of HIV infection. <u>Extremely rare</u>: Toxic shock syndrome.

Question Card 16: Combined patch . (Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers)

What is it, and what is its mode of action?	Effectiveness? Who can use it, and when can they start?	Health benefits and advantages?	Side effects and health risks?
A small, thin, square of flexible plastic worn on the body. Also called Ortho Evra and Evra. Continuously releases 2 hormones—a progestin and an estrogen, directly through the skin into the bloodstream. A new patch is worn every week for 3 weeks, then no patch for the fourth week. During this fourth week the woman will have monthly bleeding. Works by preventing the release of eggs from the ovaries (ovulation).	**Effectiveness depends on the user:** Risk of pregnancy is greatest when a woman is late to change the patch. Pregnancy rates may be slightly higher among women weighing 90 kg or more. The combined patch is new. Research on effectiveness is limited. Clinical trials of the patch suggest that it may be more effective than combined oral contraceptives, both as commonly used and with consistent and correct use. **Nearly all women can use CP safely and effectively, including women who:** Have or have not had children; Are not married; Are of any age, including adolescents and women over 40 years old; Have just had an abortion or miscarriage; Smoke cigarettes—if under 35 years old; Have anaemia now or had in the past; Have varicose veins; Are infected with HIV, whether or not on antiretroviral therapy. **Women can start using CP:** Without a pelvic examination; Without any blood tests or other routine laboratory tests; Without cervical cancer screening; Without a breast examination; Even when a woman is not having monthly bleeding at the time, if pregnancy has been reasonably ruled out.	**Return of fertility after use of combined patch is stopped:** No delay Long-term studies of the patch are limited, but researchers expect that **its health benefits are like those of combined oral contraceptives.** Therefore, the combined patch: **Helps protect against**: Risks of pregnancy; Cancer of the lining of the uterus (endometrial cancer); Cancer of the ovary; Symptomatic pelvic inflammatory disease. **May help protect against:** Ovarian cysts; Iron-deficiency anaemia. **May reduce:** Menstrual cramps; Menstrual bleeding problems; Ovulation pain; Excess hair on face or body; Symptoms of polycystic ovarian syndrome (irregular bleeding, acne, excess hair on face or body); Symptoms of endometriosis (pelvic pain, irregular bleeding). **Other advantages:** Are controlled by the woman; Can be stopped at any time without a provider's help; Do not interfere with sex.	**Protection against STI:** None **Side effects:** – Skin irritation or rash where the patch is applied. – Changes in monthly bleeding: Lighter bleeding and fewer days of bleeding; Irregular bleeding; Prolonged bleeding; No monthly bleeding. – Other: Headaches; Nausea; Vomiting; Breast tenderness and pain; Abdominal pain; Flu symptoms/upper respiratory infection Irritation, redness, or inflammation of the vagina (vaginitis). Long-term studies of the patch are limited, but researchers expect **that its health risks are like those of combined oral contraceptives:** **Very rare health risk:** Blood clot in deep veins of legs or lungs (deep vein thrombosis or pulmonary embolism). **Extremely rare health risk:** Stroke Heart attack

Question Card 17: Combined vaginal ring . (Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers)

What is it, and what is its mode of action?	Effectiveness? Who can use it, and when can they start?	Health benefits and advantages?	Side effects and health risks?
A flexible ring placed in the vagina. Also called NuvaRing. Continuously releases 2 hormones (a progestin and an estrogen) from inside the ring. Hormones are absorbed through the wall of the vagina directly into the bloodstream. The ring is kept in place for 3 weeks and removed for the fourth week. During this fourth week the woman will have monthly bleeding. Works by preventing the release of eggs from the ovaries (ovulation).	**Effectiveness depends on the user:** Risk of pregnancy is greatest when a woman is late to start a new ring. The vaginal ring is new. Research on effectiveness is limited. Clinical trials suggest that it may be more effective than combined oral contraceptives, both as commonly used and with consistent and correct use. **Nearly all women can use the vaginal ring safely and effectively, including women who:** Have or have not had children; Are not married; Are of any age, including adolescents and women over 40 years old; Have just had an abortion or miscarriage; Smoke cigarettes – if under 35 years old; Have anaemia now or had in the past; Have varicose veins; Are infected with HIV, whether or not on antiretroviral therapy. **Women can start using the vaginal ring:** Without a pelvic examination; Without any blood tests or other routine laboratory tests; Without cervical cancer screening; Without a breast examination; Even when a woman is not having monthly bleeding at the time, if pregnancy has been reasonably ruled out.	**Return of fertility after use of combined vaginal ring is stopped:** No delay Long-term studies of the vaginal ring are limited, but researchers expect that **its health benefits are like those of combined oral contraceptives:** **Helps protect against**: Risks of pregnancy; Cancer of the lining of the uterus (endometrial cancer); Cancer of the ovary; Symptomatic pelvic inflammatory disease. **May help protect against:** Ovarian cysts; Iron-deficiency anaemia. **May reduce:** Menstrual cramps; Menstrual bleeding problems; Ovulation pain; Excess hair on face or body; Symptoms of polycystic ovarian syndrome (irregular bleeding, acne, excess hair on face or body); Symptoms of endometriosis (pelvic pain, irregular bleeding). **Other advantages:** Are controlled by the woman; Can be stopped at any time without a provider's help; Do not interfere with sex.	**Protection against STI:** None **Side effects:** – Changes in monthly bleeding, including: Lighter bleeding and fewer days of bleeding; Irregular bleeding; Infrequent bleeding; Prolonged bleeding; No monthly bleeding – Other: Headaches; Irritation, redness, or inflammation of the vagina (vaginitis); White vaginal discharge. Long-term studies of the vaginal ring are limited, but researchers expect that **its health risks are like those of combined oral contraceptives:** **Very rare health risk:** Blood clot in deep veins of legs or lungs (deep vein thrombosis or pulmonary embolism). **Extremely rare health risk:** Stroke; Heart attack.

SESSION 10: Applying the Medical Eligibility Criteria to Help Clients Make Safe Informed and Voluntary Decisions (Part I)

Objectives
By the end of the session, the participants will be able to:
- Apply effectively the medical eligibility criteria for modern methods of contraception.

Total Session Time
120 minutes (two hours)

Materials
- Flipcharts, markers, tape
- Flipchart "Session objectives"
- Sufficient copies of *COCs client profiles* (Activity 1); *Clients' situations: Which client am I?* form (Activity 2)
- Sufficient copies of Handouts 1, 2, and 3

Facilitator's Resources
- Activity 1: Applying the medical eligibility criteria and guidelines for starting use of COCs
- Activity 2: Applying the medical eligibility criteria and guidelines for starting use of Progestin Only Pills (POPs)

Handouts
- Handout 1 – Applying the medical eligibility criteria for COCs
- Handout 2 – Medical eligibility criteria and guidelines for starting use of POPs
- Handout 3 – Applying guidelines for starting use of Emergency Contraceptive Pills (ECPs)

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide).
In this session, the participants will strengthen their skills to effectively help clients make safe, voluntary and informed decisions about modern methods of contraception by exploring scenarios to apply medical eligibility criteria.

Activity 1: Applying the medical eligibility criteria and guidelines for starting use of Combined Oral Contraceptives (COCs). Client profiles (40 minutes)

1.1 Divide the participants in pairs. In the next exercise the participants will use client profiles to check their knowledge of the medical eligibility criteria for Combined Oral Contraceptives (COCs). Instructions:
- ➢ Each pair receives a copy of the COCs client profiles provided in the **Facilitator's Resources** section below.
- ➢ Pairs have 20 minutes to discuss the client profiles (they do not need to write anything).
- ➢ Stop the pair work after 20 minutes and distribute Handout 1. Review it and discuss it with the participants to check to what extent their discussions enabled them to identify all the medical eligibility criteria.

1.2 Close the exercise by reminding the participants that **the medical eligibility criteria for COCs also apply to the Combined Patch and to the Combined Vaginal Rings.**

Activity 2: Applying the medical eligibility criteria and guidelines for starting use of Progestin Only Pills (POPs). Which client am I? (30 minutes)

2.1 Invite the participants to form a circle standing around you. Give to each participant a copy of the *Clients' situations: Which client am I?* form provided in the **Facilitator's Resources** section below. Instructions:

- The facilitator uses Handout 2 and reads out a criterion at a time from the **When to start POPs, if at all** column (make sure you do not read them in order). The participants must decide to which client or clients on the *Clients' situations: Which client am I?* form the criterion applies. The participants who provide the correct answer do not move, while those who do not answer or answer incorrectly will take a step backwards.
- At the end of the exercise distribute Handout 2 and briefly discuss with the participants what new information, if any, they gained from the exercise.

Activity 3: Applying the medical eligibility criteria and guidelines for starting use of Emergency Contraceptive Pills (ECPs) TRUE/FALSE (35 minutes)

3.1 Explain that *all women can use ECPs safely and effectively, including women who cannot use hormonal contraceptive methods on an on-going basis.* Because of the short-term nature of their use, there are no medical conditions that make ECPs unsafe for any woman.

Stress the following key messages:

- ECPs may be needed in many different situations, especially in case of forced sex, any act of unprotected sex, contraceptive mistake e.g. a couple used incorrectly a FAM. Therefore, if possible, give all women who want ECPs a supply in advance.
- A woman can keep them in case she needs them. Women are more likely to use ECPs if they already have them when needed.
- Also, having ECPs on hand enables women to take them as soon as possible after unprotected sex.

3.2 In order to review the information about ECPs, invite the participants to stand in front of you and explain that the TRUE/FALSE exercise that they are going to play:

- The facilitator will read a statement at a time. Those who believe the statement is TRUE will move to one side of the room, while those who feel that it is FALSE will move to the other side (please refer to Handout 3).
- The facilitator will reveal the answer after moving on to the next statement.
- At the end of the exercise, the participants receive Handout 3.

3.3 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Facilitator's Resources

Activity 1: Applying the medical eligibility criteria and guidelines for starting use of COCs

COCs client profiles:

COCs profile 1: the client is fully/nearly fully breastfeeding a baby who is less than 6 months old. When can she start using COCs, if at all?

COCs profile 2: the client is partially breastfeeding a baby who is less than 6 months old. When can she start using COCs, if at all?

COCs profile 3: the client **had a baby in the last 3 weeks that she is not breastfeeding.** When can she start using COCs, if at all?

COCs profile 4: the client is 35 years of age and she smokes. When can she start using COCs, if at all?

COCs profile 5: the client has eyes or skin unusually yellow. When can she start using COCs, if at all?

COCs profile 6: the client has high blood pressure. When can she start using COCs, if at all?

COCs profile 7: the client has had diabetes for more than 20 years or complains that diabetes has caused damage to her **arteries, vision, kidneys, or nervous system.** When can she start using COCs, if at all?

COCs profile 8: the client is taking medication for gallbladder disease. When can she start using COCs, if at all?

COCs profile 9: the client had a stroke in the past or has serious heart problems. When can she start using COCs, if at all?

COCs profile 10: the client was recently diagnosed with breast cancer. When can she start using COCs, if at all?

COCs profile 11: the client suffers from migraine headaches. When can she start using COCs, if at all?

COCs profile 12: the client is taking medications for seizure. When can she start using COCs, if at all?

COCs profile 13: the client is soon to have surgery that will keep her from walking for one week or more. When can she start using COCs, if at all?

Facilitator's Resources

Activity 2: Applying the medical eligibility criteria and guidelines for starting use of Progestin Only Pills (POPs)

Clients' situations: Which client am I?

1. I gave birth less than six weeks ago and am fully/nearly fully breastfeeding my baby.
2. I gave birth less than six weeks ago and am fully/nearly fully breastfeeding my baby, but my monthly bleeding has not returned.
3. I gave birth less than six weeks ago and am fully/nearly fully breastfeeding my baby, and my monthly bleeding has returned.
4. I am fully/nearly fully breastfeeding my baby more than six months after giving birth, and my monthly bleeding has returned.
5. I gave birth less than four weeks ago and am not breastfeeding, and my monthly bleeding has returned.
6. I am partially breastfeeding my baby more than six weeks after giving birth, and my monthly bleeding has returned.
7. I am fully/nearly fully breastfeeding my baby more than six months after giving birth, and my monthly bleeding has not returned.
8. I am partially breastfeeding my baby more than six weeks after giving birth, and my monthly bleeding has not returned.
9. I gave birth less than four weeks ago and am not breastfeeding, and my monthly bleeding has not returned.
10. I'm having a menstrual cycle that started more than five days ago.
11. I have no monthly bleeding, but it is not related to childbirth or breastfeeding.
12. It is more than seven days after my miscarriage/abortion (first or second trimester).
13. I gave birth less than six weeks ago and am partially breastfeeding my baby.
14. I am switching from a hormonal method and I am not pregnant.
15. I am switching from injectables.
16. I am switching from an UID.
17. I had a miscarriage/abortion less than seven days ago.
18. I have unusually yellow eyes/skin. I fear I have a liver problem.
19. I have a blood clot deep in my leg.
20. I had breast cancer in the past.
21. I am taking medication for seizure or rifampicin for tuberculosis.

Participant's Handouts

Session 10: Handout 1, Activity 1 – Applying the medical eligibility criteria for COCs

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

COCs client profiles	Medical Eligibility Criteria
Client is fully/nearly fully breastfeeding a baby who is less than six months old.	Give her COCs and tell her to start taking them 6 months after giving birth or when breast milk is no longer the baby's main food—whichever comes first.
Client is partially breastfeeding a baby who is less than six months old.	She can start COCs as soon as six weeks after childbirth.
Client had a baby in the last 3 weeks that she is not breastfeeding	Give her COCs now and tell her to start taking them 3 weeks after childbirth.
Client is 35 years of age and she smokes.	Do not provide COCs. Urge her to stop smoking and help her choose another method.
Client has eyes or skin unusually yellow.	If she reports serious active liver disease (jaundice, active hepatitis, mild or severe cirrhosis, liver tumor) or ever had jaundice while using COCs, do not provide COCs. Help her choose a method without hormones. (She can use monthly injectables if she has had jaundice only with past COC use.)
Client has high blood pressure.	If you cannot check blood pressure and she reports a history of high blood pressure, or if she is being treated for high blood pressure, do not provide COCs. Refer her for a blood pressure check or help her choose a method without estrogen. **Check blood pressure if possible:** If her blood pressure is below 140/90 mm Hg, provide COCs. If her systolic blood pressure is 140 mm Hg or higher or diastolic blood pressure is 90 or higher, do not provide COCs. Help her choose a method without estrogen, but not progestin-only injectables if systolic blood pressure is 160 or higher or diastolic pressure is 100 or higher. (One blood pressure reading in the range of 140–159/90–99 mm Hg is not enough to diagnose high blood pressure. Give her a backup method to use until she can return for another blood pressure check, or help her choose another method now if she prefers.)
Client has had diabetes for more than 20 years or says that diabetes has caused damage to her arteries, vision, kidneys, or nervous system.	Do not provide COCs. Help her choose a method without estrogen but not progestin-only injectables.
Client is taking medication for gallbladder disease.	Do not provide COCs. Help her choose another method but not the combined patch or combined vaginal ring.

Client had a stroke in the past or has serious heart problems.	If she reports heart attack, heart disease due to blocked or narrowed arteries, or stroke, do not provide COCs. Help her choose a method without estrogen but not progestin-only injectables. If she reports a current blood clot in the deep veins of the legs or lungs (not superficial clots), help her choose a method without hormones.
Client was recently diagnosed with breast cancer.	Do not provide COCs. Help her choose a method without hormones.
Client suffers from migraine headaches.	If she has migraine aura at any age, do not provide COCs. If she has migraine headaches *without* aura *and* is age 35 or older, do not provide COCs. Help these women choose a method without estrogen. If she is under 35 and has migraine headaches without aura, she can use COCs.
Client is taking medications for seizure.	These medications can make COCs less effective. Help her choose another method but not progestin-only pills or implants.
Client is to have surgery that will keep her from walking for one week or more.	She can start COCs two weeks after the surgery. Until she can start COCs, she should use a backup method.

Participant's Handouts

Session 10: Handout 2, Activity 2 – Medical eligibility criteria and guidelines for starting use of POPs

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

I gave birth less than six weeks ago and am fully/nearly fully breastfeeding my baby.	The client can have POPs and can start using them six weeks after giving birth.
I gave birth less than six weeks ago and am fully/nearly fully breastfeeding my baby, but my monthly bleeding has not returned.	The client can start POPs any time between six weeks and six months. No need for a backup method.
I gave birth less than six weeks ago and am fully/nearly fully breastfeeding my baby, and my monthly bleeding has returned. I am fully/nearly fully breastfeeding my baby more than six months after giving birth, and my monthly bleeding has returned. I gave birth less than four weeks ago and am not breastfeeding, and my monthly bleeding has returned. I am partially breastfeeding my baby more than six weeks after giving birth, and my monthly bleeding has returned.	The client can start POPs as advised for women having menstrual cycles.
I am fully/nearly fully breastfeeding my baby more than six months after giving birth, and my monthly bleeding has not returned. I am partially breastfeeding my baby more than six weeks after giving birth, and my monthly bleeding has not returned. I gave birth less than four weeks ago and am not breastfeeding, and my monthly bleeding has not returned. I'm having a menstrual cycle that started more than five days ago. I have no monthly bleeding, but it is not related to childbirth or breastfeeding. It is more than seven days after my miscarriage/abortion (first or second trimester).	The client can start POPs any time it is reasonably certain she is not pregnant. She will need a backup method for the first two days of taking pills.
I gave birth less than six weeks ago and am partially breastfeeding my baby.	The client can start taking POPs six weeks after giving birth, and she will also need a backup method to use until six weeks since giving birth if her monthly bleeding returns before this time.

I am switching from a hormonal method and I am not pregnant.	The client can start POPs immediately. No need to wait for her next monthly bleeding. No need for a backup method.
I am switching from injectables.	The client can begin taking POPs when the repeat injection would have been given. No need for a backup method.
I am switching from an IUD. I had a miscarriage/abortion less than seven days ago.	The client can start POPs immediately.
I have unusually yellow eyes/skin. I fear I have a liver problem. I have a blood clot deep in my leg. I had breast cancer in the past.	The client cannot use POPs. A non-hormonal method is recommended.
I am taking medication for seizure or rifampicin for tuberculosis.	The client cannot use POPs, nor COCs or implants.

Participant's Handouts

Session 10: Handout 3, Activity 3 – Applying guidelines for starting use of Emergency Contraceptive Pills (ECPs)

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

Statement	True/False
ECPs should be used within six days after unprotected sex.	FALSE: they should be used within 72 hours of exposure to unprotected sex. The sooner after unprotected sex that ECPs are taken, the more effective they are.
A woman can take ECPs at once after unprotected sex.	TRUE.
If a woman is taking a two-dose regimen, she should be told to take the next dose in 12 hours.	TRUE.
Side effects of ECPs are signs of illness.	FALSE.
ECPs will not protect from pregnancy for any future sex—even the next day.	TRUE: Provides should help the client discuss the need for and choice of on-going pregnancy prevention and, if at risk, protection from STIs including HIV.
If a woman does not want to start a contraceptive method at the time of using ECPS, a provider should give her condoms or oral contraceptives and ask her to use them if she changes her mind.	TRUE: Providers should invite her to come back any time if she wants another method or has any questions or problems.
The following contraceptive can be started the day after a woman takes the ECPs: combined oral contraceptives, progestin-only pills, combined patch, combined vaginal ring.	TRUE: No need to wait for her next monthly bleeding.
Progestin-only injectables can be started on the same day as the ECPs.	TRUE: Or if preferred, within 7 days after the start of her monthly bleeding. She will need a backup method for the first seven days after the injection. She should return if she has signs or symptoms of pregnancy other than not having monthly bleeding.
Monthly injectables cannot be started on the same day as the ECPs.	FALSE: There is no need to wait for her next monthly bleeding to have the injection. She will need a backup method for the first seven days after the injection.
Implants can be started on the same day as the ECPs.	FALSE: Implants can be started once her monthly bleeding has returned. Give her a backup method or oral contraceptives to use until then, starting the day after she finishes taking the ECPs.
An IUD can be inserted on the same day that she uses ECPs.	TRUE: No need for a backup method.
Male and female condoms, spermicides, diaphragms, cervical caps, and withdrawal can be used immediately.	TRUE.
The standard-days method can be started the same day as the ECPs.	FALSE: With the start of her next monthly bleeding.
The symptoms-based method can be started once normal secretions have returned.	TRUE.
If a woman chooses to use a FAM after using ECPs, she will need a back-up method.	TRUE: She will need the back up until she can begin the FAM of her choice.

SESSION 11: Applying the Medical Eligibility Criteria to Help Clients Make Safe Informed and Voluntary Decisions (Part II)

Objectives
By the end of the session, the participants will be able to:
- Apply effectively the medical eligibility criteria for modern methods of contraception.

Total Session Time
120 minutes (two hours)

Materials
- Flipcharts, markers, tape
- Flipchart "Session objectives"
- Sufficient copies of *Guidelines to start use of Progestin-Only Injectables* mini-survey form (Activity 1)
- Sufficient copies of Applying the guidelines to start use of Monthly Injectables. Mini survey with a difference form (Activity 2)

Facilitator's Resources
- Activity 1: Guidelines to start use of Progestin-Only Injectables. Mini-survey.
- Activity 2: Applying the guidelines to start use of Monthly Injectables. Mini survey with a difference.

Handouts
- Handout 1 – Guidelines to start use of Progestin-Only Injectables
- Handout 2 – Medical eligibility criteria for Progestin-Only Injectables
- Handout 3 – Guidelines to start use of Monthly Injectables
- Handout 4 – Medical eligibility criteria for Monthly Injectables
- Handout 5 – Applying the medical eligibility criteria for Implants
- Handout 6 – Applying the guidelines to start use of Implants

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide).
In this session, the participants will strengthen their skills to effectively help clients make safe, voluntary and informed decisions about modern methods of contraception by exploring scenarios to apply medical eligibility criteria.

Activity 1: Applying the guidelines to start use of and medical eligibility criteria for Progestin-Only Injectables. Mini-survey (45 minutes)

1.1 Inform the participants that in this session they will continue to expand their knowledge to apply the guidelines to determine medical eligibility criteria for modern contraceptive methods. In the next exercise, the focus will be on progestin-only injectables.

1.2 Distribute the *Guidelines to start use of Progestin-Only Injectables* mini-survey form (refer to the **Facilitator's Resources** section below). Instructions:
- ➢ Each person will find another participant to begin the mini-survey. They will work in pairs to

complete three questions and will then split up and pair up again with someone else. The new pairs will work on three more questions and split up and pair up again with other people, and so on till the mini-survey is completed.

- Stress that the mini-survey must be completed in 30 minutes maximum.
- Stop the exercise after 30 minutes. Distribute and review Handout 1 with the group to highlight the main learning from the activity.
- Distribute Handout 2 and explain that it contains the medical eligibility criteria for progestin-only injectables. Review it quickly with the group and encourage the participants to read it carefully in their own time as part of their on-going professional development, and remind them that most of the handouts provided in this course can be used as job aids.

Activity 2: Applying the guidelines to start use of and medical eligibility criteria for Monthly Injectables. Mini survey with a difference (30 minutes)

2.1 The guidelines to start use of Monthly Injectables are very similar to those for progestin-only injectables, but there are a few differences. Explain that in the next exercise the participants will be tasked with identifying such differences.

2.2 Distribute the form *Applying the guidelines to start use of Monthly Injectables: Mini survey with a difference* provided in the **Facilitator's Resources** section below and review with the group the instructions provided on the form. Stress that this exercise must be completed in 15 minutes. The participants can refer to Handout 1 from the previous activity.

2.3 Stop the exercise after 15 minutes. Elicit a few responses from the pairs and distribute Handout 3. Review it with the group to check their responses, and highlight the main learning points.

2.4 Distribute Handout 4 and rapidly review it with the participants. Remind them to read all handouts in their own time as part of their on-going professional development, and that most of the handouts provided in this course can be used as job aids.

Activity 3: Applying the guidelines to start use of and medical eligibility criteria for Implants. TRUE/FALSE Game (35 minutes)

3.1 Divide the participants in small teams of three-to-four people depending on the total number. Instructions:

- The participants stand in the middle of the room. The facilitator reads one statement at a time from those provided below. The statements are about the medical eligibility criteria for Implants. If participants feel that the statement is true, they will move to one end of the room or to the opposite one if they feel that it is false. The facilitator provides the correct answer before moving on to the next statement:

Statements	True/False
If a woman is not breastfeeding a baby less than six weeks old, she can start using implants.	**TRUE**: However she can start using implants as soon as 6 weeks after childbirth.
If a woman has unusually yellow yes or skin, implants are good methods to recommend.	**FALSE**: In such situations it is appropriate to help the client choose a method with no hormones.
If a woman has a superficial blood clot, she can still use implants.	**TRUE**: However, if she has **a serious problem with a blood clot in her legs or lungs,** do not provide implants. Help her choose a method without hormones.
If a woman has unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition, implants could make diagnosis and monitoring of any treatment more difficult and therefore should not be provided.	**TRUE**: Help the client choose a method to use while being evaluated and treated (not progestin-only injectables, or a copper-bearing or hormonal IUD).
Medication for seizures or rifampicin for tuberculosis or other illness can make implants less effective.	**TRUE**: If a woman is taking these medications, help her choose another method but not combined oral contraceptives or progestin-only pills.
Women who have or have had breast cancer can use implants.	**FALSE**: Help these clients choose a method without hormones.
Women who are infected with HIV, have AIDS, or are on antiretroviral (ARV) therapy cannot safely use implants.	**FALSE**: However it is important to encourage them to use condoms along with implants. Used consistently and correctly, condoms help prevent transmission of HIV and other STI. Condoms also provide extra contraceptive protection for women on ARV therapy. It is not certain whether ARV medications reduce the effectiveness of implants.

3.2 Distribute Handouts 5 and 6. Handout 5 provides the answers to the TRUE/FALSE exercise just completed. Focus on Handout 6: review it with the group. Encourage the participants to read all handouts in their own time as part of their on-going professional development, and remind them that most of the handouts provided in this course can be used as job aids.

3.3 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Facilitator's Resources

Activity 1: Guidelines to start use of Progestin-Only Injectables: Mini-survey

Provide a copy of this form to each participant:

Clients' situations	When can the client start Progestin-Only Injectables, if at all?
Having menstrual cycles or switching from a non-hormonal method.	
Switching from a hormonal method	
Fully or nearly fully breastfeeding (Less than six months after giving birth)	
Fully or nearly fully breastfeeding (More than six months after giving birth)	
Partially breastfeeding (Less than six weeks after giving birth)	
Partially breastfeeding (More than six weeks after giving birth)	
Not breastfeeding (Less than four weeks after giving birth)	
Not breastfeeding (More than four weeks after giving birth)	
No monthly bleeding (not related to childbirth or breastfeeding)	
After miscarriage or abortion	
After taking emergency contraceptive pills (ECPs)	

Activity 2: Applying the guidelines to start use of Monthly Injectables: Mini survey with a difference

Provide a copy of this form to each participant:

Applying the guidelines to start use of Monthly Injectables. Mini survey with a difference:

The guidelines for Monthly Injectables are very similar to those for progestin -only injectables, but there are a few differences for a small number of *Clients' situations*. Working in pairs, identify for which clients' situations the guidelines are different from those for progestin-only injectables, and how, and write them in the corresponding boxes in the *When can the client start injectables, if at all?* column.

Clients' situations	When can the client start Monthly Injectables, if at all?
Having menstrual cycles or switching from a non-hormonal method.	
Switching from a hormonal method	
Fully or nearly fully breastfeeding (Less than six months after giving birth)	
Fully or nearly fully breastfeeding (More than six months after giving birth)	
Partially breastfeeding (Less than six weeks after giving birth)	
Partially breastfeeding (More than six weeks after giving birth)	
Not breastfeeding (Less than four weeks after giving birth)	
Not breastfeeding (More than four weeks after giving birth)	
No monthly bleeding (not related to childbirth or breastfeeding)	
After miscarriage or abortion	
After taking emergency contraceptive pills (ECPs)	

Participant's Handouts

Session 11: Handout 1, Activity 1 – Guidelines to start use of Progestin-Only Injectables

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

Clients' situations	When can the client start Progestin -Only Injectables, if at all?
Having menstrual cycles or switching from a non-hormonal method.	If she is starting within seven days after the start of her monthly bleeding, no need for a backup method. If it is more than seven days after the start of her monthly bleeding, she can start injectables any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after the injection. If she is switching from an IUD, she can start injectables immediately.
Switching from a hormonal method	Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. If she is switching from another injectable, she can have the new injectable when the repeat injection would have been given. No need for a backup method.
Fully or nearly fully breastfeeding (Less than six months after giving birth)	If she gave birth less than six weeks ago, delay her first injection until at least six weeks after giving birth. If her monthly bleeding has not returned, she can start injectables any time between six weeks and six months. No need for a backup method. If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles.
Fully or nearly fully breastfeeding (More than six months after giving birth)	If her monthly bleeding has not returned, she can start injectables any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after the injection. If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles.
Partially breastfeeding (Less than six weeks after giving birth)	Delay her first injection until at least six weeks after giving birth.
Partially breastfeeding (More than six weeks after giving birth)	If her monthly bleeding has not returned, she can start injectables any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after the injection. If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles.
Not breastfeeding (Less than four weeks after giving birth)	She can start injectables at any time. No need for a backup method.

Not breastfeeding (More than four weeks after giving birth)	If her monthly bleeding has not returned, she can start injectables any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after the injection. If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles.
No monthly bleeding (not related to childbirth or breastfeeding)	She can start injectables any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after the injection.
After miscarriage or abortion	Immediately. If she is starting within seven days after first- or second-trimester miscarriage or abortion, no need for a backup method. If it is more than seven days after first- or second trimester miscarriage or abortion, she can start injectables any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after the injection.
After taking emergency contraceptive pills (ECPs)	She can start injectables on the same day as the ECPs, or if preferred, within seven days after the start of her monthly bleeding. She will need a backup method for the first seven days after the injection. She should return if she has signs or symptoms of pregnancy other than not having monthly bleeding.

Participant's Handouts

Session 11: Handout 2, Activity 1 – Medical eligibility criteria for Progestin-Only Injectables

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

If the client has unusually yellow eyes or skin and/or if she reports serious active liver disease (jaundice, active hepatitis, severe cirrhosis, and liver tumour):

- Do not provide progestin-only injectables. Help her choose a method without hormones.

In case the client has a high blood pressure:

- If you cannot check blood pressure and she reports having high blood pressure in the past, provide progestin-only injectables.
- Check her blood pressure if possible:
  - If she is currently being treated for high blood pressure and it is adequately controlled, or her blood pressure is below 160/100 mm Hg, provide progestin-only injectables.
  - If systolic blood pressure is 160 mm Hg or higher ordiastolic blood pressure 100 or higher, do not provide progestin-only injectables. Help her choose another method—one without estrogen.

If the client had diabetes for more than 20 years or damage to her arteries, vision, kidneys, or nervous system caused by diabetes:

- Do not provide progestin-only injectables. Help her choose another method—one without estrogen.

If the client has had a stroke, blood clot in her legs or lungs, heart attack, or other serious heart problems:

- Do not provide progestin-only injectables. Help her choose another method—one without estrogen. If she reports a current blood clot in the deep veins of the leg or in the lung (not superficial clots), help her choose a method without hormones.

If the client has vaginal bleeding that is unusual for her:

- If the unexplained vaginal bleeding suggests pregnancy or an underlying medical condition, progestin-only injectables are not recommended. Help the client choose a method to use while being evaluated and treated (but not implants or a copper-bearing or hormonal IUD). After treatment, re-evaluate for use of progestin-only injectables.

If the client has or has had breast cancer:

- Do not provide progestin-only injectables. Help her choose a method without hormones.

If the client has other conditions that could increase her chances of heart disease (coronary artery disease) or stroke, such as high blood pressure and diabetes:

- Do not provide progestin-only injectables. Help her choose another method without estrogen.

Participant's Handouts

Session 11: Handout 3, Activity 2 – Guidelines to start use of Monthly Injectables

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

The three differences with Progestin-only injectables are printed in a larger font.

Clients' Situations	When can the client start Monthly Injectables, if at all?
Having menstrual cycles or switching from a non-hormonal method.	If she is starting within seven days after the start of her monthly bleeding, no need for a backup method. If it is more than seven days after the start of her monthly bleeding, she can start injectables any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after the injection. If she is switching from an IUD, she can start injectables immediately.
Switching from a hormonal method	Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. If she is switching from another injectable, she can have the new injectable when the repeat injection would have been given. No need for a backup method.
Fully or nearly fully breastfeeding (Less than six months after giving birth)	Delay her first injection until six months after giving birth or when breast milk is no longer the baby's main food —whichever comes first.
Fully or nearly fully breastfeeding (More than six months after giving birth)	If her monthly bleeding has not returned, she can start injectables any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after the injection. If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles.
Partially breastfeeding (Less than six weeks after giving birth)	Delay her first injection until at least six weeks after giving birth.
Partially breastfeeding (More than six weeks after giving birth)	If her monthly bleeding has not returned, she can start injectables any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after the injection. If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles.

Not breastfeeding (Less than four weeks after giving birth)	She can start injectables at any time on days 21–28 after giving birth. No need for a backup method.
Not breastfeeding (More than four weeks after giving birth)	If her monthly bleeding has not returned, she can start injectables any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after the injection. If her monthly bleeding has returned, she can start injectables as advised for women having menstrual cycles.
No monthly bleeding (not related to childbirth or breastfeeding)	She can start injectables any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after the injection.
After miscarriage or abortion	Immediately. If she is starting within seven days after first- or second-trimester miscarriage or abortion, no need for a backup method. If it is more than seven days after first- or second trimester miscarriage or abortion, she can start injectables any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after the injection.
After taking emergency contraceptive pills (ECPs)	She can start injectables on the same day as the ECPs. There is no need to wait for her next monthly bleeding to have the injection. She will need a backup method for the first seven days after the injection.

Participant's Handouts

Session 11: Handout 4, Activity 2 – Medical eligibility criteria for Monthly Injectables

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

If the client had a baby in the last three weeks that she is not breastfeeding:

- She can start monthly injectables as soon as three weeks after childbirth.

If the client smokes 15 or more cigarettes a day:

- If she is 35 years of age or older and smokes more than 15 cigarettes a day, do not provide monthly injectables. Encourage her to stop smoking and help her choose another method.

If the client has a high blood pressure:

- If you cannot check blood pressure and she reports a history of high blood pressure, or if she is being treated for high blood pressure, do not provide monthly injectables. Refer her for a blood pressure check if possible or help her choose another method without estrogen.

Check her blood pressure if possible:

- If blood pressure is below 140/90 mm Hg, provide monthly injectables.
- If systolic blood pressure is 140 mm Hg or higher or diastolic blood pressure is 90 or higher, do not provide monthly injectables. Help her choose a method without estrogen, but not progestin-only injectables if systolic blood pressure is 160 or higher or diastolic pressure is 100 or higher.

One blood pressure reading in the range of 140–159/90–99 mm Hg is not enough to diagnose high blood pressure. Provide a backup method to use until she can return for another blood pressure check, or help her choose another method now if she prefers. If blood pressure at next check is below 140/90, she can use monthly injectables.

If the client had diabetes for more than 20 years or damage to her arteries, vision, kidneys, or nervous system caused by diabetes:

- Do not provide monthly injectables. Help her choose a method without estrogen but not progestin-only injectables.

If the client has had a stroke, blood clot in her legs or lungs, heart attack, or other serious heart problems:

- Do not provide monthly injectables. Help her choose a method without estrogen but not progestin-only injectables. If she reports a current blood clot in the deep veins of the leg or in the lung (not superficial clots), help her choose a method without hormones.

If the client sometimes sees a bright area of lost vision in the eye before a very bad headache (migraine aura); if she gets throbbing, severe head pain, often on one side of the head, that can last from a few hours to several days and can cause nausea or vomiting (migraine headaches):

- If she has migraine aura at any age, do not provide monthly injectables. If she has migraine headaches *without* aura *and* is age 35 or older, do not provide monthly injectables. Help these women choose a method without estrogen. If she is under 35 and has migraine headaches without aura, she can use monthly injectables.

If the client has or has had breast cancer:

- Do not provide progestin-only injectables. Help her choose a method without hormones.

If the client is planning major surgery that will keep her from walking for one week or more:

- If so, she can start monthly injectables two weeks after the surgery. Until she can start monthly injectables, she should use a backup method.

If the client has other conditions that could increase her chances of heart disease (coronary artery disease) or stroke, such as high blood pressure and diabetes:

- Do not provide monthly injectables. Help her choose a method without estrogen, but not progestin-only injectables.

Participant's Handouts

Session 11: Handout 5, Activity 3 – Applying the medical eligibility criteria for Implants

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

Statements	True/False
If a woman is not breastfeeding a baby less than six weeks old, she can start using implants.	**TRUE**: However she can start using implants as soon as 6 weeks after childbirth.
If a woman has unusually yellow eyes or skin, implants are good methods to recommend.	**FALSE**: In such situations it is appropriate to help the client choose a method with no hormones.
If a woman has a superficial blood clot, she can still use implants.	**TRUE**: However, if she has **a serious problem with a blood clot in her legs or lungs,** do not provide implants. Help her choose a method without hormones.
If a woman has unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition, implants could make diagnosis and monitoring of any treatment more difficult and therefore should not be provided.	**TRUE**: Help the client choose a method to use while being evaluated and treated (not progestin-only injectables, or a copper-bearing or hormonal IUD).
Medication for seizures or rifampicin for tuberculosis or other illness can make implants less effective.	**TRUE**: If a woman is taking these medications, help her choose another method but not combined oral contraceptives or progestin-only pills.
Women who have or have had breast cancer can use implants.	**FALSE**: Help these clients choose a method without hormones.
Women who are infected with HIV, have AIDS, or are on antiretroviral (ARV) therapy cannot safely use implants.	**FALSE**: However it is important to encourage them to use condoms along with implants. Used consistently and correctly, condoms help prevent transmission of HIV and other STI. Condoms also provide extra contraceptive protection for women on ARV therapy. It is not certain whether ARV medications reduce the effectiveness of implants.

Participant's Handouts

Session 11: Handout 6, Activity 3 – Applying the guidelines to start use of Implants

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

Clients' situations	When can the client start Implants, if at all?
Having menstrual cycles or switching from a non-hormonal method.	If she is starting within seven days after the start of her monthly bleeding (five days for Implanon), no need for a backup method. If it is more than seven days after the start of her monthly bleeding (more than five days for Implanon), she can have implants inserted if it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after insertion. If she is switching from an IUD, she can have implants inserted immediately
Switching from a hormonal method	Immediately, if it is reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. If she is switching from injectables, she can have implants inserted when the repeat injection would have been given. No need for a backup method.
Fully or nearly fully breastfeeding (Less than six months after giving birth)	If she gave birth less than six weeks ago, delay insertion until at least six weeks after giving birth. If her monthly bleeding has not returned, she can start implants any time between six weeks and six months. No need for a backup method. If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles.
Fully or nearly fully breastfeeding (More than six months after giving birth)	If her monthly bleeding has not returned, she can have implants inserted any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after insertion. If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles
Partially breastfeeding (Less than six weeks after giving birth)	Delay inserting implants until at least 6 weeks after giving birth.
Partially breastfeeding (More than six weeks after giving birth)	If he r monthly bleeding has not returned, she can have implants inserted any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after insertion. If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles.

Not breastfeeding (Less than four weeks after giving birth)	She can have implants inserted at any time. No need for a backup method.
Not breastfeeding (More than four weeks after giving birth)	If her monthly bleeding has not returned, she can have implants inserted any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after insertion. If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles.
No monthly bleeding (not related to childbirth or breastfeeding)	She can have implants inserted any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after insertion.
After miscarriage or abortion	Immediately. If implants are inserted within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method. If it is more than seven days after first- or second-trimester miscarriage or abortion, she can have implants inserted any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion.
After taking emergency contraceptive pills (ECPs)	Implants can be inserted within seven days after the start of her next monthly bleeding (within five days for Implanon) or any time it is reasonably certain she is not pregnant. Provide a backup method to start the day after she finishes the ECPs, to use until the implants are inserted.

SESSION 12: Applying the Medical Eligibility Criteria to Help Clients Make Safe Informed and Voluntary Decisions (Part III)

Objectives

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

- Apply effectively the medical eligibility criteria for modern methods of contraception.

Materials

- Flipcharts, markers, tape, blank A4 size paper sheets
- Flipchart "Session objectives"
- TRUE and FALSE signs, Activity 1
- Paper strips for Activity 1 (see the **Facilitator's resources** section)
- Sufficient copies of Handouts 1, 2, 3, and 4

Total Session Time

120 minutes (two hours)

Facilitator's Resources

- Activity 2: Copper-Bearing Intrauterine Device. TRUE/FALSE

Handouts

- Handout 1 – Applying the medical eligibility criteria for Copper-Bearing Intrauterine Device
- Handout 2 – Copper-Bearing Intrauterine Device. Guidelines to start use
- Handout 3 – Medical eligibility criteria for Levonorgestrel IUDs
- Handout 4 – Guidelines to start use of Levonorgestrel IUDs (LNG-IUD)

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide).
In this session, the participants will strengthen their skills to effectively help clients make safe, voluntary and informed decisions about modern methods of contraception by exploring scenarios to apply medical eligibility criteria.

Activity 1: Applying the medical eligibility criteria for and the guidelines to start use of Copper-Bearing Intrauterine Device (55 minutes)

1.1 Divide the participants in two teams if you have no more than six-to-eight participants. If your group is much larger than eight, divide the participants in more groups. Instructions:
- ➢ Teams will have 15 minutes to brainstorm the key issues that should be checked with a client who wants to use an IUD in order to ensure medical eligibility criteria are applied. Teams will prepare their lists on flipcharts.
- ➢ Each team will have five minutes maximum for presentation.
- ➢ The facilitator elicits comments and inputs after each presentation.
- ➢ Finally the facilitator distributes and reviews with the group Handout 1 to compare with the groups' lists, and facilitates a discussion to highlight the main learning points.

1.2 In the next exercise, the participants will check and expand on their knowledge of the guidelines for starting IUD. Instructions:
- ➢ The facilitator posts a TRUE and a FALSE flipchart on the wall, leaving some space in between the two.

- The participants stand in front of the two flipcharts. Each participant picks one paper strip from an envelope or bag that the facilitator has pre-prepared (refer to the **Facilitator's Resources** below). Each strip of paper has a statement written on and each participant will decide whether to stick her/his strip on the TRUE or FALSE flipchart without seeking help. In this game there is no I AM NOT SURE option.
- Once all the strips have been posted, the facilitator enables a rapid discussion: Should any strip be moved under a different sign, and why?
- Finally, the facilitator distributes Handout 2 and reviews it with the group vis-à-vis the lists on the wall. Any strip which is out of place is now moved to its right location.

Activity 2: Applying the medical eligibility criteria for and the guidelines to start use of Levonorgestrel IUDs (55 minutes)

2.1 The medical eligibility criteria for LNG-IUD are the same as for the **Copper-Bearing Intrauterine Device (refer to Handout 1), but there are four additional issues to be considered. These additional issues will be explored in the next exercise. Instructions:**

- The participants work individually. Each person receives a blank A4 size paper sheet on which she/he will write the four additional medical criteria for LNG-IUD. Participants have 10 minutes to complete their task.
- The facilitator stops the exercise after 10 minutes. Now the participants can mingle and will have 10 minutes to discuss their responses with other people in the group.
- After 10 minutes, the facilitator stops the discussion and elicits a few examples from a few participants. The facilitator then distributes Handout 3 and reviews it with the group to highlight similarities and differences with what the issues identified by the participants and to ensure that the participants correct their mistakes, if any.

2.2 Finally, the facilitator distributes Handout 4 and reviews it with the group to highlight similarities and differences between the guidelines to start use of the LNG-IUD and the Copper-Bearing Intrauterine Device.

2.3 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Facilitator's Resources

Activity 2: Copper-Bearing Intrauterine Device. TRUE/FALSE

- Print and cut the following paper strips:

If a client who is **having menstrual cycles starts Copper-Bearing Intrauterine Device** within 12 days after the start of her monthly bleeding, she does not need a backup method.

If a client is switching from another method, she cannot start **Copper-Bearing Intrauterine Device immediately, even if it is** reasonably certain she is not pregnant**.**

If a client wants to start Copper-Bearing Intrauterine Device more than 48 hours after giving birth, delay IUD insertion until three weeks after giving birth.

If a client is fully or nearly fully breastfeeding (less than six months after giving birth) and her monthly bleeding has returned, she can start **Copper-Bearing Intrauterine Device** any time between four weeks and six months after giving birth.

If a client is partially breastfeeding or not breastfeeding and her monthly bleeding has not returned, she can have the IUD inserted provided it is confirmed that she is not pregnant.

After miscarriage or abortion, a client can have the IUD inserted immediately, if the IUD is inserted within 12 days after first- or second-trimester abortion or miscarriage and if no infection is present. No need for a backup method.

For emergency contraception, a client can have the IUD inserted within five days after unprotected sex.

After taking emergency contraceptive pills (ECPs), the IUD cannot be inserted on the same day that she takes the ECPs. Instead, the client should be helped to choose a backup method.

Participant's Handouts

Session 12: Handout 1, Activity 1 – Applying the medical eligibility criteria for Copper-Bearing Intrauterine Device

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

The key issues providers should check with a client who wants to use an IUD to ensure medical eligibility criteria are applied include:

Did the client give birth more than 48 hours ago but less than four weeks ago?

- **If yes:** Delay inserting an IUD until four or more weeks after childbirth.

Did the client have an infection following childbirth or abortion?

- If she currently has infection of the reproductive organs during the first six weeks after childbirth (puerperal sepsis) or she just had an abortion-related infection in the uterus (septic abortion), do not insert the IUD. Treat or refer if she is not already receiving care. Help her choose another method or offer a backup method. After treatment, re-evaluate for IUD use.

Does the client have vaginal bleeding that is unusual for her?

- If she has unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition, use of an IUD could make diagnosis and monitoring of any treatment more difficult. Help her choose a method to use while being evaluated and treated (but not a hormonal IUD, progestin-only injectables, or implants). After treatment, re-evaluate for IUD use.

Does the client have any gynaecologic or obstetric conditions or problems, such as genital cancer or pelvic tuberculosis? If so, what problems?

- If there is current cervical, endometrial, or ovarian cancer; gestational trophoblast disease; pelvic tuberculosis: Do not insert an IUD. Treat or refer for care if she is not already receiving care. Help her choose another method. In case of pelvic tuberculosis, re-evaluate for IUD use after treatment.

Does the client have AIDS?

- Do not insert an IUD if she has AIDS unless she is clinically well on antiretroviral therapy. If she is infected with HIV but does not have AIDS, she can use an IUD. If a woman who has an IUD in place develops AIDS, she can keep the IUD.

Is the client at very high individual risk for gonorrhoea or chlamydia?

- Women who have a very high individual likelihood of exposure to gonorrhoea or chlamydia should not have an IUD inserted. Clearly exploring these issues effectively during counselling is extremely important.

Is it reasonably certain that the client is not pregnant?

- Providers must be sure to ask useful questions to rule out pregnancy and if necessary perform a pregnancy test.

Participant's Handouts

Session 12: Handout 2, Activity 1 – Copper-Bearing Intrauterine Device. Guidelines to start use

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

Clients' Situations	When can the client start Copper-Bearing Intrauterine Device, if at all?
Having menstrual cycles	If she is starting within 12 days after the start of her monthly bleeding, no need for a backup method. If it is more than 12 days after the start of her monthly bleeding, she can have the IUD inserted any time it is reasonably certain she is not pregnant. No need for a backup method.
Switching from another method	Immediately, if she has been using the method consistently and correctly or if it is reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. If she is switching from injectables, she can have the IUD inserted when the next injection would have been given. No need for a backup method.
Soon after childbirth	Any time within 48 hours after giving birth (requires a provider with specific training in postpartum insertion). If it is more than 48 hours after giving birth, delay IUD insertion until four weeks or more after giving birth.
Fully or nearly fully breastfeeding (Less than six months after giving birth)	If her monthly bleeding has not returned, she can have the IUD inserted any time between four weeks and six months after giving birth. No need for a backup method. If her monthly bleeding has returned, she can have the IUD inserted as advised for women having menstrual cycles.
Fully or nearly fully breastfeeding (More than six months after giving birth)	If her monthly bleeding has not returned, she can have the IUD inserted any time it is reasonably certain she is not pregnant. No need for a backup method. If her monthly bleeding has returned, she can have the IUD inserted as advised for women having menstrual cycles.
Partially breastfeeding or not breastfeeding (More than four weeks after giving birth)	If her monthly bleeding has not returned, she can have the IUD inserted *if it can be determined that she is not pregnant.* No need for a backup method. If her monthly bleeding has returned, she can have the IUD inserted as advised for women having menstrual cycles.
No monthly bleeding (not related to childbirth or breastfeeding)	Any time *if it can be determined that she is not pregnant.* No need for a backup method.
After miscarriage or abortion	Immediately, if the IUD is inserted within 12 days after first- or second-trimester abortion or miscarriage and if no infection is present. No need for a backup method. If it is more than 12 days after first- or second trimester miscarriage or abortion and no infection is present, she can have the IUD inserted any time it is reasonably certain she is not pregnant. No need for a backup method. If infection is present, treat or refer and help the client choose another method. If she still wants the IUD, it can be inserted after the infection has completely cleared. IUD insertion after second-trimester abortion or miscarriage requires specific training. If not specifically trained, delay insertion until at least four weeks after miscarriage or abortion.
For emergency contraception	Within five days after unprotected sex. When the time of ovulation can be estimated, she can have an IUD inserted up to five days after ovulation. Sometimes this may be more than five days after unprotected sex.
After taking emergency contraceptive pills (ECPs)	The IUD can be inserted on the same d ay that she takes the ECPs. No need for a backup method.

Participant's Handouts

Session 12: Handout 3, Activity 2 – Medical eligibility criteria for Levonorgestrel IUDs

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

The medical eligibility criteria for LNG-IUD are the same as for the Copper-Bearing Intrauterine Device, but there are the following four additional issues to be considered:

Did the client give birth less than four weeks ago?

- **If yes:** She can have the LNG-IUD inserted as soon as 4 weeks after childbirth.

Does the client now have a blood clot in the deep veins of her legs or lungs?

- If she reports current blood clot (except superficial clots), help her choose a method without hormones.

Does the client have severe cirrhosis of the liver, a liver infection, or liver tumour? (Are her eyes or skin unusually yellow?)

- If she reports serious active liver disease (jaundice, active hepatitis, severe cirrhosis, liver tumour), do not provide the LNG-IUD. Help her choose a method without hormones.

Does the client have or has she ever had breast cancer?

- **If yes:** Do not insert the LNG-IUD. Help her choose a method without hormones.

Participant's Handouts

Session 12: Handout 4, Activity 2 – Guidelines to start use of Levonorgestrel IUDs (LNG-IUD)

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

Clients' Situations	When can the client start Levonorgestrel IUDs , if at all?
Having menstrual cycles or switching from a non-hormonal method	**Any time of the month:** If she is starting within seven days after the start of her monthly bleeding, no need for a backup method. If it is more than seven days after the start of her monthly bleeding, LNG-IUD can be inserted any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after insertion.
Switching from a hormonal method	Immediately, if she has used the method consistently and correctly or if it is reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. If switching from injectables, LNG-IUD can be inserted when the repeat injection would have been given. Need backup method for first seven days after insertion.
Fully or nearly fully breastfeeding (Less than six months after giving birth)	If she gave birth less than four weeks ago, delay insertion until at least four weeks after giving birth. If monthly bleeding has not returned, the LNG-IUD can be inserted any time between four weeks-to-six months. No need for a backup method. If her monthly bleeding has returned, she can have the LNG-IUD inserted as advised for women having menstrual cycles.
Fully or nearly fully breastfeeding (More than six months after giving birth)	If her monthly bleeding has not returned, she can have the LNG-IUD inserted any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after insertion. If her monthly bleeding has returned, she can have the LNG-IUD inserted as advised for women having menstrual cycles.
Partially breastfeeding or not breastfeeding (Less than four weeks after giving birth)	Delay LNG-IUD insertion until at least 4 weeks after giving birth.
Partially breastfeeding or not breastfeeding (More than four weeks after giving birth)	If her monthly bleeding has not returned, she can have the LNG-IUD inserted any time *if it can be determined that she is not pregnant.* She will need a backup method for the first seven days after insertion. If her monthly bleeding has returned, she can have the LNG-IUD inserted as advised for women having menstrual cycles.
No monthly bleeding (not related to childbirth or breastfeeding)	Any time *if it can be determined that she is not pregnant.* She will need a backup method for the first seven days after insertion.

After miscarriage or abortion	Immediately, if the LNG-IUD is inserted within seven days after first- or second-trimester abortion or miscarriage and if no infection is present. No need for a backup method. If it is more than seven days after first- or second trimester miscarriage or abortion and no infection is present, she can have the LNG-IUD inserted any time it is reasonably certain she is not pregnant. She will need a backup method for the first seven days after insertion. If infection is present, treat or refer and help the client choose another method. If she still wants the LNG-IUD, it can be inserted after the infection has completely cleared. LNG-IUD insertion after second-trimester abortion or miscarriage requires specific training. If not specifically trained, delay insertion until at least four weeks after miscarriage or abortion.
After taking emergency contraceptive pills (ECPs)	The LNG-IUD can be inserted within seven days after the start of her next monthly bleeding or any other time it is reasonably certain she is not pregnant. Give her a backup method, or oral contraceptives to start the day after she finishes taking the ECPs, to use until the LNG-IUD is inserted.

SESSION 13: Applying the medical eligibility criteria to help clients make safe informed and voluntary decisions (Part IV)

Objectives
By the end of the session, the participants will be able to:
- Apply effectively the medical eligibility criteria for modern methods of contraception.

Total Session Time
120 minutes (two hours)

Materials
- Flipcharts, markers, tape, blank A4 size paper sheets
- Flipchart "Session objectives"
- Sufficient copies of the *Female sterilization medical eligibility criteria interview form*, Activity 1
- Sufficient copies of the *Vasectomy medical eligibility criteria interview form*, Activity 3

Facilitator's Resources
- Activity 1: Female sterilization medical eligibility criteria interview form
- Activity 3: Vasectomy medical eligibility criteria interview form

Handouts
- Handout 1 – Female sterilization medical eligibility criteria
- Handout 2 – Guidelines for when to perform the Female Sterilization procedure
- Handout 3 – Vasectomy medical eligibility criteria

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide).
In this session, the participants will strengthen their skills to effectively help clients make safe, voluntary and informed decisions about modern methods of contraception by exploring scenarios to apply medical eligibility criteria.

Activity 1: Applying the medical eligibility criteria for Female Sterilization. Interview carousel (55 minutes)
1.1 In the next exercise, the participants will work individually. Instructions:
- The participants sit in two rows facing each other (the facilitator joins in the exercise if there is not an even number of participants).
- The facilitator distributes the *Female sterilization medical eligibility criteria interview form* (refer to the **Facilitator's Resources** section below) to all participants and reviews it with the group.
- The facilitator decides which row will ask the questions, and which row will answer. At a signal of the facilitator, the interviews begin. Participants have five minutes to ask as many questions as possible.
- After five minutes, the facilitator gives again a signal, which means that all participants must shift of one seat sideways. Once everybody has shifted of one seat, the two rows swap roles in asking and answering questions. The process is repeated every five minutes for at least 30 minutes (or less, if most of the participants complete their interviews in less than 30 minutes).
- When playing "interviewers", participants can ask any question from the form. They can

challenge the person providing the answer if they feel it is incorrect, but have to write down what the other person eventually chooses as an answer. They do not have to follow the order in which the questions are listed in the form, but cannot ask the same question more than one time, even to different people.

1.2 The facilitator stops the exercise after 30 minutes maximum and distributes Handout 1. Now the participants will work in pairs (two people sitting opposite each other will be a pair) and will have 10 minutes to discuss the handout and briefly compare it with the results of their interviews.

1.3 Only if time permits and if appropriate for the types of providers in your group, debrief the group by discussing:

- What new learning have you gained from the exercise?
- Which of these conditions and situations have you faced in the past with clients wanting this method? How did you manage those issues?
- How will you use what you have learnt today in order to provide better services?

Activity 2: Reviewing the guidelines for when to perform the procedure for Female Sterilization (20 minutes)

2.1 Invite the participants to stand in the middle of the room to play a TRUE/FALSE exercise to review the guidelines for when to perform the procedure for Female Sterilization. The facilitator reads one statement at a time from those provided below. If participants feel that the statement is true, they will move to one end of the room or to the opposite one if they feel that it is false. The facilitator provides the correct answer before moving on to the next statement:

Statements	True/False
If a woman is having menstrual cycles or is switching from another method, the procedure can be performed any time within 7 days after the start of her monthly bleeding.	**TRUE**.
If a woman has no monthly bleeding, the procedure cannot be performed.	**FALSE**: it can be performed any time it is reasonably certain she is not pregnant.
The procedure can be performed immediately or within 7 days after giving birth, if she has made a voluntary, informed choice in advance.	**TRUE**.
After miscarriage or abortion, the procedure can be performed after 72 hours.	**FALSE**: Within 48 hours after uncomplicated abortion, if she has made a voluntary, informed choice in advance.
After using emergency contraceptive pills (ECPs), the procedure can be performed within 5 days after the start of her next monthly bleeding.	**FALSE**: The sterilization procedure can be done within 7 days after the start of her next monthly bleeding or any other time it is reasonably certain she is not pregnant. Give her a backup method or oral contraceptives to start the day after she finishes taking the ECPs, to use until she can have the procedure.

2.2 Distribute Handout 2 and review it with the participants. As usual, encourage the participants to read it carefully in their own time as part of their on-going professional development, and remind them that most of the handouts provided in this course can be used as job aids.

Activity 3: Applying the medical eligibility criteria for Vasectomy. Interview carousel (30 minutes)

3.1 In order to review the medical eligibility criteria for Vasectomy, the participants will repeat the interview carousel exercise as in Activity 1 above. However, this time the exercise will be conducted only for 20 minutes using the Vasectomy medical eligibility criteria interview form provided in the **Facilitator's Resources** section below.

3.2 Stop the exercise after 20 minutes. Now the participants will work in pairs (two people sitting opposite each other will be a pair) and will have 10 minutes to discuss the handout and briefly compare it with the results of their interviews.

3.3 **Only if time permits and if appropriate for the types of providers in your group**, debrief the group by discussing:

- What new learning have you gained from the exercise?
- Which of these conditions and situations have you faced in the past with clients wanting this method? How did you manage those issues?
- How will you use what you have learnt today in order to provide better services?

Activity 4: Ensuring informed consent for permanent methods (20 minutes)

4.1 For every contraceptive method it is essential to ensure that clients make informed and voluntary decisions, and nothing should be done to clients without their informed consent. Informed consent is especially important for female sterilization and vasectomy because these are permanent methods. Ensuring informed consent is very important to help prevent regret.

Although these issues are addressed in detail in the counselling course, the last exercise of this session aims to refresh participants' knowledge about the key elements of informed consent that should be addressed with clients considering permanent methods.

4.2 Divide the participants in pairs or small teams. Show the following flipchart:

Informed consent for permanent methods must address seven elements. Identify the missing elements:

- **The procedure to be performed on me is a surgical procedure**, the details of which have been explained to me.
- If the procedure is successful, **I will be unable to have any more children**.
- **The effect of the procedure should be considered permanent.**

Obviously there are four missing elements. The teams have five minutes to identify them.

4.3 Stop the teams after five minutes and invite each team to identify one element until all the four missing ones have been disclosed and added to the list on flipchart. If the teams cannot complete the exercise successfully, provide the solution:

- **Temporary methods of contraception are available** to me and my partner.
- **This surgical procedure involves risks, in addition to benefits**, which have been explained to me, and I understand the information that has been given to me. Among the risks is the possibility that the procedure might fail.

- **The procedure does not protect me or my partner against infection** with sexually transmitted infections, including HIV/AIDS.
- **I can decide not to have the operation at any time before the procedure is performed, even on the operating table** (without losing the right to medical, health, or other services or benefits).

4.4 **Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.**

Facilitator's Resources

Activity 1: Female sterilization medical eligibility criteria interview form

All women can have female sterilization. **No medical conditions prevent a woman from using female sterilization.** However some medical conditions may limit when, where, or how the female sterilization procedure should be performed. This exercise aims to help check our knowledge about these issues. If a client had any of the conditions below, providers should recommend **caution, delay, or special arrangements**. You will ask your colleagues what they would recommend for these specific conditions/situations and will write down their responses.

Please note:

- ***Caution*** means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition.
- ***Delay*** means postpone female sterilization. These conditions must be treated and resolved before female sterilization can be performed. Give the client another method to use until the procedure can be performed.
- ***Special*** means special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anaesthesia, and other backup medical support. For these conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen also is needed. Give the client another method to use until the procedure can be performed.

Which recommendation would you make for the following conditions/situations?	**Your colleague says…**
Past pelvic inflammatory disease since last pregnancy	
Breast cancer	
Uterine fibroids	
Previous abdominal or pelvic surgery	
Current pregnancy	
Seven–42 days postpartum	
Postpartum after a pregnancy with severe pre-eclampsia or eclampsia	
Serious postpartum or post-abortion complications (such as infection, haemorrhage, or trauma) except uterine rupture or perforation	
A large collection of blood in the uterus	
Unexplained vaginal bleeding that suggests an underlying medical condition	
Pelvic inflammatory disease	
Purulent cervicitis, chlamydia, or gonorrhoea	
Pelvic cancers (treatment may make her sterile in any case)	
Malignant trophoblast disease	
AIDS	

Fixed uterus due to previous surgery or infection	
Endometriosis	
Hernia (abdominal wall or umbilical)	
Postpartum or post-abortion uterine rupture or perforation	
Controlled high blood pressure	
Mild high blood pressure (140/90 to 159/99 mm Hg)	
Past stroke or heart disease without complications	
Heart disease due to blocked or narrowed arteries	
Blood clots in deep veins of legs or lungs	
Several conditions together that increase chances of heart disease or stroke, such as older age, smoking, high blood pressure, or diabetes	
Moderately high or severely high blood pressure (160/100 mm Hg or higher)	
Diabetes for more than 20 years *or* damage to arteries, vision, kidneys, or nervous system caused by diabetes	
Epilepsy	
Diabetes without damage to arteries, vision, kidneys, or nervous system	
Hypothyroidism	
Mild cirrhosis of the liver, liver tumours (Are her eyes or skin unusually yellow?), or schistosomiasis with liver fibrosis	
Moderate iron-deficiency anaemia (haemoglobin 7–10 g/dl)	
Sickle cell disease	
Inherited anaemia (thalassemia)	
Kidney disease	
Severe lack of nutrition (Is she extremely thin?)	
Obesity (Is she extremely overweight?)	
Elective abdominal surgery at time sterilization is desired	
Depression	
Young age	
Gallbladder disease with symptoms	
Active viral hepatitis	
Severe iron-deficiency anaemia (haemoglobin less than 7 g/dl)	
Lung disease (bronchitis or pneumonia)	
Systemic infection or significant gastroenteritis	
Abdominal skin infection	
Undergoing abdominal surgery for emergency or infection, or major surgery with prolonged immobilization	
Severe cirrhosis of the liver	
Hyperthyroidism	

Facilitator's Resources

Activity 3: Vasectomy medical eligibility criteria interview form

All men can use vasectomy. **No medical conditions prevent a man from using vasectomy.** However some medical conditions may limit when, where, or how the vasectomy procedure should be performed. This exercise aims to help check our knowledge about these issues. If a client had any of the conditions below, providers should recommend **caution, delay, or special arrangements**. You will ask your colleagues what they would recommend for these specific conditions/situations and will write down their responses.

Please note:

- ***Caution*** means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition.
- ***Delay*** means postpone vasectomy. These conditions must be treated and resolved before vasectomy can be performed. Give the client another method to use until the procedure can be performed.
- ***Special*** means special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anaesthesia, and other backup medical support. For these conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen also is needed. Give the client another method to use until the procedure can be performed.

Which recommendation would you make for the following conditions/situations?	**Your colleagues say…**
Previous scrotal injury	
Swollen scrotum due to swollen veins or membranes in the spermatic cord or testes (large varicocele or hydrocele)	
Undescended testicle—one side only.	
Active sexually transmitted infection	
Swollen, tender (inflamed) tip of the penis, sperm ducts (epididymis), or testicles	
Scrotal skin infection or a mass in the scrotum	
Hernia in the groin.	
Undescended testicles—both sides	
Diabetes	
Depression	
Young age	
Systemic infection or gastroenteritis	
Filariasis or elephantiasis	
AIDS	
Blood fails to clot (coagulation disorders)	

Participant's Handouts

Session 13: Handout 1, Activity 1 – Female sterilization medical eligibility criteria

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

All women can have female sterilization. **No medical conditions prevent a woman from using female sterilization.** However some medical conditions may limit when, where, or how the female sterilization procedure should be performed. If a client had any of the conditions below, providers should recommend **caution, delay, or special arrangements**.

- ***Caution*** means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition.
- ***Delay*** means postpone female sterilization. These conditions must be treated and resolved before female sterilization can be performed. Give the client another method to use until the procedure can be performed.
- ***Special*** means special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anaesthesia, and other backup medical support. For these conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen also is needed. Give the client another method to use until the procedure can be performed.

Conditions	Recommendation
Past pelvic inflammatory disease since last pregnancy	Caution
Breast cancer	Caution
Uterine fibroids	Caution
Previous abdominal or pelvic surgery	Caution
Current pregnancy	Delay
Seven – 42 days postpartum	Delay
Postpartum after a pregnancy with severe pre-eclampsia or eclampsia	Delay
Serious postpartum or post-abortion complications (such as infection, haemorrhage, or trauma) except uterine rupture or perforation	Delay
A large collection of blood in the uterus	Delay
Unexplained vaginal bleeding that suggests an underlying medical condition	Delay
Pelvic inflammatory disease	Delay
Purulent cervicitis, chlamydia, or gonorrhoea	Delay
Pelvic cancers (treatment may make her sterile in any case)	Delay
Malignant trophoblast disease	Delay
AIDS	Special
Fixed uterus due to previous surgery or infection	Special
Endometriosis	Special
Hernia (abdominal wall or umbilical)	Special
Postpartum or post-abortion uterine rupture or perforation	Special

Controlled high blood pressure	Caution
Mild high blood pressure (140/90 to 159/99 mm Hg)	Caution
Past stroke or heart disease without complications	Caution
Heart disease due to blocked or narrowed arteries	Delay
Blood clots in deep veins of legs or lungs	Delay
Several conditions together that increase chances of heart disease or stroke, such as older age, smoking, high blood pressure, or diabetes	Special
Moderately high or severely high blood pressure (160/100 mm Hg or higher)	Special
Diabetes for more than 20 years *or* damaged arteries, vision, kidneys or nervous system due to diabetes	Special
Complicated valvular heart disease	Special
Epilepsy	Caution
Diabetes without damage to arteries, vision, kidneys, or nervoussystem	Caution
Hypothyroidism	Caution
Mild cirrhosis of the liver, liver tumours (Are her eyes or skin unusually yellow?), or schistosomiasis with liver fibrosis	Caution
Moderate iron deficiency anaemia (haemoglobin 7 - 10 g/dl)	Caution
Sickle cell disease	Caution
Inherited anaemia (thalassemia)	Caution
Kidney disease	Caution
Diaphragmatic hernia	Caution
Severe lack of nutrition (Is she extremely thin?)	Caution
Obesity (Is she extremely overweight?)	Caution
Elective abdominal surgery at time sterilization is desired	Caution
Depression	Caution
Young age	Caution
Gallbladder disease with symptoms	Delay
Active viral hepatitis	Delay
Severe iron-deficiency anaemia (haemoglobin less than 7 g/dl)	Delay
Lung disease (bronchitis or pneumonia)	Delay
Systemic infection or significant gastroenteritis	Delay
Abdominal skin infection	Delay
Undergoing abdominal surgery for emergency or infection, or major surgery with prolonged immobilization	Delay
Severe cirrhosis of the liver	Special
Hyperthyroidism	Special
Coagulation disorders (blood does not clot)	Special
Chronic lung disease (asthma, bronchitis, emphysema, lung infection)	Special
Pelvic tuberculosis	Special

- Women who are infected with HIV, have AIDS, or are on antiretroviral (ARV) therapy can safely undergo female sterilization. Special arrangements are needed to perform female sterilization on a woman with AIDS.
- Encourage these women to use condoms in addition to female sterilization. Used consistently and correctly, condoms help prevent transmission of HIV and other STI.
- No one should be coerced or pressured into having female sterilization, and that includes women with HIV.

Participant's Handouts

Session 13: Handout 2, Activity 2 – Guidelines for when to perform the Female Sterilization procedure

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

Please note:
If there is no medical reason to delay, a woman can have the female sterilization procedure any time she wants if it is reasonably certain she is not pregnant.

Woman's situation	Female Sterilization: When to perform the procedure?
Having menstrual cycles or switching from another method	**Any time of the month** • Any time within seven days after the start of her monthly bleeding. No need to use another method before the procedure. • If it is more than seven days after the start of her monthly bleeding, she can have the procedure any time it is reasonably certain she is not pregnant. • If she is switching from oral contraceptives, she can continue taking pills until she has finished the pill pack to maintain her regular cycle. • If she is switching from an IUD, she can have the procedure immediately
No monthly bleeding	Any time it is reasonably certain she is not pregnant.
After childbirth	• Immediately or within seven days after giving birth, if she has made a voluntary, informed choice in advance. • Any time six weeks or more after childbirth if it is reasonably certain she is not pregnant.
After miscarriage or abortion	Within 48 hours after uncomplicated abortion, if she has made a voluntary, informed choice in advance.
After using emergency contraceptive pills (ECPs)	The sterilization procedure can be done within seven days after the start of her next monthly bleeding or any other time it is reasonably certain she is not pregnant. Give her a backup method or oral contraceptives to start the day after she finishes taking the ECPs, to use until she can have the procedure.

Participant's Handouts

Session 13: Handout 3, Activity 3 – Vasectomy medical eligibility criteria

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

All men can use vasectomy. **No medical conditions prevent a man from using vasectomy.** However some medical conditions may limit when, where, or how the vasectomy procedure should be performed. If a client had any of the conditions below, providers should recommend **caution, delay, or special arrangements**:

- ***Caution*** means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition.
- ***Delay*** means postpone vasectomy. These conditions must be treated and resolved before vasectomy can be performed. Give the client another method to use until the procedure can be performed.
- ***Special*** means special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anaesthesia, and other backup medical support. For these conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen also is needed. Give the client another method to use until the procedure can be performed.

Previous scrotal injury	Caution
Swollen scrotum due to swollen veins or membranes in the spermatic cord or testes (large varicocele or hydrocele)	Caution
Undescended testicle—one side only.	Caution (Vasectomy is performed only on the normal side. Then, if any sperm are present in a semen sample after three months, the other side must be done, too.)
Active sexually transmitted infection	Delay
Swollen, tender (inflamed) tip of the penis, sperm ducts (epididymis), or testicles	Delay
Scrotal skin infection or a mass in the scrotum	Delay
Hernia in the groin.	Special (If able, the provider can perform the vasectomy at the same time as repairing the hernia. If this is not possible, the hernia should be repaired first.)
Undescended testicles—both sides	Special

Diabetes	Caution
Depression	Caution
Young age	Caution
Systemic infection or gastroenteritis	Delay
Filariasis or elephantiasis	Delay
AIDS	Special
Blood fails to clot (coagulation disorders)	Special

- Men who are infected with HIV, have AIDS, or are on antiretroviral (ARV) therapy can safely have a vasectomy. Special arrangements are needed to perform vasectomy on a man with AIDS.
- Vasectomy does not prevent transmission of HIV. Encourage these men to use condoms in addition to vasectomy. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.
- No one should be coerced or pressured into getting a vasectomy, and that includes men with HIV.

SESSION 14: Providing Information Effectively to Clients About Fertility Awareness-based Methods (FAM)

Objectives

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

- Explain what FAM are and how they work.
- Provide complete and accurate information to clients requesting these methods.

Total Session Time

90 minutes (1 hour and 30 minutes)

Materials

- Flipcharts, markers, tape, blank A4 size paper sheets
- Flipchart "Session objectives"
- Sufficient number of TRUE and FALSE cards for Activity 1

Handouts

- Handout 1 – Basic facts about FAM
- Handout 2 – How Effective are FAM?
- Handout 3 – Explaining how to use Standard Days Method
- Handout 4 – Explaining how to use Calendar Rhythm Method
- Handout 5 – Explaining how to use Symptoms-based Method

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide).
This session is the first in the module about contraceptive technology. The participants begin with activities to strengthen their skills to provide effective information to clients about how to use these methods.

Activity 1: Addressing misconceptions about FAM (40 minutes)

1.1 Divide the participants in pairs or small groups. Distribute to each pair/group a set of two cards, namely a TRUE and a FALSE card. Instructions:

- The facilitator will read one statement at a time. The facilitator will then slowly count to three and the pairs will show the card indicting their answer, either TRUE or FALSE. The pair/group scoring the highest number of correct answers will win (facilitators are encouraged to prepare small prizes, if possible).

Sample TRUE/FALSE statements (facilitators are encouraged to develop their own statements, as appropriate):

Statements (Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers)	**Correct Answer**
"Fertility awareness" means that a woman knows how to tell when the fertile time of her menstrual cycle starts and ends. (The fertile time is when she can become pregnant.)	**TRUE**
FAM are sometimes called periodic abstinence or natural family planning.	**TRUE**
A woman can use only one way to tell when her fertile time begins and ends.	**FALSE**. A woman can use several ways, alone or in combination, to tell when her fertile time begins and ends.
Calendar-based methods involve keeping track of days of the menstrual cycle to identify only the start of the fertile time.	**FALSE**. Calendar-based methods involve keeping track of days of the menstrual cycle to identify the start and end of the fertile time.
Symptoms-based methods depend on observing signs of fertility.	**TRUE**
One of the symptoms to check for symptoms-based methods is cervical secretions: When a woman sees or feels cervical secretions, she may be fertile. She may feel just a little vaginal wetness.	**TRUE**
Another symptom is basal body temperature (BBT): A woman's resting body temperature goes up slightly after the release of an egg (ovulation), when she could become pregnant. Her temperature stays higher until the beginning of her next monthly bleeding.	**TRUE**
FAM work primarily by helping a woman know when she could become pregnant. The couple prevents pregnancy by avoiding unprotected vaginal sex during these fertile days—usually by abstaining or by using condoms or a diaphragm.	**TRUE**
Sometimes couples who use FAM decide to use spermicides or withdrawal during the fertile days. However, spermicides and withdrawal are the least effective methods in these circumstances.	**TRUE**
FAM have several side effects and risks.	**FALSE**. They have no side effects or health risks.
FAM does not require partners' cooperation. Couple must be committed to abstaining or using another method on fertile days.	**FALSE**. FAM require partners' cooperation. If there is no cooperation, it may be very difficult to abstain or take precautions during the fertile days.
To use FAM, women must stay aware of body changes or keep track of days, according to rules of the specific method.	**TRUE**

Distribute Handout 1.

1.2 Discuss with the participants:
- How effective are FAM?

Distribute and review Handout 2 with the participants. Discuss:
- Which information was new to you?
- Which misconceptions, if any, does this information help you to address about FAM?

Activity 2: How to explain to clients how to use FAM. Mini role-plays (45 minutes)

2.1 Divide the participants in pairs and explain the instructions:
- Each pair will have 10 minutes to prepare and rehearse a five minute maximum role-play.
- The facilitator will assign to each pair one FAM to focus on in their role-play.
- One of the participants in the pair will play a "client", and the other will be a "provider". They will pretend that the "client" had decided to choose the method that the pair has been assigned and they are now at the stage in which the "provider" is summarizing all the essential information about that method. Therefore, the "provider will have to explain to the client all the essential information concerning the FAM that the pair has been assigned.
- At the end of the 10 minute preparation time, each pair will perform their role-play and will then receive feedback from the audience.
- Finally, after each role play the facilitator will distribute the relevant Handout (3, 4, and 5) and there will be a brief discussion with the group to check if they missed any of the essential pieces of information that should be given to clients who want to start using that method.

2.2 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Participant's Handouts

Session 14: Handout 1, Activity 1 – Basic facts about FAM

Statements (Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Prog rams and USAID, 2007: Family Planning. A Global Handbook for Providers)	**Correct Answer**
"Fertility awareness" means that a woman knows how to tell when the fertile time of her menstrual cycle starts and ends. (The fertile time is when she can become pregnant.)	**TRUE**
FAM are sometimes called periodic abstinence or natural family planning.	**TRUE**
A woman can use only one way to tell when her fertile time begins and ends.	**FALSE**. A woman can use several ways, alone or in combination, to tell when her fertile tim e begins and ends.
Calendar-based methods involve keeping track of days of the menstrual cycle to identify only the start of the fertile time.	**FALSE**. Calendar-based methods involve keeping track of days of the menstrual cycle to identify the start and end of the fertile time.
Symptoms-based methods depend on observing signs of fertility.	**TRUE**
One of the symptoms to check for symptoms -based methods is cervical secretions: When a woman sees or feels cervical secretions, she may be fertile. She may feel just a little vaginal wetness.	**TRUE**
Another symptom is basal body temperature (BBT): A woman's resting body temperature goes up slightly after the release of an egg (ovulation), when she could become pregnant. Her temperature stays higher until the beginning of her next monthly bleeding.	**TRUE**
FAM work primarily by helping a woman know when she could become pregnant. The couple prevents pregnancy by avoiding unprotected vaginal sex during these fertile days—usually by abstaining or by using condoms or a diaphragm.	**TRUE**
Sometimes couples who use FAM decide to use spermicides or withdrawal during the fertile days. However, spermicides and withdrawal are the least effective methods in these circumstances.	**TRUE**
FAM have several side effects and risks.	**FALSE**. They have no side effects or health risks.
FAM does not require partners' cooperation. Couple must be committed to abstaining or using another method on fertile days.	**FALSE**. FAM require partners' cooperation. If there is no cooperation, it may be very diffic ult to abstain or take precautions during the fertile days.
To use FAM, women must stay aware of body changes or keep track of days, according to rules of the specific method.	**TRUE**

Participant's Handouts

Session 14: Handout 2, Activity 1 – How Effective are FAM?

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

Effectiveness depends on the user:

Risk of pregnancy is greatest when couples have sex on the fertile days without using another method. Pregnancy rates with consistent and correct use vary for different types of fertility awareness methods (see table, below). In general, abstaining during fertile times is more effective than using another method during fertile times.

Pregnancy rates with consistent and correct use and abstinence on fertile days.

Method	**Pregnancies per 100 Women Over the First Year**
Calendar-based methods	
Standard Days Method	5
Calendar rhythm method	9
Symptoms-based methods	
Two-Day Method	4
Basal body temperature (BBT) method	1
Ovulation method	3
Symptothermal method	2

Return of fertility after fertility awareness methods are stopped: No delay

Protection against sexually transmitted infections (STI): None

Side Effects	**Health Benefits**	**Health Risks**
None	Helps protect against Risks of pregnancy	None

Why some women say they like FAM:

- Have no side effects.
- Do not require procedures and usually do not require supplies.
- Help women learn about their bodies and fertility.
- Allow some couples to adhere to their religious or cultural norms about contraception.
- Can be used to identify fertile days by both women who want to become pregnant and women who want to avoid pregnancy.

Correcting Misunderstandings

Fertility awareness methods:

- Can be very effective if used consistently and correctly.
- Do not require literacy or advanced education.
- Do not harm men who abstain from sex.
- Do not work when a couple is mistaken about when the fertile time occurs, such as thinking it occurs during monthly bleeding.

Please note:
Women who are infected with HIV, have AIDS, or are on antiretroviral (ARV) therapy can safely use fertility awareness methods. However, these women should be counselled to use condoms consistently and correctly along with fertility awareness methods in order to help prevent transmission of HIV and other STI. Condoms also provide extra contraceptive protection for women on ARV therapy.

Participant's Handouts

Session 14: Handout 3, Activity 2 (mini role-plays) – Explaining how to use Standard Days Method

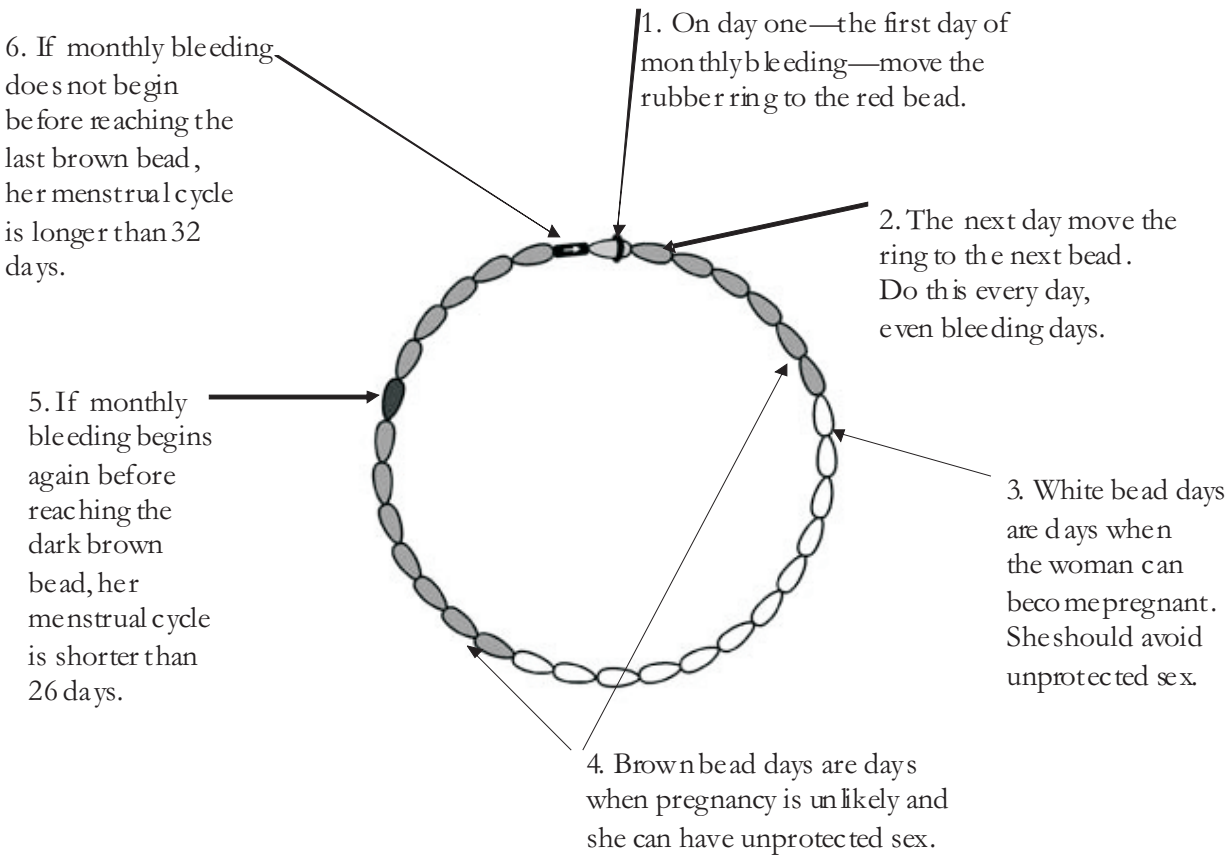
Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

IMPORTANT: A woman can use the Standard Days Method if most of her menstrual cycles are 26 to 32 days long. If she has more than two longer or shorter cycles within a year, the Standard Days Method will be less effective and she may want to choose another method.

Keep track of the days of the menstrual cycle: A woman keeps track of the days of her menstrual cycle, counting the first day of monthly bleeding as day one.

Avoid unprotected \sex on days 8–19: Days eight through 19 of every cycle are considered fertile days for all users of the Standard Days Method. The couple avoids vaginal sex or uses condoms or a diaphragm during days eight through 19. They can also use withdrawal or spermicides, but these are less effective. The couple can have unprotected sex on all the other days of the cycle—days one through seven at the beginning of the cycle and from day 20 until her next monthly bleeding begins.

Use memory aids if needed: The couple can use CycleBeads, a color-coded string of beads that indicates fertile and non-fertile days of a cycle, or they can mark a calendar or use some other memory aid.



Participant's Handouts

Session 14: Handout 4, Activity 2 (mini role-plays) – Explaining how to use Calendar Rhythm Method

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

- **Keep track of the days of the menstrual cycle:** Before relying on this method, a woman records the number of days in each menstrual cycle for at least six months. The first day of monthly bleeding is always counted as day one.
- **Estimate the fertile time:** The woman subtracts 18 from the length of her shortest recorded cycle. This tells her the estimated first day of her fertile time. Then she subtracts 11 days from the length of her longest recorded cycle. This tells her the estimated last day of her fertile time.
- **Avoid unprotected sex during fertile time:** The couple avoids vaginal sex, or uses condoms or a diaphragm, during the fertile time. They can also use withdrawal or spermicides, but these are less effective.

Update calculations monthly:
She updates these calculations each month, always using the 6 most recent cycles.

Example:

- If the shortest of her last six cycles was 27 days, 27 – 18 = nine. She starts avoiding unprotected sex on day nine.
- If the longest of her last six cycles was 31 days, 31 – 11 = 20. She can have unprotected sex again on day 21.
- Thus, she must avoid unprotected sex from day nine through day 20 of her cycle.

Participant's Handouts

Session 14: Handout 5, Activity 2 (mini role-plays) – Explaining how to use Symptoms-based Method

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

Two-Day Method

IMPORTANT: If a woman has a vaginal infection or another condition that changes cervical mucus, the Two-Day Method will be difficult to use.

- **Check for secretions:** The woman checks for cervical secretions every afternoon and/or evening, on fingers, underwear, or tissue paper or by sensation in or around the vagina. As soon as she notices any secretions of any type, colour, or consistency, she considers herself fertile that day and the following day.
- **Avoid sex or use another method on fertile days:** The couple avoids vaginal sex or uses condoms or a diaphragm on each day with secretions and on each day following a day with secretions. They can also use withdrawal or spermicides, but these are less effective.
- **Resume unprotected sex after two dry days:** The couple can have unprotected sex again after the woman has had two dry days (days without secretions of any type) in a row.

Basal Body Temperature (BBT) Method

IMPORTANT: If a woman has a fever or other changes in body temperature, the BBT method will be difficult to use.

- **Take body temperature daily:** The woman takes her body temperature at the same time each morning before she gets out of bed and before she eats anything. She records her temperature on a special graph. She watches for her temperature to rise slightly—0.2° to 0.5° C (0.4° to 1.0° F)—just after ovulation (usually about midway through the menstrual cycle).
- **Avoid sex or use another method until three days after the temperature rise:** The couple avoids vaginal sex, or uses condoms or a diaphragm from the first day of monthly bleeding until three days after the woman's temperature has risen above her regular temperature. They can also use withdrawal or spermicides, but these are less effective.
- **Resume unprotected sex until next monthly bleeding begins:** When the woman's temperature has risen, above her regular temperature and stayed higher for three full days, ovulation has occurred and the fertile period has passed. The couple can have unprotected sex on the fourth day and until her next monthly bleeding begins.

Ovulation Method

IMPORTANT: If a woman has a vaginal infection or another condition that changes cervical mucus, this method may be difficult to use.

- **Check cervical secretions daily:** The woman checks every day for any cervical secretions on fingers, underwear, or tissue paper or by sensation in or around the vagina.
- **Avoid unprotected sex on days of heavy monthly bleeding:** Ovulation might occur early in the cycle, during the last days of monthly bleeding, and heavy bleeding could make mucus difficult to observe.
- **Resume unprotected sex until secretions begin:** Between the end of monthly bleeding and the start of secretions, the couple can have unprotected sex, but not on two days in a row. (Avoiding sex on the second day allows time for semen to disappear and for cervical mucus to be observed.) It is recommended that they have sex in the evenings, after the woman has been in an upright position for at least a few hours and has been able to check for cervical mucus.

- **Avoid unprotected sex when secretions begin and until four days after "peak day":** As soon as she notices any secretions, she considers herself fertile and avoids unprotected sex. She continues to check her cervical secretions each day. The secretions have a "peak day"—the last day that they are clear, slippery, stretchy, and wet. She will know this has passed when, on the next day, her secretions are sticky or dry, or she has no secretions at all. She continues to consider herself fertile for three days after that peak day and avoids unprotected sex.
- **Resume unprotected sex:** The couple can have unprotected sex on the fourth day after her peak day and until her next monthly bleeding begins.

Symptothermal Method (basal body temperature + cervical secretions + other fertility signs)

- **Avoid unprotected sex on fertile days:** Users identify fertile and non-fertile days by combining BBT and ovulation method instructions. Women may also identify the fertile time by other signs such as breast tenderness and ovulation pain (lower abdominal pain or cramping around the time of ovulation). The couple avoids unprotected sex between the first day of monthly bleeding and either the fourth day after peak cervical secretions or the third full day after the rise in temperature (BBT), whichever happens later. Some women who use this method have unprotected sex between the end of monthly bleeding and the beginning of secretions, but not on two days in a row.

SESSION 15: Using Effectively the Medical Eligibility Criteria for Fertility-based Awareness Methods (FAM)

Objectives
By the end of the session, the participants will be able to:
- Use effectively the medical eligibility criteria for these methods.

Total Session Time
60 minutes (one hour)

Materials
- Flipcharts, markers, tape, blank A4 size paper sheets
- Flipchart "Session objectives"
- CAUTION and DELAY flipchart for Activity 1

Handouts
- Handout 1 – Caution or Delay with calendar-based methods?
- Handout 2 – Caution or Delay with symptoms-based methods?

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide).
In this session, the participants will strengthen their skills to use effectively the medical eligibility criteria for FAM. These skills are extremely important to help clients make informed, safe, and effective decisions for their reproductive lives.

Activity 1: Using effectively the medical eligibility criteria for FAM (55 minutes)

1.1 Connect this session to the previous by stressing the following:
- *All women can use calendar-based methods.* No medical conditions prevent the use of these methods, but some conditions can make them harder to use effectively.

In the next exercise, the participants will explore how to use effectively the medical eligibility criteria for FAM. Show the following flipchart:

> ***Caution*** means that addition al or special counselling may be needed to ensure correct use of the method.
>
> ***Delay*** means that use of a particular fertility awareness method should be delayed until the condition is evaluated or corrected. Give the client another method to use until she can start the calendar-based method.

Explain that the exercise will enable the participants to practice when to apply **Caution** or **Delay** with **Calendar-based Methods**. Instructions:
- The participants work in pairs.
- Each participant receives the Caution or Delay cards (please refer to the **Facilitator's resources** section below). Pairs will have five minutes in total to decide whether each situation in the cards requires Caution or Delay, or both.
- Stop the discussion after five minutes and invite the pairs to share their results. Go through one scenario at a time and allow the pairs to share their views and reasons to decide whether Caution or Delay applies.

- Finally distribute Handout 1 to enable participants to check their responses. Ask the participants to share to what extent their answers were correct.

1.2 In the next exercise the participants will continue to check their knowledge to apply the medical eligibility criteria effectively. Instructions:

- The participants stand in a semi-circle around the facilitator.
- The facilitator plays the role of different "clients" and the participants will be "providers".
- The "client" will select randomly a "provider" at a time to discuss her situation and the "provider" will explain whether the "client" can start a calendar-based method or if it is advisable to delay, and why.
- If the "provider" gives the correct answer, she/he can take a step forward toward the "client". If the answer is incorrect, the "provider" will not move.

Sample client's situations and provider's answers:

"Client's" situations: Can I start a calendar -based method…	**The answers the "providers" should give**
…if I Have regular menstrual cycles?	Yes. Any time of the month. No need to wait until the start of next monthly bleeding.
…if I have no monthly bleeding?	Delay calendar -based methods until monthly bleeding returns.
…after childbirth (whether or not breastfeeding)?	Delay the Standard Days Method until she has had three menstrual cycles and the last one was 26–32 days long. Regular cycles will return lat er in breastfeeding women than in women who are not breastfeeding.
…after miscarriage or abortion?	Delay the Standard Days Method until the start of her next monthly bleeding, when she can start if she has no bleeding due to injury to the genital tract.
…if I am switching from a hormonal method?	Delay starting the Standard Days Method until the start of her next monthly bleeding. If you are switching from injectables, delay the Standard Days Method at least until your repeat injection would have been given, and then start it at the beginning of her next monthly bleeding.
…after taking emergency contraceptive pills?	Delay the Standard Days Method until the start of her next monthly bleeding.

1.3 The next exercise will enable the participants to improve their knowledge to apply effectively the medical eligibility criteria for Symptoms-based Methods.

Explain that they will play a TRUE/FALSE game. Instructions:

- The facilitator reads one statement at a time. The participants who think that it is true will shout "TRUE!" and jump/stomp their feet or make any other noise they want, while those who believe that it is false will stay silent and not move.
- After each statement, the facilitator asks those in the TRUE and FALSE sides to provide their reasons. Finally, the facilitator reveals the solution before moving onto the next statement.

Sample TRUE/FALSE statements:

Statements	Correct Answers
All women can use symptoms-based methods.	**True:** No medical conditions prevent the use of these methods, but some condition s can make them harder to use effectively.
In the following situation, it is not necessary to use *caution* with symptoms-based methods: The woman recently had an abortion or miscarriage	**FALSE**: In this situation, caution must be used.
In the following situation, use *caution* with symptoms-based methods: Menstrual cycles have just started or have become less frequent or stopped due to older age.	**TRUE**: Menstrual cycle irregularities are common in young women in the first several years after their first monthly bleeding and in older women who are approaching menopause. Identifying the fertile time may be difficult.
In the following situation, it is not necessary to use *caution* with symptoms-based methods: A chronic condition that raises her body temperature.	**FALSE**: caution must be used for basal body temperature and symptothermal methods.
In the following situation, it is not necessary to *delay* starting symptoms-based methods: Recently gave birth or is breastfeeding.	**FALSE**: *Delay* until normal secretions have returned—usually at least six months after childbirth for breastfeeding women and at least four weeks after childbirth for women who are not breastfeeding. For several months after regular cycles have returned, use with *caution*.
In the following situation, *delay* starting symptoms-based methods: An acute condition that raises her body temperature.	**TRUE**: for basal body temperature and symptothermal methods.
In the following situation, *delay* starting symptoms-based methods: Irregular vaginal bleeding.	**TRUE.**
In the following situation, *delay* starting symptoms-based methods: Abnormal vaginal discharge.	**TRUE.**
In the following situations, *delay* or use *caution* with symptoms-based methods: Taking any mood-altering drugs such as anti-anxiety therapies (except benzodiazepines), antidepressants (selective serotonin reuptake inhibitors [SSRIs], tricyclic, or tetracyclic), anti-psychotics (including chlorpromazine, thioridazine, haloperidol, risperdone, clozapine, or lithium), long-term use of certain antibiotics, any nonsteroidal anti-inflammatory drug (such as aspirin, ibuprofen, or paracetamol), or antihistamines.	**TRUE**: These drugs may affect cervical secretions, raise body temperature, or delay ovulation.

1.4 Distribute Handout 2 and encourage the participants to review it in their own time.

1.5 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Facilitator's Resources

Activity 2: Caution or Delay with calendar-based methods?

Print and copy sufficient copies of the following cards based on the number of participants:

Case	**Caution Or Delay?** ***Caution*** means that additional or special counselling may be needed to ensure correct use of the method. ***Delay*** means that use of a particular fertility awareness method should be delayed until the condition is evaluated or corrected. Give the client another method to use until she can start the calendar-based method. **For each case presented in the opposite column, decide if you would use C or D**
The client's menstrual cycles have just started or have become less frequent or stopped due to older age. Would you use C or D with calendar based methods?	
The client recently gave birth or is breastfeeding . Would you use C or D with calendar-based methods?	
The client recently had an abortion or miscarriage. Would you use C or D with calendar-based methods?	
The client has irregular vaginal bleeding. Would you use C or D with calendar-based methods?	
If a client was using any of the following drugs: mood-altering drugs such as anti-anxiety therapies (except benzodiazepines), antidepressants (selective serotonin reuptake inhibitors [SSRIs], tricyclic, or tetracyclic), long -term use of certain antibiotics, or long -term use of any nonsteroidal anti - inflammatory drug (such as aspirin, ibuprofen, orparacetamol), would you use C or D with calendar-based methods?	

Participants' Handouts

Session 15: Handout 1, Activity 1 – Caution or Delay with calendar-based methods?

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

Case	**Caution Or Delay?** ***Caution*** means that additional or special counselling may be needed to ensure correct use of the method. ***Delay*** means that use of a particular fertility awareness method should be delayed until the condition is evaluated or co rrected. Give the client another method to use until she can start the calendar-based method.
The client's menstrual cycles have just started or have become less frequent or stopped due to older age. Would you use C or D with calendar - based methods?	Use ***caution*** with calendar-based methods: Menstrual cycle irregularities are common in young women in the first several years after their first monthly bleeding and in older women who are approaching menopause. Identifying the fertile time may be difficult.
The client recently gave birth or is breastfeeding. Would you use C or D with calendar-based methods?	***Delay*** starting calendar -based methods: *Delay* until she has had at least three menstrual cycles and her cycles are regular again. For several months after reg ular cycles have returned, use with *caution*.
The client recently had an abortion or miscarriage. Would you use C or D with calendar-based methods?	***Delay*** until the start of her next monthly bleeding.
The client has irregular vaginal bleeding. Would you use C or D with calendar-based methods?	***Delay.***
If a client was using any of the following drugs: mood-altering drugs such as anti-anxiety therapies (except benzodiazepines), antidepressants (selective serotonin reuptake inhibitors [SSRIs], tricyclic, or tetracyclic), long-term use of certain antibiotics, or long-term use of any nonsteroidal anti-inflammatory drug (such as aspirin, ibuprofen, orparacetamol), would you use C or D with calendar-based methods?	***Delay*** or use ***caution*** with calendar -based methods be cause these drugs may delay ovulation.

Participants' Handouts

Session 15: Handout 2, Activity 1 – Caution or Delay with symptoms-based methods?

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

All women can use symptoms-based methods.	**TRUE:** No medical conditions prevent the use of these methods, but some conditions can make them harder to use effectively.
In the following situation, it is not necessary to use *caution* with symptoms -based methods: The woman recently had an abortion or miscarriage	**FALSE**: In this situation, caution must be used.
In the following situation, use *caution* with symptoms-based methods: Menstrual cy cles have just started or have become less frequent or stopped due to older age.	**TRUE**: Menstrual cycle irregularities are common in young women in the first several years after their first monthly bleeding and in older women who are approaching menopause. Identifying the fertile time may be difficult.
In the following situation, it is not necessary to use *caution* with symptoms -based methods: A chronic condition that raises her body temperature.	**FALSE**: caution must be used for basal body temperature and symptothermal methods.
In the following situation, it is not necessary to *delay* starting symptoms-based methods: Recently gave birth or is breastfeeding.	**FALSE**: *Delay* until normal secretions have returned—usually at least six months after childbirth for brea stfeeding women and at least four weeks after childbirth for women who are not breastfeeding. For several months after regular cycles have returned, use with *caution*.
In the following situation, *delay* starting symptoms-based methods: An acute condition th at raises her body temperature.	**TRUE**: for basal body temperature and symptothermal methods.
In the following situation, *delay* starting symptoms-based methods: Irregular vaginal bleeding.	**TRUE.**
In the following situation, *delay* starting symptoms-based methods: Abnormal vaginal discharge.	**TRUE.**
In the following situations, *delay* or use *caution* with symptoms-based methods: Taking any mood -altering drugs such as anti -anxiety therapies (except benzodiazepines), antidepressants (selective serotonin reuptake in hibitors [SSRIs], tricyclic, or tetracyclic), anti -psychotics (including chlorpromazine, thioridazine, haloperidol, risperdone, clozapine, or lithium), long -term use of certain antibiotics, any nonsteroidal anti -inflammatory drug (such as aspirin, ibuprofe n, or paracetamol), or antihistamines.	**TRUE**: These drugs may affect cervical secretions, raise body temperature, or delay ovulation.

SESSION 16 (Optional): Essential Information about Withdrawal

Please note: This session is not included in the suggested sample agenda for this course because it is not an essential session. The contents addressed in this session have been included in the participant's Knowledge Pack. However, a session plan is provided below if facilitators feel that their group needs training on this method.

Objectives

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

- Explain what withdrawal is and identify the essential medical eligibility criteria.
- Provide complete and accurate information to clients requesting these methods.
- Enable clients to make voluntary and informed decisions about this method.

Total Session Time

40 minutes

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"

Facilitator's Resources

- Activity 1: The Withdrawal information chain

Handouts

- Handout 1 – The Withdrawal information chain

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide).
This session will enable the participants to check their knowledge about essential information on withdrawal as a contraceptive method, and practice skills to provide such information to clients in order to support their informed and voluntary decisions and choices.

Activity 1: The Withdrawal information chain (35 minutes)

1.1 Invite the participants to sit in a semi-circle and explain the instructions:

- The facilitator stands in the middle and plays the "client". The facilitator selects randomly a participant to play the "provider" and ask the first question: *What is withdrawal and how does it work as a contraceptive method?* If the "provider" gives a correct and complete answer, she/he will replace the facilitator as the "client" and will ask the next question to another participant randomly selected to be the "provider", and so on. However, if the "providers" do not give correct and complete answers, they cannot become "clients" and another "provider" has to be consulted on the same question until the correct and complete answer is given.
- Please note: The activity should be completed in 25 minutes. A list of questions is provided in the **Facilitator's Resources** section below. Facilitators should print and cut the questions, and give each question to the persons that will play the "client", one question at a time.

1.2 Finally, distribute Handout 1 and briefly review it with the participants to highlight the main

issues that may have not been correctly of fully addressed during the activity.

1.3 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Facilitator's Resources

Activity 1: The Withdrawal information chain

The facilitator will ask the first question:
What is withdrawal and how does it work as a contraceptive method?
The following questions should be printed and cut to use during the activity:

1. **How effective is withdrawal?**
2. **What protection does it provide against STI?**
3. **What are the side effects of withdrawal?**
4. **What are the known health benefits?**
5. **What are the known health risks?**
6. **If a man has a tendency to ejaculate prematurely, what advice could he be given?**
7. **If a man ejaculates before withdrawing, what can be done?**
8. **If a man cannot sense consistently when he is about to ejaculate, what advice can he be given?**
9. **If a man has ejaculated recently, how would this impact the effectiveness of withdrawal?**

Participant's Handouts

Session 16: Handout 1, Activity 1 – The Withdrawal information chain

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

1. **What is withdrawal and how does it work as a contraceptive method?** The man withdraws his penis from his partner's vagina and ejaculates outside the vagina, keeping his semen away from her external genitalia. It is also known as coitus interruptus and “pulling out.” It works by keeping sperm out of the woman's body.

2. **How effective is withdrawal?** *Effectiveness depends on the user:* Risk of pregnancy is greatest when the man does not withdraw his penis from the vagina before he ejaculates with every act of sex. One of the least effective methods, as commonly used (73%). When used correctly with every act of sex, effectiveness rate can reach 96%.

3. **What protection does it provide against STI?** None.

4. **What are the side effects of withdrawal?** None.

5. **What are the known health benefits?** None.

6. **What are the known health risks?** None.

7. **If a man has a tendency to ejaculate prematurely, what advice could he be given?** Suggest an additional or alternative family planning method.

8. **If a man ejaculates before withdrawing, what can be done?** Explain ECP use in case a man ejaculates before withdrawing.

9. **If a man cannot sense consistently when he is about to ejaculate, what advice can he be given?** Suggest an additional or alternative family planning method.

10. **If a man has ejaculated recently, can he still use withdrawal effectively?** Before sex he should urinate and wipe the tip of his penis to remove any sperm remaining.

SESSION 17: Providing Information Effectively to Clients About Lactational Amenorrhea Method (LAM)

Objectives

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

- Explain what LAM is and identify the essential medical eligibility criteria.
- Provide complete and accurate information to clients requesting these methods.
- Enable clients to make voluntary and informed decisions about this method.

Total Session Time

75 minutes (one hour and 15 minutes)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- Sufficient copies of the *LAM mini survey form* (see **Facilitator's Resources** section)

Facilitator's Resources

- Activity 1: The LAM mini survey form

Handouts

- Handout 1 – The LAM mini survey form. Keys

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide).
This session continues to address contraceptive technology still with the aim of strengthening the participants' skills to provide effective information to clients about how to use these methods and supporting their informed and voluntary decisions and choices.**Activity 1: Reviewing our**

knowledge about LAM, and especially about the relevant medical eligibility criteria (60 minutes)

1.1 Distribute the *LAM mini survey form* (please refer to the Facilitator's resources section below). Explain the instructions:

- Participants will work individually. Initially, they will have 20 minutes maximum to complete the form.
- Next, they will mingle and discuss their answers with the other participants for 20 minutes, i.e. each answer with a different person in order to interact with as many people in the group as time permits. As they check their answers, they can change or amend them.
- Finally, the facilitator will distribute Handout 1 and will conduct a short discussion to enable the participants check their answers with those provided in the handout.

1.2 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Facilitator's Resources

Activity 1: The LAM mini survey form

1. What is the **Lactational Amenorrhea Method (LAM), and how does it work as a contraceptive method?**
2. LAM requires three conditions. What are they?
3. How is “fully breastfeeding” defined?
4. How is “nearly fully breastfeeding” defined?
5. What is the effectiveness rate of LAM?
6. What are the side effects associated with LAM?
7. What are the known health benefits of LAM?
8. What are the known health risks of LAM?
9. What protection against STI does LAM provide?
10. Is LAM more effective for thin or for overweight women?
11. Identify at least <u>three</u> medical eligibility criteria for which breastfeeding women may be advised to consider other contraceptive methods, and why:

Participant's Handouts

Session 17: Handout 1, Activity 1 – The *LAM mini survey form.* Keys

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

What is the Lactational Amenorrhea Method (LAM), and how does it work as a contraceptive method?

A temporary family planning method based on the natural effect of breastfeeding on fertility. ("Lactational" means related to breastfeeding. "Amenorrhea" means not having monthly bleeding.) It works primarily by preventing the release of eggs from the ovaries (ovulation). Frequent breastfeeding temporarily prevents the release of the natural hormones that cause ovulation. *Return of fertility after LAM is stopped:* Depends on how much the woman continues to breastfeed.

LAM requires three conditions. What are they?
1. The mother's monthly bleeding has not returned
2. The baby is fully or nearly fully breastfed and is fed often, day and night
3. The baby is less than six months old

How is "fully breastfeeding" defined?
It includes both exclusive breastfeeding (the infant receives no other liquid or food, not even water, in addition to breast milk) and almost-exclusive breastfeeding (the infant receives vitamins, water, juice, or other nutrients once in a while in addition to breast milk).

How is "nearly fully breastfeeding" defined?
The infant receives some liquid or food in addition to breast milk, but the majority of feedings (more than three-fourths of all feeds) are breast milk.

What is the effectiveness rate of LAM?
Effectiveness depends on the user: Risk of pregnancy is greatest when a woman cannot fully or nearly fully breastfeed her infant. As commonly used, effectiveness rate is 98%. When used correctly, its effectiveness rate is over 99%.

What are the side effects associated with LAM?
None. Any problems are the same as for other breastfeeding women.

What are the known health benefits of LAM?
Helps protect against: Risks of pregnancy.
Encourages: The best breastfeeding patterns, with health benefits for both mother and baby.

What are the known health risks of LAM?
None.

What protection against STI does LAM provide?
None.

Is LAM more effective for thin or for overweight women?
It is just as effective among fat or thin women.

Identify at least three medical eligibility criteria for which breastfeeding women may be advised to consider other contraceptive methods, and why:
All breastfeeding women can safely use LAM, but a woman in the following circumstances may want to consider other contraceptive methods:

- Has HIV infection including AIDS.
- Is using certain medications during breastfeeding (including mood altering drugs, reserpine, ergotamine, anti-metabolites, cyclosporine, high doses of corticosteroids, bromocriptine, radioactive drugs, lithium, and certain anticoagulants).
- The newborn has a condition that makes it difficult to breastfeed (including being small-for-date or premature and needing intensive neonatal care, unable to digest food normally, or having deformities of the mouth, jaw, or palate).

SESSION 18: Helping Effectively Clients to Deal with Side Effects

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

- Provide accurate and correct information to clients about possible side effects, warning signs, and complications of the most commonly used modern methods of contraception, and address misconceptions effectively.
- Effectively manage side effects and complications and enable clients to make voluntary informed decisions about these issues.

Total Session Time
120 minutes (two hours)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- Sufficient copies of the **role**-play scenarios for Activity 1
- Sufficient copies of the *What would you do* form for Activity 2

Facilitator's Resources

- Activity 1: Sample role-play scenarios
- Activity 2: What would you do?

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide).
In this session, the participants will strengthen their skills to effectively help clients make safe, voluntary and informed decisions about the options they may have when experiencing side effects or complications of modern methods of contraception. It is very important that the participants have read carefully the information on these issues provided in the knowledge pack for this course. Unless they have read it, they will not be able to benefit from this session.

Activity 1: Providing accurate and correct information to clients about side effects and complications of the most commonly used modern methods of contraception: Mini role-plays (55 minutes)

1.1 Divide the participants in pairs. Instructions:
- ➢ Pairs receive role-play scenarios (refer to the **Facilitator's Resources** section below). They will have five minutes to rehearse a five minute role play that they will perform in front of the whole group.
- ➢ After each five minute role-play is performed in front of the whole group, debrief in the following way:
  - Begin from the person who played "provider" and ask how what she/he did well in the interaction. Next, ask what she/he would do differently, and how, if given the chance to repeat the interaction
  - Ask the person who played "client" what she/he thinks that the "provider" did well to address her/his issues, and what the "provider" could have done better, and how.
  - Now open the feedback to the larger group and ask what the "provider" did well and what could have done better, and how.

Try to perform as many scenarios as possible.
If necessary, refer the participants to the relevant section of the knowledge pack of this course, especially if they cannot identify important issues that should have been addressed in their role-plays.

> ***Note for Facilitators***
>
> It is important that facilitators review the relevant sections of the knowledge pack of this course in preparing for this session. Facilitators should be very conversant with the content in order to be able to stir the discussion to focus on key issues.

Activity 2: Manage side effects and complications and enable clients to make voluntary informed decisions about these issues: Critical incident (55 minutes)

2.1 Distribute the *What would you do?* form to all participants. Instructions:

- The participants sit in a circle. They play a fruit salad game or similar so that one person is left without a seat and will stand in the middle. She/he selects one of the other participants who in turn will choose and ask a question from the form. The person standing in the middle has to answer. If the other participants agree that the answer is correct and complete, the person in the middle can swap place with anyone else she/he wants, and that person will now continue the process.

2.2 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Facilitator's Resources

Activity 1: Sample role-play scenarios

Print, cut, and distribute different scenarios to the pairs. You can also add more scenarios with other methods.

Scenario 1:
The client you are seeing is very interested in COCs. However she is saying a few things that clearly show she has misconceptions, especially about the possible side effects and complications. You have to dispel misconceptions about COCs and provide accurate and complete information about possible side effects and complications.

Scenario 2:
The client you are seeing is very interested in POPs. However she is saying a few things that clearly show she has misconceptions, especially about the possible side effects and complications. You have to dispel misconceptions about POPs and provide accurate and complete information about possible side effects and complications.

Scenario 3:
The client you are seeing is very interested in Progestin-only Injectables. However she is saying a few things that clearly show she has misconceptions, especially about the possible side effects and complications. You have to dispel misconceptions about Progestin-only Injectables and provide accurate and complete information about possible side effects and complications.

Scenario 4:
The client you are seeing is very interested in *Monthly Injectables*. However she is saying a few things that clearly show she has misconceptions, especially about the possible side effects and complications. You have to dispel misconceptions about *Monthly Injectables* and provide accurate and complete information about possible side effects and complications.

Scenario 5:
The client you are seeing is very interested in *Implants*. However she is saying a few things that clearly show she has misconceptions, especially about the possible side effects and complications. You have to dispel misconceptions about *Implants* and provide accurate and complete information about possible side effects and complications.

Scenario 6:
The client you are seeing is very interested in *Copper Bearing Intra-uterine Device*. However she is saying a few things that clearly show she has misconceptions, especially about the possible side effects and complications. You have to dispel misconceptions about *Copper Bearing Intra-uterine Device* and provide accurate and complete information about possible side effects and complications.

Scenario 7:
The client you are seeing is very interested in *female sterilization/tubal ligation*. However she is saying a few things that clearly show she has misconceptions, especially about the possible side effects and complications. You have to dispel misconceptions about *female sterilization/tubal ligation* and provide accurate and complete information about possible side effects and complications.

Scenario 8:
The male client you are seeing is very interested in *vasectomy*. However she is saying a few things that clearly show she has misconceptions, especially about the possible side effects and complications. You have to dispel misconceptions about *vasectomy* and provide accurate and complete information about possible side effects and complications.

Scenario 9:
The client you are seeing is very interested in *spermicides and diaphragms*. However she is saying a few things that clearly show she has misconceptions, especially about the possible side effects and complications. You have to dispel misconceptions about *spermicides and diaphragms* and provide accurate and complete information about possible side effects and complications.

Scenario 10:
The client you are seeing is very interested in *male condoms*. However she is saying a few things that clearly show she has misconceptions, especially about the possible side effects and complications. You have to dispel misconceptions about *male condoms* and provide accurate and complete information about possible side effects and complications.

Scenario 11:
The client you are seeing is very interested in fe*male condoms*. However she is saying a few things that clearly show she has misconceptions, especially about the possible side effects and complications. You have to dispel misconceptions about fe*male condoms* and provide accurate and complete information about possible side effects and complications.

Scenario 12:
The client you are seeing is very interested in emergency contraceptive pills. However she is saying a few things that clearly show she has misconceptions, especially about the possible side effects and complications. You have to dispel misconceptions about emergency contraceptive pills and provide accurate and complete information about possible side effects and complications.

Facilitator's Resources

Activity 2: What would you do?

Print, copy, and distribute to each participant (facilitators are encouraged to modify or add scenarios to meet the needs of their groups):

Sample critical incident scenarios:

1. A client has come to see you complaining that after taking COCs for a few months, she is experiencing bleeding at unexpected times (irregular bleeding). What would you do to help her manage this problem?
2. A client using COCs comes to see you because she has missed three pills in the first two weeks. What would you do to help her manage this problem?
3. A client using COCs comes to see you because she has missed three pills in the third week. What would you do to help her manage this problem?
4. A client using COCs comes to see you because she has had severe vomiting for more than two days. What would you do to help her manage this problem?
5. A client who is not breastfeeding and is taking POPs complains of frequent or irregular bleeding. What would you do to help her manage this problem?
6. A client who is taking POPs complains of having headaches and breast tenderness. What would you do to help her manage this problem?
7. A client who is taking ECPs complains of having nausea and abdominal pain. What would you do to help her manage this problem?
8. A client who is taking ECPs complains of change in timing of monthly bleeding. What would you do to help her manage this problem?
9. A client using Progestin-only injectables complains of having prolonged bleeding. What would you do to help her manage this problem?
10. A client using Progestin-only injectables complains of not having monthly bleeding. What would you do to help her manage this problem?
11. A client using Progestin-only injectables complains of having migraines with aura. What would you do to help her manage this problem?
12. A client using Monthly Injectables complains of weight gain. What would you do to help her manage this problem?
13. A client using Implants complains of having irregular bleeding that lasts more than 8 days at a time. What would you do to help her manage this problem?
14. A client using Implants complains of having heavy or prolonged bleeding. What would you do to help her manage this problem?
15. A client using Implants complains of having an infection at insertion site. What would you do to help her manage this problem?
16. A client using the Copper-Bearing Intrauterine Device complains of having more cramps and pain during monthly bleeding. What would you do to help her manage this problem?
17. A client using the Copper-Bearing Intrauterine Device complains that her partner can feel the string during sex. What would you do to help her manage this problem?
18. A client using the Copper-Bearing Intrauterine Device complains of having severe pain in lower abdomen. What would you do to help her manage this problem?
19. After undergoing female sterilization, a client complains of having redness and pain at incision site. What would you do to help her manage this problem?
20. After undergoing female sterilization, a client complains of having an abscess near the incision site. What would you do to help her manage this problem?
21. After undergoing a vasectomy, a client complains of having blood clots. What would you do to help her manage this problem?
22. A few months after a vasectomy, a client complains of still having pain. What would you do to help her manage this problem?

SESSION 19: Ensuring Clients Understand how Modern Methods of Contraception Work

Objectives

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

- Explain accurately and correctly to clients how modern methods of contraception work in language that clients can understand.

Total Session Time

120 minutes (two hours)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- Sufficient copies of the **role**-play scenarios for Activity 1
- Sufficient anatomical models, samples of modern contraceptive methods as per role-play scenarios, and other relevant job aids and IEC materials available at the training site

Facilitator's Resources

- Activity 1: Sample role-play scenarios

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide).
In this session, the participants will strengthen their skills to effectively explain to clients during a FP visit how modern methods of contraception work by using job aids and in language that clients can understand. Participants should have read the relevant sections of the knowledge pack for this course to be able to benefit from this session.

Activity 1: Demonstrating how contraceptive methods work: Mini role-plays (120 minutes)

Please note: Prior to conducting this session, remind the participant to review all the relevant handouts they have receive during the course as well the Knowledge Pack of this course in order to be able to benefit from and contribute to this session.

1.1 Divide the participants in pairs. Instructions:

- Pairs receive role-play scenarios (refer to the **Facilitator's Resources** section below). They will have five minutes to rehearse a five minute role play that they will perform in front of the whole group.
- After each five minute role-play is performed in front of the whole group, debrief in the following way:
  - Begin from the person who played "provider" and ask how what she/he did well in the interaction. Next, ask what she/he would do differently, and how, if given the chance to repeat the interaction
  - Ask the person who played "client" what she/he thinks that the "provider" did well to explain the method, and what the "provider" could have done better, and how.
  - Now open the feedback to the larger group and ask what the "provider" did well, and what could have done better to explain the method, and how.

As many scenarios as time permits should be role-played.

1.2 Reserve the last 10 minutes for evaluating the session. Show again the session objectives and discuss how the objective has been achieved by asking the participants to identify specific learning they take away from the entire session.

Facilitator's Resources

Activity 1: Sample role-play scenarios

Print, cut, and distribute different scenarios to the pairs. You can also add more scenarios with other methods.

Scenario 1:
The client you are seeing has decided to use COCs and she has asked you to explain again how they work and how they should be taken. You have five minutes to do it.

Scenario 2:
The client you are seeing has decided to use POPs and she has asked you to explain again how they work and how they should be taken. You have five minutes to do it.

Scenario 3:
The client you are seeing has decided to use Progestin-only Injectables and she has asked you to explain again how they work and what she should be aware of. You have five minutes to do it.

Scenario 4:
The client you are seeing has decided to use *Monthly Injectables* and she has asked you to explain again how they work and what she should be aware of. You have five minutes to do it.

Scenario 5:
The client you are seeing has decided to use Implants and she has asked you to explain again how they work and what she should be aware of. You have five minutes to do it.

Scenario 6:
The client you are seeing has decided to use the *Copper Bearing Intra-uterine Device* and she has asked you to explain again how it works and what she should be aware of. You have five minutes to do it.

Scenario 7:
The client you are seeing has decided to use *female sterilization/tubal ligation and* she has asked you to explain again how it works and what she should be aware of. You have five minutes to do it.

Scenario 8:
The male client you are seeing has decided to use *vasectomy and* he has asked you to explain again how it works and what he should be aware of. You have five minutes to do it.

Scenario 9:
The client you are seeing is very interested in *spermicides and diaphragms*. However she is saying a few things that clearly show she has misconceptions, especially about the possible side effects and complications. You have to dispel misconceptions about *spermicides and diaphragms* and provide accurate and complete information about possible side effects and complications. You have five minutes to do it.

Scenario 10:
The client you are seeing has decided to use *male condoms and* she has asked you to explain again how it works and what she should be aware of. You have five minutes to do it.

Scenario 11:
The client you are seeing has decided to use fe*male condoms and* she has asked you to explain again how it works and what she should be aware of. You have five minutes to do it.

Scenario 12:
The client you are seeing has decided to use emergency contraceptive pills *and* she has asked you to explain how they work and what she should be aware of. You have five minutes to do it.

SESSION 20: Infection Prevention in Health Care Facilities

Objectives
By the end of the session, the participants will be able to:
- Explain infection prevention terminology.
- Identify key reasons why infection prevention is important to ensure safe health service provision.
- Identify and demonstrate sound infection prevention practices.

Total Session Time
120 minutes (two hours)

Materials
- Flipcharts, markers, tape
- Flipchart "Session objectives"
- *Infection prevention in health care facilities* flipchart (Activity 1)
- Sufficient copies of paper strips for *find your match* (Activity 1)

Facilitator's Resources
- Activity 1 (Step 1.3): Find your match!

Handouts
- Handout 1 – Defining Infection prevention in health care facilities
- Handout 2 – Infection prevention terminology
- Handout 3 – Practicing infection prevention

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide).
In this session, the participants will expand their knowledge of and strengthen their skills to effectively ensure sound infection prevention practices in health care facilities.

means (45 minutes)
1.1 Brainstorm rapidly with the group:
- ➢ How can we define what infection prevention practices in health care facilities are? (clarify that you are not looking for examples of practices, but for a definition of the term *infection prevention in health care facilities*)

Record a few responses and show the following flipchart for comparison:

Infection prevention in health care facilities

Strategies adopted by health workers (although infection prevention is not restricted to health workers) to prevent/minimize the transfer of infections from one person to another either directly or indirectly.

Infection prevention practices are part of what is known as *Standard Precautions* (previously known as Universal Precautions). They are called *standard* for the very reasons that these measures provide the gold benchmarks for ensuring that health workers protect themselves and everyone else in a health care facility from infections.

1.2 Invite the participants to stand in the middle of the room to play a TRUE/FALSE exercise. The facilitator reads a statement at a time from those provided below. If participants feel that the statement is true, they will move to one end of the room or to the opposite one if they feel that it is false. The facilitator provides the correct answer before moving on to the next statement:

Statements	True/False
There are many different types of germs that potentially can cause infections in health care facilities.	**TRUE**: Germs ((infectious organisms) of concern in the clinic include bacteria (such as staphylococcus), viruses (particularly HIV and hepatitis B), fungi, and parasites.
In the clinic, infectious organisms can be found in blood, body fluids with visible blood, or tissue.	**TRUE.**
Faeces, nasal secretions, saliva, sputum, sweat, tears, urine, and vomit are not considered potentially infectious unless they contain blood	**FALSE.**
The organisms can be passed through mucous membranes or broken skin, such as cuts and scratches, and by needle sticks with used needles and other puncture wounds.	**TRUE.**
However, these infectious organisms cannot pass from clinics to communities.	**FALSE**: Infectious organisms can pass from clinics to communities when waste disposal is not proper or staff members do not wash their hands properly before leaving the clinic.
Needle sticks or cuts are among the causes of infections in health care settings among health providers.	**TRUE.**
The average risk of HIV infection after a needle stick exposure to HIV-infected blood is 30 infections per 1,000 needle sticks.	**FALSE:** The average risk of HIV infection after a needle stick exposure to HIV-infected blood is **three** infections per 1,000 needle sticks.
The risk after exposure of the eye, nose, or mouth to HIV-infected blood is estimated to be about 10 infections per 1,000 exposures.	**FALSE:** The risk after exposure of the eye, nose, or mouth to HIV -infected blood is estimated to be about **one** infection per 1,000 exposures.
(Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs INFO Project, and USAID, 2007: Family Pl anning. A Global Handbook for Providers)	

1.3 Distribute Handout 1 and review only the last three bullet points with the participants. Discuss:

- As health providers, what are your main concerns about infection prevention in your facilities?
- What attitudes of providers will support the implementation of sound infection prevention practices?
- What attitudes of providers will hinder the implementation of sound infection prevention practices?

1.4 Invite the participants to stand again in the middle of the room. Distribute to each participant two of the strips of paper provided in the Facilitator's resources section below and explain that they will play an exercise called find your match. Explain the exercise using the instruction provided in the Facilitator's resources section.

1.5 Reserve the last five minutes of the activity to discuss:

- Which of these practices are you most familiar with?

- Which of these practices you feel need improving in your facility, and why?

1.4 Distribute Handout 2 and encourage the participants to read it carefully in their own time.

Activity 2: Practicing infection prevention (70 minutes)

2.1 In this activity, the facilitator will first demonstrate and /or provide guidelines for the following infection prevention practices:
- Wash hands.
- Wear and dispose of gloves.
- Process instruments that will be re-used.
- Dispose safely of used syringes and needles (if possible, use auto-disable syringes and needles).
- Prepare and use chlorine solution to wipe surfaces.
- Dispose of single use equipment and supplies properly and safely.
- Wash linen.

2.2 After demonstrating each practice, the facilitator will ask the participants to work in pairs to conduct a demonstration and give feedback to each other. Alternatively, a volunteer (a different one for each practice) can demonstrate in front of the group and receive feedback, including repeating any missed or incorrect step.

2.3 Distribute Handout 3 and encourage the participants to read it carefully in their own time.

2.4 Reserve the last 5 minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Facilitator's Resources

Activity 1 (Step 1.3): Find your match!

Instructions: Print and cut as many copies of the table below depending on the number of participants. Give to each person two strips of paper, one from column one and the other from column two, and ensure that they do not match. This means that each participant will receive one term and one definition, but the latter will not be of the term she/he has received. Next, each person must find two other people, namely one who has the definition matching her/his term, and another with the term matching the definition that she/he received at the beginning of the activity

Terms	Definitions
Asepsis and aseptic technique	Efforts made to prevent entry of microorganisms into any area of the body where they are likely to cause infection.
Antisepsis	The prevention of infection by killing or inhibiting the growth of microorganisms on skin and other body tissues using a chemical agent (antiseptic).
Decontamination	The process that makes objects safer to be handled by staff before cleaning (i.e. reduces, but does not eliminate the number of microorganisms on instruments and other items). Objects to be decontaminated include large surfaces (e.g. pelvic examination or operating tables), surgical instruments, gloves and other items contaminated with blood or body fluids.
Cleaning	The process that physically removes all visible blood, body fluids or any other foreign materials such as dust or dirt from skin or inanimate objects.
Disinfection	The process that physically removes all visible blood, body f luids or any other foreign materials such as dust or dirt from skin or inanimate objects.
High level disinfection (HLD)	Boiling, steaming or the use of chemicals eliminates all microorganisms except some bacterial endospores from inanimate objects.
Sterilization	The process that eliminates all microorganisms (bacteria, viruses, fungi and parasites) including bacteria endospores from inanimate objects.

Participant's Handouts

Session 20: Handout 1, Activity 1 – Defining Infection prevention in health care facilities

Infection prevention in health care facilities

Strategies adopted by health workers (although infection prevention is not restricted to health workers) to prevent/minimize the transfer of infections from one person to another either directly or indirectly.

Infection prevention practices are part of what is known as *Standard Precautions* (previously known as Universal Precautions). They are called *standard* for the very reasons that these measures provide the gold benchmarks for ensuring that health workers protect themselves and everyone else in a health care facility from infections.

Statements	True/False
There are many different types of germs that potentially can cause infections in health care facilities.	**TRUE**: Germs ((infectious org anisms) of concern in the clinic include bacteria (such as staphylococcus), viruses (particularly HIV and hepatitis B), fungi, and parasites.
In the clinic, infectious organisms can be found in blood, body fluids with visible blood, or tissue.	**TRUE.**
Faeces, nasal secretions, saliva, sputum, sweat, tears, urine, and vomit are not considered potentially infectious unless they contain blood	**FALSE.**
The organisms can be passed through mucous membranes or broken skin, such as cuts and scratches, and by needle sticks with used needles and other puncture wounds.	**TRUE.**
However, these infectious organisms cannot pass from clinics to communities.	**FALSE**: Infectious organisms can pass from clinics to communities when waste disposal is not proper or staff members do not wash their hands properly before leaving the clinic.
Needle sticks or cuts are among the causes of infections in health care settings among health providers.	**TRUE.**
The average risk of HIV infection after a needle stick exposure to HIV-infected blood is 30 infections per 1,000 needle sticks.	**FALSE:** The average risk of HIV infection after a needle stick exposure to HIV-infected blood is **three** infections per 1,000 needle sticks.
The risk after exposure of the eye, nose, or mouth to HIV-infected blood is estimated to be about 10 infections per 1,000 exposures.	**FALSE:** The risk after exposure of the eye, nose, or mouth to HIV-infected blood is estimated to be about **one** infection per 1,000 exposures.
Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers	

- **Consider every person** (patient or staff) as potentially infectious and susceptible to infection.
- Proper infection prevention practices must be followed in order to minimize the risk of infection and serious disease for the client, the provider and all facility staff members.
- People with infections, both clients and staff member, may not have any sign or symptoms of the infections they are carrying. This is particularly notable for HIV and Hepatitis viruses. Therefore, it is important for all staff to practice proper infection prevention with all clients at all times.
- As a RH/FP provider, you are responsible for the safety of clients and staffs. This includes ensuring that appropriate infection prevention practices are followed at your facilities. In almost all settings, there is room for improving infection prevention practices, and providers play an important role in this on-going improvement process.

Participant's Handouts

Session 20: Handout 2, Activity 1 – Infection prevention terminology

Terms	Definitions
Asepsis and aseptic technique	Efforts made to prevent entry of microorganisms into any area of the body where they are likely to cause infection.
Antisepsis	The prevention of infection by killing or inhibiting the growth of microorganisms on skin and other body tissues using a chemical agent (antiseptic).
Decontamination	The process that makes objects safer to be handled by staff before cleaning (i.e. reduces, but does not eliminate the number of microorganisms on instruments and other items). Objects to be decontaminated include large surfaces (e.g. pelvic examination or operating tables), surgical instruments, gloves and other items contaminated with blood or body fluids.
Cleaning	The process that physically removes all visible blood, body fluids or any other foreign materials such as dust or dirt from skin or inanimate objects.
Disinfection	The process that physically removes all visible blood, body fluids or any other foreign materials such as dust or dirt from skin or inanimate objects.
High level disinfection (HLD)	Boiling, steaming or the use of chemicals eliminates all microorganisms except some bacterial endospores from inanimate objects.
Sterilization	The process that eliminates all microorganisms (bacteria, viruses, fungi and parasites) including bacteria endospores from inanimate objects.

Participant's Handouts

Session 20: Handout 3, Activity 2 – Practicing infection prevention

Source: World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

Wash hands

Hand washing may be the single most important infection-prevention procedure.

- Wash hands before and after examining or treating each client. Hand washing is not necessary if clients do not require an examination or treatment.
- Use clean water and plain soap, and rub hands for at least 10 to 15 seconds.
- Be sure to clean between the fingers and under fingernails.
- Wash hands after handling soiled instruments and other items or touching mucous membranes, blood, or other body fluids. Wash hands before putting on gloves, after taking off gloves, and whenever hands get dirty.
- Wash hands when you arrive at work, after you use the toilet or latrine, and when you leave work.
- Dry hands with a paper towel or a clean, dry cloth towel that no one else uses, or air-dry.

Steps involved in hand washing

Palms together
In between the fingers
From above and below
And now the thumbs
Rotate finger tips in the palms
Don't forget the wrists
Rinse the hands and fly away

Wear gloves

- Wear gloves for any procedure that risks touching blood, other body fluids, mucous membranes, broken skin, soiled items, dirty surfaces, or waste. Wear surgical gloves for surgical procedures such as insertion of implants. Wear single-use examination gloves for procedures that touch intact mucous membranes or generally to avoid exposure to body fluids. Gloves are not necessary for giving injections.
- Change gloves between procedures on the same client and between clients.
- Do not touch clean equipment or surfaces with dirty gloves or bare hands.
- Wash hands before putting on gloves. Do not wash gloved hands instead of changing gloves. Gloves are not a substitute for hand washing.
- Wear clean utility gloves when cleaning soiled instruments and equipment, handling waste, and cleaning blood or body fluid spills.

For injections, if possible use new auto-disable syringes and needles

- Auto-disable syringes and needles are safer and more reliable than standard single-use disposable syringes and needles, and any disposable syringes and needles are safer than sterilizing reusable syringes and needles. Reusable syringes and needles should be considered only when single use injection equipment is not available and if programs can document the quality of sterilization.
- Cleaning the client's skin before the injection is not needed unless the skin is dirty. If it is, wash with soap and water and dry with a clean towel. Wiping with an antiseptic has no added benefit.

Wipe surfaces with chlorine solution

- Wipe examination tables, bench tops, and other surfaces that come in contact with unbroken skin with 0.5% chlorine solution after each client.

Dispose of single use equipment and supplies properly and safely

- Use personal protective equipment—goggles, mask, apron, and closed protective shoes— when handling wastes.
- Needles and syringes meant for single use must not be reused. Do not take apart the needle and syringe. Used needles should not be broken, bent, or recapped. Put used needles and syringes immediately into a puncture-proof container for disposal. If needles and syringes will not be incinerated, they should be decontaminated by flushing with 0.5% chlorine solution before they are put into the puncture-proof container. The puncture-proof sharps container should be sealed and either burned, incinerated, or deeply buried when three-fourths full.
- Dressings and other soiled solid waste should be collected in plastic bags and, within two days, burned and buried in a deep pit. Liquid wastes should be poured down a utility sink drain or a flushable toilet, or poured into a deep pit and buried.
- Clean waste containers with detergent and rinse with water.
- Remove utility gloves and clean them whenever they are dirty and at least once every day.
- Wash hands before and after disposing of soiled equipment and waste.

Wash linens

- Wash linens (for example, bedding, caps, gowns, and surgical drapes) by hand or machine and line-dry or machine-dry. When handling soiled linens, wear gloves, hold linens away from your body, and do not shake them.

Process instruments that will be reused

- High-level disinfect or sterilize instruments that touch intact mucous membranes or broken skin.
- Sterilize instruments that touch tissue beneath the skin.

The Four Steps of Processing Equipment

1. ***Decontaminate to kill infectious organisms such as HIV and hepatitis B*** and to make instruments, gloves, and other objects safer for people who clean them. Soak in 0.5% chlorine solution for 10 minutes. Rinse with clean cool water or clean immediately.

Making a Chlorine Solution

Use the following formula to prepare a dilute chlorine solution from liquid:

$$\frac{\%\ \text{Chlorine in solution}}{\%\ \text{Chlorine solution desired}} - 1 = \text{number of parts water needed per part chlorine}$$

Example: to make a 0.5% chlorine solution from bleach with 3.5% active chlorine

$$\left[\left(\frac{3.5\%}{0.5\%} \right) - 1 = 7 - 1 = 6 \right]$$

Thus, add six parts water to one part liquid bleach

Thus, add six parts water to one part liquid bleach

Instruments should not be exposed to chlorine for prolonged periods, a 10-minute time period is sufficient for decontamination.

2. ***Clean to remove body fluids, tissue, and dirt***. Wash or scrub with a brush with liquid soap or detergent and water. Avoid bar soap or powdered soap, which can stay on the equipment. Rinse and dry. While cleaning, wear utility gloves and personal protective equipment—goggles, mask, apron, and enclosed shoes.

3. ***High-level disinfect or sterilize:***
   - **High-level disinfect to kill all infectious organisms** except some bacterial endospores

(a dormant, resistant form of bacteria) by boiling, by steaming, or with chemicals. High-level disinfect instruments or supplies that touch intact mucous membranes or broken skin, such as vaginal specula, uterine sounds, and gloves for pelvic examinations.

- **Chemical HLD -** Cover all items with correct dilution of properly stored disinfectant:
  - Glutaraldehyde solution.
  - 0.5% or 0.1% chlorine solution.
  - 8% formaldehyde solution.
  - Jointed instruments, such as ring forceps, should be opened or unlocked.
  - Soak items for 20 minutes or as per manufacturer's instructions.
  - Nothing should be added to or removed from the chemical solution once timing has begun. After soaking items, rinse them with boiled water (which has been boiled for 20 minutes).
  - Air-dry before use or storage.

- **Sterilize to kill all infectious organisms**, including bacterial endospores, with a high-pressure steam autoclave, a dry-heat oven, chemicals, or radiation. Sterilize instruments such as scalpels and needles that touch tissue beneath the skin. If sterilization is not possible or practical (for example, for laparoscopes), instruments must be high-level disinfected.

Modes of sterilization

- **Steam sterilization** where items are processed at 121 degree centigrade and under pressure of about 106 kPa for 30 minutes for wrapped items and 20 minutes for unwrapped items and timing starts when the desired temperature and pressure are reached.

- **Dry heat sterilization**: items are processed at 170 degrees centigrade for 60 minutes or at 160 degree centigrade for 120 minutes and items should be allowed to cool before they are removed from the oven.

- **Chemical sterilization:** Depending on the chemicals to be used, appropriate solutions as indicated in manufacturers manual. Soak items for 10 hours in formaldehyde but use is discouraged because of its effect on breathing. ***Nothing should be added or removed once timing had begun*** and all items should thereafter be rinsed with water previously boiled for 20 minutes.

- ***Boiling:***
  - Completely immerse items in water. Cover and boil for 20 minutes (start timing when the water begins to boil).
  - Jointed instruments, such as ring forceps, should be opened or unlocked during HLD.
  - All items must be completely covered during boiling (place items that float in a weighted, porous bag).
  - Do not add anything to the pot after the water begins to boil.
  - Air-dry before use or storage.

4. Store instruments and supplies to protect them from contamination. Proper storage of HLD or sterilized items is as important as the HLD or sterilization process itself.

- Items should be stored dry.
- If possible, store processed items in a sterile or HLD container in an enclosed cabinet.
- Do not store pick-up forceps in a bottle filled with antiseptic solution (microorganisms will multiply in the standing solution even if an antiseptic has been added).

- HLD or sterilize pick-up forceps each day and store them dry in a high-level disinfected or sterile bottle.

Wrapped items must be considered contaminated when:

- The package is torn or damaged.
- The wrapping is wet.
- The expiration date has passed.

Wrapped items can be used for up to one week. Wrapped items sealed in plastic can be used for up to one month. Unwrapped items must be used immediately or stored in a covered sterile or HLD container (for up to one week).

SESSION 21: The Role of Health Providers in Ensuring Sound Infection Prevention Practices in Health Care Facilities

Objectives
By the end of the session, the participants will be able to:
- Explain key components of disease transmission.
- Identify the supplies required for infection control.
- Identify the roles of health providers in infection prevention.

Total Session Time
75 minutes (one hour and 15 minutes)

Materials
- Flipcharts, markers, tape, blank A4 size paper sheets
- Flipchart "Session objectives"
- Flipchart "Supplies" for Activity 1

Handouts
- Handout 1 – Breaking the chain of infection in health care settings
- Handout 2 – The roles and responsibilities of providers in ensuring infection prevention in health care settings
- Handout 3 – Surveillance and notification of diseases

Advanced Preparation
Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

Introduction to the Session (5 minutes)
Introduce and review the session objectives (show them on flipchart or slide).
In this session, the participants will explore their attitudes to supporting sound infection prevention and will expand their knowledge about their role in ensuring effective infection prevention practices in health care settings.

Activity 1: Breaking the chain of infections in health care settings. The role of providers in ensuring sound infection prevention practices (40 minutes)

1.1 The infection prevention practices that we explored in the previous session are very important because they enable preventing or breaking the chain of infection. Distribute Handout 1 and review it with the participants.

1.2 In order to ensure sound infection prevention practices, facilities also must have the necessary supplies. Show the following flipchart:

Indispensable	Supplies	Desirable
	Clean water	
	Hand washing soap	
	Antiseptics	
	Supplies and equipment for sterilization or high - level disinfections (HLD) of instrument	
	Sterile or HLD gloves	
	Utility gloves	
	Hypochlorite solution(Bleach)	
	Bucket (plastic preferred)	
	Container for measuring bleach	
	Detergent (liquid preferably) for instruments and facilities	
	Brush for cleaning instruments	

1.3 Ask the participants to work individually. Each person will place a mark next to each supply whether they believe that it is indispensable (i.e. an absolute must have for infection prevention) or desirable (i.e. infection prevention can still be ensured if that supply is not available at the facility). Participants cannot seek advice to complete the exercise and will have only five minutes to finish it.

1.4 Ask the participants to gather around the flipchart and to bring with them Handout 1. Ideally, everybody will have marked every supply as *Indispensible*, because they all are. However, if any of the supplies have been marked Desirable, discuss:

- If a facility believes that a supply (or supplies) is only a *Desirable* and not an *Indispensible* item, how could this affect the chain of infection? (Use Handout 1 as you discuss this question).
- Which infection prevention practices could be compromised, and how? And what could be the potential consequences for clients, providers, and the community?

Please note: It is useful to discuss the above questions even if all the supplies have been marked *Indispensible*.

Through the discussion, help the providers realize how sometimes attitudes about infection prevention practices may jeopardize even good guideline and systems.

1.5 As you start introducing the issues of guidelines for infection prevention, remind the participants that in fact the list of supplies discussed in the previous exercise reflects the current guidelines in Nigeria. The guidelines also clearly identify the roles and responsibilities of providers in ensuring effective infection prevention practices in health care settings. Ask the participants to work in pairs for five minutes to discuss what these roles and responsibilities are.

1.6 Stop the pairs after five minutes. Invite the pairs to share the results of their discussions. Distribute Handout 2 and review it with the group. Discuss:

- How do these points reflect what really happens in your health facilities?
- What needs improving in your health facilities to comply with the guidance outlined in the handout? What can you do to help improve the situation?

Activity 2: Surveillance and Notification of diseases (30 minutes)

2.1 In activity 1, we touched briefly on this issue, which we will now expand on. Invite the participants to stand in the middle of the room to play a CORRECT/INCORRECT exercise (use the same rules as per TRUE/FALSE exercises):

Statement	Correct/Incorrect
Surveillance is the monitoring of spread of disease.	**INCORRECT:** Surveillance can be defined as a system of constant monitoring and watchfulness over all aspects of the occurrence spread of diseases and the use of information gathered for the purpose of designing preventive and control measures.
The purpose of surveillance is to provide early detection of outbreaks of infections/diseases.	**INCORRECT:** The purpose of surveillance is to plan interventions, mobilize and allocate resources and predict or provide early detection of outbreaks. It involves data collection, collation and analysis.
The strategy adopted in Nigeria for Survei llance and Notification of diseases is the Integrated Disease Surveillance and Response Strategy (IDSRS).	**CORRECT.**
The LGA level is the focus for integrating surveillance functions.	**CORRECT.**
The Nigerian IDSRS includes 35 diseases in its list.	**INCORRECT:** There are 40.
The 40 diseases in the Nigerian IDSRS are grouped into three categories.	**INCORRECT:** There are four categories.
The three categories are: 1. Epidemic prone diseases e.g. Cholera, Meningitis. 2. Diseases for eradication and elimination e.g. Guinea worm, Neonatal tetanus. 3. Diseases that are internationally regulated e.g. SARS, SARI, Malaria.	**INCORRECT:** There are four categories: 1. Epidemic prone diseases e.g. Cholera, Meningitis. 2. Diseases for eradication and elimination e.g. Guinea worm, Neonatal tetanus. 3. Diseases that are internationally regulated e.g. SARS, SARI. 4. Diseases of public health importance e.g. HIV, Hepatitis B, Malaria, Tuberculosis etc.

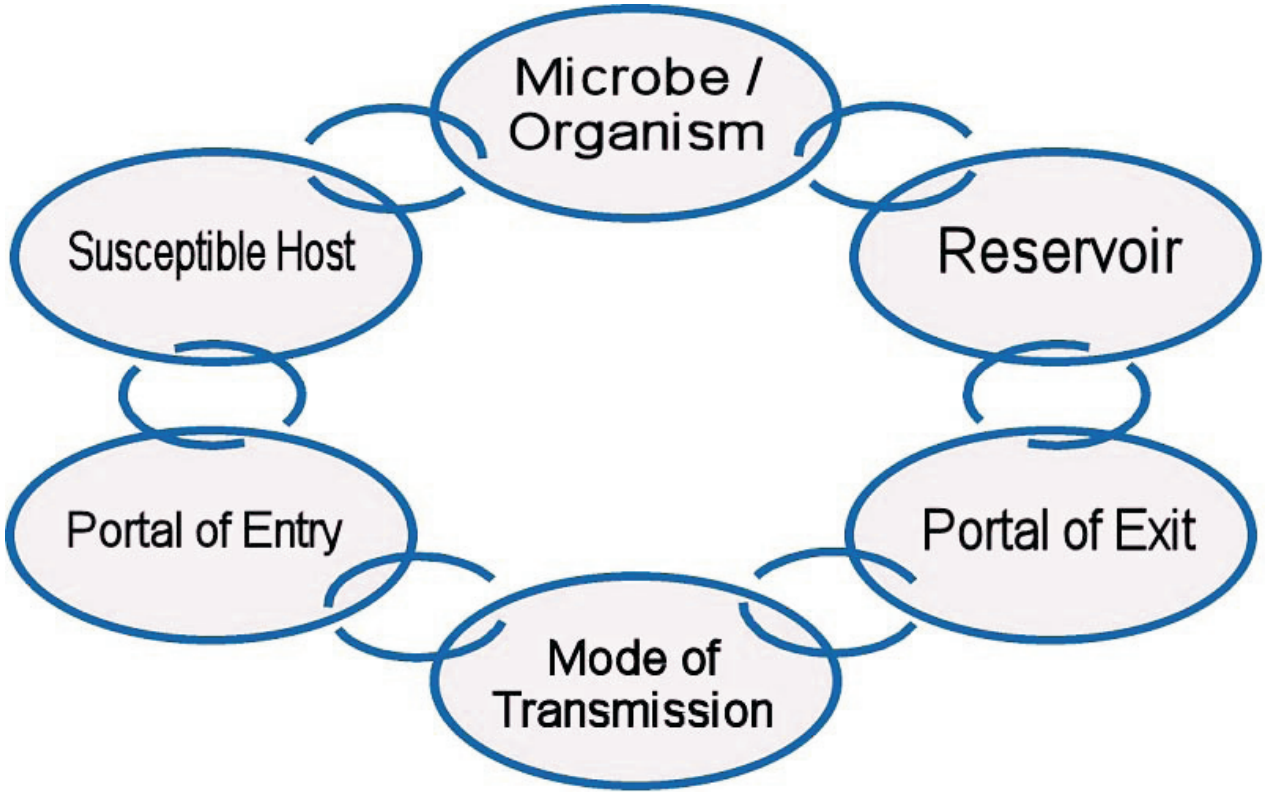
2.2 Distribute Handout 3 and encourage the participants to review it in their own time.

2.3 Reserve the last five minutes for evaluating the session. Show again the session objectives and discuss how each objective has been achieved by asking the participants to identify specific learning they take away from the entire session for each objective.

Participant's Handouts

Session 21: Handout 1, Activity 1 – Breaking the chain of infection in health care settings

The spread of micro-organisms from their source to a susceptible host is frequently referred to as the chain of infection:



Agent: Microbe/organisms such as bacteria, viruses, fungi, parasites etc.
Reservoir: people, animals, plants, soil, air and other solutions, instrument used in other clinical procedures.

Portal of Exit: e.g. broken skin, blood stream, mucus membrane, respiratory tract, genitourinary tract, gastrointestinal tract, and placenta.

Mode of transmission: through touching, sexual intercourse, droplets, insect bite, ingestion, instrument, air, etc.

Portal of entry: mucus membrane, respiratory tract, blood stream, broken skin.
Susceptible host: client, service providers, ancillary staff and members of the community.

Participant's Handouts

Session 21: Handout 2, Activity 1 – The roles and responsibilities of providers in ensuring infection prevention in health care settings

Health care providers play an important role in improving the infection prevention practices in the facilities where they work. The provider's role in effective infection prevention efforts begins with a basic understanding of infection transmission and proper infection prevention practices. Along with good infection prevention practices, he/she has a responsibility to supervise infection prevention services of other staff and to facilitate improved infection prevention practices in the facilities.
Following the guidelines below will help to begin the improvement of infection prevention practices:

- Establish procedures to address situations in which clients and staff are exposed to risk of infection.
- Provide staff with orientations and training before new infection prevention procedures are established.
- Provide adequate equipment, supplies, and facilities for implementing new or improved infection prevention practices.
- Conduct periodic reviews to make sure the implementation of infection prevention practices is going well, and to bring to light any staff concerns.
- Comply with the Surveillance and Notification of diseases on the Integrated Disease Surveillance and Response list.

Initially, all staff members (including nurses, physicians, cleaners and housekeepers) will need to be oriented to the importance of infection prevention. Topics such as the following should be addressed:

- The process of disease transmission (the chain of infections) and potential routes of infection in the hospital or clinic environment.
- The key role each staff member plays in infection prevention.
- Practices for minimizing disease transmission (including hand washing, use of gloves, gowns, and other protective barriers, decontamination of gloves and instruments, and other proper waste disposal).
- Regular updates of staff members should take place routinely.

Participant's Handouts

Session 21: Handout 3, Activity 2 – Surveillance and notification of diseases

Surveillance can be defined as a system of constant monitoring and watchfulness over all aspects of the occurrence spread of diseases and the use of information gathered for the purpose of designing preventive and control measures. It enables to plan interventions, mobilise and allocate resources and predict or provide early detection of outbreaks. It involves data collection, collation and analysis.

The strategy adopted in Nigeria for Surveillance and Notification of diseases is the Integrated Disease Surveillance and Response Strategy (IDSRS).

Integrated Disease Surveillance and Response is a common platform for communicable disease, provides information for a rational use of resources for disease control and prevention.

The LGA level is the focus for integrating surveillance functions.

There are 40 notifiable diseases in Nigeria on the IDSR list and they are grouped into 4 categories:

1. Epidemic prone diseases e.g, Cholera, Meningitis.
2. Diseases for eradication and elimination e.g. Guinea worm, Neonatal tetanus.
3. Diseases that are internationally regulated e.g. SARS, SARI.
4. Diseases of public health importance e.g. HIV, Hepatitis B, Malaria, Tuberculosis etc.

SESSION 22: Concluding the Course

Objectives

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

- Self-assess their course learning.
- Identify doable steps to integrate their learning into their work practice.
- Evaluate the course.

Total Session Time

75 minutes (one hour and 15 minutes)

Materials

- Flipcharts, markers, tape
- Flipchart "Session objectives"
- Sufficient copies of the participant's self-assessment questionnaire (Appendix 1)
- Sufficient copies of the Individual Action Plan Form provided in Appendix 5 (this form should be distributed the day before conducting this session)
- Sufficient copies of the end of course evaluation form (Appendix 4)

Advanced Preparation

Read carefully the session plan and prepare all materials in advance, as per the detailed instructions in the activities below.

> ***Note for Facilitators***
>
> Facilitators should distribute the Individual Action Plan Form the day before conducting this session and ask the participants to complete it before the next day. Therefore, participants will be expected to come to this session with their individual action plans already developed.

Introduction to the Session (5 minutes)

Introduce and review the session objectives (show them on flipchart or slide).
This is the last session of the course. It provides an opportunity for the participants to self- assess what they have learnt through the course, to develop their individual action plans, and to evaluate the course to enable improvements and revisions for the future use of the program.

Activity 1: Post Course Self-Assessment (20 minutes)

1.1 Distribute blank copies of the same form that was used for the self-assessment at the beginning of the course. Remind the participants to use the same personal identification code that they used for the initial self-assessment. The facilitator/s will compile the pre and post self-assessment scores during Activities 2 and 3 in order to return both forms to each participant by the end of the session.

Activity 2: Individual Action Plans (25 minutes)

2.1 Ask the participants to mingle for 10 minutes to share their action plans with others in the group. Stop this informal sharing after 10 minutes and facilitate a discussion:

- Each participant shares at least two actions from her/his plan.
- The other participants offer their advice, comments, and suggestions to pre-empt or overcome challenges to implement those actions.

Activity 3: End of Course Evaluation (25 minutes)

3.1 Distribute the end of course evaluation form to each participant (see Appendix 4) and allow 15 minutes for completion.

3.2 Finally, invite the participants to sit in a circle and give them an opportunity to express their final thoughts about the course. Conclude by thanking the participants, and distribute the certificates of participation if they have been planned by the organizers.

APPENDIX 1: PRE AND POST COURSE PARTICIPANT'S SELF-ASSESSMENT QUESTIONNAIRE

Dear Participant,

This questionnaire aims to help you self-assess your learning in this course. You will be given the same form at the end of the course and you will be able to see how much you have learnt.

Nobody except you will know that these are your answers. Simply create your own PIC (personal identification code), just like a password or a bank pin. You can use letters, numbers, or a combination of letters and numbers, for example A1R. The most important thing is that you will find a way to remember your PIC because you will have to use it again when you fill in this questionnaire at the end of the course. Please make sure to write your PIC somewhere safe where you will be able to find it when you need it at the end of the course.

PIC: _____ Date: _____

QUESTIONS:

1. Family planning is defined as:

a. Having the desired number of children as often as necessary
b. Having children by choice and not by chance
c. A way of thinking and living that is adopted voluntarily by individuals and couples, upon the basis of knowledge, attitude and responsible decision in order to promote health and welfare of the family group and thus contribute effectively to the social economic development of a nation.
d. Spacing birth, preventing abortion and having limited number of children in order to curtail population growth.

2. Family Planning has benefits for:

a. Father
b. Mother
c. Child
d. Community/society
e. All of the above
f. None of the above

3. Benefits of Family Planning Include the following:

a. Promoting access to opportunities for personal and social development
b. Supporting planned social development
c. Promoting maternal and child health through improved standards of living
d. Promoting respect and dignity in intimate relationships (e.g. between husband and wife) and generally among the family members
e. All of the above

4. The female reproductive system includes the following, except:

a. Uterus
b. Ovaries
c. Fallopian tubes
d. Vas deferens
e. Vestibular glands
f. All of the above

5. The male reproductive system includes the following, except:

a. Prostate gland
b. Vestibule
c. Penis
d. All of the above
e. Scrotum

6. The following are modern family planning methods, except:

a. Intra uterine device
b. Implanon
c. Emergency contraceptive pills
d. Coitus interruptus
e. Injectables

7. History taking in family planning helps to achieve the following purposes, except:

a. Identifying contraindication to method use
b. Providing baseline information about the client
c. Improving client-provider interaction
d. Providing guidance for providers to explain why a method may not be clinically suitable under certain circumstances
e. Satisfying provider's curiosity about a client's personal matters

8. Clients' rights include the following, except:

a. Right to privacy
b. Right to information
c. Right to dignity
d. Right to prescription
e. Right to informed choice

9. Quality of care in Family Planning clinics can be ensured by service providers through the following, except:

a. Timely intervention
b. Commodity stock out
c. Respecting clients' rights
d. Ensuring technical competence
e. Ensuring sound infection prevention practices

10. Infections can be controlled in Family Planning clinics through the following, except:

a. Proper disposal of sharps
b. Proper hand washing
c. Proper processing of instruments and storage
d. Using torn gloves
e. Regular cleaning

11. Family Planning services can be integrated with the following, except:

a. Immunization services
b. Post abortion care
c. HIV and AIDS care
d. Antenatal care
e. All of the above

12. In STI/HIV/AIDS prevention, ABCD stands for (please write in full):

a. A _____

b. B _____
c. C _____
d. D _____

13. The term MEC in family planning means?

_____

_____

_____

_____

14. The Social Ecology Model has four spheres of influence. Please list them:

_____

_____

_____

_____

_____

APPENDIX 2: KEYS FOR THE PRE AND POST COURSE PARTICIPANT'S SELF-ASSESSMENT QUESTIONNAIRE

The correct answers are highlighted in **bold**.

1. Family planning is defined as:
- a. Having the desired number of children as often as necessary
- b. Having children by choice and not by chance
- **c. A way of thinking and living that is adopted voluntarily by individuals and couples, upon the basis of knowledge, attitude and responsible decision in order to promote health and welfare of the family group and thus contribute effectively to the social economic development of a nation.**
- d. Spacing birth, preventing abortion and having limited number of children in order to curtail population growth.

2. Family Planning has benefits for:
- a. Father
- b. Mother
- c. Child
- d. Community/society
- **e. All of the above**
- f. None of the above

3. Benefits of Family Planning Include the following:
- a. Promoting access to opportunities for personal and social development
- b. Supporting planned social development
- c. Promoting maternal and child health through improved standards of living
- d. Promoting respect and dignity in intimate relationships (e.g. between husband and wife) and generally among the family members
- **e. all of the above**

4. The female reproductive system includes the following, except:
- a. Uterus
- b. Ovaries
- c. Fallopian tubes
- **d. Vas deferens**
- e. Vestibular glands
- f. All of the above

5. The male reproductive system includes the following, except:
- a. Prostate gland
- **b. Vestibule**
- c. Penis
- d. All of the above
- e. Scrotum

6. The following are modern family planning methods, except:
- a. Intra uterine device
- b. Implanon
- c. Emergency contraceptive pills
- **d. Coitus interruptus**
- e. Injectables

7. History taking in family planning helps to achieve the following purposes, except:
- a. Identifying contraindication to method use
- b. Providing baseline information about the client
- c. Improving client-provider interaction

d. Providing guidance for providers to explain why a method may not be clinically suitable under certain circumstances
e. Satisfying provider's curiosity about a client's personal matters

8. Clients' rights include the following, except :
a. Right to Privacy
b. Right to information
c. Right to dignity
d. Right to prescription
e. Right to informed choice

9. Quality of care in Family Planning clinics can be ensured by service providers through the following, except:
a. Timely intervention
b. Commodity stock out
c. Respecting clients' rights
d. Ensuring technical competence
e. Ensuring sound infection prevention practices

10. Infections can be controlled in Family Planning clinics through the following, except:
a. Proper disposal of sharps
b. Proper hand washing
c. Proper processing of instruments and storage
d. Using torn gloves
e. Regular cleaning

11. Family Planning services can be integrated with the following, except:
a. Immunization services
b. Post abortion care
c. HIV and AIDS care
d. Antenatal care
e. All of the above

12. In STI/HIV/AIDS prevention, ABCD stands for (please write in full):
Abstinence
Be faithful
Correct and consistent condom use
Discuss i.e. talking openly about STI and HIV is a way of prevention

13. The term MEC in family planning means?
Medical Eligibility Criteria

1. The Social Ecology Model has four spheres of influence. Please list them:
Individual; Interpersonal & community; Institutional; Policy

APPENDIX 3: PARTICIPANT'S DAILY EVALUATION AND REFLECTION FORM

Day of course: **Date:**

1. How much did you benefit from today's sessions?

   Very much ____ Much ____ Not much ____

2. What are the most important things you learned from today's sessions? Why?

   _____

   _____

3. What action do you plan to take to apply to your work the ASK (attitudes-knowledge-skills) you learned today?

   _____

   _____

4. What should be improved for the next days? How?

   _____

   _____

   Other comments:

   _____

   _____

APPENDIX 4: PARTICIPANT'S CLINICAL TRAINING END OF COURSE EVALUATION FORM

Please do not write your name on this form.

Duration of your course (how many days):

Dates of your course:

Venue:

1. Relevance of the topics covered in regards to your needs

5 4 3 2 1

……

very relevant relevant fairly relevant not relevant no opinion

If no opinion, comment…….....

2. Organization of topics covered

5 4 3 2 1

……

very well organized fairly organized poorly organised No opinion

If no opinion, comment…….....

3. Quality of topics presented by facilitators

5 4 3 2 1

……

very well presented well presented fairly presented poorly presented no opinion

If no opinion, comment…….....

4. To what extent have the topics covered helped you to master the required skills?

5 4 3 2 1

……

very well mastered well mastered fairly well mastered poorly no opinion

If no opinion, comment…….....

5. How applicable is the new knowledge/skills gained from the course to your

professional activities and responsibilities?

5 4 3 2 1

……

very applicable fairly not no opinion
applicable applicable applicable

If no opinion, comment…….....

6. How would you rate the course duration?

5 4 3 2 1

……

too long adequate fair too short no opinion

If no opinion, comment…….....

7. How would you rate the course's organization in terms of?

	Excellent	Good	Fair	No Opinion	Poor
(a) Selection of session topics	5	4	3	2	1
(b) Training methods/techniques	5	4	3	2	1
(c) Documents support (hand out/reading materials)	5	4	3	2	1
(d) Course facilitation	5	4	3	2	1
(e) Logistics	5	4	3	2	1
(f) Venue	5	4	3	2	1
(g) Others (specify): _____	5	4	3	2	1

Comments:_____

_____

_____

_____

_____

_____

_____

Thanks!

APPENDIX 5: INDIVIDUAL ACTION PLAN FORM

Dear Participant,

You are now almost at the end of your participation in this course. We would like to give you an opportunity to think of specific actions you will take to bring your learning from this course into your work. We also hope that you will use this form as an additional tool to help you assess your performance in the future.
Thank you!

#	Specific action to be taken	Reason for selecting this action	Time – by when this action will be implemented	Indicator
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

What opportunities and resources (people, materials, management support, extra skills, etc.) do you have that will help you implement your action plan?

_____

_____

_____

What barriers might impede implementation?

_____

How will you overcome these barriers?

What resources (people, materials, management support, extra skills, etc.) will you need to complete the implementation of your action plan?

Any other comments?

References

Family Health International, 2008: How to Be Reasonably Sure a Client is Not Pregnant

Family Health International, 2008: Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives

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Family Health International, 2008: Checklist for Screening Clients Who Want to Initiate Contraceptive Implants

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Royal College of Nursing, 2006: Vaginal and pelvic examination. Guidance for nurses and midwives

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World Health Organization, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and USAID, 2007: Family Planning. A Global Handbook for Providers

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Family Planning
On-the-Job Training Curriculum

COURSE 2: CLINICAL SERVICE PROVISION TRAINING
Facilitator's Manual

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COURSE 2 CLINICAL SERVICE PROVISION TRAINING

Facilitator's Manual

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