Comprehensive FAMILY PLANNING Training Manual

Participant's Manual

March 2017

RMNCAH UN JOINT PROGRAMME

Acknowledgements

The development of this Comprehensive Family Planning Training Manual is based on the Vanuatu Reproductive, Maternal Newborn Child and Adolescent Health Policy and Implementation Strategy for 2017 -2020, Vanuatu National Family Planning Guideline 2016, Vanuatu National RH policy 2015 and the National Population Policy 2011-2020. This is the participant's manual. It can be used as a course manual during training and it can also be used from out of training by all health workers at place of work.

The manual has benefited from the contributions of many people from staffs of the Reproductive Health in the Ministry of Health, staffs at the Maternal and Child Health at Vila Central Hospital, Medical Doctors at Vila Central Hospital, Vanuatu Centre for Nursing Education, Vanuatu Family Health Association and the Health Program of the Wan Smol Bag Theatre. These individual organizations have played their role well in the development and preparation of the manual.

I would like to thank Dr. Sophaganine Ty, the Consultant for her devoted time put into the development of the manual. I also acknowledge the continuous support of the UNFPA to the Ministry of Health Vanuatu in Reproductive Health Programs and in this case the Comprehensive Family Planning Training Manual – Participants Guide. A word of thank you also to RMNCAH UN Joint Program for coordination of the development and printing of the manual. The cooperation by the UN Joint Partners for health is gratefully acknowledged.

I now take this opportunity to ask and invite the Ministry of Health to use the training manual and train as many health workers upskilling them to professionally provide FP services to meet the increasing demand that the country is now experiencing. Let us all work together and give positive Family Planning values to the health of our individual members of our families for better future.

George Taleo
Director-General
Ministry of Health

Forward

By Hon. Jerome LUDVAUNE, Minister of Health

Family Planning as a health service is already integrated into the overall reproductive health services of the Vanuatu Ministry of Health (MOH). Over the years the MOH trained its health workers to administer the different types of Family Planning methods available to female and male users in the reproductive age groups at all health facilities across the country covering hospitals, health centres, dispensaries and even at aid posts where condoms are accessed.

The current MOH workforce showed that the Vanuatu MOH does not have adequate trained FP health personnel in its workforce. The health workers who were trained are aging and are in the process of exiting the workforce. The lack of sufficient health personnel trained in FP meant that all nurses especially in the province and community managing health centres and dispensaries have to be trained in FP methods. A trained FP health personnel managing a rural facility would be able to provide FP services to the people within the facility catchment. This will help to increase coverage as well as reach out more into areas that are difficult to reach.

This Comprehensive Family Planning Training Manual is yet another milestone for the MOH. It is designed to help health workers address Family Planning issues in the country. The training that it offers covers health professionals from hospital setting right down to dispensary level. The manual is designed in such a way that it is interactive and enables a positive learning environment for teacher trainee interaction.

Family Planning services has its own challenges and although Vanuatu communities view the service differently based on the different cultures and beliefs they have, it cannot be overemphasized the fact that the future wellbeing of individual families depend on the decisions they make now. It is here that Family Planning contraceptives matters most and I would like to commend the work of UNFPA / UNJP on RMNCAH in continuing to make it possible for families to have a choice of making a decision about their family.

I would like to thank all those who have contributed in the realization of this manual. I therefore ask the MOH to use the manual well and help to address FP issues in the country thereby bringing its unmet needs of Family Planning to zero.

Hon. Jerome LUDVAUNE (MP)
Minister of Health
Vanuatu

ACRONYMS

ARI	Acute respiratory infections
ARV	Antiretroviral
CPR	Contraceptive prevalence rate
CYP	Couple-years of Protection
COC	Combined oral contraceptive
ECPs	Emergency contraceptive pills
FSH	Follicle Stimulating Hormone
FP / FAB	Family planning / Fertility awareness based
GnRH	Gonadotropin-releasing hormone
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
IMR	Infant mortality rate
IUD	Intra Uterine Contraceptive Devices
ICPD	International Conference on Population and Development
IEC	Information education and communication
KPAs	Key Policy Areas
LH	Luteinizing hormone
MDG / MOH	Millennium Development Goal / Ministry of Health
MMR	Maternal mortality rate
POPs	Progestogen-only Pills
PID	Pelvic inflammatory disease
POI	Progestogen-only injectable
RH	Reproductive Health
STI	Sexually transmitted infection
SRH / SRHR	Sexual reproductive health / Sexual reproductive health rights
TB / TT	Tuberculosis / Tetanus toxoid
UNFPA / UN	United Nations Population Fund / United Nations
WHO	World Health Organization

Contents

How to use this manual

This manual is designed for training health professionals (family doctors and nurses) from the hospital and primary health care level in the provision of Family Planning services.

The concept of the manual is designed for an interactive working style, with active involvement of the trainees in the learning process.
This manual offer to participants the model to be followed during the training workshop, in order to follows the training activities, so that they could acquire the necessary knowledge, abilities and skills for providing quality, client-focused family planning services.

At the end of the workshop, participants will be able to provide general and specific counselling for contraception; to initiate, monitor and evaluate the use of contraceptives by their clients and to correctly manage the contraceptives supplies.

The manual contains three parts:
Part 1: Guidelines for the MoH Program Management of Family Planning including Policy environment.
Part 2: The FP guidelines for client services and facility/clinic management.

- Reproductive Health and over view of Family Planning
- Male's reproductive anatomy and physiology
- Female's reproductive anatomy and physiology
- Client counselling and sexual health promotion
- Fertility and fertility awareness
- Contraception
- Sexual transmitted diseases (including HIV) and their consequences on reproductive and sexual health
- Legal and ethical issues

Part 3: The evaluation criteria and monitoring components.

Each session contains:

- **Objectives of the session** – contains necessary technical information for conducting the activities of each session.
- **Flipcharts/Overheads** – contain necessary information for conducting a specific activity.
- **Participant's Material/Handouts –** will be distributed during the workshop, linked to different activities

This manual need to be used with:

- Family Planning Trainer's manual-2016;
- Vanuatu National Family Planning Guideline 2016;
- Vanuatu National RH policy 2015;
- National Population Policy 2011-2020

PART 1: Guidelines for the MoH Program Management of Family Planning including Policy environment

Objectives of the session:

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

- Understand the link between Sexual Reproductive Health and Family Planning
- Understand Key Policy Areas (KPAs) for Reproductive Health in Vanuatu
- Understand the policy environment related to FP in Vanuatu

Flipcharts/Diagrams:

Millennium Development Goals (MDGs)

Sustainable Development Goals

Source: http://www.un.org/sustainabledevelopment/sustainable-development-goals/

Policies:

Health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society. (WHO, 2016)

A policy is used by a government, business or political party in order to influence or help determine the course of action that an organization takes in certain situations

Link between policy and strategy **Policy:** - Guidance - Policy is defined as a definite course of action. - Policies tend to be a requirement dictated by a higher order **Strategy:** - Strategy decision, putting policy in to affect - Strategy is an educated method or a series of plans dedicated to a specific result. - Strategies may be used in an attempt to follow a policy	

Participant's Material/Handouts:

GLOBAL DIRECTION

Every individual has the right to make their own choices about their sexual and reproductive health.

To maintain their own right for sexual and reproductive health, people need access to accurate information and the safe, effective, affordable and acceptable contraception method of their choice. They must be informed and empowered to protect themselves from sexually transmitted infections. Individuals, particularly women, must have access to services that can help them have a fit pregnancy, safe delivery and healthy baby.

At the global level, Reproductive rights and **sexual and reproductive health (SRH) framework** has been developed to provide overall guidance to response for implementing the Reproductive Health and Rights elements of the UNFPA Strategic plan 2008-2011. The framework builds on the goals of the **International Conference on Population and Development (ICPD),** 1994; the Millennium Summit, 2000, with its adoption of the **Millennium Development Goals (MDGs);** the 2005 World Summit; and the addition, in 2007, of the goal of universal access to reproductive health to MDG 5, for improving maternal health.

On September 25th 2015, countries adopted a set of goals to end poverty, protect the planet, and ensure prosperity for all as part of a new Sustainable Development Agenda which comprised of 17 goals. Each goal has specific targets to be achieved over the next 15 years.

The 17 STG's goals are: (Mark H, 2015)

	17 Sustainable Development Goals
Goal 1	End poverty in all its forms everywhere
Goal 2	End hunger, achieve food security and improved nutrition and promote sustainable agriculture
Goal 3	Ensure healthy lives and promote well-being for all at all ages
Goal 4	Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
Goal 5	Achieve gender equality and empower all women and girls
Goal 6	Ensure availability and sustainable management of water and sanitation for all

Goal 7	Ensure access to affordable, reliable, sustainable and modern energy for all
Goal 8	Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all
Goal 9	Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation
Goal 10	Reduce inequality within and among countries
Goal 11	Make cities and human settlements inclusive, safe, resilient and sustainable
Goal 12	Ensure sustainable consumption and production patterns
Goal 13	Take urgent action to combat climate change and its impacts*
Goal 14	Conserve and sustainably use the oceans, seas and marine resources for sustainable development
Goal 15	Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss
Goal 16	Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
Goal 17	Strengthen the means of implementation and revitalize the global partnership for sustainable development

The SRH Framework (UNFPA, 2008)

The **SRH framework** will be implemented within a set of three principles and approaches:

1. **Human rights-based approach, gender equality and cultural sensitivity**:

It's an obligation to allow everyone to understand their rights and to exercise their reproductive rights through access affordable, quality SRH services.

2. **Equity**:

The framework is applied with an equity perspective, requiring that increased attention be given to several dimensions of social disadvantage, including wealth, locality, gender, age, religion, disability and ethnic/indigenous origin.

3. **Social participation**.

It understands the human rights-based approach as a set of obligations (entitlements for citizens) of States to their citizens to allow them to exercise their reproductive rights through access to affordable, quality SRH services.

International Conference on Population and Development (**ICPD**)
The ICPD Programme of Action calls for and defines reproductive and sexual health care in the context of primary health care to include:

1. Family planning;
2. Antenatal, safe delivery and post-natal care;
3. Prevention and appropriate treatment of infertility;

International Conference on Population and Development (ICPD)

The first United Nations coordinated an ICPD met in Cairo, Egypt from 5–13 September 1994. Its resulting Program of Action is the steering document for the United Nations Population Fund (UNFPA).

The programme of Action of the ICPD in 1994 has central focus of development is human beings. It also established that increasing access to health and education, and protecting human rights, especially those of women and adolescents, including their sexual and reproductive health and rights, would ultimately secure a better social and economic future and contribute to slower population growth.

According to the official ICPD release, the conference delegates achieved consensus on the following four qualitative and quantitative goals: (UNFPA, 1995)

1. **Universal education**: Universal primary education in all countries by 2015
2. **Reduction of infant and child mortality-**
    - reduce infant and under-5 child mortality rates by one-third or to 50-70 deaths per 1000 by the year 2000.
    - By 2015 all countries should aim to achieve a rate below 35 per 1,000 live births and under-five mortality rate below 45 per 1,000.
3. **Reduction of maternal mortality**: A reduction by ½ the 1990 levels by 2000 and ½ of that by 2015
4. **Access to reproductive and sexual health services including family planning**

Twenty years later (2014), the comprehensive ICPD Beyond 2014 Review overwhelmingly supported the consensus that investing in individual human rights, capabilities and dignity – across multiple sectors and through the life course.
The Framework of Actions is organized around five pillars of development: (UN, 2014)

- Dignity and Human Rights,
- Health, Mobility and Place,
- Governance and Accountability, and
- Sustainability.

The Millennium Development Goals (MDGs)

It is a commitment by all 189 United Nations member states and at least 23 international organizations, committed to help achieve the following Millennium Development Goals by 2015:

1. To eradicate **extreme poverty** and **hunger**
2. To achieve universal **primary education**
3. To promote **gender equality and empower women**
4. To reduce **child mortality**
5. To improve **maternal health**
6. To combat **HIV/AIDS, malaria, and other diseases**
7. To ensure **environmental** sustainability
8. To develop a **global partnership for development**

VANUATU CONTEXT

In Vanuatu, the current Reproductive Health Policy (2016-2018) and accompanying Implementation Strategies have been developed to support the Government and all stakeholders within the country to work towards the full attainment of its citizens' sexual and reproductive health and rights (SRHR), with particular focus on groups such as women, girls and people with disabilities, whose limited power over their sexual and reproductive choices, and limited access to accurate information and relevant services can contribute to their vulnerability.

In addition, SRHR in Vanuatu was developed based on the human rights, embarrassed gender equality for all people particularly for women and follows seven guidance principles:

1. Human rights/SRHR;
2. Gender empowerment and equity;
3. Individual and community empowerment;
4. Engagement with males;
5. Multi-sectoral engagement and coordination;
6. Data collection and reporting to inform evidence-based, quality programming; and
7. Ensuring reproductive health in response to climate change and emergencies:

The policy directs the promotion of all aspects of SRHR, including:

- Advancement of gender equality and empowerment of women.
- Elimination of violence against women (also referred to as gender-based violence).
- Elimination of discrimination.

- Achievement of full, equal participation of women in cultural, economic, political and social life.
- Enabling of women to control their fertility

The Key Policy Areas for Reproductive health service includes:

KPA1: Safe Motherhood: antenatal, perinatal, postpartum and newborn care.
KPA2: **Family Planning.**
KPA3: Adolescent Sexual and Reproductive Health (ASRH).
KPA4: STIs, including HIV.
KPA5: Gender-based violence and sexual assault.
KPA6: Morbidities of the reproductive system: cancer, infertility, menopause and abortions.
KSA7: Reproductive Health Commodities Security.
KSA8: Child Survival and Health

PART 2: The FP guidelines for client services and facility/clinic management.

Lesson 1: Reproductive Health and over view of Family Planning

Objectives of the session:

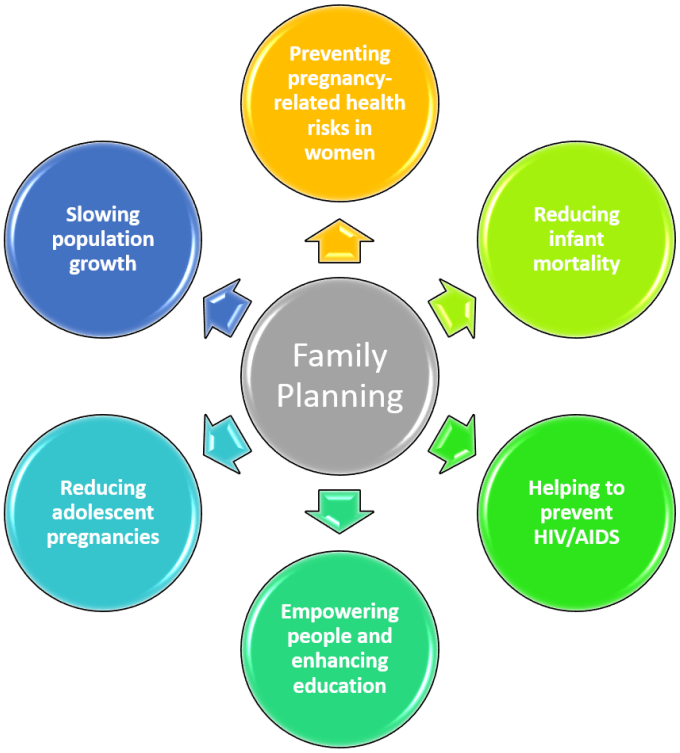
By the end of the session, the participants will be able to:

- define the concepts of Reproductive Health and Family Planning
- describe the objectives of Family Planning and services
- describe the benefits of Family Planning (for individuals, health professionals, community)

Flipcharts/Diagrams:

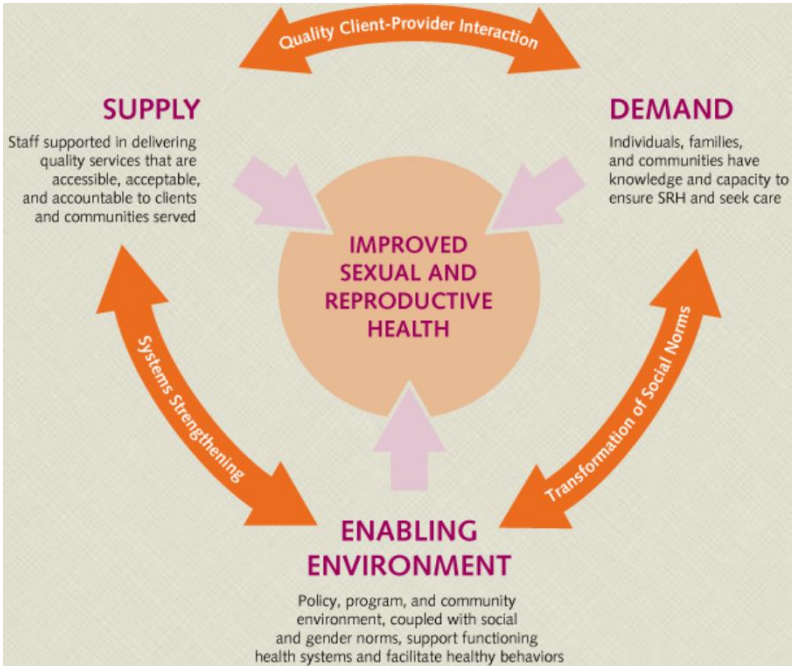
Components of Reproductive Health

Benefit of FP



Source:https://www.google.com/search?q=components+of+reproductive+health&biw=1366&bih=643&source=lnms&tbm=isch&sa=X&sqi=2&ved=0ahUKEwiqqYj656TOAhWFkpQKHVCsB-kQ_AUIBygC#imgrc=tZfBQ9Arnug7FM%3A

Improve sexual reproductive health (Engender Health, web)



Participant's Material/Handouts:

1) Definition

Reproductive Health (RH): health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. (WHO, 2016)

Sexual health- is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (WHO, 2010)

Family Planning (FP) defines the individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. (WHO, 2016)

2) The importance of reproductive health

- Reproductive health is a **crucial part of general health** and a central feature of human development. It is a reflection of health in all ages, during childhood, and crucial during adolescence and adulthood, sets the stage for health beyond the reproductive years for both women and men.

- At each stage of life **individual needs differ**. Failure to deal with RH problems at any stage in life sets the scene for later health and developmental problems.

- RH is a **universal concern**, however, is of special importance for women particularly during the reproductive years.

- **Women bear by far the greatest burden** of RH problems. Women are at risk of complications from pregnancy and childbirth; they also face risks in preventing unwanted pregnancy, suffer the complications of unsafe abortion, bear most of the burden of contraception, and are more exposed to contracting, and suffering the complications of reproductive tract infections, particularly sexually transmitted diseases (STISs).

- **Elderly and men** also have RH concerns and needs though their biological nature and general health. The involvement of men in FP and reproductive

health programs is very important audience for the services. This not only men have reproductive health concerns of their own, but their health status and behaviours also affect women's reproductive health.

- **Young people** of both sexes, are also particularly vulnerable to RH problems because of a lack of information and access to services.

- **Adolescent girls** are less likely than older women to access sexual and reproductive health care, including modern contraception and skilled assistance during pregnancy and childbirth.
    - **Complications in pregnancy and childbirth** are the leading causes of death among adolescent girls ages 15-19 in low- and middle-income countries, resulting in thousands of deaths each year. (WHO, 2012)
    - The **risk of maternal mortality** is higher for adolescent girls, especially those under age 15, compared to older women. (WHO, 2010)
- SRH reduces poverty, advances development and protects human rights: (Greene E., 2005)
    - **Reduces poverty**- Having fewer children, with more time between their births, enables families to invest more in each child's education, food and health and wellbeing of the family, especially the woman.
    - **Furthers primary education, especially for girls-** Fewer children means that families and governments can spend more per child. This is especially important for girls, whose education is often sacrificed when resources are limited.
    - **Promotes women's rights and gender equality-** In addition to supporting women to gain equal rights to make decisions, providing access to information and services; SRH empowers women to pursue opportunities of their choice and to participate in a social and economic life outside the home.

3) Why is Family Planning (FP) Important?

By enabling individuals and couples to make their own decisions about the number, spacing and timing of pregnancies. Family Planning plays an important role in helping people to benefit from educational, economic or social opportunities, and particularly to improve their health and wellbeing.

FP could provide benefits for individuals and families **Supporting Family Health and Welfare by**: (FP guideline, Vanuatu, 2015)

- Avoiding unplanned and high risk pregnancy,
- Reducing physical and emotional burden on parents,
- Avoiding disease from overcrowding, and

- Making the most of income and opportunities

1. **Avoiding unplanned and high-risk pregnancy** by reduce-

- Risk of becoming pregnant before the age of 18 years or after the age of 35 years.
- Risk of death for young children if the space between births is less than two years.
- Having more than four children increases.
- Pregnancy and childbirth in mothers with certain medical problems.

2. **Reducing physical and emotional burden on parents: -**

- FP can help individuals and parents to decide on the number, spacing and timing of their children which they can afford for.

3. **Avoiding disease from overcrowding**

- Overcrowded households which can facilitate the spread of disease such as tuberculosis (TB).

4. **Making the most of income and opportunities**

- better standard of living, more time for looking after their children and companionship.
- providing them with a better opportunity to gain a good education and employment.

4) Family Planning Services Objectives

Family planning refers to the factors that may be considered by a couple in a committed relationship and each individual involved in deciding if and when to have children.

The services objectives include:

- facilitating individual/couple to decide whether and when to have children.
- prevention of unwanted pregnancies, abortion and child abandonment.
- identifying individual's personal needs to able him/her to make an informed choice of a contraceptive method.
- ensuring correct use of the chosen contraceptive.
- prevention of sexually transmitted infections (STIs).
- prevention and early detection of cervical and breast cancer.
- maintaining/ improving the quality of couple's life.

Family planning services:

What Should Be Included in Family Planning Services?

- **Awareness** raising about FP - its purpose and available services - through IEC and Behavior Change Communication at the individual, family, community and national levels.
- Community **outreach** on FP services.
- Counselling of individuals and couples.
- **Provision of contraceptive** commodities through health facilities, community volunteers and stores.
- provision of FP information and commodities at **postnatal care**
- **screening** for STIs, breast and cervical cancers.
- **Follow-up and referrals**, including for infertility management.

Where and When Should FP Services Be Provided

- Clinic-based FP services and Community-based FP services
- Family Planning services should be provided by the most appropriately trained staff available who can provide good quality, safe care

5) Benefits of Family Planning (WHO, 2016)

1. Preventing pregnancy-related health risks in women:

- empowers woman's ability to choose if and when to become pregnant.
- allows spacing of pregnancies and can delay pregnancies.
- prevents unintended pregnancies.
- enables women who wish to limit the size of their families.
- reduces the need for unsafe abortion.

2. Reducing infant mortality

- prevent closely spaced and ill-timed pregnancies and births, which contribute to some of the world's highest infant mortality rates.

3. Helping to prevent HIV/AIDS

- reduces the risk of unintended pregnancies among women living with HIV, resulting in fewer infected babies and orphans.
- male and female condoms provide dual protection against unintended pregnancies and against STIs including HIV.

4. Empowering people and enhancing education

- enables people to make informed choices about their sexual and reproductive health.

- provide opportunity for women to pursue additional education and participate in public life.
- having smaller families allows parents to invest more in each child.

5. Reducing adolescent pregnancies

- Babies born to adolescents have higher rates of neonatal mortality which lead to long-term implications for the individuals, their families and communities.

6. Slowing population growth

- FP is a key to slowing unsustainable population growth and the resulting negative impacts on the economy, environment, and national and regional development efforts.

Lesson 2: Male reproductive anatomy and physiology

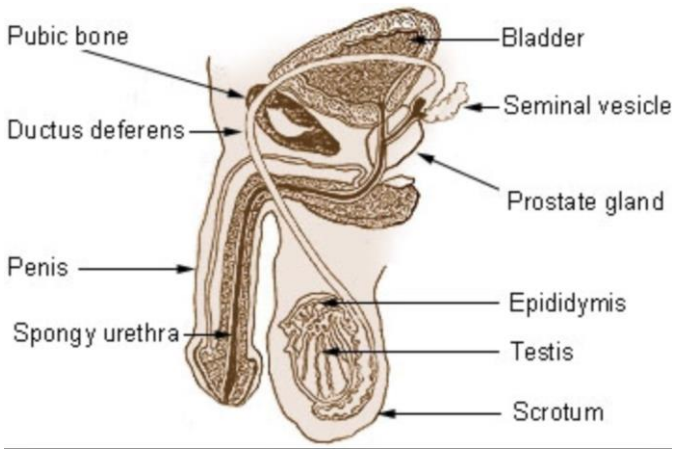
Objectives of the session:

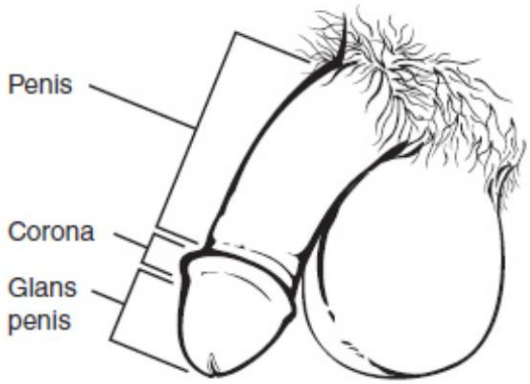
By the end of the session, the participants will be able to:

- Define and use correctly all of the **key words**
- Identify and describe the **basic anatomical features** of the male reproductive organs
- Describe the **functions** of the main anatomical structures in the male reproductive system

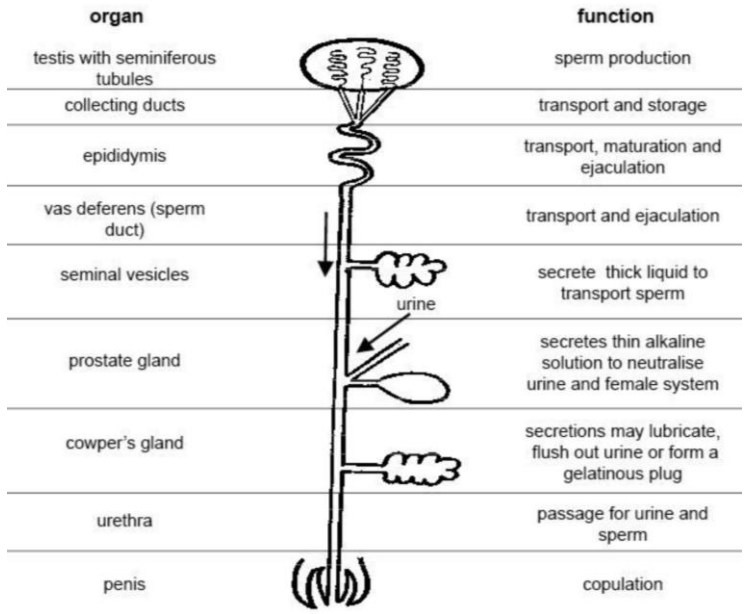
Flipcharts/Overheads:

Male Reproductive System

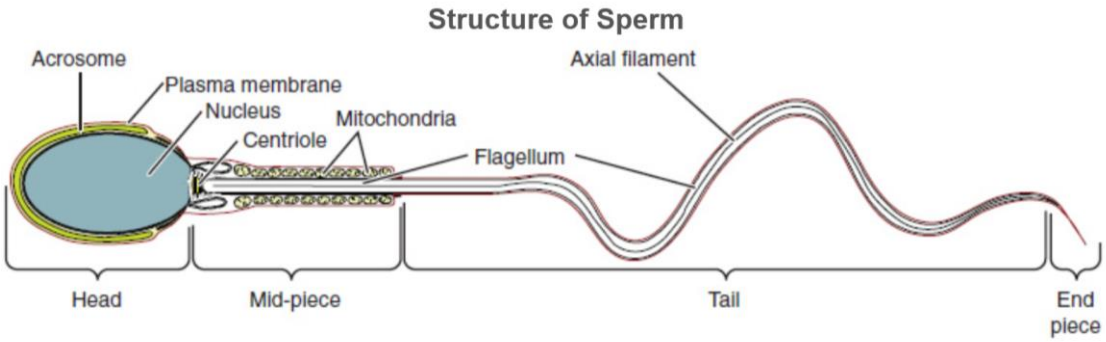




Male reproductive Health organ and it's functions (www.pinterest.com)



Sperm cells (Openstax web)



Participant's Material/Handouts:

1) Anatomy

The **male reproductive system** consists of a number of sex organs that play a role in the process of human reproduction . These organs are located on the outside of the body and within the pelvis.

External genital organ:

- **Penis**: It has a long shaft and an enlarged bulbous-shaped tip called the glans penis, which supports and is protected by the foreskin.
- **Scrotum**: is a pouch-like structure that hangs behind the penis. It holds and protects the testicles.

Internal genital organs:

- **Epididymis**: - Is a long, coiled tube attached to each testis. The epididymis collects and houses the sperm as it matures, before it moves along the vas deferens
- **Vas deferens** (also known as the sperm duct):- are the tubes approximately 30 centimeters long, joining each testicle to the seminal vesicles, Carries the spermatozoa from the epididymis to ejaculatory dust.
- **Glands**: Three accessory glands provide fluids that lubricate the duct system and nourish the sperm cells. They are the seminal vesicles, the prostate gland, and the bulbourethral glands (Cowper glands).
- **Testes**: The testes are the male gonads- that is, the male reproductive organs. The testes are each approximately 4 to 5 cm in length and are housed within the scrotum. They produce both **sperm** and **androgens**, such as testosterone, and are active throughout the reproductive lifespan of the male.

2) Hormone (Openstax web)

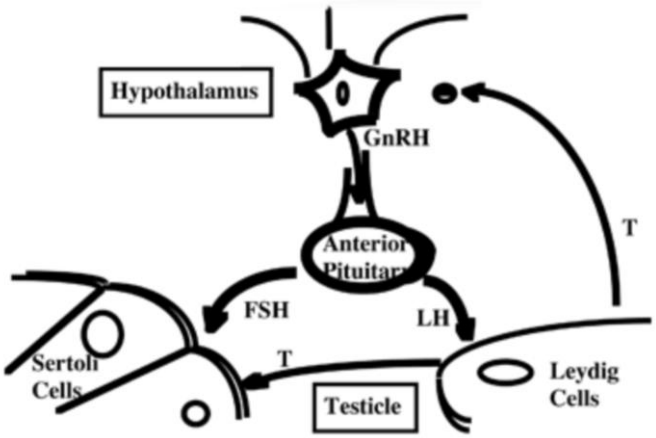
Testosterone: an androgen, is a steroid hormone produced by Leydig cells.

- In male embryos, testosterone is secreted by Leydig cells by the seventh week of development, with peak concentrations reached in the second trimester.
- This early release of testosterone results in the anatomical differentiation of the male sexual organs.
- In childhood, testosterone concentrations are low. They increase during puberty, activating characteristic physical changes and initiating spermatogenesis.
- The roles of testosterone are: - support muscle development, bone growth, the development of secondary sex characteristics, and maintaining libido (sex drive) in both males and females. In females, the ovaries secrete small amounts of testosterone, although most is converted to estradiol. A small amount of testosterone is also secreted by the adrenal glands in both sexes.

3) Sperm production

The process begins at puberty, after which time sperm are produced constantly throughout a man's life.

Sperm production is hormonally driven. Brain hormones (**hypothalamus and anterior pituitary)** govern sperm production and are precisely controlled. The male genitalia are responsible for sperm and ejaculate production. (The Turek Clinic, Web)

The hypothalamus secretes gonadotropin-releasing hormone (GnRH), which acts on the anterior pituitary gland, stimulating it to release follicle stimulating hormone (FSH) and leutinizing hormone (LH). FSH and LH are released into the bloodstream and act only on the testes to encourage spermatogenesis (action of FSH) and testosterone production by neighboring Leydig cells (action of LH) between the seminiferous tubules	**The hormone axis that controls sperm production. T=Testosterone** 

Sperm cells: - are divided into a head, containing DNA; a mid-piece, containing mitochondria; and a tail, providing motility

Sperm count:

Semen parameter	Normal Values
Total sperm count (million)	>39
Sperm concentration (million/ml)	>15
Total sperm motility (%)	>40
Progressive sperm motility	>32
Morphology (%)	>4
Vitality (%)	>58
Agglutination	Absent
White blood cells (million/ml)	<1

Source: www.myfertilityfocus.com

Lesson 3: Female's reproductive anatomy and physiology

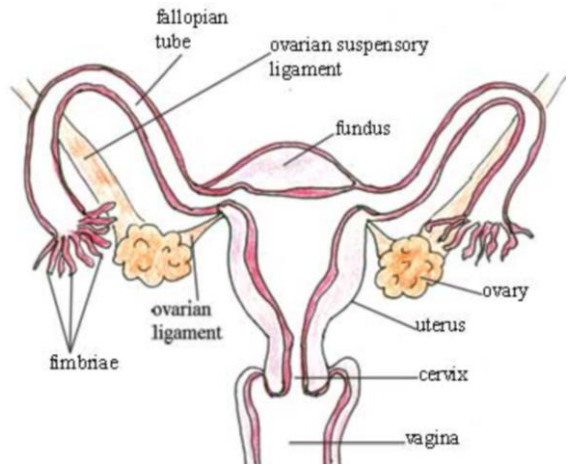
Objectives of the session:

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

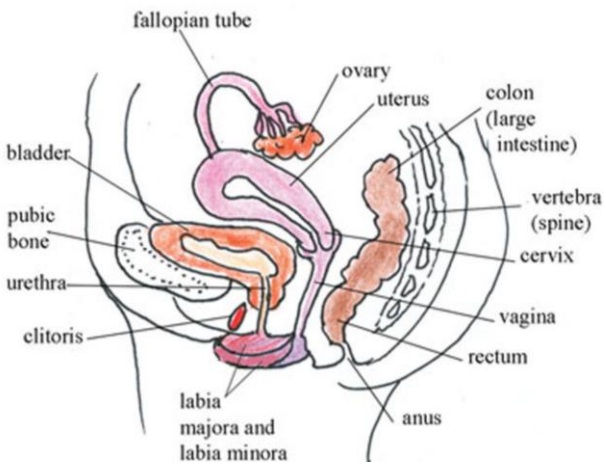
- Define and use correctly all of the **key words**
- Identify and describe the **basic anatomical features** of the external female genitalia and the internal reproductive organs
- Describe the **functions** of the main anatomical structures in the female reproductive system

Flipcharts/Overheads:

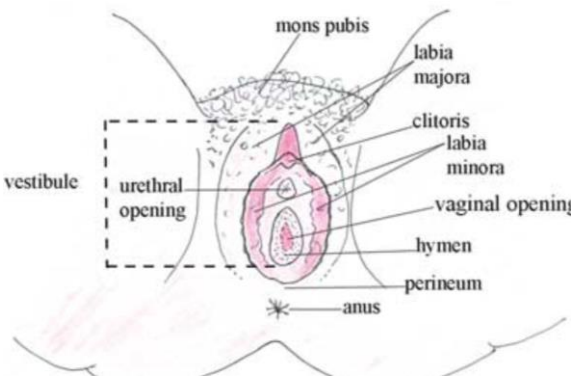
Internal female genital organs



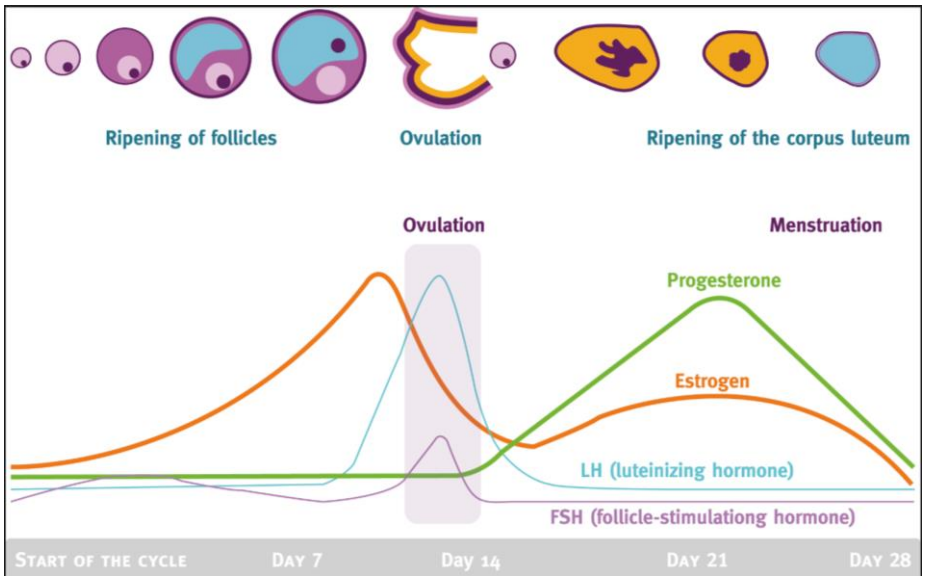
Internal female genital organs



External female genital organs



Menstrual Cycle Hormones (www.newhealthadvisor.com)



Participant's Material/Handouts:

1) Some common directional terms used in anatomy

Superior: above

Inferior: below

Medial: towards the midline of the body

Lateral: away from the midline (sides, edges)

Anterior: in front of

Posterior: behind, at the back of

2) Anatomy and physiology (The Open University, web)

The reproductive role of females is far more complex than that of males. The structure divided in to two parts: External female genitalia and internal female genitalia.

External female genitalia:

Is area which are visible externally, surrounding the **urethral** and vaginal **openings**, including the **mons pubis, labia majora, labia minora, vestibule** and **perineum.**

Structures in the external female genitalia have a nerve supply, which can respond to different sensory stimuli (touch, pain, pressure and temperature).

- **Mons pubis**: The mons pubis is a thick, hair-covered, fatty and semi-rounded area overlying the symphysis pubis.

- **Labia majora and labia minora:**
  - **labia majora** are two elongated, hair-covered, fatty skin folds that enclose and protect the other organs of the external female genitalia.
  - **labia minora** are two smaller tissue folds enclosed by the labia majora. They protect the opening of the vagina and the urethra. The labia minora normally have an elastic nature, which enables them to distend and contract during sexual activity, and labour and delivery. (The Open University, web)

- **Vestibule**: The vestibule is the area between the labia minora, and consists of the clitoris, urethral opening and the vaginal opening.
  - **Clitoris**: is a short erectile organ at the top of the vestibule, which has a very rich nerve supply and blood vessels. Its function is sexual excitation and it is very sensitive to touch
  - **urethral opening**: is the mouth or opening of the urethra
  - **vaginal opening**: is the entrance to the vagina

- **Perineum and hymen: is** the skin-covered muscular area between the vaginal opening and the anus. It has strong muscles and it helps to support the contents of the pelvic cavity.
  The hymen is a fold of thin vaginal tissue which partially covers the vaginal entrance in girls.

Internal female genitalia:

- **Fallopian tubes:** there are two fallopian tubes — one on each side of the uterus — and the finger-like ends of each tube (called the fimbriae) are close to the ovary on the same side, and open to the pelvic cavity.

- **Ovaries:** are paired female reproductive organs that produce the eggs (ova). They lie in the pelvic cavity on either side of the uterus, just below the opening of the fallopian tubes.
  The eggs are held in small 'pits' in the ovaries, named **ovarian follicles.** Every month, several ovarian follicles begin to enlarge and the ovum inside it begins to mature, but usually only one will be matured and released from the ovary. The moment when the ovum is released is called **ovulation.**

  The enlarging ovarian follicles also produce the female reproductive hormones, **oestrogen** and **progesterone**, which are important in regulating the monthly menstrual cycle, and throughout pregnancy.

- **Uterus:** is a hollow, muscular organ in which a fertilised ovum becomes embedded and develops into a foetus. Its major function is protecting and nourishing the foetus until birth.
  During pregnancy, the muscular walls of the uterus become thicker and stretch in response to increasing foetal size during the pregnancy. The uterus must also accommodate increasing amounts of **amniotic fluid** and the **placenta.**

  The uterus has four major anatomical divisions:
  - **Body**: the major portion, which is the upper two-thirds of the uterus.
  - **Fundus**: the domed area at the top of the uterus, between the junctions with the two fallopian tubes.
  - **Endometrial cavity**: the triangular space between the walls of the uterus.
  - **Cervix**: the narrow neck at the upper end of the vagina.

The wall of the uterus has three layers of tissue

- **The perimetrium:** the outermost thin membrane layer covering the uterus.
- The **myometrium**: the thick, muscular, middle layer.
- The **endometrium**: the thin, innermost layer of the uterus, which thickens during the menstrual cycle.

- **Cervix:** is the lower, narrow neck of the uterus, forming a tubular canal, which leads into the top of the vagina. It is usually about 3 to 4 cm (centimetres) long.

- **Vagina:** is a muscular passage, 8 to10 cm in length, between the cervix and the external genitalia. The secretions that lubricate the vagina come from glands in the cervix.

3) Hormones and menstrual cycle

Hormones are signalling chemicals that are produced in the body and circulate in the blood; different hormones control or regulate the activity of different cells or organs.

In The Beginning:

- The first hormone releases is the Follicle Stimulating Hormone (**FSH**) which stimulates the eggs in the ovaries to start getting ready to be released. This happens in the first week (Day 1 through 7) of the cycle.
- During the second week of your cycle (**Day 8 through 13**) the mature eggs begin to release the hormone **Estrogen.** This helps completely ripen the eggs and get them ready to be released. Estrogen will also help the lining of your uterus to become thicker in case a fertilized egg.

The Middle of your Cycle:

- Around **day 14** of your cycle, this surge of LH causes you to release an egg.
- The increased hormones also make the mucous around your cervix very thin and stretchy. This will help to "grab" the sperm and give it a ride up to your mature egg.
- The body begins to produce more estrogen and now **progesterone** that will help maintain a pregnancy if your egg becomes fertilized. The progesterone encases the lining of the uterus in mucous to help keep the egg implanted. If the egg does not get fertilized then everything will start breaking down, hormones shut down and the uterine lining gets ready to shed.

The End to the Beginning Again:

- The end of the cycle is the shedding of the uterine lining that built up. This is also the beginning of your cycle, again and starts you over at Day1.
- **Prostaglandins released**: These chemicals cause the pain during period such as cramping, backaches, headaches, etc.

Menstrual cycle: (womenheath.gov, 2014)

The **menstrual cycle** is the series of changes a woman's body goes through to prepare for a pregnancy. About once a month, the uterus grows a new lining (endometrium) to get ready for a fertilized egg. When there is no fertilized egg to start a pregnancy, the uterus sheds its lining

A cycle is counted from the first day of 1 period to the first day of the next period. The average menstrual cycle is 28 days long. Cycles can range anywhere from 21 to 35 days in adults and from 21 to 45 days in young teens.

In the **first half of the cycle**, levels of estrogen start to rise because lining of the uterus grows and thicken. This lining of the uterus is a place that will nourish the embryo if a pregnancy occurs. At the same time the lining of the uterus is growing, an egg (ovum), in one of the ovaries starts to mature. At about day 14 of an average 28-day cycle, the egg leaves the ovary. This is called ovulation.

After the **egg has left the ovary**, it travels through the fallopian tube to the uterus. Hormone levels rise and help prepare the uterine lining for pregnancy.

A **woman becomes pregnant** if the egg is fertilized by a man's sperm cell and attaches to the uterine wall. If the egg is not fertilized, it will break apart. Then, hormone levels drop, and the thickened lining of the uterus is shed during the menstrual period.

Difference range of problems with menstrual period:

Amenorrhea	The lack of a menstrual period. This term is used to describe the absence of a period. It could cause by- Pregnancy, Breastfeeding, Extreme weight loss, Eating disorder, Stress, Serious medical conditions…etc.
Dysmenorrhea	Painful periods, including severe cramps
Abnormal uterine bleeding	Vaginal bleeding that's different from normal menstrual periods. It includes - Bleeding between periods, bleeding after sex, spotting anytime in the menstrual cycle, bleeding heavier or for more days than normal or Bleeding after menopause.

Lesson 4: Client counselling and sexual health promotion

Objectives of the session:

By the end of the training in FP counselling, participants will be able to:

- Describe affective of interpersonal **communication** skills
- Identify **effective** communication
- Describe the **counseling process**
- Acknowledge the process of **decision** making and **solving problems**
- Describe the **Six Elements** of Effective Counselling
- List the **rights** of the FP client
- Family Planning Counseling Needs of Diverse Groups

Flipcharts/Overheads:

Principles of this "Decision-Making Tool" (WHO)

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

Participant's Material/Handouts:

Counselling:

The face-to-face, **personal communication in which one person helps another to make decisions** and then to act on them.

1) What is Family Planning Counselling

FP Counselling is a two-way process of communication between a health worker and client/s in which individuals and couples are able and supported to ask questions

about FP, and to receive accurate, tailored information to assist their identifying their Reproductive Health and Family Planning needs.

The aim of counselling is to support individuals and couples to overcome their fears and misapprehensions, and to make informed decisions about:

- Whether they need and/or want to use contraception.
- Their choice of a suitable contraceptive method, including how to properly use it.

Good family planning counseling- procedures have two major elements and occur when:

- **Mutual trust** is established **between client and provider.** The provider shows respect for the client and identifies and addresses her/his concerns, doubts, and fears regarding the use of contraceptive methods.
- The client and service provider give and **receive relevant, accurate, and complete information** that enables the client to make a decision about family planning.

2) Why is Family Planning Counselling is important

FP Counselling is an important method of Behaviour Change Communication, as it provides health workers an opportunity to promote to their clients:

- Better acceptance of Family Planning
- Appropriate choice of contraceptive method
- Effective use of contraceptive method
- Longer continuation
- Efficient use of staff time

3) Family Planning Counsellors.

Family Planning Counsellors.

An understanding of, and respect for clients' rights.

- A sensitive, friendly and non-judging approach which fosters openness and trust in the client/s.
- An understanding of how to facilitate discussion
- An excellent knowledge and understanding of all available FP methods.
- An appreciation of the cultural and psychological reasons which affect clients' decisions about FP.
- The ability to recognize when he/she cannot adequately help a client and so refer them to another facility

4) Interpersonal Communication Skills

Verbal Communication:

These skills enable a counsellor to effectively build a working alliance and engage clients in discussion that is both helpful and meaningful.
Clarity of speech, remaining calm and focused, being polite and following some basic rules of etiquette will all aid the process of verbal communication.

QUESTIONING

Questions during the counselling session can help to open up new areas for discussion. They can assist to pinpoint an issue and they can assist to clarify information that at first may seem ambiguous to the counsellor.

Counsellors should be knowledgeable about the different types of questioning techniques, including the appropriate use of them and likely results. It is also important to be aware and cautious of over-questioning.

Asking too many questions sends a message to the client that the counsellor is in control and may even set up a situation in which the client feels the counsellor has all the answers.

There are two main types of questions used in counselling: (1) Open and (2) Closed:

- **Open Questions** - Open questions are those that cannot be answered in a few words, they encourage the client to speak and offer an opportunity for the counsellor to gather information about the client and their concerns.
  For example:
  - Could you tell me what brings you here today?
  - Why do you think that?

- Closed Questions - Closed questions are questions that can be answered with a minimal response (often as little as "yes" or "no"). They can help the counsellor to focus the client or gain very specific information. Such questions begin with: is, are or do.
  For example:
  - Are you living alone?
  - Do you enjoy your job?

Non-verbal Communication:

Non-verbal communications include facial expressions, gestures displayed through body language and the physical distance between the communicators. These non-verbal signals can give clues and additional information and meaning over

and above verbal communication.
The comments types of Non-Verbal Communication include:

- Body Movements
- Posture
- Eye Contact
- Closeness or Personal Space
- Facial Expressions

Note: Personal Presentation and Personal Appearance are also important in Interpersonal Communication Skills

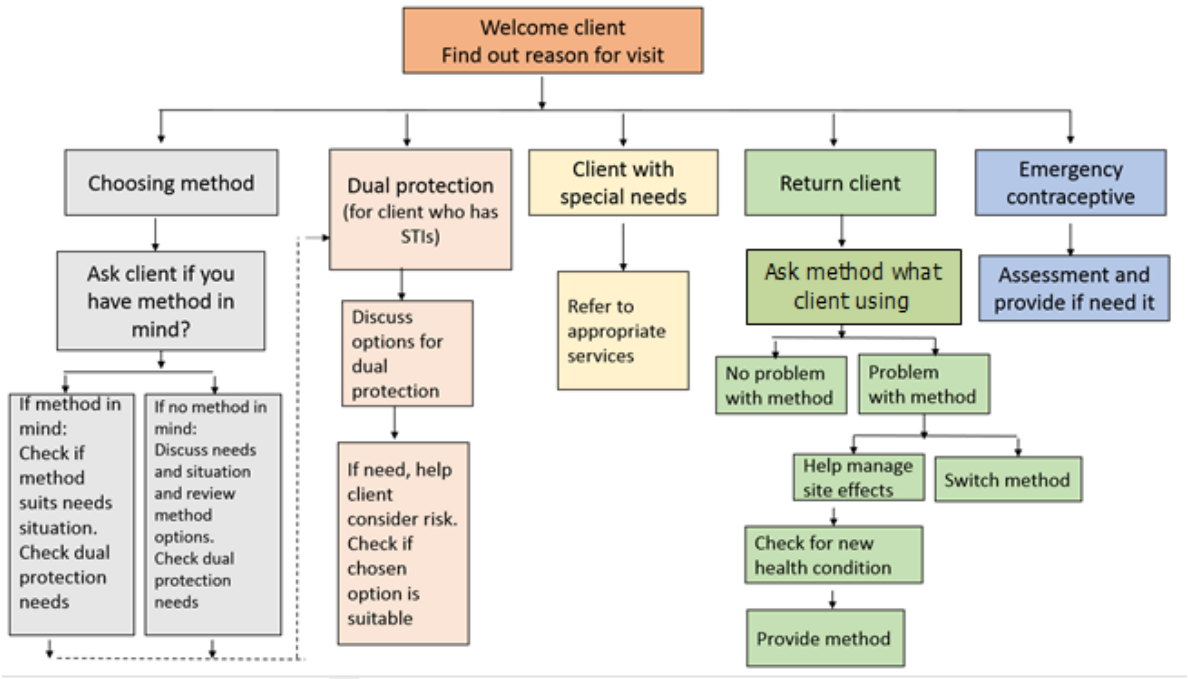
5) Six elements of effective FP Counselling

Effective Family Planning Counselling is often said to result from inclusion of the following six key elements: (GATHER)

G	Greet clients
A	Ask clients about themselves
T	Tell clients about available Family Planning methods
H	Help clients choose a Family Planning method
E	Explain how to use a method
R	Return for follow-up visit

6) Process of decision making and solving problems

The tool below encourages the provider to solicit input from the client to make the next step in the decision making or problem-solving process.



7) Types of Family Planning Counseling

General Counseling

- Usually takes place on first family planning visit
- Needs of clients discussed
- Client concerns addressed
- General information about methods/options given
- Questions answers
- Misconceptions/myths discussed
- Decision-making and method choice begins

Method-specific Counseling

- Decision-making and method choice made
- More information on method choice given
- Screening process and procedures explained
- Instructions about how and when to use method given
- What to do if there are problems discussed
- When to return for follow-up discussed
- Client should repeat back key instructions
- Client given handouts/information to take home when available

Return/Follow up counseling

- Problems and side effects discussed and managed
- Continuing use encouraged unless major problems exist

- Instructions should be repeated
- Questions answered and client concerns addressed

8) FP and client's right

Right to privacy

The rights of the client to privacy and confidentiality should be considered at all times. When a client is undergoing a physical examination it should be carried out in an environment in which her/his right to bodily privacy is respected. When receiving counseling, undergoing a physical examination, or receiving surgical contraceptive services, the client should be informed about the role of each individual inside the room.

The client's permission must be obtained before obtain the procedure.
The client should understand that s/he has the right to refuse with any procedures if they are not comfortable with.

Right to access:

Every individual or couple has the right to choose Family Planning, and to obtain and use contraceptives. As this right extends to all, a single or unmarried person or couple also have the right to access Family Planning advice and commodities

Two important elements to be considered:

- That the individual or couple's choice to use or not to use Family Panning is respected, regardless of one's own opinions.
- That the individual and couple should not be forced to use any Family Planning method against their will.

9) FP Counselling Stages Practice

Case study 1: Amina

Client Description
You are a 30-year-old married woman with four children. You want to avoid pregnancy and want a reliable method, but you are not sure which method you can use.

Case study 2: Rose

Client Description
You are a 19-year-old unmarried woman with a steady boyfriend and no children. You have come to talk with the health worker because you had unprotected sex three days ago and want help preventing pregnancy.

Case study 3:

Client Description
The client is a 15-year-old female. She attends high school in a neighboring town where she stays with her aunt and uncle. She has a sexual relationship with her teacher, who is in his mid-20's. She insists that she wants this relationship. She does not know if he has sex with other women. She does not want to get pregnant.

Case study 4:

Client Description
The client is a 35-year-old man. His wife is pregnant. He occasionally sleeps with other women, but does not say whether they are sex workers or not. He wants to use condoms with his other partners so that he does not pass an infection to his wife. You know his wife.

Case study 5:

Client Description
The client is a 28-year-old married woman who is breastfeeding a three-month-old baby, her third child. She does not want another child and wants to know how to prevent another pregnancy. She sometimes gives the baby formula.

Please refer to **Instructions for Roleplays** in annex 1

Lesson 5: Fertility and –Fertility awareness based (FAB) methods

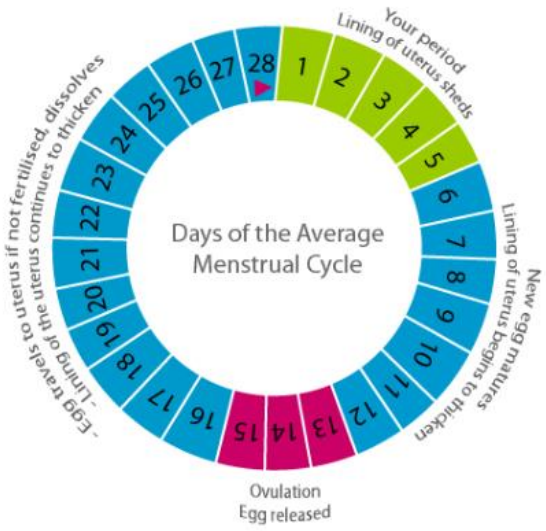
Objectives of the session:

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

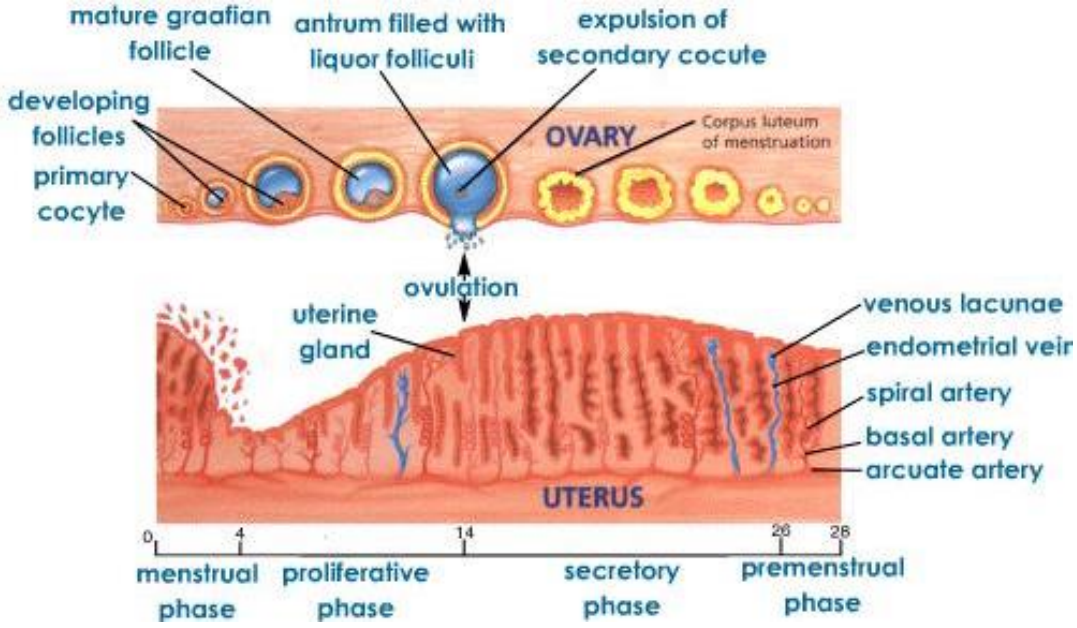
- Define fertility.
- Identify and describe the different types of **Fertility based Awareness Methods**
- Understanding the **Side Effects, Health Benefits and Health Risks**

Flipcharts/Overheads:

The menstrual cycle (www.creaconceptions.com)



Phases of Menstrual cycle (www.tutorvista.com)



Participant's Material/Handouts:

1) What Are Fertility based Awareness Methods

Fertility awareness' means the ability to know if a woman is fertile or infertile to determine if having sexual intercourse on the particular day could result in pregnancy. It can be used to:

- Understand your own menstrual cycle
- Avoid a pregnancy.
-

For this method to be effective the following are essential:

- Good communication and understanding should be present between spouses
- Sexual behaviour of couples will have to be modified.

Fertility-awareness based methods can also be used to achieve pregnancy by having intercourse during the fertile phase.

What is fertility?

Fertility is the ability of a person to bear children. It is necessary for both a man and a woman to be fertile in order for them to bear a child.

The human capacity to reproduce involves a man and a woman and their contributions in the conception of a child. A man contributes the sperm cell and the woman, an egg cell. This picture is the fertilized egg cell. At this point, the sperm cell and the egg cell have united, in the process called **fertilization**.

A mature, viable egg is the ultimate indicator of female fertility while mature, motile and adequate number of sperms is the indicator of male fertility.

Why is fertility awareness necessary?

- Allow people ability and capacity to understand and fully appreciate their fertility.
- Empowers the person to make a truly healthy, informed and responsible decision on his/her family life aspirations.

Note;

- A woman is fertile when she has the ability to become pregnant. This is signaled by the menarche, her first menstruation at around 8-12 years of age.

- A woman is fertile only on certain days of each menstrual cycle. These are the days when she can become pregnant.

2) Side Effects, Health Benefits and Health Risks of FAB

How Effective?

Effectiveness depends on the user: Risk of pregnancy is greatest when couples have sex on the fertile days without using another method.

- As commonly used, in the first year about 25 pregnancies per 100 women using periodic abstinence (how these women identified their fertile time is not known. Pregnancy rates for most of the specific fertility awareness methods as commonly used are not available.) This means that 75 of every 100 women relying on periodic abstinence will not become pregnant.
- Pregnancy rates with consistent and correct use vary for different types of fertility awareness methods
- In general, abstaining during fertile times is more effective than using another method during fertile times.

Side effect: - None

Health Benefits and Health Risks

- Health Benefits: Help protect against the risk of pregnancy
- Health Risks: None

3) How does FAB method work?

FAB work by keeping sperm out of the vagina in the days near ovulation, when a woman is most fertile, and when she is most likely to become pregnant.

For this method, women should get very familiar with their own menstrual cycle; she should know when is her fertile days-- so it can help her to avoid a pregnancy.

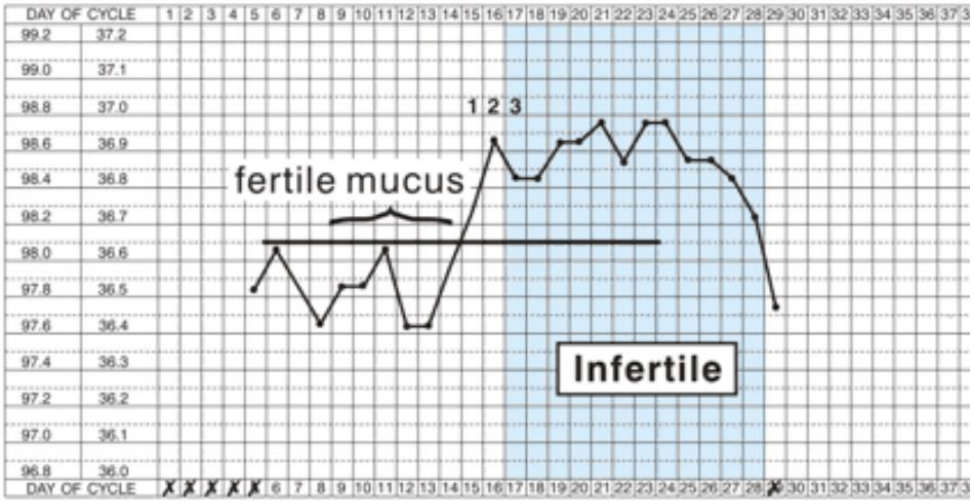
4) Types of Fertility awareness based (FAB) methods

a. Basal body temperature (BBT)

Women's body temperature is lower during the first part of your cycle. It usually rises slightly after ovulation — when an egg is released. The body temperature stays elevated for the rest of women cycle. It falls again just before your next period.

Tracking down the body temperature every day can help women know when she is ovulating. To prevent pregnancy, women should not have unprotected vaginal intercourse until three days after her ovulate each cycle.
For this method, woman is required to record their body temperature on each day and put on the chart. Below is an example of body temperature pattern in women.

The pattern of body temperature may change when women don't get enough sleep, some illness, stress, jet lag, or smoking.



b. Calendar Method (Rhythm Method)

It works best in women with regular cycles.
With the calendar method, women need to keep a record of the length of each menstrual cycle in order to determine when they are fertile.

Circle day-one of each cycle, which is the first day of your period. Count the total number of days in each cycle. Propose to do at least for eight cycles.

Chart Your Calendar Pattern

<u>Predict the first fertile day in your current cycle</u>

- Find the **shortest cycle** in your record
- Subtract 18 from the total number of days
- Count that number of days from day one of your current cycle, and mark that day with an X. Include day one when you count.
- The **day marked X is your first fertile**

Example:

- Total number of days of her short cycle is 28 days. Thus, 28 subtract 18 = 10
- Count 10 days, starting from first day of her period and mark " X" on that day
- "X" day is the first fertile day of her current cycle

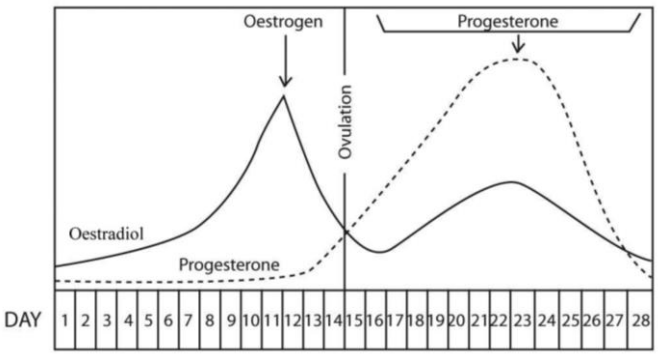
Predict the last fertile day in your current cycle

- Find the **longest cycle** in your record.
- Subtract 11 days from the total number of days.
- Count that number of days from day one of your current cycle, and mark that day with an X. Include day one when you count.
- The day marked X is the last fertile day.

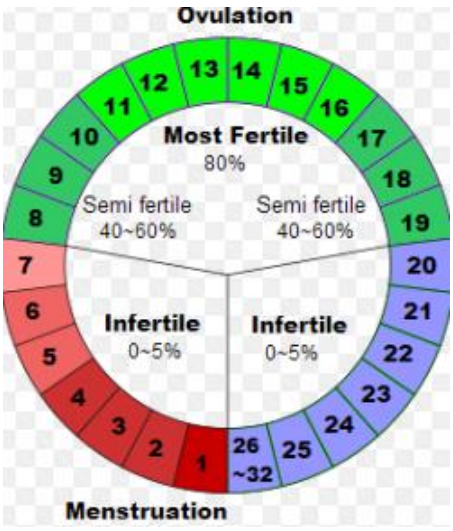
Example:

- Total number of days of her long cycle is 31. Thus, 31 subtract 11 = 20
- Count 20 days, starting from first day of her period and mark " X"
- The day marked X is the last fertile day

Ovulation chart



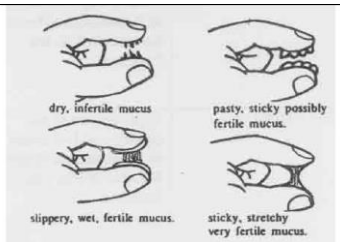
Safe period calculation method (www.gynecologist.co.in)



c. Mucus or Billing's Method

The hormones that control women cycle make the cervix produce mucus; it changes in quality and quantity just before and during ovulation. It is important that women can learn to recognize these changes.

- **After menstrual period**, there are usually a few days without mucus. These are called **"dry days**." These may be safe days if the cycle is long.
- **When an egg starts** to ripen, more mucus is produced. It appears at the opening of the vagina. It is generally yellow or white and **cloudy**. And it feels **sticky or tacky**
- Women will have the most mucus just **before ovulation**. It looks clear and feels slippery — like raw egg white. When it can be stretched between the fingers. These are the "**slippery days." It is the peak of her fertility**.
- After about four slippery days, you may suddenly have less mucus. It will become cloudy and tacky again. And then you may have a few more dry days before your period starts. These are also safe days.

Testing the mucus	**To use the Mucus Method correctly a couple must:**
	- avoid intercourse during a period - have intercourse only after checking the mucus - stop having intercourse as soon as fertile mucus is noticed and for 3 days after the fertile mucus has finished - intercourse may be re-started on the 4th day after the "peak" - any bleeding or spotting during the cycle should be considered potentially fertile and intercourse avoided.

d. Sympto-thermal Method

This method uses a combination of calendar, temperature and mucus method to work out the fertile time of the cycle. It has the advantage over using just one method in that a woman can compare symptoms and signs to better pin-point ovulation.

e. Withdrawal method

How does withdrawal method work?

Withdrawal prevents pregnancy by keeping sperm out of the vagina. Pregnancy cannot happen if there is no sperm present.

Effectiveness (Planned Parenthood, 2014)

As like other birth control methods, the pull out method is much more effective when you do it correctly.

- 4 out of 100 women will become pregnant each year if they **always** do it correctly
- 27 out of 100 women will become pregnant each year if they **don't always** do it correctly.

Benefits

Withdrawal method is simple, and convenient. Women and men like it because it can be used to prevent pregnancy when no other method is available. There are no medical or hormonal side effects. No prescription is necessary.

Advantages

- It's requires great self-control, experience, and trust
- It is not work for men who ejaculate prematurely
- is not work for the men who don't know when to pull out
- is not recommended for teens and sexually inexperienced men because it takes lots of experience before a man can be sure to know when he's going to ejaculate

f. Post-partum family planning (WHO, 2015)

All post-partum women should be counselled and provided with the family planning method they choose prior to their discharge from the birthing facility. All methods of family planning are appropriate for postpartum women, however the time for starting each method depends on a woman's breastfeeding status.

Return to fertility post-partum

The period of infertility following delivery in non-breastfeeding women is usually around 6 weeks. The period of infertility for breastfeeding mothers is longer than for non- breastfeeding mothers. The return of fertility, however, is not predictable (conception can occur before the woman has signs or symptoms of the first menses). This period of temporary infertility is due to the effect of suckling which causes a surge in Prolactin thereby inhibiting ovulation. Ovulation remains disrupted or suppressed, as long as the frequency, duration and intensity of suckling are high. Ovulation in a lactating woman often naturally resumes around 6 months postpartum

Family planning for exclusively breastfeeding women

Breastfeeding women need contraceptive methods before or at the time fertility recovers during lactation. This will depend on personal and social circumstances. It is crucial that contraceptives provided for breastfeeding mothers must be safe and effective without affecting lactation and health.

Family planning for non-breastfeeding women

Although most non-breastfeeding women will resume menstrual cycles within 4 to 6 weeks after delivery, only about one-third of first cycles will be ovulatory and even fewer will result in pregnancy. In order to avoid all risk of pregnancy, however, family planning method should be started at the appropriate time.

g. Lactational Amenorrhoe Method (LAM) (WHO, 2015)

Criteria:
The clients must be meet the criteria below:

a) amenorrhoea
b) exclusive breastfeeding
c) less than 6 months postpartum

Exclusive Breastfeeding shall only be considered an effective natural method of contraception when the baby is exclusively breast-fed. This means the baby sucks from the breast on demand (day and night).

Additional FP methods:
Women shall be recommended to use additional FP to reduce the risk of accidental pregnancy, especially if the:

- mothers' periods return
- baby is also artificially fed or started on solid food
- baby is 4 months old or more

Promoting exclusive breast feeding: Exclusive and on demand breastfeeding should be encouraged for all women. It's the best method of nutrition for the baby and to promote mother-child bonding.

How does LAM method work

While a woman is continuously exclusive breastfeeding, her body does not make a hormone that is necessary for ovulation — the release of an egg from an ovary. Pregnancy cannot happen if an egg is not released. (Planned Parenthood, 2014)

Who can use LAM Method

- When the mother and baby satisfy all the necessary criteria given above
- When other methods of contraception cannot be used

Who cannot use LAM Method

- When the mother and baby cannot satisfy all the above criteria
- When the mother must not get pregnant or does not want to risk another pregnancy, immediately or in the future for medical or social reasons
- When the mother is still on certain medication such as antimetabolites, certain anticoagulants, corticosteroids, lithium, mood-altering drugs, radioactive drugs and reserpine.
- If baby have congenital malformations of the mouth, jaw or palate, newborns that are small for date or premature and need intensive neonatal care

h. Post miscarriage family planning(WHO, 2015)

Post miscarriage family planning should include the following components:

- Counselling about contraceptive needs in terms of the client's reproductive goals taking into account what is feasible in the community she lives.
- Information and counselling about all available methods, their characteristics, effectiveness and side effects
- Follow-up care
  STI risk assessment.

Post abortion care package - include

When to Start

Post- miscarriage FP services need to be initiated immediately because ovulation may occur within 2 weeks (as early as 11 days) following treatment of first trimester incomplete abortion.

At a minimum, all women receiving post-miscarriage need counselling and information to ensure they understand:

- can become pregnant again before the next menses,
- there are safe contraceptive methods to prevent or delay pregnancy, and

- where and how they can obtain FP services and methods.

Lesson 6: Contraception

Objectives of the session:

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

- Steps in decision making at a Family Planning visit
- Characterize the following contraceptive methods based on mechanism of action, effectiveness, side effects, benefits, eligibility criteria and interventions for certain problems during use;

1. Combined oral contraceptives
2. Progestin only pills
3. Injectable contraceptives
4. Hormonal implants
5. Tubal ligation and vasectomy
6. IUD
7. Barrier methods
8. Emergency contraception

Participant's Material/Handouts:

1) Steps in decision making at a Family Planning visit

Clear and concise family planning information should be given to all clients prior to the initiation of any FP methods. The providers should go through a sequence of steps to assist individual clients to reach a decision regarding a particular FP method.

The following steps are:

Step 1: Reason of visit

Client may be present at your clinic for several reasons; enquiring on FP information, post-natal or post-abortion care, recover from miscarriages, or replenish their FP.

Step 2: Determine method of preference:

- Check what the client knows and understand about the method and whether she/he needs more information to make an informed choice
- Assessing contraceptive needs, including need for confidentiality from partner
- Assessing STI protection needs
- Describing options and helping the client make a choice
- Provide appropriate counselling.

Step 3: Clinical assessment including STI/RTI assessment

- Checking the history of the client
- Performing appropriate clinical examination(s)
- Perform laboratory tests if they are needed
- Explain to the client that everyone needs to consider protection from both pregnancy and STIs such as HIV/AIDS and others

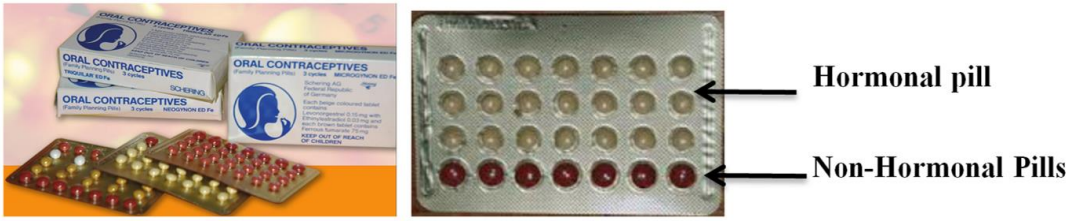
Step 4: Review medical eligibility

- There are some restrictions or contradictions in relation to certain FP methods. Therefore, evaluating the client is important to ensure the preferred method is suitable.

Step 5: Method provision

- Performing procedure/providing contraceptive method
- Instructing on the method use and follow up

2) Combined oral contraceptives (WHO, global handbook, 2015)



Key Points for Providers and clients

1. **Take one pill every day.** For greatest effectiveness a woman must take pills daily and start each new pack of pills on time.

2. **Bleeding changes are common but not harmful.** Typically, irregular bleeding for the first few months and then lighter and more regular bleeding.
3. **take any missed pill as soon as possible.** Missing pills risks pregnancy and may make some side effects worse.
4. **can be given to women at any time to start later.** If pregnancy cannot be ruled out, a provider can give her pills to take later, when her monthly bleeding begins.

a. Types of COC

In Vanuatu, the combined oral contraceptive pills are low dose monophasic (fixed concentration of estrogen and progesterone) pills and are available as 28 days' pills. The COCs are usually supplied in packs, each pack containing 3 'cards one card for each month.

In 28 days' pills one pill containing hormones (active pill) is taken every day for 21 days followed by the 7 placebo (inactive, non-hormonal) pills which are taken one pill each day on the last 7 days.

The low dose COCs commonly available in Vanuatu is Microgynon ED. It contains Ethinyl Estradiol 0.03 mgms and Levonorgestrel 0.15 mgms. The seven non hormonal pills contains ferrous fumarate 75 mgms.

b. Effectiveness and return to fertility

Effectiveness

The effectiveness depends on the user: the risk of pregnancy is greatest when a woman starts a new pill pack for 3 or more days late, or misses 3 or more pills near the beginning or end of a pill pack.

Return to fertility

When the woman stops taking the COC, her fertility returns to normal soon after stopping COC. Use of the pill does not alter a woman's capacity for normal fertile cycles. If a woman does not resume normal cycles after stopping the COC, a specific cause other than pill use should be sought.

c. Side effects

The common side effect with COC includes:

- Changes in bleeding patterns: lighter bleeding, irregular bleeding, frequent bleeding, or no monthly bleeding

- Others: - headaches, dizziness, nausea, breast tenderness, weight change, mood changes, acne (can improve or worsen, but usually improves). It's also increases blood pressure.

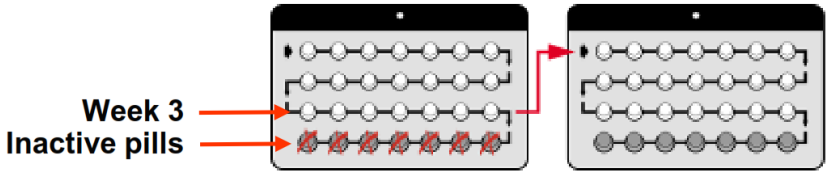
d. Instruction on how to Use the Pill

Take one pill each day

- If you miss 1 or 2 active pills in a row or start a pack 1 or 2 days late:
    - Always take a pill as soon as you remember
    - Continue to take one pill every day
    - No need for additional protection

- If you miss 3 or more active pills in a row or start a pack 3 or more days late
    - Take a pill as soon as possible, continue taking 1 pill each day, and use condoms or avoid sex for the next 7 days

- If you miss these pills in week 3, ALSO skip the inactive pills and start a new pack.*



With 21-pill packs, skip the pill-free interval and start a new pack

- **If you miss any inactive pills:** Throw away the missed pills and continue taking pills, 1 each day.
-

e. When to start pills

A woman can start COCs on any day of the menstrual cycle if it is reasonably certain that she is not pregnant. Use the pregnancy checklist or a pregnancy test as necessary.

- **If menstrual bleeding started in the past 5 days:** She can start now; no extra protection is needed.

- **If menstrual bleeding started more than 5 days ago or if she is amenorrheic (not having menstrual periods):**
    - Start pills now if reasonably certain she is not pregnant; no need to wait for the next menstrual period.
    - She should avoid sex or use condoms for 7 days after taking the first pill.

Postpartum

- If she is exclusively breastfeeding, delay pills until the infant is 6 months old or until breastfeeding is discontinued.
- If she is not exclusively breastfeeding, delay pills 3 weeks.

f. Methods for Counteracting Rumours and Misinformation

- When a client mentions with a rumor, **always listen politely. Don't laugh.**
- **Define** what a rumor or misconception is.
- **Find out where the rumor came from** and talk with the people who started it or repeated it. Check whether there is some basis for the rumor.
- Explain the **facts**.
- **Use strong scientific facts** about family planning methods to counteract misinformation.
- **Always tell the truth**. Never try to hide side effects or problems that might occur with various methods.
- **Clarify information** with the use of demonstrations and visual aids.
- **Give examples of people who are satisfied users** of the method (only if they are willing to have their names used). This kind of personal testimonial is most convincing.
- **Reassure the client** by examining her and telling her your findings.
- **Counsel** the client about all available family planning methods.
- Reassure and let the client know that you care by conducting **home visits**.

ROLE PLAY

Role Play Scenario 1: Adolescent client is interested in and is eligible for COCs

COCs Scenario 1: Client Information Sheet

Client Description

You are a 17-year-old female who has been counselled about the benefits of using family planning by a nurse at the antenatal clinic. You were pregnant but miscarried one month ago. You read the pamphlet on family planning method options that was

given to you by the provider at the clinic and have made a decision about which method you believe best suits your needs.

Offer this information *only* when the provider asks relevant questions:

- You have had a steady boyfriend for about six months.
- Your boyfriend was taking antibiotics recently after he went to see a doctor at the STI clinic.
- You do not use condoms.
- Your last period started five days ago and were very regular each month prior to the miscarriage.
- You feel healthy and have no health problems.
- You would like to have a child someday, but your boyfriend says he is not ready, so you have chosen to use COCs because you believe that COCs would best suit your needs.

COCs Scenario 1: Observer Information Sheet

Make note of whether the provider performs these case-specific tasks:

- Asks about the client's reproductive health goals, fertility intentions, and life plans
- Ensures that the client understands the contraceptive options described in the pamphlet, including emergency contraception, and has made an informed choice to use COCs
- Determines the client's medical eligibility using the COCs screening checklist
- Provides COCs, instructions on correct use, including what to do if pills are missed, and information about resupply
- Encourages her to be tested for STIs
- Explains the benefit of using condoms and offers couples counseling to support correct and consistent condom use
- Discusses benefits of healthy timing and spacing of pregnancies, noting it is best to wait until at least age 18 and at least six months after miscarriage before attempting to become pregnant

Methods for which the client is eligible:

- COCs
- DMPA or NET-EN
- Implants
- Male or female condoms

Role Play Scenario 2: Postpartum, partially breastfeeding client is interested in and is eligible for COCs

COCs Scenario 2: Client Information Sheet

Client Description

You are a 23-year-old woman and have come to the clinic because your seven-month-old baby has a mild fever. You use this visit to ask about pregnancy spacing. You do not want another child for at least two years.

Offer this information *only* when the provider asks relevant questions:

- You are interested in COCs but your husband is not in favor of the idea; he believes the pills could harm the baby through the mother's milk.
- You stopped fully breastfeeding a month ago, but you are still partially breastfeeding.
- Your monthly bleeding returned two weeks ago, and since then you have not had sex because your husband is traveling.
- You have no medical problems.
- You feel comfortable talking to your husband about contraception.

COCs Scenario 2: Observer Information Sheet

Make note of whether the provider performs these case-specific tasks:

- Asks about the client's reproductive health goals, fertility intentions, and life plans
- Ensures client understands pregnancy risk; no longer protected by LAM
- Addresses her husband's concern; provides information about COCs and breastfeeding and corrects misunderstandings
- Confirms eligibility for COCs using the checklist
- Provides COCs, instructions on correct use, including what to do if pills are missed, and information about resupply
- Offers couples counseling, particularly if the husband needs further reassurance about the safety of COCs

Methods for which the client is eligible:

- COCs
- Injectables(DMPA or Depo)
- Injectable Noristerate/
- Implants(Jadelles Implano)
- IUD
- Male or female condoms

Role Play Scenario 3: Client requires management of COC side effects and review of instructions for missed pills

COCs Scenario 3: Client Information Sheet

Client Description

You are a 20-year-old woman who has never been pregnant. A month ago you purchased COCs from a nearby pharmacy. You have been taking the pills every day for one month but have been experiencing nausea and spotting. When you told your friend about this, she suggested that you stop taking the pills because you might be pregnant. You stopped taking the pills two days ago and have come to the clinic to see if you are pregnant.

Offer this information *only* when the provider asks relevant questions:

- You are in school and do not want to become pregnant for at least two years.
- You last had sex nine days ago, but you were taking the pills.
- You do not think that you are pregnant, but you are concerned about the nausea and spotting.
- You were taking the pill in the morning before school or after class in the late afternoon.
- The two pills that you skipped were the brown ones in the last row.
- You have experienced mild nausea, but no vomiting.
- You have no health problems.

COCs Scenario 2: Observer Information Sheet

Make note of whether the provider performs these case-specific tasks:

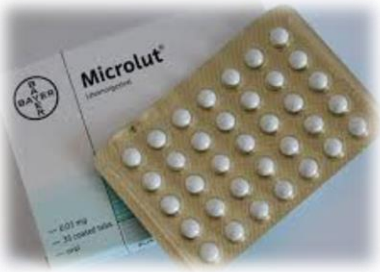
- Asks about the client's reproductive health goals, fertility intentions, and life plans
- Assesses the risk of pregnancy and rules it out based on the fact that the client took all active (hormonal) pills consistently and correctly.
- Discusses common COC side effects, particularly during the first few months, and offers reassurance
- Recommends taking the pills with meals or before bed to reduce nausea symptoms
- Suggests taking the pills at the same time each day to reduce spotting
- Provides missed pill information: instructs client to throw away the two inactive pills that she missed and take the next pill in her pack today
- Offers resupply or encourages the client to purchase a new pack of pills ahead of time
- Reviews the benefits of using condoms (dual protection) to prevent HIV/STIs

Methods for which the client is eligible:

- COCs
- DMPA orDepo/NET-EN

- Implants(Jadelle/Implano
- IUD
- Male or female condoms

3) Progesterone only pills



Progesterone-only Pills (POPs) are oestrogen-free oral contraceptives containing a low dose of progesterone. Progesterone-only pills are also referred to as 'minipills'. POP are good for breast feeding women and can also be taken by non-breast feeding women.

Key Points for Providers and clients

1. Take one pill every day. No breaks between packs
2. Safe for breastfeeding women and their babies
3. Bleeding changes are common but not harmful
4. Can be given to a woman at any time to start later (If pregnancy cannot be ruled out a provider can give her pills to take later, when her monthly bleeding begins)

a. Types of progesterone-only pills (POPs)

Progesterone -only pills available in Vanuatu is Microlut each pill containing active substance i.e. levonorgestrol 0.03 mgms. Each pack has 3 strips/ cycles each strip has 35 tablets.

b. Effectiveness and return to fertility

Effectiveness

Effectiveness depends on the user: For women who have monthly bleeding, risk of pregnancy is greatest if pills are taken late or missed completely.

- For breast feeding women: when the pills are taken correctly, there are 3 pregnancies per 1000 women using POPs over the first year
- For non-breast feeding women: POP is less effective. When the pills are taken correctly, there are 9 pregnancies per 1000 women using POPs over the first year

Return to Fertility

When the woman stops taking the POP, her fertility returns to normal soon after stopping POP. Use of the pill does not alter a woman's capacity for normal fertile cycles. If a woman does not resume normal cycles after stopping the POP, a specific cause other than pill use should be sought.

c. Side effects

The possible side effects are:

- Changes in bleeding patterns including: longer delay in return of monthly bleeding after childbirth for breastfeeding women, frequent bleeding, irregular bleeding, infrequent bleeding, prolonged bleeding, no monthly bleeding.
- Other side effect includes: headache, dizziness, mood changes, breast tenderness, abdominal pain, and nausea.

d. Instruction on how to Use the Pill

Start the pill at any time in their menstrual cycle

e. When to start

A woman can start using POPs any time she wants if pregnancy can be ruled out.

Fully or nearly fully breastfeeding Less than 6 months after giving birth	- Can start 6 weeks after giving birth - If her monthly bleeding has not returned: - start POPs any time between 6 weeks and 6 months. **NO** need for a backup method. - If her monthly bleeding has returned: - start POPs as advised for women having menstrual cycles
More than 6 months after giving birth	- If her monthly bleeding has not returned: - can start POPs any time if pregnancy can be ruled out. **Plus**-backup method for first 2 days. - If her monthly bleeding has returned: - start POPs as advised for women having menstrual cycles
Partially breastfeeding	
Less than 6 months after giving birth	- Start taking POP 6 weeks after giving birth - If her monthly bleeding returns: - give her a backup method to use until 6 weeks since giving birth
More than 6 months	- If her monthly bleeding has not returned: - Can start

after giving birth	POPs any time if pregnancy can be ruled out, **Plus**- need backup method for first 2 days.
Not breastfeeding Less than 6 months after giving birth More than 6 months after giving birth	- Can start POPs at any time, **NO** need for a backup method - If her monthly bleeding has not returned: - Can start POPs any time if pregnancy can be ruled out, **Plus**- backup method for first 2 days - If her monthly bleeding has returned: - start POPs as advised for women having menstrual cycles.
Switching from a hormonal method	- Immediately, if she has been using the hormonal method consistently and correctly - If she is switching from injectable: - Can begin taking POPs when the repeat injection would have been given. **NO** need for a backup method.
Having menstrual cycles or switching from a non-hormonal method	- At any time - If start POPs within 5 days after her monthly bleeding:- **NO** need for a backup method - If start POPs more than 5 days after her monthly bleeding: - needs a backup method for first 2 days. - If she is switching from an IUD,: - she can start POPs immediately
No monthly bleeding (not related to childbirth or breastfeeding)	- Can start POPs any time if pregnancy can be ruled out, **Plus**- need a backup method for first 2 days.
After miscarriage or abortion	- Can start immediately - If she start within 7 days after 1st or 2nd trimester miscarriage or abortion, **NO** need for a backup method - If it is more than 7 days after 1st or 2nd trimester miscarriage or abortion: - start POPs any time if pregnancy can be ruled out, **Plus**- need a backup method for first 2 days
After taking emergency contraceptive pills (ECPs)	- Can start POPs the day after she finishes taking the ECPs - A new POP user should begin a new pill pack - A continuing user who needed ECPs due to pill-taking errors can continue where she left off with her current pack.

	- All women - need backup method for first 2 days.

ROLE PLAY

Role Play Scenario 1: 25 years old client is interested with POPs

POPs Scenario 1: Client Information Sheet

Client Description

You are a 25 year-old female who has been counselled about the benefits of using family planning by a nurse at the antenatal clinic. You were pregnant but miscarried one month ago. You read the pamphlet on family planning method options that was given to you by the provider at the clinic and have made a decision about which method you believe best suits your needs.

Offer this information *only* when the provider asks relevant questions:

- You have had a steady boyfriend for about six months.
- Your boyfriend was taking antibiotics recently after he went to see a doctor at the STI clinic.
- You do not use condoms.
- Your last period started five days ago and were very regular each month prior to the miscarriage.
- You feel healthy and have no health problems.
- You would like to have a child someday, but your boyfriend says he is not ready, so you have chosen to use POPs because you believe that POPs would best suit your needs.

POPs Scenario 1: Observer Information Sheet

Make note of whether the provider performs these case-specific tasks:

- Asks about the client's reproductive health goals, fertility intentions, and life plans
- Ensures that the client understands the contraceptive options described in the pamphlet, including emergency contraception, and has made an informed choice to use POPs
- Determines the client's medical eligibility using the POPs screening checklist
- Provides COCs, instructions on correct use, including what to do if pills are missed, and information about resupply
- Encourages her to be tested for STIs
- Explains the benefit of using condoms and offers couples counseling to support correct and consistent condom use
- Discusses benefits of healthy timing and spacing of pregnancies, noting it is best to wait until at least age 18 and at least six months after miscarriage before attempting to become pregnant

Methods for which the client is eligible:

- COCs
- Injectable(DMPA /Depo or NET-EN)
- Implants(Jadelle/Implano
- Male or female condoms

4) Injectable contraceptives

Key Points for Providers and client

1. **Bleeding changes are common but not harmful.** Typically, irregular bleeding for the first several months and then no monthly bleeding.
2. **Return for injections regularly.** Coming back every 3 months (13 weeks) for DMPA or every 2 months for NET-EN is important for greatest effectiveness.
3. **Gradual weight gain is common.**
4. **Return of fertility is often delayed.** It takes several months longer on average to become pregnant after stopping progestin-only injectable than after other methods.

The progestogen-only injectable (POI) contraceptives are synthetic steroid hormones resembling the female hormone progesterone. The injectable hormone is released slowly into the blood stream from the site of the injection.

a. Types of progestogen-only injectable (POI)

Currently depot-medroxyprogesterone acetate (DMPA) known as Depo-Provera® is the injectable contraceptive widely available in Vanuatu. Each dose of DMPA/Depo-Provera contains 150 mgms of medroxy progesterone acetate and is given every 3 months (12 weeks) as **deep intramuscular injection**.

Another type of Progestogen-only injectable is Norethisterone enantate (NET-EN) and each dose of NET-EN contains 200 mgms and is given every 2 months (8 weeks).

Both methods do not contain estrogen, so it can be used throughout breastfeeding and by women who cannot use methods with estrogen.

b. Effectiveness & return to fertility

The effectiveness

The effectiveness is depending on the regularity of the injection.

- The risk of pregnancy is about 3 pregnancies per 100 women using progestin-only injectables over the first year.
- If the women follow the regular schedules, the risk of pregnancy is about 3 per 1,000 women over the first year.
  Average time of return fertility is about 4 months for DMPA and 1 month for NET-EN

Return to Fertility

When a client stops taking Progestogen-only injectable (POI), it may take several months for return to fertility. The median delay in return to fertility with DMPA/ Depo-Provera is 10 months and for NET-EN (Noresthisterone- enantate)is 6 months from the date of the last injection regardless of the duration of use.

c. SIDE EFFECTS

- Changes in bleeding patterns: NET-EN affects bleeding patterns less than DMPA-
  - First 3 months: Irregular bleeding, or prolonged bleeding
  - At one year: No monthly bleeding, infrequent bleeding, or irregular bleeding
- Other side effects: weight gain, headaches, dizziness, abdominal bloating and discomfort, mood change, or less sex drive.

d. When to start

Fully or nearly fully breastfeeding Less than 6 months after giving birth	- Can give injection at 6 weeks after birth - If monthly bleeding has not returned,- can start injection at any time between 6 weeks to 6 months, **NO** need back up method - If monthly bleeding has returned, - can start injectable as advised for women having menstrual cycles
More than 6 months after giving birth	- If monthly bleeding has not returned, - can start injectable at any time if pregnancy can be ruled out, **Plus** – backup method for first 7 days

	- If her monthly bleeding has returned, - can start injectable as advised for women having menstrual cycles
Partially breastfeeding Less than 6 months after giving birth	- Can give injection at 6 weeks after birth
More than 6 months after giving birth	- If monthly bleeding has not returned, - can start injectable at any time if pregnancy can be ruled out, **Plus** – backup method for first 7 days - If her monthly bleeding has returned, - can start injectable as advised for women having menstrual cycles
Not breastfeeding Less than 6 months after giving birth	- Can start injectable at any time. No need for a backup method
Less than 6 months after giving birth	- If monthly bleeding has not returned, - can start injectable any time if pregnancy can be ruled out, **Plus** – backup method for first 7 days - If her monthly bleeding has returned, - can start injectable as advised for women having menstrual cycles
No monthly bleeding (not related to childbirth or breastfeeding)	- Can start injectable at any time if pregnancy can be ruled out, **Plus** – backup method for first 7 days
After miscarriage or abortion	Can start immediately. - If starting injection within 7 days after first or second-trimester miscarriage or abortion, **NO** need for a backup method. - If starting injection more than 7 days after first or second trimester miscarriage or abortion: - can start injection at any time it pregnancy can be ruled out, **Plus**- backup method for first 7 days
After taking emergency contraceptive pills (ECPs)	- Can start injectable on the same day as the ECPs - If injection given within 7 days after the start of her monthly bleeding. She will need a backup method for first 7 days, and advise women to return if she has signs or symptoms of pregnancy

e. Giving the injection

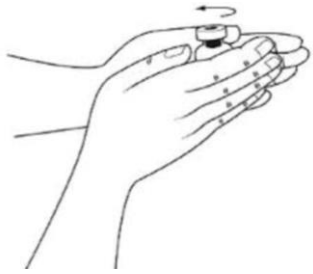
Step 1: Get one 1 dose of injectable, needle, and syringe

- DMPA: 150 mg for intramuscular injection. NET-EN: 200 mg for injections into the muscle
- Check for expiration date, and make sure that the vial is not leaking
- For DMPA: use a 2 ml syringe and a 21–23 gauge intramuscular needle
- For NET-EN: use a 2 or 5 ml syringe and a 19-gauge intramuscular needle (can also use 21-23 gauge)
- Use a disposable auto-disable syringe and needle from a new sealed package

Step 2: Wash Hands

- Wash hands with soap and water
- Wash injection site with soap and water if injection site is dirty
- No need to wipe site with antiseptic

Step 3: Prepare vial



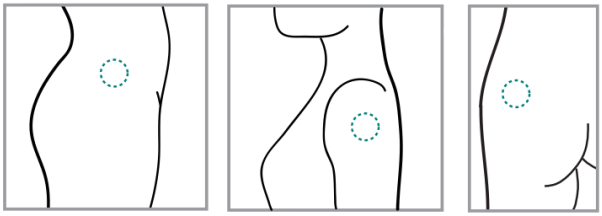
- DMPA: Gently shake the vial
- NET-EN: Shaking the vial is not necessary
- No need to wipe top of vial with antiseptic
- If vial is cold, warm to skin temperature before giving the injection.

Step 4: Fill syringe

Pierce top of vial with sterile needle and fill syringe with proper dose.

Step 5: Inject formula

- Insert sterile needle deep into the hip, or at the upper arm (deltoid muscle), or at buttocks (upper outer portion), whichever the woman prefers.
- Inject the contents of the syringe
- Do not massage injection site.



Step 6: Dispose of disposable syringes and needles safely

- Do not recap, bend, or break needles before disposal
- Place in a puncture-proof sharps container
- Do not re-use disposable syringes and needles

f. Managing for the late injection

If repeat dose late less than 4 weeks of DMPA, or less than 2 weeks of NET-EN	Can receive her next injection. No need for tests, evaluation, or a backup method.
If repeat dose late more than 4 weeks of DMPA, or more than 2 weeks of NET-EN	Can receive her next injection if: - has not had sex since 2 weeks after her last injection, or - used a backup method or has taken ECPs after any unprotected sex since 2 weeks after her last injection, or - fully or nearly fully breastfeeding and she gave birth less than 6 months ago **Plus -** need a backup method for first 7 days after the injection

g. Common site affects

- No monthly bleeding
- Irregular bleeding
- Weight gain
- Abdominal bloating and discomfort
- Heavy or prolonged bleeding
- Ordinary headaches
- Mood changes or changes in sex drive
- Dizziness

CASE STUDY

Case Study 1

Leiwia is a 20-year-old mother of a two-month-old infant. Leiwia has heard that spacing children about three years apart is good for her health and for her family's well-being. Many of her friends are using Depo and say it is a simple, good, affordable method. She has come to the clinic with her husband to learn more about it.

Question Set A

During the session, Leiwia asks several questions about Depo, and also says she is concerned about the side effects she's heard about, especially not having monthly bleeding. She thinks that if she does not have monthly bleeding, blood will build up inside her body.

1. What key information about injectable would you want to make sure that Leiwia understands?
2. What are the advantages of progestin-only injectable? (List at least four)
3. What are the limitations of progestin-only injectable?
4. How would you respond to Leiwia concern about not having monthly bleeding?
5. What other information would you offer Leiwia?

Question Set B

After counselling on long acting methods as well as injectable, Leiwia makes an informed decision to use injectable. Earlier in the session, you learned that Leiwia is eight weeks postpartum, has been exclusively breastfeeding her infant and her menses have not yet returned. She plans to start weaning the baby and begin using formula when she returns to work in one month. She has no health problems.

1. What tool might you use to help screen for medical eligibility?

2. Does Lewis's current situation affect her eligibility for Depo and/or NET-EN /Noris use? Why or why not?
3. Can Leiwia initiate injectable immediately? Does she need to use a backup method?

Question Set C

You determine Leiwia is eligible for injectable contraceptives and you provide her first injection of DMPA on March 19, 2010.

1. What information do you tell Leiwia after giving her the injection?
2. What is the date for her reinjection visit?
3. What is the reinjection window during which Leiwia may return for reinjection and still be protected from pregnancy?
4. What should she do if she is late for her next injection?
5. What can she expect regarding side effects and what do you tell her about how to manage them?

Question Set D

Leiwia returns to the clinic on July 15 for reinjection. During the session she complains that she has experienced prolonged bleeding and spells of dizziness over the past two or three months.

1. Is Leiwia eligible to receive her reinjection today? Why or why not?
2. How will you address her concerns about side effects?
3. What will you discuss regarding Leiwia's lateness for reinjection?

5) Hormonal implants

Key messages

- Implants are small flexible capsules that are placed just under the skin of the upper arm
- It provides long-term pregnancy protection
- Need specifically trained skill provider to insert and remove
- Less work for client once implants are in place
- Changing bleeding pattern is comment, but is not harmful

a. Types of implants

Jadelle is the hormonal implant that is available in Vanuatu. Jadelle has two rods with outer sheaths made of silicon, each rod measures 2.5mm in diameter and 43 mm in length and contains 75mg of levonorgestrel (total 150mgms). Protection from

pregnancy is provided within 24 hours when inserted during the first 7 days of a woman's menstrual cycle. Jadelle can be left in place for up to 5 completed years.

Jadelle It's 2 rods, effective for 5 years	**Implanon** 1 rod, effective for 3 years
	

b. Effectiveness and return to fertility

The effectiveness

Implants is one of the most effective and long-lasting family planning methods.

- Less than 1 pregnancy per 100 women using implants over the first year.
- Jadelle and implanon start to lose effectiveness sooner for heavier women.

Return to Fertility

When the rods are removed, the return of fertility is immediate; if the client does not want another pregnancy and does not want to use implants any longer, she should begin using another contraceptive method right away.

c. Side effects

Changes in bleeding patterns:

- First several months: lighter bleeding, irregular bleeding, infrequent bleeding, or no monthly bleeding.
- After about one year: lighter bleeding, irregular bleeding, or infrequent bleeding.

Other side effects: headaches, abdominal pain, acne, weight change, breast tenderness, dizziness, mood changes, nausea

d. Who can use progestin-only implants

Women of any parity or reproductive age, married or unmarried, who:

- Want to use this method of contraception
- Have no known conditions that preclude safe use (such conditions are rare)

e. Who should not initiate progesterone-only implants

- Women who have the following known conditions:
- Exclusive breastfeeding while less than six weeks postpartum
- Acute deep venous thrombosis (unless on established anticoagulant therapy)
- Unexplained vaginal bleeding (before evaluation)
- History of or current breast cancer
- Severe cirrhosis; malignant liver tumors; or benign liver tumors, with the exception of
- focal nodular hyperplasia (which is a tumor that consists of scar tissue and normal liver cells)

f. Use of progesterone-only implants by women with HIV and AIDS

Women with HIV and AIDS who do not take antiretroviral drugs (ARVs) can use progesterone-only implants without restrictions. Women with AIDS who take antiretroviral drugs (ARVs) can generally use progesterone-only implants, since the effectiveness of implants seems not to be significantly affected by ARVs.

g. Provide follow-up and counseling for

- Any client concerns or questions
- Side effects, especially irregular bleeding or spotting or amenorrhea
- Any signs of complications (although rare), counsel the woman to come back immediately if any of the following symptoms develop:
    - infection at the insertion site
    - very bad headaches that start or become worse after initiation
    - unusually heavy or prolonged bleeding
    - severe pain in the lower abdomen (symptom of ectopic pregnancy)
    - unusually yellow skin or eyes

Explain to the client that implants can be removed any time for any reason.

h. Dispelling myths regarding progesterone-only implants

Progesterone-only implants **do not:**

- Break and move around within a woman's body
- Cause birth defects
- Cause cancer

i. Implants are convenient, safe and effective for adolescents

- According to the World Health Organization implants are safe and suitable for ne arly all women, including adolescents. (WHO, 2007)

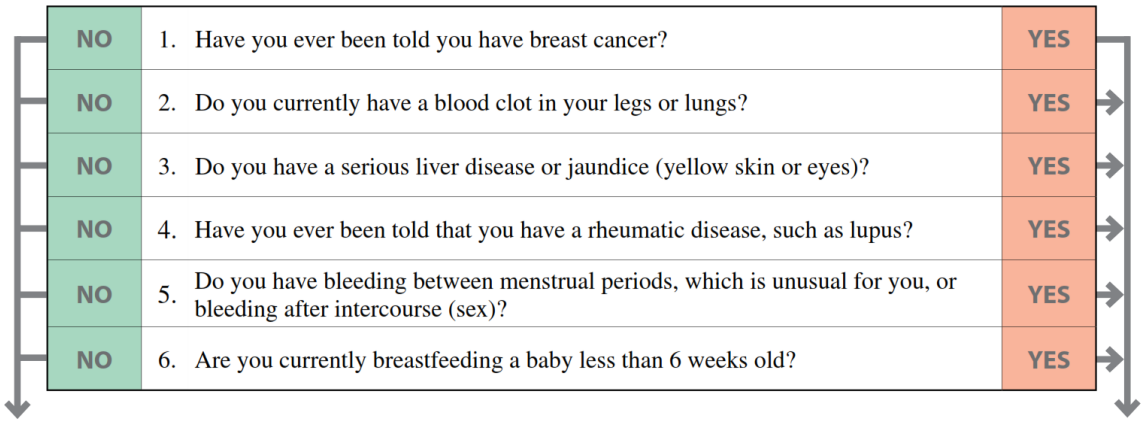
- The implant is effective for three years, and young women who want to become pregnant, fertility return immediately once the rods are removed
- The implant is discreet and easy to use. Unlike pills and condoms, the implant does not depend on the regular compliance of the user.
- Adolescents are less likely to have certain medical conditions that preclude them from using the implant (i.e. deep vein thrombosis, liver tumors and breast cancers) (WHO, 2004)

The implant can help delay the first pregnancy among adolescents.

- Compared to women in their twenties, teens are twice as likely to die from child birth related causes and their babies face a 50% higher risk of dying before the age of 1 years old. (ESD, web)
- Health experts recommend that young women delay their first pregnancy until at least age 18, when the risk of adverse outcomes for mother and baby are reduced. (UNICEF, 2006)

j. Checklist for Screening Clients Who Want to Initiate Contraceptive Implant (UNAID; FHI, 2008)

To determine if the client is medically eligible to use implants, ask questions 1–6. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions after question 6.



If the client answered **NO** to ***all of questions 1–6,*** she can use implants. Proceed to questions 7–12.

If the client answered **YES** to ***question 1,*** she is not a good candidate for implants. Counsel about other available methods or refer.

If the client answered **YES** to ***any of questions 2–5,*** implants cannot be initiated without further evaluation. Evaluate or refer as appropriate, and give condoms to use in the meantime. See explanations for more instructions.

If the client answered **YES** to ***question 6,*** instruct her to return for implant insertion as soon as possible after the baby is six weeks old.

k. Implant Checklist for Providers

Before inserting the implant

- We offer a **variety of contraceptive methods**, and you can choose the one you want.
- It will **hurt** a bit to get the implant inserted and probably a bit more to get it removed.
- The implant will **change your bleeding pattern**
- The insertion and removal procedures may **bruise** your arm and leave a small visible scar.

Getting Ready

- Have the client **wash her entire arm** and hand with soap and water, and dry with clean towel or air-dry
- **Cover** the procedure table and arm support with a clean cloth.
- Ask the **client to lie on her back** on the table so that the arm in which the implants will be placed is turned outwards and bent at the elbow and is well supported.
- Prepare a **clean instrument** tray

Before Insertion

- **Wash hands thoroughly** with antiseptic soap and water and dry with clean towel or air-dry.
- Put **sterile gloves** on both hands before each procedure.
- **Clean the insertion** site with a cotton or gauze swab soaked in antiseptic solution.
- Use **sterile surgical drape** with a hole in it to cover the arm. If sterile drape is not available, use a clean drape **or linen** that has been washed, dried, ironed, and stored in a clean closet.
- When **giving local anesthetic**, use a new disposable syringe and needle,

During Insertion

- Make sure that the ends of the rods nearest to the incision are not too close (not less than 5 mm) to the incision. If the tip of the rod protrudes from or is too close to the incision, it should be carefully removed and reinserted in the proper position.
- While inserting the implants, try not to remove the trocar from the incision. Keeping the trocar in place minimizes tissue trauma, decreases the chances of infection, and minimizes insertion time.

After Insertion

- Press down on the incision with gauze for a minute or so to stop any bleeding, and then clean the area around the insertion site with antiseptic solution on a swab.
- Use an adhesive bandage or surgical tape with sterile cotton to cover the insertion site. Check for any bleeding.
- Dispose of contaminated objects (gauze, cotton…etc.)
- Decontaminate all surfaces that could have been contaminated by blood
- Wash hands with soap and water and dry with clean towel or air-dry

CASE STUDES:

Scenario 1:
Your client is a healthy 24-year-old woman who gave birth to her first child five months ago. She has been Exclusively breastfeeding and has not had a menstrual period since giving birth She is returning to work in two weeks and will begin supplementing with formula.

Scenario 2:
Your client is a 30-year-old woman who is married, monogamous, and has three children. She has HIV but has no symptoms and has no other health problems. She has been using condoms consistently and correctly but is still concerned that she might become pregnant.

Scenario 3:
Your client is a 42-year-old woman with five children. Six months ago, she was admitted to the hospital with severe chest pain and shortness of breath. She was diagnosed with a blood clot in her lung. She is now on anticoagulant therapy (blood thinners). She has no other health problems. She has not had sex since her last menses.

ROLE PLAY

Role Play Scenario 1—Client with HIV is interested in and is eligible for implants

Scenario 1—Client Information Sheet

Client Description

You are a 29-year-old married woman with HIV. You are monogamous and have three children. You have met previously with a provider at the PMTCT clinic, have learned about different methods of contraception, and are very interested in implants.

Offer this information *only* when the provider asks relevant questions:

- You and your spouse are both HIV-positive.
- Your youngest child is two years old.
- You do not want to become pregnant again for now.
- You have been using condoms consistently and correctly.
- You worry about a condom slipping or breaking and desire a more effective method that is easy to use.
- You feel healthy, have regular menstrual cycles every four weeks, and have no other health problems.

Make note of whether the provider addresses these case-specific issues:

- Assesses the client's reproductive health goals, fertility intentions, and life plans
- Ensures that the client understood the contraceptive options described by the PMTCT provider and has made an informed choice to use implants
- Makes certain that the client understands and is willing to tolerate the potential side effects caused by use of implants
- Determines the client's medical eligibility using the implants screening checklist
- Describes implant insertion and follow-up procedures
- Explains the benefits of continuing to use condoms even though both partners are HIV-positive
- Offers couples counseling

Methods for which the client is eligible:

- Implants
- COCs
- Injectables (DMPA or NET-EN)
- IUD
- Male or female condoms
- Standard Days Method

Role Play Scenario 2—Client without children is interested in but is *not* eligible for implants

Scenario 2—Client Information Sheet

Client Description

You are a 28-year-old married woman with a busy professional career. You do not want to have children. You have been married and monogamous for over eight years. You have recently seen a promotion for progestin-only implants and have come to the family planning site to learn more about them.

Offer this information *only* when the provider asks relevant questions:

- You are interested in implants, but your husband is concerned that they will make you infertile.
- You are currently using COCs but are tired of the daily pill-taking routine.
- You do not want to have children, but your husband has recently said that he might want children someday.
- You have recently had unexplained bleeding after intercourse.
- You feel healthy and have no other health problems.
- Your last period started four days ago.
- You smoke cigarettes, about 10 to 15 per day

Scenario 2—Observer Information Sheet

Make note of whether the provider addresses these case-specific issues:

- Assesses the client's reproductive health goals, fertility intentions, and life plans
- Ensures that the client understands the possible side effects of implants, especially the likelihood of irregular bleeding (which is very different from the regular bleeding pattern of COCs)
- Describes implant insertion and follow-up procedures
- Determines the client's medical eligibility using the implants screening checklist
- Explains that the client is not eligible at this time due to unexplained bleeding and must be evaluated to determine the cause before implants are initiated
- Offers couples counseling to address the husband's concern about infertility and to correct misunderstandings about implants

Methods for which the client is eligible:*

- COCs
- Male or female condoms

*After the cause of the unexplained bleeding is determined, the client may be eligible for implants, DMPA, NET-EN, or an IUD.

Role Play Scenario 3—Postpartum, breastfeeding client is interested in but is not currently eligible for implants

Scenario 3—Client Information Sheet

Client Description

You are a 20-year-old woman who gave birth to your first child four weeks ago. You are unmarried and are not in a serious relationship. You read about progestin-only implants in a family planning brochure, and you have come to the family planning site to learn more.

Offer this information only when the provider asks relevant questions:

- You love your infant, but your pregnancy was unintentional.
- You use condoms pretty consistently.
- You are in school, want to finish, and cannot afford to have another child anytime soon.
- You have not had a menstrual period since your baby was born.
- You are fully breastfeeding, but you intend to start weaning the baby soon because of the demands of school.
- You feel healthy and have no health problems.
- You have not had sex since the baby was born, but you do have a casual boyfriend.

Scenario 3—Observer Information Sheet

Make note of whether the provider addresses these case-specific issues:

- Assesses the client's reproductive health goals, fertility intentions, and life plans
- Ensures that the client has made a fully informed decision to use implants and understands the possible side effects, especially the likelihood of irregular bleeding
- Describes implant insertion and follow-up procedures
- Determines the client's medical eligibility using the implants screening checklist
- Discusses the need to postpone implant insertion until six weeks postpartum and the options for preventing unintended pregnancy until that time

Methods for which the client is eligible:*

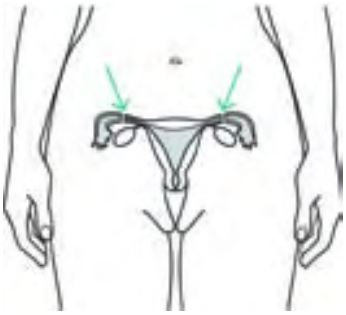
- LAM
- IUD
- Male or female condoms

*At six weeks postpartum, the client will be eligible for implants, or Depo or Norethisterone-Entate. She will also become eligible for COCs after she stops breastfeeding.

6) Female and Male sterilization

Female sterilization (TUBALIGATIONS)

Female Sterilization is a permanent contraception for women who will not want more children. The procedure is also called: tubal sterilization, tubal ligation, voluntary surgical contraception, tubectomy, bi-tubal ligation, tying the tubes, minilap, and "the operation." In Bislama this is also referred to as "tanem basket" or "fasem tiub".



Key messages:

- It is a permanent method and not reversible
- Involves a physical examination and surgery
- No long-term side effects

a. Types of Female sterilization

There are 2 surgical approaches most often used:

1) **Minilaparotomy** involves making a small incision in the abdomen. The fallopian tubes are brought to the incision to be cut or blocked
2) **Laparoscopy** involves inserting a long thin tube with a lens in it into the abdomen through a small incision. This laparoscope enables the doctor to see and block or cut the fallopian tubes in the abdomen.

The procedure is works because the fallopian tubes are blocked or cut. Eggs released from the ovaries cannot move down the tubes, and so they do not meet sperm.

b. The Effectiveness

It is very effective method, but carries a small risk of failure. Reversal surgery is difficult, expensive, and not available in Vanuatu.

- Less than 1 pregnancy per 100 women over the first year after having the sterilization procedure.
- A small risk of pregnancy remains beyond the first year of use and until the woman reaches menopause.

c. Side Effects: None

Female Sterilization method is safe for all women. Proper counselling and informed consent is needed.

Note:

- Female Sterilization is also safe for women who are infected with HIV, have AIDS, or on antiretroviral (ARV)
- Woman can have the female sterilization procedure at any time she wants if she has no medical reason to delay or if pregnancy can be ruled out

d. Ensuring Informed choice

Women should receive practical information about the procedure, particularly its permanence. It will help woman to make a right informed choice without regret.
A signed Informed Consent should be obtained from client prior to the procedure.
The information should be included in the Informed Consent:

- Informed about the available of temporary contraceptive
- Female sterilization is a surgical procedure
- There are certain risks of the procedure as well as benefits
- If it is successful, the procedure can prevent client from getting pregnant for life
- It is an irreversible method
- Client can decide to not undergo with procedure at any time before it takes place

e. Support information for client

Before the procedure --Woman should:
- Use another contraceptive until the procedure
- Not eat anything for 8 hours before surgery. She can drink clear liquids until 2 hours before surgery
- Not take any medication for 24 hours before the surgery (unless she is told to do so)
- Wear clean, loose-fitting clothing to the health facility if possible
- If possible, bring a friend or relative to help her go home afterwards.

After the procedure--Woman should:
- Rest for 2 days and avoid vigorous work and heavy lifting for a week
- Keep incision clean and dry for 1 to 2 days
- Avoid rubbing the incision for 1 week.
- Not have sex for at least 1 week. Or avoid sex until all pain is gone
- Take Ibuprofen (200–400 mg), or paracetamol (325–1000 mg), or other pain reliever if need it (not take aspirin)

Plan the follow-up visit
- Following up at 7 to 10 days after the procedure
- Checks the site of the incision, looks for any signs of infection, and removes any stitches

Note: advise the client to come back if she have any of the following symptoms:
- bleeding, pain, pus, heat, swelling, or redness of the wound that becomes worse or does not go away
- develops high fever (greater than 38° C/101° F)
- experiences fainting, persistent light-headedness, or extreme dizziness in the first 4 weeks and especially in the first week

f. Performing the Sterilization Procedure

Explaining the Procedure

Details information on the procedure should be provided to client prior to the surgical procedure taken place.

a) Mini-laparotomy Procedure

Step 1: Perform proper infection-prevention procedures.

Step 2: Performs pelvic examination to assess the condition and mobility of the uterus.

Step 3: Local anaesthetic is injected above the pubic hair line. The woman usually receives light sedation to relax, she will stay awake at all-time throughout the procedure.

Step 4: A small incision, about 2 to 5 centimetres in the anesthetized area

Step 5: Each tube is identified, tied and cut.

Step 6: Closes the incision with stitches.

Step 7: Provide instructions on what to do after she leaves the clinic or hospital.

Laparoscopy Procedure

Step 1: Follow proper infection-prevention procedures at all time.

Step 2: Perform pelvic examination to assess the condition and mobility of the uterus.

Step 3: Local anaesthetic is injected under her navel. Laparoscope inserted and tubes identified and ligated.

Step 4: Removes the instrument and laparoscope.

Step 5: Closes the incision with stitches and covers it with an adhesive bandage.

Step 6: Provide instructions on what to do upon discharge from the clinic or hospital.

Note: the woman can be discharged six to twelve hours after the procedure if clinically stable

CASE STUDIES:

Case study 1:

A woman, 35 years old, married with 3 children arrives at the clinic. She relies on her husband's income from factory work to support the family. During the consultation, she said she would like to have tubulisation.

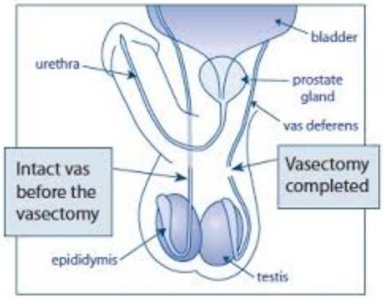
- Explain the counselling steps you would follow to deal with this situation.

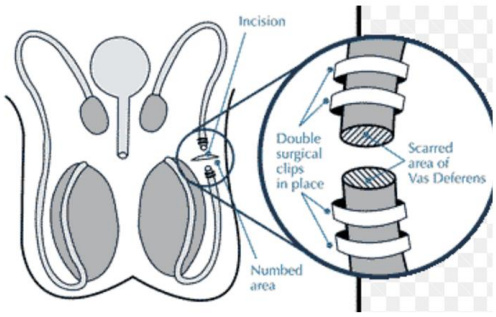
Case study 2:

A man, 35 years old, married with 3 children arrives at the clinic. He is very keen for his wife to have tubaligation because he doesn't want to have any more children.

- Explain the counselling steps you would follow to deal with this situation.

Male sterilization (VASECTOMY)





Vasectomy is a simple minor surgical procedure. It can be performed as an outpatient procedure. The vas deferens on each side of the scrotum is identified by palpation before entering the scrotum. The vas deferens on each side is occluded so that the sperm are not released into ejaculation.

It works by closing off each vas deferens, keeping sperm out of semen. Semen is ejaculated, but it cannot cause pregnancy.
Reversal surgery is difficult, expensive, and not currently available in Vanuatu.

Key messages:

- It is a **Permanent method**, very effective protection against pregnancy. Reversal is usually not possible.
- **Involves a safe, simple surgical procedure.**

- It takes about **3-month delay in taking effect**. In the meantime, it is advised that another form of contraception is used.
- **Does not affect male sexual performance.**

Male sterilization should be performed only by trained and competent medical assistants and doctors.

a. The Effectiveness

Vasectomy is one of the most effective methods but carries a small risk of failure.

- Where men cannot have their semen examined at three months after the procedure, pregnancy rates are about 2 to 3 per 100 women over the first year.
- Where men can have their semen examined after vasectomy, less than 1 pregnancy per 100 women over the first year.
- Vasectomy is not fully effective for 3 months after the procedure.
- A small risk of pregnancy remains beyond the first year after the vasectomy
- Over 3 years of use: about 4 pregnancies per 100 women

b. The side Effects

The side effect is **none**.

The complication is uncommon. However, possible complication includes scrotal or testicular pain, infection at the incision site, bleeding under the skin that may cause swelling or bruising.

Note: Vasectomy **does not**:

- remove the testicles
- decrease sex drive including erectile dis-function
- affect sexual function
- cause a man to grow fat or become weak, less masculine, or less productive
- cause any diseases later in life
- prevent transmission of sexually transmitted infections, including HIV

c. Who can have Vasectomy

Almost all men 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
- Are at high risk of infection with HIV or another STI
- Are infected with HIV, whether or not on antiretroviral therapy

Proper counselling and **informed consent** need to be done prior to the procedure.

Certain medical conditions may need more caution and delay the procedure, or need special arrangements for the clients. Those conditions are:

- have any problems with genitals such as infections, swelling, injuries, or lumps on your penis or scrotum
- have any other medical condition such as: diabetes, depression, young age, lupus with positive (or unknown) antiphospholipid anti-bodies or on immunosuppressive treatment.

d. Ensuring Informed choice

Client should receive practical information about the procedure, particularly its permanence. It will help client to make a right informed choice without regret.

The client must understand the following information prior to taking the procedure:

- The availability of **temporary contraceptives**
- **Voluntary** vasectomy is a surgical procedure
- There are **certain risks** of the procedure as well as benefits
- If successful, the procedure will prevent the client from ever having any more children
- The procedure is considered **permanent** and probably cannot be reversed
- The client **can decide to not undergo** with the procedure at any time before it takes place (without losing rights to other medical, health, other services or benefits).

e. Technique for Vasectomy

a) Reaching the Vas: No-Scalpel Vasectomy

No-Scalpel Vasectomy is a standard technique. This procedure is to reach each of the 2 tubes in the scrotum (vas deferens) that carry sperm to the penis by:

- Making a small puncture instead of 1 or 2 incisions in the scrotum
- No stitches required to close the skin
- Special anaesthesia technique needs only one needle puncture instead of 2 or more.

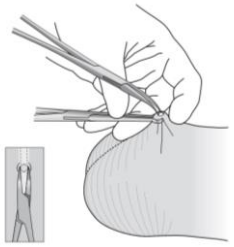
Advantages:

- Less pain and bruising
- Fewer infections and less collection of blood in the tissue
- short procedure

f. Performing the Vasectomy Procedure

Explaining the Procedure

Details information on the procedure should be provided to client prior to actual procedure taking place.

Step 1:	Follow proper infection-prevention procedures at all time.
Step 2:	Give an injection of local anaesthetic in his scrotum to prevent pain. He stays awake throughout the procedure
Step 3:	Try to feels the skin of the scrotum to find each vas deferens— the 2 tubes in the scrotum that carry sperm
Step 4:	Makes an incision in the skin: - Using the no-scalpel vasectomy technique, the provider grasps the tube with specially designed forceps and makes a tiny puncture in the skin at the midline of the scrotum with a special sharp surgical instrument. - Using the conventional procedure, the provider makes1 or 2 small incisions in the skin with a scalpel 
Step 5:	lifts out a small loop of each vas from the incision, cut each tube and tie one or both cut ends closed with thread (or close off the tubes with heat or electricity)
Step 6:	The incision may be closed with stitches or covered with an adhesive bandage
Step 7:	Client should receive instructions on what to do upon discharge from the clinic. He should rest for 15 to 30 minutes before leaving the clinic.

g. Support information for client

Before procedure Wear clean, loose-fitting clothing to the health facility.

After procedure

- Rest for 2 days if possible
- Put cold compresses on the scrotum for the first 4 hours to help to reduce pain and bleeding. He may experience some discomfort, swelling, and bruising. These should go away within 2 to 3 days

- Wear snug underwear or pants for 2 to 3 days to help support the scrotum
- Keep the incision site clean and dry for 2 to 3 days.
- Not have sex for at least 2 to 3 days
- Use condoms or another effective family planning method for 3 months after the procedure.
- Suggest ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever if he have any experience of pain or discomfort after the procedure

Plan for follow-up visit	Inform client for come back any time if he has problems. Need to return in 3 months for semen analysis

CASE STUDIES:

Case study 1:

A man, 30 years old, married with 3 children arrives at the clinic. He is the only person have regular income to support his family. During the consultation, he said she would like to have vasectomy.

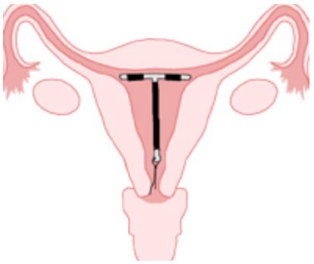
- Explain the counselling steps you would follow to deal with this situation.

Case study 2:

A man, 45 years old, married with 3 children arrives at the clinic. He is very keen for his vasectomy done today because he doesn't want to have any more children.

- Explain the counselling steps you would follow to deal with this situation.

7) Intrauterine Contraceptive Device (IUD)



The Intra Uterine Contraceptive Devices (IUD) is a small flexible device that is inserted into the uterus through the vagina. The IUD is a safe effective long term reversible method for FP.

Key messages:

- It provides long-term pregnancy protection
- Need to be inserted into the uterus by a specifically trained skill provider
- Little required of the client once the IUD is in place
- Bleeding changes are common
- Return of fertility after IUD is removed: no delay

a. Types of IUD available in Vanuatu

The IUD currently available in Vanuatu is the Copper T 380A. The Copper T 380A is small, flexible and shaped like a T with a plastic frame and copper on the stem and the arms, with a total exposed copper area of 380 square mm. It usually has a double stranded white string at its base, which extends through the cervix so that the IUD can be removed.

b. Primary mechanisms of action

Prevents fertilization by:

- Impairing viability of sperm
- Interfering with sperm movement

c. Effectiveness and return of fertility

Effectiveness

IUD is one of the most effective and long-lasting methods.

- Less than 1 pregnancy per 100 women using an IUD over the first year
- Over 10 years of IUD use: About 2 pregnancies per 100 women.

Return to Fertility

Fertility returns immediately after the removal of IUD.

d. Side effects

Changes in bleeding patterns are common in the first 3 to 6 months: prolong and heavy bleeding, irregular bleeding, or more cramps or pain during monthly bleeding.

e. Complications

- Complication with IUD is uncommon.
- Perforation of the wall of the uterus by the IUD or an instrument used for insertion is very rare, however, it usually heals without treatment.
- Miscarriage, preterm birth, or infection in women with IUD is also very rare.

Note: IUD **Does Not**--

- increase the risk of contracting STIs, including HIV
- increase the risk of miscarriage (after the IUD is removed)
- make women infertile
- cause birth defects
- cause cancer
- affect the heart or brain
- cause discomfort or pain for the woman during sex

f. WHO CAN USE IUD

Almost all women can use IUDs safely and effectively, including women who:

- have or have not had children
- are not married
- in any age
- just had an abortion or miscarriage
- breastfeeding
- do hard physical work,
- had ectopic pregnancy
- had pelvic inflammatory disease (PID)
- have vaginal infections, have anaemia
- are infected with HIV or on antiretroviral therapy.

g. WHO CAN NOT USE IUD

IUD **should not be given** to the category of women stated below:

- give birth more than 48 hours ago but less than 4 weeks
- have an infection following childbirth or abortion
- have unusual vaginal bleeding
- have any gynecologic, obstetric conditions, or problems such as genital cancer or pelvic tuberculosis
- have AIDS
- at very high individual risk for gonorrhoea or chlamydia
- suspect of pregnancy

h. Inserting the IUD

Explaining to client:

Details information on IUD should be given to client prior to insertion. The information includes:

- Explain the procedure

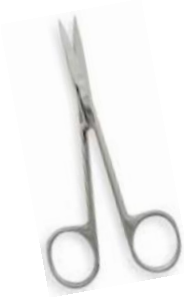
- Show her the instruments: - speculum, tenaculum, sound, including the IUD and inserter in the package.
- Inform clients that she will be expected some discomfort or cramping during the procedure,
- Ask her to tell you any time when she feels discomfort or pain.
- Some medications such as Ibuprofen, paracetamol, or other pain reliever may be given 30 minutes before insertion to help reduce cramping and pain. (Do not give aspirin, which slows blood clotting)

<u>Instruments</u>: below is the list of the instruments need for IUD insertion

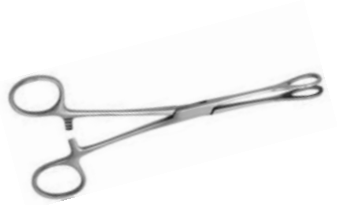
Speculum

Tenaculum

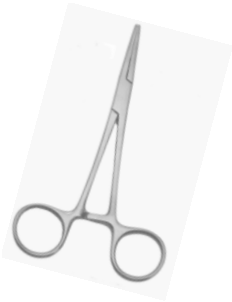
Uterine Sound



Scissor



Forceps



Narrow-Forceps

flashlight

Bowl for cotton balls

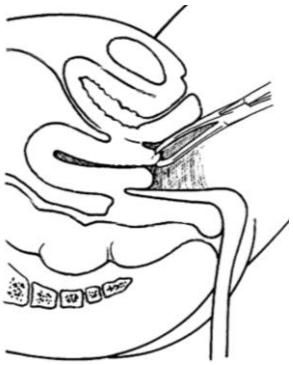
Gloves

Insertion procedures:

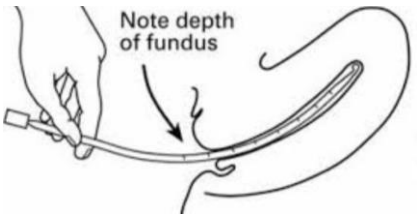
Step 1: Conducts a pelvic examination.
The aim of pelvic examination is to assess the eligibility of the client. Conduct bimanual examination and speculum examination to inspect the vagina and the cervix.

Step 2: cleans the cervix and vagina with appropriate antiseptic

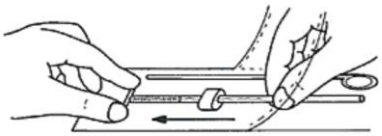
Step 3: slowly inserts the tenaculum through the speculum and closes the tenaculum just enough to gently hold the cervix

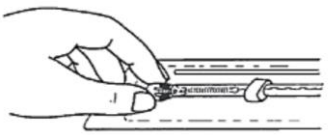


Step 4: slowly and gently passes the uterine sound through the cervix to measure the depth and position of the uterus

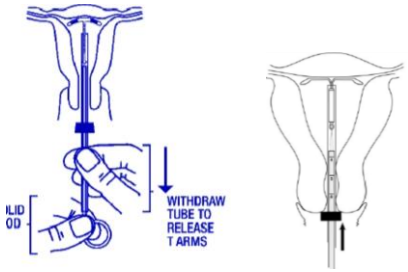


Step 5: loads the IUD into the inserter while both are still in the unopened sterile package

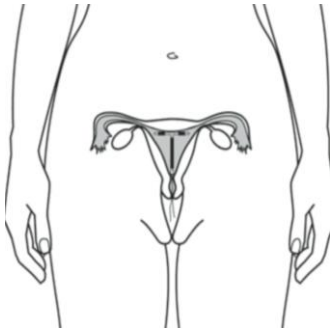




Step 6: slowly and gently inserts the IUD and removes the inserter.



Step 7: Cuts the strings on the IUD, leaving about centimetres hanging out of the cervix.



Step 8: Let the client rests until she feel ready to get dress.

<u>Sopport women after IUD insertion</u>:

- Advise women to take ibuprofen (200–400 mg), or paracetamol (325–1000 mg) if she feel pain or cramp
- She may expect some small bleeding or spotting immediately after insertion
- She need to check the IUD's strings from time to time, particularly in the first few months and after monthly bleeding, to confirm that her IUD is still in place
- Remind women to return for check-up at her first monthly bleeding or 3 to 6 weeks after IUD insertion

IUDIUD

i. Removing the IUD

Removing an IUD is usually simple. It can be done at any time of the month. Moreover, it's easier to remove during monthly bleeding, when the cervix is naturally softened.

<u>Procedures:</u>

Step 1: Explain to the client what will happen during removal.

Step 2: Inserts a speculum to see the cervix and IUD's strings and carefully cleans the cervix and vagina with an antiseptic solution.

Step 3: Asks the woman to take deep breaths and to relax

Step 4: Using narrow forceps, the provider pulls the IUD's strings slowly and gently until the IUD comes completely out of the cervix

ROLE PLAY

Scenario 1—Client is interested in and is eligible for an IUD

Scenario 1—Client information Sheet

Client Description:
You are a 23-year-old woman who gave birth to your first child six weeks ago, and you have abstained from sexual intercourse since the birth. You and your husband are mutually monogamous. You are interested in IUDs.

Offer this information only when the provider asks relevant questions:

- You have been married for one year.
- You and your spouse are both HIV positive.
- You do not want to become pregnant.
- You used condoms before, but worry about condom slippage and breakage.
- You feel healthy and have no other health problems.
- You are not breastfeeding because you don't want to pass HIV to the baby.

Make note of whether the provider performs these case-specific tasks:

- Assesses the client's reproductive health goals, fertility intentions, and life plans
- Ensures that the client understands her contraceptive options, including emergency contraception
- Screens client for medical eligibility using the checklist
- Outlines insertion and follow-up procedures
- Emphasizes the benefits of using condoms even though both partners are HIV-positive
- Offers couples counseling

Methods for which the client is eligible:

- Implants
- IUD
- DMPA or NET-EN
- COCs

Scenario 2—Client is interested in and is not yet eligible for an IUD

Scenario 2—Client Information Sheet

Client Description

You are a 32-year-old married woman. You do not want to have children. You have been married and monogamous for over eight years. You have recently seen a promotion for IUDs and have come to the family planning site to learn more about them.

Offer this information only when the provider asks relevant questions:

- You are interested in an IUD, but your husband is concerned that they will make you infertile.
- You do not want to have children but your husband has recently said that he does.
- You have recently had unexplained bleeding after intercourse.
- Your last menstrual cycle started four days ago.
- You feel healthy and have no other health problems.

Scenario 2—Observer Information Sheet

Make note of whether the provider performs these case-specific tasks:

- Assesses the client's reproductive health goals, fertility intentions, and life plans
- Ensures the client understands possible side effects, especially the likelihood of cramping and prolonged bleeding
- Addresses the husband's concern about infertility and corrects misunderstandings about IUDs
- Screens client for medical eligibility using the checklist
- Explains the needs for an evaluation or exam to determine cause of unexplained bleeding (before initiation of an IUD)
- Offers couples' counseling, particularly if husband needs further reassurance about the safety of IUDs

Methods for which the client is eligible:

- COCs
- Male or female condoms

Scenario 3—Client is interested in but is not eligible for an IUD

Scenario 3—Client Information Sheet

Client Description

You are a 20-year-old woman who gave birth to your first child three weeks ago. You are unmarried and are not in a serious relationship. You read about IUDs in a family planning brochure, and you have come to the family planning site to learn more.

Offer this information only when the provider asks relevant questions:

- You adore your child, but your pregnancy was unintentional.

- You use condoms consistently.
- You are in school and want to finish. You do not think you can afford to have another child.
- You have not had a menstrual period since your baby was born.
- You are fully breastfeeding, but you intend to stop because of the demands of school.
- You have not had sex since the baby was born, but you do have a casual boyfriend.
- You feel healthy and have no health problems.

Scenario 3—Observer Information Sheet

Make note of whether the provider performs these case-specific tasks:

- Assesses the client's reproductive health goals, fertility intentions, and life plans
- Ensures the client understands her contraceptive options described in the FP brochure.
- Ensures the client understands possible side effects, especially those related to cramping and prolonged bleeding
- Screens clients for medical eligibility using the checklist
- Discusses the need to postpone IUD insertion until client is four or more weeks postpartum
- Briefly explains insertion and follow-up procedures

Methods for which the client is eligible:*

- Male or female condoms

** She is not currently eligible for an IUD because she is less than four weeks postpartum.*

8) Barrier methods

Mechanical barriers such as male condoms and female condoms, prevent the sperm from entering the vagina and uterine cavity.

Condoms used correctly and consistently is the only method currently available for **DUAL PROTECTION. -** i.e. they prevent pregnancy as well as STIs including HIV/AIDS

Types of barrier methods

Male condoms are available in Vanuatu. Other barrier contraceptive methods are female condoms.

a. MALE CONDOMS

Male condom is a sheath, or covering, that fits over a man's erect penis. It is also called "rubbers", "raincoats," or "umbrellas". It works by forming a barrier that keeps sperm out of the vagina, preventing pregnancy. It also keeps infections in semen, on the penis, or in the vagina from infecting the other partner.
Condoms come in all shapes, sizes, and materials. Most male condoms are made of a type of rubber called "latex". Non-latex condoms (polyurethane) are also available in the market.

Effectiveness

Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS, reduces the risk of other sexually transmitted Infections (STIs). Condom use may reduce the risk of genital human papillomavirus (HPV) infection and HPV-associated diseases, e.g., genital warts and cervical cancer (CDC, 2014).

Protection against pregnancy
When used correctly with every act of sex, the chance of pregnancy is approximately 2 out of every 100 women. (WHO, 2011)

Protection against HIV and other STIs
When used consistently and correctly, condom use prevents 80% to 95% of STI's including HIV transmission that would have occurred without condoms

ELIGIBILITY

Barrier methods should be provided to any client who requests it, received appropriate counselling and made an informed decision.

Indication:

Condoms are appropriate for most couples because it rarely causes any side effects. They are also appropriate for couples:

- Where the husband wants to actively participate in family planning.
- Where a client needs or desires protection against STIs, including HIV transmission
- Where the wife has conditions that are considered precautions for other methods of family planning.
- Where the wife is in the first 6 months of lactation and wants to use a contraceptive

- Waiting for surgical contraception or IUD insertion
- Where a client needs a temporary alternative or backup to another method (e.g., for the first 3 months following vasectomy etc.)

Precautions: there is possible of allergy to latex in either man or woman.

WHAT CONDOM USERS SHOULD NOT DO

Some practices can increase the risk that the condom will break and should be avoided.

- Do not unroll the condom first and then try to put it on the penis
- Do not use lubricants with an oil base because they damage latex
- Do not use a condom if the condom is expired or damaged
- Do not use a condom that feels brittle, dried out, or very sticky
- Do not reuse condoms

Also, do not use the same condom when switching between different penetrative sex acts, such as from anal to vaginal sex. This can transfer bacteria that can cause infection.

EXPPLAIN THE 5 BASIC STEPS OF USING MALE CONDOM (Source: WHO Handbook, 2011)

Basic Steps	Important Details	
1. Use a new condom for each act of sex	- Check the condom package. Do not use if torn or damaged. Avoid using a condom past the expiration date—do so only if a newer condom is not available. - Tear open the package carefully. Do not use fingernails, teeth, or anything that can damage the condom.	
2. Before any physical contact, place the condom on the tip of the erect penis with the rolled side out	- For the most protection, put the condom on before the penis makes any genital, oral, or anal contact.	

3. Unroll the condom all the way to the base of the erect penis	- The condom should unroll easily. Forcing it on could cause it to break during use. - If the condom does not unroll easily, it may be on backwards, damaged, or too old. Throw it away and use a new condom. - If the condom is on backwards and another one is not available, turn it over and unroll it onto the penis.	
4. Immediately after ejaculation, hold the rim of the condom in place and withdraw the penis while it is still erect.	- Withdraw the penis. - Slide the condom off, avoiding spilling semen. - If having sex again or switching from one sex act to another, use a new condom.	
5. Dispose of the used condom safely	Wrap the condom in its package and put in the rubbish or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing	

ROLE PLAY

Scenario 1—Client is interested in and eligible for male condoms

Scenario 1—Client Information Sheet

Client Description

You are a 41-year-old man. You have two teenage daughters with your wife and a two-year-old son by your current girlfriend, who was using oral contraceptive pills, but forgot to take them for several days and became pregnant. Your wife now has an IUD. You are interested in using condoms with your girlfriend until she decides on a reliable contraceptive method that suits her better.

Offer this information <u>only</u> when the provider asks relevant questions:

- You have no serious health problems.
- You have had experience with condoms on occasion, but felt that they dulled your sensitivity and reduced pleasure.
- You are not interested in a vasectomy at this time.

- You have not been tested for STIs or HIV and you do not know if your partners have been tested.

Scenario 1—Observer Information Sheet

Make note of whether the provider performs these case-specific tasks:

- Assesses the client's reproductive health goals, fertility intentions, life plans
- After client reveals male condoms as his method of choice, discusses effectiveness, prevention of pregnancy and protection from STIs and HIV (dual protection)
- Provides condoms, gives instructions on correct use, practices to avoid, and where to go for resupply
- Asks client to demonstrate correct use
- Offers suggestions for making condom use more enjoyable
- Suggests he refer his girlfriend to the clinic for FP counseling
- Discusses benefits of testing for STIs/HIV and suggests testing for himself and his partners

Methods for which the client is eligible:

- Male or female condoms

Scenario 2—Allergy to latex condoms

Scenario 2—Client Information Sheet

Client Description

You are a 23-year-old married man with one child. You have come to the clinic because after having sex with your wife your genitals became very red and itchy, there were red spots in several other places on your body, and you felt dizzy.

Offer this information <u>only</u> when the provider asks relevant questions:

- You have no other serious health problems.
- Have just started using condoms with your wife, because she does not want another child for a while.
- Your wife had previously used a calendar method for FP and you abstained from sex during her fertile days.
- You had used a condom just once or twice in the past.
- You and your wife are faithful to each other.
- You want another child in the future.

Scenario 2—Observer Information Sheet

Make note of whether the provider performs these case-specific tasks:

- Assesses the client's concerns, reproductive health goals, fertility intentions, life plans

- Asks questions about his symptoms and condom use and determines latex allergy
- Advises client to stop using latex condoms immediately
- Assesses STI risk
- Advises client on other FP options, including plastic female or male condoms, and suggests he bring his wife in for FP counseling
- Provides treatment or refers for treatment of latex allergy.

Methods for which the client is eligible:

- Plastic male condoms or synthetic female condoms

b. FEMALE CONDOMS

A female condom is a sheath, or lining that fits loosely inside a woman's vagina made of thin, transparent, soft plastic film. It has a 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. The product comes with the lubricated with a silicone-based lubricant on the inside and outside.

THE EFFECTIVENESS

- Effectiveness depends on the user: Risk of pregnancy or sexually transmitted infection (STI) is greatest when female condoms are not used with every act of sex.
- When used correctly with every act of sex, the chance of pregnancy is approximately 5 out of 100 women in the first year

Note: Female condoms--

- Cannot get lost in the woman's body.
- Are not difficult to use, but correct use needs to be learned.
- Do not have holes that HIV can pass through.

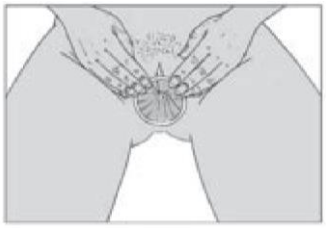
- Are used by married couples. They are not only for use outside marriage.
- Do not cause illness

WHO CAN USE FEMALE CONDOMS

All women can use plastic female condoms. No medical conditions prevent the use of this method.

THE 5 BASIC STEPS OF USING FEMALE CONDOM

Basic Steps	Important Details	
1. Use a new female condom for each act of sex	- Check the condom package. Do not use if torn or damaged. Avoid using a condom past the expiration date—do so only if newer condoms are not available. - If possible, wash your hands with mild soap and clean water before inserting the condom.	
2. Before any physical contact, insert the condom into the vagina	- Can be inserted up to 8 hours before sex. For the most protection, insert the condom before the penis comes in contact with the vagina. - Choose a position that is comfortable for insertion—squat, raise one leg, sit, or lie down. - Rub the sides of the female condom together to spread the lubricant evenly. - Grasp the ring at the closed end, and squeeze it so it becomes long and narrow. - With the other hand, separate the outer lips (labia) and locate the opening of the vagina. - Gently push the inner ring into the vagina as far up as it will go. Insert a finger into the condom to push it into place. About 2 to 3 centimetres of the condom and the outer ring remain outside the vagina.	 

3. Ensure that the penis enters the condom and stays inside the condom	- The man or woman should carefully guide the tip of his penis inside the condom—not between the condom and the wall of the vagina. - If his penis goes outside the condom, withdraw and try again. - If the condom is accidentally pulled out of the vagina or pushed into it during sex, put the condom back in place.	
4. After the man withdraws his penis, hold the outer ring of the condom, twist to seal in fluids, and gently pull it out of the vagina	- The female condom does not need to be removed immediately after sex. - Remove the condom before standing up, to avoid spilling semen. - If the couple has sex again, they should use a new condom. - Reuse of female condoms is not recommended	
5. Dispose of the used condom safely	- Wrap the condom in its package and put it in the rubbish or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing.	

SUPPORT THE USER

- Ensure client understands correct use
- Ask the client how many condoms she thinks she will need until she can return
- Explain why using a condom with every act of sex is important
- Explain about emergency contraceptive pills (ECPs)
- Discuss barriers of using condoms

TIPS FOR THE NEW USERS

- Suggest to a new user that she practice putting in and taking out the condom before the next time she has sex. Re-assure her that correct use becomes easier with practice.
- Suggest she try different positions to see which way insertion is easiest for her.
- The female condom is slippery. Some women find insertion easier if they put it in slowly, especially the first few times.
- If a client is switching from another method to the female condom, suggest that she continue with the previous method until she can use the female condom with confidence.

HELPING CONTINUING USERS

- Ask how the client is doing with the method and whether she is satisfied. Ask if she has any questions or anything to discuss.
- Ask especially if she has any trouble using female condoms correctly and every time she has sex
- Give her more female condoms and encourage her to come back for more before her supply runs out
- Ask a long-term client about major life changes that may affect her needs—particularly plans for having children and STI/HIV risk

ROLE PLAY

Scenario 1—Client is interested in and eligible for female condoms

Scenario 1—Client Information Sheet

Client Description

You are a 17-year-old female who has been referred for contraception from an HIV care and treatment provider. You were pregnant but miscarried two months ago. You read the pamphlet on family planning method options given to you by the provider and have made a decision about which method you believe best suits your needs.

Offer this information only when the provider asks relevant questions:

- You have had a steady boyfriend for about six months.
- You are both HIV-positive.
- Your boyfriend was taking antibiotics recently after he went to see a doctor at the STI clinic.

- You want to use female condoms because they would give you some control and you can delay pregnancy for now.
- You are not sure how you want to discuss this with your partner. When asked where, when and how, you choose the bench in front of your house, after Friday night dinner; suggesting to your partner that you want to avoid reinfecting each other.
- You feel healthy, have no other health problems, and your menses returned to a regular pattern after miscarriage.
- You might consider another method in addition to female condoms.

Make note of whether the provider performs these case-specific tasks:

- Assesses the client's reproductive health goals, fertility intentions, life plans
- Ensures that the client understood the contraceptive options in the pamphlet, including emergency contraception
- After client reveals female condoms as her method of choice, reviews the benefits of dual protection
- Provides female condoms and instructions on correct use and resupply
- Helps client explore approaches for negotiating condom use; asks client if she would like to role-play the conversation; does role play if client wishes
- Offers couples counseling

Methods for which the client is eligible:

- Male or female condoms
- COCs
- DMPA or NET-EN
- Implants
- Standard Days Method

Scenario 2—Client is pregnant and wants protection from STIs

Scenario 2—Client Information Sheet

Client Description

You are a 22-year-old woman and you are pregnant. You have come to talk with the provider about condoms, because you want protection from sexually transmitted infections (STIs). Your boyfriend previously gave you an STI, for which you received treatment, and you don't want to risk getting another STI while you are pregnant.

Offer this information <u>only</u> when the provider asks relevant questions:

- You are interested in using male and female condoms.
- You have previously used only male condoms and only a few times.
- You have no medical problems.

You feel comfortable talking to your boyfriend about using condoms. When asked where, when, and how, you choose: to talk to him at a local restaurant; over the weekend sometime; and you will insist he use a condom or you will not have sex—for the health of your baby.

Scenario 2—Observer Information Sheet

Make note of whether the provider performs these case-specific tasks:

- Assesses the client's reproductive health goals, fertility intentions, life plans
- Provides condoms (male or female condoms, according to the client's decision) and instructions on correct use and resupply
- Asks about discussing condoms with partner and helps client decide when, where, and what approach to use for negotiating condom use
- Offers couples counseling

Methods for which the client is eligible:

- Male or female condoms

Scenario 3—Managing problems with female condoms; negotiating condom use

Scenario 3—Client Information Sheet

Client Description

You are a 20-year-old woman who has never been pregnant. You and your boyfriend have been using male condoms, but he often doesn't have any with him, so you use withdrawal. A few days ago you bought female condoms from a pharmacy. You have had trouble inserting the condoms and something feels wrong when your boyfriend inserts his penis inside your vagina.

Offer this information <u>only</u> when the provider asks relevant questions:

- You do not want to become pregnant.
- You last had sex three days ago and used withdrawal.
- Your period is very regular and started seven days ago.
- You have no health problems.
- You don't want to carry male condoms, because when you previously offered condoms to your boyfriend, he became upset and thought you were sleeping with someone else.
- You want to use female condoms because they protect you from STIs and HIV and from getting pregnant.

- You might consider using another contraceptive method in addition to condoms, but you are not ready to make a choice today.
- You aren't sure how your boyfriend will respond. When asked where, when, how, you choose: in the park, which is very public; Sunday afternoon; because you don't want to get pregnant because you both want to finish school.
- You would like the provider to help you practice what you will say to your boyfriend.

Scenario 3—Observer Information Sheet

Make note of whether the provider performs these case-specific tasks:

- Assesses the client's reproductive health goals, fertility intentions, life plans
- Rules out pregnancy
- Asks about problems with using female condoms
- Provides female condoms and instructions on correct use
- Demonstrates the five steps, observes client as she practices
- Advises on how to improve comfort and increase effectiveness
- Reviews benefit of dual method use to ensure protection from pregnancy when partner refuses to use condoms or client does not have condoms handy
- Discusses use of emergency contraception in case condom is not used or is used incorrectly
- Asks about discussing condoms with partner and asks if client would like to role play the conversation; does a role play practice with client
- Provides instructions on resupply and other places to get female condoms

Methods for which the client is eligible:

- Male or female condoms
- DMPA or NET-EN
- COCs
- Implants
- IUD
- Standard Days Method

9) Emergency contraception

Emergency contraception often called "morning after pills". It refers to contraceptive methods that can be provided to women following unprotected sexual intercourse to prevent an unintended pregnancy. In Vanuatu emergency contraception is available in all health centres. Emergency contraceptive pills are effective and safe for the majority of women who may need them, as well as being simple to use.

The mechanism of action of emergency contraceptive pills depends on the time during the menstrual cycle that they are taken. Emergency contraceptive pills may inhibit or

delay ovulation, inhibit tubal transport of the egg or sperm, interfere with fertilization or alter the endometrium, thereby inhibiting implantation of a fertilized egg.

Notes: Emergency contraceptive pills:

- Do not cause abortion
- Do not cause birth defects if pregnancy occurs
- Are not dangerous to a woman's health
- Do not promote sexual risk-taking
- Do not make women infertile

a. TYPES OF EMERGENCY CONTRACEPTION

The following are the types of emergency contraceptive pills (ECP)

- Levonorgestrel contraceptive pills (Postinor): Each pack has 2 tablets each tablet containing Levonorgesterol 0.75 mgms. Dedicated packaging is available in Vanuatu.
  Administration: 1 tablet containing 0.75 mg levonogestrel (LNG) and after 12 hours, another tablet

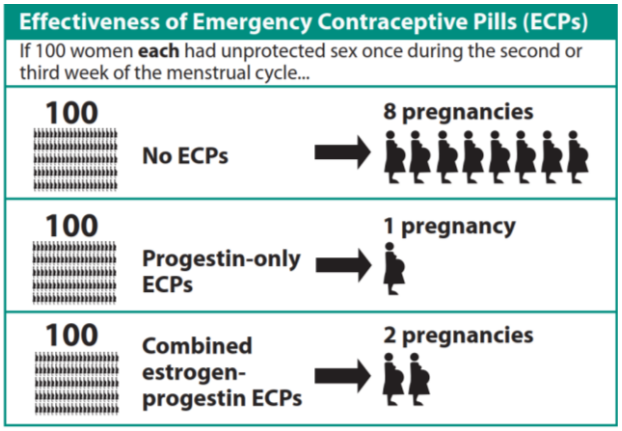
- Combined oral contraceptive pills (Combined ethinylestradiol and levonorgestrel- Microgynon)
  Administration: first dose: 4 pills, and second dose: another 4 pills the same type as the ones used for the first dose, 12 hours later.

- **IUD**: IUD should be inserted in the first 5 days after unprotected sex.

a. WHEN TO TAKE

Take **as soon as possible** after unprotected sex. It can also prevent pregnancy when taken any time up to 3 days after unprotected sex. However, the effectiveness is better if ECPs can be taken soon after having unprotected sex.

b. EFFECTIVENESS OF EMERGENCY CONTRACEPTIVE PILLS



Source: WHO, FP Guideline 2011

Note:

- All women can use ECPs safely and effectively
- Return of fertility: immediately after taking ECPs
- Protection against sexually transmitted infections (STIs): None

c. ELIGIBILITY FOR EMERGENCY CONTRACEPTION

Emergency contraception is meant to be used only following an unprotected act of sexual intercourse to prevent pregnancy. The following are a number of situations when a woman can use or may need to use emergency contraception:

- When a woman has been a **victim of rape/sexual assault**.
- After **incorrect or inconsistent use of regular contraceptive methods**
  - Failed withdrawal method, when ejaculation has occurred in the vagina or on the external genitalia;
  - Miscalculation of the infertile period when using periodic abstinence for e.g. while using cycle beads, failure to abstain from sexual intercourse during the fertile days;
  - Being late for a contraceptive injection;
  - Missed 3 or more active (hormonal) combined oral contraceptive pills in the first week and had unprotected intercourse
  - Missed one or more Progesterone only Pills by more than 3 hours and had unprotected intercourse
  - Unprotected intercourse prior to the effective time of vasectomy

- Accidental **failure of other contraceptive methods** such as:

  - Condom breakage or slippage
  - IUD expulsion

d. SIDE EFFECTS

The most common reporting side effect includes:

- **Changes in bleeding patterns**: irregular bleeding for 1–2 days after taking ECPs, or monthly bleeding that starts earlier or later than expected
- **A week after taking ECPs**: nausea, abdominal pain, fatigue, headaches, breast tenderness, dizziness, and vomiting

e. Dosing Information (FP Global Handbook, 2011)

Pill Type	Total doses need
Levonorgestrel-only	1.5 mg of levonorgestrel in a single dose
Estrogen-progestin	0.1 mg ethinyl estradiol + 0.5 mg levonorgestrel. Follow with same dose 12 hours later
Progestin-only pills with levonorgestrel or norgestrel	- Levonorgestrel pills: 1.5 mg levonorgestrel in a single dose. - Norgestrel pills: 3 mg norgestrel in a single dose

Note:
Women can take them at once. If she is using a 2-dose regimen, tell her to take the next dose in 12 hours.

f. MANAGING SIDE EFFECTS

Nausea: routine use of anti-nausea medications is not recommended.
Vomiting:

- Should repeat another dose (plus Anti-Nausea medication) if vomits happen within 2 hours after taking ECPs,
- If vomiting continues, she can take the repeat dose by placing the pills high in her vagina

Note: Women should be encouraged in choosing other methods of FP to prevent pregnancy for any future sex.

Frequently Asked Questions and Their Answers (WHO, Fact Sheet, 2010)

1. What if the ECPs don't work and I don't get my period?

Answer: If you have not menstruated for a week after your expected menstruation, you may be pregnant. Your provider will give you a pregnancy test to see if you are pregnant. If you are pregnant, your provider will discuss options with you.

2. If a woman is breastfeeding can she use ECPs?

Answer: Yes. A woman who is exclusively breastfeeding and who has not had a menstrual period since delivery is unlikely to be at risk of pregnancy and therefore may not need ECPs. However, a woman who is providing supplemental feeding to her infant or who has had menses since delivery may be at risk for pregnancy. A single treatment with ECPs is unlikely to have an important effect on milk quantity or quality. Some hormones may pass into the breast milk, but they are unlikely to affect the infant adversely.

3. Are ECPs safe?

Answer: YES, emergency contraceptive pills can be given even to women who cannot use oral contraceptive pills regularly, such as those with a history of hypertension or severe migraine.

This is because emergency contraceptive pills are taken for a short span of time and, consequently, will have fewer side-effects than oral contraceptive pills. It will not have side effects that may have developed due to use of oral contraceptive for long periods.

4. How will emergency contraceptive pills affect a woman's menses?

Answer: Emergency contraceptive pills have no significant impact on a woman's menses. Only 10-15 percent of the women who use emergency contraceptive pills will have menstrual problems. A woman's menses will be at about the expected time, or at most a week early or late (usually 2-3 days). In a few cases, menstrual flow might be heavier, lighter or more spotty than usual.

5. Will emergency contraceptive pills protect a woman from future unprotected intercourse?

Answer: NO. Emergency contraceptive pills do not protect a woman from any future unprotected intercourse.

6. Will emergency contraceptive pills harm an existing pregnancy or a pregnancy caused by the failure of emergency contraceptive pills?

Answer: ECPs cannot terminate or interrupt an established pregnancy and will not stop a fertilized egg from implanting in the uterus, nor can they harm a developing embryo. ECPs are ineffective once implantation has begun.

7. What should a woman do if vomiting is severe after the first dose of ECPs and she cannot take her second dose?

Answer: Non-prescription, anti-nausea medication generally is not effective once nausea is present. If vomiting is severe, one option is for her to place the second dose of pills high into the vagina. Although studies are not complete about how effective this is, LNG is absorbed through the vaginal wall and she will get some benefit. If the woman has no other options, (vomiting being severe) vaginal placement seems more reasonable than not taking the second dose. Inform the woman that the treatment may be less effective if the second dose is not taken.

8. Can emergency contraceptive pills be taken if there is problem in the leg (such as varicose veins)?

Answer: YES. As the dose of hormones in emergency contraceptive pills is relatively low, the short exposure to estrogen and/or progestin does not appear to alter blood-clotting mechanisms, as in the case of combined oral contraceptives, which are used over a longer period.

9. Should we provide ECPs if the woman had unprotected sex on a day when her risk of pregnancy was not very high?

Answer: Yes, often a woman cannot be sure she is infertile at any one time during her cycle. Therefore, ECPs should be provided any time unprotected sex occurs and the woman is concerned that she is at risk of pregnancy.

10. How many times can one take emergency contraceptive pills in a month?

Answer: Emergency contraceptive pills are not intended for repeated use. These pills should be used only as an emergency method for back-up support. However, given that there is little likelihood that limited repeated use will cause harm, emergency contraceptive pills should not be denied only because a woman has used them before, even within the same menstrual period. All women who use ECPs, particularly those who use them repeatedly, should be informed that
ECPs are less effective and have more side-effects than regular contraceptives.

11. How soon after taking ECPs should a regular contraceptive be started?

Answer: Regular contraceptive methods (such as condoms. DMPA and pills) can be resumed immediately after taking ECPs. Alternatively, clients could switch over to condoms till the start of the next menstrual cycle. Other regular contraceptives such as IUD or implants, can be started within 7 days of the next menstrual period.

12. Can ECPs be taken before intercourse?

Answer: Yes. No data is available about how long the contraceptive effect of ECPs persists after the pills have been taken. Presumably ECPs taken immediately before intercourse are as effective as ECPs taken immediately afterwards. However, if a woman has the opportunity to plan to use a contraceptive method before intercourse, a method other than ECPs, such as condoms or another barrier method, it is recommended.

13. Is emergency contraception the same as abortion?

Answer: NO. Emergency contraception and abortion are entirely different. Emergency contraceptives only prevent pregnancy from unprotected sex by preventing or delaying ovulation. In an abortion, a fertilized foetus is removed.

14. Do ECPs interact with other drugs?

Answer: No specific data is available about the interaction of ECPs with other drugs that the client may be taking. However, it seems reasonable that drug interactions would be similar to those with regular oral contraceptive pills. Women taking drugs that may reduce the effectiveness of oral contraceptives (including, but not limited to, Rifampin, and certain anticonvulsant drugs) should be advised that the effectiveness of ECPs may be reduced.

Lesson 7: Sexual transmitted infections (including HIV) and their consequences on reproductive and sexual health

Objectives of the session:

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

- Identify and describe the different types of **STIs**
- Define conduct **risk assessment** for STIs
- Conduct **history taking, physical examination and counselling**
- Making **diagnosis** of STIs
- Management of **FP planning clients with STIs**

Participant's Material/Handouts:

1) The transmission of STIs (SPC, 2012; Vanuatu STI guidelines, 2007)

The most common mode of transmission of STIs is through unprotected penetrative sexual intercourse (vaginal, oral and anal). Contact of intact skin with genital secretions and discharge poses only a small risk of becoming infected. However, contact of the mucous membrane with infected secretions poses a greater risk of infection.

Other, modes of transmission include:
mother-to-child transmission:

- during pregnancy (e.g. HIV, syphilis and hepatitis B virus)
- at delivery (e.g. gonorrhea, chlamydia and HIV)
- after birth (e.g. HIV)

through the unsafe and unsterile use of needles or injections or other contact with blood or blood-products (e.g. syphilis, HIV and hepatitis).

2) The Common sexually transmitted pathogens and their clinical presentation (SPC, 2012)

Disease	Pathogen	Symptoms and signs
Bacterial infections		
Gonorrhea	Neisseria gonorrhoeae	Urethral discharge; vaginal discharge; lower Abdominal pain in women; cervicitis; neonatal conjunctivitis. May be asymptomatic
Chlamydia	Chlamydia trachomatis	Urethral discharge; vaginal discharge; lower Abdominal pain in women; cervicitis; neonatal conjunctivitis. Often asymptomatic
Syphilis	Treponema pallidum	Anogenital ulcers (chancre); inguinal swelling; generalized skin rash
Cancroid	Haemophilus ducreyi	Genital ulcers with inguinal swelling (bubo) in the majority of cases

Granuloma inguinale or Donovanosis	Klebsiella granulomatis	Nodular swellings and ulcerative lesions of the inguinal and anogenital areas
Viral infections		
Acquired Immunodeficiency Syndrome (AIDS)	Human immunodeficiency virus (HIV)	Urethral discharge; vaginal discharge; lower abdominal pain in women; cervicitis; neonatal conjunctivitis. May be asymptomatic
Genital herpes	Herpes simplex virus type 2 (HSV-2)	Urethral discharge; vaginal discharge; lower abdominal pain in women; cervicitis; neonatal conjunctivitis. Often asymptomatic
Genital warts	Human papilloma virus (HPV)	Anogenital ulcers (chancre); inguinal swelling; generalised skin rash
Viral hepatitis	Hepatitis B virus (HBV)	Genital ulcers with inguinal swelling (bubo) in the majority of cases
Molluscum contagiosum	Molluscum contagiosum virus (MCV)	Nodular swellings and ulcerative lesions of the inguinal and anogenital areas
Other		
Trichomoniasis	Trichomonas vaginalis	Asymptomatic; profuse, frothy vaginal discharge

3) Risk assessment for STIs

A brief risk assessment can guide decisions about what screening tests for STIs are indicated for particular patients. The content of a brief risk assessment should cover the following areas (5 Ps): (CDPH, 2011)

Past STIs:	"Have you ever had an STIs in the past?"
Partners:	"Have you had sex with men, women, or both?" "In the past six months, how many people have you had sex with?" "Have any of your sex partners in the past 12 months had sex with other partners while they were still in a sexual relationship with you?"
Practices:	Do you have….vaginal sex (penis in vagina)?" …anal sex (penis in anus/butt)?"

(sexual/needle sharing)	…oral sex (penis in mouth or mouth on vagina/vulva)?" "Have you ever used needles to inject/shoot drugs?"
Prevention:	"What do you do to prevent STIs and HIV?" "Tell me about your use of condoms with your recent partner."
Pregnancy plans and prevention:	"How would it be for you if you were to get pregnant now?" "What are you doing to prevent pregnancy now?

4) Conduct history taking and physical examination

History taking:

Taking a sexual history from a patient is challenging. The patient needs to tell the health care provider about symptoms that occur in the genital area and about their sexual behaviours and practices. Local cultural standards about sex, and concerns over confidentiality may make some patients feel uncomfortable discussing such sensitive information.

The patient's basic needs

The patient may be concerned or embarrassed, so it is important that the environment and the health care provider set him or her at ease.

- ***The environment***

Confidentiality and privacy are crucial: somewhere to talk where others cannot see or hear is important, as is also informing the patient that everything that is discussed will be kept confidential to the best of the ability of the health care provider(s).

- ***The health care provider***

Perhaps most important of all: patients need to feel that the health care provider understands and respects them and wants to listen. To do this, you need to develop a rapport with the patient and be **non-judgemental**.

Establishing a good rapport with the patient

Good communication skills are essential in establishing a good rapport with a patient. These include:

- our verbal skills: the way we talk to the patient and ask questions;
- our non-verbal skills: how we behave towards the patient.

A first step should be to greet the patient in an appropriately friendly manner and introduce yourself.

- Smile and use a welcoming tone of voice.
- Introduce yourself.
- Use the patient's name, Offer the patient a seat.
- Begin the history taking only when you have privacy.
- Make eye contact if culturally appropriate.
- Be respectful and understanding and using verbal and non-verbal skills for history taking.

Specific verbal skills (SPC, 2012)

Facilitation	Facilitation is a technique using words, sounds and gestures to encourage patients to keep on talking. Nodding the head and raising the eyebrows are two examples of non-verbal facilitation. Its aim is gently to encourage the patient to continue. Here is an example of spoken facilitation in practice.
Direction	This approach is useful when a patient is confused and does not know where to begin or when the patient is not sure how to prioritize what issues are of concern. It helps people to sort out ideas and give information in a sequence.
Summarizing and checking	Summarizing and checking enable you to find out if you have understood the patient correctly. The patient is also able to correct any misunderstanding. To do this, you paraphrase what the patient has said, then ask if your summary is correct. Use this skill when the patient has mentioned a number of things that you want to confirm.
Empathy	This may be the most important skill of all when dealing with the patient's feelings. If you notice that a patient is anxious or tense, for example, you can express your empathy by commenting on what you have noticed. This shows that you allow the patient to express his or her fears and establishes more open communication between you. Like facilitation, it encourages the patient to continue speaking.
Reassurance	Reassurance is a useful way to show that you accept the patient's feelings and that the problem need not last forever. You indicate with words or gestures that the patient's anxiety can be addressed.
Expressing partnership	Expressing partnership confirms a commitment to help the patient. This commitment could be with the health care provider personally, as in the example below, or on behalf of the health care team.

Important of history taking

- To make an accurate diagnosis,
- To establish the patient's risk of transmitting or contracting an STI, including HIV,
- To find out about partners who may have been infected (contact tracing/partner notification).

The information we need to collect:

- **The patient's general details**: age, gender, Number of children, Locality or address, Employment

The patient's present and past illness: Presenting complaints and duration-

Men:	- If a urethral discharge – pain while passing urine? Frequency? - If scrotal swelling – history of trauma?
Women:	- If a vaginal discharge – pain while passing urine? Frequency? - Risk assessment positive? - Lower abdominal pain – vaginal bleeding or discharge? - Painful or difficult pregnancy or childbirth? - Painful or difficult or irregular menstruation? Missed or overdue period?
Men and women:	- If a genital ulcer – is it painful? Recurrent? Appearance? Spontaneous onset? - If an inguinal bubo – is it painful? Associated with genital ulcer? - Swellings elsewhere in the body? - Other symptoms, such as itching or discomfort?

- **The patient's medical history.**
    - Other illness – type? Dates? Any treatment and response? Results of tests?
    - Medications currently being taken
    - Drug allergies

- **The patient's sexual history — address the following, known as the 5Ps.**
    - Partners
    - Prevention of pregnancy
    - Protection from STIs
    - Practices
    - Past history of STIs

- Any past STI – type? Dates? Any treatment and response? Results of tests?

Examination

The purpose of a physical examination is to confirm any STI symptoms the patient has described.

Examining the most private parts of a person's body requires tact, sensitivity and respect on the part of the health care provider. Patients may be embarrassed or uncomfortable. We suggest ways to help the patient understand the importance of the examination and overcome his or her embarrassment.

The health providers should:

- ensure privacy;
- explain what you are going to do and why an examination is important;
- ask the patient for his or her permission to make an examination;
- appear calm and avoid rushing during the examination, even though you may have little time;
- approach the examination in a confident way, yet sensitive to the patient's needs.

Note: a third party must always be present during a physical examination of a client by a service provider of the opposite sex

Examining male patients

The examination should be carried out with the area between the chest to the knees unclothed; make sure you cover the patient with a sheet and expose only those parts that you are examining.

Examine the mouth and look for sores, lumps and other abnormalities.

Examine the skin of the chest, abdomen, back, buttocks, perineum and genitals and around the anus. Look for rashes and sores.

Palpate the neck, the axillae, the supraclavicular areas, the epitrochlear areas and the area under the chin for enlarged lymph nodes. Palpate the groins, feeling for inguinal lymph nodes and buboes.

Palpate any lumps and ulcers. Note the presence or absence of genital ulcers or tender swelling of the inguinal lymph nodes (also known as buboes). Palpate the scrotum, feeling for the testis, epididymis and spermatic cord.

Retract the foreskin, or ask the patient to retract the foreskin, and look for genital ulcers and urethral discharge. If a discharge is present, note whether it is coming from the urethra. If there is no obvious discharge, give the urethra a gentle squeeze and massage it forward to try and express any discharge.

Record the presence or absence of discharge, ulcers, vesicles, rashes, warts, buboes and lymphadenopathy. Note the amount and colour of any urethral discharge.

Examining female patients

The examination should be carried out with the area between the chest to the knees unclothed; make sure you cover the patient with a sheet and expose only those parts that you are examining

Do a general examination. Examine the mouth and look for sores, lumps and other abnormalities.

Look for rashes, swellings and sores on the chest, back and abdomen. Palpate the neck, the axillae, supraclavicular, submandibular, axillary and epitrochlear areas for enlarged lymph nodes.
Palpate the abdomen, feeling for areas of tenderness and for swellings. Check particularly for tenderness deep in the pelvis.
Examine the pubic area and palpate for any inguinal lymph nodes.
Inspect the labia majora and minora, the urethral meatus, clitoris, introitus and the anus and perineum. Note any discharge, ulcers, warts or growths.

Separate the labia and insert a warm well-lubricated bivalve speculum and inspect the vaginal walls and the cervix. Look carefully for ulcers, warts and for cervical and vaginal discharge.

Note the colour, quantity and the odour of the discharge. In order to carry out a speculum examination the patient should lie with her legs bent at the knees and the feet and knees separated.

A good, bright light source is necessary in order to inspect inside the vagina. When you have completed inspecting the vagina and cervix, remove the speculum and insert the index and middle fingers of your hand into the vagina and carry out a digital bimanual examination.
The bimanual examination is carried out with the two fingers inside the vagina and with the other hand placed on the lower abdomen. With your fingers inside the

vagina and the other hand on the abdomen, examine the pelvis for swellings and tenderness. Check for cervical motion tenderness by moving the cervix gently laterally. Remember that if a patient has extensive, painful genital ulcers, it may not be possible to perform a speculum examination.

Do not hurt your patient.

5) Making diagnosis of STIs

STI's can be diagnosed by:

Diagnostic approach	**Advantages**	**Limitations**
Aetiologic diagnosis – diagnosis is based on the results of laboratory tests	- The most accurate way to make a Diagnosis - Once a diagnosis is made, the patient is given appropriate treatment if he/she has not been treated syndromically initially - The only method of making a diagnosis of STI in persons who do not have symptoms or signs of infection - This approach can be used in conjunction with the syndromic approach - The number of rapid diagnostic tests available is limited	- Laboratory testing facilities may not be available in the health facility or the central laboratory - Trained personnel to carry out the tests may not be available - Depending on the type of tests, this approach may be expensive - There could be delays in receiving the results of tests and this could - lead to delay in treating infections - Laboratory tests are available for all types of STIs
Syndromic diagnosis – diagnosis is based on the recognition of a pattern of symptoms and signs	- Covers most of the common STIs - Problem-oriented - Highly sensitive and does not miss mixed infection	- This approach can be used only in patients who have symptoms or signs of infection - As patients treated syndromically receive

	- Patients are provided with treatment at the first visit - Makes STI care more accessible as it can be implemented at all health facilities - Uses flowcharts that guide providers through logical steps in managing patients	treatment for more than one infection, there is a degree of overtreatment - There is a limited number of STI syndromes. - There is a lack of specificity of some syndromes, particularly the vaginal discharge syndrome

6) Management FP planning clients with STIs (WHO, 2015)

Women at high risk of acquiring STI's, including HIV can use the following hormonal contraceptive methods without restriction:

- combined oral contraceptive pills (COCs),
- combined injectable contraceptives
- contraceptive patches and rings,
- progestogen-only pills (POPs), progestogen-only injectables (Depo and noristerate), and levonorgestrel (LNG), and etonogestrel (ETG) implants

IUD and STIs patients

Intrauterine device (IUD) is used for women with increased risk of sexually transmitted infections (STIs)

IUD initiation	Some women at increased risk (very high individual likelihood) of STIs generally should not have an IUD inserted until appropriate testing, counseling and treatment occur.
IUD continuation	Women at increased risk of STIs can generally continue use of IUD

Note:
It is critically important that women and couples at risk of STI infection, including HIV must be informed about and have access to male and female condoms, and other measures to prevent and reduce their risk of STI infection, including HIV), regardless of which form of contraception they choose.

Lesson 8: Legal and ethical issues

Objectives of the session:

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

- understand the legal right of individual in accessing RH including family planning services

Participant's Material/Handouts:

There are many ethical aspects which derive from the application of reproduction control in women's health. Women's health can be enhanced if women are given the opportunity to make their own reproduction choices about sex, contraception and application of reproductive technologies.

By the use of contraception, it is possible to lessen maternal, infant and child morbidity and mortality and to reduce the prevalence of sexually transmitted infections.

Reproductive rights

Reproductive rights are legal rights and freedoms relating to reproduction and reproductive health. The World Health Organization defines reproductive rights as follows:

> Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence. (WHO, SRH, 2016)

Upholding human rights is fundamental in the current Vanuatu SRHR policy. In addition, the policy strongly emphasizes respect for an individual's reproductive health rights, regardless of their age, gender, ethnicity, religious persuasion, place of origin or marital status.

SRHR includes the right of all persons to:

- Seek, receive, and impart information related to sexuality;
- Receive sexuality education;
- Have respect for bodily integrity;
- Choose their partner;

- Decide to be sexually active or not;
- Have consensual sexual relations;
- Have consensual marriage;
- Decide whether or not, and when, to have children; and
- Pursue a satisfying, safe, and pleasurable sexual life.

Who should have access to FP services: (Vanuatu, FP guideline, 2016)

Family Planning services should be provided to all women and men of reproductive age (usually said to be age 15-49 years) who express a need, including but not limited to:

- A woman who does not want to interrupt her studies or her work by having a baby.
- A woman, man or couple who are not ready and/or able to take on the responsibility of a child.
- A family who cannot financially support a (or another) child.
- A family with little land to divide up between their children.

The target groups for FP information education and communication (IEC) are:

- **All women and men** of reproductive age (usually said to be age 15-49 years).
- **All young people** (including those younger than 15 years) to ensure they have the information to make informed choices about sex and pregnancy.
- **National and community leaders**, whose position and influence can help to create environments and processes which enable information about Family Planning to be available.

Family planning for young people

Definition:

Although the legal age for consent to sexual activity in Vanuatu is 16 (Vanuatu Age of Consent and Statutory Rape Laws), the evidence suggests that it is common for teenagers to have had sexual intercourse before this age.

The age of consent is the minimum age at which an individual is considered legally old enough to consent to participation in sexual activity. Individuals aged 15 or younger in Vanuatu are not legally able to consent to sexual activity, and such activity may result in prosecution for statutory rape or the equivalent local law. (AgeOfConsent.net. 2016)

Thus, family planning should be provided (with informed consent) to all individual age 16 and older.

For those aged 15 and younger who - "can consent," "has the capacity to consent" or "can make his or her own health care decisions, "the consent of another person, such as parent or guardian, is not needed.

PART 3: The evaluation criteria and monitoring components

Lesson 1: Selection indicators

Objectives of the session:

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

- Understand different levels of indicators for monitoring the RH program
- Calculate the minimum indicators required to monitor FP program in the country and how they link to regional and global indicators

Participant's Material/Handouts:

Data collection and usage

Performance indicators should provide data to managers for evidence based and support policy decision making

The indicators selected to measure progress toward a given result should be the minimum number and require the minimum effort necessary to ensure that progress towards a specific result is sufficiently captured

In the FP and health sector:
(1) **higher-level indicators**-those measuring health status or fertility-are generally well-established.
(2) **second level-monitoring** use of services-are also typically well-established and have been field-tested across various program and country settings.
(3) **lower-level indicators**: which tend to focus on the supply and demand of health and family planning services, are often more program-specific and may be best defined according to the special priorities and working conditions of a given mission's program.

Example of indicator measured RH in difference level of health system: (USAID, 1999)

Higher-level Indicators.

Trends in health status and fertility reflect the explicit purpose for which family planning, child survival, and HIV/ AIDS programs are undertaken.

The example indicators include:

1. Total fertility rate (TFR)
2. Under-five mortality rate (U5MR)
3. Infant mortality rate (IMR
4. Maternal mortality ratio (MMR)
5. HIV /STI prevalence or incidence
6. Nutritional status
7. Prevalence of vitamin A deficiency

Second-level Indicators

These indicators track people-level impact in terms of use of services or other behaviour.

The example indicators include:

Family Planning: - Contraceptive prevalence rate (CPR) - Couple-years of protection (CYP)	**Maternal Health:** - Births attended by medical personnel - Use of prenatal care services - Immunization Coverage among Women of Reproductive Age
Child Survival: - Immunization coverage - Treatment of acute respiratory infections (ARI) - Treatment of fever (presumptive malaria) - Infant feeding practices - Exclusive breastfeeding - Complementary feeding - Vitamin A supplementation	**HIV /STI Prevention:** - Reported condom use with non-regular partner - Reported condom use with regular partner - Reported non-regular sexual partners - Treatment of STIs **Infectious Diseases:** - Use of insecticide-treated bednets - Prevention of malaria among pregnant women

Third-level Indicators

These indicators monitor progress in improving access to and quality of sustainable family planning and health services and the generation of demand for these services. The example indicators include:

1. Access/availability	1.1. access to family planning services 1.2. supply of contraceptives 1.3. service delivery points
2. Quality	2.1. service delivery according to protocols 2.2. systems performance (training, supervision, logistics, stock-outs)
3. Demand	3.1. mean desired family size 3.2. desire to space or limit births 3.3. Unmet need for family planning 3.4. approval of family planning 3.5. Knowledge of Modem Methods of Family Planning
4. Sustainability	4.1. public resource allocation for FP 4.2. mobilization of private sector 4.3. Contraceptive Supply

Millennium Development Goal (MDG) 5 (SDG 3): indicators for Improve maternal health

MDG Targets	Indicators:
Target 5a: Reduce by three-quarters the maternal mortality ratio	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel
Target 5b: Achieve universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage 5.6 Unmet need for family planning

Maternal Health Indicators measure in the Pacific

- MMR - MDG.5.1
- Maternal Deaths
- Birth attendance skilled - MDG.5.2
- Contraceptive prevalence rate - MDG.5.3
- Adolescent birth rate – MDG.5.4

- Antenatal coverage –MDG.5.5
- Total fertility rate
- Unmet family planning --MDG.5.6

UNFPA-Indicator for Strategic Plan, 2014-2017 (see details calculation in annex 2

Lesson 2: Glossary of Family Planning Indicators (PMA, 2016)

Indicator	Definition/calculation
Higher-level Indicators.	
Total fertility rate (TFR)	Number of children that would be born per woman if she were to pass through the childbearing years bearing children according to a current schedule of age-specific fertility rates Unit: Children per woman
Under-five mortality rate (U5MR)	Number of deaths among children under age five in a given year per 1,000 live births in that same year. Unit: Deaths per 1,000 live births
Infant mortality rate (IMR)	Number of deaths in infants (children under age one) in a given year per 1,000 live births in that same year. Unit: Deaths per 1,000 live births.
Maternal mortality ratio (MMR)	Number of maternal deaths per 100,000 live births, where a maternal death is one which occurs when a woman is pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management Unit: Maternal deaths per 100,000 live births
HIV /STI prevalence or incidence	**HIV Sero-prevalence** Percentage of a specified population whose blood tests positive for HIV. Unit: Percent. **STI Prevalence among Women** Number of pregnant women age 15-24 with positive serology for syphilis divided by the population of

	pregnant women of that age attending antenatal clinics whose blood has been screened. Unit: Percent.
Nutritional Status among Children	Percentage of children age 12-23 months whose weight is more than two standard deviations below the median weight achieved by children of that age. Unit: Percent
Prevalence of vitamin A deficiency	An estimate of the proportion of children, 12 to 59 months of age, with serum values of vitamin A less than or equal to 0.70 µmol/l. Unit: Percent.
Second-level Indicators	
Contraceptive Prevalence Rate (CPR) for modem methods	Percentage of women of reproductive age (15-49) who are currently using (or whose partner is currently using) a modern method of contraception Unit: Percent.
Couple-years of Protection (CYP)	An estimate of the protection against pregnancy provided by family planning services during a period of one year, based upon the volume of all contraceptives sold or distributed free of charge to clients during that year. Unit: Couple-years of protection
Immunization Coverage among Children	Percentage of children under one year of age who have received each vaccination at the recommended age and interval, as stated in the national immunization policy. Unit: Percent.
Infant Feeding Practices: Exclusive Breastfeeding	Percentage of infants less than four months of age who are being exclusively breastfed. Unit: Percent.
Infant Feeding Practices: Complementary Feeding	Percentage of infants six to nine months of age (181 days to 299 days) still breast-feeding and also receiving complementary weaning foods. Unit: Percent.
Vitamin A Supplementation	Percentage of children 6-60 months of age receiving vitamin A supplementation in the previous six months. Unit: Percent.

Births Attended by Trained Medical Personnel	Percentage of births attended by trained health personnel, excluding traditional birth attendants Unit: Percent.
Use of prenatal care services	Percentage of women seen at least once during their pregnancy by a doctor or other persons trained with midwifery skills for reasons related to the pregnancy. Unit: Percent.
Unmet need for family planning	Percentage of fecund, sexually active women ages 15–49 who are not using contraception and do not wish to become pregnant at all (unmet need for limiting) or within the next two years (unmet need for spacing) Unit: Percent.
Immunization Coverage among Women of Reproductive Age	Percentage of women age 15-49 receiving two or more tetanus toxoid (TI) doses during or before their pregnancies Unit: Percent.
Third-level Indicators	
Access/availability - Access to family planning services - Supply of contraceptives - Service delivery points	**Access to family planning services:** Percentage of the population who live within a reasonable distance from a family planning service delivery point. Unit: Percent. **Supply of contraceptives:** Number of contraceptives distributed (free or for sale). Unit: Number. **Service delivery points** Percentage of service delivery points that encountered a stock-out of any item during the past 12 months
Quality - Service delivery according to protocols	**Service delivery according to protocols:** percentage of service deliveries provide services according to protocols (counselling, treatment, FP…ETC) **Systems performance:**

- Systems performance (training, supervision, logistics, stock-outs)	Number of people attending training sessions. Percentage of trainees who apply the skills to their subsequent work. Percentage of facilities with personnel who report one or more visits by their supervisor in the past three months Percentage of storage capacity available to the program that meets acceptable standards with respect to temperature, humidity, ventilation, etc.
Demand - Mean desired family size - Desire to space or limit births - Unmet need for family planning - Approval of family planning - Knowledge of Modem Methods of Family Planning	**Mean desired family size:** The average number of children that women (or couples) of reproductive age would choose to have if they could have exactly the number of children desired (Evaluation Project). Unit: Children per woman (or couple) **Desire to space or limit births:** Percentage of women currently married or in union who are fecund and who desire not to have additional children or to delay the birth of their next child. Unit: Percent. **Unmet need for family planning** Percentage of women currently married or in union who are fecund and who desire either to terminate or postpone childbearing, but who are not currently using a contraceptive method. Unit: Percent. **Approval of family planning:** Percentage of men and women who approve of couples using contraception to avoid pregnancy. Unit: Percent **Knowledge of Modem Methods of Family Planning:** Percentage of the target population who can name, without prompting, at least 3 or more modem methods of contraception.

	Unit: Percent
Sustainability - Public resource allocation for FP - Mobilization of private sector - Contraceptive Supply	**Public resource allocation for FP**: Percentage of routine vaccines paid for by the national government. Percentage of national health budget allocated to FP or/HIV /AIDS/STI programs **Mobilization of private sector:** Number (or percentage) of facilities with cost recovery mechanisms in place. Percentage of recurrent costs recovered through cost recovery. **Contraceptive Supply:** Number of contraceptives distributed (free or for sale) Unit: Number
Other indicators for FP (To be used to monitor or evaluation of the program)	
Long acting CPR	Proportion of women ages 15-49 using a long-acting contraceptive method, which includes an IUD, implant, and sterilization (male and female)
Total number of modern contraceptive users	A count of the number of females ages 15–49 who are current users of modern methods of contraception
Demand satisfied by modern contraception	Percentage of women ages 15–49 who do not want to get pregnant who are using modern contraception
Adolescent fertility rate	Age-specific fertility rates for women age 15-19
Intention to use contraception	Percentage of women not currently using a method of contraception who intend to use a method in the future
Unintended births	Percentage of births in the past 5 years to females ages 15–49 that are reported to be mistimed (wanted later) or unwanted
Method mix	Composition of current methods used by women ages 15–49
Median duration of contraceptive use, by main method	Among females who have used a modern contraceptive method in past 12 months, but who are not currently using, the number of months at

	which half of such women stopped using the method for any reason
Method chosen by self or jointly	Percentage of women ages 15–49 currently using a modern contraceptive method, or who used a modern method in past 12 months, reporting they decided on method themselves or jointly with a partner or provider
Method information index	Percentage of recent/current users reporting they were informed about other methods and side effects, and if informed of side effects, what to do
Paid for services	Percentage of recent/current users who have paid any fees for family planning services in the past 12 months
Satisfaction with provider	Percentage of women ages 15–49 using a modern contraceptive method, or who used a modern method in past 12 months, who would return to their provider and would refer a relative or friend to that provider
Received method from public SDP	Percentage of recent/current contraceptive users reporting they obtained their contraceptive method from a public service delivery point
Sterilized users told method was permanent	Percentage of sterilized users counselled on method
Reasons for non-use	Reasons for non-use of contraceptive methods among married women who express a desire to postpone their next birth by two or more years
Age at first marriage	Median age at first marriage for women ages 25-49
Age at first sex	Median age at first sex for women ages 25-49
Age at first contraceptive use	Median age at first contraceptive use for female ever users ages 15-49
Number of living children at first contraceptive use	Average number of living children at first contraceptive use among women ages 15-49 who have ever used contraception
Women having first birth by age 18	Percentage of all women ages 18-24 who had their first birth before age 18
Received family planning information from provider	Percentage of women ages 15-49 reporting they received family planning information from a provider who visited them in the past 12 months
Recent exposure to mass media family planning messages	Percentage of women ages 15-49 reporting exposure to family planning messages on radio, television or in print in past 12 months

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Annexes

Annex 1: Instructions for Roleplays

Provider Instructions for Role Plays

Pretend that you are meeting the client for the first time. Ask the client for his or her name, gender (male or female) and age. Pretend that there is a health centre nearby to which you can refer the client, if needed. Remember to:

- Assess the client's reproductive health (RH) goals, concerns, and fertility intentions.
- Address the primary and secondary reasons for the client's visit.
- Facilitate the client's decision-making process.
- Integrate information and services related to other RH issues as appropriate.
- Help the client act on her or his decision(s).

Observer Instructions for Role Plays

Prior to the start of the interaction:

- Review the Role Play Observation Checklist so that you are familiar with the behaviours tha you are observing and where they appear on the checklist.
- Review the case-specific issues on the observer information sheet for the role play.

While observing the interaction between the provider and client, remember to:

- Use the observation checklist to take notes on what happens during the interaction.
- Record how well the provider addresses the case-specific issues in the space provided.
- Be prepared to give feedback to the provider regarding how well he or she addressed the client's needs.

Pay particular attention to whether the provider:

- Helped the client deal with anxiety
- Facilitated communication with a partner
- Allowed the client to make an informed decision
- Ensured that the client met the medical eligibility criteria for the method she chose
- Helped the client carry out her decision

Client Instructions for Role Plays
Prior to the start of the interaction:

- Read the client information sheet and make sure you understand your character's situation.
- Pick a name for your character. Tell the provider your name, age, and whether you are male or female.
- During the interaction, offer information *only* when the provider asks relevant questions. Use the information given in your client information sheet to respond to the provider's questions.

Feel free to ask questions of the provider.

Role Play Observation Checklist

Case: _____ Provider: _____ Client: _____ Observer: _____ Date: _____

Overall: Communicate Effectively and Maintain Rapport	Yes	No	N/A	**Help** Client Make an **Informed Decision** or Address a Problem	Yes	No	N/A
Shows **respect** and avoids judging client				**Asks** client if he or she has **any questions** about methods of interest			
Maintains **relaxed**, friendly and attentive body postures and eye contact				**Asks** client to **choose a method**			
Uses simple, **clear** language				**Agrees** on decision or plan in partnership with client			
Uses **open-ended** and probing questions **correctly**				Provide Assistance to **Support** Client's Decision			
Listens carefully to client (paraphrases and reflects)				Gives **contraceptive** method and **condoms** for dual-method use, if needed			
Asks client about feelings (and shows empathy)							
Encourages client participation							
Explains what will occur during visit and procedures				**Explains** and/or demonstrates **correct use**			
Ensures **client understanding** and corrects misunderstandings				**Asks client to explain** or demonstrate correct use, and **reinforces** client's understanding and/or corrects client's demonstration.....			
Offers to **involve** client's **partner**.....				**Reminds client** about side effects and reasons for returning....			
Records data according to protocols.....				**Gives** treatment, **supplies**, medications (as indicated)			
Establish Rapport and Assess Client's Needs and Concerns				Role plays or rehearses **negotiation skills** and helps client plan approach.....			
Greets client appropriately				**Arranges follow-up**, resupply, and referral to other services, as needed			
Ensures **confidentiality** and privacy and that client is comfortable				Case-Specific Observations or Questions:			
Asks about **reason** for **visit**							
Asks about **client's partner**(s), children, family, sexual behaviou health							

Asks about **plans** to have children, desire for FP (e.g., spacin limiting)				.....			
				.....			
Explores STI risk and what client does to avoid STIs				.....			
Identifies areas to **evaluate during physical** exam (if indicate				.....			
				.....			
Provide Information and Options Related to Client's Concerns				.....			
Advises on preventing **STIs** (i.e., abstain, fewer partners, use condoms)				.....			
				.....			
Advises on achieving desired **pregnancy** as **safely** as possible				.....			
				.....			
Explains benefits of FP and healthy spacing				.....			
Helps client **identify FP** methods suited to her or his needs.....				.....			
Gives information on FP methods of interest				.....			
Responds to other client questions or concerns							

Annex 2: INDICATORS METADATA
UNFPA Strategic Plan, 2014-2017: Integrated Results Framework[1]

Indicators	Definition and method of computation
Goal: Achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the ICPD agenda, to improve the lives of adolescents and youth, and women, enabled by population dynamics, human rights, and gender equality	
Impact indicator 1: Maternal mortality ratio	**Definition** The maternal mortality ratio (MMR) is the annual number of *maternal deaths* from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 *live births*, for a specified year. **Method of computation** The maternal mortality ratio is calculated by dividing recorded (or estimated) maternal deaths by total recorded (or estimated) live births in the same period and multiplying by 100,000. The measurement requires information on pregnancy status, timing of death (during pregnancy, during childbirth, or within 42 days of termination of pregnancy), and cause of death. $Maternal\ Mortality\ Ratio = \frac{Number\ of\ Maternal\ Deaths}{Number\ of\ Live\ Births} \times 100{,}000$
Impact indicator 2: Adolescent birth rate	**Definition** The adolescent birth rate is the annual number of *live births to adolescent women per 1,000 adolescent women*. The adolescent birth rate is also referred to as the age-specific fertility rate for women aged 15–19.

[1] The indicators note in this table are selected from UNFPA strategic plan 2014-17 and could be calculated to measure RH services at the country level

	Adolescent women are for the purpose of this indicator defined as women 15 to 19 years of age. **Method of computation** The adolescent birth rate is calculated as the number of live births to adolescent women divided by the total number of adolescent women and multiplied by 1,000. $$Adolescent\ birth\ rate = \frac{Number\ of\ live\ births\ to\ adolescent\ women}{Number\ of\ adolescent\ women} \times 1{,}000$$
Impact indicator 3: HIV prevalence among population aged 15-24 years	**Definition** The prevalence of *Human Immunodeficiency Virus (HIV)* among the population 15–24 years of age is the number of individuals aged 15–24 living with HIV expressed as a percentage of the total population aged 15–24. **Method of computation** This indicator is calculated by dividing the number of cases of HIV among the population aged 15–24 years by the total population aged 15–24 and multiplying by 100.
Impact indicator 4: Percentage of women 20-24 married/in-union before age 18	**Definition** This indicator is the number of women 20-24 that are married/in union before age 18 expressed as a percentage of the total number of women aged 20-24 This indicator is used to represent the prevalence of child marriage in developing countries. It is estimated among women 20-24, at the time when all women are not exposed to the risk of getting married before age 18. **Method of computation**

	This indicator is calculated by dividing the number of women 20-24 that are married/in union before age 18 by the total number of women aged 20-24 and multiplying by 100.
Impact indicator 5: Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	**Definition** Women aged 15-49 who currently have or ever had an intimate partner, who report experiencing physical or sexual violence by at least one of these partners in the past 12 months. *Ever married or partnered women aged 15-49* include women who have ever been married or had an intimate partner. An *intimate partner* is defined as a cohabiting partner, whether or not they had been married at the time. These women are asked if they experienced physical or sexual violence from a male intimate partner in the past 12 months. *Physical or sexual violence* is determined by asking women if their partner did any of the following: • Slapped her or threw something at her that could hurt her; • Pushed her or shoved her; • Hit her with a fist or something else that could hurt; • Kicked, dragged, or beat her up; • Choked or burnt her; • Threatened her with, or actually used a gun, knife or other weapon against her; • Physical forced her to have sexual intercourse against her will; • Forced her to do something she found degrading or humiliating; • Made her afraid of what he would do if she did not have sexual intercourse with him. **Method of computation** Numerator: Women surveyed aged 15-49 reporting at least one incident corresponding to any one of the items listed above in the last 12 months

	Denominator: Total women surveyed aged 15-49 who currently have or had an intimate partner
Outcome 1: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access	
Outcome 1 indicator 2: Contraceptive prevalence rate (total)	**Definition** The contraceptive prevalence rate (CPR) is the proportion of sexually active women (married and unmarried) aged 15-49 who are using, or whose sexual partners are using a method of contraception. Where available, the most recent nation-wide survey results (e.g. DHS/MICS) will be used for country level data. **Method of computation** This indicator is calculated by dividing the number of women aged 15 to 49 who are married or in a union who are using, or whose sexual partners are using a method of contraception by the total number of women aged 15 to 49 and multiplying by 100.
Outcome 1 indicator 3: Proportion of demand for contraception satisfied (total)	**Definition** The proportion of demand satisfied for contraception (PDS) is the component of total demand for contraception that are current users of contraceptive methods. The *total demand for contraception* constitutes those who are currently using a contraceptive method [CPR] and those who are in need of contraceptives (for spacing or limiting) but are not currently using any method [Unmet Need]. **Method of computation**

	The proportion of demand satisfied (PDS) is calculated as: PDS= CPR/(CPR + Unmet Need)
Outcome 1 indicator 7: Percentage of the women and men aged 15-49 who had more than one sexual partner in the past 12 months who reported use of a condom during their last intercourse	**Definition** This indicator is the total number of women and men aged 15-49 who had more than one sexual partner in the past 12 months who reported use of a condom during their last intercourse expressed as a percentage of the total number of women and men aged 15-49 who had more than one sexual partner in the past 12 months. **Method of computation** Numerator: Number of respondents (aged 15–49) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex Denominator: Number of respondents (15–49) who reported having had more than one sexual partner in the last 12 months
Outcome 2: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health	
Outcome 2 indicator 1: Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major	**Definition** Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. **Method of computation**

misconceptions about HIV transmission	**Numerator:** Number of respondents aged 15-24 years who gave correct answers to all of the five following questions: 1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? 2. Can a person reduce the risk of getting HIV by using a condom every time they have sex? 3. Can a healthy-looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing food with someone who is infected? **Denominator:** Number of all respondents aged 15-24 years.
Outcome 3: Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth	
Outcome 3 indicator 3: Percentage of women aged 15–49 who think that a husband/partner is justified in hitting or beating his wife/partner under certain circumstances	**Definition** This indicator is the proportion of women aged 15–49 who think that a husband/partner is justified in hitting or beating his wife/partner under certain circumstances **Method of calculation** Numerator: Total number of women aged 15–49 who responded *yes* to any of the following: In your opinion, is a husband justified in hitting or beating his wife in the following situations: 1. If she goes out without telling him? 2. If she neglects the children? 3. If she argues with him? 4. If she refuses to have sex with him? 5. If she burns the food?

	Denominator: Total number of women aged 15–49 who responded to this question on the survey.
Outcome 4: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality	
Outcome 4 indicator 5: Proportion of new national development plans that address population dynamics by accounting for population trends and projections in setting development targets	**Definition** This indicator is the proportion of national development plans approved during the reporting year that address population dynamics in setting development targets on the basis of population trends and projections. **Method of computation** Numerator: Number of national development plans approved in the reporting year that address population dynamics by accounting for population trends and projections in setting development targets. Denominator: Total number of national development plans approved during the reporting year. National development plans include 5 year and 10 year plans, as well as PRSPs.