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COMPREHENSIVE FAMILY PLANNING TRAINING

Day 1

Unit 1- Orientation to FP training

Session 1.1:

- Overview of the FP Comprehensive Skills training
- Post training jobs and tasks of a comprehensive FP Clinical skills trainee
- Goal of FP training
- Training objectives
- Clinical objectives
- Training schedule

Training Methodology

- Power point slides
- Flip charts
- Participatory Training methods;
  - Brainstorming
  - Lecturette/interactive presentation
  - Role play
  - Case study
  - Simulation
  - Skills practice on models
  - Field experience
  - Individual and group assignments
  - Demonstration and return demonstration
- Clinical *practice on real clients*

- **Evaluation methods to be used;**
  - Pre/post knowledge assessment
  - Review sessions like where are we and process review
  - Performance assessment using observation and checklists during theory and practicum training
  - Written and verbal participants' reactions at the end of training
  - Trainer/trainee feedback sessions at the end of the day and during practicum
  - Knowledge and skills application plans

1.2: Overview of FP Comprehensive Skills Training

Session Objectives

By the end of the session trainees will be able to:

1. Compare own expectations with objectives of the training
2. Identify roles of trainees and trainers in meeting objectives of the training
3. Outline the post training jobs and tasks of a family planning service provider
4. Discuss the process and evaluation of the training
5. Agree on workshop norms
6. Explain workshop logistics

Training Goal:

Two weeks training - include days of classroom and five days of clinical practicum aimed to;

- Develop competencies of trainees to enable them provide quality integrated Comprehensive FP Services so as to maximize availability, accessibility and quality of FP services at all levels of service delivery.

Training Objectives

- *By the end of the two weeks training trainees will be able to:*

1. Use knowledge of RH anatomy and physiology; to educate and counsel clients for;
   - to educate and counsel clients for informed choice during selection of FP methods
   - Have in-depth knowledge for management of contraceptive related side effects and complications
2. Apply selected RH and development concepts to FP services
3. Plan, conduct and evaluate client education sessions on Family Planning related issues

Objectives cont’

4. Counsel clients to make an informed choice and continue to use contraceptive methods.
5. Perform infection prevention practices for Family Planning services.
6. Screen clients for eligibility to use the various FP methods.
7. Manage clients for contraceptive services at initial and routine follow-up visits.
8. Manage clients with contraceptive related side effects and complications.
9. Describe the process of integrating FP services into existing services

Objectives Cont’d

10. Demonstrate ability to maintain, report and use accurate records of FP services
11. Develop a feasible back-home application plan to establish/strengthen FP services as an integrated part of other Health Services
12. Evaluate the training.

Clinical objectives:

During practicums, trainees will perform the following minimum number of FP procedures according to laid down standards:

- Group client Education sessions that include integrating STD, HIV/AIDS information into FP client education. - 2
- Counseling for informed choice (at least one male) - 3
- Screening clients for FP method use:
  - Taking and recording client's History - 3
  - Performing relevant Physical Assessment - 3

Cont'd

- Initiating clients on FP methods:
  - COC – 3,
  - POP – 2,
  - Injectable progestins – 3,
  - Condoms - 2
  - Natural methods – 2,
  - Implants – 3,
  - Interval IUD - 3
  - Identifying and recruiting potential clients for FP services - 3
- Conducting routine follow-up of clients - 1

Cont'd

- Manage clients with FP related side effects and complications:

  - COC - 2

  - POP - 2

  - Injectable progestins - 3

  - Condoms - 2

  - Implants - 2

  - IUD - 2

- Records management

  - Correct filling of FP client card - 5

  - Correct filling of FP client register/other related registers - 5

Post training jobs and tasks of a Clinical skills training

- Educate and Counsel Clients for Family Planning and Reproductive Health Services
- Perform infection prevention practices for FP services
- Manage Clients for FP services
- Manage Integrated FP services

The end

Questions??????

Unit 2

SELECTED CONCEPTS & RATIONALE FOR FP/RH SERVICE DELIVERY

Session objective

- *By the end of the session, trainees will be able to:*
- 1. Define family planning.
- 2. Define postpartum family planning.
- 3. List at least three components of family planning services.
- 4. Explain selected terms and concepts used in family planning services.
- 5. Discuss the rationale for FP/RH Services

Unit 2 cont'd

Concepts

- **Meaning of Family planning**
  - Is a basic human right for an individual/couple to exercise control over their fertility, make informed decision on the number of children they want to have, when to have the first and last pregnancy and the space between pregnancies.
- **Meaning of Post-Partum Family planning**
  - the prevention of unintended pregnancy and closely spaced pregnancies through the first 12 months following childbirth

Concepts Cont’

Components of FP services and modalities for delivery

- ***components of FP services:***
  - Client education about Family Planning methods
  - Counseling for informed choice and continuity
  - Initiating FP methods (screening; providing method and giving instructions on how to use)
  - Routine follow up of clients on FP methods
  - Management of contraceptives related side effects and complications

Cont’

- Family planning services can be delivered in various modalities and settings such as:

    - In clinic setting: Integrated into the existing services and as vertical service in standalone clinic
    - Community based approach
    - Outreaches included into immunization, VCT

- **High Risk Concept in FP/RH service delivery**
    - **“4 Toos” Concept**

Concepts Cont’

Voluntary informed choice

- Client makes his/her own choice of method upon receiving correct and complete information about FP methods; explores her reproductive goals, FP needs and ability to use a method without being coerced/ forced.

Reproductive Health

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

This implies that people are able to:

- Have satisfying and safe sex life
- Have capability to reproduce
- Have freedom to decide if, when and how often to do so.

Concepts cont’

Reproductive health rights

- Reproductive rights embrace certain rights that are already recognized in international human rights documents and national laws. The reproductive rights include;
  – the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children
  – the right to information regarding sexual and reproductive health
  – the right to attain the highest standard of sexual and reproductive health
  – the right to make decisions concerning reproduction, free of discrimination, coercion and violence.

Cont'd

Safe motherhood

- This is the concept that no woman or fetus or baby should die or be harmed by pregnancy or child birth and can be made possible by providing timely, appropriate and comprehensive quality obstetric care during preconception, pregnancy, child birth and puerperium

Service Integration

- This is a way of providing preventive health services and/or curative services at one health facility by one or more competent service providers on daily basis depending on their competencies.

Clients' rights in relation to FP and provider needs

- *Information*
- *Access:*
- *Choice:*
- *Safety*
- *Privacy*
- *Confidentiality*
- *Dignity*
- *Comfort*
- *Continuity*
- *Opinion*

Some population Concepts

- **What are vital statistics?**
  - rates of indices concerned with or related to life or rates related to biological and social events taking place in the community under consideration; e.g. Births, illness, deaths, marriages.
- **What is an indicator?**
  - Measurable variable (especially a trend or fact), that indicates the state or condition of something.
    - E.g Infant mortality rate, - Total fertility rate, - Maternal mortality ratio, - Population growth Rate, - Contraceptive prevalence rate, - Couple years of protection (CYP), - Unmet need/unmet demand for Family planning

1.2 Rationale for FP/RH Services

Statistical Indicators

- The contraceptive prevalence rate among married women in Uganda has slightly risen from 30 percent in 2011 to 39 percent in 2016.
- It is estimated that 28 percent of women have an unmet need for family planning, both for spacing and limiting births.
- The Contraceptive Prevalence Rate varies from region to region and for urban and rural settings. However, the total demand for family planning is estimated at 83 percent (UDHS 2016).
- Uganda's Total Fertility Rate (TFR) has remained among the highest in the world, moving from 6.2 in 2011 to 5.4 children per woman in 2016.)

Rationale cont'd

- The use of injectables and condoms has risen rapidly and are now the dominant methods.
- The provision of long-term and permanent methods is low
- Nearly 55 percent of Uganda's population **(34.9 million)** is under 15 years of age.

Notable FP Challenges

- Despite a notable increase in the use of injectable contraceptives, the 2016 Uganda Demographic and Health Survey showed a decline in the utilization of long-acting and permanent methods (LAPMs), such as intrauterine devices (IUDs) and both female and male sterilization

- UDHS 2016 shows that the most preferred methods are injectable Depo Provera at 19 percent and Implants at 6 percent

- The continuing HIV/AIDS epidemic poses several serious challenges, including its impact on available resources for RH programmes, particularly FP services.

Challenges Cont’

- HIV/AIDS epidemic has resulted in a large population of HIV positive women and men who have a substantial degree of unmet need for FP

- The need to ensure equitable access to RH services, including FP, by all persons who need them, including groups with special needs - persons with disabilities (PwD) and hard-to-reach populations - pastoral or nomadic communities, migrant workers in industries and farms, refugees, and internally displaced persons (IDPs)

Its therefore imperative that the Family planning programs address these new challenges.

Rationale Cont'

Through the integration of FP and HIV services, these departments must ensure not only that;

- all service providers are adequately trained in the special needs of HIV-positive clients;
- all service providers intensify the fight against stigma, discrimination, and other barriers so that all HIV-positive individuals have easy access to reproductive health (RH) and FP services throughout the country.
- persons with disabilities (PwD) and hard-to-reach populations will require special planning and approaches to improve access to quality services for all.

Rationale Cont’

Population Status and vital indicators; Uganda’s Population Pyramid

Contraceptive Prevalence Rate (CPR)

- This is percentage of all women of reproductive age (15-49 years), who are using a method of contraception to delay, or limit pregnancy.
- It is calculated by dividing the number of Women of Reproductive Age (WRA) who are using a method by the total number of WRA respectively.

Cont’

- According to UDHS 2016, CPR is 39% (Urban (57.5%) and Rural (46.8%) and by region; North Central (47.4%), West Nile (21.8%), Eastern – Busoga (31%) Western – Bunyoro (31%) and Tooro (43.3%), East Central (32%), South-western- Kigezi (46.5 %) and Ankole (43.1), Kampala (48.7%) and Karamoja (7.3 %).

Unmet need for Family planning:

- This is a term used to describe the number of people or the percentage of the population who desire to use contraceptives to space or limit births but for a variety of reasons including lack of access to information or services, are not currently using contraceptives.

- Currently in Uganda the unmet need for Family planning has lowered to 28 % (UDHS 2016) while the total demand is 83%.

Consequences of rapid population growth

1. **Increased demand for education - pressure on the available facilities.**

- Uganda has a large proportion of young people less than 24 years (make up about 69% of total population) (National Population Census 2014).

2. Increased pool of under-employed or unemployed labor force - absorption into gainful employment is difficult.

- Uganda is predominantly a young population; these are relatively under trained, un-skilled and inexperienced.

3. Increased demand for housing/shelter especially in urban areas.

4. Increased demand for food resulting into shortage of food.

Cont'

5. Increased demand for health care; shortage of health workers; inadequate health facilities.

6. Shortage of land which results into deforestation and encroaching of wetlands, hence disrupting the normal ecosystem in many districts turning them into deserts, disruption of water bodies and contamination.

7. Rapid, uncontrolled, rural urban migration which presents negative consequences e.g. slums, high crime rate and high level of unemployment.

Use of important indicators (vital statistics)

To;

- show the patterns of health and disease in a community
- assess the health status of a community
- compare vital experiences (e.g. birth rate) of one population with another (for area difference)
- compare the vital experiences of a population over a period of time – for time trends
- make a decision and plan for preventive action
- determine the effectiveness and/or impact of e.g. Health Program

Application of these concepts during FP/RH service delivery

- young child clinics and pediatric wards;
- - post-natal clinics and wards;
- - ante-natal clinics;
- - out-patient clinics;
- - outreaches;
- - home visits;
- - youth/adolescent centers;
- - maternity wards

The end

Questions??????

What are the benefits of family planning?

Benefits of family planning

1. Gives the mother enough time to recover from the previous pregnancy and child birth
2. Give the mother time to look after the child properly
3. Some family planning methods protects against certain cancers
4. Condoms prevents STIs/HIV
5. Provides peace of mind to enjoy sex without fear of pregnancy
6. The child has full enjoyment of love and care from both parents
7. Normal physical and emotional development for the child
8. Adequate resources for school fees, medical care

10. Family planning reduces strain on forest,water,land

Concerns or Questions

summary

- Lack of access to family planning services has led to many women dying during pregnancy , labour and child birth
- It has also negatively impacted the survival of babies, the environment, house hold economies and food security

Thanks

Unit 4

Anatomy and physiology in relation to FP

Session objectives:

By the end of the session trainees will be able to:-

1. Identify parts of male and female reproductive organs using a diagram.
2. Review the functions of each part identified.
3. Apply the knowledge of anatomy and physiology of male and female reproductive systems to FP/RH

Internal female Repro. organ

Side View

Front View

Bladder

Pubic bone

Cervix

Urethra

Fallopian tube

Ovary

Uterus

Vagina

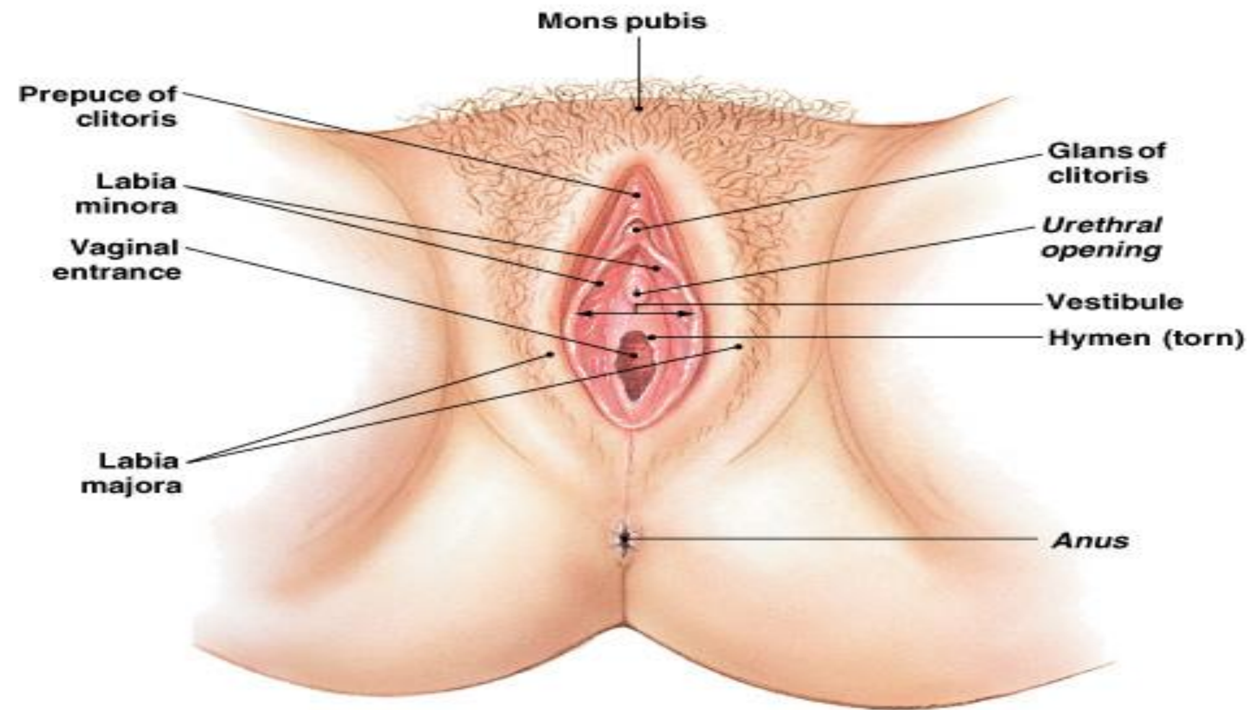
Rectum

Anus

Endometrium

Cervix

The female reproductive system



CLITORIS

- Small cylindrical-shaped mass of erectile tissue under the top of the labia minora.

FUNCTION.

- It is the principle organ of sexual pleasure(sexual arousal)

Application to RH/FP

- In counseling couples who complain of the female partner's delay in reaching orgasm, the service provider may explain the importance of gently stimulating the clitoris as a foreplay by the male partner.

Cont’d

- In cultures where the clitoris is excised, counseling should include:
- ✓ The risks of extensive tears during delivery due to scarring tissues as a result of excision of the clitoris.
- ✓ Infection (from the un-sterile clitoris excision tools) could spread to the urinary genital tract or peritoneum.
- The Clitoris can be excessively large (like a penis) in some congenital abnormalities. (Refer to Gynaecologist.)

URETHRA

- This is a passage of urine.

APPLICATION TO FP/RH

- The female urethra is short 3-4cm and is therefore prone to easy entry of the micro-organisms to the bladder(Cystitis).
- Service providers should take note in advising clients about personal hygiene especially during menses, pregnancy, and partum period when the vulva is usually more moist with increased vaginal discharge.

LABIA MINORA

- Two inner folds of skin extending from the clitoris down to the perineum forming the boundary of the vulva. They are covered by labia majora.

Note; Health providers who notice longer than usual labia minora should acknowledge this condition silently as a way of respecting cultural practices.

Vagina

- This is a canal extending from the vaginal orifice to the cervix and lies between the rectum and the urinary bladder. It is approximately 10.2 cm long on the posterior wall and 7.6 cm on the anterior wall. The upper end is divided into 4 fornices; 1 anterior,1 posterior, and 2 lateral.
- It is lined by stratified epithelium in folds known as ruggae.
- The outer coat of connective tissues is richly supplied with blood.

VAGINAL FUNCTIONS

- Outlet for menstrual flow.
- Entry for the penis during sexual intercourse.
- Passage for baby at birth.
- Produces mucous for lubrication during coitus and provides acid media which guards against growth of bacteria.(normal PH of the vagina is 4.0 or lower)

Application to RH/FP

- This is where the female condom is applied.
- Threads for IUD device can be felt in the vagina.
- Can be infected by STD/Genital tract infections.
- It runs upwards and backwards therefore, this point should be observed when introducing a speculum.

Cont’d

- Can tear during rape or child birth.
- In STIs, this is where vaginal pessaries are inserted.
- Male condom can be found here if it slips off during intercourse.
- This where Spermicides are inserted.
- In some congenital abnormalities, there may be a double vagina or a transverse septum and this may prevent entry of speculum.
- During pelvic examination, the health provider assesses the laxity of pelvic and vaginal muscles including signs of rectocele, cystocele, or uterine prolapse *[Surgical repair is also necessary.]*

CERVIX

- This the lower part of the uterus that projects into the vagina.
- In non-pregnant woman, it feels like a nose while in pregnancy it feels like lips.
- Opening of the cervix is called the OS. In nulliparous woman, it is round, smooth with a dimple in the middle, while in multiparous women, it appears like a slit and sometimes irregular.
- Pelvic congestion due to hormonal influence during the menstrual cycle or pregnancy makes the cervix appear bluish/purplish.

CERVICAL FUNCTIONS

- Allows menstrual blood to come out of the uterus.
- Allows sperms to enter the uterus from the vagina.
- Dilates and permits the birth of a baby from the uterus.
- Secretes different types of mucus during the different phases of menstrual

Application to RH/FP

- Site of cervical cancer and some STDs.
- Area that is inspected for cancer of the cervix and PAP smear is taken from.
- Examined for signs of pregnancy, diagnosis of labor and abortion.
- May be torn during rape, delivery or traumatized by foreign bodies inserted to induce abortion.

Cont'd

- Cervix may be incompetent leading to spontaneous abortions.
- This is where Shirodka/Mcdonald stitch is applied to help maintain pregnancy.
- Is absent in some congenital abnormalities or after a total hysterectomy.
- During pelvic examination, any of the following findings are abnormal and must be attended to, and the client must be counseled and or educated about the medical/nursing action being taken:

✓ Protrusion of the cervix into the vaginal vault of more than 3cm.

✓ Protruding masses or enlargement of the cervix or sore(ulcer).

Cont'd

- ✓ Purulent or foul smelling discharge.
- ✓ Blood discharge of unknown origin or ulcerations.
- ✓ When the cervix is friable(bleeds easily) on touch.
- ✓ When the color is bluish/purplish.
- ✓ When there is unrepaired tear sustained during childbirth.
- The different types of cervical mucus are referred to when counseling clients about fertility awareness FP methods, Cervical Mucus Method (CMM), Moon beads.

UTERUS

The uterus has a fundus, body, and cervix and can be located in 3 positions. It can also lean in 3 different positions:

- ✓ **Anteverted;** The uterus leans towards the bladder.
- ✓ **Retroverted;** The uterus leans towards the rectum.
- ✓ **Mid-line;** The uterus lies in the midline plane.

FUNCTIONS OF THE UTERUS

- Shade as menstrual flow.
- Provides as a site for implantation of fertilized ovum.
- Provides a site for placenta attachment.
- Carries and nourishes the unborn baby.
- Contracts and retracts during labour to expel the fetus.
- Contracts to control bleeding after delivery.

APPLICATION TO FP/RH

- Knowledge and understanding of the normal position, size, shape and consistency can help the provider to:
- ✓ Assess he uterine normality and abnormality on pelvic examination.
- ✓ This is where IUCD is placed.
- Can be ruptured during obstructed labour.
- Can be perforated during unsafe abortion.
- Can be removed during hysterectomy.
- Can be congenitally absent.
- Can be infected with STD or affected by abnormal growths e.g. Fibroids or cancer.
- It may be abnormal .e.g. may have two horns, septum or can be very small.

FALLOPIAN TUBES

- These are two thin tubes about 11 cm long found on both sides of the uterus.
- The lumen in each tube is the size of a needle, and is lined with cilia which sweep the ova towards the uterus.
- Each tube has the fimbriated end which picks up the ovum during ovulation.
- During ovulation the tubes are at their highest peak of peristaltic motility.
- Has 3 portions; Cornual, Isthmus, Fimbrial.

FUNCTIONS

- A passage way for sperms as they swim towards the ovum after ovulation.
- The tube propels the fertilized ovum towards the uterus.
- Fertilization occurs in the ampulla of the tube.

Application to RH/FP

- Can be infected by STDs and delayed treatment or if not treated correctly, can lead to scarring, blockage and infertility.
- Infection following poor technique procedures can damage the tubes. Therefore asepsis must be maintained when carrying out certain procedures.

Cont'd

- Infection can cause adhesions that block the lumen of the tubes leading to infertility or ectopic pregnancy.
- The fallopian tubes are the commonest site of ectopic pregnancy and can rupture leading to severe internal bleeding.
- The motility of the tubes can be reduced by hormonal influence.
- Knowledge of the fallopian tubes can be used when counseling clients for tubal ligation.

OVARIES

- These are two almond shaped glands located at the end of each of the fallopian tubes.
- They contain female eggs(ova).

Functions

- They release a mature egg(ovum) into the fallopian tube every month.
- Secrete female hormones, Oestrogen and Progesterone which change a girl into a woman at puberty.
- Continues to secrete female hormones after puberty.

APPLICATION TO FP/RH

- Can be infected by STIs.
- Can be affected by cancer.
- It can get cystic and may twist, rupture or bleed into the abdomen and cause severe abdominal pain.
- Hormonal methods of contraception work by affecting the ovarian function.
- Can be affected by mumps leading to severe abdominal pain and infertility.
- May be infected or absent leading to infertility.

EXTERNAL MALE ORGANS

Penis
Glans
Median raphe
Scrotum

Male Reproductive organs

Bladder
Pubic bone
Vas deferens
Urethra
Erectile tissue
Penis
Seminal vesicle
Prostate
Rectum
Epididymis
Scrotum
Testis

MALE REPRODUCTIVE ORGANS: PENIS:

- The penis is a cylindrical shaped organ consisting of; body, root, and glans.
- The root lies in the perineum and the body surrounds the urethra.
- The penis is formed by three elongated masses of erectile tissue and muscle.
- The penile muscles are spongy, with a rich blood supply.
- The glans is enlarged tip through which the urethra is exposed to the exterior, with a loose fitting skin, **Prepuce;** Foreskin that protects head of penis.

FUNCTION

- Penis contains the urethra for passing urine.
- Deposits sperms in the vagina during sexual intercourse.
- Principle organ of sexual pleasure(sexual arousal)
- Penile erection is controlled by male hormone-testosterone, so vasectomy does not interfere with erection.

Application to RH/FP

- The male condom is fitted on an erected penis.
- Penile erection is controlled by the nervous system and the male hormone-testosterone. This explains why vasectomy does not interfere with penile erection.
- It can be infected by STIs.

Cont'd

- In uncircumcised men the prepuce can easily be infected with STIs.
- The prepuce is the skin which is removed during male circumcision.

Scrotum

- This is loose contractile, deeply pigmented skin pouch.
- It is divided into two compartments each holding one testis, one epididymis and a spermatic cord.
- The scrotum lies below the symphysis pubis, in front of the upper parts of the thighs and behind the penis.

FUNCTION

- Contains and protects the testes.
- Regulates the temperature of the testes by:

a) Maintaining the temperature of less than 2 degrees Celsius bellow that of the body.(which is critical for normal function of the testes).

b) Contractile sac which contracts and brings testis closer to body to increase temperature.

Application to RH/FP

- Long distance travelling/driving or wearing tight underpants may cause raised temperature of the testes leading to temporary low production of sperms.

- Boys/ inexperience parents worrying about relaxed and contractile state of the scrotum can be reassured that this is a normal action of the scrotum.

MALE URETHRA

- This is a single tube approximately 15 cm running from the bladder through the penis to the exterior.
- The lumen is bigger than that of the female.

FUNCTION

- This is a passage for urine and seminal fluid.

Application to RH/FP

- It can be infected by STIs.
- A catheter may be passed through to drain urine from the bladder.
- It may be blocked by an enlarged prostate, or stricture caused by infection.

TESTES

- These are two oval reproductive glands also referred to as gonads.
- They are equivalent to ovaries in female.
- They measure 5cm Long,2.5cm wide,3cm thick, and weigh10-15grams.

Functions

- Testes secrete the male hormone called testosterone that helps to make men masculine.
- Testes produce spermatozoa.(a man produces sperms from puberty to old age continuously)

APPLICATION TO FP/RH

- Testosterone is the hormone that helps make men masculine.
- The mature sperm can live to about 3-5 days in a woman's genitals after ejaculation.
- Testis may fail to descend and lead to a risk of infertility and cancer.
- The knowledge on sperm maturation and the average time this process lasts is useful for effective counseling related to fertility awareness.
- After 4 weeks, if sperms are not passed to the vas-deferens, they are absorbed in the body. This knowledge is helpful when answering the misconception that" sperm produced after vasectomy can cause swelling in scrotum"
- It can be infected by STIs..

VAS-DEFERENENS

- These are 2 tubes each of which runs upward from the epididymis, along the posterior boarder of the testis, through the inguinal canal and pelvic cavity and arch over the posterior aspect of the bladder.
- Part of the vas-deferens which is 45 cm or(8 inches)long lies in the scrotal sac and is easy to reach on palpation.

Function

Transport sperms from epididymis and empties them into the seminal vesicle.

APPLICATION TO FP/RH

- This is the site for vasectomy.
- Vasectomy does not affect sperm production, they continue to be produced by the testis but after maturing they degenerate and are absorbed into the body.
- After vasectomy the male hormones and other factors maintain sexual desire.
- It can be infected with STIs, and become blocked leading to infertility.

SEMINAL VESICLES

- These two accessory glands lie posterior to and at the base of the urinary bladder, in front of the rectum.
- They are convoluted, pouch like about 5 cm long.
- They will continue to produce semen after vasectomy.
- After vasectomy, there is need to use a temporary method for 3 months.

Functions

- They empty semen into the urethra through the seminal vesicle ducts and ejaculatory ducts.
- They secrete the liquid portion of the semen, which contributes to the viability of the sperm.

Function Cont'd

- The fluid contains simple sugars like Fructose which provides nutrition for sperms.
- Mature sperms are stored here until they are ejaculated during sexual intercourse or are passed out during wet dreams.

Application to RH/FP

- The seminal vesicle continues to produce semen even after vasectomy.
- This information helps to dispel the myth that a man will continue to ejaculate but the ejaculation will have no sperms.

COWPER'S GLANDS

- These are two accessory glands about the size of peas, and lying beneath the prostate, on either side of the membranous urethra. The ducts open into the urethra.

FUNCTION

- Production of semen and an alkaline secretion, which protects sperm against the acid secretions of the male urethra and vagina. The fluid produced neutralizes acidity in the urethra.

Application to RH/FP

- After removal of prostate gland, the Cowper's glands continues to secrete alkaline; Alkaline is important for normal viability of sperms in the female genital tract.
- The semen continues to be produced even after the vasectomy, contributing to the ejaculate which has no sperm.

The Menstrual Cycle and its Application to FP

Session objective

By the end of the session trainees will be able to:

1. State the meaning of six terms commonly used in describing menstrual cycle namely:
   - Menstrual cycle; Menstruation; Ovulation; Hormones; Corpus Luteum; Feedback mechanism
2. Discuss the functions of the five hormones that influence changes in the menstrual cycle.
3. Explain the different changes that occur in the ovaries, uterus and cervix during each of the three phases of the menstrual cycle.
4. Apply the knowledge of the menstrual cycle to FP.

Meaning of terms

Menstrual cycle:

- The menstrual cycle is the name given to the cyclic changes in the reproductive system of the mature female that take place in anticipation for pregnancy. It starts from day 1 of menstruation to the day before the first day of the next menstruation.
- On average, it is usually of 28 days duration, but may vary from 21 – 35 days or more. It consists of three phases:
- 1) Menstrual phase
- 2) Estrogen (proliferative) phase
- 3) Progesterone (secretory) phase

Menstruation:

- Is the blood loss through the vagina that occurs with shedding of the endometrium at the start of each cycle. This bleeding may last for two to seven days.

Con’t

Ovulation

- This is the release of a mature ovum from the ovary. This occurs 14 days before day one of the next menstruation. Some women experience pain (Mittleschmerz) on the side of the ovary from which ovulation has occurred

Hormones

- These are natural chemicals carried in the blood stream that influence how glands and organs work.

Feedback mechanism

- Low levels of hormones give feedback messages to the brain Hypothalamus) to release Gonadotropin Releasing Hormone (GnRH) at appropriate intervals which make the anterior pituitary lobe release FSH and LH

Cont'd

Corpus luteum (Yellow Body)

- This is the shell from which the ovum has been released. The corpus luteum produces some estrogen and large amounts of progesterone.

Phases of the menstrual cycle and clinical applications

- Low levels of hormones give feedback messages to the brain (hypothalamus) to release GnRH at appropriate intervals which make the anterior pituitary lobe release FSH or LH.

Menstrual phase

- Approximately day 1 – 7; occurs when there is no pregnancy.

Cont'd

Changes which take place:

- ***Ovaries:*** Corpus luteum (shell that ovum has been released from) shrivels and dies. Levels of progesterone and estrogen drop.
- **Uterus:** Endometrium is shed.
- **Cervix:** Blood comes out and is visible externally.
- **Hypothalamus**: Receives a message to release GnRH.

Cont'd

Clinical applications:

- The uterus is not ready for pregnancy during this period; therefore, it is safe to start clients on FP methods between days 1-7 as the chances of pregnancy are extremely low in the majority of women.

Estrogen (Proliferative) phase

- Approximately day 7-14; Changes which take place:
- ***Anterior pituitary lobe, r***eleases Follicle Stimulating Hormone (FSH) to the ovaries due to presence of GnRH.

Ovaries

- FSH stimulates/activates the ovarian follicles (eggs) to grow and as they do so high levels of estrogen and some progesterone are released.
- ***Uterus***
- Estrogen starts re-growth of inner lining of the uterus. It becomes thick and firm.

Cont'd

Cervix

- Estrogen makes cervical mucus thin, clear, and stretchy to assist entry and to nourish sperm.

Clinical applications

- The small amount of estrogen in COCs is not enough to stimulate the endometrium to grow thick. - why women on COCs have light periods.
- The presence of estrogen and progesterone in hormonal contraceptives makes the hypothalamus not produce GnRH so that the ovarian follicles do not develop.
- Thin, stretchy cervical mucus is a sign of fertility.
- Sperm can survive in this cervical mucus for up to three days if sexual intercourse takes place before and immediately after thin mucus starts. Hence fertilization can occur the "Peak" period.
- Women on progestin-only FP methods have irregular periods, episodes of spotting.
- POCs in some women relaxes vaginal muscles and in some women it may cause loss of libido.

Progesterone (Secretory) phase

- Approximately day 14-28;

Changes which take place:

Anterior Pituitary Lobe: High levels of estrogen cut off FSH and bring on Luteinizing Hormone

Ovaries:

- Luteinizing Hormone makes the follicles grow faster and one matures and is released out of the ovary into the fallopian tube. This mature egg is ready for fertilization. This process is called ovulation. A mature follicle is released from a shell. This shell yellow body or corpus luteum, releases high levels progesterone and estrogen.

Cont’

Uterus:

- Progesterone makes the endometrium thicker and richer in blood supply. Endometrial glands coil and make it soft and produce/secrete nutrients rich in sugar and glycogen. The endometrium is ready for implantation.

Cervix

- Mucus becomes dryer and stickier, plugging the cervix and blocking the passage of sperms. If no pregnancy occurs:
  - Corpus luteum shrinks and levels of estrogen and progesterone drop.
  - Endometrium begins to shrink and shed, starting a new cycle.
- If pregnancy occurs:
  - Corpus luteum continues to produce progesterone and estrogen until the
  - placenta takes over.

Clinical applications

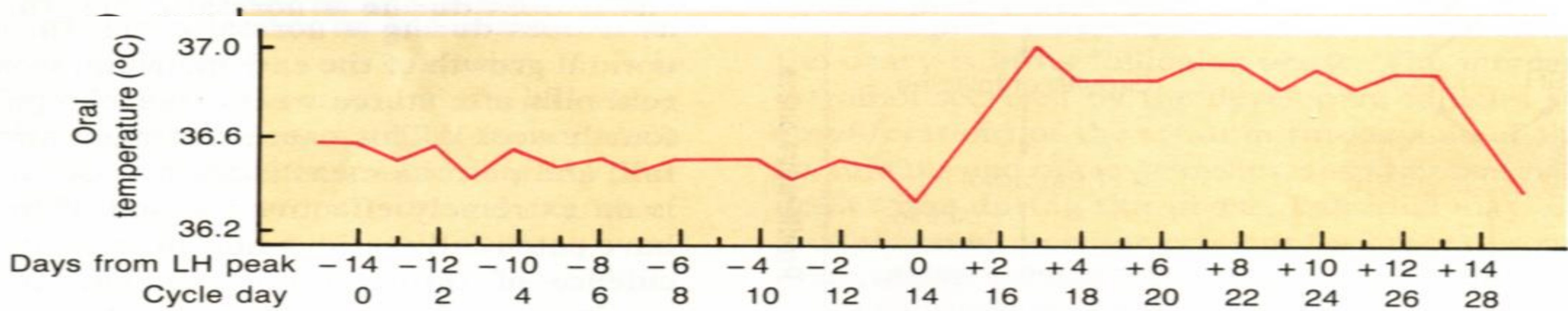
- Progestin in FP methods alters the cervical mucus making it thick and not easy for sperms to pass through. Hence the quick (24 hours) protection against pregnancy by injectables, POP and contraceptive implants.
- The fact that ovulation occurs before menstruation explains the risk of pregnancy before menses in post-abortion and post-partum women and unnoticed pregnancy in women with Lactation Amenorrhea.
- Just as the lowering of hormones causes shedding of the endometrium if a woman forgets to take 3 or more pills, she gets a withdrawal (lowering of hormones) bleeding.

Cont’

- Methods that contain high progestin levels with no withdrawal, such as injectables or contraceptive implants switch off FSH and LH and therefore, can cause amenorrhea with prolonged use.

- Emergency contraceptive (ECP) prevents fertilization.

- **Application of menstrual cycle physiology to family planning (pg 77-78)**

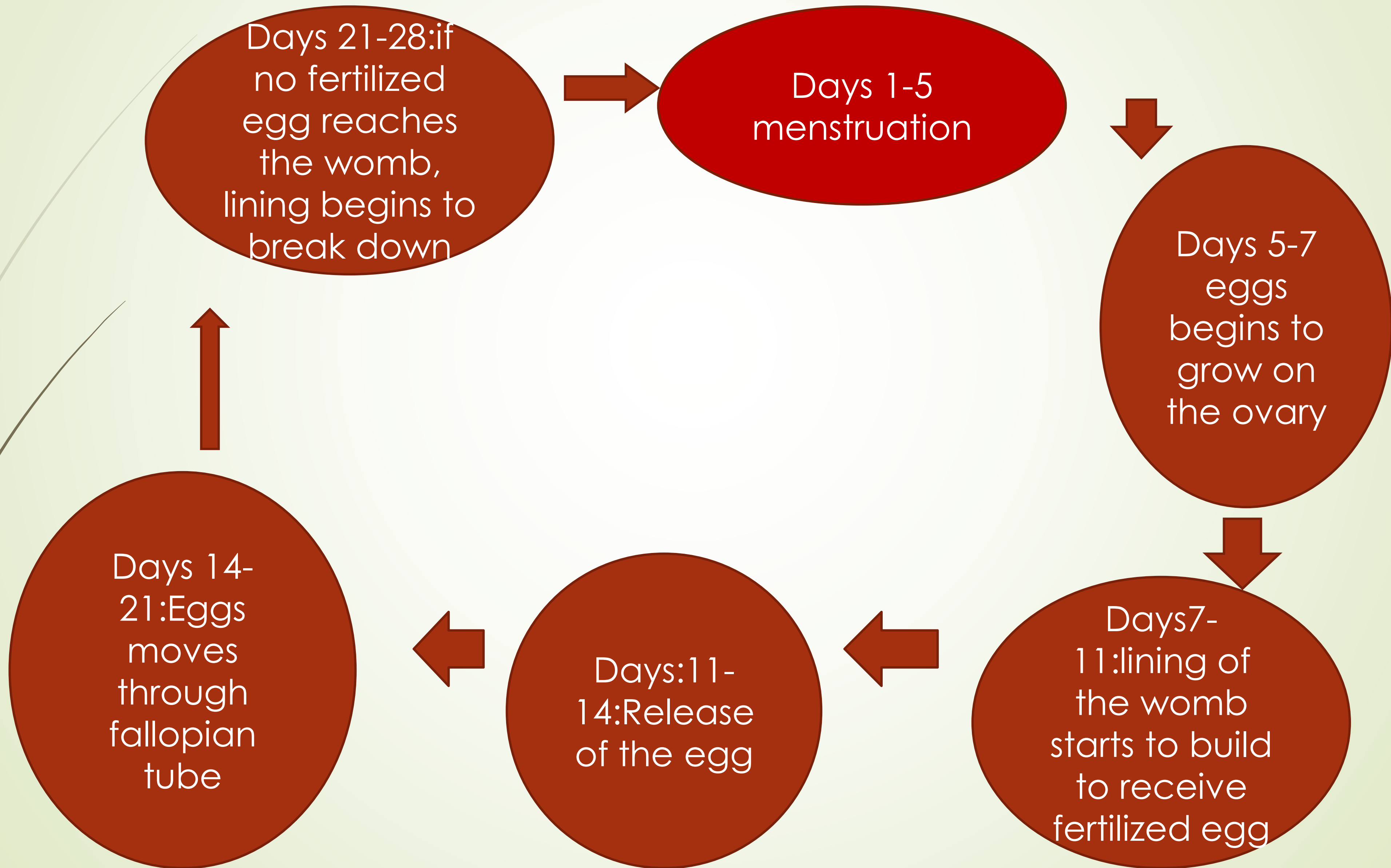


Cyclic changes in ovarian hormones secretion also cause cyclic changes in basal temperature.

On the day of the LH peak, when estrogen secretion begins to decline, there is a slight drop in basal body temperature.

Starting about one day after the LH peak, the basal body temperature sharply rises as a result of progesterone secretion and remains elevated throughout the luteal phase of the cycle.

What happens during the menstrual cycle



Days 21-28:if no fertilized egg reaches the womb, lining begins to break down
Days 1-5 menstruation
Days 5-7 eggs begins to grow on the ovary
Days7-11:lining of the womb starts to build to receive fertilized egg
Days:11-14:Release of the egg
Days 14-21:Eggs moves through fallopian tube

DESCRIPTION OF THE FAMILY PLANNING METHODS

GROUP WORK

Information sharing *(brain storm)*

- List the modern family planning methods in Uganda.
- Describe how each method is used
- Advantages of each method
- List the side effects of each method

Any questions??

summary

- Family planning methods if correctly and consistently used offer protection against unwanted pregnancies.

Only condoms offer dual protection

THANK YOU

FP methods

Short Acting

- *Barrier methods*
- *Oral contraceptive pills*
- *Injectables*
- *Lactational amenorrhea method (LAM)*
- *Fertility awareness-based methods*

FP methods

Long acting:

- Implants
- IUCD
- Female and Male sterilisation

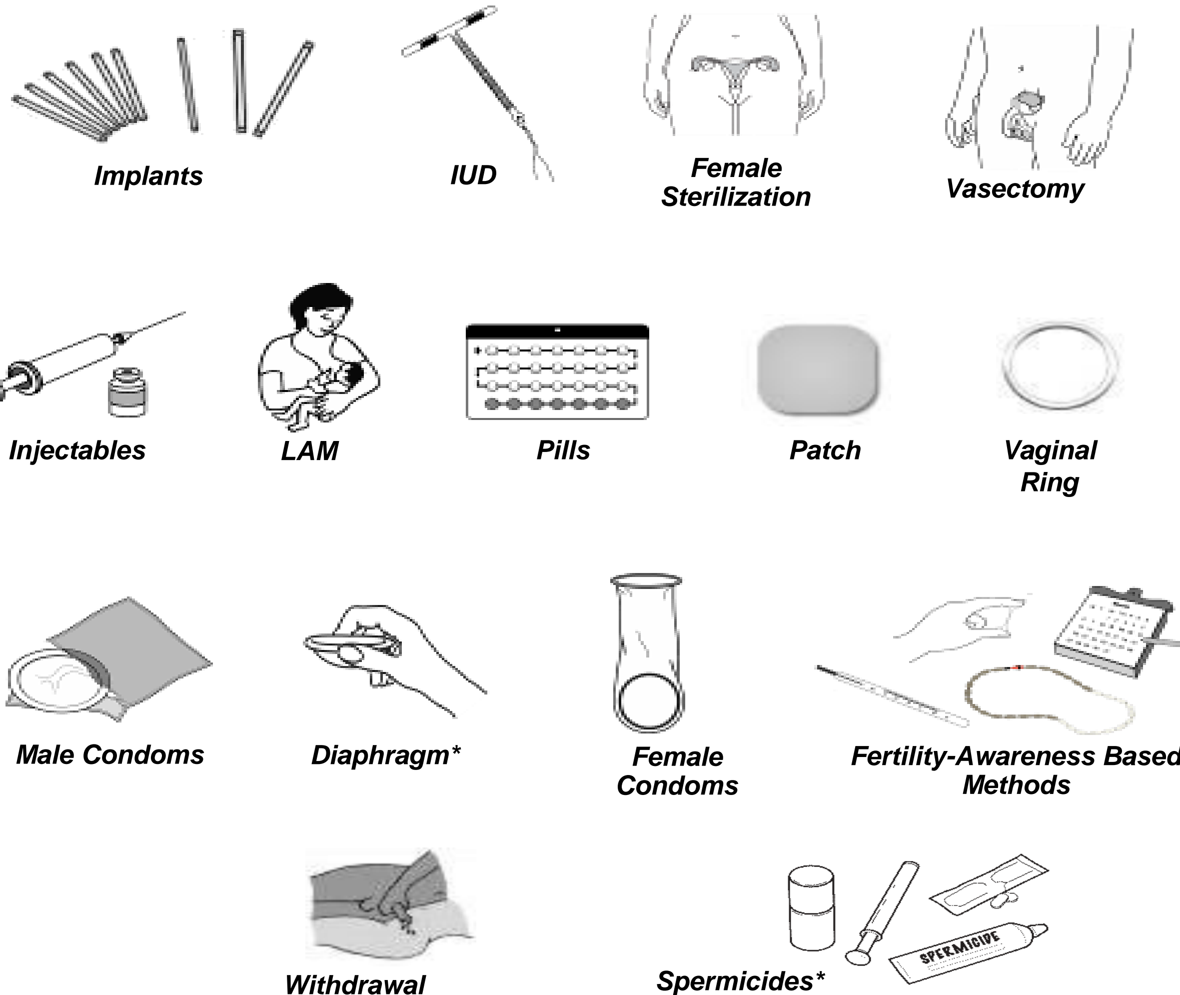
Comparing Effectiveness of FP Methods

More effective

Less than 1 pregnancy per 100 women in 1 year

Less effective

About 30 pregnancies per 100 women in 1 year



How to make your method more effective

Implants, IUD, female sterilization: *After procedure, little or nothing to do or remember*

Vasectomy: *Use another method for first 3 months*

Injectables: *Get repeat injections on time*

Lactational Amenorrhea Method *(for 6 months): Breastfeed often, day and night*

Pills: *Take a pill each day*

Patch, ring: *Keep in place, change on time*

Condoms, diaphragm: *Use correctly every time you have sex*

Fertility-awareness based methods: *Abstain or use condoms on fertile days. Newest methods (Standard Days Method and TwoDay Method) may be easier to use.*

Withdrawal, spermicides: *Use correctly every time you have sex*

** Spermicides and diaphragms with spermicide should not be used by women with HIV or at risk of HIV.*

Description of FP methods

Long acting:

- Implants
- IUCD
- Female and Male sterilisation

INTRA- UTERINE CONTRACEPTIVE DEVICES/IUCD

Specific objectives cont..

By the end of unit, learners will be able to :

- Define IUCD
- Describe the mechanism of action of IUCD and effectiveness
- Describe indications, contra indications, advantages and limitations of IUCD use including eligibility criteria for use.

Specific objectives

- Describe the side effects associated with IUCD.
- State the rumors and misconceptions associated with IUCD and facts to dispel them

Definition

A small plastic flexible device containing copper or steroid hormones that is placed in the uterine cavity by a trained service provider to prevent pregnancy.

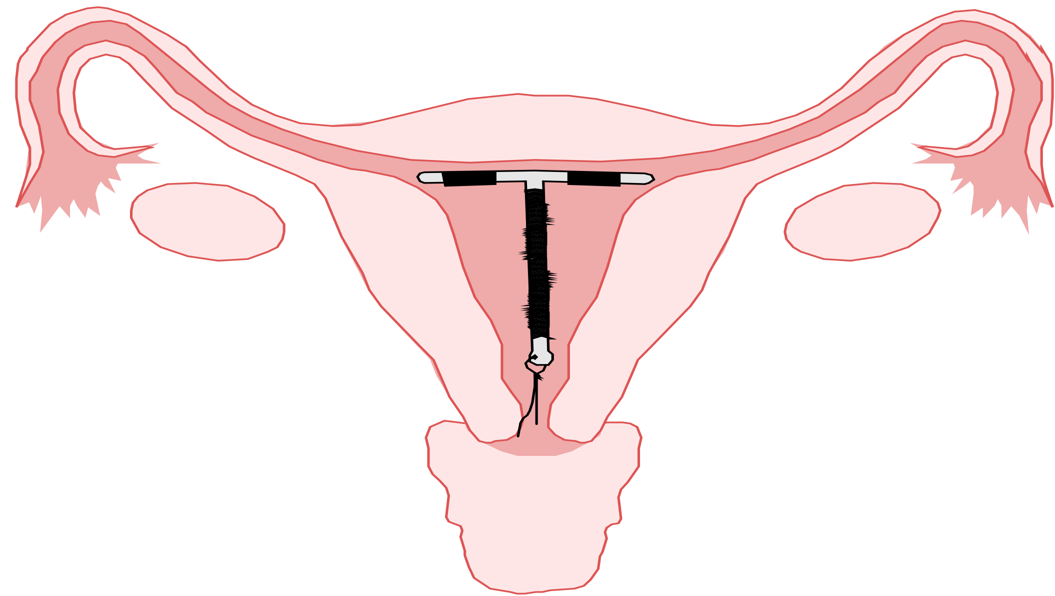
It is a safe and highly effective long acting and reversible contraceptive method

Effectiveness

- It is a reliable method (99% effective) and the client can be with it for up to 12 years.

Mechanism of action

- S – sperm immobilization
- O – ova transportation acceleration
- F – fertilization interference
- I – implantation prevention



Mechanism of action of copper IUCD

- Copper based devices release copper and work mainly by preventing fertilization.
- Copper ions decrease sperm motility and function by altering the uterine and tubal fluid environment

- The device also stimulates foreign body reaction in the endometrium that releases macrophages and prevents implantation.

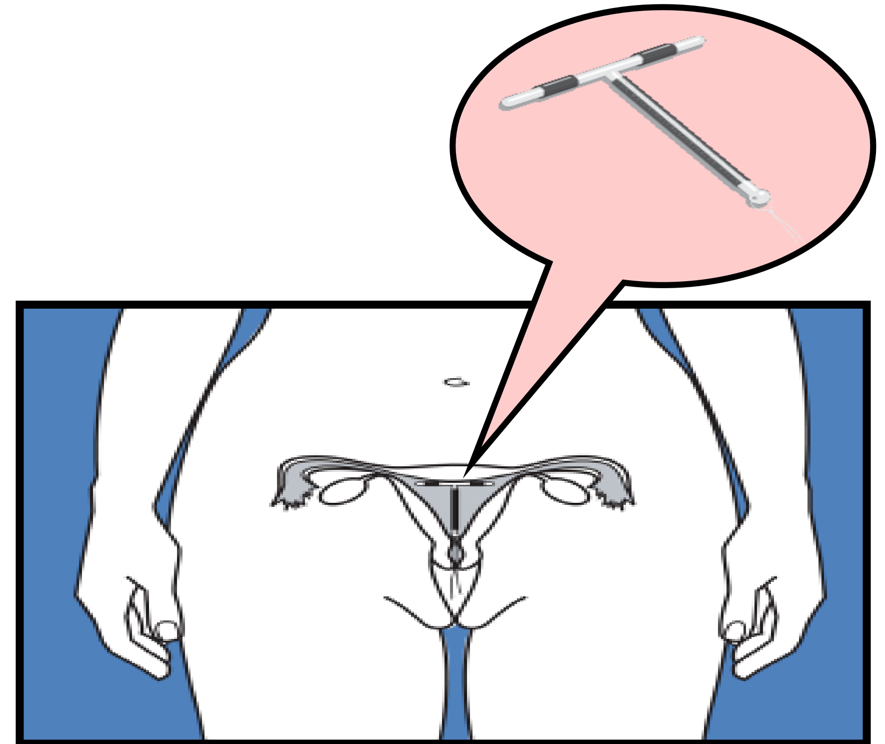
Types of IUCDs and their duration of effectiveness

Copper based devices:	**Duration of effectiveness**
• Copper T 380A	12 years
• TCu380S	8 years
• Copper T2OO	8 years
• Gynefix	8 years
• NOVA T	5 years
• Multiload- MLCu-375	5 years
• Multiload ML Cu -250	3 years
• Copper T- 220	3 years
Hormone releasing IUCDs:	
• Mirena (LNG-20IUS),	5 years
• Lingus- (LNG-IUS)	5 years

Advantages of IUCD (1)

Contraceptive benefits

- Highly effective and safe
- Immediate effectiveness
- Long-acting protection
- Easily reversible
- No systemic effects
- Complications are rare
- Immediate return of fertility upon removal



Advantages (2)

Other Benefits

- Do not interfere with intercourse
- Can be used by women who are breastfeeding
- Can be used by women immediately after delivery
  - IUCDs –including the Copper IUCDs may help protect from endometrial cancer
- IUCD help prevent ectopic pregnancy
- Hormonal IUCDs may reduce menstrual bleeding or cause amenorrhoea
- Doesn't require daily attention from the user
- One time procedure and is cost effective
- Does not interact with any medicines the client may be taking.

Disadvantages

- Insertion and removal require trained provider
- Require appropriate infection prevention practices during insertion and removal
- Do not protect against STIs/HIV/AIDS
- May be expelled or translocated
- Perforation of the uterus may occur, but is rare

Side effects

- Menstrual changes: There may be increase in the duration/amount of menstrual bleeding or spotting or light bleeding during the first few days or months after insertion

- Discomfort or cramps during IUCD insertion and for the next few days which subsides in due course.

Myths and misconceptions

- Myth: IUCD are abortificient
- Fact: IUCD prevent pregnancy by slowing sperm movement
- Myth: IUCD can migrate to other organs eg heart
- Fact: IUCD usually stays in the uterus until it is removed. If it does come out by itself, it comes out through the vagina

Myths and misconceptions con't…

- Myth: IUCD interferes with sex.
- Fact: IUCD is located in the uterus, not the vaginal canal, neither the woman nor her partner will feel it during sex. The partner may feel the strings.
- Myth: The IUCD may rust inside the woman's body
- Fact: IUCD will not rust inside her body, even after many years.

Myths and misconceptions con’t

- Misconception: IUCD increases a woman’s risk of ectopic pregnancy.
- Fact: IUCD reduces the risk of ectopic pregnancy by preventing pregnancy. Women who use copper-bearing IUCDs are 91% less likely than women using no contraception to have an ectopic pregnancy (Sivin 1991).
- Misconception: IUCD causes PID, and it needs to be removed to treat PID.
- Fact: several studies done show that PID among IUCD users is rare. Risk of PID attributable to IUCD is 0.15% to 0.30%
- Misconception: IUCD causes infertility.
- Fact: Infertility caused by tubal damage is associated not with IUCD use, but with chlamydia infection. Moreover, there is an immediate return to fertility after an IUCD has been removed

Myths and misconceptions

- Misconception: IUCD is unsuitable for use in nulliparous women.
- Fact: Nulliparous women can generally use the IUCD. However, expulsion rates tend to be slightly higher in nulliparous women compared to parous women
- Myth: IUCDs cause PID
- Fact: PID incidence for IUD users same as for general population. Increased Incidence may only occur during 1st month after insertion
- *Preexisting STI at time of insertion may cause PID , **NOT** IUD itself,*

Fact conti…..

- No ↑ risk of chlamydia acquisition

There is ↑ Risk of upper genital tract infection at insertion, compared to women with no STI. Comparable PID rates between women with STI and IUD insertion vs STI and no insertion

- LNG IUD may ↓ PID
- NO apparent effect among HIV+ women

Facts on IUD and Nulliparous women

- *High acceptability rate (60%)*
-
- *No concern for future infertility*
- *Expulsion rate same for nullips/multips (5%)*
- *Slightly higher insertion pain*
  — Same as for parous women without labor or SVD
  — Pain scores low regardless (2.7 vs 1.9)
- *Similar rates of continuation/satisfaction between nullips and multips (80% and 88%, respectively)*

Facts

IUD Use Post-Abortion or Postpartum

- Insertion post-abortion does **NOT** increase:
  — Post-abortion endometritis or PID
  — Expulsion rates after 1st trimester insertion
- Insertion immediately postpartum does **NOT** increase PID/endometritis
- Insertion postpartum has an "acceptable" expulsion rate

IUD: Non-contraceptive Benefits

- Intrauterine contraceptives including CU –IUDs decrease the risk for endometrial cancer
- The levonorgestrel-releasing intrauterine system (LNG-IUS) can be used as a first-line option to treat menorrhagia
  - May be used in the presence of fibroids, unless they significantly distort or enlarge the uterine cavity
  - Produces a 97% decrease in menstrual blood loss
  - In a retrospective study, 80% of women who were prescribed the LNG-IUS for menorrhagia chose not to undergo a hysterectomy, as opposed to 9% of women who received normal care for the condition

Myths and misconceptions (IUD and HIV)

- Misconception: IUCD cannot be safely used by HIV-infected women who are clinically well.

- Facts: HIV-infected women who are clinically well can generally use the IUCD

- Misconception: IUCD interferes with ARV therapy.

- Fact: Women who have AIDS, are on ARV therapy, and are clinically well can generally use the IUCD

Medical Contraindications for IUD

- Pregnancy
- Immediately after puerperal sepsis or a septic abortion
- Undiagnosed abnormal vaginal bleeding
- Malignancy of the genital tract
- Known anomalies or fibroids that significantly distort the uterine cavity in a way that is incompatible with IUD insertion

Medical Contraindications for IUD cont’d

- Current pelvic inflammatory disease
- Current purulent cervicitis, chlamydial infection, or gonorrhea
- Allergy to any component of an IUD or Wilson's disease (for copper-containing IUDs)
- Known pelvic tuberculosis

IUD: Counseling Topics

- Effectiveness of intrauterine contraception
- Mechanism of action
- No protection against HIV or other sexually transmitted infections
- Non-contraceptive benefits
- Side effects
  - At insertion—variable discomfort, some cramping later
  - First few days—light bleeding, mild cramping
  - First few months—intermenstrual bleeding, cramping
    - Copper IUD: Heavier or prolonged menses
    - LNG-IUS: Gradual decrease in menstrual flow
- Instructions not to check the IUD string
- Return for follow-up appointment after at 6 weeks

IUCD Counseling Topics

- Characteristics of IUCDs
- Effectiveness and how IUCDs work
- Instructions for use and follow-up
- signs of complications that require immediate

return to the clinic

When to Insert an IUD

- Any time during menses
- Any other time during a woman's cycle if:
  - She used appropriate contraception;
  - She was not sexually active, or
  - Her pregnancy test was negative

- Any time after a pregnancy, a spontaneous abortion, a miscarriage, or an induced abortion if a woman has not engaged in unprotected intercourse and immediately after delivery.

Intrauterine Contraceptives: Key messages

- Efficacy equivalent to sterilization
- Broad options for insertion timing
- Can be inserted into nulliparous women
- Can be inserted after abortion or delivery
- Cost-effective, safe , highly effective , reversible and provides protection immediately on insertion
- The user should check for strings after menstruation and on every pad before disposal

Copper IUCDs – Common Side Effects

- Cramping and increased or prolonged menstrual bleeding

- Possible bleeding between menstrual periods

Side effects are most common during the first 3 months.

Abnormal bleeding patterns

Spotting or light bleeding between menstrual periods and heavier or prolonged menstrual bleeding

MANAGEMENT

- Reassure that this problem usually decreases over time.
- If she requires treatment give a short course of NSAIDs e.g. Ibuprofen
- If persistent spotting or heavy or prolonged bleeding, exclude gynaecologic problem.
  - If gynaecologic problem is identified, treat the condition or refer for care.
  - If no gynaecologic problems are found, and she finds the bleeding unacceptable, especially if there are clinical signs of anaemia remove the IUCD and help her choose another method.

Abdominal cramping

- Inform client that some abdominal cramping may occur in the first 24-48 hours
- If cramping continues give analgesics

- Examination should rule out partial expulsion of the IUCD, ectopic pregnancy or PID (see below).

- Treat dysmenorrhoea with analgesics.
  - If persistent, rule out pelvic pathology (refer or manage as appropriate

IUCDs – Pelvic Inflammatory Disease (PID)

Risk of PID in IUCD users:

- Low overall Risk of PID attributable to IUCD is 0.15% to 0.30%
- Risk of PID higher during first 20 days after insertion
  - Due mostly to presence of gonorrhea or chlamydia at time of insertion
  - Similar to risk of PID in women with gonorrhea and chlamydia who are not using IUCD

IUDs – Reducing the Risk of PID

- Do not insert IUD if:
  - at high individual risk of STIs, or
  - clinical symptoms and signs of an STI are present
- Counsel about risk of PID
- Follow infection prevention procedures during insertion
- Recommend follow-up visit at 3 to 6 weeks to check for infection
- Return immediately if any symptoms of PID develop
    - Lower abdominal pain
    - PV discharge
    - Backache
    - Fever

Management of PID

- Treat the PID using appropriate antibiotics.

- There is no need for removal of IUCD if she wishes to continue its use

- If symptoms do not improve after a few days of antibiotics, IUD removal may be considered and antibiotic treatment continued.
- In all cases woman should be closely monitored until PID is fully resolved.

IUCD and uterine Perforation

Risk of uterine perforation:

- Linked to skill and experience of provider
- Reduced through intensive coaching during training
- Greater for postpartum insertions performed between 48 hours and 4 weeks after delivery

Diagnosis of perforation

- Patient complains of suddenly significant pain during the insertion procedure or uterine sound,

- If the loaded intrauterine contraceptive (IUD) inserter tube passes into the uterus beyond 9–10 cm without fundal resistance being felt.

Management of Perforation During Insertion

- If uterine perforation occurs at the time of insertion:
  - Remove the device
  - Provide alternative contraception
  - Monitor for excessive bleeding
  - Follow up as appropriate
  - Insert another device after next menses if desired by patient

Symptoms of partial or complete expulsion

- May go unnoticed
- Irregular bleeding,
- pain during intercourse (for either woman or partner)
- Unusual vaginal discharge,
- May have bleeding after sex.
- Missing or longer IUCD strings and
- Delayed or missed menstrual period

Management of complete or partial expulsion

- If complete expulsion of the IUCD is confirmed (e.g., seen by the woman or confirmed by ultrasound or X-ray):
  - Replace IUCD now if desired and appropriate (no signs of infection, pregnancy ruled out);
  - Provide alternative method if possible, as well as a back-up method if needed.

Management of complete or partial expulsion conti….

- If partial IUCD expulsion is confirmed by health care provider:
  - Remove the IUCD and replace IUCD now if desired and appropriate (no signs of infection, pregnancy ruled out);
  - Provide alternative method if possible, as well as a back-up method if needed.

Pregnancy with IUCD

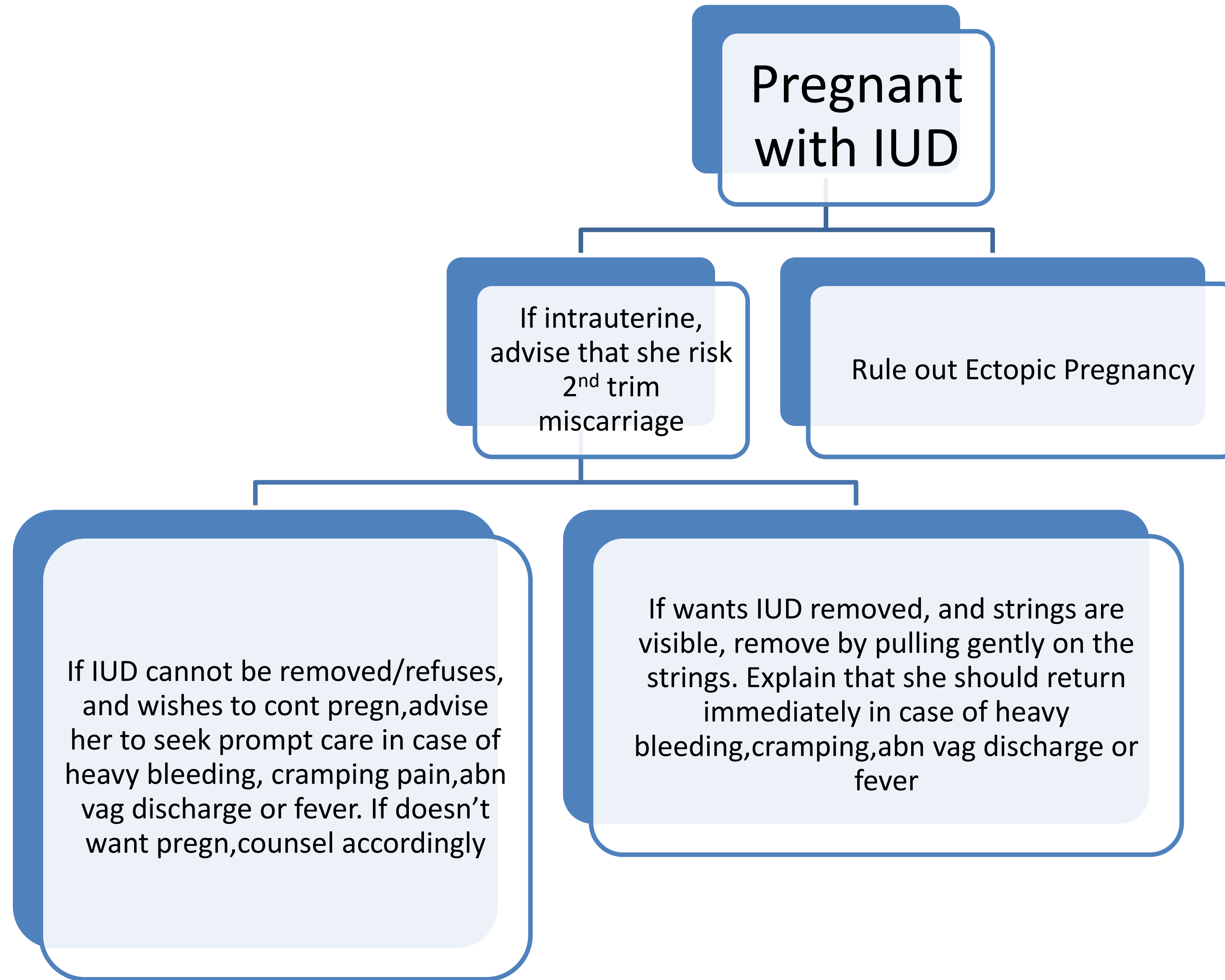
- Exclude ectopic pregnancy (ultrasound scan where available; otherwise careful clinical monitoring).

- If woman wants IUCD to be removed, but the IUCD strings are not visible determine if IUCD is still in the uterus by Ultra sound. If the IUCD is not located, this may suggest that an expulsion of the IUCD has occurred.

Pregnancy with IUCD

- If IUCD cannot be removed or woman refuses to have it removed but she wishes to continue the pregnancy, advice her to seek care promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge, fever.
- If woman wants IUCD to be removed and the IUCD strings are visible or can be retrieved safely from the cervical canal (in the 1st 3 months)
  - Remove IUCD by pulling on the strings gently.
  - Explain that she should return promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever.

Management of Pregnancy with IUD



Equipment for IUD insertion

i. Bivalve (Cuscos) speculum (small, medium, or large)
ii. Uterine tenaculum
iii. Uterine sound
iv. Forceps (e.g., uterine dressing, sponge)
v. Long Scissors
vi. Bowl for antiseptic solution
vii. Kidney dish
viii. Scissors

Xix. Gloves (high-level disinfected or sterile surgical gloves or new examination gloves)

X. Antiseptic solution for cleaning cervix (preferably Savlon)

Xi. Gauze or cotton balls

Xii Light source sufficient to visualize cervix (flashlight will suffice)

Xiii. Copper T 380A IUD in unopened, undamaged sterile package

Inserting the loaded Cu T-380A IUD

i. Ensure the mother has emptied the bladder before conducting a pelvic examination; ensure the

- to assess eligibility
- perform a bimanual examination
- insert a speculum into the vagina to inspect the cervix.
- Clean the cervix and vagina with appropriate antiseptic
- Ask the woman to take a slow deep breath and relax

ii. Gently insert the tenaculum at position 2 or 10 clock face and gently close the tenaculum to hold the cervix and stabilize the uterus steadily.

iii. Gently and slowly pass the uterine sound through the cervix to measure the depth and position of the uterus.

Cont'd

iv. Load the IUD onto the inserter

v. Using the tenaculum which is still in place on the cervix after sounding the uterus, pull firmly to pull the uterine cavity and cervical canal in line with the vaginal canal.

vi. Gently place the loaded inserter tube through the cervical canal. Keep the blue depth gauge in a horizontal position.

vii. Advance the loaded IUD until the blue depth gauge touches the cervix or resistance of the uterine fundus is felt. Keep the blue depth gauge in a horizontal position.

Cont’

viii. Hold the tenaculum and the white rod in place in one hand, with your other hand, withdraw (pull toward you) the inserter tube until it touches the thumb grip of the white rod. This will release the arms of the TCu 380A.

ix. Once the arms have been released, again very gently and carefully, push the inserter tube upward, toward the top of the uterus, until you feel a slight resistance.

- This step ensures that the arms of the T are as high as possible in the uterus.

x. Hold the inserter tube still while removing the white rod

Cont’

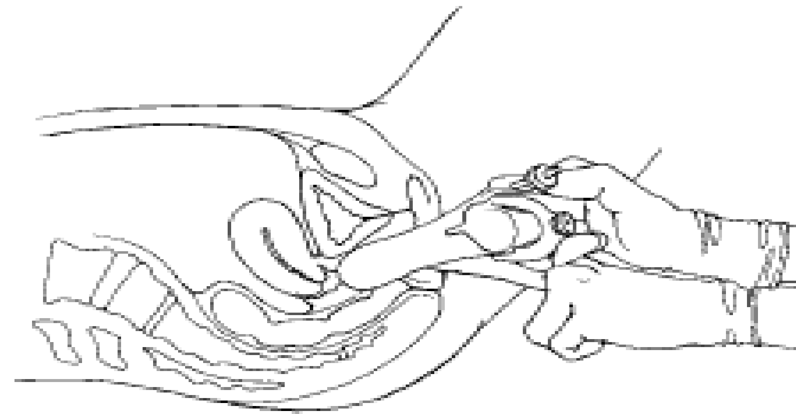
xi. Gently and slowly withdraw the inserter tube from the cervical canal.

- The strings should be visible protruding from the uterus.
- Cut the strings so that they protrude only 3-4 centimeters into the vagina.
- Remove the tenaculum. If the cervix is bleeding from the tenaculum site, press a swab to the site, using clean forceps, until the bleeding stops.

xii. Gently remove the speculum and put all of the instruments used in 0.5% chlorine solution for 10 minutes for decontamination.

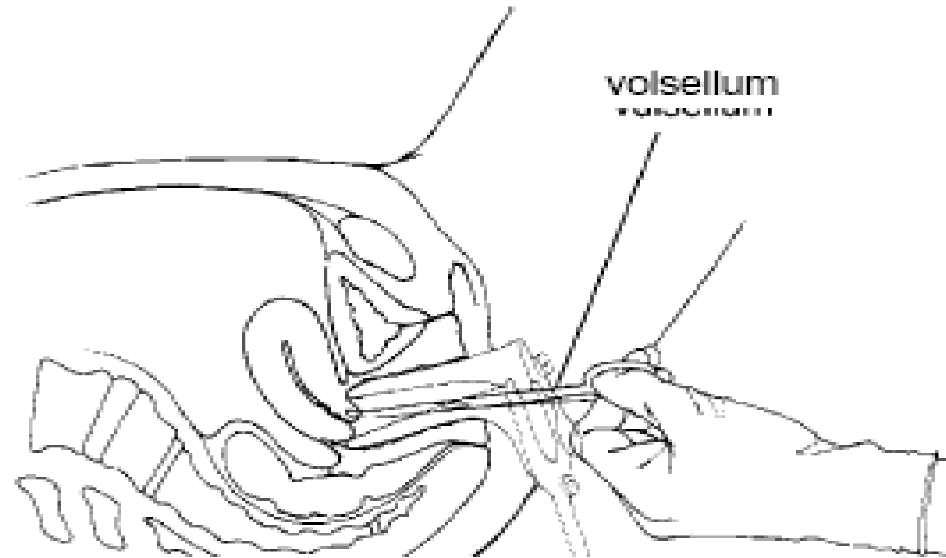
Steps In IUD Insertion

Figure 6.2 Inserting the Speculum



Steps In IUD Insertion cont..

Figure 6.3 Gently Grasping the Cervix with the Volsellum



Steps In IUD Insertion cont…

Fig. 6.4 Sounding an anteverted uterus

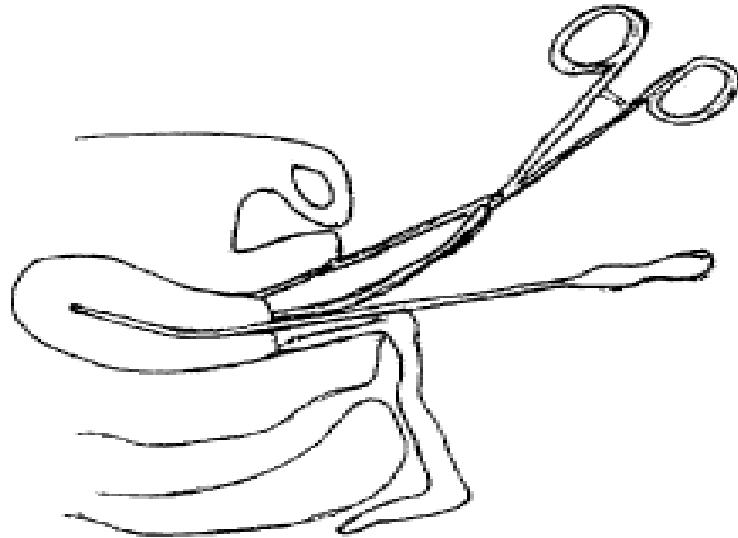
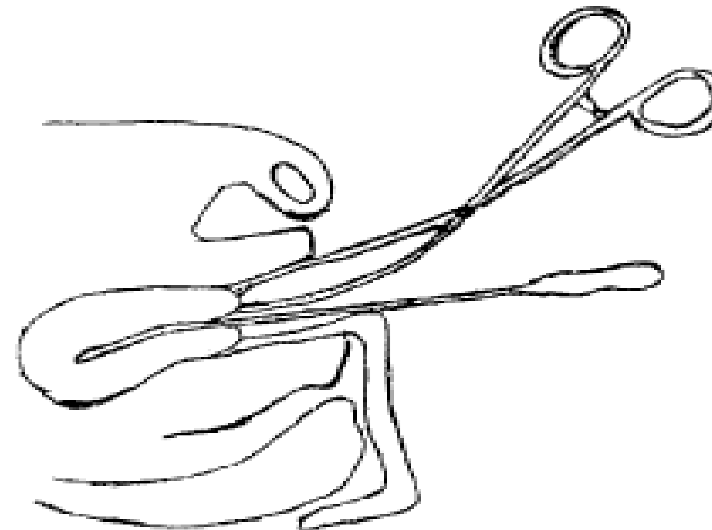


Fig. 6.5 Sounding a retroverted uterus



Steps cont…..

Figure 6.6 Inserting the Loaded IUCD

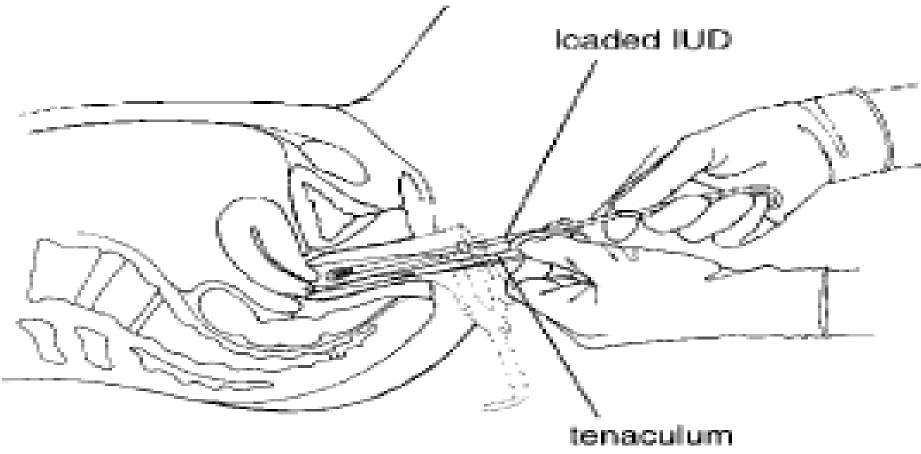
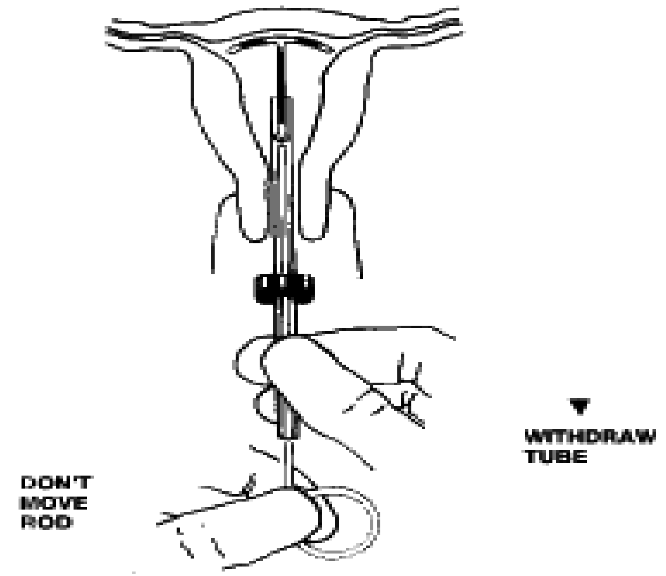
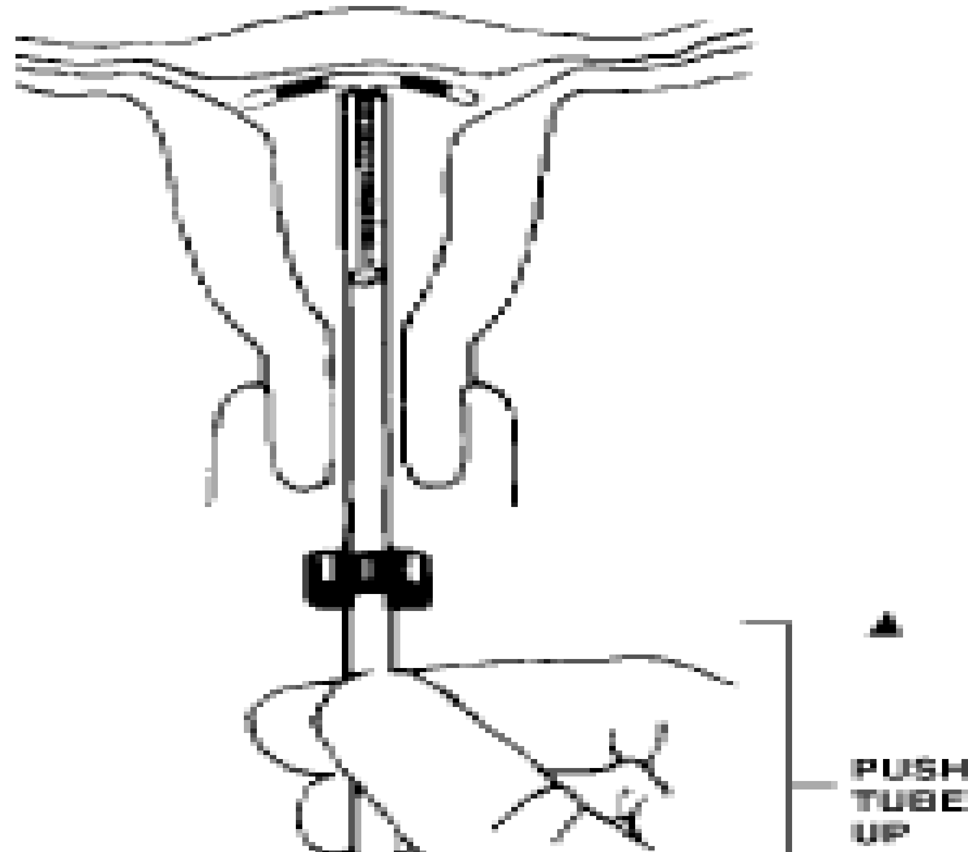


Figure 6.7 Withdrawing the insertion tube to release IUCD arms



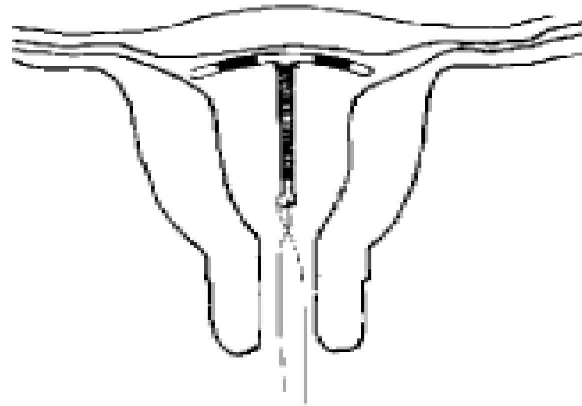
Steps In IUD Insertion conti….

Figure 6.8a Positioning IUCD high in the uterus

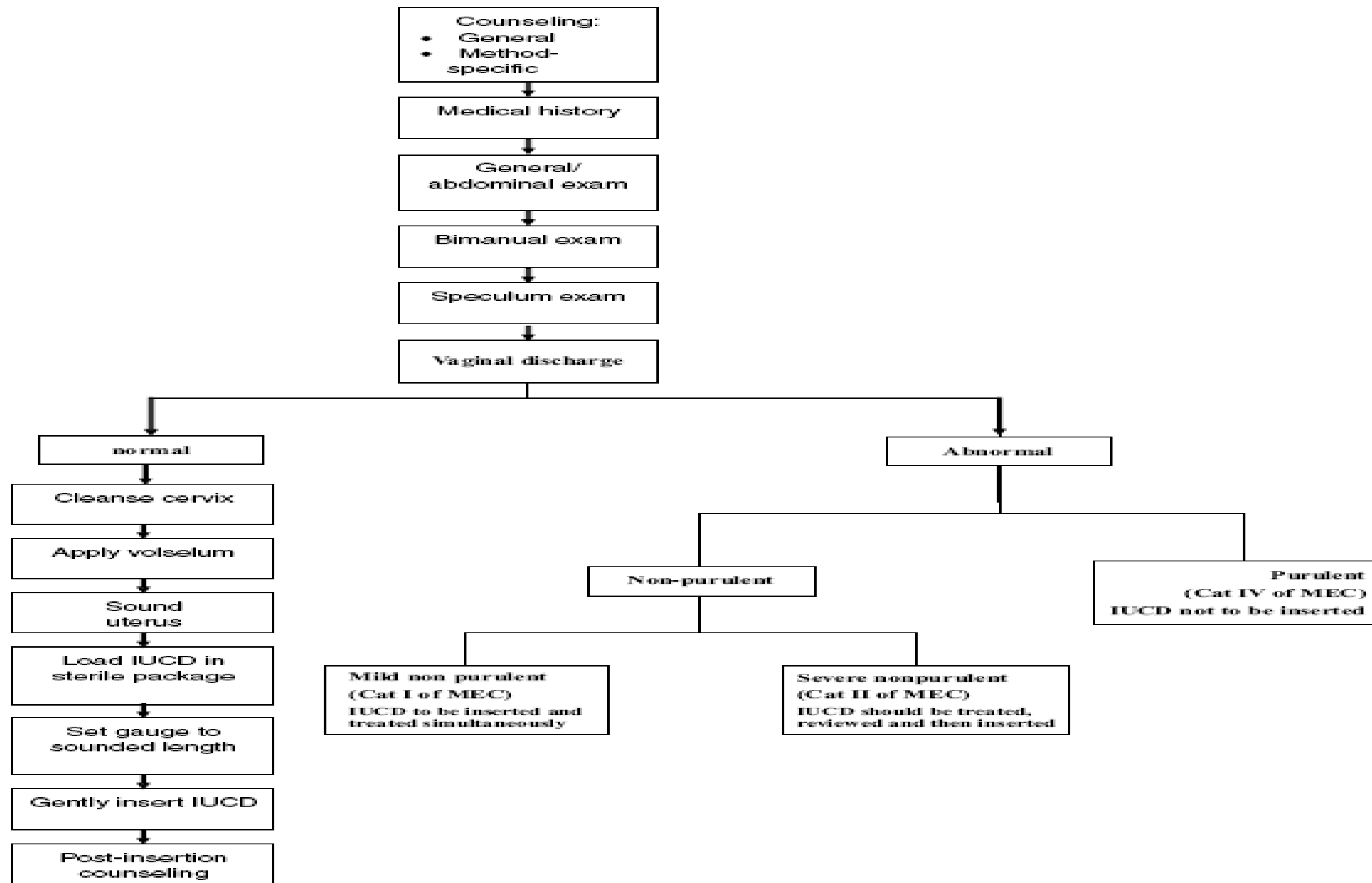


Steps In IUD Insertion cont..

Figure 6.8b IUCD
fully inserted in uterus



Summarizing steps involved in IUD insertion



IUCD insertion procedure

- Pre – insertion tasks
- Insertion procedure (always rule out pregnancy by use of IUD checklist)
- observe (Infection Prevention during procedure)

Post IUCD insertion counseling

- Instruct the client to check pad for expelled IUCD during menses
- Discuss what to do if the client experiences any side effects or problems
- Assure the client that she can have the IUCD removed at any time
- Advice her to return if she experiences any problem or after 1 month

Removal of IUCD

- Pre-removal counselling
- Explore reproductive goals
- Removal procedure
- Post – removal tasks (IP)
- Post – removal counselling

Return visits

- Clients should return for a routine checkup after the first post-insertion menses (4 to 6 weeks) but not later than three months after insertion. (Schedule a follow up appointment before she leaves)
- Advice the client to **return to the clinic at any time,** before her appointment date if she:
  - Has any questions or concerns
  - Experiences any warning signs (PAINS) or
  - Wishes to have the IUD removed

Warning signs

The woman should be advised to return to the clinic **immediately** if she experiences any **“PAINS”**

i. **P: Period-related problems or pregnancy symptoms.**

- late periods with signs of pregnancy few days post insertion
- spotting between periods or after intercourse
- bleeding twice as long or twice as heavy as usual
- she should return to the clinic immediately

Cont’

ii. **A: Abdominal pain or pain during intercourse.**

- generalized lower abdominal pain with/without pain during intercourse (?PID)
- crampy lower
- abdominal pain with/without pain (for her or her partner) during intercourse (?IUD expulsion

iii. **I: Infection.** Any signs/symptoms of infection

- purulent or foul-smelling vaginal discharge -? exposure to STI. The risk of infection is greatest during the first 20 days post-insertion.

Cont’

iv. N: Not feeling well, fever, and chills

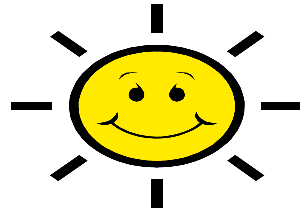
– ? signs/symptoms

v. **S: String problems.** If the IUD strings are;

- missing
- shorter
- longer

- She should use a back-up method of contraception until she can come in for evaluation.

THANKS



Hormonal Methods

CONTRACEPTIVE IMPLANTS

Specific Objectives 1

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

- Define implants
- Describe the various types of implants that are commonly used in Uganda
- Discuss the mechanism of action and effectiveness of implants
- Discuss MEC for implant use- indications, contraindications

Specific Objectives-2

- **List the benefits of implants**
- Describe the precautions and common side effects of implants
- Be able to counsel clients for implant use
- Be demonstrate competency in implant insertion and removal skills

Content

- **Definition**
- Types
- MEC
- When to initiate implants
- Benefits
- Side effects and their management
- Insertion procedure
- Removal procedure
- Instructions after insertion/removal
- Client follow up
- Obtaining contraceptive implants

Definition of Impants

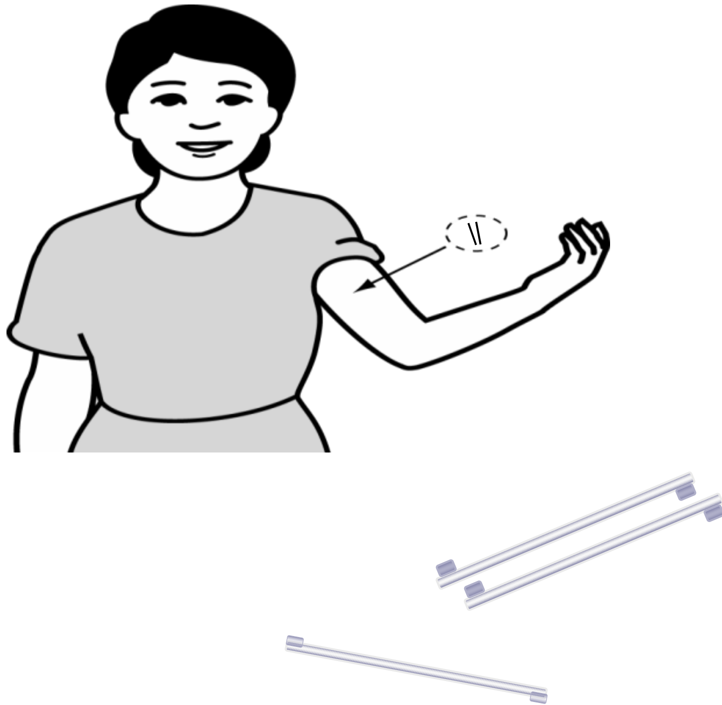
- Contraceptive implants are small hormone bearing capsules or rods which when inserted under the skin of a woman's upper arm and release the progestin hormone slowly over a long period to prevent pregnancy

Mechanism of Action

Implants prevent pregnancy by:

- Making cervical mucus so thick that sperm cannot pass through it
- Suppressing ovulation in <u>many cycles</u>
- Making the endometrium too thin for implantation to take place
- Inhibits egg transportation

Subdermal Implants



- Progestin-filled rods or capsules that are inserted under the skin
- Second generation implants
  - Jadelle and Sinoplant (Zarin): 2-rod system,
    effective for 5 years
  - Implanon: 1-rod system,
    effective for 3 years
- Mechanism of action similar to injectables

Contraceptive Implants: Characteristics

- Serum levels of etonogestrel or levonorgestrel are detectable within hours of insertion and suppression of ovulation occurs within I day of insertion (advice sex after 24 hours)
- Rapid return of fertility
  - Menstrual cycle returns within three months
- Continuous contraceptive protection for three-five years
- Does not contain estrogen
  - Appropriate for lactating women after the fourth postpartum week
  - No fluctuating hormone levels
- Inconspicuous
- Requires clinician visit for insertion and removal
- Does not protect against sexually transmitted infections

Types of Available Implants

Implant	Design	Hormone	Duration of effectiveness
Jadelle	2 rods	Levanorgestrel 75mg/rod	5 years
Implanon	1 rod	Etonogestrel 68mg	3 years
Sino-implant Zarin	2 rods	Levanorgestrel 75mg/rod	4 years (possibly 5)

Implant Systems

6-Rod
Norplant (No Longer In the Market)

2-Rod
Jadelle

1-Rod
Implanon

New Implants Can Expand Access

- What is New About Implants?
- Implant Characteristics Important to Women
- Use Could Increase if Barriers are overcomed

What is New About Implants?

- *Jadelle* and *Sino-Implant (II)* improvement on *Norplant* for delivery of levonorgestrel.
  - Two rod systems with 75 mg of levonorgestrel in each rod.
  - Easier to insert and remove than *Norplant*.
  - Effectiveness and safety comparable to *Norplant*.
  - *Jadelle* is labeled for 5 years of use and *Sino-Implant (II)* is labeled for 4 years of use.

What is New About Implants? cont

- *Implanon* : provides a one-rod option.
  - Single rod system with 68 mg of etonogestrel.
  - Easier to insert and remove than *Norplant*.
  - Highly effective and safe.
  - Insertion is different from other implants, so training in proper insertion is essential.
  - Labeled for 3 years of use.

Contraceptive Benefits/ Advantages

- safe and Highly effective (99.95% effective)
- Effective immediately if inserted within the first seven days of menstrual cycle (effective within 24 hours of insertion)
- Immediate return to fertility
- Offers continuous, long-term protection
- Reduces menstrual flow
- Convenient no need for regular scheduled revisits
- Suitable for nearly all women
- Continuation rate high among users
- Side effects resolve immediately after removal

Benefits / Advantages Cont…

- Protect against endometrial cancer
- Help prevent ectopic pregnancy (but do not eliminate risk altogether)
- Do not affect breastfeeding
- Protect against iron deficiency anaemia
- May make sickle cell crises less frequent and less painful

Limitations/ side effects

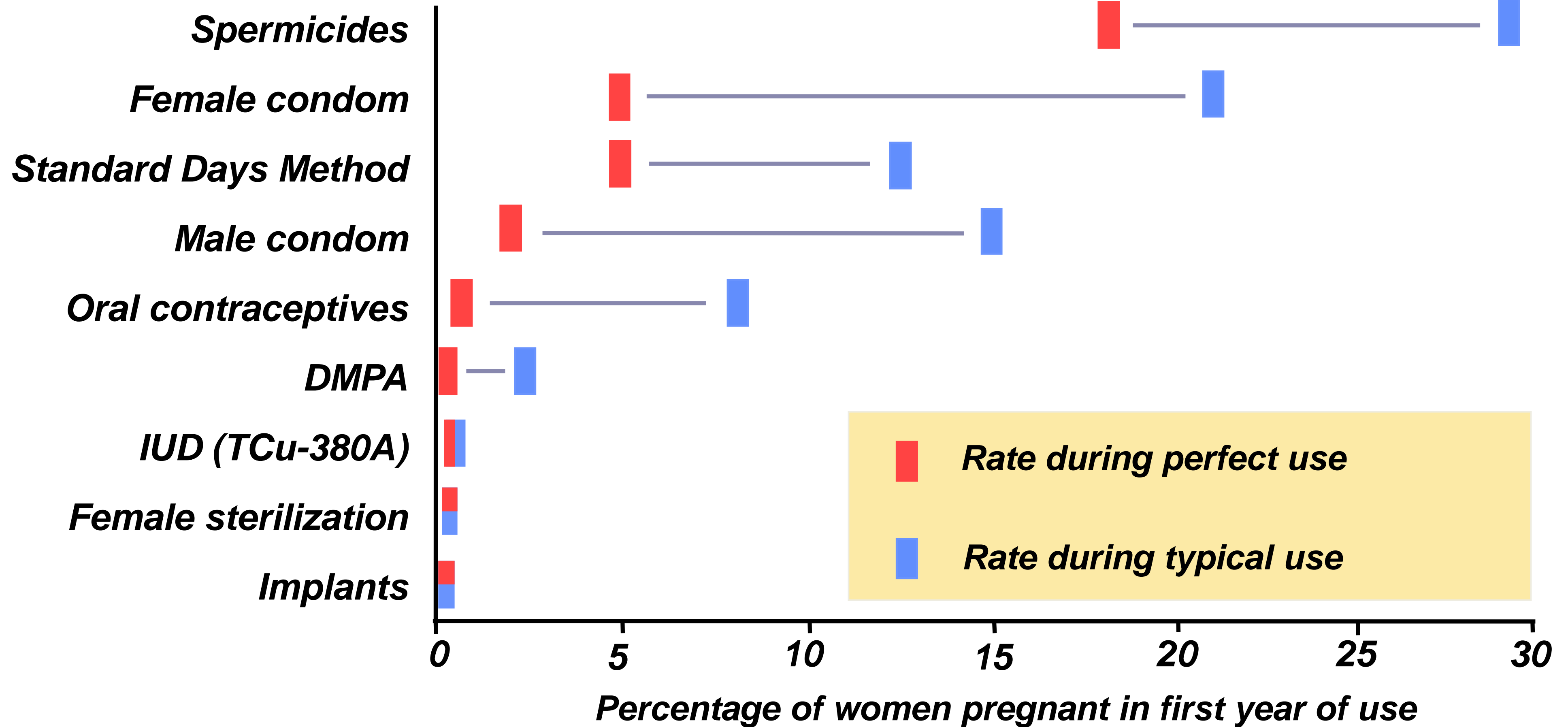
- Must only be inserted and removed by trained providers
- Require minor surgical procedure with appropriate infection prevention practices for insertion and removal
- Removal services must be available at sites where insertion is done

Implants – Side Effects

- First several months:
  light bleeding/spotting, prolonged irregular bleeding, infrequent bleeding, amenorrhea
- After one year:
  light bleeding for fewer days, irregular bleeding, infrequent bleeding, amenorrhea
- Other side effects: nausea, headaches, breast tenderness, weight change, abdominal pain
  - less common than with progestin-only injectables
  - diminish after the first few months

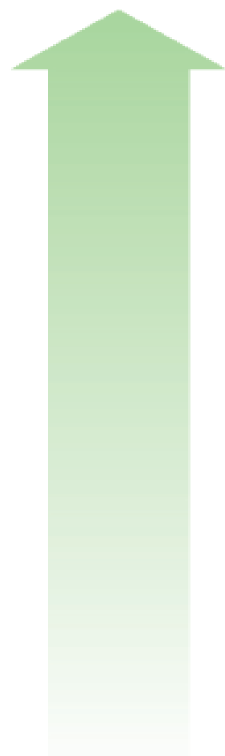
Source: Shoupe, 1991; CCP and WHO, 2007.

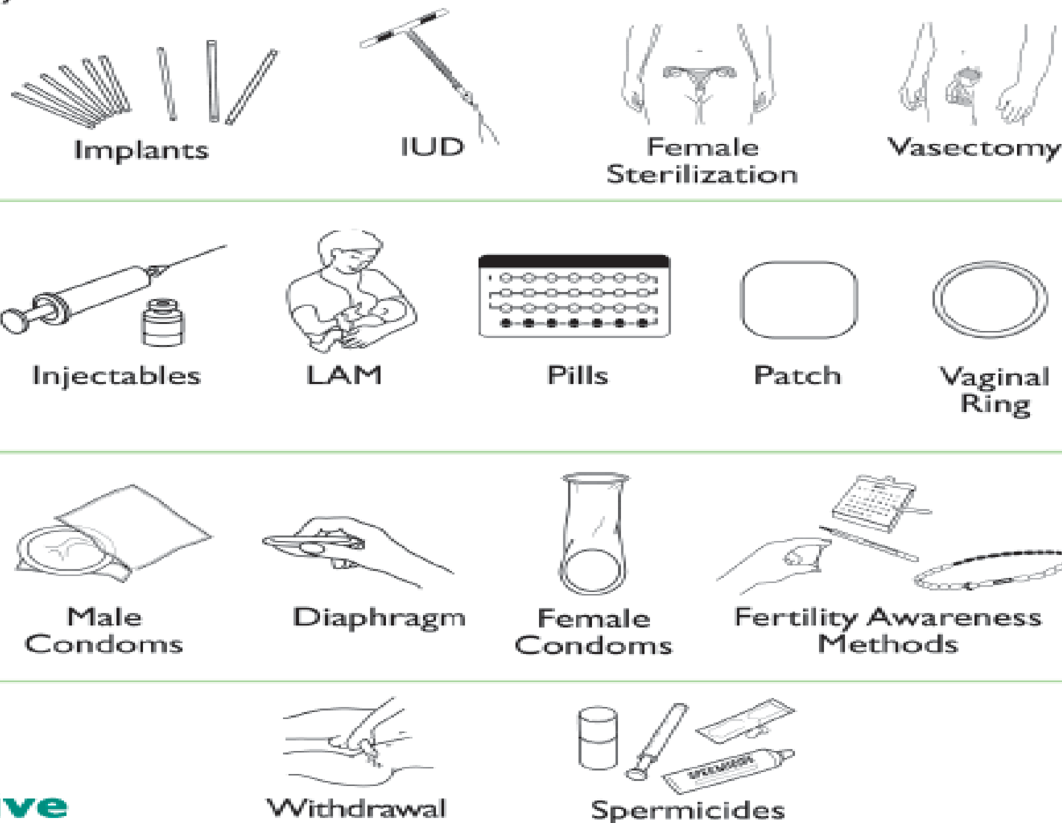
Pregnancy Rates by Method



Source: CCP and WHO, 2007.

Comparing Effectiveness of Family Planning Methods





How to make your method more effective

Implants, IUD, female sterilization: After procedure, little or nothing to do or remember

Vasectomy: Use another method for first 3 months

Injectables: Get repeat injections on time

Lactational Amenorrhea Method (for 6 months): Breastfeed often, day and night

Pills: Take a pill each day

Patch, ring: Keep in place, change on time

Condoms, diaphragm: Use correctly every time you have sex

Fertility awareness methods: Abstain or use condoms on fertile days. Newest methods (Standard Days Method and TwoDay Method) may be easier to use.

Withdrawal, spermicides: Use correctly every time you have sex

ISBN-13: 978-0-9788563-0-4
ISBN-10: 0-9788563-0-9

MEC- Category 1

- Women who have achieved desired family size but do not want a permanent method
- Women having major and minor surgery without prolonged immobilization
- Women with non migranous headache or depressive disorders
- Women with goiter, benign breast tumors, benign ovarian tumors, fibroids, endometriosis, severe dysmenorrhoea, CA endometrium, CA ovary

Who Can Use Implants Category 1 and 2 Examples (not inclusive):

WHO Category	Conditions
Category 1	***breastfeeding after 6 weeks postpartum, heavy smokers, complicated valvular heart disease, endometriosis, endometrial or ovarian cancer, thyroid disorders***
Category 2	***blood pressure ≥160/100, history of DVT/PE, diabetes with vascular complications, heavy or prolonged vaginal bleeding patterns, multiple risk factors for CVD***

Source: WHO, 2004; updated 2008.

MEC- Category 3/4

- Women with history of or current breast cancer
- Women with undiagnosed abnormal vaginal bleeding
- Women who cannot tolerate menstrual changes
- Women with migraine or aura
- Women receiving treatment with rifampicin and certain anticonvulsants

category 3 and 4

Who Should Not Use Implants

WHO Category	*Conditions*
Category 3	***breastfeeding before 6 weeks postpartum, acute DVT/PE, unexplained vaginal bleeding, history of breast cancer, severe liver disease and most liver tumors, systemic lupus disease*** ***continuation only: ischemic heart disease, stroke, migraine with aura***
Category 4	***current breast cancer***

Source: WHO, 2004; updated 2008.

Implant Use by Women with HIV

WHO Eligibility Criteria	
Condition	**Category**
HIV-infected	1
AIDS	1
ARV therapy	2

Source: WHO, 2004, updated 2008; Mildvan, 2002.

- Women with HIV or AIDS can use without restrictions
- Some ARV drugs reduce blood progestin level
- Efficacy is not affected because implants provide consistent dose of hormone over time
- Dual method use should be encouraged

Warning Signs

- Severe arm pain
- Expulsion of capsules
- Severe headache

Use Could Increase if Barriers Overcome

- Worldwide implant use is low due to high cost of the method.
- Costs have fallen in the past few years.
- Continued donor support and subsidized prices can make it easier for programs to provide implants.

Use Could Increase if Barriers Overcome

- Introducing or expanding implant services requires that programs have capacity to deliver the method:
  - Equipment and facilities to provide implants
  - Staff trained to perform insertions and removals and counsel clients
  - Well-functioning logistics system to maintain the supply of implants

Who can use implants

- Women of reproductive age
- Women of any parity, including nulliparous with established menses
- Women who want highly effective, long-term protection against pregnancy
- Women with sickle cell disease
- Breastfeeding mothers after 6 weeks postpartum or immediate postpartum if not breastfeeding

Preparing to Offer New Implants

- Who Can Provide Implants?

Competency-Based Training Helps :Providers Learn By Doing

- Helping Clients Make an Informed Choice
- Access to Removal Services Is Necessary to Good Quality of Care

Who Can not use implants

- Breastfeeding women less than 6 weeks postpartum
- Women who have active liver disease (viral hepatitis, severe cirrhosis, liver tumours)
- Women who have undiagnosed abnormal vaginal bleeding (before evaluation)
- Women who have breast cancer or women with a history of breast cancer

Who Can not use implants

- Women who cannot tolerate menstrual changes
- Women who currently have DVT, Hardened heart vessels (ischaemic heart disease) or stroke
- Women with migraine
- Women receiving treatment with Rifampicin (for TB) and certain anti-convulsants (for epilepsy)

Contraceptive Implant: Tolerability

- A 2-year study investigated the efficacy and tolerability of IMPLANON^{TM} (N=330)
- Reasons for discontinuing participation in the study:
  - Irregular bleeding: 13%
  - Other adverse events: 23%
- Adverse events attributed to the study medication:
  - Acne: 14.5%
  - Emotional lability: 14.2%
  - Headache: 12.7%
  - Weight gain: 12.1%
  - Dysmenorrhea: 9.7%
  - Depression: 7.3%
- Implant site symptoms:
  - Mild pain of short duration: <5%

Common Myths About Contraceptive Implants Among Clinicians

- Insertion and removal is time-consuming and difficult to learn – ***Not true!***
  - Time to insert is 1.1 minutes
  - Time to remove is 2.6 minutes
- Implants are associated with a higher risk of ectopic pregnancy – ***Not true!***
  - No pregnancies were reported during 5,629 woman-years of use
  - The baseline ectopic pregnancy rate in the United States is 1.97%

Helping Clients Make an Informed Choice

- Counsel the client about possible side effects, particularly bleeding changes
- Screen the client, using the WHO Medical Eligibility Criteria
- Describe and answer questions about the insertion and removal procedures
- Determine whether she can have the implants inserted immediately

Contraceptive Implant: Administration

- If no hormonal contraceptive has been used in past month:
  - Insert within 5 days of initiation of menses
- If switching from combination contraceptives, insert within 7 days of last active tablet
- If switching from a progestin-only method:
  - Any day if using the progestin-only pill
  - Same day as intrauterine device or implant removal
  - On due date for next contraceptive injection

Insertion Timing

–Insertion within 5 days of initiation of menses

Switching from combined OC

–Insertion within 7 days of last active tablet

–Switching from injectable

IMPLANON INSERTION TECHNIQUE

- **Preparation for the procedure:**

During insertion, special attention should be given to the following:

- ***Asepsis***
- ***Correct sub-dermal placement* of *Implanon***
- ***Careful technique to minimize tissue trauma***

The equipment needed for insertion

- An examining table for the patient to rest her arm on a sterile cloth
- A marker pen
- Antiseptic solution
- Sterile gloves
- Local anesthetic spray, or injection of 1ml lidocaine & syringe
- Preloaded, sterile Implanon applicator containing a single rod
- Sterile gauze and compress

Steps for Implanon Insertion

- **Step 1:** Allow the client to lie on her back with her non dominant arm turned outwards and bent at the elbow. If preferred, a sitting position can be taken.
- **Step 2**: Arrange the materials and instruments so that they are accessible.

Steps Cont…………………

- Figure 21: Positioning of the client's arm

Figure 22: Marking the insertion site

Guiding Mark

Insertion Site

8~10 cm

Medial Epicondyle

Steps cont…….

- **Step 3**: Mark the insertion site.
- **Step 4**: Prepare the insertion site with a cotton swab soaked with antiseptic.
- **Step 5**: Anesthetize with an anesthetic spray, or with 2ml of lidocaine (1 %), starting with a raised skin wheal applied just under the skin along the planned 'insertion channel'.

Steps Cont……………………………

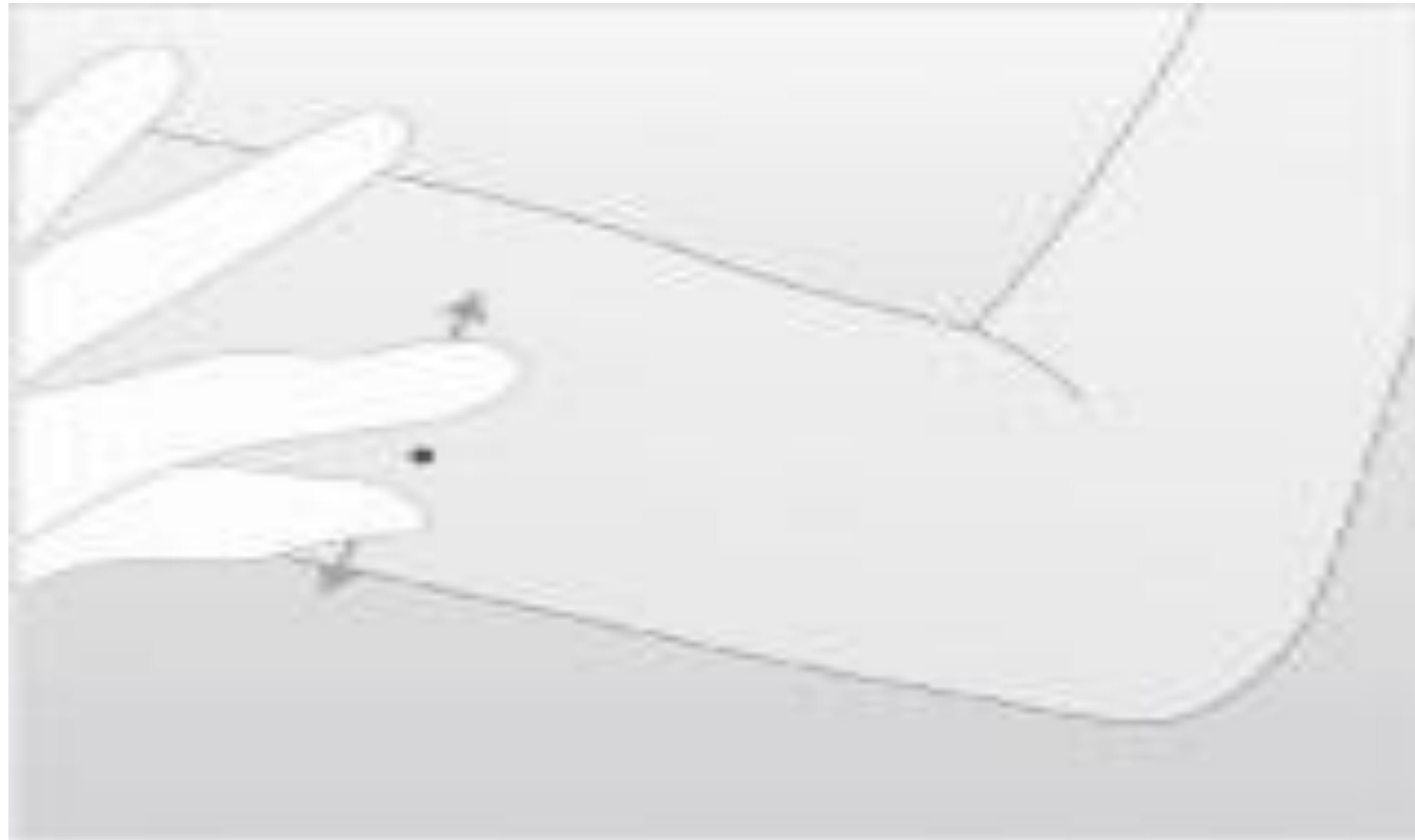
- **Step 6:** Carefully remove the sterile disposable applicator carrying the Implanon rod from its blister. Keep the shield on the needle and look for the Implanon rod, seen as a white cylinder inside the needle tip.
- **Step 7**: Following visual confirmation of the Implanon rod, lower the Implanon rod back into the needle by tapping the plastic part of the cannula and then remove the needle shield.

Steps cont……………………….

- **Step 8**: Hold the applicator in such a way that the tip of the needle is facing upwards, to prevent the Implanon from dropping out.
- **Step 9**: Apply counter traction to the skin at the proposed Implanon insertion site.
- **Step 10**: At a slight angle (<20o), insert the tip of the needle with the beveled side upwards into the insertion site.

Steps Cont................

- Figure 24: Stretching the skin around the insertion site



Steps cont……………………

- Figure 23: Insertion of the applicator

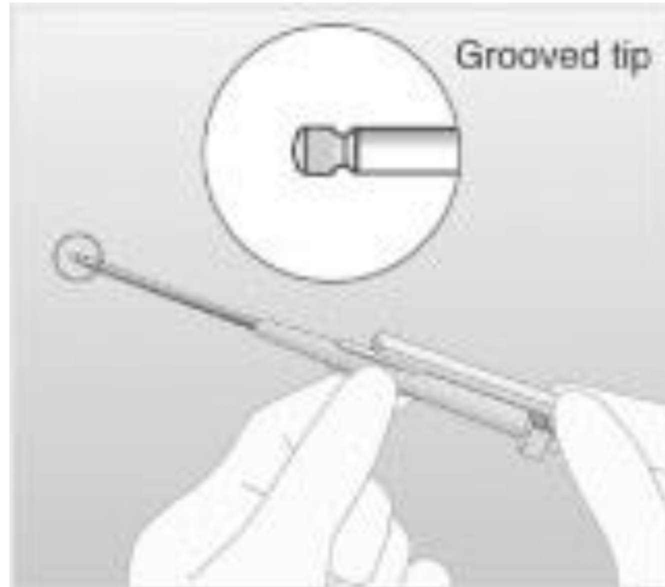
Steps cont...........................

- **Step 11**: Lower the applicator to a horizontal to align it with the arm. Lift the skin up with the tip of the needle but keep the needle in the subdermal connective tissue.
- **Step 12**: While tenting (lifting) the skin, gently push the needle to its full length.

Steps Cont……………………………

- Figure 25: Advancing the applicator horizontally

Confirm that the implanon is inserted



Steps Cont……………………

- **Step 16:** Confirm that Implanon has been inserted by checking the tip of needle for the absence of Implanon.

Implanon post insertion tasks

- **Step 1:** Always verify the presence of Implanon in the patient's arm immediately after insertion by palpating both ends of the implant. You should be able to confirm the presence of the 40 mm rod.
- **Step 2:** Place a small adhesive bandage over the insertion site. Request that the patient palpate Implanon

Post Insertion steps cont

- **Step 3:** Apply a pressure bandage with sterile gauze to minimize bruising.
- The patient may remove the pressure bandage in 24 hours and the small bandage over the insertion site in three to five days.
- **Step 4:** Complete the USER CARD and give it to the patient to keep. Also, complete the Patient Chart Label and affix it to the patient's medical record.
- **Step 5:** The applicator is for single use only. Dispose off the applicator in accordance with the IP practices for handling of hazardous waste.

JADELLE INSERTION TECHNIQUE

- **Pre-procedure preparations**
- **Step 1:** Allow the subject to lie on her back with her non dominant arm
- turned outwards and bent at the elbow. If preferred, a sitting position can be
- taken. Jadelle will be inserted sub-dermally.
- **Step 2:** Arrange the materials and instruments so that they are accessible.

Steps for insertion……………………

- **Step 3:** Mark the insertion site, about 8-10 cm above the medial epicondyle of the humerus, to one side or the other of the groove between the biceps and the triceps (sulcus bicipitalis medialis).

Pre insertion cont …..

- **Step 4:** Prepare the insertion site with a cotton swab soaked with antiseptic.
- **Step 5:** Place sterile or clean surgical drape over arm (optional).
- **Step 6:** Using a sterile needle and syringe, inject a small amount of local anesthetic 1% (without epinephrine) just under the skin at the incision site to raise a small wheal.

Insertion procedure

- **Step 1:** Make a shallow, 2 mm incision with a scalpel just through the skin at insertion site.
- **Step 2:** Insert trocar and plunger through the incision at a shallow angle with the bevel facing up.
- **Step 3:** While tenting the skin, slowly and smoothly advance trocar and

plunger toward one of the marks on the skin nearest the shoulder.

Steps for insertion…………..

- **Step 4:** Remove the plunger.
- **Step 5:** Load first rod into trocar using either the gloved thumb and forefinger of one hand or a forceps, keeping the other hand cupped under the trocar in order to catch the rod if it falls.
- **Step 6:** Re-insert plunger and push rod toward the tip of trocar just until resistance is felt.

Insertion procedure

- **Step 1:** Make a shallow, 2 mm incision with a scalpel just through the skin at insertion site.
- **Step 2:** Insert trocar and plunger through the incision at a shallow angle

with the bevel facing up.

- **Step 3:** While tenting the skin, slowly and smoothly advance trocar and

plunger toward one of the marks on the skin nearest the shoulder.

Steps cont………….

- **Step 4:** Remove the plunger.
- **Step 5:** Load first rod into trocar using either the gloved thumb and forefinger of one hand or a forceps, keeping the other hand cupped under the trocar in order to catch the rod if it falls.
- **Step 6:** Re-insert plunger and push rod toward the tip of trocar just until resistance is felt.

Steps cont…………..

- **Step 7:** Hold plunger firmly in place with one hand and slide trocar out of incision until it reaches plunger handle.
- **Step 8:** Withdraw trocar and plunger together until mark nearest the tip
- just clears incision;do not remove trocar from incision.
- **Step 9:** Move the tip of the trocar laterally away from the end of rod to be sure it is completely free of the trocar.

Steps Cont..............

- **Step 10:** Redirect trocar about *15°* to follow the second mark on skin
- (making a "V" arrangement); then advance trocar and plunger to the mark
- nearest the hub of the trocar.
- **Step 11:** Place the second rod using the same technique (steps 4-8).
- **Step 12:** Remove trocar from incision

Post insertion tasks

- **Step 1:** Verify the presence of Jadelle in the patient's arm immediately after
- insertion by palpation.
- **Step 2:** Place a small adhesive bandage over the insertion site.
- **Step 3:** Request that the patient palpate the rods.
- **Step 4:** Apply a pressure bandage with sterile gauze to minimize bruising.

Post task insertion……………………..

- **Step 5:** Pressure bandage can be removed in 24 hours
- **Step 6:** Small bandage over the insertion site can be removed in three to five days.

IMPLANON NXT INSERTION INSTRUCTIONS

- **Getting Ready**
- **Step 1**: Greet the client, rule out pregnancy, determine that the client wants an implant, is aware of common side effects, accepts them, and has no medical condition that makes implants an inappropriate method per WHO MEC.
- **Step 2:** Explain the insertion technique and take the time to answer any

questions the client may have.

Steps for insertion cont……………………….

- **Step 3:** Help position client on the table.
- **Step 4:** Determine the optimal insertion area by measuring 8–10cm from the medial epicondyle of the humerus.
- **Step 5:** Prepare an instrument tray.

Pre-Insertion Tasks

- **Step 1**: Wash hands thoroughly with soap and water and dry them.
- **Step 2:** Apply antiseptic solution to the incision area two times.
- **Step 3:** After verbally checking again to be sure the client is not allergic to the local anesthetic agent or related drugs, fill a syringe with about 1mL of local anesthetic (1% without epinephrine).

Pre insertion Tasks cont……….

- **Step 4:** Insert the needle just under the skin at the incision site (point closest to the elbow).
- **Step 5:** Put sterile gloves on both hands. (A separate pair of gloves must be worn for each client to avoid cross-contamination.)

Pre insertion Tasks.......................

- **Step 6:** Arrange instruments and supplies so that they are easily accessible. Make sure that the Implanon NXT package is intact and the tip of the rod is not protruding out of the trocar
- **Step 7:** After inspection, open and remove the sterile preloaded disposable Implanon NXT applicator.

Inserting the Rod

- **Step 1:** Hold the applicator just above the needle at the textured surface area. Remove the transparent protection cap by sliding it horizontally in the direction of the arrow away from the needle.

Figure 30: Preparing the trocar

Purple Slider

Steps cont……………………….

- **Step 2:** With your free hand, stretch the skin around the insertion site with thumb and index finger
- **Step 3**: Puncture the skin with the tip of the needle angled about 30°

Figure 31: Puncture angle

Steps cont……………………..

- **Step 4:** Lower the applicator to a horizontal position. While lifting or tenting the skin with the tip of the needle, slide the needle to its full length.
- **Step 5:** Keep the applicator in the same position with the needle inserted to its full length.

Figure 33: Releasing and removing the applicator/trocar

Steps cont…………….

- **Step 6:** Always verify the presence of the implant in the woman's arm immediately after insertion by palpation.

Figure 34: Palpating the rod after insertion

Steps Cont…………………………

- **Step 7:** The applicator is for single use only and should be disposed of in accordance with the IP practices for handling of hazardous waste.

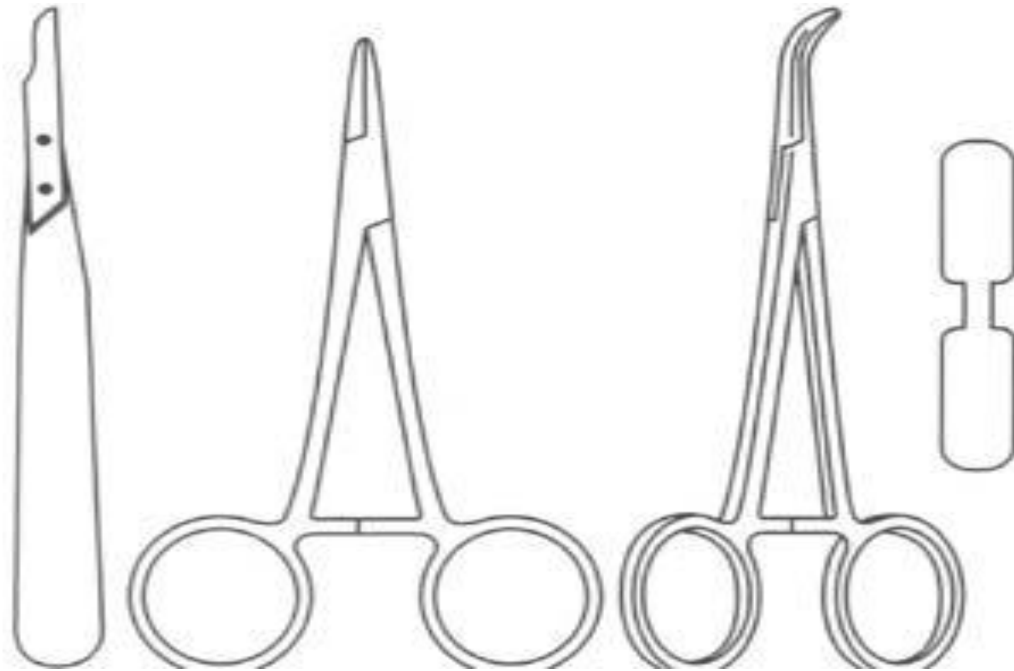
Counseling Post Insertion

- To expect some soreness after anaesthesia wears off
- Keep insertion area dry for 4-5 days
- Can remove gauze after 1 to 2 days
- Adhesive plaster after 7 days
- Return to clinic if rod(s) come out

Counseling Post insertion cont…..

- Advise on where to seek care in case of problems
- Return if any signs of inflammation(pain,heat,redness) appear
- EMPHASIZE – Implants must be removed on the exact due date.(Write down the date)

Implant removal equipment



Access to Removal Services is Necessary

- Access to services for implant removal could strongly influence public perceptions of implants.

- Clinics that offer implants should develop and communicate a clear policy on removal that states the following:
  - When a woman wants her implants removed, she should be able to have them removed promptly, without undue waiting, regardless of where or when the implants were inserted.

  - A woman should not feel pressured to keep her implants. They should be removed whatever her reason, whether it is personal or medical.

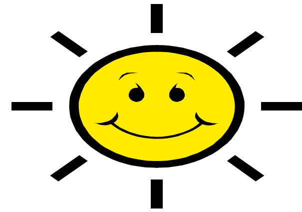
Contraceptive Implant: Key messages

- Option available worldwide
- Easy and quick to insert and remove
- Efficacy equivalent to sterilization
- Safe and rapidly reversible
- Irregular bleeding patterns may be a problem for some patients
- Majority of reproductive-age women are candidates, including adolescents
- Appropriate option for those preferring a long-term progestin-only method and do not want injections or an intrauterine device

Key messages; cont .. Reducing Costs Will Improve Access

- Costs could come down with the development of better technology and further research into making the production processes cheaper.
- Implants could become cheaper as orders increase.
- Generic production of implants could reduce prices dramatically.
  - An example is *Sino-Implant (II)*
- Strategies for reducing the price of implants includes pursuing registration of *Sino-Implant*

THANKS



COCs:-Definition

- These are pills containing synthetic oestrogen and progestins similar to the natural hormones in a woman's body.

Mechanism of Action

- Suppression of ovulation
- Thickening of the cervical mucous
- Possibly changing the endometrial lining making implantation unlikely

Those who can use COC

Sexually active women of reproductive age

- Women with established menses
- Women of any parity, including nulliparous with established menses
- Women who want highly effective protection against pregnancy
- Breastfeeding mothers more than 6 months postpartum
- Women who can follow a daily routine of pill taking

Those who can use COC

- Post-abortion clients (should begin within 7 days)
- Women with anaemia from heavy menstrual bleeding
- Women with severe menstrual pains
- Women with a history of ectopic pregnancy

Those who should not use COC.

- Breastfeeding mothers before 6 months postpartum
- Women who are pregnant or suspected of being pregnant
- Women with unexplained or suspicious abnormal vaginal bleeding
- Women with a history of blood clotting disorders
- Women with a history of heart disease
- Women with active liver disease (viral hepatitis, mild to severe cirrhosis, benign or malignant tumours).
- Women with hypertension (BP equal to or more than 160/100)

Those who should not use COC

- Women with diabetes mellitus complicated by vascular diseases
- Women who smoke and are older than 35 years
- Women with known thrombogenic mutations (e.g. Factor V Leiden; Prothrombin mutation; Protein S, Protein C and Antithrombin deficiencies)
- Women with symptomatic gall bladder disease including those on medical treatment
- Women receiving treatment with drugs that affect liver enzymes; Rifampicin (TB), phenytoin, carbamazepine, barbiturates, primidone, topiramate and oxcarbazepine (epilepsy), griseofulvin (fungal disease), certain antiretrovirals (HIV).

When to start:

- Anytime of the menstrual cycle when the service provider is reasonably sure that the client is not pregnant.
- Six months after delivery if breast feeding.
- Within three weeks post delivery if not breastfeeding
- Within seven days post abortion
- Immediately when switching from another reliable method.
- Between day 1 to day 7 of the menstrual cycle

Use with care in the following situations

- Women over 40 years old
- Women with unexplained vaginal bleeding
- Women with migraine
- Women who suffer from obesity (equal or > 30kg/m2 BMI)
- Women taking medication for epilepsy, TB, fungal disease or HIV
- Women with gall-bladder disease
- Women with breast lumps
- Hypertension
- Women with sickle cell disease
- Women who smoke and are <35 years
- Uncomplicated diabetes (no vascular disease or diabetes of >20 years).

Clients Instructions for use of COCs ctd

- Take 1 pill each day, preferably at the same time each day
- Take the first pill on the first to the seventh day (first day is preferred) after the beginning of your menstrual period
- Some pill packs have 28 days. Others have 21 pills. When the 28-day pack is empty, you should immediately start taking pills from a new pack. When the 21-day pack is empty, wait 1 week (7 days) and then begin taking pills from a new pack.
- If you vomit within 30 minutes of taking a pill, take another pill or use a backup method if you have sex during the next 7 days

Clients Instructions for use of COCs cont..

- If one pill is missed, take as soon as remembered even if it means taking two pills the next day
- If two or more pills are missed in a row, take two pills each day until all missed pills have been taken and use a back-up method (e.g., condom or foaming tablets) for seven days. If two pills will be taken in one day, take the second pill 6 hours later
- If you miss 2 or more menstrual periods, you should come to the clinic to check if pregnant.

Contraceptive Benefits

- Highly effective
- Effective immediately
- Easy to use
- Safe
- Can be provided by trained non-clinical service provider
- Pelvic examination not required to initiate the method
- Reversible
- Return to fertility immediate
- Can be used as emergency contraceptive.

Benefits ctd…

Non-contraceptive Benefits

- Reduces menstrual cramps and pain
- Decreases menstrual flow hence prevention of anaemia
- Improvement of hirsuitism
- Protects against ovarian and endometrial cancer
- Decrease the risk of benign breast disease
- Protects against ectopic pregnancy by preventing ovulation
- Improves acne
- Enhances sexual enjoyment
- Improves other medical condition like osteoporosis, anaemia, endometriosis and rheumatoid arthritis

Limitations

- Does not protect against STI/HIV/AIDS
- Effectiveness is lowered when taken with other drugs e.g anti TB like Rifampicin, anti epilepsy drugs e.g. phenobarbitone, phenytoin)
- Serious Side effects though rare. (e.g., myocardial infarction, stroke, venous thrombosis/embolism and benign liver tumours (aenomas).
- Requires strict daily pill taking preferably at the same time every day
- Affects quantity and quality of breast milk.
- Effectiveness may also be lowered in the presence of gastroenteritis, vomiting and diarrhoea

Side effects of COCs

1. **Acne**

- ***Management***
- Recommend cleaning of face twice a day and avoid heavy creams
- Counsel as appropriate
- Provide a low dose pill if available. If no other pill is available and the client wants to change, help client make an informed choice of a non-hormonal contraceptive.

Amenorrhoea

Management

- Missed pills or pills taken late raises risk of pregnancy. Clients on 21-day pack may forget to leave a pill free week for menses. Re-instruct client on taking pills correctly.
- If pregnant, stop pills and refer to prenatal clinic
- If client is taking COC's correctly, re-assure. Explain absent menses due to lack of build up of uterine lining: no menstrual blood present. If client unsatisfied, try a 50ug oestrogen pill if available and if no contraindication.
- If client is taking COC's correctly, reassure. If client unsatisfied and pregnancy has been carefully ruled out, amenorrhoea may still be due to insufficient hormonal stimulation of the lining of the uterus.

Amenorrhoea management *ctd*

- Switch to 50ug of oestrogen pill with stronger progesterone. If not available, continue with the same pill until client can change to another method

- Rule out pregnancy. If not pregnant, explain that if her periods were irregular before the COC's, they will be irregular when COC's are stopped and may take some months to return. Help the client make an informed choice of another contraceptive method.

- If she is disturbed by the absence of menses, have the client change the method.

Spotting or bleeding between menses

Management

- Reassure
- If yes, reinstruct. If no, switch to a higher oestrogen pill (not >50ug oestrogen) for several cycles until spotting resolves. Return to lower dose pill. If spotting returns, continue with the 50ug pill
- If gynaecological problems present, refer to the doctor if possible or manage according to clinic guidelines
- Client may require higher dose of COC's (refer to handout on "Drug interactions with COC's")
- If possible, do the VIA/VILI/pap smear if more than one year has passed since the last one.

Nausea

Management

- Take after the evening meal
- If pregnant, discontinue the pill and refer to prenatal clinic
- Evaluate for infection (Gall bladder disease, hepatitis, gastroenteritis)
- Switch to a lower oestrogen pill or progestin only method or change to a non- hormonal method.

Breast fullness or tenderness

Management

- If pregnant discontinue the pill, refer to prenatal clinic
- Take a detailed family history of breast cancer. If physical exam shows lump or discharge suspicious for cancer, help the client make an informed choice of another method, refer to a physician
- If breasts are not infected, recommend appropriate clothing for support. If there is infection, use warm compress and advise to continue breast-feeding, if appropriate. Refer to a physician.
- Decrease oestrogen in pill or if already on lowest oestrogen, decrease progestin. If the lowest dose oestrogen pill is unacceptable, help client make an informed choice of a progestin only or another method.

High Blood pressure

Management

- Allow 15 minutes rest then repeat BP reading, continue COC's unless this visit SBP>140mmHg or DBP >90mmHg. If > or remains 140/90, stop the pill, refer to the doctor for further management and give another method. If second reading shows BP< 140/90, continue COC's or consider changing to a lower oestrogen or progestin only pill and check BP every visit.

High Blood pressure

Management

- Allow 15 minutes rest then repeat BP reading, continue COC's unless this visit SBP>140mmHg or DBP >90mmHg. If > or remains 140/90, stop the pill, refer to the doctor for further management and give another method. If second reading shows BP< 140/90, continue COC's or consider changing to a lower oestrogen or progestin only pill and check BP every visit.

Headaches

Management

- If not severe or frequent or associated with nausea, reassure and continue with COC's
- Refer to a physician. Discontinue the pill and help client make an informed choice on a non hormonal method
- Regardless of history, check BP and if elevated, see BP above.
- If worse on COC's, switch to a non-hormonal method. If not worse or better, explore the headaches. COC's can be continued unless high BP or neurological symptoms or signs develop.

Headaches ctd.

- Refer for treatment for sinusitis, continue pill. Recommend use of backup while on antibiotics.
- Try to find the cause of problem and take appropriate action. Have the eyes examined.
- Stop COC's. Give another non-hormonal method and refer to a physician.

Management

Depression

- Counsel as appropriate
- If yes, then help client make an informed choice of a non-hormonal method. If COCs is not the cause, then continue with the method.

Loss of Libido

- If client is concerned, refer or manage appropriately.

Weight gain

- ***Management***
- Give dietary instruction
- Help the client chose a non-hormonal method
- Give a low dose COC pill

Warning signs

- A- Abdominal pain (severe)
- C- Chest Pain (severe), cough, with shortness of breath
- H- Headaches (severe), dizziness, weakness, numbness
- E- Eye problems (vision loss or blurring), speech problems
- S- Severe leg pain (calf or thigh)
- If any of the above signs are noticed, STOP COC and report to health facility immediately.

Rumours and Misconceptions

- Identify rumours in the catchment area and clarify them with facts.

FP methods ctd..

CICs

- These are similar to COC but administered monthly

Progestin Only Pills (POPs)

- **Definition**
- These are pills containing synthetic progesterone similar to the natural hormones in a woman’s body.

Mechanism of Action

- Thickening of the cervical mucus
- Suppression of ovulation
- Thinning the endometrial lining making implantation unlikely

Those who can use POP

- Clients of reproductive age
- Women of any parity including nulliparous
- Women immediately postpartum if not breastfeeding
- Breast feeding mothers six weeks postpartum
- Heavy smokers of any age
- Women who cannot COCs, due to oestrogen-related contraindications
- Post abortion clients within 7 days
- Women with oestrogen related side effects
- Women with mild hypertension (BP of 160/100)
- Those with sickle cell disease and valvular heart disease.

Those who can use POP cotd.

- Women who cannot COCs, due to oestrogen-related contraindications
- Post abortion clients within 7 days
- Women with oestrogen related side effects
- Women with mild hypertension (BP of 160/100)
- Those with sickle cell disease and valvular heart disease.

Those who cannot use POP

- Breastfeeding women less than 6 weeks postpartum
- Women who are pregnant or suspected of being pregnant
- Women with unexplained abnormal vaginal bleeding
- Women who have breast cancer or history of breast cancer
- Women with active liver disease (viral hepatitis, severe cirrhosis), and liver-tumour (benign and malignant)
- On concurrent drugs (antituberculosis eg Rifampicim; antifungals eg Griseofulvin; Antiepileptics eg Phenytoin, Phenobarbitone)
- Women with current DVT or pulmonary embolism

Use with care in the following situations

- Women with a history or past ectopic pregnancy
- Women who are on ARVs and who are doing well on therapy
- Migraine with aura at any age
- Women with history of DVT and pulmonary embolism or in prolonged post-operative immobilization.

2. Use with care incase of :

- Women with gall-bladder disease and cirrhosis (mild) of liver
- Tuberculosis, thyrotoxicosis, epilepsy and HIV/AIDS
- Women who are taking anti-epileptic, anti-HIV, anti-fungal and anti-tuberculosis drugs.
- Women with current and history of ischaemic heart disease and stroke (CVA)
- Women with undiagnosed breast lumps
- Women with unexplained vaginal bleeding

When to initiate use of POPs

- If the woman is breastfeeding and has not resumed her menses: any time between 6 weeks and 6 months after childbirth
- After child birth, not breastfeeding: any time within the first 3 weeks

- After miscarriage/abortion: within the first 7 days method can be initiated without need for backup protection. After 7 days, condom should be used as a backup method for 2 days.

- Having menstrual cycles: Any time if reasonably sure that she is not pregnant. If initiated within 5 days after menstrual cycle, no backup method needed. Otherwise, backup method (condom) should be used for the next 2 days.

Clients instructions for use of POPs

- POPs are usually started on the first day of menses
- Take a pill daily at the same time, preferably after the eening meal, until the packet is finsished (for 35 days)
- As soon as you finish the first pack of minipills, start the next packet the next day, NEVER MISS A PILL AND NEVER REST in between the packets
- Minipills are taken everyday without stopping. They are taken every day even throughout the menstrual cycle
- If you forget a pill, take it as soon as you remember and take your next pill at the regular time. You must also use condoms and foaming tablets if you have sex within the next 48 hours whenever you miss a pill or take it 3 or more hours later than the usual time

Clients instructions for use of POPs cont..

- If you forget to take two pills in a packet, take one pill twice a day for 2 days, then one pill daily, but use a back-up method such as condoms if you have sex within the next 48 hours because you are not protected against pregnancy.
- If you occasionally forget to take pills for 2 days, this is probably not the best method of contraception for you
- If you do not have a menstrual period within 45 days of your last period, you should go to the clinic for a pregnancy test

Clients instructions for use of POPs cont..

- You may have some spotting between periods. Some women have perfectly regular cycles using POPs.
- Many women, however, experience irregular cycles and infrequent periods (one or two periods per year). Continue taking the pills during the spotting and bleeding periods according to your routine.
- Report to the clinic immediately if any of the warning signs are noted

Benefits of POPs

Contraceptive benefits

- Highly effective
- Immediate return to fertility on discontinuation
- Pelvic exam is not required to initiate use
- Safe
- Easy to use, no rest period
- Can be provided by non-medical staff
- Reversible

Non-contraceptive benefits

- Does not affect breastfeeding
- Lighter and shorter periods
- Decrease breast tenderness
- Do not increase blood clotting
- Reduced risk of thromboembolism
- Reduced risk of dysmenorrhoea
- Protects against endometrial cancer
- Protects against PID
- Protects against benign breast disease.

Limitations

- Slightly lower level of contraceptive protection than COCs
- Requires strict daily pill taking preferably at the same time every day
- Effectiveness is lowered when taken with other drugs e.g anti TB like Rifampicin, anti epilepsy drugs e.g. phenobarbitone, phenytoin)
- Does not protect against STI/HIV/AIDS
- Increased risk of ectopic pregnancy and ovarian cysts
- Risk of pregnancy when pill missed

Side effects

- **Headache**
- ***Management***
- Refer to a doctor if "yes" answer is associated to any of the symptoms.
- Discontinue POP's and help client make an informed choice of a non-hormonal method
- If not severe, frequent or associated with nausea, re-assure.

Amenorrhoea

Management

- Regardless of history, check the blood pressure. If elevated, **“see high blood pressure below”.**

- Refer for treatment for sinusitis, continue POP's. Be aware that some antibiotics cause decreased effectiveness of POP's so recommend the use of back up method while on antibiotics eg ampicillin, tetracycline.

- Missed pills or pills taken late raises risk of pregnancy. Re-instruct client on taking pills correctly.

- If pregnant, stop pills and refer to prenatal clinic. If not pregnant, see below

Amenorrhoea cont..

- If less than 45 days since last bleeding, and no signs or symptoms of pregnancy, re-assure the client.
- If more than 45 days since last bleeding but no signs of pregnancy, do a urine test. Consider helping client to make an informed choice for another method.
- Switch to COC's if no contraindications. If contraindications to COC's are present, help the client make an informed choice of a non-hormonal method.

Spotting or bleeding between menses

- ***Management***
- If no problem, reassure. If problems, refer to a physician if possible or manage according to standards.
- If yes, reinstruct on how to take POP's. If no, explain that spotting /bleeding is very common with POP's.
- If possible, visualise the cervix and do a pap smear if more than a year has passed since the last one.
- POP's may be continued if client has STI/PID. Treat STI/PID per standards.

High blood pressure

Management

- Continue unless this visit shows SBP>140mmHg or DBP>90mmHg

- If POP's are discontinued, help the client make an informed choice for another non-hormonal method.

Mood changes/nervousness

Management

- Counsel, if it worsens help client select an alternative method

Warning signs

- A.C.H.E.S
- Missed pill
- Periods late (more than 45 days after
- normal periods)

Rumours and misconceptions

- Identify rumours and misconceptions in the catchment area and clarify them with facts

Injectabe Family planning methods

Training objectives

- Describe the different types of injectable contraceptives.
- Explain how depo-IM and Sayana® Press are similar and how they are different.
- List counseling messages about injectable contraceptives and Sayana Press.
- Demonstrate how to screen clients for eligibility for Sayana Press reinjection.
- Show how to handle sharps safely, including Sayana Press.
- Show how to give an injection with Sayana Press

What are injectable contraceptives?

- Very effective, long-lasting, reversible, private method of contraception.
- Are like a natural hormone made by a woman's body.
- Injected with a syringe in the muscle (IM) or in the fatty tissue (subcutaneous or SC)
- Released slowly into the blood from the injection site.

What kind of injectable contraceptive is DMPA?

DMPA is a progestin-only injectable.

- DMPA is made with progestin only.
- Progestin is like the natural hormone made by a woman's body.
- Progestin-only injectables like DMPA must be reinjected every 3 months (13 weeks).

Combined injectables.

- There are other kinds of injectables made with estrogen and progestin combined. They will not be used in this study.

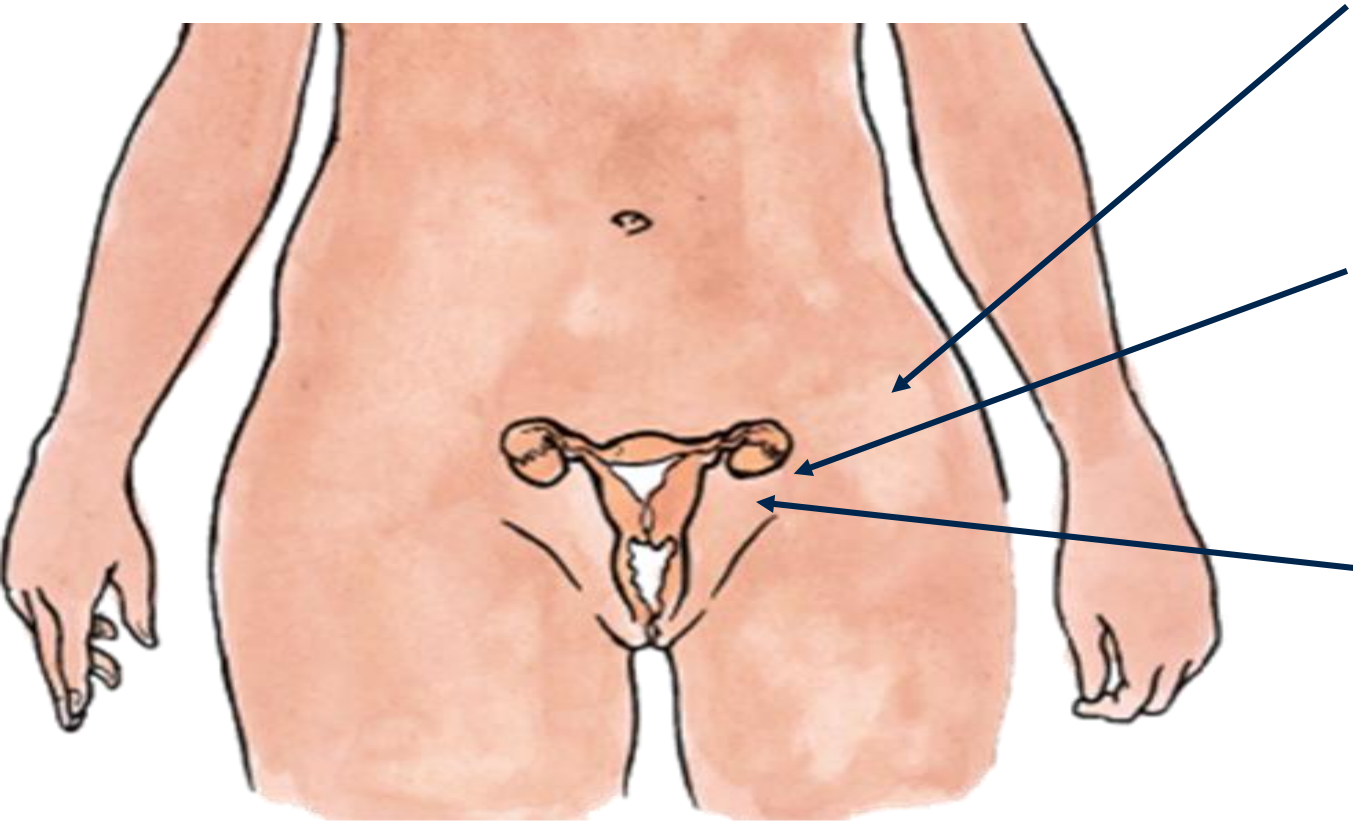
What are some of the names of DMPA?

- DMPA is the most common progestin-only injectable.
- DMPA can have different brand names or names that show how it is injected (IM or subcutaneous). Some of these names are:
  - **Depo-Provera®**
  - **depo-IM**
  - **depo-subQ**

Depo Provera (DMPA), Noristerat (NET_EN) and Sayana Press (MPA)

- **Effectiveness:**
- Very effective – 3 pregnancies per 1000 women in first year of use when
- injections are given regularly (perfect use).Injectables are effective within 48hrs. Specifically for DMPA, effectiveness
- will last 12 weeks and NET-EN for 8 weeks.
- Pregnancy rates become higher (3 per 100 women) for women who are late for an injection or who miss an injection or if there are stock outs (typicaluse).

How do progestin-only injectables work?



- They prevent ovulation (the release of eggs from the ovaries).
- They prevent implantation of an egg by keeping the walls of the womb thin.
- They prevent sperm from entering the womb by thickening the mucus at the opening of the womb.

Who can use DMPA

Any woman of reproductive age who desires an effective, reversible, and long-lasting method, including a woman who:

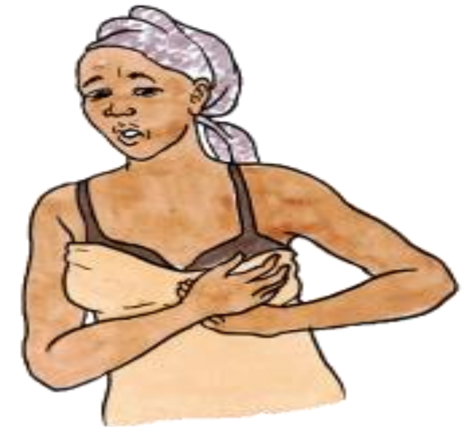
- is breastfeeding a baby who is at least 6 weeks old.
- has or has not had children.
- cannot or does not want to use other methods (i.e., those containing estrogen).
- has a sexually transmitted infection including HIV (DMPA may be used, but male or female condoms must also be used if a woman or her partner are at risk).
- is taking medicines, including ARVs to treat AIDS.

Who should not continue using DMPA (part 1)

Your client must stop using DMPA if she:

becomes pregnant

develops very high blood pressure



is told she has breast cancer

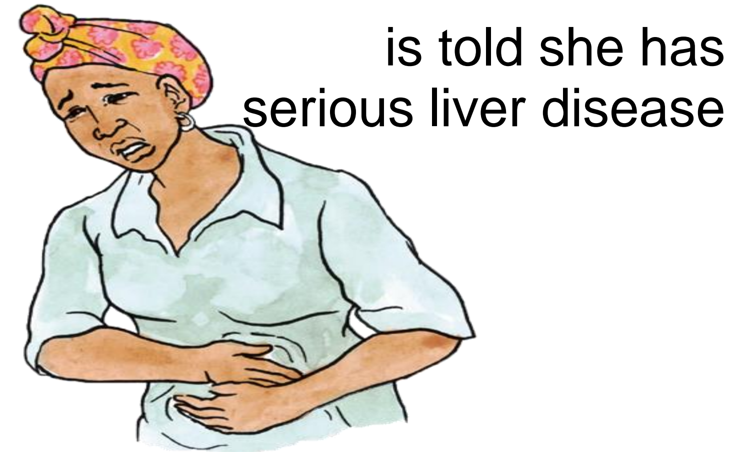
starts having very bad headaches

Source: WHO, 2010.

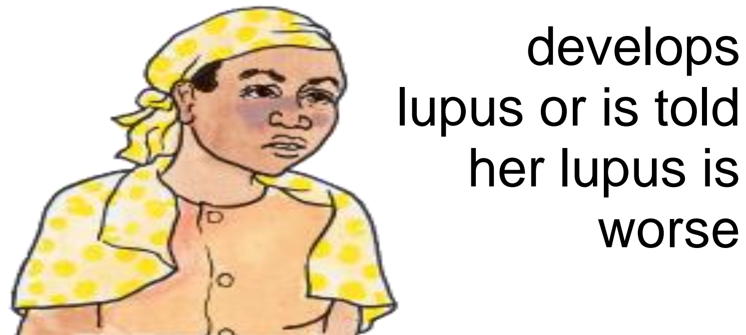
Who should not continue using DMPA (part 2)

Your client must stop using DMPA if she:

is told her diabetes is worse



is told she has serious liver disease



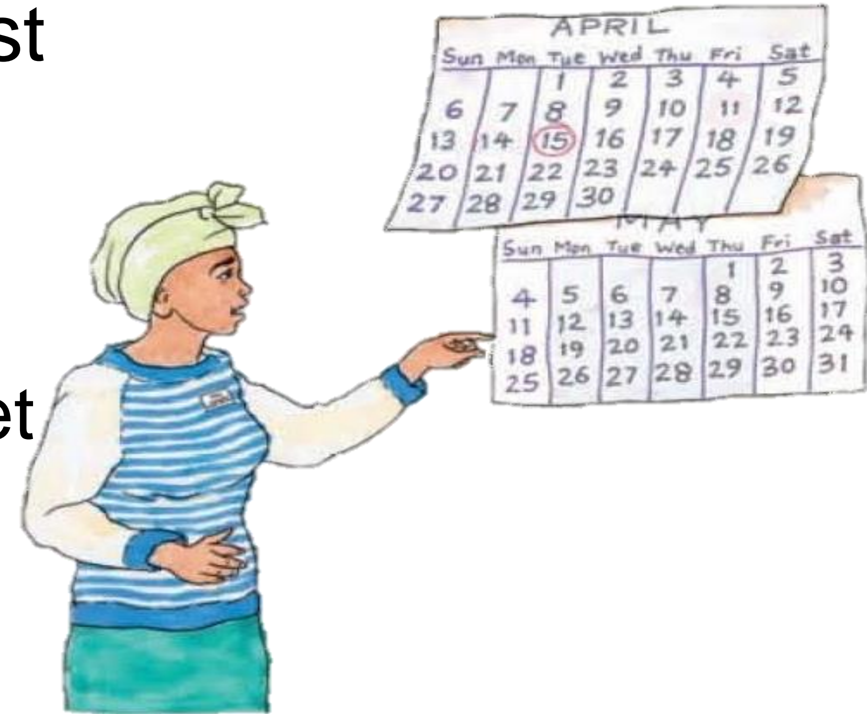
develops lupus or is told her lupus is worse

has had a heart attack, stroke, or blood clots

Source: WHO, 2004; updated 2008.

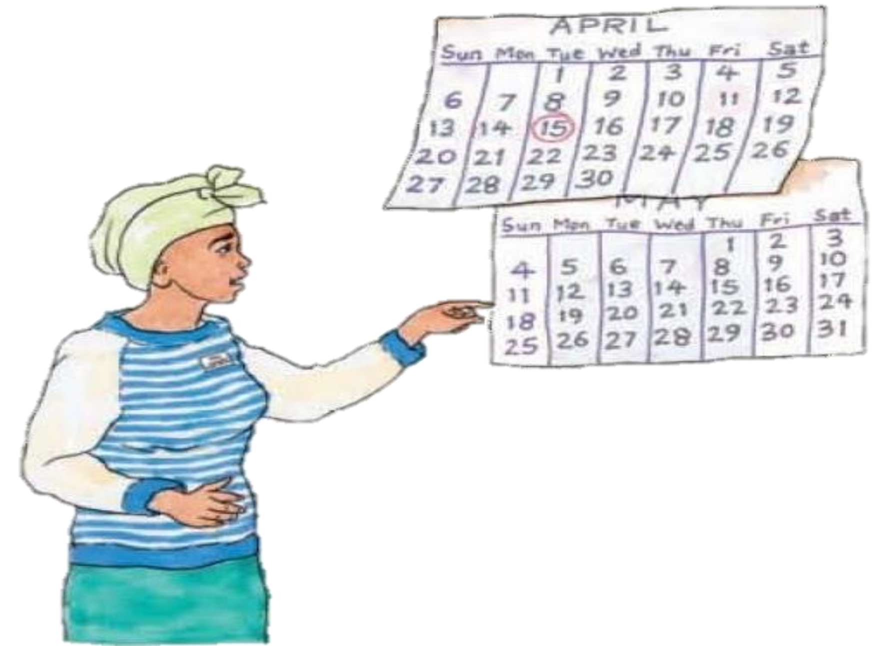
Check that your client is on time for reinjection

- Find out when your client received her last DMPA injection.
- Count 13 weeks from her last injection to find her reinjection date.
  - If today is her reinjection date, she can get the injection.
  - If she is up to 2 weeks early or up to 4 weeks late, she can get the injection.
  - If she is more than 4 weeks late, follow late reinjection procedures.



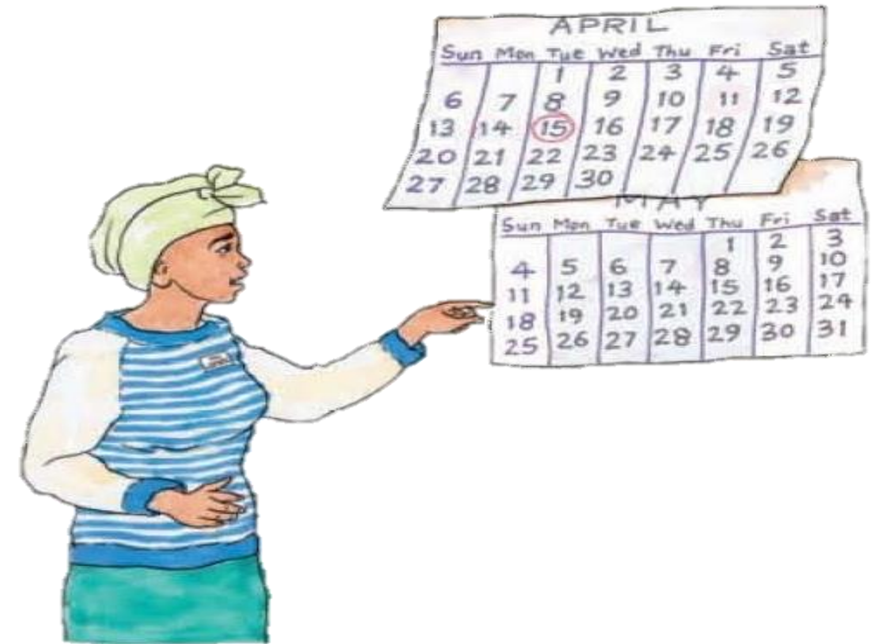
What if my client is more than 4 weeks late for reinjection?

- If your client is more than 4 weeks late for reinjection, you must rule out pregnancy before giving the injection.
- If you rule out pregnancy and give the injection, the client must use a back-up method for 7 days.
- After 7 days, the client will be protected by the DMPA.



What if my client is more than 4 weeks late and pregnancy cannot be ruled out?

- Tell her that she might be pregnant and what she must do next to find out if she is pregnant.
- If she does not get the injection, tell her that she must use condoms or not have sex until she can get another injection.



Check that your client is on time for reinjection

- Use the practice calendars with a partner to calculate the reinjection window if your client received her last injection on the following dates:

Sayana Press given	Reinjection date	Last day to inject without ruling out pregnancy
10 December 2013		
9 January 2014		
12 March 2014		
4 July 2014		

- What should you do if your client received her last injection on 12 March 2014 and arrives for reinjection on 13 July 2014?

2013

January

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February

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2014

January

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April

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May

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June

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July

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August

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September

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October

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November

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December

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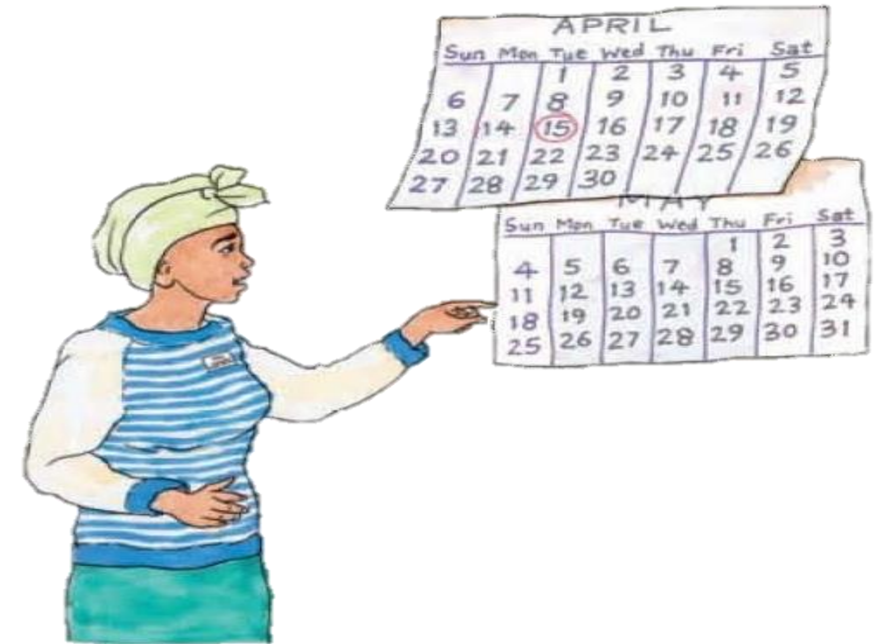
Decide the next injection date

- Use a calendar to count 13 weeks from today. This is the reinjection date.
- Write the reinjection date, and the type of injection you have just given (Sayana Press), on the client's reminder card.
- Tell her if she is late for her next injection, she should use condoms or not have sex until she gets another injection.



GROUP ACTIVITY

Decide the next injection date

- Use the practice calendar with a partner to calculate the reinjection window if you give your client Sayana Press on each of the following dates:

DMPA given	Reinjection date
21 November 2013	
7 February 2014	
16 June 2014	
10 September 2014	

- How will you help your client remember when to get her next Sayana Press injection?
- What should your client do if she will be late for reinjection?

Why women might like DMPA

- Safe
- Effective
- Easy to use
- Long lasting
- Reversible
- Can be discontinued without a provider's help
- Does not interfere with sex
- Can be used privately
- Can be used by breastfeeding women
- Eventually most women stop having monthly bleeding

Why women might not like DMPA

- Causes side effects, mainly menstrual changes.
- Action cannot be stopped immediately.
- Might take more time to become pregnant after stopping.
- Provides no protection against STIs/HIV.

Advantages and non contraceptive benefits

- It is very effective
- Does not suppress lactation
- Client only has to remember the return date for subsequent injections i.e. it is private; no one can know that the woman is on it
- Can be used at any age
- No estrogen side effects
- May reduce the frequency of epileptic and sickle cells crisis
- Helps to prevent ectopic pregnancies and iron deficiency anaemia

Disadvantages and common side effects of the Injectable POCs

- Spotting (most common at first)
- Amenorrhea (normal after first year of use)
- Heavy bleeding (rare)
- Weight gain
- Delayed return of fertility, about 4 months longer wait for pregnancy after stopping use
- Mild Headaches
- Breast tenderness
- Loss of libido
- Moodiness

Side effects cont…………….

- Nausea
- Acne or hair loss
- Requires repeated visits
- Does not protect against STIs or HIV

What is Uniject™?

Learning objectives

- Explain what Uniject is and how it works.
- Name the parts of a Uniject.
- Explain the expected benefits of Uniject

What is Uniject?

An injection system that is:

- Single-dose
- Prefilled
- Easy to use
- Not reusable
- Small in size

Names of the parts of Uniject

Reservoir

Will be 3/4 full

Large air bubble is normal

Valve

Prevents re-use

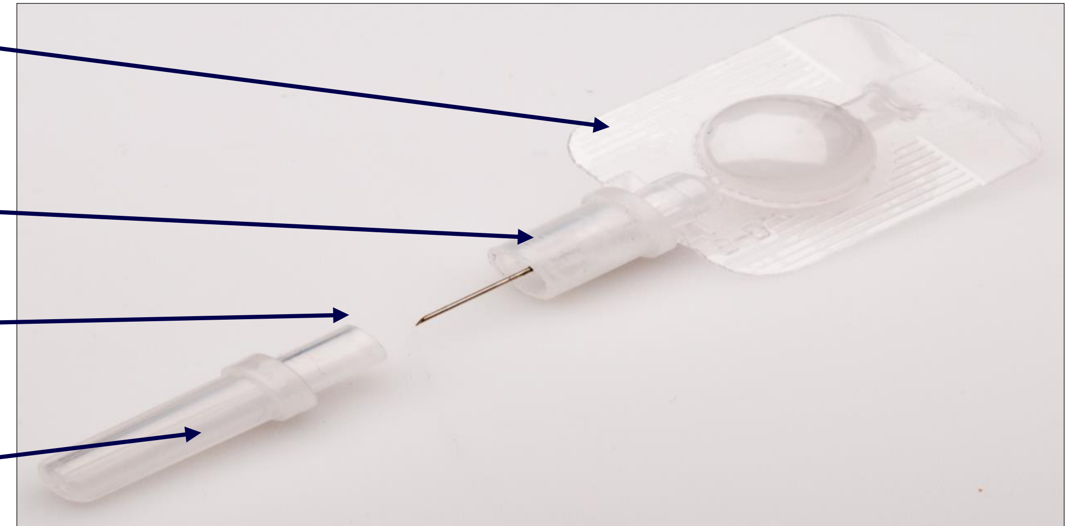
Port

Hold Uniject here to prepare and inject

Needle

9.5 mm for Sayana Press

Needle shield



Expected benefits of Uniject

- Allows more women to receive injectable contraceptives:
  - Easier and quicker to use.
  - Community-based providers can reach women in the community.
- Helps the injection to be safe:
  - Prefilled with correct dose.
  - Assures sterile injection.
  - Less waste to dispose of.
- Clients may prefer the smaller needle.

Depo-IM and Sayana Press: Two formulas of the same contraceptive

What is Sayana Press?

- A new formula of DMPA.
- Lower dose than depo-IM.
- Injected into the fatty tissue right under the skin.
- Only available in Uniject in most countries.

How depo-IM and Sayana Press are similar

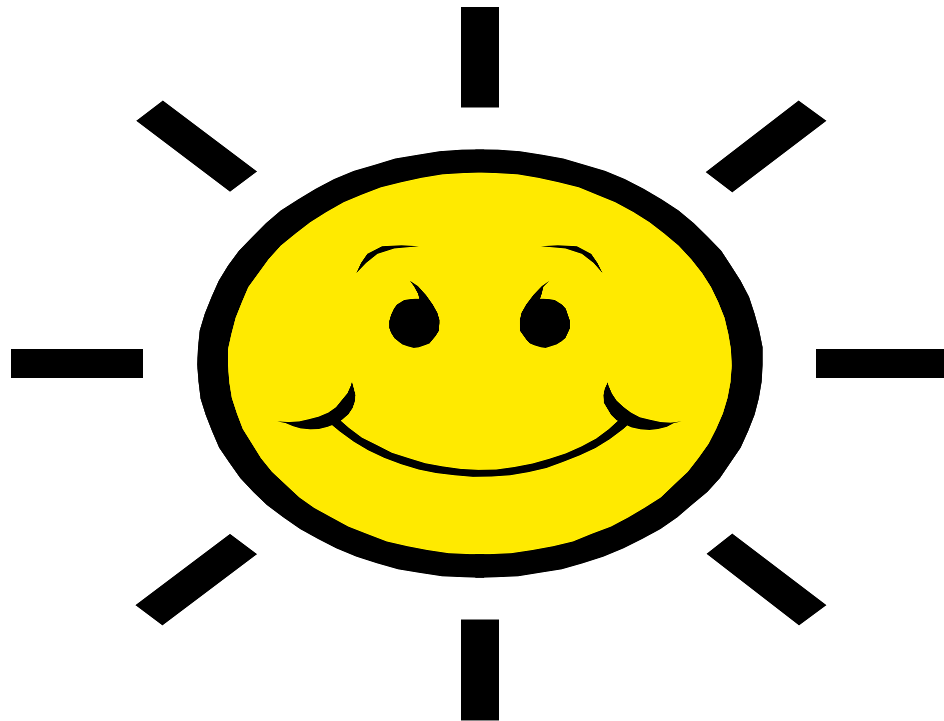
Both depo-IM and Sayana Press:

- Are injectable contraceptives.
- Are made with the same drug, progestin.
- Are delivered every 3 months (13 weeks).
- Have a similar reinjection grace period.
- Are equally effective.
- Have the same side effects, except that Sayana Press might cause temporary irritation at the injection site.

How depo-IM and Sayana Press are different

Feature	Depo-IM	Sayana Press
Mg/dose	150 mg	104 mg
Package	Vial and syringe	Prefilled Uniject syringe
Type of injection	Intramuscular (deep into the muscle)	Subcutaneous (in the fatty tissue under the skin)
Where to inject	• Arm (deltoid muscle) • Hip • Buttocks	• Anterior thigh (front of thigh) • Abdomen • Back of arm
Skin irritation	Skin irritation at injection site is not likely	Skin may be a little irritated at injection site

End



UNIT 9

BARRIER METHODS

Barrier methods of FP

Definition

- Barrier methods prevent the sperm from gaining access to the upper reproductive tract and making contact with the egg.

Mechanism of Action

- Condoms prevent the entry of sperm into the vagina

Condoms

- **EFFECTIVENESS**
- The effectiveness of barrier methods is largely dependent on the way in which they are used. For example, condoms are only moderately effective in typical use (15 percent pregnancy rate), but much more effective when used consistently and correctly (2percent pregnancy rate

Barrier methods cont…

- **Types:**
- These methods include male and female condoms, spermicides, diaphragms, and cervical caps. Whereas condoms, diaphragms, and cervical caps are mechanical barriers, spermicidal are chemicals that interfere with the movement of the sperm and its ability to fertilize the egg.

Condoms Cont…

- Male and female condoms help prevent both pregnancy and most STIs (including HIV), because when used correctly, the condoms keep sperm and any disease organisms in semen out of the vagina; also, they prevent any disease organisms in the vagina from entering the penis

Advantages and non contraceptive benefits

- Prevents STI's, including HIV/AIDS, as well as pregnancy when used correctly with every act of sexual intercourse
- Can be used alone or with another FP method as dual method
- Helps prevent conditions caused by STI's e.g. PID, infertility in both men and women and possibly cancer of the cervix
- Safe, no hormonal side effects

Advantages and non contraceptive benefits cont..

- Offer occasional contraception with no daily upkeep
- Involves men to take responsibility for contraception and for prevention of STIs
- Increased sexual enjoyment because there is no worry about STI or pregnancy
- Helps men with premature ejaculation maintain an erection.
- Easy to obtain, sold in many places including vending machines.
- Can be used immediately after childbirth

Disadvantages and common side effects

- Deteriorates (loses potency) quickly if storage is poor
- Slipping off, tearing and spillage of sperms can occur especially among in experienced users and users with inadequate vaginal lubrication
- Couple must take time to put the condom on erect penis before sex
- User must be highly motivated to use correctly and consistently

Disadvantages and common side effects

- A man's co-operation is required for a woman to protect herself from pregnancy and disease
- May embarrass some people to buy, ask partner to use, put on, take off and throw away
- Latex condoms may cause itching for a few people who are allergic to rubber. Some people may be allergic to the lubricant in some brands.
-

Who can use condoms?

- Condoms can be used by any man or woman regardless of his or her health status. People who may want to consider condom use include:

Who should not use

- Men or women who have allergy to rubber
- Men who are un willing to use condoms consistently and correctly
- Men who cannot maintain an erection when using a condom

Signs of problems that requires urgent medical attention

- Sever reaction to the rubber or the lubricant in some brands of condoms
- Barrier methods can be used without restriction

FEMALE CONDOM

Overview

What is it?

- The Female Condom (FC) is a pouch, made of polyurethane, made to fit into a woman's vaginal canal during sexual intercourse.
- It helps prevent both pregnancy and some STIs including HIV.

Advantages

Contraceptive Benefits

- Fairly effective if used properly
- Immediately effective
- Effectiveness of FC is similar to male condom and to other vaginal methods

Advantages

Non-Contraceptive Benefits

- Highly effective protection against STI/HIV/AIDS with consistent and proper use
- Protects against PID
- Woman-controlled method
- Can be used by almost every woman
- No need to see health care provider before using
- Easy to use with a little practice
- No health risk associated with the methods

Limitations

- Requires to be inserted before sexual intercourse
- Expensive- for single use only. Not to be reused.

Who can use the female condom?

- All women of reproductive age
- Women of any parity, including nulliparous
- Women needing to rule out possible pregnancy before proceeding with another method
- Women needing a back-up method
- Women needing temporary methods of contraception
- Post-abortion clients before initiating more appropriate methods
- Women with sickle cell, diabetes, hypertension
- Breastfeeding women

Who should not use the female condom?

- Persons (woman and partner) who are allergic to the material from which the condom is made
- Couples who want highly effective protection against pregnancy; where the woman has conditions that make pregnancy dangerous (see Appendix 3).

Do not use the condom if:

- The package is broken
- The condom is brittle or dried out
- The colour is uneven or changed
- It has expired

Instructions for use of the female condom:

Step 1

- Check condom package and expiry date
- Rub condom to spread lubricant
- Open the package carefully
- Tear at the notch on the top right of the package
- Do not use scissors or a knife to open.

Instructions for use of the female condom cont..

- **Step 2**
- The outer ring covers the areas around the opening of the vagina
- The inner ring is used for insertion and to help hold the sheath in place during intercourse
- **Step 3**
- While holding the sheath at the closed end, grasp the flexible inner ring and squeeze between the thumb and second or middle finger with index finger placed in the middle of inner ring so it becomes long and narrow.

Instructions for use of the female condom cont..

- **Step 4**
- Choose a position that is comfortable for insertion – squat, raise one leg, sit or lie down
- **Step 5**
- Gently insert the inner ring into the vagina past the pubic bone. Feel the inner ring go up and move into place.
- **Step 6**
- Place, the index finger on the inside of the condom, and push the inner ring up as far as it will go.
- Pouch must be inserted straight and not twisted
- Be sure the sheath is not twisted. The outer ring should remain on the outside of the vagina.

Instructions for use of the female condom cont..

- **Step 7**
- The female condom is now in place and ready for use with your partner.
- **Step 8**
- When you are ready, gently guide your partner’s penis into the sheath’s opening with your hand to make sure that it enters properly – be sure that the penis is not entering on the side, between the sheath and the vaginal wall.
- **Step 9**
- Remove the condom, twist the outer ring and gently pull the condom out.
- **Step 10**
- Wrap the condom in the package or in tissue, and throw it in the garbage.
- Do not put it into the toilet.

Removal of female condom

- Should be done before standing up
- Squeeze and twist outer ring to prevent spillage of semen
- Pull the pouch out gently

Male Condoms

- **What Are Male Condoms?**
- Sheaths, or coverings, that fit over a man's erect penis.
- Also called rubbers, "raincoats," "umbrellas," skins, and prophylactics; known by many different brand names.
- Most are made of thin latex rubber.
- Work by forming a barrier that keeps sperm out of the vagina, preventing pregnancy. Also keep infections in semen, on the penis, or in the vagina from infecting the other partner.

How Effective?

- *Effectiveness depends on the user:* Risk of pregnancy or sexually transmitted infection (STI) is greatest when condoms are not used with every act of sex. Very few pregnancies or infections occur due to incorrect use, slips, or breaks.

Protection against pregnancy:

- As commonly used, about 15 pregnancies per 100 women whose partners use male condoms over the first year. This means that 85 of every 100 women whose partners use male condoms will not become pregnant.
- When used correctly with every act of sex, about 2 pregnancies per 100 women whose partners use male condoms over the first year.

Disposal of used condoms

In the case of female condom:

- At the end of intercourse the woman should hold the outside rim of the female condom and carefully pull out the device without spilling semen.
- The used condom can be thrown into a pit latrine, burnt or buried. It should not be left where children will find it and play with it.
- Condoms must not be reused.

Protection against HIV and other STIs:

- Male condoms significantly reduce the risk of becoming infected with HIV when used correctly with every act of sex.
- When used consistently and correctly, condom use prevents 80% to 95% of HIV transmission that would have occurred without condoms
- Condoms reduce the risk of becoming infected with many STIs when used consistently and correctly.
  - Protect best against STIs spread by discharge, such as HIV, gonorrhea, and chlamydia.
- Also protect against STIs spread by skin-to-skin contact, such as herpes and human papillomavirus

Side Effects, Health Benefits, and Health Risks

- **Side Effects**
- None
- **Known Health Benefits**
- Help protect against:
- Risks of pregnancy
- STIs, including HIV
- May help protect against:
- Conditions caused by STIs:
  - Recurring pelvic inflammatory disease and chronic pelvic pain
  - Cervical cancer
  - Infertility (male and female)

Side Effects, Health Benefits, and Health Risks

- May help protect against:
- Conditions caused by STIs:
  – Recurring pelvic inflammatory disease and chronic pelvic pain
  – Cervical cancer
- Infertility (male and female)

- All men and women can safely use male condoms except those with:
- Severe allergic reaction to latex rubber latex allergy, eg Mild irritation in or around the vagina or penis or mild allergic reaction to condom; Severe allergic reaction to condom;

Dual Protection

- Dual protection is protection against STIs (including HIV/AIDS) and unplanned pregnancy; it can be achieved either by the consistent and correct use of condoms, or the use of one method to protect against unplanned pregnancy (e.g., a hormonal method or IUCD) and a second method to protect against STIs and HIV (a male or
- female condom).

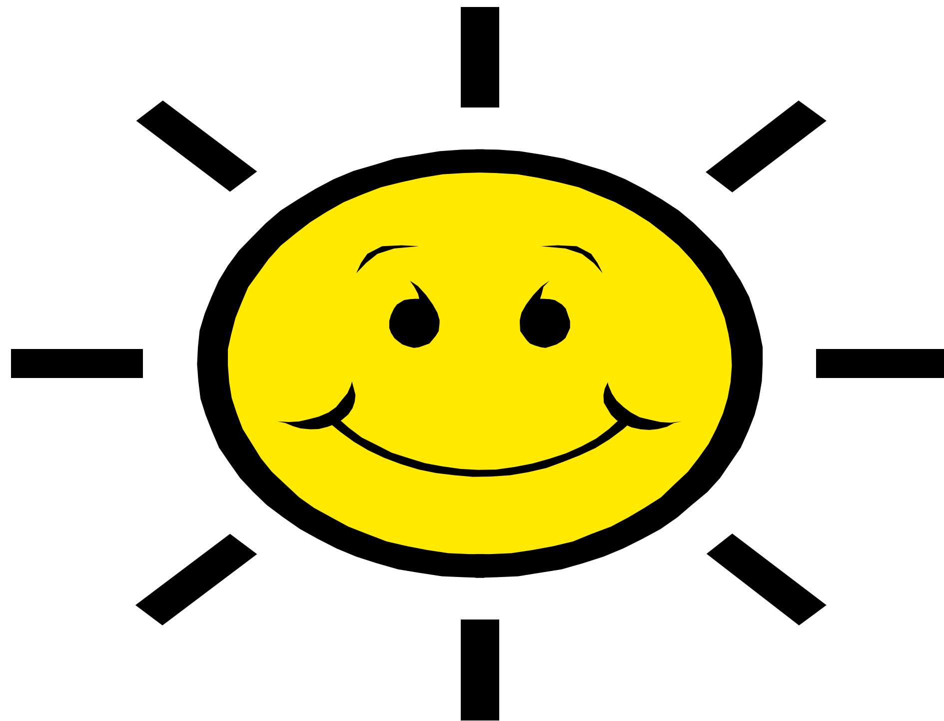
Dual Method cont…….

- Dual protection is also implied in the avoidance of risky sex (i.e., in mutual monogamy between uninfected partners combined with a contraceptive method for those wanting to avoid pregnancy). Male involvement is crucial to the success of dual protection.

Dual protection cont…….

- All FP clients should receive counseling about dual protection, specifically regarding the importance of the correct and consistent use of condoms. FP service providers must adopt a more positive attitude towards the condom as an effective method of contraception; and condoms must be available, affordable, and of good quality

THANKS



UNIT 10

NATURAL FAMILY PLANNING METHODS

Objectives

By the end of the unit the learners will be able to:

- Define natural family planning
- Describe various types of natural family planning methods
- Describe the mechanism of action of Natural Family Planning
- Explain theoretical and use effectiveness of NFP
- Discuss eligibility criteria

Objectives

- Describe advantages and limitations/rationale for each
- Explore the rumours and misconceptions associated with Natural Family Planning and dispel them
- Explain the various records/charts and equipments used in Natural Family Planning
- Demonstrate use of knowledge acquired in Natural Family Planning to assist clients to make an informed choice
- Explain the instructions for use and follow-up of the client

Definition

- Way by which a couple will learn to achieve or avoid a pregnancy by applying proper sexual behaviour during the fertile and infertile phases of the menstrual cycle.

Natural Family Planning methods

- Billings method (cervical mucus)
- Basal body temperature (BBT)
- Sympto-thermal method
- Calendar/Rhythm method
- Standard Days method
- Coitus interruptus

Mechanism of Action

- Abstinence during the fertile period so that the sperm and egg do not meet.

- The secretions have a peak day; when they are most slippery, stretch and wet, the couple continues to avoid genital sex until four days after the peak day.

Who can use

- All clients of reproductive age
- Women with regular menstrual cycles
- Couples willing to abstain from intercourse for more than one week each cycle
- Couples who are able to maintain effective events records

Who should not use

- Women with irregular cycles (e.g. around menarche and peri-menopausal periods) or before cycles are well established
- Women who dislike touching their genitals
- Women whose partners will not cooperate
- Couples who want highly effective protection against pregnancy; where the woman has conditions that can be made worse by pregnancy

Benefits Of NFP

- No physical side effects
- Free
- Promotes involvement of male partner
- Increases knowledge of reproductive system
- Can be used either to achieve or avoid the pregnancy
- Encourages couple communication and co-operation

Limitations of NFP

- Low effectiveness
- Requires daily record keeping

- Vaginal infections interfere with normal mucus
- Does not protect against STI, HBV, HIV/AIDS

- Long period of training and counselling is required before use of the methods

- Both partners must be willing to co-operate and participate

- Too long abstinence 10-15 days of every cycle
- Frustration due to long abstinence

Rumours and Misconceptions

- Identify rumours and misconceptions in the catchment area and clarify with facts

LAM

Overview of Lactation Amenorrhoea Method (LAM)

Objectives

By the end of the unit the learners will be able to:

- Define Lactation Ammenorrhoea.(LAM)
- Describe the physiology and mechanism of action of Lactation Ammenorrhoea.
- Explain theoretical and use effectiveness of LAM
- Discuss eligibility criteria
- Describe advantages and limitations of LAM
- Demonstrate use of knowledge acquired on LAM to assist clients to make an informed choice
- Explain on follow-up of the client

Lactation Ammenorrhoea Method (LAM)

Definition

- The term Lactation Ammenorrhoea Method (LAM) refers to the traditional method of breast-feeding as a family planning method, but adds the results of a scientific study.
- It has been established that by following three basic guidelines, a woman is provided with up to 98% protection from pregnancy.

Mechanism of action

- Inhibits ovulation.

Physiology of LAM

- The physiology of LAM is based on the hypothalamus, pituitary and ovarian feedback system.
- Suckling at the breast sends the neural signals to the hypothalamus
- This mediates the level and the rhythm of Gonadotrophin releasing hormone
- (GnRH) secretion. The GnRH influences pituitary release of follicle stimulating hormones (FSH) and lutenizing Hormone (LH), the hormones responsible for the follicle development and ovulation. Hence breast-feeding results in decreased and disorganized follicular development

Effectiveness of LAM depends on the following factors:

- The woman’s menstrual periods have not resumed, AND
- The baby is exclusively or nearly exclusively breastfed, AND
- The baby is less than 6 months old

Who can use LAM

- Women who breastfeeds exclusively (full time or almost full time), day and night
- Women whose baby/babies is/are less than six months old and
- Women whose monthly periods have not yet began (within six months since delivery

Who should not use LAM

- Women who are not breastfeeding at least nearly fully
- Women with resumed menses
- Where the baby is more than 6 months old
- Couples who want highly effective protection against pregnancy; where the woman has conditions that make pregnancy dangerous
- Whose baby breastfeeds irregularly or at longer than 6 hourly interval and sleeps through out the night.
- Whose breast milk flow is reduced for any reason

Benefits of LAM

Contraceptive Benefits

- Protection against pregnancy as long as full breastfeeding is practised
- Does not interfere with sexual activity

Non-contraceptive Benefits

- Provides passive immunization for the child
- Decreases exposure to pathogens in water or other milk
- Best source of nutrition for infants
- Affordable – no direct cost for family planning
- No hormonal side effects
- Counselling for LAM encourages starting a follow-on method at the proper time

Limitations

- Effectiveness only lasts as long as breastfeeding is being practised exclusively
- Breastfeeding can cause MTCT of HIV
- Does not protect one against STIs/HIV/AIDS

Rumours and misconceptions

- Identify rumours and misconceptions and dispel them with facts

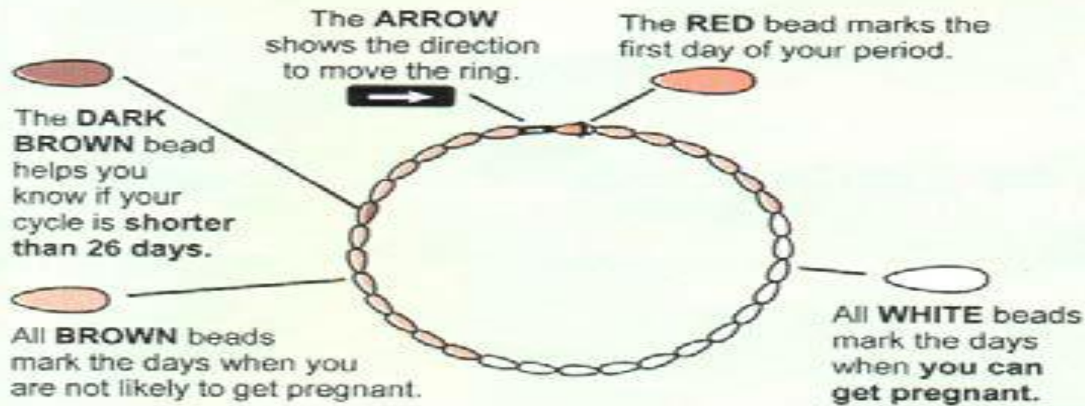
Note:

- Counsel woman in advance about future contraceptive options and to initiate another method as soon as:
  - Supplementary feeding begins or baby starts to skip his regular meals
  - Menstruation begins
  - Baby is about 6 months old

Using moon bead

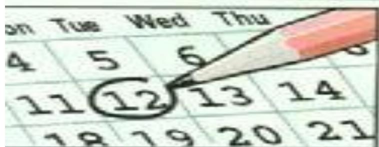
What do the colors mean?

MoonBeads are a string of 32 beads, a rubber ring and a cylinder with an arrow.

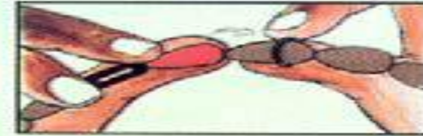


How do you use MoonBeads?

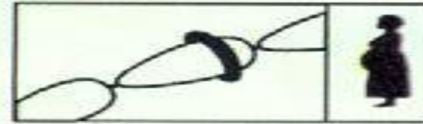
The day you get your period move the ring to the RED bead.



Also mark that day on the calender

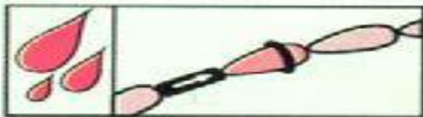


Move the ring one bead each day. Move it even on the days when you have your period.



Do not have unprotected sex when the ring is on any WHITE bead. You can get pregnant on those days.

You can have sex when the ring is on any BROWN bead. You are not likely to get pregnant on those days.



Move the ring to the RED bead again when your next period starts. Skip over any beads that are left.

When to contact your healthcare provider.

If you had unprotected sex on a WHITE bead day, contact your provider. If you think you might be pregnant because you have not gotten your period, contact your provider.

If you get your period before you reach the DARK BROWN bead, this means that your cycle is shorter than 26 days. Contact your provider.

Instructions for clients on SDM with Cycle Beads

Using CycleBeads

- On the first day of your period, move the ring to the RED bead. Also mark that day on your calendar.
- Every morning move the ring to the next bead. Always move the ring in the direction of the arrow. Move the ring even on days when you have your period.

Instructions cont.........................

- When the ring is on any WHITE bead, use a condom or avoid sex to prevent pregnancy.
- You can get pregnant on these days if you have unprotected sex.
- When the ring is on a BROWN bead you can have sexual intercourse. These are days when pregnancy is very unlikely.

- When the ring is on any WHITE bead, use acondom or avoid sex to prevent pregnancy.
- You can get pregnant on these days if you have unprotected sex.
- When the ring is on a BROWN bead you can have sexual intercourse. These are days
- when pregnancy is very unlikely.

- The day your next period starts, move the ring to the RED bead again. Skip over any remaining beads.

Monitoring cycle length

- To use CycleBeads, your period must come between the dark brown bead and the last brown bead.
- If you start your period before you put the ring on the DARK BROWN bead, it means it has come too soon to use the method.
- If you have not started your period by the day after you put the ring on

the last BROWN bead, it means your period is too late to use this

method.

Monitoring Length cont……………………..

- Visit your provider if more than once in a year your period came too soon

or too late. Also see your provider if you had sex on a white bead day.

Instructions for clients on TwoDay method

- What secretions are and when to check Secretions are a liquid fluid that you can feel in your genital area during several days of the month.
- Pay attention to your secretions every day starting at noon and at least

twice in the afternoon and evening

Instuctions cont................

- You can tell if you have secretions by seeing or touching them, or by

feeling them while you go about your daily activities.

- Secretions are not always the same. As days go by, they look and feel

different. For a TwoDay method user, ANY secretions indicate that you

can get pregnant.

Knowing if you are fertile today

- To know if you can get pregnant, ask yourself every night if you had

secretions today. If yes, you can get pregnant. If no, then ask if you had

secretions yesterday. You are fertile if you had secretions either today or

yesterday. You are not fertile if you had NO secretions for two consecutive

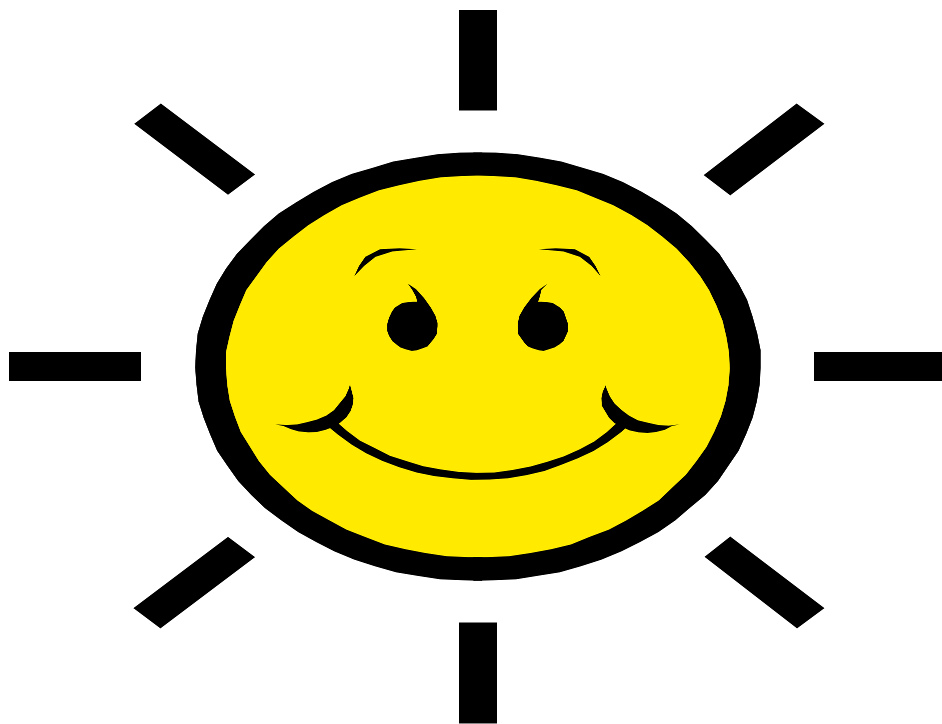
days.

Knowing the fertile days…………………..

- You can keep track of your secretions to help you remember if you had secretions yesterday. Use a calendar to record your secretions.

- On the first day that you use this method, you should assume that you can become pregnant. The first few days use condoms or avoid sex to prevent pregnancy from occurring.
- Always avoid unprotected sex on fertile days to prevent a pregnancy.
- Follow the instructions in the TwoDay method card.

THANKS



Sterilization

- Sterilization: Female sterilization and male vasectomy are permanent method of contraception and highly effective

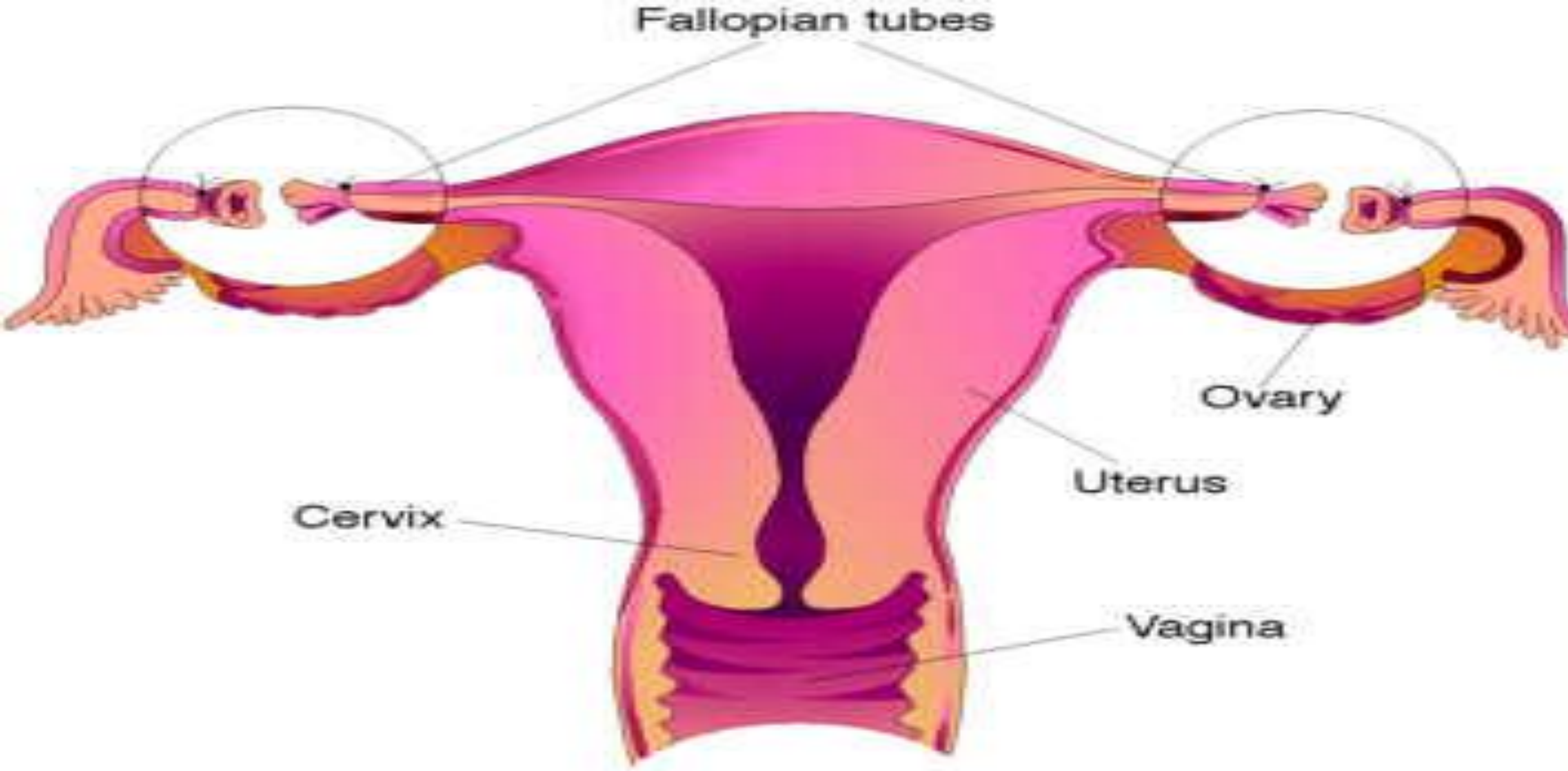
- 28% of reproductive age women undergo tubal ligation and 10% of men undergo vasectomy.
- Sterilization methods include:

1- Vasectomy in males.
2- Tubal Ligation in females .

Tubal Ligation

- This involves mechanically blockage of both the fallopian tubes to prevent the sperm from reaching and fertilizing the ovum

- Failure rate: 0.5%


Fallopian tubes
Ovary
Uterus
Cervix
Vagina

Tubal Ligation

Advantages:

- intended to be permanent
- highly effective
- safe
- quick recovery
- lack of significant long-term side effects
- cost effective

Tubal Ligation

Disadvantage:

- possibility of patient regret
- difficult to reverse
- future pregnancy could require assisted reproductive technology (such as IVF)

Cont.

Complication:

A women may experienced anasthetic problem or may be damage to intra-abdominal during the procedure.

NOTE:

ectopic pregnancy can be a late complications

and any sterilized women who misses her period and has symptom of pregnancy should seek

medical advice.

UNIT 7

MANAGING CLIENTS FOR FP SERVICES

Session objectives:

By the end of the session trainees will be able to:

1. Outline the purpose of screening clients for contraceptive use
2. Explain the procedure of screening clients for FP method use under the following:

   - History taking
   - Screening for medical eligibility using checklists
   - Physical assessment

3. Demonstrate the ability to screen clients for FP method use following the WHO Medical Eligibility Criteria and Checklists.

7.1 Screening Clients for Contraceptives Use

Purposes of screening clients for FP method use is to;

- Rule out contra-indications/precautions to FP method use
- Identify reproductive health problems and manage accordingly
- Screen for STI and HIV
- Gather baseline data for future reference
- Follow up on problems and have possible solutions
- Determine eligibility for method of choice, according to WHO medical eligibility criteria

7.2 WHO MEC WHEEL

By the end of the session trainees will be able to:

1. Explain the WHO Medical Eligibility Criteria
2. Explain the adapted Uganda MEC wheel and describe the key features.
3. Demonstrate ability to use knowledge of the WHO MEC to initiate clients on FP methods.

Con't

Medical Eligibility Criteria was developed by WHO to provide guidance for healthcare providers on the safe use of contraceptive methods for clients with medical conditions or other characteristics.

How to use this wheel

Category	With clinical judgement	With limited Clinical judgement
1	Use method in any circumstance	Yes (Use the method)
2	Generally use method	
3	Use of method not usually recommended unless other more appropriate methods are not available or not acceptable	NO (Do not use the method)
4	Method not to be used	

7.4: Conducting Routine Follow-Up Visits for Family Planning

Session objectives

- *By the end of the session, trainees will be able to:*
- 1. State the meaning of routine follow-up and the times to do it
- 2. Explain the important questions to ask when conducting routine follow up of clients on FP methods.
- 3. Demonstrate ability to conduct routine follow-up of clients on FP methods.

Cont’

Helping Continuing Users

- Ask the client if she has had any new health problems since her last visit.
- Ask the client about major life changes that may affect her needs particularly STI/HIV risk and plans for having children.
- Ask how the client is doing with the method and whether she is satisfied.
- Ask if she has any questions or anything to discuss.

Role Play - groups of 4

- Conduct follow up visits for clients on FP methods.

End

Questions ????????????

Components of screening clients for FP

- History taking
- Screening to be reasonably sure that the client is not pregnant
- Screening for medical eligibility using method specific checklists
- Targeted Physical examination
- Laboratory investigations(option

History taking

Reasons for taking history is to:

- Get an understanding of the client's general health status
- Find if there are reasons why a client should not use some methods
- Find out any problems that may need treatment or referral
- Find out any problems that may have come about as a result of using a family planning method
- Make and keep a record of a client's health history
- Find out if there is a need for a physical examination
- Decide what to talk more about during counseling

Details of history taking

- **Name, age and address** for identification
- **Social**
- **Family**
- **Medical**
- **Menstrual**
- **Reproductive**
- **Conduct physical examination from head-to-toe**

MANAGING CONTRACEPTIVE RELATED SIDE EFFECTS AND COMPLICATIONS

Session objectives

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

1. Identify the difference between side effects and complications

2. Explain the SOAP process

3. Apply the SOAP process to manage clients with common and rare contraceptive side effects and complications

4. Demonstrate ability to manage clients with contraceptive side effects and complications **effects and complications**

Cont’

- Side effects are the minor problems which are short lived and usually subside within two-three months, and complications are those problems which require urgent medical attention

”The SOAP approach to managing side effects and complications of FP methods

The acronym SOAP is

- S - Subjective
- O - Objective
- A - Assessment
- P - Plan

Cont'

Subjective: Collect information on the situation from the client through history taking or counseling.

Objective: Collect information on the situation from physical examination, investigation and/or observation.

Assessment: Review subjective and objective information and make conclusion/diagnosis.

Plan: Determine strategy to resolve the situation

Small group work – 4 groups

Managing Side effects/complication of FP

Group 1: Nausea, dizziness, headaches in clients using COC

Group 2: Acne, high blood pressure and breast tenderness in clients using COC

Group 3: Unwanted weight gain or loss, depression and loss of libido in clients using Depo Provera.

Group 4: Lower abdominal pain, loss of strings, abnormal vaginal discharge in clients using IUD.

In their groups, ask trainees to record their discussions on newsprint according to SOAP.

End

- Questions ???????????

HEALTH EDUCATION

- Meaning of health education
- Steps of health education
- Benefits of health education
- Difference between health education and counseling

Meaning of health education

- Organized series of activities enabling young people to acquire knowledge and skills about SRH to increase control over their lives.

Steps of health education

Step one: Planning group talk

- Identify the needs
- Find out the target group
- Select priority messages and materials (remember to review them)
- Set objectives
- Decide on time, prepare venue and influential's

STEP TWO: Delivering the session

- Explain purposes and objectives
- Give content in a simple way
- Use visual aids appropriately
- Allow participation

STEP THREE: Evaluate the session

- Find out why the talk was good
- Asses feelings
- Learnings
- Repeat omitted points
- Application

Counseling for FP/RH services

Session objectives

By the end of the session trainees will be able to:

1. Describe counseling under the following headings:

- Meaning of counseling
- Purposes of counseling
- Differences between counseling and client education on their family planning rights
- Counseling skills, attitudes and factors that influence effective counseling

2. Discuss the REDI Counseling Framework

Objective cont'

3. Identify the steps followed when:

- counseling a client for informed choice of family planning method
- counseling high-risk clients for FP/RH services

4. Explain considerations taken when counseling HIV/AIDS clients for FP/RH services

5. Demonstrate ability to use counseling skills to:

- to counsel high-risk and PLHA for FP/RH services
- help clients make voluntary informed decisions for FP/ RH

Counseling for FP/RH services

Meaning of counseling

Is a face to face communication between a service provider and one or more people where the service provider helps the individual or group of people to make a decision or decisions and act on it/them

Family planning counseling

Is different from other kinds of medical counseling because it involves, in most cases, healthy individuals as opposed to those who are sick.

The final choice as a result of FP counseling is made by the client.

Purpose

Purpose of counseling in FP/RH service delivery

- To recruit high risk clients for FP/RH services
- To help clients voluntarily select an FP method
- Help clients accept and continue utilizing FP/RH services or FP methods.

Cont’

Differences between counseling and client education

Client education is providing information using a variety of methods, for example, radio, talk shows, drama, songs, whereas counseling is a face to face communication involving discussion (talking) between the persons concerned, making an informed choice and acting on it

Cont'

- **Factors influencing effective counseling**
  - Privacy and confidentiality
  - Showing concern/care
  - Empathy
  - Preparedness and technical competence of provider
  - Positive attitude of the service provider
  - Use of common language
  - Accuracy of information
  - Respect and understanding
  - Use of visual aids
  - Adequate time for both provider and client
  - Being flexible

Support materials for counseling

- Client records
- Samples of contraceptives
- Visual aids, diagram of male and female reproductive system
- Flip chart
- Models of pelvis, penis (if available)
- Posters etc

Counseling skills

Effective counseling needs;

- Listening actively
- Asking open-ended and probing questions
- Paraphrasing
- Summarizing
- Attentive behaviour
- Observing
- Use of non-verbal cues
- Reflecting feelings
- Seeking clarification
- Use of effective silence

Counseling attitudes

- Caring
- Non-judgemental
- Empathetic
- Showing concern and willingness to help
- Being friendly
- Open facial expression
- Respectful

Cont’

Preparation for counseling

- Room/place to ensure privacy and confidentiality
- Timing convenient to provider and client
- Arrange seating place which is comfortable and conducive to counseling
- Alert other staff in clinic not to interrupt
- Collect all the necessary visual aids

THE REDI COUNSELING FRAMEWORK

Acronym "REDI"

- **R** - **Rapport** Building
- **E** - **Exploration**
- **D** - **Decision** Making
- **I** - **Implementing** the Decision

REDI Cont’

- **REDI** was designed specifically to incorporate the client’s comprehensive needs and to incorporate a focus on the client’s responsibilities and actions.
- ‘
- REDI emphasizes life circumstances of the client, including the client’s relationships, sexual practices, social context, and individual risk for contracting HIV and other STIs.
- It puts the client in the center of decision, and developing a plan for implementing.

REDI Cont'

- Both the client and counselor identify potential barriers to the implementation of the decision and then address them accordingly
- REDI recognizes that many client decisions are never implemented because of barriers that have not been identified at the time of decision making
- Counseling process applies the same skills, attitudes, and knowledge, whether the framework is REDI or GATHER.

How REDI Facilitates Counseling

- Emphasizes the client's right and responsibility for making a decision and carrying it out
- Provides guidelines for how to explore the client's sexual relationships and social context
- Helps identify the barriers that a client may face in carrying out this decision, build skills and develop strategies to help the client address them

Cont’

- A guide to informed and voluntary decision making
- Treats the client as a whole person with different and interrelated needs and circumstances
- Helps providers guide the client through a reality check, identify potential barriers, and strategies to overcome them.

The framework & social context

- Clients need to make realistic decisions that they can carry out successfully and safely.
- Examining the social context helps them to understand the potential outcomes of their decisions and answer questions like;
  - *Who has the decision-making power and who influences decisions?*
  - *What will happen if the partner/family finds out that a woman is using FP in secret?*
  - *What will happen if/when the client experiences side effects such as bleeding?*
  - What economic pressures might affect the client's decisions?

The framework & informed voluntary consent

- Helps provider tailor the information to the client's needs and circumstances
- The client reach realistic decisions after having considered his or her life circumstances
- Remind the client to weigh options and consider their implications as well anticipate potential barriers to implementation
- Guides providers in helping clients to better understand their personal risks for unintended pregnancy

The framework

Read with participants (trainee handbook pg 41 – 46)

During the Counseling Session

- Accept to discuss the FP method which a client has chosen.
- Provide brief information about the rest of the available methods e.g. benefits, similarities and differences of how the methods prevent pregnancy and their side effects
- List to what the client know about the method and try your best to decide if the information the client has given is enough

Cont’

- Be flexible, while ensuring that the client will use the selected method correctly.
- Aim to provide counseling session that takes no more than 30 minutes.

Note: the provider can describe in detail all family planning methods to only those clients who have almost no previous knowledge of the FP method.

Counseling High risk clients

- Points to remember when counseling HIV positive women on family planning methods
  - Adolescents with HIV also have the same range of options for contraception as those who are uninfected.
  - Recommend all HIV positive clients to use a dual method.
  - Counsel on Emergency Contraception where applicable

Points to remember

When counseling HIV positive women taking ARVs on family planning methods, note;

- HIV positive women can use any of the available FP methods.
- Take a history to include what ARVs she is taking. Is she taking Nevirapine or Efavirenz?
- If a client is taking Nevirapine and is using Depo-Provera, counsel her to get the next injection of DMPA immediately at the end of three months.
- If a client is taking Nevirapine and is taking COCs, she must take COCs regularly every day and not miss any Pills.

Cont’

Conclusion

Good counseling is associated with client satisfaction and method continuation. It improves the reputation of the facility which in turn encourages more clients to come for services. Counselors should be on the alert not to miss any opportunities to provide counseling on the many issues of reproductive health. They should model assertive behaviors and teach negotiation skills.

Cont’

- **ROLE-PLAY SCRIPTS**

Family Planning and ARVs

Session objectives:

By the end of this session, trainees will be able to:

1. List common first line ARVs used in Uganda.
2. Explain the family planning and pregnancy considerations when using ARVs.
3. Identify the TB drug that reduces the effectiveness of certain FP methods.
4. Discuss dual protection and dual method use.

Family Planning and ARVs

Session objectives:

By the end of this session, trainees will be able to:

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4. Discuss dual protection and dual method use.

Family Planning and ARVs Cont’

Interaction Between 1st Line ARVs And Contraceptives

ARV Basics:

- The WHO recommends four alternative regimens for "first-line therapy."
- Each "triple-therapy" regimen contains two Nucleoside Reverse Transcriptase Inhibitors (NRTIs) and a Nonnucleoside Reverse Transcriptase Inhibitor (NNRTI).
- Currently the most commonly used NNRTI is Efavirenz (EFZ).
- ARVs are recommended for all who test HIV-positive.
- Another class of ARVs—protease inhibitors—can have interactions with contraceptive hormones, but are not included in first-line regimens.

Cont’

The first line drugs used for antiretroviral therapy (ART) in adults and adolescents in Uganda

- *The first line ARV regimes in Adults and Adolescents in Uganda are:*
- *1. Tenofovir (TDF) and Lamivudine (3TC) plus Efavirenz*
  - *ALTERNATIVE*
- *2. Zidovudine(AZT) and Lamivudine (3TC) plus Nevirapine or Efavirenz.*

The best combinations will always include three different drugs. Combinations usually include two Nucleosides plus either a non-Nucleoside or a protease inhibitor. The two non-Nucleosides are Nevirapine and Efavirenz.

Types of ARVs

Nucleoside Reverse Transcriptase Inhibitors or Nucleosides include	Non Nucleoside Reverse Transcriptase Inhibitors or non-Nucleosides include
• Lamivudine (3TC) • Zidovudine AZT) • Didanosine (ddi) • Abacavir (ABC)	• Nevirapine (NVP) • Efavirenz (EFZ)
Nucleotide reverse transcriptase inhibitor (NtRTI) include:	**Protease Inhibitors (PIs) include:**
• Tenofovir (TDF)	• Nelfinavir (NFV) • Indinavir (IDV) • Saquinavir (SQV) • Lopinavir/r (Kaletra) (LPV) • Atazanavir (ATV) • Ritonavir (RTV)

Cont'

Family planning and pregnancy consideration when HIV positive women are taking antiretrovirals (ARVs)

- HIV positive women on ARVs can use any of the available FP methods according to WHO medical eligibility criteria (2015)
- If an HIV positive woman comes to the clinic, and is on ARVs. Try to find out what specific ARVs she is taking.
  - *If taking Nevirapine or Efavirenz in whatever combination, and wants to start or is using Depo-Provera, emphasize that it is important to return for her next injection on the date indicated on the appointment card or shortly before the appointment date.*
  - *The 2 weeks grace period (providing the injection up to 2 weeks late) is* ***not*** *advisable for these clients because NVP may reduce the progestin in DMPA at the end of the three months.*

Cont’

- If client is on Nevirapine or Efavirenz in whatever combination and wants to start COCs, emphasize on taking pill regularly to avoid getting pregnant.
- If on Nevirapine or Efavirenz, and wants to start a FP method, help her to make **an informed choice of family planning method**.

Cont’

- **TB drug that reduces the effectiveness of some FP methods**
  - **Rifampicin** for treatment of Tuberculosis affects the use of FP methods, - makes COC, POP, or Implants become less effective
  - Depo-Provera can be given to a client taking Rifampicin

Note:

- Client given Rifampicin, Efavirenz is usually given instead of Nevirapine. If your client desires Depo-Provera, advise client to come to the clinic immediately every three months for the repeat injection.
- **Always consider the need for *dual protection* from pregnancy and STI/HIV when providing health services to people with HIV.**

Cont’

The need for Contraception for people with HIV

- Desires regarding fertility is the same for people regardless of the HIV status. There may be a greater need to control fertility and family size because of:
  - a woman’s health
  - the health of other family members
  - to prevent HIV transmission to a child

Hence the subject of contraception should be:

- addressed when individuals come in contact with HIV treatment and care providers (during HIV counseling and testing, EMTCT visit, within ART program, or home based care visits)
- followed-up regularly at every visit, as people’s needs and health change
- integral part of the preparation process for ART

Counseling Sessions

- Scenarios
- Case studies

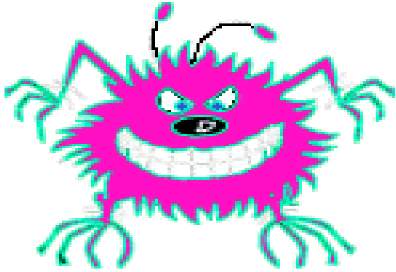
The End

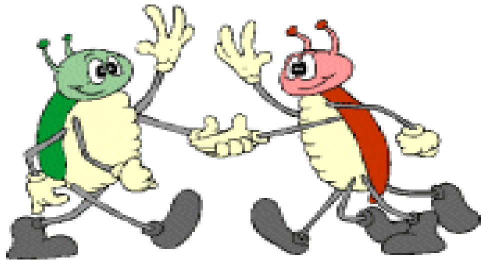
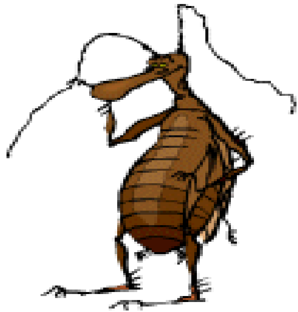
Questions ????????????????

INFECTION PREVENTION

By the end of the session trainees will be able to:

1. Appreciate the meaning of infection prevention
2. Describe the disease transmission cycle
3. Outline key IP principles/Universal precautions
4. Discuss appropriate personal protective equipment and gloving
5. Discuss appropriate hand washing and antiseptics
6. Outline safe handling of sharps
7. Discuss key steps and principles involved in instrument processing
8. Discuss proper housekeeping and waste disposal



IP Training

Introduction

Appropriate infection prevention practices must be followed to minimize the risk of infection and serious diseases for the client, provider, all facility staff members, and the community. People with infections, both clients and staff members, may not have any signs or symptoms of the infections they carry e.g HIV, hepatitis…. **it is important for *all* staff to practice proper infection prevention.**

Goal

- To prepare team members to deliver high quality services, particularly in terms of infection prevention,

- Health care providers should be committed to providing high quality services to clients through:
  - maximizing client satisfaction
  - ensuring successful outcomes by preventing failure and complications, and
  - proper management of complications when they occur.

Definitions

Infection :

- The successful invasion of microorganisms in to the body resulting into illness

Infection Prevention:

- It is the collective effort made by health care providers and clients to prevent or minimize the risks of transmitting infections to clients or to other health care providers
- Measures taken during service provision and maintenance of health facilities to reduce chances of health workers and clients getting infected.

Purpose of IP

I. To minimize the spread of infection from person to person.

II. To prevent the transmission of serious life threatening diseases such as hepatitis B and HIV/AIDs

III. To provide high quality and safe services

IV. Lower the cost of health care services since prevention is cheaper than treatment,

Causes of Infection

Microorganisms – two types

- **Normal Flora** - normally present on our skin, respiratory tact, intestinal and digestive tracks.

- **Pathogens** – **Not** normally found on or in the human body and which carry disease.

MODE OF TRANSMISSION

I. **Direct contact** :– Direct transfer of microorganisms e.g.; touch, sexual intercourse, fecal/oral transmission, droplets – influenza

II. **Vehicle:** Materials that serve as a means of Transfer of microbes e.g. instruments

III. **Airborne:** organisms carried by air currents eg TB measles

IV. **Vector:** invertebrate animals e.g. mosquitoes , flea etc

DISEASE TRANSMISSION CYCLE

Susceptible host
- Client
- Service provider
- Hospital staff
- Community members

Reservoir
- People
- Water
- Instrument
- Equipment

Infectious agents
- **Bacteria, Fungi, Parasites**
- **Viruses, etc**

Place of exit
- Respiratory/digestive tract
- Skin/vascular system
- Mucus membrane

Pot of entry
- Broken skin
- Puncture wound
- Surgical site
- Mucous membranes

Mode of transmission
- Contact
- Vehicle
- Airborne
- Vector

The disease transmission cycle

The six components of the disease transmission cycle include:

1. **Agent**; disease-producing microorganisms

2. **Reservoir**; place where disease transmitting agent lives such as in or on humans, animals, plants, soil, air or water.

3. **Place of entry**; where the agent enters the next host.

4. **Place of exit**; where the agent leaves the host

5. **Mode of transmission**; how the agent travels from place to place (or person to person)

6. **Susceptible host**; person who can become infected

Key Principles Underpinning IP

- Infection prevention is the foundation for any high quality service
- MSI centres must '*first do no harm*'
- Clients and team members have a right **not to get an infection at a MSI centre**
- Clients and team members can go on to infect families and the wider community

Principles (Cont.)

- Infection prevention is a team responsibility
- Infection prevention is important for the sustainability of the programme
- Cheap and simple precautions can prevent the spread of infection.

Infection Prevention Measures

Standard precautions

- Consider every person (client or staff) infectious.
- Hand washing
- Wearing gloves
- Use Protective barriers (gowns, aprons, gurgles, gumboots etc)
- Proper instrument processing
- Proper disposal of sharps
- Effective waste disposal practices.

Prevention measures (Cont')

- Maintaining a clean environment
- Distancing/separation /restriction of movement client, staff and of visitors
- Create awareness on policies, protocol and guidelines
- Staff health management:
  - Post Exposure prophylaxis,
  - Health monitoring,
  - Vaccination(HBV, Yellow fever)

Hand Washing

- Hand washing may be the single most important procedure in preventing infection.
- Three kind of hand washing-

  i) Routine hand washing.

  ii) washing with antiseptics and running water.

  iii) An alcohol hand rub.

HAND WASHING (Cont.)

STEPS:

– Use a plain or antiseptic soap.

– Vigorously rub both hands together for about10-15 seconds.

– Rinse with clean running water from a tap or bucket.

– Dry hands with a clean towel or air dry them.

N.B: Should Avoid using a communal towel

HANDS WASHING(CONT.)

Wash hand Your Hands:

- After arriving at work
- Before and after examining each client
- After touching anything that might be contaminated
- Before putting on gloves for clinical procedures
- After removing gloves
- After using the toilet or latrine
- Before leaving work

Alcohol Hand Gel/ solutions

- Use 3 to 5 ml for each application and continue rubbing the solution over the hands for about 2 to 5 minutes, using a total of 6 to 10 ml per scrub.

Gloving

- Three kinds of gloves:
  - Surgical gloves.
  - Single use exam gloves.
  - Utility or heavy duty gloves

Wear gloves:

- When performing a procedure in the clinic or operating room
- When handling soiled instruments, gloves and other items
- When disposing of contaminated waste items (cotton, gauze or dressings)

Aseptic Techniques

Refers to the practices performed just before or during a clinical or surgical procedures.

A septic techniques includes:

- Using barriers
- Surgical scrub and gloves.
- Client preparation
- Establishing and maintaining sterile field.
- Using good surgical techniques; - creating a safer surgical/procedure area.

Personal protective equipment

Personal protective equipment safeguards clients and staff.

- Gloves
- Aprons
- Eyewear
- Footwear

Instrument Processing.

- Instrument processing is vital for reducing infection during clinical/surgical procedure.
- Correct handling process helps reduce the health team from infection.

Steps for instrument processing

I. Decontamination.

II. Cleaning.

III. Sterilization or high level disinfection.

IV. Storage.

Cont’

Decontamination of equipment

- This is the method used to neutralize or remove harmful agents from contaminated equipment or supplies and should be based on:
  - Risk of infection associated with the instrument or piece of equipment
  - Decontamination process the object can tolerate
  - Decontamination should be done immediately after use and before

Equipment, mops, buckets, and cloth should be decontaminated with a disinfectant (0.5% chlorine) solution for 10 minutes, cleaned in detergent and water, rinsed in cold water and dried before sterilization or use.

Chlorine Preparation

- **To make a 0.5% chlorine solution ; <u>0.5%</u> - Is the WHO standard recommended strength of the <u>solution</u> for decontamination**
- The formula is: **(% of Chlorine you have/ % of chlorine to make -0.5%) – 1 = the water parts to be added to make the solution which is at the concentration of 0.5% for decontamination**
- There must be a % of sodium hypochlorite in the manufacture container
- ***Example 1, formula 1: How would you make a solution from a <u>6% chlorine</u> manufacturers' strength?***

{Given 1 litre of 3.85% chlorine/0.5 }- 1 = Water parts

- ***= (6/0.5) - 1 = 3.85x10/0.5x 10 = 3850/050 = 38.5/5 = 7.7***

7.7 – 1= <u>6.7 water parts</u>. Note the bottle is 750 mls. So you need to measure

6x750 mls and add 0.7 of 750 mls; = 0.7 x 750 = 7/10 x 750 = 525 mls

NB: DO NOT ROUND UP

WASTE DISPOSAL

Principles:

- Prevents spread of infection to clinic personnel who handle waste
- Prevents spread of infection to local community
- Protects those who handle wastes from accidental injury

Practices:

- Wearing utility gloves,
- Waste segregation at source of generation(**General**,, **infectious, Highly Infectious**, **Chemical Wastes**)
- place contaminated items (gauze or cotton) in leak-proof container (with a lid) or plastic bag.
- Dispose by incineration, burning or burial

HOUSEKEEPING

- Schedules should be posted and followed
- Wear utility gloves and shoes when cleaning client-care areas
- Minimize scattering of dust and dirt
- Scrub when cleaning
- Wash from top to bottom
- Change cleaning solutions when they are dirty

HOUSE KEEPING(Cont.)

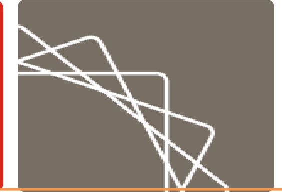
Room Arrangement

- Put everything in the right place
- Make all equipment and supplies needed accessible
- Arrange the room so that you can move around easily and safely

Sharps containers

- Tin with a lid
- Thick plastic bottle
- Heavy plastic box
- Heavy cardboard box

Effectiveness of methods for processing equipment



Method	**Effectives (removal or Inactivation of microbes)**	**End Point**	When to reprocess if not used
Decontamination	Kills HBV and HIV	10 min soak in 0.5% chlorine solution	
Cleaning (water only)	Up to 50%	Until visibly clean	
Cleaning (detergent With Rinsing water)	Up to 80 %	Until visibly clean	
High Level Disinfection	95% (does not inactivate some endospores)	Boiling, steaming or chemical for 20 minutes	Re-process if instruments are not used after 24 hours
Sterilization	100%	Autoclave, dry heat or chemical for recommended time	Sterilized instruments should be reprocessed after **seven** days if not used.

Advantages Of Infection Prevention:

- Prevents post procedure infections
- Results in high-quality and safe services
- Prevents infections in staff
- Protects the community
- Prevents the spread of antibiotic-resistant microorganisms
- Lowers the cost of health care

Color coded bins – waste segregation

Coloured buckets

Pedal operated bins

The End

Questions?????????????

UNIT 8

INTEGRATING FAMILY PLANNING INTO EXISTING SERVICES

Session objectives

By the end of the session trainees will be able to:

1. Review meaning and rationale of integration.
2. Discuss advantages and limitations of integrating FP into other health services.
3. Discuss the modalities of service integration based on an illustration.
4. Outline the steps a service provider should follow in planning to establish/strengthen FP integration with existing health services.
5. Illustrate smooth client flow and services to be integrated at different service delivery points.
6. Demonstrate ability to plan and organize FP/RH integrated services that ensures smooth client flow.

Cont’

Integration: Is a way of providing preventive health services and/or curative services at one health facility by one or more competent service providers on daily basis.

Rationale of integrating health services is to;

- Improve reproductive health service delivery.
- Methods of counseling and management have considerable overlap
- Access, early care and treatment and early contraception guidance
- Collectively use fewer resources available.
- It is a good entry points for other services, especially family planning.

Guidelines for Strengthening/Establishing Integrated Daily Health Services

Guidelines:

i. Orienting staff on integrating FP/Health service delivery

ii. Assessing strength and limitations of the existing services to identify opportunities for integration

iii. Preparing the health facility staff

iv. Organizing and re-organizing services

v. Organizing / re- organizing space and client flow

vi. Orienting the community on integrated services

Purposes of a good client flow at an integrated health facility

1. To ensure systematic client movement.
2. Reduce waiting time for clients.
3. Encourage continuity of FP/RH services.
4. Provides opportunities for easy identification of high risk groups for FP/RH Services.
5. Opportunity for easy consultation/referral within the different service areas at the health facility.
6. Maximum utilization of staff, space and resources.
7. Provision of privacy and confidentiality and ensure continuity of services.

Simulations

- Practice client flow at a facility

Records and Reports

By the end of the session trainees will be able to:

- 1. Define the Logistics Management System and its purpose
- 2. Define common terms used in logistics management:
- - Pull and the Push system; - AMC; - Minimum and Maximum Stock; - Stock on hand
- 3. Describe the importance of a stock card in commodity management
- 4. Demonstrate ability to determine quantities of contraceptives to order using Stock on Hand, AMC and Maximum Stock
- 5. Describe how to order for contraceptives following the MoH Procurement System
- 6. Explain the guidelines for proper storage of FP commodities and supplies
- 7. Discuss the main challenges of FP logistic management and possible solutions

Meaning of records

It is a written information collected and kept/stored to help service providers, health facility in-charges, supervisors, health sub- district In- charges, District Health Officers and Ministry of Health to;

- Plan effectively
- Improve services.

Purpose of keeping records

i. Monitor and evaluate client treatment and progress.

- Provide information that can be used to improve the quality of services and increase the number of clients.

ii. Monitor and evaluate the activities at the health facility in relation to set targets:

- Number of clients both new and returning
- Number of clients served monthly, quarterly and annually
- Family planning methods supplied by type
- Number of clients who drop out.
- Budgets that are planned and set at the district and national level

Cont'

iii. Ensure that ample methods and supplies are available and are within recommended period of use (not expired).

iv. To provide information for accountability of commodities received.

v. To provide solutions to critical management issues in an attempt to ensure quality service delivery

vi. To report outputs of facilities to the district and in turn to national level like MoH, NMS.

vii. To use the information for planning at both local and national levels to improve efficiency.

Tools to collect records in FP clinic

1. Family planning client cards
2. Integrated family planning register
3. Stock control card (HMIS 015)
4. Requisition and issue voucher (HMIS 017)
5. Health unit family planning summary form
6. Record of stock outs (Table 9 - HMIS)
7. Monthly summary form (HMIS 105)
8. Women's passport
9. VHT family planning register

How to avoid under stocking and overstocking?

- Always make sure that the right amount of stock is available by using the minimum and maximum method.
- Before you figure out maximum and minimum levels, you must first determine the average monthly consumption.
- The **Average Monthly Consumption (AMC)** is the number of issue units consumed per month
- *Where there is no stock-out:*
  - **AMC** = Total amount consumed (out) in 3 months ÷ 3
- *Where there is a stock-out:*
  - **AMC** = stock issued in 3 months ÷ no. of days when item was available x 30 days *OR (consumption per day x 30)*

Cont'

- **Minimum stock** is the amount or quantity of a product that we do not want to fall below. (For contraceptives it is the quantity that will last 2 months)
- **Minimum Stock**
  = 2 x Average Monthly Consumption (2 months supply)
- **Maximum stock** is the amount or quantity of a product that we do not want to exceed. (For contraceptives it is the quantity that will last 5 months)
- **Maximum stock** = 5 x AMC (5 months supply)

Caculations

Example:

Joyce MC used 30 vials of Depo- provera in the month of January, 40 vials in February and 20 vials in March.

- ***Question:*** What is Joyce MC's average monthly consumption (AMC)?

- Answer: Average monthly consumption (AMC) is
  - 30 + 40 + 20/3 = 90/ 3 =30 vials

  Continue to practice calculating minimum and maximun stock uing the above formulae

Con’t

Stock On Hand or Balance on Hand

- The total number of usable FP supplies available in the store

End

- Questions

Records and Reports

Session objectives:.

By the end of the session trainees will be able to:

1. Explain meaning of records
2. Discuss purposes of keeping records and reports in FP/RH service delivery
3. List six RH/ FP data management tools
4. Describe how to fill information on each FP data management tool
5. Discuss how to capture data from different FP service delivery areas within a health facility.
6. Explain the system of submitting reports to higher level authorities

Meaning of records

- Written information collected and kept/stored to help service providers, health facility in-charges, supervisors, health sub- district In-charges,District Health Officers and Ministry of Health to plan effectively and improve services.

Purposes of keeping records and reports in FP/RH service delivery

- Monitor and evaluate client treatment and progress.
- Provide information that can be used to improve the quality of services and increase the number of clients.
- Monitor and evaluate the activities at the health facility in relation to set targets
- Ensure that ample methods and supplies are available and are within recommended period of use (not expired).
- To provide information for accountability of commodities received.
- To provide solutions to critical management issues in an attempt to ensure quality service delivery

Purposes Cont……..

- To report outputs of facilities to the district and in turn to national level like MoH, NMS.
- To use the information for planning at both local and national levels to improve efficiency.

RH/ FP data management tools

- Family planning client cards
- Integrated family planning register
- Stock control card (HMIS 015)
- Requisition and issue voucher (HMIS 017)
- Health unit family planning summary form (Table 4 - HMIS)
- Record of stock outs (Table 9 - HMIS)
- Monthly summary form (HMIS 105)
- Women’s passport
- VHT family planning register

HMIS Reporting Structure

- Refer to page 302 of the Trainees manual

Capture data from different FP service delivery areas within a health facility

- Practice on actual tools

END OF THE SESSION

ANY QUESTIONS????

Monitoring and Evaluation of FP Services at Health Facility level

Session objectives:

By the end of the session trainees will be able to:

1. State the meanings of monitoring and evaluation
2. State the purposes of monitoring and evaluating FP services
3. List at least 3 sources of information to be monitored
4. Outline the use of clinic data as a way of self assessment and monitoring FP services at clinic level
5. Suggest possible actions/intervention to counteract negative findings from monitoring and evaluation of FP services

Cont’

Monitoring in relation to FP

- This is the systematic and continuous measurement of how the FP services are being offered in relation to recommended quality of care indicators

Evaluation for FP Services

- Evaluation is a process that is used to determine whether the program is carrying out its planned activities and the extent to which the program is achieving its stated objectives

Purposes of monitoring and evaluation

The purpose is to assess the;

- Scope, effect and impact of training health workers and implementation of services (FP / RH)
- Quality and quantity of services provided at various service delivery points to ensure adequate and appropriate response to the FP / RH needs for all clients.
- Response levels and trends to the FP / RH services as a factor of quality and quantity of services provided

3 sources of information to be monitored

- FP Registers
- HMIS monthly summary sheet
- Integrated PNC and FP registers

use of clinic data as a way of self assessment and monitoring FP services at clinic level

- Why is there monthly decrease in number of new acceptors and revisits?
- Why is it that most clients prefer injectables to pills?
- Which month were the condoms mostly preferred?

Possible actions to counteract negative findings from monitoring and evaluation of FP services

- Decision making
- Identifying problem areas
- Application of problem solving process or SOAP
- Community facility dialogue for improving quality of services

End

- Questions ????

UNIT 9:

EVALUATING TRAINING

Work plan

Back Home Application Work Plan to Strengthen Family Planning Services

- A work plan is a summary of flexible activities that are planned to solve particular work problem/problems or to implement what was learnt in a workshop, in a way that is appropriate for a particular work situation within a given period.

Purposes

- To identify priority problems related to the topic(s) of the training, in a way that all staff members of a particular place become aware of them.
- To have a team approach to solving these problems using each other as a resource.
- To have a quick reference of the activities that will occur to solve the identified problems in particular health unit/service area within a given period.
- To have orderly or meaningful sequence of assignments.
- To identify roles and responsibilities of each individual or staff members in a team to implement the assignments.
- To provide feedback to senior staff about the above application plan and the relevant resources that may be needed in a particular service area.

The End

- Questions