SKILLS TRAINING COURSE IN PROGESTIN-CONTAINING SUBDERMAL IMPLANT (CSI) INSERTION, REMOVAL AND REPLACEMENT

TRAINERS' MANUAL

2014

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SAMPLE FOREWORD

The Department of Health has committed to offer a broad range of choices of modern family planning methods to clients of diverse eligibilities and to deliver quality family planning services by strengthening the training system in acquiring knowledge and skills. In line with this, the Training Manual on Progestin-Containing Subdermal Implant (CSI), also known as the Family Planning (FP) implant, has been published with the goal of establishing a training system that will implement a national standardize training of health workers all over the country. It is expected that with this training manual, service provision on CSI will improve in performance and quality.

The manual contains the important topics and essential components of teaching and learning the standardize procedure of CSI insertion and removal technique. The topics also include counseling, informed choice and voluntarism, client assessment, local anesthesia, infection prevention, follow-up care guidelines and managing side effects and complications. The overall objective of the manual is to build competence in the knowledge, skills and attitudes of health service providers on CSI insertion and removal.

I encourage the dissemination and use of this manual by health service providers in the implementation of training and expanding CSI services and increase the number competent CSI providers across the country.

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

"PLACE ACKNOWLEDGEMENT HERE"

SAMPLE ACKNOWLEDGEMENT

The Department of Health would like to acknowledge stakeholders and partners who have contributed their time and expertise to the development of this manual on Skills Training Course in Progestin-Containing Subdermal Implant Insertion and Removal.

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It is hoped that the manual shall be fully implemented as the resource manual in the established training system across the country and achieve its goal of provision of quality CSI services.

ACRONYMS

AO	Administrative Order
BTL	Bilateral Tubal Ligation
CCT	Conditional Cash Transfer
CIC	Combined Injectable Contraceptive
CHD	Center for Health and Development
CSI	Contraceptive Subdermal Implant
COCs	Combined Oral Contraceptives
DOH	Department of Health
FP	Family Planning
GIDA	Geographically Isolated and Disadvantaged Area
HLD	High Level Disinfection
IUD	Intrauterine Device
LCE	Local Chief Executive
LAPM	Long Acting and Permanent Method
LGU	Local Government Unit
MNCHN	Maternal and Newborn and Child Health and Nutrition
MLLA	Mini-laparotomy under Local Anesthesia
MDGs	Millennium Development Goals
NHTS	National Household Targeted Survey
NBB	No Balance Billing
NSV	No Scalpel Vasectomy
PHO	Provincial Health Office

PHIC	Philippines Health Insurance Corporation
POI	Progestin Only Injectable
POP	Progestin Only Pill
STIs	Sexually Transmitted infections
VAWC	Violence Against Women and Children
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

SKILLS TRAINING COURSE IN PROGESTIN-CONTAINING SUBDERMAL IMPLANT INSERTION, REMOVAL AND REPLACEMENT

Methodology:
Illustrated Lecture

Time Allotted: 30 minutes

Advance Preparation:
Laptop and LCD Projector; Sound System, Microphones
Meta-cards for Levelling of Expectation
Pre-test
Training Kit

SKILLS TRAINING COURSE **IN** **CONTRACEPTIVE SUB-DERMAL IMPLANT** **INSERTION AND REMOVAL** _____ **(HOST)** _____ **(VENUE)** _____ **(DATE)**	**Flash the Course Title Slide before the start of the Opening Activities.**
OPENING ACTIVITIES • **PRAYER** • **NATIONAL ANTHEM** • **WELCOME REMARKS** • **INTRODUCTION OF PARTICIPANTS AND TRAINERS/FACILITATORS** • **LEVELING OF EXPECTATIONS** • **PRE-TEST** • **OVERVIEW OF THE COURSE**	**Flash the Slide on Opening Activities for the flow of events.**

OVERVIEW	
Inclusion of the Contraceptive Sub-dermal Implant as one of the Modern Methods of the National Family Planning Program DEPARTMENT OF HEALTH ADMINISTRATIVE ORDER NO. 2014 s_____	**State the Title Slide of DOH AO No. 2014 s____**
RATIONALE • **Approximately six million Filipino women are estimated to have unmet need for modern Family Planning (FP) either for:** – ***limiting*** **(women who want no more children) or** – ***spacing*** **(women who want a child after three or more years).** • **About half a million of these women have unplanned/unintended pregnancies, which may lead to a 20 percent increase in complications from pregnancy and childbirth, including untimely deaths.** • **The Philippines is lagging behind in reducing maternal mortality,:** – **221 per 100,000 live births (2011 FHS)** – **5 2 per 100,000 live births (2015 MDG Target)**	**State the Rationale for the Course as contained in the DOH AO as shown in the next 2 slides.**

## STRATEGIES TO REDUCE MMR • **DOH Administrative Order No. 2012-0009:** – **the "National Strategy towards Reducing Unmet Need for Modern Family Planning as a Means to Achieving MDGs on Maternal Health", provided the comprehensive approach to reduce unmet need for modern FP services.** • **Broaden the array of effective modern FP methods available for clients, giving them wider options for selecting a method consistent with their beliefs and appropriate to their health status, helping couples achieve their desired family size.** • **Contraceptive implants shall be part of the full range of FP modern methods positioned as an option to use for women who are desirous of long-term reversible contraception (LARC).**	
## SPECIFIC GUIDELINES – **The procurement and distribution of modern FP commodities and supplies, through a full-service logistics management system** – **Service provision by frontline skilled health professionals in health facilities of LGUs and the DOH, as well as those of the private sector.** – **Capacity building enhancement** – **Systems of monitoring and evaluation of performance** – **Social and behavioral change communication (SBCC) activities** – **Recording and reporting of data through Field Health Services Information System (FHSIS)**	**State the Specific Guidelines of the DOH AO as shown in the slide.**
## DOH FAMILY HEALTH OFFICE • **Develop policies, standards, guidelines and tools;** • **Provide technical inputs to the development of a training design and curriculum including instructional materials** • **Provide technical inputs to the development of communications plan and IEC materials** • **Ensure the conduct of training to qualified providers** • **Provide technical assistance to Regional Health Offices through the Operations Cluster, as well as other implementing partners;** • **Ensure the availability of contraceptive sub-dermal implants** • **Mobilize technical assistance and leverage resources from development partners to support the mainstreaming of activities;** • **Establish as comprehensive FP database management system**	**State the Roles of the Different sectors as shown in the next 6 slides.**

OTHER DOH OFFICES

- The **Materials Management Division (MMD)** shall be responsible for overseeing a full-service logistics management system to be implemented by a competent, capable, efficient, and affordable private sector provider, subject to procurement and contracting laws, rules and regulations.
- The **Health Promotion and Communication Services (HPCS)** shall develop and implement an FP communication plan and prototype materials at the national, regional and local levels, particularly on the use of contraceptive implant, in coordination with FHO, POPCOM and other development partners.
- The **Epidemiology Bureau** shall provide technical oversight on the implementation of the FHSIS to include data collection, procession, and reporting on modern FP use (including contraceptive sub-dermal implants).

DOH REGIONAL HEALTH OFFICES

With the supervision of their respective Operations Clusters, and the DOH-ARMM

- **Coordinate and provide technical assistance (including assistance on logistics management within the overall system used by MMD) to LGUs, NGO partners, and other stakeholders;**
- **Reproduce and distribute IEC and training materials;**
- **Monitor and evaluate the implementation of this Order by LGUs, NGOs and other partners, including the use of information systems (i.e., FHSIS) to streamline data collection, processing and reporting;**
- **Ensure capacity building and quality service provision at provincial/city/municipal levels;**
- **Certify and accredit both training and service providers.**

DOH RETAINED HOSPITALS

The **DOH-retained Hospitals,** except special and specialty hospitals not focusing on women's health, shall:

- **Include contraceptive sub-dermal implants in the full range of modern FP methods available at their level;**
- **Create FP outreach teams and make them available for dispatch to respond to the needs for insertion/removal of contraceptive implant especially in urban and rural poor communities;**
- **Serve as resource and learning centers for technical assistance, training and research on contraceptive sub-dermal implants;**
- **Serve as end referral facilities that will complement contraceptive sub-dermal implant services provided by LGU hospitals and other health facilities, including management of complications.**

FDA, PHIC, POPCOM

- **The Food and Drug Administration (FDA) shall continually conduct appropriate tests on all prospective contraceptive sub-dermal implants prior to issuance of appropriate authorizations to ensure safety, efficacy, purity and quality.**
- **The Philippine Health Insurance Corporation (PHIC) shall review its existing benefit packages for modern FP and give due recognition to developing mechanisms to finance the provision of contraceptive sub-dermal implants.**
- **The Commission on Population (POPCOM) shall assist in generating demand for modern family planning services including contraceptive sub-dermal implants, in coordination with FHO and HPCS. POPCOM shall also ensure that identified prospective clients with unmet needs are referred to appropriate health care providers.**

LGU

- **Ensure the availability of modern FP services including contraceptive sub-dermal implants in all local government hospitals and other health facilities;**
- **Ensure service quality and safety throughout the continuum of care, through supportive supervision;**
- **Lead efforts for advocacy and demand generation;**
- **Coordinate with DOH and aligning its data management and information systems;**
- **Monitor and evaluate program implementation within their respective jurisdictions;**
- **Identify referral facilities for appropriate modern FP services within their service delivery networks.**

PRIVATE SECTOR

- **Private-sector providers** are encouraged to provide modern FP services and products including contraceptive sub-dermal implants to clients within their respective service delivery networks.
- **Development Partners** shall ensure that their assistance and support to the family planning programs and activities of the DOH shall be consistent with the provisions of this Order. International development partners shall coordinate FP-related projects and activities with the Bureau of International Health Cooperation (BIHC) and the FHO.

“PLACE FINAL DOH A.O. ON CSI HERE”

DRAFT ADMINISTRATIVE ORDER
No. 2014 - _____

SUBJECT: **Inclusion of the Progestin-Containing Subdermal Implant (CSI) (also known as the Family Planning [FP] implant}, as one of the Modern Methods of the National Family Planning Program**

I. RATIONALE

Approximately six million Filipino women are estimated to have unmet need for modern Family Planning (FP) either for *limiting* (women who want no more children) or for *spacing* (women who want a child after three or more years). About half a million of these women have unplanned/unintended pregnancies, which may lead to a 20 percent increase in complications from pregnancy and childbirth, including untimely deaths. The Philippines is lagging behind in reducing maternal mortality, which stands at 221 per 100,000 live births (2011 FHS) compared with 2015 MDG targets at 52.

Addressing these challenges and in support of the strategic thrust to attain health-related MDGs by the year 2015, the Administrative Order No. 2012-0009, the National Strategy towards Reducing Unmet Need for Modern Family Planning as a Means to Achieving MDGs on Maternal Health, provided the comprehensive approach to reduce unmet need for modern FP services. One strategy employed by the DOH is to broaden the array of effective modern FP methods available for clients, giving them wider options for selecting a method consistent with their beliefs and appropriate to their health status, helping couples achieve their desired family size. Contraceptive implants shall be part of the full range of FP modern methods positioned as an option to use for women who are desirous of long-term reversible contraception.

Contraceptive subdermal implants are long acting reversible hormonal contraceptives that are effective for 3 to 5 years. The DOH, through the Food and Drugs Administration (FDA) in the exercise of its mandate to conduct appropriate tests on all applicable health products prior to the issuance of appropriate authorizations to ensure safety, efficacy, purity and quality (Republic Act No. 3720, as amended by RA 9711), has issued certificates of product registration (CPR) as early as 19 January 2011 for specific products that are FP implants.

II. OBJECTIVE

This Order provides the guidelines and implementing mechanisms for the adoption of the progestin-containing subdermal implant into the National Family Planning Program.

III. SCOPE AND COVERAGE

This Order shall apply to the health sector, from both the public and private sectors: DOH Central Office, Centers for Health Development (CHDs), and DOH-retained hospitals; Central offices and regional units of the Commission on Population (POPCOM),

Philippine Health Insurance (PhilHealth), and other DOH attached agencies; LGUs as provided for in their agreements with the DOH that involve resource transfers, and DOH-ARMM as provided for in the Memorandum of Agreement between DOH and ARMM dated 23 April 2009; Development Partners, in the context of their strategic agreements for health with the Government of the Philippines; private health care providers; and all others concerned.

IV. DEFINITION OF TERMS

1. **Progestin-containing Subdermal Implant (CSI)**– This will also be known as the FP implant. This implant is a reversible contraceptive effective for three to five years. Its primary contraceptive effects are through inhibition of ovulation by suppressing the luteinizing hormone surge and increased cervical mucus viscosity, making it difficult for the sperm cells to pass through with less than 1 pregnancy over the first year (5 per 10,00 women). Implant has a continuation rate of 84% (Trussel J. Contraceptive failure rates in the Unites States, 2011). In terms of client satisfaction, implant and intra-uterine devices have the highest rates of satisfaction and 12-month continuation (Peipert et al, Continuation and Satisfaction of Reversible Contraception, 2011).

2. **FP Competency-based Training (FP CBT)** – training for FP on infection prevention, client assessment, provision of certain FP methods, counseling, and FP clinic management that uses a laddered approach, exposing participants to levels of training based on developed knowledge, skills, and behavior. The modified training system, which is performance-based, develops the knowledge, attitudes and skills of participants on the requirements of quality FP service provision.

3. **Informed Choice and Voluntarism (ICV)** – a standard in the delivery of FP services, ensuring that clients freely make their own decision based on accurate and complete information on a broad range of available modern FP methods, and not by any special inducements or forms of coercion or misrepresentation.

4. **National Housing Targeting System for Poverty Reduction (NHTS-PR)** – an information management system that identifies who and where the poor are, with its implementation being spearheaded by the DSWD. In compliance with EO No. 867, s. 2010, the DOH as a national government agency has adopted the NHTS-PR as a mechanism in prioritizing the beneficiaries of its programs and projects.

5. **National Online Stock Inventory and Reporting System (NOSIRS)** – a logistics management initiative with standard and formal reporting systems that can generate logistics information at all levels of the health care system. NOSIRS utilizes Supply Management Recording (SMR) as the recording tool to efficiently track the status of commodities at health facilities and hospitals nationwide.

6. **Private Healthcare Providers (PHCPs)** – are health providers (both for-profit and not-for-profit) that are not directly operated or controlled by the state or any of its instrumentalities. PHCPs may be natural or juridical persons, and they may either provide health care services or goods. Examples of PHCPs are private health care providers, practice health professionals, non-government organization clinics, etc.

7. **Service Delivery Network (SDN)** – refers to the network of facilities and providers within the province-wide or city-wide health system offering a core package of services (which include modern FP) in an integrated and coordinated manner, pursuant to MNCHN Strategy Manual of Operations (DOH DM No. 2011-0117).

8. **Unmet Need for Modern FP (UMFP)** – the number of women who are fecund and sexually active but are not using any modern method of contraception, and report not wanting any more children (limiting) or wanting to delay the birth of their next child (spacing).

V. GENERAL GUIDELINES

The implementation of this Order shall be aligned with the continuing implementation of the Philippine Reproductive Health Program (AO No. 1-A, s. 1998) and the National Strategy Towards Reducing Unmet Need for Modern FP as a means Towards Achieving MDGs on Maternal Health (AO No. 2012-0009).

VI. SPECIFIC GUIDELINES

A. The procurement and distribution of modern FP commodities and supplies, including contraceptive subdermal implant shall be through a full-service logistics management system from acquisition by the DOH all the way to direct distribution to service delivery points.

B. This order shall be primarily carried out by frontline skilled health professionals in health facilities of LGUs and the DOH, as well as those of the private sector. Technical oversight and supervision shall be provided by the DOH through its Operations Clusters and the Regional health Offices.

C. Contraceptive subdermal implants and related counseling services shall be provided at service delivery points (e.g., RHUs, private clinics, public or private hospitals) as part of the full range of modern FP methods. These service delivery points shall necessarily include all DOH-retained hospitals except special and specialty hospitals not focusing on women's health.

D. The FP clinical competencies of skilled health professionals shall be continually enhanced, and shall include training on the provision of contraceptive subdermal implants following the principles of informed choice and voluntarism. Furthermore, this training shall include systems of monitoring and evaluation of performance prior to certification. All DOH Regional Medical Centers shall be designated as training centers on the provision and use of contraceptive subdermal implants.

E. Social and behavioral change communication (SBCC) activities shall include information on contraceptive subdermal implants, and shall be customized and targeted for direct delivery at the inter-personal level to prospective clients with unmet needs. Modern FP program information and educational materials as well as family health use plan shall be revised/amended to include the necessary materials on contraceptive subdermal implants.

F. The recording and reporting of data on contraceptive subdermal implants shall be through existing Field Health Services Information System (FHSIS) recording and reporting forms, to include the FP Form 1. All public FP health care providers shall follow the existing FHSIS guidelines in the submission of reports from the different levels of care. Private sector and NGO providers shall submit reports on service statistics to their designated LGU health facilities.

VII. ROLES AND RESPONSIBILITIES

A. The **Family Health Office** shall ensure the implementation of this Order. Specifically, it shall:

1. Develop policies, standards, guidelines and tools relative to the provision of contraceptive subdermal implants;

2. Provide technical inputs to the development of a training design and curriculum including instructional materials, in coordination with the Health Human Resource Development Bureau (HHRDB) and other partners;

3. Provide technical inputs to the development of communications plan and IEC materials, in coordination with the Health Promotion and Communication Services (HPCS);

4. Ensure the conduct of training to qualified providers, as allowed by law, on the provision of FP subdermal implants by DOH-accredited institutions at the regional, provincial and city levels;

5. Provide technical assistance on the implementation of this Order to Regional Health Offices through the Operations Cluster, as well as other implementing partners;

6. Ensure the availability of contraceptive subdermal implants at identified health facilities of LGUs, in coordination with Regional health Offices and Operations Clusters;

7. Mobilize technical assistance and leverage resources from development partners to support the mainstreaming of activities;

8. Establish as comprehensive FP database management system to include contraceptive subdermal implants, in coordination with the Knowledge Management Information Technology Services (KMITS) and Epidemiology Bureau.

B. The **Materials Management Division (MMD)** shall be responsible for overseeing a full-service logistics management system to be implemented by a competent, capable, efficient, and affordable private sector provider, subject to procurement and contracting laws, rules and regulations.

C. The **Health Promotion and Communication Services (HPCS)** shall develop and implement an FP communication plan and prototype materials at the national, regional and local levels, particularly on the use of contraceptive implant, in coordination with FHO, POPCOM and other development partners.

D. The **Epidemiology Bureau** shall provide technical oversight on the implementation of the FHSIS to include data collection, procession, and reporting on modern FP use (including contraceptive subdermal implants).

E. The **Center for Health Development (CHDs)/Regional Health Offices** witht he supervision of their respective Operations Clusters, and the DOH-ARMM shall be responsible for the implementation of this Order at local health systems. Specifically, they shall:

   a. coordinate and provide technical assistance (including assistance on logistics management within the overall system used by MMD) to LGUs, NGO partners, and other stakeholders;

   b. Reproduce and distribute IEC and training materials;

c. Monitor and evaluate the implementation of this Order by LGUs, NGOs and other partners, including the use of information systems (i.e., FHSIS) to streamline data collection, processing and reporting;

d. Ensure capacity building and quality service provision at provincial/city/municipal levels;

e. Certify and accredit both training and service providers.

F. The **DOH-retained Hospitals,** except special and specialty hospitals not focusing on women's health, shall:

a. Including contraceptive subdermal implants in the full range of modern FP methods available at their level;

b. Create FP outreach teams and make them available for dispatch to respond to the needs for insertion/removal of contraceptive implant especially in urban and rural poor communities;

c. Serve as resource and learning centers for technical assistance, training and research on contraceptive subdermal implants;

d. Serve as end referral facilities that will complement contraceptive subdermal implant services provided by LGU hospitals and other health facilities, including management of complications.

G. The **Food and Drug Administration (FDA)** shall continually conduct appropriate tests on all prospective contraceptive subdermal implants prior to issuance of appropriate authorizations to ensure safety, efficacy, purity and quality.

H. The **Philippine Health Insurance Corporation (PHIC)** shall review its existing benefit packages for modern FP and give due recognition to developing mechanisms to finance the provision of contraceptive subdermal implants.

I. The **Commission on Population (POPCOM)** shall assist in generating demand for modern family planning services including contraceptive subdermal implants, in coordination with FHO and HPCS. POPCOM shall also ensure that identified prospective clients with unmet needs are referred to appropriate health care providers.

J. **Local Government Units (LGUs)** are encouraged to be responsible for the management of program implementation at the provincial/city/municipal level by:

1. Ensuring the availability of modern FP services including contraceptive subdermal implants in all local government hospitals and other health facilities;

2. Ensure service quality and safety throughout the continuum of care, through supportive supervision;

3. Leading efforts for advocacy and demand generation;

4. Coordinating with DOH and aligning its data management and information systems;

5. Monitoring and evaluating program implementation within their respective jurisdictions;

6. Identifying referral facilities for appropriate modern FP services within their service delivery networks.

K. **Private-sector providers** are encouraged to provide modern FP services and products including contraceptive subdermal implants to clients within their respective service delivery networks.

L. **Development Partners** shall ensure that their assistance and support to the family planning programs and activities of the DOH shall be consistent with the provisions of this Order. International development partners shall coordinate FP-related projects and activities with the Bureau of International Health Cooperation (BIHC) and the FHO.

VIII. REPEALING AND SEPARABILITY CLAUSE

All other orders, rules, regulations and other related issuances inconsistent with or contrary to this Order are hereby repealed, amended, or modified accordingly. All provisions of existing issuances such as AO No. 1-A s. 1998, AO No. 43, s. 2000, AO No. 50-A, s. 2001, AO No. 2011-0005, and AO 2012-0009, among others which are not affected by this Order shall remain valid and in effect.

In the event that any provision or part of this Order is declared unauthorized or rendered invalid by any Court of law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

IX. EFFECTIVITY

This Order shall take effect immediately.

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

SKILLS TRAINING COURSE IN CONTRACEPTIVE SUBDERMAL IMPLANT INSERTION, REMOVAL AND REPLACEMENT

COURSE DESIGN

SKILLS TRAINING COURSE IN PROGESTIN-CONTAINING SUBDERMAL IMPLANT INSERTION , REMOVAL AND REPLACEMENT **OVERVIEW OF THE COURSE**	**Flash the Title Slide to start the presentation of the Course Design.**

DESCRIPTION
• 2-days competency-based clinical skills training course to enable the trainees to include the provision of Contraceptive Sub-dermal Implant in their professional practice.
• Consists of:
  • 1-½ days DIDACTICS
  • ½ day PRACTICUM (Training Center)
  • PRACTICUM/POST-TRAINING MONITORING/EVALUATION (PTM/E)– to be scheduled
  • Supportive Supervision (at the Trainee's Facility) towards competency and proficiency
	State the Course Description as presented in the slide.

GOALS • **Provide latest information on Contraceptive Sub-dermal Implant** • **Provide the knowledge and skills needed for performing Contraceptive Sub-dermal Implant Insertion and Removal.** • **Provide knowledge and skills needed to prevent, recognize and manage complications related to insertion, use and removal.** • **Provide the knowledge and skills to integrate implant services into their existing service delivery system.**	**State the Goals of the Course as presented in the slide.**
SPECIFIC OBJECTIVES • Apply the principles of counseling and voluntarism for contraceptive sub-dermal implant. • Practice infection prevention measures in the provision of contraceptive sub-dermal implant • Explain the indications and precautions for Contraceptive Sub-dermal Implant based on the WHO Medical Eligibility Criteria for contraceptive use. • Perform complete evaluation screening of Contraceptive Sub-dermal Implant clients.	**State the Specific Objectives of the Course as presented in the next 2 slides.**

SPECIFIC OBJECTIVES

- Perform the standard Contraceptive Sub-dermal Implant Insertion and Removal.
- Recognize and manage side effects and complications.
- Provide routine follow-up and monitoring of adverse reactions
- Develop an action plan on the integration of contraceptive sub-dermal implant services into his/her practice.

TRAINING MODULES

SESSIONS	TOPICS
	Course Design
	Review of the Different FP Methods
MODULE1	Introduction to Implant
MODULE 2	Counseling
MODULE 3	Prevention of Infection
MODULE 4	Client Assessment
MODULE 5	CSI Insertion and Removal
MODULE 6	Management of Side Effects/Complications
MODULE 7	Follow-Up, Monitoring and Reporting
MODULE 8	Management of CSI Services/Action Planning
	Course Evaluation

Present the different modules/sessions of the course as shown in the slide.

TEACHING/LEARNING METHODS

- Illustrated lectures
- Group Discussions
- Role Play
- Demonstration and return demonstrations
- Simulated practice with anatomic (arm) models
- Video Presentation
- Guided clinical activities on preparation and actual CSI insertion under local anesthesia
- Case studies
- PTM/E; Supportive Supervision

State the Learning Methods that would be employed in the course as shown in the slide.

TRAINING MATERIALS • Facilitators' Guide • Participants' handbook • Power-point slides • Arm models for simulated practice (RITA : Implant Training Arm) • CSI kits with: – ____ number of CSI units – Other supplies	**Enumerate the different materials needed for the course as shown in the slide.**
COURSE DURATION • 2 days with didactic and practicum sessions spread out • Training site should ensure at least 2 clients for the course duration for CSI insertion • There should be collaboration with the CHD/PHO for demand generation to meet the case loads during practicum at the Training Center and the respective trainees' facilities.	**State the course requirements, duration and demand generation as shown in the slide.**
TRAINERS • **Trainers of the course are obstetricians or doctors in accredited training centers who are:** – **Proficient in performing CSI Insertion and Removal and skilful in preventing and managing complications** – **Proficient in performing standard CSI Insertion and Removal procedure** – **Proficient and committed to provide training in CSI Insertion and Removal** – **Willing to coach (supportive supervision) trainees during their practicum and post-training monitoring and follow-up in their respective facilities**	**State the qualifications of a Trainer for the course as shown in the slide.**

TRAINEES SELECTION CRITERIA
 	
• Doctors of Medicine , (nurses and midwives) who are:
  • Affiliated with facilities where CSI can be performed in accordance with DOH standards.
  • Working in areas with a high demand for FP particularly CSI.
  • Supportive of FP, interested in being trained on CSI and committed to regularly performing CSI after the training.
	Give the Trainee selection criteria as presented in the slide.

SUGGESTED COURSE COMPOSITION • **1:10 trainer/trainee ratio during the didactic part** • **1:5 trainer/trainee ratio during the clinical practice on actual clients during the 2-day course** • **1:1 trainer/trainee ratio on supportive supervision**	**State the ideal course composition as shown in the slide.**

POST-TRAINING FOLLOW-UP
 	
• Conducted 3,6, and 9 months after training (Supportive Supervision)
• Purposes of this follow-up are to:
  ○ To assess the performance of the trainee as a service provider
  ○ To assist the trainee resolve problems on setting-up and integrating CSI to the health service provision system,
• Frequency depends on the need of the trainee and of the facility towards successful integration of quality CSI services.
	Discuss the conduct of post-training monitoring and evaluation as shown in the slide.

CERTIFICATION • CERTIFICATE OF TRAINING/ATTENDANCE • after completing the requirements of the course (level 1 and 2 evaluation): • complete attendance • passing score in the post-test- 75% • Satisfactory and competent skills rating based on the skills checklist • CERTIFICATE OF COMPLETION OR COMPETENCY AS SERVICE PROVIDER • after level 3 post-training evaluation • After complying with required case loads (#___) • CERTIFICATION OF ACCREDITATION / PROFICIENCY (by a Third Party) Professional Organization) for PRC and Philhealth – after level 4 post-training evaluation (?)	**Discuss the Certification process as shown in the slide.**

NARRATIVE

Course Description

This two-day competency-based clinical skills training course is designed to enable the trainee to perform standardized Contraceptive Subdermal Implant insertion and removal procedure in their FP service provision. The course consists of didactic sessions and practicum phase spread out in the 2 days duration. Didactic starts on Day 1 until Day 2 while practicum starts on Day 2 and onwards with supportive supervision on the trainees' facilities. The practicum for the CSI technique shall involve demonstration and return demonstration using arm models proceeding with actual clients after competency in the models is attained.

Goals

The goal of the training course is to have a pool of CSI service providers equipped with;

1. the knowledge, skills and attitude in performing the standardize procedure of CSI Insertion and Removal ;
2. the knowledge and skills needed to prevent, recognize and manage complications related to the CSI Insertion and Removal procedure
3. the knowledge, skills and attitude to integrate CSI services into their existing service delivery system; and the latest updates in CSI service provision.

Specific Objectives

At the end of this 2-day course, the trainee will be able to:

1. Apply the principles of counseling including informed choice and voluntarism and correct myths and misconceptions on contraception:
2. Practice infection prevention measures in the provision of CSI services.
3. Perform complete screening evaluation of CSI clients including use of the WHO MEC and Pregnancy Checklist
4. Perform with competency the standardize technique of CSI.
5. Recognize and manage possible side effects and potential complications on CSI.
6. Provide routine follow-up care, monitoring and reporting
7. Discuss the components of post-training monitoring and evaluation

8. Develop an action plan on the integration of CSI in the service delivery system at their facility/community.

Training/Learning Methods

- Illustrated lectures and discussions
- Individual and group exercises
- Role Playing
- Case studies
- Demonstration and return demonstrations
- Simulated practice with anatomic (arm) models
- Guided clinical activities on performance of CSI procedure

Training Materials

- Facilitators' Guide
- Participants' handbook
- Power-point slides
- Arm models for simulated practice
- CSI kits with ____ number of CSI units

Trainers

Trainers of the course are obstetricians or doctors in accredited training centers who are:

- Proficient in performing CSI Insertion and Removal and skilful in preventing and managing complications
- Proficient in performing standard CSI Insertion and Removal procedure
- Proficient and committed to provide training in CSI Insertion and Removal
- Willing to coach (supportive supervision) trainees during their practicum and post-training monitoring and follow-up in their respective facilities

Venue of Training

- Training sites are accredited FP training centers particularly CSI with certified trainers on CSI.
- Training sites should have available clients for the practicum phase;
- There may be situation to consider on-site training if participants find difficulty in moving out from their current clinics/workplace.

Trainees Selection Criteria

Trainees to this course shall be doctors of medicine (pending for nurses and midwives) who are:

- Affiliated with facilities where CSI can be performed in accordance with DOH standards;
- Working in areas with a high demand for CSI;
- Supportive of Family Planning and interested in being trained on CSI in order to regularly perform CSI after the training and determined to establish and implement CSI service delivery program in the facility/community.

Methods of Evaluation

Trainee

- Attendance
- Pre- and post-test
- Participation in discussions, role play, case studies
- Assessment of the skills on BTL/MLLA using the "Performance Checklist on CSI Insertion and Removal"

Course

- Course evaluation accomplished by participants

Course Duration

The course duration will be for 2 days with didactic and practicum sessions spread out within the 2 days course. Supportive supervision on the trainees' facilities would be conducted on schedule as agreed by the trainer and trainee or depending on urgency for provision.

Course Caseload Requirement

- Minimum number of cases performed even if competency-based training;
- Number of trainees shall depend on the number of trainers and case load;
- The training institution shall prepare at least 2 clients per trainee during the 2-day course.
- There should be collaboration with the CHD/PHO for demand generation to meet the case loads during practicum at the Training Center and the respective trainees' facilities.
- Trainees will not be responsible for demand generation during the 2-day course but on supportive supervision in their respective facilities

Suggested Course Composition

- 1:10 trainer/trainee ratio during the didactic part
- 1:5 trainer/trainee ratio during the clinical practice on actual clients during the 2-day course
- 1:1 trainer/trainee ratio on supportive supervision

Evaluation and Certification

EVALUATION LEVEL	PURPOSE	EVALUATION INSTRUMENTS/TOOLS	TIME TO GATHER DATA

Level 1 – REACTION	Measures how the trainees felt about the training or learning experience (e.g. course objectives and expectations are met, mastery of the subject matter by the speaker, conduciveness of the training venue, etc.)	Course Evaluation Questionnaire Recap	During and right after the2-day training
Level 2- LEARNING	Measures knowledge, attitude and/or skills gained by the trainees	Pre- and post-test Skills Performance Checklist	At the start, during and right after the training
Level 3- BEHAVIORAL	Measures extent to which trainees applied the learning in their workplace or organization	Action Plan Post-training Monitoring Checklist Observation Interview with Supervisor and/or peer	3, 6 and 12 months after the training
Level 4- IMPACT	Measures the long-term effects of training on the organization, community or society	Visit Interviews Cost-benefit Analysis	3 to 5 years after the training

- A **Certificate of Training/Attendance** is awarded by the training institution to trainees after having satisfactorily and competently completed the requirements of the 2-day course (Level 1 and 2 Evaluation i.e., complete attendance, passing score of 80% in the post-test, and satisfactory skills rating based on the skills checklist). The regional director, the chief of hospital of the training institution and the trainer shall be the signatories of the certificate.
- A **Certificate of Competency** as a Service Provider on CSI shall be given after completion of the Case Loads or after level 3 post-training evaluation
    - After complying with required case loads of (#___)

- A **Certificate of Accreditation** shall be given by a Third Party Professional Organization as a requirement for continuing accreditation with PRC and Philhealth or after level 4 post-training evaluation.

Post-training Follow-up, Monitoring/Evaluation

- Post-training follow-up/evaluation shall be conducted 3,6 and 9 months after training to assess the performance of the trainee as a service provider.
- The purposes of the follow-up are:
    - to evaluate trainee's performance and to correct deficiencies in knowledge and skills, especially adherence to service standards
    - to assist the trainee resolve problems/difficulties in setting-up CSI and integrating the learned skills to the health service provision system, and
    - to evaluate the results of training on the inclusion of CSI services in the trained service provider's facility (e.g., increase in client load for FP, utilization of services, etc.).

The frequency of conducting the follow up shall depend on the need of the trainee and of the facility towards successful integration of quality CSI service as a whole (e.g. availability of supplies, status of recording and reporting of clients, etc).

References

The Philippine Clinical Standards Manual on Family Planning 2006

The Global Handbook for Providers on Family Planning, 2011 updated

The DOH Training Modules on Family Planning Competency-based Training in Family Planning (FPCBT) Level 1 and 2

The John Hopkins' Training and Reference Manual on Contraceptive Subdermal Implant

The MSD Training Manual on Contraceptive Subdermal Implant

Schedule of Activities

TIME	MODULES/SESSIONS
	DAY 1

8:00-9:00	• Registration
	• Opening Ceremonies
	  o Invocation; National Anthem
	  o Welcome Remarks
	• Introduction of Participants
	• Pre-test; Leveling of Expectations
	• Overview including AO on CSI and Mechanics of the Course

9:00-12:00	**The Different Family Planning Methods**
12:00-1:00	**LUNCH BREAK**
1:00-1:30	**Module 1. Introduction to the Contraceptive Subdermal Implant**
1:30-4:30	**Module 2: Counseling**
4:30-5:00	**Module 3. Infection Prevention**
5:00-6:00	**Module 4: Client Assessment**
DAY 2	
8:00-8:30	**Recap of Day 1**
8:30-10:30	**Module 6: Insertion and Removal** **Demo and Return Demo on Arm Model**
10:30-12:00	**Module 7: Management of Potential Complications**
12:00-1:00	**LUNCH BREAK**
1:00-3:00	**Practicum on Actual Clients**
3:00-4:00	**Module 8: Follow up Care, Monitoring and Recording**
4:00-4:30	**Action Planning**
4:30-5:00	Closing Activities o Post-test o Course Evaluation o Closing Remarks

REVIEW OF THE DIFFERENT FAMILY PLANNING METHODS

For health personnel who have not gone through the Family Planning Competency-based training course- Level 1 and who want to train in Contraceptive Subdermal Implant, a review of the different Family Planning methods is very essential. Knowledge of these methods - particularly the method description, mechanism of action, effectiveness, advantages, disadvantages, side effects and possible complications with corresponding management- are important for counseling purposes and in compliance to Informed Choice and Voluntarism principle. Where there are clients who would be found ineligible to accept contraceptive subdermal implant at the time of consultation, the health provider must be

able to provide alternative methods competently or counsel the client accordingly.

Methodology:
Illustrated Lectures
Brainstorming
Demonstration

Time Allotment: 3 hours

Advanced Preparation:
Samples of the Different Family Planning Commodities

SKILLS TRAINING COURSE IN SUB-DERMAL CONTRACEPTIVE IMPLANT INSERTION AND REMOVAL **REVIEW OF THE DIFFERENT FAMILY PLANNING METHODS**	Flash the Title Slide for the Review of the Different Family Planning methods as shown in the slide.
OVERVIEW • **This module discusses the different Family Planning Methods as part of the broad range of choices in the provision of FP services stipulated in the Philippine Family Planning Program.**	State the Overview as shown in the slide.

SESSIONS **Session 1: The Fertility Awareness-based (FAB) Methods and the Lactational Amenorrhea method (LAM)** **Session 2: Hormonal Contraceptive Methods** **Session 3: Barrier Methods** **Session 4: Long-acting and Permanent Methods**	State the 4 Sessions as shown in the slide.
Outline of Discussion for ALL FP Methods • Introduction of the Method • Mechanism of Action • Effectiveness • Advantages • Disadvantages • Side Effects • Potential Complications • Correcting Misconceptions	State how the Different Methods will be discussed in the review as shown by the order presented in the slide.

OVERVIEW

This module discusses the different Family Planning Methods as part of the broad range of choices in the provision of FP services stipulated in the Philippine Family Planning Program.

There are 4 Sessions in this module, namely:

Session 1: The Fertility Awareness-based (FAB) Methods and the Lactational Amenorrhea method (LAM)
Session 2: Hormonal Contraceptive Methods
Session 3: Barrier Methods
Session 4: Long-acting and Permanent Methods

SESSION 1: The Fertility Awareness-based (FAB) Methods and the Lactational Amenorrhea method (LAM)

There are two (2) methods in this session—The Fertility Awareness-Based (FAB) & the Lactational Amenorrhea (LAM) methods.

SESSION OBJECTIVES
At the end of this session, the participants will be able to understand FAB & LAM as contraceptive methods.

The module contains the following Sub-sessions:
Introduction to the Session

Sub-session 1 Fertility Awareness-Based Methods
Sub-session 2 Lactational Amenorrhea Method (LAM)

SUB-SESSION 1
FERTILITY AWARENESS-BASED METHODS

Session 1 **The Fertility Awareness-based (FAB) Methods** **and the** **Lactational Amenorrhea method (LAM)**	**Present Session 1 on FAB and LAM by flashing the Title Slide.**
Sub-Session 1 **The Fertility Awareness-based (FAB) Methods**	**Proceed to Sub-session on FAB by flashing the slide.**

FERTILITY AWARENESS-BASED METHODS • **FP methods which involve** – **Determination of the fertile & infertile periods of a woman** – **Observation of the signs and symptoms of fertility and infertility during the menstrual cycle** – **Timing of sexual intercourse to achieve or avoid pregnancy** • **Effectiveness depends on the couple's ability to identify fertile and infertile periods and motivation to practice abstinence when required**	**Tell participants the definition and effectiveness of FAB as shown in the slide.**
SIGNS OF FERTILITY • Changes in the **cervical mucus**: determines the beginning and end of the fertile days. • Changes in the **basal body temperature**: determines when ovulation has passed and the fertile days have ended.	**Tell the participants the Signs of Fertility as shown in the slide**
The FAB Methods 1. **Billings Ovulation Method (BOM)** 2. **Basal Body Temperature Method (BBT)** 3. **Sympto-thermal Method (STM)** 4. **Standard Days Method (SDM)** 5. **Two-Day Method (TDM)**	**Enumerate the different FAB methods and ask participants what they know of these methods.**

Billings Ovulation Method

- Based on the daily observation of what a woman sees and feels at the vaginal area throughout the day.
- Cervical mucus changes indicate whether days are fertile or infertile and can be used to avoid or achieve pregnancy.
- The woman is instructed to observe and record her feeling of dryness or wetness in her vaginal area during the day. She abstains from sexual intercourse during the fertile, "wet" days
- With perfect (correct) use, this method is 97% effective. However, with typical use, it is 80% effective.

Define the Billing's Ovulation method as presented in the slide.

Billings Ovulation Method

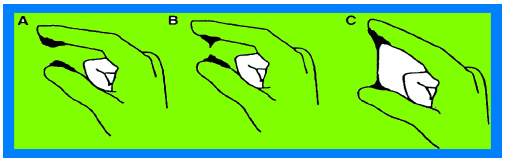
CYCLE DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Month January Date	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Feb 1	2	3	4	5	6	7	8	9	10	11
Symbol	R	R	R	S	S	D	D	D	D	D	X	X	X	X	●	1 M	2 M	3 D	D	D	D	D	D	D	D	D	D	D	D	R	
What do you feel?	WET	WET	WET	WET	WET	dry	dry	dry	dry	dry	WET	WET	WET	WET	WET	Dry	dry	dry	dry	dry	dry	dry	dry	dry	dry	dry	dry	dry	dry	WET	
What is seen?	blood	blood	blood	sticky	sticky	none	none	Pasty	Pasty mucus	Stretchy mucus	Stretchy mucus	Slippery mucus	Slippery mucus	Slippery mucus	Slippery mucus	sticky	sticky	NONE	NONE	NONE	NONE	NONE	NONE	NONE	NONE	NONE	NONE	NONE	NONE	blood	
Intercourse						♥		♥		♥									♥	♥	♥	♥	♥	♥	♥	♥		♥	♥		
Medication Taken / fever																															

Explain further the Billing's Ovulation method with the help of the chart presented in the slide. Ask participants the meaning of the different signs and symbols.

OVULATION METHOD

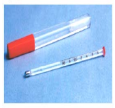
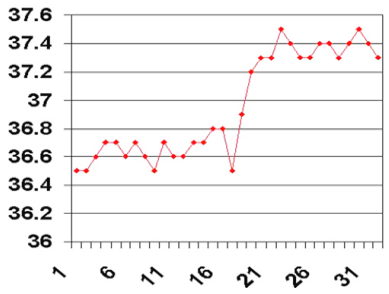
(CERVICAL MUCOUS OR BILLINGS)

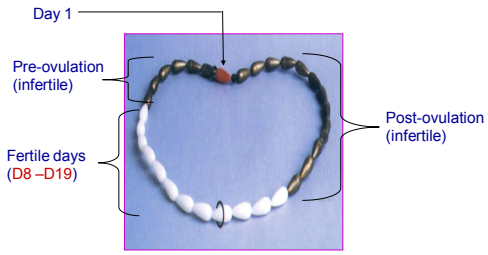
Abstinence is required from the beginning of menses until 4 days after slippery mucus is identified.



A = Intermediate type mucous B = Infertile type mucous
C = Fertile type mucous

Tell participants the appearance of the cervical mucus during the menstrual cycle and the fertile period using the OM.

Basal Body Temperature • Based on the changes in a woman's resting body temperature which is lower before ovulation until it rises to a higher level after ovulation. • Infertile days begin from the fourth day of the high temperature reading to the last day of the cycle. • All days from the start of the menstrual cycle up to the third high temperature reading are considered fertile days. • Effectiveness: 99% (perfect use) and 80% (typical use)	**Explain the Basal Body Temperature method with the help of the information in the slide.**
Basal Body Temperature  	**Explain further BBT using the picture/graph in the slide**
Sympto-thermal Method • Based on the combination of the Basal Body Temperature & Billings Ovulation Method together with other signs (breast engorgement, unilateral lower abdominal pain) which indicate that the woman is fertile or infertile. • Effectiveness as correctly used: 98%	**Describe the Sympto-thermal method using the information in the slide.**

## Standard Days Method • Calculation of fertile and infertile days for menstrual cycles of 26 to 32 days • Works for women with menstrual cycles of 26-32 days • Identifies cycle days 8-19 as the woman's fertile period; sexual intercourse must be avoided during this period • Colored beads are used to help the woman keep track of her fertile & infertile days.	**Explain the Standard Days Method using the information in the slide.**
## Standard Days Method  	**Show the fertile and infertile periods using the SDM cycle-beads with the help of the picture slide.**
## Advantages of FAB Methods • Effective when used correctly and consistently. • No physical side effects • No prescription required • Inexpensive; no medication involved • No follow-up medical appointments required • Better understanding of the couple about their sexual physiology and reproductive functions. • Encourage shared responsibility for family planning • Foster better communication between partners	**Tell participants the Advantages and Disadvantages of the FAB using the next 2 slides.**

## Disadvantages of FAB Methods • **May inhibit sexual spontaneity** • **Except for SDM, need extensive training** • **Require consistent and accurate record keeping and close attention to body changes** • **Require periods of abstinence from sexual intercourse** • **Can be used only by women whose cycles are within 26-32 days (Specific to SDM)** • **Offer no protection against STI, HIV and AIDS**	
## Potential Problems • **Inability to abstain from sex during the fertile period (for all FAB methods)** • **Long or short cycles (for SDM)** • **Very irregular menstrual cycles (for calendar-based methods)** • **Difficulty in recognizing the different types of secretions (for ovulation method)** • **Difficulty in recognizing the presence of secretions (for 2-day method)**	**Tell participants about potential problems with the use of FAB as shown in the slide.**
## Correcting Misconceptions • **Can be very effective if used correctly and consistently** • **Do not require literacy or advanced education** • **Do not harm men who abstain from sex** • **Do not work when the couple is mistaken about fertile period**	**Tell participants the correct responses concerning FAB as shown in the slide.**

Sub-session 2 **Lactational Amenorrhea method (LAM)**	**Introduce the Session on LAM by flashing the Title Slide.**
LAM **L ACTATIONAL (breastfeeding)** **A MENORRHEA (no menses)** **M ETHOD** 	**Ask participants what they know of the LAM and supplement using the slide.**
Mechanism of Action • **Works primarily by preventing the release of eggs from the ovaries (ovulation)** • **Frequent breastfeeding temporarily prevents the release of the hormones that cause maturation and release of the ovum.**	**Discuss the Mechanism of Action of LAM using the information in the slide.**

## Effectiveness 	
• **As perfect use = 99.5% effective**
• **Perfect use means that the woman:**
  • **Has started breastfeeding as soon as possible after birth**
  • **Has avoided separation from her baby to be able to breastfeed as required**
  • **Breastfeeds the infant on demand with no more than 4 hours interval during the day and 6 hours at nighttime.**
• **As typically used = 98% effective**
	Tell participants of the Effectiveness of LAM and the meaning of perfect use as shown in the slide.

## Advantages • **Can be started immediately after delivery** • **Economical and easily available** • **Does not require prescription** • **No side effects or precautions for use** • **No commodities or supplies needed** • **Fosters mother-child bonding** • **Serves as a bridge to using other methods** • **Consistent with religious and cultural practices**	**Tell participants of the Advantages and Disadvantages of LAM as presented in the next 2 slides.**
## Disadvantages • **Fully or nearly fully breastfeeding pattern may be difficult for some women to maintain** • **The duration of the method's effectiveness is limited to a brief six-month postpartum period** • **There is no protection against sexually transmitted infections, including HIV**	

<table>
<tr>
<td>Choice of FP Methods for Postpartum Breastfeeding Women

Categories of choice of FP methods for postpartum breastfeeding women.

<table><tr><td>1st choice:
Nonhormonal methods other than LAM</td><td>IUD, condom, tubal ligation, NFP, or vasectomy (for partner)</td></tr><tr><td>2nd choice:
Progestin-only methods</td><td>DMPA and progestin-only pills (both can be initiated after 6 weeks postpartum)</td></tr><tr><td>3rd choice:
Methods containing estrogen (only after 6 months)</td><td>COCs (recommended only after 6 months when the baby is less dependent on breast milk for nutrition.</td></tr></table></td>
<td>Ask participants the choice of FP methods for women aside from LAM for post-partum breastfeeding women as shown in the table.</td>
</tr>
<tr>
<td>Potential Problems

• Not enough milk
• Sore breasts
• Sore or cracked nipples</td>
<td>Tell participants the potential problems that may be encountered with LAM.</td>
</tr>
<tr>
<td>Correcting Misconceptions

• Just as effective among fat and thin women
• Can be used by women with normal nutrition. No special foods are required.
• Can be used for the full 6 months without the need for supplemental foods.
• Can be used for the entire full 6 months without worry that the woman might run out of milk.</td>
<td>Ask participants what misconceptions that may be encountered with the use of LAM and offer responses to address them as shown in the slide.</td>
</tr>
</table>

NARRATIVE:

Fertility Awareness-Based (FAB) methods are family planning methods that focus on the awareness of the beginning and end of the fertile time of a woman's menstrual cycle. These methods involve:

- Determination of the fertile and infertile periods of a woman within the menstrual cycle.

- Observation of the signs and symptoms of infertility and fertility during the menstrual cycle.

Effectiveness depends on the couple's ability to identify fertile and infertile periods and motivation to practice abstinence when required

Signs of Fertility

There are two main naturally occurring fertility signs that a woman can observe to determine when she can or cannot become pregnant. These are:

1. Changes in the **cervical mucus**: Cervical mucus can be used to determine the beginning and end of the fertile days.
2. Changes in the **basal body temperature**: Basal body temperature can be used to determine when ovulation has passed and the fertile days have ended

The FAB methods

1. **BILLINGS OVULATION METHOD (BOM)** is based on the daily observation of what a woman sees and feels at the vaginal area throughout the day. Cervical mucus changes indicate whether days are fertile or infertile and can be used to avoid or achieve pregnancy. With perfect (correct) use, this method is 97% effective. However, with typical use, it is 80% effective.
2. **BASAL BODY TEMPERATURE (BBT)** is based on a woman's resting body temperature (i.e., body temperature after 3 hours of continuous sleep) which is lower before ovulation until it rises to a higher level beginning around the time of ovulation. Her infertile days begin from the fourth day of the high temperature reading to the last day of the cycle. All days from the start of the menstrual cycle up to the third high temperature reading are considered fertile days. With perfect use, this method is 99% effective while with typical use, its effectiveness is 80%.
3. **SYMPTOTHERMAL METHOD (STM)** is based on the combined technology of the Basal Body Temperature and the Billings Ovulation Method i.e. the resting body temperature and on the observations of mucus changes at the vaginal area throughout the day together with other signs (e.g. breast engorgement, unilateral lower abdominal pain) which indicate that the woman is fertile or infertile. This method is 98% effective as correctly used.
4. **STANDARD DAYS METHOD (SDM**) is based on a calculated fertile and infertile period for menstrual cycle lengths that are 26 to 32 days. Women who are qualified (i.e., with 26 to 32 days menstrual cycles) to use this method are counseled to abstain from sexual intercourse on days 8-19 to avoid pregnancy. Couples on this method use a device, the color-coded "cycle beads", to mark the fertile and infertile days of the menstrual cycle

   How to use the CycleBeads

   Assess the length of the menstrual cycle if it falls within the range of 26–32 days by considering the following information:

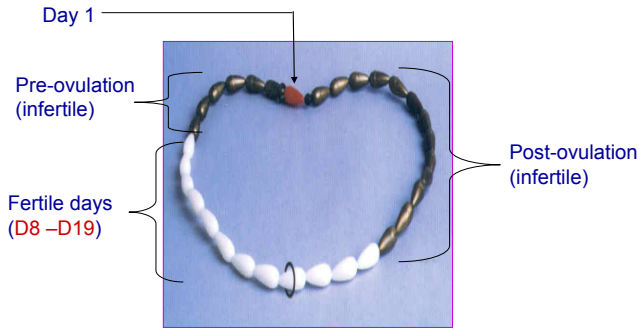
   - The last menstrual period (LMP)

- The previous/past menstrual period (PMP)
- When she expects her next menses

-If the cycle length is less than 26 days or more than 32 days, the client cannot use the method.

-If the cycle meets the criteria, provide an SDM card and cycle beads, which can be used in marking the days of the cycle

Show the woman the CycleBeads and instruct her on how to use it:



- On the first day of the menstrual cycle (i.e., first day of menstrual bleeding), she puts the ring on the red bead and marks with an "x" the date on the calendar.
- She moves the ring to a bead each day. It is recommended that she moves the ring every morning upon waking up so that she does not forget. The brown beads signify infertile days while the white beads signify fertile days.
- When the ring is on a white bead, she abstains from sexual intercourse.

Draw the client's attention to the dark brown and black beads. Tell her that if she experiences menstrual bleeding before the dark brown bead, this means that her cycle is short and less than 26 days. If the ring has reached the black bead and she still does not experience menstrual bleeding, then her cycle is more than 32 days. If either happens twice in a year, she cannot reliably use the SDM as her FP method.

Advantages of FAB methods:

- Effective when used correctly and consistently.
- No physical side effects
- No prescription required
- Inexpensive; no medication involved
- No follow-up medical appointments required
- Better understanding of the couple about their sexual physiology and reproductive functions.
- Encourage shared responsibility for family planning
- Foster better communication between partners

Disadvantages of FAB methods:

- May inhibit sexual spontaneity
- Except for SDM, need extensive training- takes about two to three cycles to accurately identify the fertile period and how to effectively use it.
- Require consistent and accurate record keeping and close attention to body changes
- Require periods of abstinence from sexual intercourse, which may be difficult for some couples
- Require rigid adherence to daily routine of awakening at a fixed time, without enduring any disturbance before taking the temperature (specific for BBT and STM)
- Can be used only by women whose cycles are within 26-32 days (Specific to SDM)
- Offer no protection against STI, HIV and AIDS

Potential Problems with the use of FAB

- Inability to abstain from sex during the fertile period (for all FAB methods)
- Long or short cycles (for SDM)
- Very irregular menstrual cycles (for calendar-based methods)
- Difficulty in recognizing the different types of secretions (for ovulation method)
- Difficulty in recognizing the presence of secretions (for 2-day method)

Correcting Misconceptions

- Can be very effective if used correctly and consistently
- Do not require literacy or advanced education
- Do not harm men who abstain from sex
- Do not work when the couple is mistaken about fertile period such as thinking that it occurs during the monthly bleeding.

Key Points on the FAB Methods

- Fertility awareness-based methods require cooperation of both partners.
- A woman or couple using FAB methods must be aware of body changes or keep track of fertile and infertile days according to the rules of the specific FAB method being practiced.
- To avoid pregnancy, the couple should abstain from love making during the fertile phase. To achieve pregnancy, the couple can time love making during the fertile phase.
- FAB methods have no side effects or health risks.

- SDM can be used by women with 26-32 days menstrual cycles.

SUB-SESSION 2
LACTATIONAL AMENORRHEA METHOD

The Lactational Amenorrhea Method (LAM) is a contraceptive method that relies on the condition of infertility that results from specific breastfeeding patterns. LAM is the use of breastfeeding as a temporary family planning method. "Lactational" means related to breastfeeding. "Amenorrhea" means not having menstrual bleeding.

There are three criteria that must be met to use LAM:

1. **Woman fully or nearly fully breastfeeds infant**.
    - "Fully/Nearly Fully" breastfeeding may be interpreted as:
        - **a.** "Fully"(or exclusive) means no supplements of any sort are given. Infant receives no other liquid or food, not even water in addition to breast milk.
        - **b.** "Nearly fully" means very small amounts (one or two swallows) of water, vitamins or ritual foods are given not more than once per day. For LAM to remain effective, 85% or more of feedings must be breastfeeds.
        - **c.** Simply put, the woman should use both breasts to breastfeed her baby on demand with no more than a four-hour interval between any two daytime feeds and no more than a six-hour interval between any two nighttime feeds.
2. **Amenorrhea.** Mother's monthly bleeding has not returned. In the first 6 to 8 weeks postpartum (i.e., in the first 56 days postpartum), there is often continued spotting. This is not considered to be a menstrual period if the woman is fully lactating.
3. **Infant is less than six months old**. If she is fully breastfeeding and her menses have not returned, the effectiveness of LAM diminishes over time. Ovulation resumes in 20% to 50% of women near the end of the six-month postpartum.

If any of the criteria is not met, it is no longer LAM.

ADVANTAGES OF LAM

1. It can be started immediately after delivery.
2. It is economical and easily available.
3. It does not require a prescription.
4. No action is required at the time of intercourse.
5. There are no side effects or precautions to its use.
6. No commodities or supplies are required for clients or for the family planning program.
7. Fosters mother-child bonding
8. It serves as a bridge to using other methods because LAM is used for a limited time

only..

9. It is consistent with religious and cultural practices.

DISADVANTAGES OF LAM

1. Fully or nearly fully breastfeeding pattern may be difficult for some women to maintain.
2. The duration of the method's effectiveness is limited to a brief six-month postpartum period. If a mother and child are separated for extended periods of time (because the mother works outside of the home), LAM effectiveness decreases.
3. There is no protection against sexually transmitted infections, including HIV.
4. In addition, it may be difficult to convince some providers who are unfamiliar with the method that LAM is a reliable contraceptive.

   NOTE: If returning to a clinic will be difficult for the client, provide a complementary family planning method for use, when needed. Use condoms with LAM if there is a risk of STI/HIV infection.

CHOOSING AN FP METHOD FOR POSTPARTUM BREASTFEEDING WOMEN

The health benefits of breastfeeding for infants have been established. For this reason the Philippine Maternal and Child Health Program has instituted measures to ensure that breastfeeding is promoted in facilities providing maternal and child health services. One such measure is the issuance of the "Milk Code" which promotes breastfeeding and discourages milk formula for infants.

Pregnant women during their prenatal consultations are counseled for breastfeeding practice immediately after delivery. Maternal and child health service providers are mandated to assist women implement breastfeeding as soon as possible after delivery.

Having placed high priority on breastfeeding, the table below categorizes the family planning methods as recommendations for breastfeeding postpartum women who for some reason may not be qualified for LAM.

Categories of choice of FP methods for postpartum breastfeeding women.

1st choice: Nonhormonal methods other than LAM	Intrauterine device, condom, tubal ligation, natural family planning, or vasectomy (for the woman's partner)
2nd choice: Progestin-only methods	DMPA and progestin-only pills (both of which can be initiated after 6 weeks postpartum)
3rd choice: Methods containing estrogen (only after 6 months)	Combined oral contraceptives (COCs are recommended only after 6 months when complementary foods are introduced and the baby is less dependent on breast milk as its sole source of nutrition.) Estrogen can reduce breast milk volume.

POTENTIAL PROBLEMS;

- BABY IS NOT GETTING ENOUGH MILK
- SORE BREASTS
- SORE OR CRACKED NIPPLES

CORRECTING MISCONCEPTIONS:

- JUST AS EFFECTIVE AMONG FAT AND THIN WOMEN
- CAN BE USED BY WOMEN WITH NORMAL NUTRITION. NO SPECIAL FOODS ARE REQUIRED.
- CAN BE USED FOR THE FULL 6 MONTHS WITHOUT THE NEED FOR SUPPLEMENTAL FOODS.
- CAN BE USED FOR THE ENTIRE FULL 6 MONTHS WITHOUT WORRY THAT THE WOMAN MIGHT RUN OUT OF MILK.

KEY POINTS ON LAM

- A family planning method based on breastfeeding.
- Can be effective for up to 6 months after childbirth, as long as monthly bleeding has not returned and the woman is fully or nearly fully breastfeeding.
- Requires breastfeeding often, day and night.

SESSION 2: HORMONAL CONTRACEPTIVE METHODS

SESSION OVERVIEW

There are currently three (3) hormonal contraceptive methods included in the Philippine Family Planning Program:

1. The **low-dose combined estrogen-progestin Low-dose COCs** is one of the most popular reversible contraceptive combination developed to date. Women worldwide in both developed and developing countries use it safely.
2. **Progestin only pills (POPs)** contain small amount of progestin only. They are highly recommended oral contraceptive for breastfeeding women because they do not interfere with milk production.
3. **Progestin-only injectable contraceptives** are also progestin only preparation given intramuscularly.

However, two other methods are already approved by the Food and Drugs Administration and already in the market, namely, the monthly administered **Combined Injectable Contraceptive (CICs**) and the single-rod **Contraceptive Subdermal Implant (CSI).**

MODULE SUB-SESSIONS

The module has the following sessions:

Sub-Session 1	Low-Dose Combined Oral Contraceptives (Low-Dose COCs)
Sub-Session 2	Combined Injectable Contraceptives (CICs)
Sub-Session 3	Progestin Only Pills (POPs)
Sub-Session 4	Progestin-Only Injectables (POIs)
Sub-session 5	Contraceptive Subdermal Implant (CSIs) – will be discussed in a separate Module

Session 2 **Hormonal Methods**	Flash the title slide on Hormonal Contraceptive methods.
HORMONAL METHODS **There are currently FIVE (5) hormonal contraceptive methods available in the Philippines:** • **Combined Oral Contraceptives (COCs)** • **Combined Injectable Contraceptive (CICs)** • **Progestin only Pills (POPs)** • **Progestin-only Injectable (POIs)** • **Contraceptive Sub-dermal Implants (CSIs)**	Tell participants the 5 hormonal methods as presented in the slide. These represent the 5 sub-sessions for discussion.
Hormonal Methods There are also other delivery forms such as: • The "Patch" • Vaginal Ring – NuvaRing • *Spray* • *Gel* • *Intra-uterine System -IUS* Hormonal methods do not protect against STDs.	Tell the different delivery systems for hormonal contraceptives as shown in the slide.

Combined Oral Contraceptives

Mechanism of Action

- **Prevents ovulation**
  - **Actually, estrogen prevents ovulation by suppressing hypothalamic gonadotrophin-releasing factor thus preventing pituitary FSH and LH release; also stabilizes the endometrium which prevents inter-menstrual or breakthrough bleeding**
  - **Progestins prevents ovulation by suppressing LH release.**
- **Progestins also thickens the cervical mucus, which makes it difficult for sperm to pass through.**

Hormonal contraceptives do not disrupt an existing pregnancy.

Effectiveness

Low-dose COCs are effective, if perfectly use 99.7%, if typically use 92%.

Factors affecting effectiveness:

- Correct and consistent use.
- Proper storage, observance of shelf life and expiration date.
- Vomiting or Diarrhea
- Drug Interactions

Advantages of COC

- Increased bone density
- Reduced menstrual blood loss and anemia
- Decreased risk of ectopic pregnancy
- Improved dysmenorrhea from endometriosis
- Fewer menstrual complaints
- Decreased risk of endometrial and ovarian cancer
- Reduction in various benign breast diseases
- Inhibition of hirsutism progression
- Improvement of acne
- Prevention of atherogenesis
- Decreased incidence and severity of acute salpingitis
- Decreased activity of rheumatoid arthritis

Disadvantages

- Requires regular and dependable supply
- Client-dependent – compliance to daily routine of taking the pills, often not used correctly and consistently, lowers its effectiveness; strong motivation needed to take pills correctly
- Offers no protection against STIs/HIV
- Not most appropriate choice for lactating women (unless there is no other method available and risk of pregnancy is high) as it can suppress lactation
- Effectiveness may be lowered when taken with certain drugs such as rifampicin and most anti-convulsants
- Increased risk to users over 35 years old who smoke and have other health problems

Who Cannot Use – WHO MEC 3 and 4

- Pregnancy
- Smoking and are 35 years old or over
- Over 35 with severe headache
- 35 or over and stopped smoking less than a year ago
- Breastfeeding for the first 6 months
- Liver and gallbladder disease
- Overweight (more than 90 kgs)
- History of current thrombosis
- History or current heart disease
- Undiagnosed vaginal bleeding

Possible Side Effects

- **spotting (especially if a woman forgets to take her pills or takes them late)**
- **amenorrhea**
- **nausea**
- **breast tenderness**
- **headaches**
- **depression (rare)**

Warning Signs

J-A-C-H-E-S

J	**Jaundice**
A	**Abdominal pain, severe**
C	**Chest pain, shortness of breath**
H	**Headache, severe**
E	**Eye problems, blurring of vision**
S	**Severe leg pains**

SEEK IMMEDIATE CONSULTATION

CORRECTING MISCONCEPTIONS

- **Low-dose COCs appear to have no apparent overall effect on risk of breast cancer.**
- **COCs do not disrupt an existing pregnancy.**
- **Does not cause birth defects and will not harm fetus even if the woman becomes pregnant while taking the pills or accidentally starts the pill when she is already pregnant**
- **Most women do not gain or lose weight due to COCs.**
- **Generally, COCs do not change mood or sex drive of a woman.**
- **COCs cannot be used as a pregnancy test**
- **COCs are safe for women with varicose veins.**

Combined Injectable Contraceptives

COMBINED INJECTABLE CONTRACEPTIVES (CICs)

- **The combined injectable is a contraceptive containing estrogen and progestin in an injectable form.**
- **Norifam, which is presently available in the country, contains Norethisterone 50 mg. and Estradiol Valerate 5 mg in oily solution.**

Mechanism of Action

- **The contraceptive effect is primarily on ovulation inhibition and thickening of the cervical mucus.**
- **The contraceptive effect is similar to that achieved by daily intake of the COC.**

Effectiveness

- **Effectiveness in preventing pregnancy in the first year of use is:**
  - **Correct use (no missed or late injections): 99%**
  - **Typical use (some missed or late injections): 97%**

Advantages

- **Advantages are similar to that of the COC with the following additional benefits:**
  - **Does not require daily action. No need to take a pill daily.**
  - **Private. No one else can tell that the woman is using a contraceptive.**
  - **More regular monthly bleeding as compared to DMPA.**

Disadvantages

- **Requires injection every month.**
- **Delayed return to fertility after the woman stops the method. It takes an average of about 1 month longer than with the COC.**
- **Does not protect against sexually transmitted infections (STIs), including HIV.**

Side Effects

- Changes in monthly bleeding which lessen within 3 months of starting injections include:
  - Lighter and fewer days of bleeding
  - Irregular
  - Infrequent or prolonged bleeding
  - No monthly bleeding
- Headaches
- Dizziness
- Breast tenderness

Who Cannot Use CIC

- **Pregnancy**
- **Breastfeeding an infant that is less than 6 months old**
- **Smoke cigarettes and are 35 years old or older**
- **Hypertension**
- **Migraine headaches**
- **Serious diseases of the liver, heart, or blood vessels**
- **Breast cancer**
- **Undiagnosed abnormal vaginal bleeding**

Warning Signs

- The client is advised to immediately return to the clinic or consult a physician when any of the following occurs:
  - **J** - Jaundice
  - **A** - Abdominal pain (severe)
  - **C** - Chest pain
  - **H** - Headaches (severe)
  - **E** - Eye problems such as acute loss of vision in one eye, seeing flashes
  - **S** - Severe leg pains

CORRECTING MISCONCEPTIONS

- CICs can stop monthly bleeding but this is not harmful. Blood is not building up in the body.
- Does not cause birth defects and will not harm fetus even if the woman becomes pregnant while taking the CIC or accidentally starts the CIC when she is already pregnant
- CICs do not change mood or sex drive of a woman.
- CICs do not make woman infertile.
- CICs do not cause itching.
- CICs do not cause early menopause.

Progestin-only Pills

PROGESTIN-ONLY PILLS

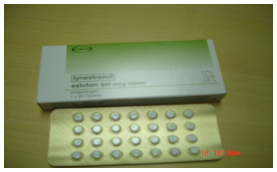
Contains a small amount of only one kind of hormone…. Progestin; thus called "mini-pills"

Does not contain estrogen

Kinds of POPs Available:

.5 mg lynestrenol (Exluton, Daphne)

75 ug desogestrel (Cerazette)



Both are available in 28 tablet package.

Mechanism of Action

- **Prevents ovulation in about half of menstrual cycles.**
- **Causes thickening of the cervical mucus, which make it more difficult for sperm to pass through.**

Effectiveness

For breastfeeding women, POPs are very effective:

- **99%** when typically use
- **99.5%** when perfectly use

- **POPs are less effective for women not breastfeeding.**
- **It is particularly important that POPs be taken at the same time every day. When taken even a few hours late, they lose their effectiveness.**

Advantages

- **Can be used by nursing mothers starting 6 weeks after childbirth. Quality and quantity of breast milk are not affected.**
- **No estrogen side effects.**
- **Women take one pill every day with no break. Easier to understand than taking 21-day combined pills.**
- **Can be very effective during breastfeeding.**
- **Even less risk of progestin-related side effects, such as acne and weight gain, than with low-dose combined oral contraceptives.**
- **May help prevent:**
  - **Benign breast disease**
  - **Endometrial and ovarian cancer**
  - **Pelvic inflammatory disease**

Disadvantages

- **Women who are not breastfeeding experience changes in menstrual bleeding.**
- **Less common side effects include headaches and breast tenderness.**
- **Must be taken at about the same time each day to be effective.**
  - **For women who are not breastfeeding, even taking a pill more than 3 hours late increases the risk of pregnancy and missing 2 or more pills increases the risk greatly.**
- **Does not protect against STIs/HIV.**
- **Effectiveness is lowered when certain drugs for epilepsy (phenytoin and barbiturates) or tuberculosis (rifampicin) are taken.**
-

Who Cannot Use the Method?
(Category 3 and 4)

Category 4: **Breast cancer within the past 5 yrs**

Category 3:

- **Current DVT/PE**
- **Active viral hepatitis**
- **Liver tumor (benign or malignant)**
- **Severe decompensated cirrhosis**
- **History of breast cancer with no evidence of disease for the last 5 years**
- **Breastfeeding and less than 6 weeks postpartum**
- **Migraine with an aura or development of migraine without an aura at any age that develops during POP use**
- **Drug treatment affecting liver enzymes: rifampicin and certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidine, topiramate, oxcarbazepine)**

Side Effects

- **Amenorrhea (**No monthly bleeding**)**
- **Irregular bleeding** (bleeding at unexpected times that bothers the client)
- **Ordinary headaches**
- **Nausea or dizziness**

Correcting Misconceptions

- POPs do not affect milk production.
- POPs do not cause birth defects
- Women who stop using POPs can become pregnant as quickly as women who stop non-hormonal methods
- POPs do not cause cancer
- POPs do not affect the women's sexual behavior nor cause mood change
- POPs reduce the risk of ectopic pregnancy

Progestin-only Injectable

PROGESTIN-ONLY INJECTABLE

- An injectable contraceptive containing a synthetic progestin, which resembles the female hormone progesterone
- Available preparations:
  - DMPA(depot-medroxyprogesterone acetate) 150 mg. given every 3 months
  - Noristerat (norethisterone enanthate) 200 mg. given every 2 months

Mechanism of Action

- **Inhibits Ovulation** - After a 150-mg-injection of DMPA , ovulation does not occur for at least 14 weeks. Levels of the follicle stimulating hormone (FSH) and luteinizing hormone (LH) are lowered and an LH surge does not occur.
- **Thickens the Cervical Mucus** - The cervical mucus becomes thick, making sperm penetration difficult.

Effectiveness

- Progestin-only injectable is a highly effective contraceptive method.
- Effectiveness if perfectly used is **99.7**%, if typically used **97.0%.**

Advantages

- **Reversible**
- **No need for daily intake**
- **Does not interfere with sexual intercourse**
- **Perceived as culturally acceptable by some women**
- **Private since it is not coitally dependent**
- **Has no estrogen-related side effects such as nausea, dizziness, nor serious complications such as thrombo-phlebitis or pulmonary embolism**

Advantages

- **Does not affect breastfeeding–quantity and quality of breast milk do not seem to be affected**
- **Has beneficial non-contraceptive effects:**
  - **Helps prevent iron-deficiency anemia because of the scanty menses and the consequent amenorrhea**
  - **May make seizures less frequent in women with epilepsy**
  - **Reduces the risk of ectopic pregnancies**
  - **Prevents endometrial cancer**

Disadvantages

- **Return to fertility is delayed—average is about 10 months from the last injection.**
- **Requires an injection every 2 or 3 months to continue its effects**
- **Does not protect against STI/HIV/AIDS**
- **Menstrual irregularity during the first few months of use**
- **Amenorrhea; some women get anxious if they do not have menses**
- **Not possible to discontinue immediately, until DMPA is cleared from the woman's body**
- **There may be bone loss for long-term users but study shows possibility of reversibility**

Who Cannot Use POI?

- **Category 4: Breast cancer within the past 5 years**
- **Category 3:**
  - **Current DVT/PE**
  - **Unexplained vaginal bleeding**
  - **Breastfeeding and less than 6 weeks after childbirth**
  - **Severe hypertension (more than 160/100 mm Hg)**
  - **Diabetes with vascular disease or for more than 20 years**
  - **Current or history of ischemic heart disease or stroke**
  - **History of breast cancer with no evidence of disease for the last 5 years**
  - **Acute viral hepatitis**
  - **Benign and malignant liver tumor**

Side Effects

- Change in menstrual bleeding patterns, include:
  - Amenorrhea: Reassure the client that amenorrhea is an expected side effect, and that she can expect menstrual cycles to return to normal within 6 months of discontinuing the POI.
  - Menstrual irregularity: Breakthrough bleeding and spotting are common.
- On very rare occasions, allergic reactions immediately follow an injection of POI.

Correcting Misconceptions

- **POIs do not cause birth defects and will not harm fetus if a woman becomes pregnant while using them or accidentally starts POIs when she is already pregnant**
- **POIs do not disrupt an existing pregnancy nor can they be used to cause an abortion**
- **Bleeding episodes should not be used as a guide for the injection schedule; rather should be given every 3 months for DMPA irrespective of whether a woman has bleeding or not**
- **POIs are not used t regulate monthly periods especially for those with irregular cycle**

Correcting Misconceptions

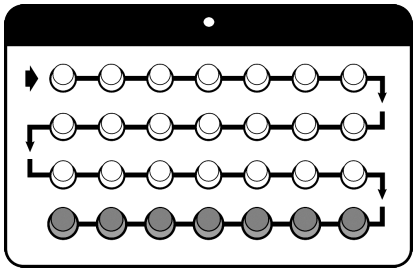
- **Women younger than 35 who smoke any number of cigarettes and women 35 and older who smoke less than 15 cigarettes a day CAN safely use POIs**
- **Generally, POIs do not cause change in a woman's mood or sexual drive.**
- **POIs are safe for women with varicose veins. Women with DVT/PE should not use POIs**
- **POIs do not cause a woman to be infertile but there may be a delay in regaining fertility after stopping them; usually it takes around 5 months before they become pregnant**

NARRATIVE

SUB-SESSION 1

COMBINED ORAL CONTRACEPTIVES (COCs)

Low-dose COCs, otherwise known as pills or oral contraceptives, contain hormones similar to the woman's natural hormones –estrogen and progesterone. They are taken daily to prevent conception.



Most women use low-dose COCs successfully when properly counseled on how to use them and what potential side effects to expect. Service delivery for low-dose COCs can and should be relatively uncomplicated.

Two types of pill packets are available in the Philippines. One type has 28 pills in a packet, with 21 "active" pills containing hormones and 7 "inactive or reminder" pills of a different color. The reminder pills do not contain hormones. Another type of pills contain only the 21 "active/hormone containing" tablets.

Monophasic pills provide the same amount of estrogen and progesterone in every hormonal pill.

Biphasic pills have the first 10 pills with one dosage and the next 11 pills having another level of estrogen and progestin.

Triphasic pills have the first 7 pills or so with one dosage, the next 7 pills have another dosage and the last 7 pills with yet another dosage.

All prevent pregnancy in the same way.

Differences in side effects, effectiveness and continuation appear to be slight.

Other types of hormonal contraceptives are in the form of patch, implant, spray, gel, vaginal ring and intrauterine device.

Mechanism of Action

Low-dose COCs prevent ovulation by suppressing follicle-stimulating hormone (FSH) and luteinizing hormone (LH). It also causes thickening of the cervical mucus, which makes it difficult for sperm to pass through.

Low-dose COCs do not disrupt an existing pregnancy.

Effectiveness

Low-dose COCs are effective, if perfectly use 99.7%, if typically use 92%.

- Many women may not take the pills correctly and risk becoming pregnant. The

most common mistakes are starting new packets late and running out of pills.

- The overall continuation rate among low-dose COCs users is low:
    - 25%-50% of women will stop the low-dose COCs within one year.
    - Most women stop for non-medical reasons

Factors affecting effectiveness:

1. Correct and consistent use.

   Low-dose COCs must be taken daily, preferably at the same time of the day or night.

   Low-dose COCs should be started within the 1st seven days of the menstrual cycle (day1-7).

   If client missed pills, advise them to follow the recommended practice for managing missed pills)

2. Proper storage, observance of shelf life and expiration date.

   Pills should be stored at room temperature with proper ventilation. Too much heat may harden the pills and reduce the bioavailability of the hormone content of the pills.

3. Vomiting or Diarrhea

   If vomits within 2 hours after taking a pill, she should take another pill from her pack as soon as possible, then keep taking pills as usual.

   If with vomiting or diarrhea for more than 2 days, follow instructions for 1 or 2 missed pills above.

4. Drug Interactions

   Effectiveness may be lowered when taken with certain drugs such as rifampicin and most anti-convulsants

Advantages of COCs

- Safe as proven by extensive studies
- Reversible, rapid return of fertility
- Convenient, easy to use, no need to do anything at the time of sexual intercourse
- Has significant non-contraceptive benefits
    - Monthly periods regular and predictable
    - Reduces symptoms of gynecologic conditions such as painful menses and endometriosis
    - Reduces the risk for ovarian and endometrial cancer
    - Decreases risk of iron-deficiency anemia
    - Can be used at any age from adolescence to menopause

Disadvantages of COCs

- Requires regular and dependable supply
- Client-dependent – compliance to daily routine of taking the pills, often not used correctly and consistently, lowers its effectiveness; strong motivation needed to take pills correctly
- Offers no protection against STIs/HIV
- Not most appropriate choice for lactating women (unless there is no other method available and risk of pregnancy is high) as it can suppress lactation
- Effectiveness may be lowered when taken with certain drugs such as rifampicin and most anti-convulsants
- Increased risk to users over 35 years old who smoke and have other health problems

WHO CANNOT USE COCs?

Category 4. DONOT USE THE METHOD

- Breastfeeding and less than 6 weeks postpartum
- Current and history of ischemic heart disease or stroke
- Smoking 15 or more cigarettes per day in a woman aged 35 years or more
- Raised BP (160/100 or more)
- Hypertension with vascular disease
- Diabetes mellitus with vascular complications (hypertension, nephropathy, retinopathy or neuropathy) of more than 20 years duration
- Past or present evidence of DVT/PE
- Major surgery with prolonged immobilization
- Complicated vascular heart disease
- Breast cancer within the past 5 years
- Acute viral hepatitis
- Benign or malignant liver tumor
- Severe (decompensated) cirrhosis

Category 3: DONOT USE the method unless no other appropriate method is available under close supervision

- Smoking less than 15 cigarettes a day in a woman aged 35 years or more
- Raised blood pressure 140-159/90-99 mm Hg
- Migraine without aura in a woman aged 35 years or more (if migraine develops during use of COCs, it becomes a category 4 contraindication)
- History of breast cancer with no evidence of disease for 5 years

- Breastfeeding from 6 weeks to less than 6 months postpartum
- Less than 21 days postpartum
- Mild compensated cirrhosis
- History of cholestasis related to past COC use
- Symptomatic gall bladder disease
- Drug treatment affecting liver enzymes: rifampicin and certain anticonvulsants.

Possible Side Effects and Management

Possible side effects which are common during the first 3 months of use of the COC are:

- spotting (especially if a woman forgets to take her pills or takes them late)
- amenorrhea
- nausea
- breast tenderness
- headaches
- depression (rare)

SIDE EFFECTS	POSSIBLE CAUSE(S)	MANAGEMENT
Amenorrhea/ scanty menses	• Possible pregnancy • Inadequate endometrial build-up	• Check for pregnancy • Reassurance
Spotting/breakthrough bleeding	• Missed pills • More common with low dose COCs • Taking pills at different times of the day • Vomiting and/or diarrhea within 2 hours of intake • Drug interaction	• Encourage regular intake of pills at the same time each day • Avoid missing pills • Take another pill from another pack when diarrhea or vomiting occurs within 2 hours of intake • Change method if taking rifampicin or anti-convulsants
Nausea	• Possible flu or infection • Possible pregnancy • Taking pills on an empty stomach	• Check for flu, infection or pregnancy • Take pills at bedtime or with food
Headaches	• Estrogen effect	• Take analgesics (paracetamol) • Refer if getting worse
Breast tenderness	• Effect of hormones in pills	• Recommend use of supportive bra • Take pain relievers

		• Try hot or cold compress

Warning Signs

J - Jaundice

A - Abdominal pain (severe)

C - Chest pain

H - Headaches (severe)

E - Eye problems such as acute loss of vision in one eye, seeing flashes

S - Severe leg pains

The above signs may not be due to COC use. However, if these signs occur in a client using the COC, she is instructed to immediately seek consultation for proper investigation and management of the underlying problem.

Correcting myths and misconceptions

1. Compliance is increased in low-dose COCs users:
2. When clients are active participants in the counseling process;
3. When they are given thoughtful replies to their questions and concerns; and
4. When accurate and detailed information is provided.
5. Low-dose COCs are safe, effective, and reversible. They are some of the most extensively studied medications ever used by human beings. Serious side effects are very rare.
6. Low-dose COCs have many non-contraceptive health benefits).
7. Low-dose COCs appear to have no apparent overall effect on risk of breast cancer.
8. Low-dose COCs may be used by healthy, non-smoking women throughout their reproductive lives, starting in the teen-age years and into their forties.
9. (Clients should be provided with enough pills for more than three cycles, provided they have a safe place to store them and the program has enough stocks. Give them more than three cycles only after they have completed a three-month trial period on the Low-dose COCs.)
10. Low-dose COCs do not protect against STIs and HIV. Women at risk of infection must also be offered condoms.
11. Low-dose COCs are not recommended for breastfeeding women because they can reduce the milk supply**)**.
12. A woman is protected only as long as she takes the pill regularly
13. COCs do not disrupt an existing pregnancy.
14. Does not cause birth defects and will not harm fetus even if the woman becomes pregnant while taking the pills or accidentally starts the pill when she is already pregnant

15. Most women do not gain or lose weight due to COCs.
16. Generally, COCs do not change mood or sex drive of a woman.
17. COCs cannot be used as a pregnancy test
18. COCs are safe for women with varicose veins.
19. COCs can be safely taken by a woman throughout her life.
20. Women younger than age 35 who smoke can use low dose COCs
21. COCs should be take at the same time each day to reduce side effects and for consistent use.

KEY MESSAGES

- Low-dose COCs are safe, effective, and reversible. They are some of the most extensively studied medications ever used by human beings. Serious side effects are very rare.
- Low-dose COCs have many non-contraceptive health benefits.
- Low-dose COCs may be used by healthy, non-smoking women throughout their reproductive lives, starting in the teen-age years and into their forties.
- Clients should be provided with enough pills for more than three cycles, provided they have a safe place to store them and the program has enough stocks. Give them more than three cycles only after they have completed a three-month trial period on the Low-dose COCs. Low-dose COCs do not protect against STIs and HIV. Women at risk of infection must also be offered condoms.
- Low-dose COCs are not recommended for breastfeeding women because they can reduce the milk supply

SUB-SESSION 2
COMBINED INJECTABLE CONTRACEPTIVES (CICs)

The combined injectable is a contraceptive containing estrogen and progestin in an injectable form.

Norifam, which is presently available in the country, contains Norethisterone 50 mg. and Estradiol Valerate 5 mg in oily solution.

Mechanism of Action

The contraceptive effect is primarily on ovulation inhibition and alteration of the cervical mucus.

The contraceptive effect is similar to that achieved by daily intake of the COC.

Advantages

Advantages are similar to that of the COC with the following additional benefits:

- Does not require daily action. No need to take a pill daily.
- Private. No one else can tell that the woman is using a contraceptive.
- More regular monthly bleeding as compared to DMPA.

Disadvantages

- Requires injection every month.
- Delayed return to fertility after the woman stops the method. It takes an average of about 1 month longer than with the COC.
- Does not protect against sexually transmitted infections (STIs), including HIV.

Effectiveness

Effectiveness in preventing pregnancy in the first year of use is:

- Correct use (no missed or late injections): 99%
- Typical use (some missed or late injections): 97%

Possible Side Effects

- Changes in monthly bleeding which lessen within 3 months of starting injections include:
    - Lighter and fewer days of bleeding
    - Irregular
    - Infrequent or prolonged bleeding
    - No monthly bleeding
- Headaches
- Dizziness
- Breast tenderness

Who Cannot Use

Women with the following conditions are advised not to use the CIC:

- Pregnancy
- Breastfeeding an infant that is less than 6 months old
- Smoke cigarettes and are 35 years old or older
- Hypertension

- Migraine headaches
- Serious diseases of the liver, heart, or blood vessels
- Breast cancer
- Undiagnosed abnormal vaginal bleeding

How to Use

- First injection is given on the first day of the menstrual cycle.
- Succeeding injections are given every 30 +/- 3 days.
- The injectable must be stored at controlled room temperature (15-30°C). Do not freeze.
- Administration:
    - Follow infection prevention measures for administering injections.
    - Slow deep intramuscular injection preferably intragluteal, alternatively into the upper arm.
    - Place a plaster over the injection site after injection to prevent any reflux of the solution.
- Client instructions
    - What to expect:

      Vaginal bleeding episode will occur within one or two weeks after the first injection. This is normal and if use is continued, bleeding episodes will occur at 30 days interval. Pregnancy should be rule out if no withdrawal bleeding occurs within 30 days after an injection.
    - Follow-up
        - Return to the clinic every 30 days for your next injection. Try to come on time.
        - If, for some reason, the next injection was not given after 30 days, abstain from sexual intercourse or use a condom until you get the next injection.
        - Come back to the clinic no matter how late you are. You may still be able to use the injectable.
        - Return to the clinic at any time if:
            - You develop any of the warning signs.
            - You have any questions or problems.
            - You think you are pregnant.

Warning Signs

The combined injectable contraceptive has the following warning signs similar to the COCs.

The client is advised to immediately return to the clinic or consult a physician when any of the following occurs:

J - Jaundice

A - Abdominal pain (severe)

C - Chest pain

H - Headaches (severe)

E - Eye problems such as acute loss of vision in one eye, seeing flashes

S - Severe leg pains

Correcting Misconceptions

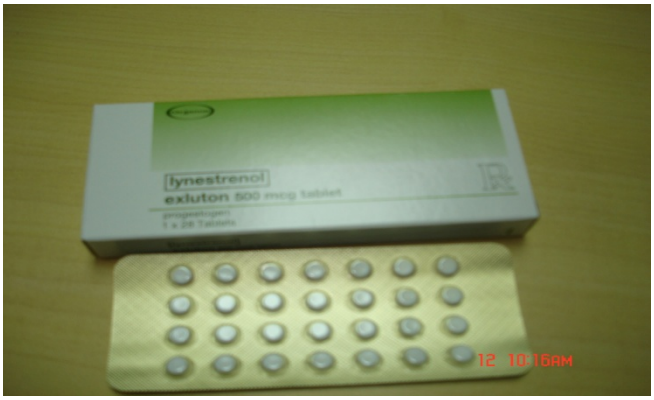
- CICs can stop monthly bleeding but this is not harmful. Blood is not building up in the body.
- Does not cause birth defects and will not harm fetus even if the woman becomes pregnant while taking the CIC or accidentally starts the CIC when she is already pregnant
- CICs do not change mood or sex drive of a woman.
- CICs do not make woman infertile.
- CICs do not cause itching.
- CICs do not cause early menopause.

Sub-Session 3
PROGESTIN ONLY PILLS (POPs)

There are two kinds of POPs available:

1. 0.5 mg lynestrenol (for example: Exluton, Daphne)
2. 75 ug desogestrel (for example: Cerazette)

Both are available in 28 tablet package.



MECHANISM OF ACTIONS

1. Prevents ovulation in about half of menstrual cycles.
2. Causes thickening of the cervical mucus, which make it more difficult for sperm to pass through.

EFFECTIVENESS

For breastfeeding women, POPs are very effective:

99% when typically use

99.5% when perfectly use

POPs are less effective for women not breastfeeding.

It is particularly important that POPs be taken at the same time every day. When taken even a few hours late, they lose their effectiveness.

ADVANTAGES

- Can be used by nursing mothers starting 6 weeks after childbirth. Quality and quantity of breast milk are not affected.
- No estrogen side effects.
- Women take one pill every day with no break. Easier to understand than taking 21-day combined pills.
- Can be very effective during breastfeeding.
- Even less risk of progestin-related side effects, such as acne and weight gain, than with low-dose combined oral contraceptives.
- May help prevent:
    - Benign breast disease
    - Endometrial and ovarian cancer
    - Pelvic inflammatory disease

DISADVANTAGES

- Women who are not breastfeeding experience changes in menstrual bleeding. This includes irregular periods, spotting or bleeding between periods (common), and amenorrhea possibly for several months (less common). A few women may have prolonged or heavy menstrual bleeding.
- Less common side effects include headaches and breast tenderness.
- Must be taken at about the same time each day to be effective. For women who are not breastfeeding, even taking a pill more than 3 hours late increases the risk of pregnancy and missing 2 or more pills increases the risk greatly.
- Does not protect against STIs/HIV.
- Effectiveness is lowered when certain drugs for epilepsy (phenytoin and barbiturates) or tuberculosis (rifampicin) are taken.

WHO CAN USE POPS?

Category 1: Use the method without restriction.

POPs can be used by women in any of the following circumstances:

- Breastfeeding 6 weeks after childbirth
- Smoke cigarettes
- Have no children
- Adolescents and over 40 years old
- Have just had an abortion or miscarriage
- Have breast disease
- Experiencing heavy painful menstruation, irregular periods
- Have thyroid diseases
- Have benign ovarian tumors, uterine fibroids
- Have valvular heart disease
- Suffering from STIs and PID

Category 2: Generally use the method but with more than the usual follow-up.

- Current history of ischemic heart disease or stroke (if either develops during POP use, it becomes Category 3).
- History of hypertension where blood pressure cannot be evaluated
- Elevated blood pressure (systolic >160 or diastolic >100 mmHg)
- Hypertension with vascular disease
- Diabetes with or without complications
- History of DVT/PE
- Major surgery with prolonged immobilization
- Mild compensated cirrhosis
- Gall bladder disease
- Undiagnosed breast mass
- Previous ectopic pregnancy
- Known hyperlipidemia
- Irregular, heavy, or prolonged vaginal bleeding or unexpected vaginal bleeding
- Treatment with griseofulvin
- Antiretroviral therapy

WHO CANNOT USE THE METHOD?

Category 4: Do not use the method.

- Breast cancer within the past 5 years

Category 3: Do not use the method unless no other appropriate method is available under close supervision.

- Current DVT/PE
- Active viral hepatitis
- Liver tumor (benign or malignant)
- Severe decompensated cirrhosis
- History of breast cancer with no evidence of disease for the last 5 years
- Breastfeeding and less than 6 weeks postpartum
- Migraine with an aura or development of migraine without an aura at any age that develops during POP use
- Drug treatment affecting liver enzymes: rifampicin and certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidine, topiramate, oxcarbazepine)

Management of Possible Side Effects

1. **Amenorrhea (**No monthly bleeding**)**

- Reassure that this is normal for breastfeeding women. It is not harmful.
- For non-breastfeeding women, reassure that some women using POPs stop having monthly bleeding and not harmful. There is no need to lose blood monthly and woman is not infertile. Blood is not building up inside her. (Some women are happy to be free from monthly bleeding).

2. **Irregular bleeding** (bleeding at unexpected times that bothers the client)

- Reassure that many women using POPs experience irregular bleeding, whether breastfeeding or not. It is not harmful and becomes less or stops after several months of use. However, other possible causes are vomiting/diarrhea and taking anticonvulsants or Rifampicin.
- To reduce bleeding, teach her to make up for missed pills properly.
- Consider other underlying conditions unrelated to method use and refer appropriately

3. **Ordinary headaches**

- Suggest pain relievers (Paracetamol, Aspirin, Ibuprofen)
- If get worse or occur more often during POP use, warrants evaluation.

4. **Nausea or dizziness**

- Suggest taking POPs at bedtime or with food.

What effect do POPs have on ovulation?

POPs prevent ovulation in 50 percent of cycles in lynestrenol preparation and 97 percent of the cycles in desogestrel preparation. .

When can POPs be started for breastfeeding women?

- If the client is breastfeeding and she wishes to use the pill, she can start POPs after the 6th week postpartum.
- If the client is more than 6 weeks postpartum and her menstrual cycle has returned, she can start the POPs.
- If the client is not breastfeeding, she can start POPs immediately or at any time within the first 6 weeks postpartum.

Are there special considerations when switching from POPs to other hormonal methods?

- The client can start POPs immediately if she has been using her other hormonal method consistently and correctly, or if she is reasonably certain she is not pregnant.
- If her previous method was an injectable contraceptive, she should start POPs when the repeat injection would have been given.

If a woman is using POPs during breastfeeding, when should she be advised to switch to another method?

- Women can rely on POPs after the first 6 weeks and safely use them during the entire duration of breastfeeding.
- Women can continue using POPs after they stop breastfeeding, provided that they have been informed of the advantages and disadvantages of the method and are willing to use the POPs correctly and consistently.
- Breastfeeding women using POPs should be advised not to switch to low-dose COCs or other methods containing estrogen until at least 6 months postpartum.
- Breastfeeding women can switch to non-hormonal methods at any time, as appropriate.

When breastfeeding, is there a best time of day to take POPs?

POPs may be taken at any time of the day and consistently taken at the same time for

effective use during breastfeeding. The client may wish to select a certain time to help her remember to take a pill every day. It may help to link this time to a daily event.

Instructions on Use

Once the client has chosen POPs as her preferred contraceptive method, the health provider should:

- Briefly explain how POPs work to prevent pregnancy
- Show and let client handle a package of pills
    - Explain how to take the pills:
    - Take the first pill on the first day of your period or on any of the next 4 days.
    - Take one pill everyday, at the same time each day (e.g. between 6pm and 8pm--an evening meal may be a good time to take the pills).
    - Take the pills non-stop, from one packet to another.
    - Do not miss a day.
    - Have a backup method of contraception (condoms) especially:
        - When you are waiting to start POPs.
        - If you miss a pill, until you restart or until your next period.
        - If you may be at risk of infection from STIs.
- **How to Manage missed pills**
    - Remember to emphasize the importance of not forgetting any pill, even just for a few hours.
    - Advice the client that if she misses one or more pills, she may have spotting or breakthrough bleeding, and more importantly she will be at a greater risk of becoming pregnant.
    - She needs to restart taking the pills as soon as possible.
    - If she missed taking the pills by more than 3 hours, advise her to abstain from sexual intercourse or use a barrier method of contraception during the first 48 hours after restarting the pills.
    - If the client is breastfeeding and amenorrheic and has missed one or more pills by more than 3 hours, she needs to take one pill as soon as possible and continue to take the pills as usual.
    - If she is less than 6 months postpartum, no additional contraceptive protection is needed.
- Keep track of your periods while you take POPs. If you have more than 45 days with no period, see your care provider for an examination and pregnancy test.
- If you have spotting or bleeding between periods, keep taking the pills on schedule. If your bleeding is very heavy, or if you have pain, fever or cramps, return to the clinic. In most cases, the bleeding is not serious and will stop in a few days. Bleeding

is especially likely if you have missed a pill. Bleeding will be more common in the first months that you take the pill.

- If you decide to become pregnant, plan to stop your pills 2 months before you want to get pregnant and use another method like condoms. This gives time for your normal cycle to reestablish itself and makes it easier for your care provider to determine your pregnancy due date.

Guidelines and instructions for follow up

- See your care provider regularly for routine checkups. Feel free to come to the clinic if you have any questions.
- If there are any problems or questions the client may come back to the clinic "anytime
- If you have any of the following symptoms or problems, come to the clinic:
    - Abdominal pain, tenderness, or fainting (This could be due to an ovarian cyst or ectopic pregnancy). Don't stop the pills, but come to the clinic right away.
    - Extremely heavy bleeding (twice as long or twice as much as usual).
    - Any very bad headaches (that start or become worse after taking POPs).
    - Skin or eyes become yellow.
    - If you think you might be pregnant

Correct Myths and Misconceptions about POPs:

- POPs do not affect milk production.
- POPs do not cause birth defects and will not otherwise harm the fetus if a woman becomes pregnant while taking POPs or accidentally takes POPs when she is already pregnant
- Women who stop using POPs can become pregnant as quickly as women who stop nonhormonal methods
- POPs do not cause cancer
- POPs do not affect the women's sexual behavior nor cause mood change
- POPs reduce the risk of ectopic pregnancy

SUB-SESSION 4
PROGESTIN ONLY INJECTABLE (POIs)

It is important that health service providers understand the nature, safety, characteristics and mechanism of action, side effects, and management of side effects of progestin-only injectable.

The progestin-only injectable (is a three-month injectable contraceptive. POI contains a

synthetic progestin, which resembles the female hormone progesterone. Each standard dose contains 150 mg of the hormone, which is released slowly into the blood stream from the site of intramuscular injection, providing the client/user with a safe and highly effective form of contraception.

Available POIs commercially:

1. Depot medroxyprogesterone acetate (DMPA) – part of the Phil FP program): given every 3 months
   - Depo-Provera (in 1 mL 150 mg) and
   - Depo Trust (3 mL 150 mg);
2. Norethisterone enanthate (NET-EN) given every 2 months.
   - Noristerat (1 mL 200 mg)

Another preparation of DMPA, which contains only 104 mgs of progestin, is available but not in the Philippines. It is also given subcutaneously every 3 months.

Mechanism of Action of POIs.

- **Inhibits Ovulation** - After a 150-mg-injection of DMPA , ovulation does not occur for at least 14 weeks. Levels of the follicle stimulating hormone (FSH) and luteinizing hormone (LH) are lowered and an LH surge does not occur.
- **Thickens the Cervical Mucus** - The cervical mucus becomes thick, making sperm penetration difficult.

Effectiveness of POIs

Progestin-only injectable is a highly effective contraceptive method. Effectiveness if perfectly used is **99.7**%, if typically used **97.0%.**

Safety of progestin-only injectable

Progestin-only injectable is a very safe contraceptive. Like other progestin-only contraceptives, it can be used by women who want a highly effective contraceptive, including those who are breastfeeding or who are not eligible to use estrogen-containing low-dose combined oral contraceptives.

Studies by the World Health Organization (WHO) reassure us that DMPA presents no overall risks for cancer, congenital malformations, or infertility. This research has evaluated more than 3 million woman-months of DMPA use.

The research found that:

- DMPA, like oral contraceptives, exerts a strong protective effect against endometrial cancer.

- Its use does not increase the risk of breast cancer overall.
- There is no relation between ovarian cancer and the use of DMPA. Researchers had expected that DMPA, like oral contraceptives, would protect women against ovarian cancer.

DMPA does not affect the risk of developing liver cancer in areas where hepatitis is endemic.

Advantages of POIs

- Reversible
- No need for daily intake
- Does not interfere with sexual intercourse
- Perceived as culturally acceptable by some women
- Private since it is not coitally dependent
- Has no estrogen-related side effects such as nausea, dizziness, nor serious complications such as thrombo-phlebitis or pulmonary embolism
- Does not affect breastfeeding–quantity and quality of breast milk do not seem to be affected
- Has beneficial non-contraceptive effects:
  - Helps prevent iron-deficiency anemia because of the scanty menses and the consequent amenorrhea
  - May make seizures less frequent in women with epilepsy
  - Reduces the risk of ectopic pregnancies
  - Prevents endometrial cancer

Disadvantages of Progestin-only injectable

- Return to fertility is delayed—average is about 10 months from the last injection.
- Requires an injection every 2 or 3 months to continue its effects
- Does not protect against STI/HIV/AIDS
- Menstrual irregularity during the first few months of use
- Amenorrhea; some women get anxious if they do not have menses
- Not possible to discontinue immediately, until DMPA is cleared from the woman's body
- There may be bone loss for long-term users but study shows possibility of reversibility

Who cannot use DMPA?

Category 4: DONOT USE THE METHOD

- Breast cancer within the past 5 years

Category 3: DO NOT USE THE METHOD unless no other appropriate method is available under close supervision

- Current DVT/PE
- Unexplained vaginal bleeding
- Breastfeeding and less than 6 weeks after childbirth
- Severe hypertension (more than 160/100 mm Hg)
- Diabetes with vascular disease or for more than 20 years
- Current or history of ischemic heart disease or stroke
- History of breast cancer with no evidence of disease for the last 5 years
- Acute viral hepatitis
- Benign and malignant liver tumor

MANAGEMENT OF POSSIBLE SIDE EFFECTS

Your success in helping your client understand the cause/nature of side effects and complications related to progestin-only injectable and how well you manage such cases will largely determine the client's satisfaction and continuing use of the method.

When side effects are not well managed, many women stop using progestin-only injectable due to fear and misunderstanding.

On very rare occasions, allergic reactions immediately follow an injection of progestin-only injectable.

The possibility of change in menstrual bleeding patterns, include:

- Amenorrhea: Reassure the client that amenorrhea is an expected side effect, and that she can expect menstrual cycles to return to normal within 6 months of discontinuing the POI.
- Menstrual irregularity: Breakthrough bleeding and spotting are common.

CORRECT INFORMATION ABOUT MYTHS AND MISCONCEPTION.

a. POIs do not cause birth defects and will not harm fetus if a woman becomes pregnant while using them or accidentally starts POIs when she is already pregnant

b. POIs do not disrupt an existing pregnancy nor can they be used to cause an abortion

c. Bleeding episodes should not be used as a guide for the injection schedule; rather should be given every 3 months for DMPA irrespective of whether a woman has bleeding or not

d. POIs are not used t regulate monthly periods especially for those with

irregular cycle

e. Women younger than 35 who smoke any number of cigarettes and women 35 and older who smoke less than 15 cigarettes a day CAN safely use POIs
f. Generally, POIs do not cause change in a woman's mood or sexual drive.
g. POIs are safe for women with varicose veins. Women with DVT/PE should not use POIs
h. POIs do not cause a woman to be infertile but there may be a delay in regaining fertility after stopping them; usually it takes around 5 months before they become pregnant

SUMMARY:

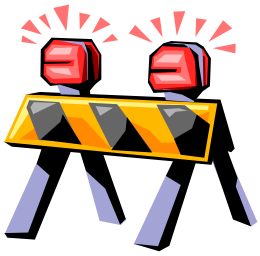
- Bleeding changes are common but not harmful. Typically, irregular bleeding for the first several months then no monthly bleeding
- Return for injections regularly. Every 3 months for DMPA
- Injections can be as much as 2 weeks early or late. Clients should come back even if later
- Gradual weight gain is common
- Return of fertility is often delayed. It takes several months longer on average to become pregnant after stopping POIs than after other methods.

SUB-SESSION 3
BARRIER METHODS – MALE CONDOM

Sub-session 3 **Barrier Methods**	

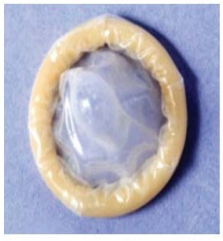
Barrier Methods

- **Female condom**
- **Male condom**
- **Spermicides**
- **Diaphragm**
- **IUD: ParaGard & Mirena (IUS)**



Male Condom

The Male Condom



Mechanism of Action

- Acts as barrier that prevents the sperm from getting into the vagina
- Helps prevent both pregnancy and STIs
- Stops disease organisms in the vagina from entering the penis

Effectiveness

- Condoms in order to be effective must be used correctly and consistently every time one is engaging in sex.
- If perfectly used 98% ; if typically used 85%.

Advantages

- Protects against sexually transmitted diseases, including HIV
- Easy to use
- Usually easy to obtain
- Usually inexpensive
- Safe, effective, and portable
- Helps protect against cervical cancer
- Allows men to share more responsibility for family planning
- Helps some men with premature ejaculation or to maintain erection
- Convenient for short-term contraception

Disadvantages

- **Coitus-related (must be used during sexual intercourse)**
- **Some men complain of decreased sensitivity**
- **Interrupts the sexual act**
- **Slipping off, tearing, spillage of sperm can occur, especially among inexperienced users**
- **Allergy to latex (rare)**
- **Requires high motivation for consistent and correct use**
- **Deteriorates quickly when storage conditions are poor**
- **Causes some men difficulty in maintaining erection**

Who Cannot Use Condom

- **Either or both of the sex partners with an allergy to latex rubber can not use the method.**
- **In general, anyone CAN use condoms safely and effectively if not allergic to latex.**
- **Only one medical condition prevents use of condoms and this is if either or both of the sex partners have severe allergy to latex rubber (severe redness, itching, swelling after condom use). The service provider can learn of this condition by asking the client and no tests or examinations need to be performed.**
- **If the client is at risk of STIs, including HIV, he/she may want to keep using condoms despite the allergy.**

Correcting Misconceptions

- **Do not make men sterile, impotent, or weak.**
- **Do not decrease men's sex drive.**
- **Cannot get lost in the woman's body.**
- **Do not have holes that HIV can pass through.**
- **Are not laced with HIV.**
- **Do not cause illness in a woman because they prevent semen or sperm from entering her body.**
- **Do not cause illness in men because sperm "backs up."**
- **Are used by married couples. They are not only for use outside marriage.**

Female Condom (Vaginal Pouch)  •Can be used with both water and oil-based lubricants •Should not be used concurrently with male condom •In-vitro test showed impermeable to HIV, CMV and Hep B	

The condom is one of the barrier methods. Barrier methods mechanically or chemically prevent fertilization or the union of the egg and sperm cell. The male condom is the only FP method included in the Philippine FP Program that prevents both pregnancy and sexually-transmitted infections (STIs).

DESCRIPTION

The condom is a sheath made of thin, latex rubber made to fit over a man's erect penis

MECHANISM OF ACTION

- Prevents entry of sperm into the vagina.
- Sperm and disease-causing organisms including HIV do not pass through intact latex rubber or polyurethane condoms.
- Some condoms have a spermicidal coating which adds to its effectiveness.

EFFECTIVENESS

- Condoms in order to be effective must be used correctly and consistently. If perfectly used **98%**; if typically used **85%**.

Condoms are …

- The only contraceptives, to date, that offers dual protection from STI, HIV and also prevents pregnancy.
- Condoms prevent sexually transmitted diseases to include HIV, gonorrhea, syphilis, chlamydia, and trichomoniasis. Condoms offer some protection, but not as much against herpes, genital wart virus (HPV), and other diseases that can cause sores on skin not covered by condoms.
- Condom use can reduce the risk of HIV infection by 80%-90%. They can reduce their

risk of STIs to a very low level if used **correctly and consistently**.

The most common condom failures that result in pregnancy or STI transmission are due to user-related causes. Below is the list of the use-related causes for condom failures;

1. **Inconsistent use**- inconsistent use means condoms are not used in every sexual intercourse.

2. Incorrect use

Common mistakes encountered when using condoms:

- Unrolling a condom before putting it on (this causes tears or breaks);
- Not "pressing the tip" of the condom
- Tears caused by wearing of rings and fingernails;
- Putting a condom on with the rolled rim toward the body instead of away from it; and
- Stretching/pulling on the condom which weakens the thin rubber wall.

3. Other causes:

- Failure to hold on to the rim of condom when withdrawing, resulting in spills/ leaks; and
- Having intercourse first, then stopping to put condom on before ejaculation.
- Condom Breakage - Condom breaks can occur due to:
    - Inadequate vaginal lubrication;
    - Defects in the condom itself;
    - Poor or improper storage with exposure to heat, ultraviolet light, and/or humidity; and
    - Application of certain mineral and vegetable oils as lubricants, which can weaken the latex

Condoms are more likely to break if:

- Used after the expiration date on package;
- Seal on the package is broken;
- Not produced by a reliable manufacturer; or
- Stored in high temperatures or exposed to sunlight.

Inexperienced users tend to report more condom breaks than those who have been shown and those who understand how to use condoms correctly.

ADVANTAGES

- Protects against sexually transmitted diseases, including HIV
- Easy to use
- Usually easy to obtain

- Usually inexpensive
- Safe, effective, and portable
- Helps protect against cervical cancer
- Allows men to share more responsibility for family planning
- Helps some men with premature ejaculation or to maintain erection
- Convenient for short-term contraception

DISADVANTAGES

- Coitus-related (must be used during sexual intercourse)
- Some men complain of decreased sensitivity
- Interrupts the sexual act
- Slipping off, tearing, spillage of sperm can occur, especially among inexperienced users
- Allergy to latex (rare)
- Requires high motivation for consistent and correct use
- Deteriorates quickly when storage conditions are poor
- Causes some men difficulty in maintaining erection

THE WHO MEDICAL ELIGIBILITY CRITERIA FOR CONDOM USE

Category 1: Use the method without restriction.

- Couples who are reliable users and who ask for it
- Couples who wish to use a backup method when the use of another method is interrupted; e.g., immediate post-vasectomy client
- Couples with high risk of STIs
- Couples who use it as a temporary method until another method is used
- A woman who is at high risk for or is unwilling to use other contraceptive methods (There are no systemic effects from condom use.)
- A woman who is breastfeeding and needs contraception (Condoms have no effect on lactation and are a complementary FP method for lactating women who no longer meet LAM criteria.)
- When other methods are medically contraindicated to either of the couple or for their personal reasons.
- The male condom can help men who have problems with premature ejaculation; it can aid them in postponing ejaculation.

Category 4: Do not use the method.

- Either or both of the sex partners with an allergy to latex rubber can not use the

method.

- In general, anyone CAN use condoms safely and effectively if not allergic to latex.
- Only one medical condition prevents use of condoms and this is if either or both of the sex partners have severe allergy to latex rubber (severe redness, itching, swelling after condom use) The service provider can learn of this condition by asking the client and no tests or examinations need to be performed.

If the client is at risk of STIs, including HIV, he/she may want to keep using condoms despite the allergy.

Correcting Misconceptions

The use of male condoms,

- Do not make men sterile, impotent, or weak.
- Do not decrease men's sex drive.
- Cannot get lost in the woman's body.
- Do not have holes that HIV can pass through.
- Are not laced with HIV.
- Do not cause illness in a woman because they prevent semen or sperm from entering her body.
- Do not cause illness in men because sperm "backs up."
- Are used by married couples. They are not only for use outside marriage.

Key Learning points

1. Use of condoms encourages men's participation in contraception.
2. When used consistently and correctly, condoms provide effective protection from pregnancy and from sexually transmitted diseases.
3. Correct and consistent condom usage protection against HIV and other STIs.
4. Only one medical condition prevents use of condoms and this is if either or both of the sex partners have severe allergy to latex rubber (severe redness, itching, swelling after condom use)
5. Condoms help to protect women from cervical cancer and pelvic inflammatory disease (PID).
6. Condoms should always be provided along with another method to any client:
    - Who might be at risk for sexually transmitted diseases;
    - Who uses oral contraceptives (in case she forgets to take a pill);
    - Who had a vasectomy (Condoms should be used until zero sperm count or within 3 months after vasectomy.
    - Who might need condoms for any reason.

SESSION 4
LONG-ACTING AND PERMANENT METHODS

Long-acting and Permanent Methods	

SUB-SESSION 1
THE INTRA-UTERINE DEVICE (IUDs)

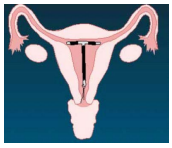
The Intra-uterine Device	

2 Types of IUD

- **Copper-bearing, which includes the TCu380A (TCu 380A, TCu 380A with Safe Load; and TCu 200), the Multiload (MLCu 250 and Cu375), and the Nova T**
- **Medicated with a steroid hormone, such as Mirena@, the levonorgestrel-releasing intrauterine system (LNG-IUS)**

The TCu380A (Copper T)

- **widely used;**
- **well known for its effectiveness, ease of insertion and removal, wide margin of safety, acceptability to clients, and low cost;**
- **"Use and forget" method**
- **effective for at least 12 years.**
- **US FDA classifies IUDs as drugs**



The TCu380A (Copper T)

A pre sterilized package containing:

- **a clear plastic *inserter tube* with a *blue-depth-gauge,* which can be moved along the length of the tube and functions as a cervical stop.**
- **A white *plastic rod* is used in conjunction with the inserter tube to place the *CuT380A* in the uterus. The strings and stem of the T will already be inside the inserter tube. The package also contains an *identification card*.**

The TCu380A (Copper T)

- **The TCu380A looks like the letter "T" and contains barium sulfate so that it can be seen by X-ray.**
- **314 sq mm of fine copper wire wrap the stem and the arms each have 33 sq mm copper bracelets, thus totalling 380 sq mm of copper.**
- **The copper bands on each "arm" of the T ensure that copper is released high in the fundus of the uterus.**
- **A thin polyethylene string is attached to the bottom of the stem for easy removal.**

Effectiveness

- **The IUD is a highly effective form of long-term, reversible contraception, with an associated failure (pregnancy) rate of less than 1 % (0.8%) in the first year of use (Trussell2004a).**

Advantages

- **Highly effective and very safe**
- **Reversible and economical**
- **May be safely used by lactating and immediate postpartum women**
- **Good choice for women who cannot use other methods**
- **Long duration of use (up to 12 years for TCu 380A)**
- **Once inserted they are convenient and extremely easy to use, providing worry-free continuous protection**
- **Allows privacy and control over her fertility (Client does not have to use anything at the time of sexual intercourse.)**
- **Does not interact with medications client may use**
- **No systemic side effects as its effects are confined to the uterus**

## Disadvantages • **Requires a pelvic exam to insert the IUD;** • **Requires a trained health service provider to insert/remove the IUD** • **Does not protect against STIs;** • **Increases the risk for PID for women with STIs** • **Device may be expelled, possibly without the woman knowing it (especially for postpartum insertions)** •	
## Side Effects • **Menstrual changes such as spotting/light bleeding (between periods);** • **Discomfort or cramping during IUD insertion and for the next several days.**	
## Warning Signs The signs of complication can be easily remembered **PAINS** • **P**eriod late • **A**bdominal pain • **I**nfection • **N**ot feeling well • **S**trings missing or longer	

Potential Risks • Potential health risks associated with the IUD, are uncommon or rare, include: – ***Uterine perforation*** – ***Expulsion*** – ***Infection***	
Correcting Misconceptions • The IUD *does not* act as an abortifacient. • The IUD *does not* increase a client's risk of ectopic pregnancy. • The IUD *does not* cause PID, nor does the IUD need to be removed to treat PID. • The IUD ***does not*** cause infertility. • The IUD ***is suitable*** for use in nulliparous women. • The IUD ***can be*** safely used by HIV-infected women who are clinically well. • The IUD ***does not*** increase the risk of HIV transmission. • The IUD ***does not*** interfere with ARV therapy.	

The TCu380A

The main IUD featured in this learning package is the TCu380A (or Copper T), which is:

- widely used;
- well known for its effectiveness, ease of insertion and removal, wide margin of safety, acceptability to clients, and low cost; and
- effective for at least 12 years.

The TCu 380A Insertion package

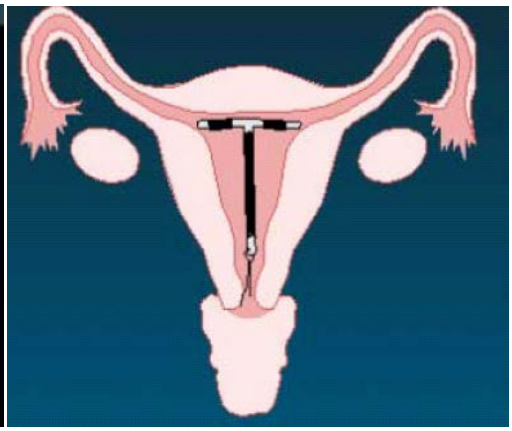
- Each TCu380A comes in a pre sterilized package that contains the equipment needed to insert the IUD.
- The package includes a clear plastic *inserter tube* with a *blue-depth-gauge,* which can be moved along the length of the tube and functions as a cervical stop.
- A white *plastic rod* is used in conjunction with the inserter tube to place the *CuT380A* in the uterus. The strings and stem of the T will already be inside the inserter tube. The package also contains an *identification card*.

The TCu380A looks like the letter "T" and contains barium sulfate so that it can be seen

by X-ray.

There are small copper bands on each "arm" of the T, which ensure that copper is released high in the fundus of the uterus. The "stem" is also wound with copper wire. A thin polyethylene string is attached to the bottom of the stem for easy removal.

Copper T 380A IUD



Copper T 380A IUD inside the Uterus

Types of IUDs

Common types of IUDs available worldwide are as follows:

- Copper-bearing, which includes the TCu380A (TCu 380A, TCu 380A with Safe Load; and TCu 200), the Multiload (MLCu 250 and Cu375), and the Nova T
- Medicated with a steroid hormone, such as Mirena@, the levonorgestrel-releasing intrauterine system (LNG-IUS)

Mechanism of Action

Copper-bearing IUDs, such as the Copper T, act primarily by preventing fertilization (Rivera et al. 1999). Copper ions decrease sperm motility and function by altering the uterine and tubal fluid environment, thus preventing sperm from reaching the fallopian tube and fertilizing the egg.

Effectiveness

The IUD is a highly effective form of long-term, reversible contraception, with an associated failure (pregnancy) rate of less than 1 % (0.8%) in the first year of use (Trussell2004a).

Effective Life

The latest scientific evidence shows that the TCu380A is effective for at least 12 years (United Nations Development Programme et al. 1997), although the US Food and Drug Administration (USFDA) has approved it for only 10 years (as of this printing). Clients who have had a Copper T inserted should be advised that it should be replaced or removed 12 years from the date of insertion.

Shelf Life

According to the USFDA, the shelf life of each presterilized Copper T 380A insertion package is 7 years. It is important to note that the expiration date on the IUD package refers only to the shelf life of the sterility of the package, and not to the contraceptive effectiveness of the IUD itself. This means that even if an IUD is inserted on the day before the expiration date (provided the package is not torn or damaged), it is still effective for the full lifespan of contraceptive efficacy. In other words, the Copper T 380A would be effective for a full 12 years from that date. On the expiration date, the IUD should be discarded.

Advantages

The IUD has the following advantages:

- Highly effective and very safe
- Reversible and economical
- May be safely used by lactating and immediate postpartum women
- Good choice for women who cannot use other methods
- Long duration of use (up to 12 years for TCu 380A)
- Once inserted they are convenient and extremely easy to use, providing worry-free continuous protection
- Allows privacy and control over her fertility (Client does not have to use anything at the time of sexual intercourse.)
- Does not interact with medications client may use
- No systemic side effects as its effects are confined to the uterus

Disadvantages

- Requires a pelvic exam to insert the IUD;
- Requires a trained health service provider to insert/remove the IUD
- Does not protect against STIs;
- Increases the risk for PID for women with STIs
- Device may be expelled, possibly without the woman knowing it (especially for postpartum insertions)

Return to Fertility

A client's fertility returns immediately after an IUD is removed (Andersson et al. 1992; Belhadj et al. 1986). This message should be made very clear to clients having an IUD removed: unless they want to get pregnant, they should have another IUD inserted immediately after removal (if desired and appropriate) or start another contraceptive method.

Health Benefits and Potential Health Risks

Nonhormonal IUDs, such as the Copper **T,** may protect against endometrial and cervical cancer (Hubacher and Grimes 2002).

Potential health risks associated with the IUD, which are uncommon or rare, are discussed below.

- ***Uterine perforation***

  Perforation of the uterus during IUD insertion has been shown to be rare, with fewer than 1.5 perforations per 1000 insertions occurring in large clinical trials (United Nations Development Programme et al. 1997; Trieman et al. 1995). This minimal risk is associated with level of provider skill and experience (Harrison-Woolrych et al. 2003). When the IUD is inserted by a skilled provider, the risk has been shown to be as low as 1 per 1000 insertions (WHO 1987) and 1 per 770-1600 insertions (Nelson 2000). If perforation occurs, the risk of serious complications is low and the need for surgical intervention rare (Penney et al. 2004).

- ***Expulsion***

  Although IUD failure is rare, expulsion is the most common cause (ARHP 2004). In the first year of IUD use, 2-8% of women spontaneously expel their IUDs (Trieman et al. 1995). There are several factors that increase the risk of expulsion:

  - skill and experience of the provider is the most common factor (Chi 1993)

    Correct insertion, with the IUD placed high in the uterine fundus, is thought to reduce the chances of expulsion.

  - timing

    Expulsion is most likely to occur within the first 3 months postinsertion and is more common in women who are nulliparous, have severe dysmenorrhea, or have heavy menstrual flow (Zhang et al. 1992).

    The risk of expulsion is higher (11-25% after 12 months of use) when the IUD is inserted immediately after childbirth (more than 10 minutes but less than 48 hours after delivery of the placenta) (Trieman et al. 1995), and higher when inserted immediately after a second-trimester abortion (Grimes, Schulz, and Stanwood 2002).

- ***Infection***

  According to the latest research, the risk of upper genital tract infection among IUD users is less than 1 %, which is much lower than previously thought. This minimal risk is highest within the first 20 days after IUD insertion, and is related to insertion technique (due to lack of proper infection prevention practices) rather than to the IUD itself (Hatcher et al. 2004). After the first 20 days, the risk of infection among IUD users appears to be comparable to that among non-IUD users (Hatcher et al. 2004).

Possible Side Effects

A common side effect of copper-bearing IUDs is menstrual changes. Use of the Copper T

has been associated with an increase of up to about 50% in the duration/amount of menstrual bleeding, and this is the most common reason for removal (Penney et al. 2004). Changes in bleeding patterns, such as spotting/light bleeding (between periods), may also occur in the first few weeks. Finally, some women may experience discomfort or cramping during IUD insertion (Grimes 2004) and for the next several days. Cramping/ pain and changes in bleeding amount/patterns usually are not harmful for the client and often subside within the first few months after IUD insertion. Women should be advised of this common side effect before IUD insertion, and assessed for and counseled about it if needed afterward. Non-steroidal anti-inflammatory drugs (NSAID) can lessen symptoms (WHO 2004b), and good counseling can encourage continued use of the method (Backman et al. 2002; Zetina-Lozano 1983).

Warning Signs

The service provider should instruct the client to immediately seek consultation when:

- She thinks that she may be pregnant. This is when she has missed a menstrual period and has signs of pregnancy.
- She thinks that the IUD might be out of place. For example when, the strings are missing or the hard plastic of the IUD is felt.
- She has symptoms of infection like increasing or severe pain in the lower abdomen, pain during sexual intercourse, unusual vaginal discharge, fever, chills, nausea and/or vomiting.

The signs of complication can be easily remembered **PAINS**

Period late

Abdominal pain

Infection

Not feeling well

Strings missing or longer

Addressing Common Misconceptions About the IUD

Many misconceptions about the IUD remain despite scientific evidence to the contrary. The following section presents recent research to refute some of these misconceptions, while providing a basis for new recommendations and practices related to IUD.

The IUD *does not* act as an abortifacient.	Studies suggest that the IUD prevents pregnancy primarily by preventing fertilization rather than inhibiting implantation of the fertilized egg (Rivera et al. 1999; Alvarez et al. 1988; Segal et al. 1985). This is particularly true of the copper -bearing IUDs.
The IUD *does not* increase a client's risk of ectopic pregnancy. **The absolute number of ectopic pregnancies among IUD users is much lower than that among the general population.**	The IUD reduces the risk of ectopic pregnancy by preventing pregnancy. Because IUDs are so effective at preventing pregnancy, they also offer excellent protection against ectopic pregnancy. Women who use copper-bearing IUDs are 91 % less likely than women using no contraception to have an ectopic pregnancy (Sivin 1991). The following points should be considered:

	○ Less than 1% of IUD users become pregnant which reduces a woman's risk for ectopic pregnancy. ○ IUD users are 50% less likely to have an ectopic pregnancy than are women using no contraception. ○ However, in the unlikely event that an IUD user becomes pregnant, she has equal chances of having an ectopic pregnancy as non-users. Since ectopic pregnancy is a serious condition that requires emergency care, this condition must be considered. ○ Among IUDs, the TCu380A and Multi[oad Cu375 are lowest in rates of ectopic pregnancy (WHO 1987). A long-term study of women using the TCu380A found the rate to be less than 1 (0.09%) per 100 women at 1 year, and less than 1 (0.89%) per 100 women at 10 years (Ganacharya, Bhattoa, and Batar 2003). ○ Women with a history of ectopic pregnancy can use the IUD with no restrictions.
The IUD *does not* cause PID, nor does the IUD need to be removed to treat PID.	Strict randomized controlled trials and literature reviews reveal that PID among IUD users is rare (ARHP 2004; Grimes 2000). Early studies that reported a link between PID and IUD use were flawed and poorly designed. Inappropriate groups were used for comparison, infection in IUD users was over-diagnosed, and there was a lack of control for confounding factors (Buchan et al. 1990; Vessey et al. 1981). Here are some important points about PID and the IUD based on more recent research: ▪ During the first 3-4 weeks after IUD insertion, there is a slight increase in the risk of PID among IUD users compared to non-IUD users, **but it is still rare** (less than 7/1000 cases). After that, an IUD user appears to be no more likely to develop PID than a non-IUD user (Farley et al. 1992). ▪ PID in IUD users is caused by the STIs gonorrhea and chlamydia, not the IUD itself (Darney 2001; Grimes 2000). However, the risk is still very low, with an estimated 3 cases per 1000 insertions in settings with a high prevalence (10%) of these STIs (Shelton 2001). ▪ If PID occurs, the infection can be treated while the IUD is kept in place, if the client so desires. Studies have shown that removing the IUD does not have an impact on the clinical course of the infection. If the infection responds to treatment within 72 hours, the IUD does not need to be removed (WHO 2004b). ▪ Randomized controlled trials and cohort studies reveal that

	the monofilament string does not increase the risk of PID (Grimes 2000). ▪ Women who have a history of PID can generally use the IUD (the advantages generally outweigh the risks), provided their current risk for STIs is low.
The IUD ***does not*** cause infertility.	Infertility caused by tubal damage is associated not with IUD use, but with chlamydia (current infection or --- as indicated by the presence of antibodies--- past infection) (Hubacher et al. 2001). Moreover, there is an immediate return to fertility after an IUD has been removed (Belhadj et al. 1986). In one study, 100% of women who desired pregnancy (97 of 97) conceived within 39 months of IUD removal (Skjeldestad and Bratt 1988).
The IUD ***is suitable*** for use in nulliparous women.	Nulliparous women can generally use the IUD (the advantages generally outweigh the risks). In theory, the smaller size of a nulligravid uterus may increase the risk of expulsion, whereas uterine enlargement, even if due to an abortion, may promote successful IUD use (Hatcher et al. 2004). Expulsion rates tend to be slightly higher in nulliparous women compared to parous women (Grimes 2004).
The IUD ***can be*** safely used by HIV-infected women who are clinically well.	HIV-infected women who are clinically well can generally use the IUD (the advantages generally outweigh the risks). A large study in Nairobi showed that HIV-infected women had no significant increase in the risk of complications, including infection in early months, than HIVnegative women (Sinei et al. 2001). In another study ofHIV-infected and HIV-negative IUD users with a low risk of ST!, no differences were found in overall or infection-related complications between the two groups (Sinei et al. 1998).
The IUD ***does not*** increase the risk of HIV transmission.	There is no current evidence that use of the IUD in HIV-infected women leads to increased risk of HI V transmission. Studies have shown that among HIVinfected women using the IUD, there is no increase in viral shedding and no statistically significant increase in HIV transmission to male partners (ARHP 2004; Richardson et al. 1999).
The IUD ***does not*** interfere with ARV therapy.	Women who have AIDS, are on ARV therapy, and are clinically well can generally use the IUD (advantages generally outweigh the risks). Because it is a non-hormonal family planning method, the IUD is not affected by liver enzymes and will not interfere with or be affected by ARV therapy (ARHP 2004; Hatcher et al. 2004).

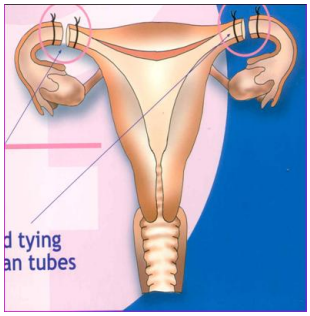
SUB-SESSION 2
BILATERAL TUBAL LIGATION

VOLUNTARY SURGICAL CONTRACEPTION

- BILATERAL TUBAL LIGATION **(BTL)**
- NON-SCALPEL VASECTOMY **(NSV)**

What is BTL?

- **A safe and simple surgical procedure which provides permanent contraception for women who do not want any more children**
- **Involves cutting or blocking the 2 fallopian tubes**



Mechanism of Action

- **The service provider makes a small incision in the woman's abdomen and ties and cuts the 2 fallopian tubes on each side of the uterus. These tubes carry eggs from the ovaries to the uterus.**
- **With the tubes blocked, the woman's egg cannot meet the man's sperm.**
- **The woman continues to have menstrual periods after BTL.**

Effectiveness

- **BTL is very effective with an effectiveness rate of 99.5%.**
- **Effectiveness depends partly on how the tubes are blocked, but pregnancy rates are low.**

Advantages

- **Very effective**
- **Permanent. A single decision leads to lifelong, safe prevention of pregnancy.**
- **Nothing to remember, no supplies needed, and no repeated clinic visits required**
- **No interference with sex. Does not affect the woman's ability to have sex.**
- **Increased sexual enjoyment because no need to worry about pregnancy.**

Advantages

- **Has no hormonal side effects**
- **No effect on breast milk.**
- **No known long-term side effects or health risks**
- **Can be performed just after a woman gives birth (immediately and within 7 days after childbirth)**
- **For interval cases, can be done 6 weeks after delivery.**
- **Can be performed at any day of the menstrual cycle provided you are reasonably sure that the woman is not pregnant.**

Disadvantages

- **Requires minor surgery**
- **Compared with vasectomy, BTL is:**
  - **Slightly more risky**
  - **Often more expensive**
- **Considered to be permanent as reversal surgery is difficult, expensive and success cannot be guaranteed**
- **If pregnancy happens (very rare), there is a greater risk for ectopic pregnancy compared to women who have not undergone the procedure**
- **Does not protect against STIs including HIV/AIDS**

Side Effects and Complications

There are no long-term side effects of BTL.

- **Common side effect: pain over the operative site which diminishes in a day or two.**

- **Complications of surgery, which include the following, are uncommon:**
  - **Infection or bleeding at the incision**
  - **Internal infection or bleeding**
  - **Injury to internal organs**
  - **Anesthesia risk:**
    - **With local anesthesia alone or with sedation, rare risk of allergic reaction or overdose**
    - **With general anesthesia, occasional delayed recovery and side effects. Complications are more severe than with local anesthesia.**

Warning Signs

- **Bleeding, pain, pus, heat, swelling or redness of the wound that becomes worse or is persistent. These are signs of infection of the incision site.**
- **High grade fever is a sign of more severe infection.**
- **Fainting, persistent light-headedness, or extreme dizziness**
- **Missed period which signifies pregnancy**

TIMING OF BTL

- **POSTPARTUM:**
  - IMMEDIATELY AFTER DELIVERY
  - DELAYED (12-24 hours post-partum)
    - DECREASED POSTPARTUM HEMORRHAGE
    - ASCERTAINED NEWBORN HEALTH
- **POST-ABORTAL**
  - IMMEDIATELY AFTER AN ABORTION
- **INTERVAL:**
  - WITHIN 1 WEEK OF MENSES
  - ANYTIME IF REASONABLY CERTAIN CLIENT IS NOT PREGNANT

Correcting Misconceptions

BTL:

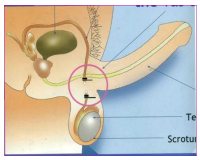
- **Does not make woman weak**
- **Does not cause lasting pain in the back, uterus or abdomen**
- **Does not remove woman's uterus or lead to a need to have it removed**
- **Does not cause hormonal imbalance**
- **Does not cause changes in menstrual bleeding**
- **Does not cause weight changes, appetite or appearance**
- **Does not affect mood or sexual drive**
- **Substantially reduces risk of ectopic pregnancy**

Non-Scalpel Vasectomy

VASECTOMY

- No scalpel vasectomy (NSV) is the DOH-approved procedure

- Vasectomy is known as male sterilization as it provides permanent contraception for men who decide they will not want any more children.
- It is a safe, simple and quick surgical procedure. The procedure can be done in a clinic or office with proper infection prevention practices.



Mechanism of Action

- The service provider makes a small puncture in the man's scrotum and ties and cuts the 2 vas. The vas carries sperm from the testicles.
- Semen is still produced and found in the tubes after the blocked vas
- With the 2 vas blocked, there will be no sperm in the semen.
- The man continues to have erections and ejaculate semen.

Effectiveness

- Vasectomy is very effective at 99.9% for correct use and 99.8% with typical use.
- More effective when used correctly. This means using condoms or his woman partner using another effective family planning method (e.g., pills, injectable) consistently for at least 3 months after the procedure and after a semen check showing no sperm has been performed.

Advantages

- **Very effective**
- **Permanent. A single decision leads to lifelong, safe and effective family planning**
- **Nothing to remember except to use condoms or another effective method for at least 3 months after the procedure**
- **Does not affect the man's ability to have sex.**
- **Increased sexual enjoyment because no need to worry about pregnancy.**

Advantages

- **No supplies to get, and no repeated clinic visits required**
- **No known long-term side effects or health risks**
- **Compared to BTL, vasectomy is:**
  - **More effective**
  - **Safer**
  - **Easier to perform**
  - **Less expensive**
  - **Able to be tested for effectiveness at any time**
  - **If pregnancy occurs in the man's partner, less likely to be ectopic**

Disadvantages

- **Requires minor surgery by a specially trained health care provider**
- **Not immediately effective. The couple should use another effective family planning method for at least 3 months after the procedure.**
- **Permanent. Reversal surgery is more difficult, expensive, may not be available in some areas, and success is not guaranteed. Men who may want to have more children in the future should choose a different method.**
- **Does not protect against STIs including HIV/AIDS**

Side Effects

- **Discomfort for 2-3 days**
- **Pain in the scrotum, swelling and bruising which decreases for about 2-3 days**

Warning Signs

- **Severe bleeding or blood clots after the procedure**
- **Redness, heat, swelling, pain at the incision site**
- **Pus at the incision site**
- **Pain lasting for months**

Correcting Misconceptions

Vasectomy:

- **Does not remove the testicles**
- **Does not decrease sex drive**
- **Does not affect sexual function**
- **Does not cause a man to grow fat or become less masculine or less productive**
- **Does not cause any illnesses in the future**
- **Does not prevent STI, HIV/AIDS**

- Bilateral tubal ligation (BTL) is known as female sterilization as it provides permanent contraception for women who will not want any more children.
- It is a safe and simple surgical procedure to tie and cut the 2 fallopian tubes located on both sides of the uterus.

MECHANISM OF ACTION

- The service provider makes a small incision in the woman's abdomen and ties and cuts the 2 fallopian tubes on each side of the uterus. These tubes carry eggs from the ovaries to the uterus.
- With the tubes blocked, the woman's egg cannot meet the man's sperm.

The woman continues to have menstrual periods after BTL.

EFFECTIVENESS

- BTL is very effective with an effectiveness rate of 99.5%.
- Effectiveness depends partly on how the tubes are blocked, but pregnancy rates are low.

ADVANTAGES

- Very effective
- Permanent. A single decision leads to lifelong, safe prevention of pregnancy.
- Nothing to remember, no supplies needed, and no repeated clinic visits required
- No interference with sex. Does not affect the woman's ability to have sex.
- Increased sexual enjoyment because no need to worry about pregnancy.
- Has no hormonal side effects
- No effect on breast milk.
- No known long-term side effects or health risks
- Can be performed just after a woman gives birth (immediately and within 7 days after childbirth)
- For interval cases, can be done 6 weeks after delivery.
- Can be performed at any day of the menstrual cycle provided you are reasonably sure that the woman is not pregnant.

DISADVANTAGES

- Requires minor surgery
- Compared with vasectomy, BTL is:
    - Slightly more risky
    - Often more expensive
- Considered to be permanent as reversal surgery is difficult, expensive and success cannot be guaranteed

- If pregnancy happens (very rare), there is a greater risk for ectopic pregnancy compared to women who have not undergone the procedure
- Does not protect against STIs including HIV/AIDS

POSSIBLE SIDE EFFECTS

There are no long-term side effects of BTL.

- Common side effect: pain over the operative site which diminishes in a day or two.
- Complications of surgery, which include the following, are uncommon:
  - Infection or bleeding at the incision
  - Internal infection or bleeding
  - Injury to internal organs
  - Anesthesia risk:
    - With local anesthesia alone or with sedation, rare risk of allergic reaction or overdose
    - With general anesthesia, occasional delayed recovery and side effects. Complications are more severe than with local anesthesia.

TIMING OF BTL

Timing of performing BTL can either be:

- Postpartum,
- Interval, or
- Postabortion

Postpartum BTL

BTL can be performed immediately or within 7 days after childbirth. The procedure is not recommended between 8 days to 6 weeks postpartum due to difficulty in accessing the tubes at this time and greater risk for infection.

Interval

When not associated with a recent pregnancy, BTL can be performed:

- From 6 weeks after childbirth if it is reasonably certain that the woman is not pregnant.
- Within 7 days after the start of the woman's menstrual cycle.
- At any time convenient for the woman if it is reasonably certain that she is not pregnant.

Postabortion

After a miscarriage, BTL can be performed after 48 hours after an uncomplicated miscarriage (i.e., no signs of infection, no heavy bleeding).

WARNING SIGNS

Problems affect women's satisfaction with BTL. It is, therefore, important that the service provider attends to clients complaining of the following warning signs of complications and refer her to a facility or health service provider who can assess and manage her complaint.

These warning signs are:

- Bleeding, pain, pus, heat, swelling or redness of the wound that becomes worse or is persistent. These are signs of infection of the incision site.
- High grade fever is a sign of more severe infection.
- Fainting, persistent light-headedness, or extreme dizziness
- Missed period which signifies pregnancy

Correcting Misconceptions

BTL:

- Does not make woman weak
- Does not cause lasting pain in the back, uterus or abdomen
- Does not remove woman's uterus or lead to a need to have it removed
- Does not cause hormonal imbalance
- Does not cause changes in menstrual bleeding
- Does not cause weight changes, appetite or appearance
- Does not affect mood or sexual drive
- Substantially reduces risk of ectopic pregnancy

SUB-SESSION 3
NO SCALPEL VASECTOMY (NSV)

- Vasectomy is known as male sterilization as it provides permanent contraception for men who decide they will not want any more children.
- It is a safe, simple and quick surgical procedure. The procedure can be done in a clinic or office with proper infection prevention practices.

MECHANISM OF ACTION

- The service provider makes a small puncture in the man's scrotum and ties and cuts the 2 vas. The vas carries sperm from the testicles.
- Semen is still produced and found in the tubes after the blocked vas
- With the 2 vas blocked, there will be no sperm in the semen.
- The man continues to have erections and ejaculate semen.

EFFECTIVENESS

- Vasectomy is very effective at 99.9% for correct use and 99.8% with typical use.
- More effective when used correctly. This means using condoms or his woman partner using another effective family planning method (e.g., pills, injectable) consistently for at least 3 months after the procedure and after a semen check showing no sperm has been performed.

ADVANTAGES

- Very effective
- Permanent. A single decision leads to lifelong, safe and effective family planning
- Nothing to remember except to use condoms or another effective method for at least 3 months after the procedure
- Does not affect the man's ability to have sex.
- Increased sexual enjoyment because no need to worry about pregnancy.
- No supplies to get, and no repeated clinic visits required
- No known long-term side effects or health risks
- Compared to BTL, vasectomy is:
    - More effective
    - Safer
    - Easier to perform
    - Less expensive
    - Able to be tested for effectiveness at any time
    - If pregnancy occurs in the man's partner, less likely to be ectopic

DISADVANTAGES

- Requires minor surgery by a specially trained health care provider
- Not immediately effective. The couple should use another effective family planning method for at least 3 months after the procedure.
- Permanent. Reversal surgery is more difficult, expensive, may not be available in some areas, and success is not guaranteed. Men who may want to have more children in the future should choose a different method.
- Does not protect against STIs including HIV/AIDS

POSSIBLE SIDE EFFECTS

- Discomfort for 2-3 days

- Pain in the scrotum, swelling and bruising which decreases for about 2-3 days

WARNING SIGNS OF POSSIBLE COMPLICATIONS

- Severe bleeding or blood clots after the procedure
- Redness, heat, swelling, pain at the incision site
- Pus at the incision site
- Pain lasting for months

CORRECTING MISCONCEPTIONS

Vasectomy:

- Does not remove the testicles
- Does not decrease sex drive
- Does not affect sexual function
- Does not cause a man to grow fat or become less masculine or less productive
- Does not cause any illnesses in the future
- Does not prevent STI, HIV/AIDS

MODULE 1: Introduction to the Contraceptive Subdermal Implant

SKILLS TRAINING COURSE IN CONTRACEPTIVE SUB-DERMAL IMPLANT INSERTION AND REMOVAL **MODULE 1** **Introduction to** **The Contraceptive** **Sub-dermal Implants (CSI)**	

LEARNING OBJECTIVES

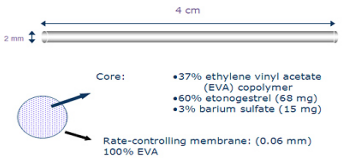
- **Discuss the Contraceptive Sub-dermal Implant in terms of its:**
  - **mechanism of action**
  - **advantages and disadvantages**
  - **effectiveness**
  - **return to fertility**
  - **possible side effects**
  - **health benefits and potential health risks**
- **Address common misconceptions on the Implant**
- **Provide evidence based facts in response to frequently asked questions about the Implant**

Description

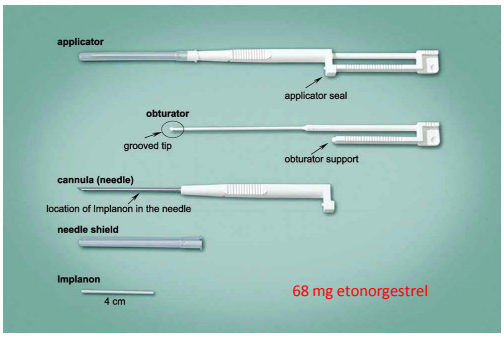
- An implant contraceptive containing a synthetic progestin, **etonogestrel**, an active metabolite of the third generation progestin, desogestrel;
- **Preparations (rods or capsules):**
  - **Implanon –** single rod, containing 68 mgs of etonogestrel, for 3 years (registered in 80 countries since 1998)
  - **Jadelle –** 2 rods, containing levonorgestrel, good for 5 years
  - **Zarin (Sino-Implant II) –** 2 rods, also with LNG, good for 4 years
  - **Norplant –** 6 capsules, good for 5-7 years (Phased out in 2012)

Description

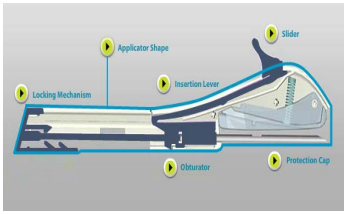
- IMPLANON- 4 cm long and 2 mm in diameter and is made of a soft, copolymer (ethylene vinyl acetate or EVA)
- Inserted just below the skin on the inner side of a woman's non-dominant upper arm.



Delivery System of Implanon



Delivery System of Implanon NXT



Mechanism of Action

- **Inhibits Ovulation**
  - **Ovulations were not observed in the first 2 years of use of the implant and only rarely in the third year, The decrease in FSH and LH prevents the LH surge.**
- **Thickens the Cervical Mucus**
  - **The cervical mucus becomes thick, and decreased amount, making sperm penetration difficult.**
  - If inserted at the right time of the cycle, IMPLANON is effective immediately (within 24-72 hours).
- **Etonogestrel (ENG) levels over 3 years**

Weeks 5-6	60-70 mcg
Year 1	35-45 mcg
Year 2	30-40 mcg
Year 3	25-30 mcg

EFFECTIVENESS

Highly effective

- **Perfect use: 99.95%**
- **Common/typical use: 99.95%**

Effectiveness is dependent on having implant inserted and replaced on time.

ADVANTAGES

- It is convenient, safe, and over 99% effective.
- Prevents against pregnancy for up to 3 years, can be removed anytime client wants it removed.
- Return of fertility is immediate upon removal.
- It is invisible but palpable.
- Can be used without anything else.

DISADVANTAGES

- Removal issues: cost and in few cases, difficulty in removal.
- Side effects: headaches, severe stomach and abdomen pains, irregular bleeding, hair loss, nausea, nervousness, pain at insertion site, sore breasts, etc.
- The implant could come out if not properly inserted.
- This does not offer protection from STIs.

Side Effects

- Changes in Menstrual Pattern – ranges from amenorrhea to heavy menstrual bleeding
- Dysmenorrhea
- Headache
- Body Weight Changes
- Acne and other skin reactions
- Breast tenderness
- Abdominal pain
- Emotional lability

Potential Complications

- **Infection at site of insertion**
- **Persistent Ovarian Follicles**

Warning Signs

- **Severe headaches**
- **Heavy bleeding = twice as much and twice as long**
- **Severe lower abdominal pain**
- **Signs of pregnancy**
- **Unresolved infection at insertion site**

Correcting Misconceptions	
Implants: – **Stop working once removed. Their hormones do not remain in the woman's body,** – **Can stop monthly bleeding but this is not harmful. Blood is not building up inside the woman's body** – **Do not make women infertile** – **Do not move to other parts of the body** – **Substantially reduce the risk of ectopic pregnancy**	

The Department of Health, in its initiative to fill the unmet needs for modern Family Planning in the Philippines, which stands at 19.3% (spacing, 10.5% ; limiting, 8.8%) highlights Long-Acting and Permanent Method (LAPM) in filling this needs.

In a low resource setting such as the Philippines, a contraceptive option that is safe, highly effective, long-acting and well-accepted should be included in the contraceptive menu offered to Filipino women. The contraceptive subdermal implants are of two variants: the 2-rods levenorgestrel containing implants (e.g. Jadelle) and the single-rod etonogestrel implants (e.g. the classic and the NXT Implanon).

The single-rod etonogestrel implant is a progesterone-only subdermal contraceptive that is effective for 3 years but may be removed before that if the woman so wishes, with prompt return of fertility. It is 99.95% effective in preventing pregnancy and has a very good continuation rate of 84% in 1 year compared with other reversible methods.

The provider who wishes to insert etonogestrel implants should undergo training to make sure that the correct technique is utilized. Most of the pregnancies that result after insertion are due to incorrect technique or the wrong day in the menstrual cycle when it was inserted.

Currently, the2 etonogestrel single-rod implant systems are now available for use as part of the Philippine Family Planning Program (PFPP). Both have 68-mg etonogestrel rod, 4 cm in length, about the size of a matchstick, which is preloaded in a disposable applicator. The classic requires 2-hand application in contrast the the NXT which can be inserted with 1 hand. NXT can be detected by X-ray because it has barium which the classic does not have.

The discussion in this module pertains to both the classic and the NXT and the technique of insertion will be separately described and illustrated for the classic and the NXT.

The active drug, etonogestrel, a metabolite of a third generation progestin, Desogestrel, is contained in an ethylene vinyl acetate membrane that allows gradual and continuous release

into the bloodstream for 3 years. The rate of diffusion decrease over 3 years but on the 3rd year, the concentration of the drug in the bloodstream remains inhibitory to ovulation.

Week 5-6	**60 – 70 mcg**
Year 1	**35 – 45 mcg**
Year 2	**30 – 40 mcg**
Year 3	**25 – 30 mcg**

Mechanism of Action

There are 2 primary mechanisms of actions through which etonogestrel exert its contraceptive effects:

1. **Thickening of the cervical mucus preventing sperm entry into the uterus;**
2. **Inhibition of ovulation**

Single-rod etonogestrel implants are immediately effective within 24-72 hours of insertion the level of the active drug in the bloodstream effectively thickens and lessens cervical mucus preventing sperm penetration. This mechanism of action is most likely more important among the 2 mechanisms of action of ETG.

With the small amount of etonogestrel hormones released into the bloodstream, ovulation is inhibited through negative feedback in the pituitary and the hypothalamus which lowers the secretion of FSH and LH preventing adequate LH surge in the mid-cycle that is necessary for ovulation to occur. The inhibitory level of ETG is reached in 24 hours post-insertion.

Effectiveness

There has been worldwide clinical experience through research and clinical evaluation with the single-rod etonogestrel implants all of which gives more than ample evidence of how effective the method is. The quoted effectiveness of this method is 99.95% which means that there will be 5 pregnancies in 10,000 users in the first year. Over 3 years there will be 1 pregnancy in 1,000 users.

Effectiveness is one of the factors that a woman or a couple considers before deciding on a method. Because the 1-rod etonogestrel implant is not user-dependent in terms of effectiveness as there are no missed pills for oral contraceptives or missed appointments for hormonal injections, the typical and perfect effectiveness of the method is the same at 99.95%.

Comparing the effectiveness of the various contraceptive methods offered to a woman is an important aspect of counselling and should be presented using a job-aid such as the chart in Figure 1.

In certain medical conditions such as epilepsy, tuberculosis or HIV/AIDS, the medications used to treat them nay reduce the effectiveness of ETG. Anti-epilepsy drugs, such as barbiturates, phenytoin and carbamazepine, anti-Tb drug rifampicin and HIV/AIDS medication such as non-nucleoside reverse transcriptase inhibitors (NNRTIs) and ritonavir-boosted protease inhibitors induce an increase of liver enzymes that break down ETG. It should be noted, however, that such is minor and the WHO MEC (2011) still categorize clients who are on these drugs as Category 2 which means that they can generally use ETF implants. Caution, however, should be given to clients and use of condom for dual protection should be advised.

Advantages

It is convenient, safe, and over 99% effective. It prevents against pregnancy for up to 3 years, and can be removed anytime client wants it removed. Return of fertility is immediate upon removal. It is invisible but palpable. It can be used without anything else.

Pregnancy

Pregnancies following the insertion of ETG implant in the experience of the UP-PGH-Ortoll Reproductive Health Center from 2011-2013 were mostly due to wrong timing of insertion. Those who were pregnant on follow up were retrospectively assessed (eg. Ultrasound dating of pregnancy)to be already pregnant when the implant was inserted. These were assured that ETG implants do not cause birth defects and no special care was needed other than removal of the implant. This experience clearly underscores the importance of conscientious and meticulous screening for pregnancy prior to insertion.

One of the misconceptions that may be encountered with the use of the ETG implants is that it increases the frequency of ectopic pregnancy. The ectopic pregnancy rate is 2.7-3.0 per 1,000 woman-years in women aged 15-44 who are not using any contraceptive method. Compare this with the ectopic pregnancy rate of _____ in users of implant clearly showing that the frequency of ectopic pregnancy does not increase with the use of the ETG implants.

However, if a woman who had an ETG implant got pregnant, she should be evaluated for the possibility of ectopic pregnancy especially if she has lower abdominal pains and bleeding.

Possible Side Effects

The vast majority of ETG implant users will experience any one or 2 of the side effects attributed to the method. These side effects are manageable and not life-threatening. It is important to understand that although these side effects may be considered minor, they may not disturb the client that she would opt to discontinue the method. Those who had their ETG implants removed because of side effects may have received inadequate counselling and ineffective re-assurance from the provider. Making the client understand the likelihood of her

developing any one of the side effects and re-assuring her that these side effects do not harm in any way imperil her health should be emphasized in the counselling.

Changes in the menstrual pattern are the most common side effects encountered in ETG implant users. Because it is progesterone-only contraceptive, the estrogen levels in the users are unpredictable unlike COCs which provide a predictable and adequate level of estrogen and therefore better cycle control.

The type of menstrual changes that may develop in the first 3 months of insertion of the ETG implant is broadly predictive of the user's bleeding pattern. 20% of the ETG users will have amenorrhea and 20% will have frequent and/or prolonged bleeding. ETG users are more likely to have infrequent bleeding or amenorrhea rather than irregular bleeding. The bleeding profile in implant users is generally better compared with DMPA users.

Other side effects are likewise non-life-threatening and manageable but cause enough discomfort for the client to discontinue the method. These include headaches, abdominal cramps, acne, weight changes, breast tenderness, dizziness, mood changes and nausea. Whether these side effects are directly attributed to the ETG is not really clear.

Adverse Conditions

There are 2 adverse conditions that the providers of implants should know about; namely, infection and persistent ovarian follicles.

This training on ETG single-rod implant has a module on infection prevention which is universal to all procedures in the reproductive health field. Meticulous attention to skin cleansing, aseptic technique and correct placement of the rod will prevent infection and scar formation. It is not unusual for bruising and some tenderness to develop post-insertion but these improve in a couple of days. The rod should not be visible under the skin but must be readily palpable. The client should be told that some scar formation or darkening of the skin over the insertion entry may develop. Expulsion of the rod is not a problem if it is correctly inserted.

Progesterone-only contraceptive methods such as the POPs and DMPAs have been known to sometimes cause persistent ovarian follicles and this may likewise be seen in ETG implant users. The vast majority of the users who develop this adverse condition are asymptomatic and the cysts are discovered incidentally on routine pelvic examination or ultrasound. This condition does not require treatment unless complications such as torsion occur. Re-assurance when this condition is discovered is an important aspect of the management.

Implants and HIV/AIDS

ETG implants do not protect the users from STI, HIV/AIDS and hepatitis. Whether users of progesterone-only contraceptives including implants are at increased risk of acquiring HIV is not

really clear so the current recommendation of the WHO to strongly advise condom use and other HIV preventive measures in women on progesterone-only contraceptive method should be followed.

Correcting Misconceptions

Implants:

- Stop working once removed. Their hormones do not remain in the woman's body,
- Can stop monthly bleeding but this is not harmful. Blood is not building up inside the woman's body
- Do not make women infertile
- Do not move to other parts of the body
- Substantially reduce the risk of ectopic pregnancy

MODULE 2: Counseling for Contraceptive Subdermal Implant

MODULE OVERVIEW

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

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

This module develops the service provider's skills on counseling. As such, it will strengthen the provider's understanding of values, client's rights, and skills on interpersonal communication as basic capabilities for counseling. Counseling skills using the GATHER approach shall then be acquired as opportunities to practice these skills shall also be developed.

MODULE OBJECTIVE

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

SESSIONS

The module contains the following sessions:

Introduction to the Module

Session 1 Values Clarification

Session 2 Informed Choice and Voluntarism;

Session 2 Verification of Informed Consent

Session 3 Types of Communication in FP/RH

Session 4 Effective Communication Skills

Session 5 Steps in Counseling Using the GATHER Approach

Skills Training Course for Contraceptive Sub-dermal Implant Insertion and Removal **Module 2** **Counseling**	

OVERVIEW
 	
• **This module:**
  ◦ **Develops the service provider's skills on family planning counseling using the GATHER approach.**
  ◦ **Strengthens the provider's understanding of values, clients' rights, and skills on interpersonal communication as basic capabilities for counseling.**
 	
• **Knowledge, attitude, and skills acquired from this module will enable service providers to provide quality FP/RH services through effective counseling.**	

SESSION 1
VALUES CLARIFICATION

LEARNING OBJECTIVES

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

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

NARRATIVE

DEFINITION OF TERMS

Value is a belief, idea, principle, or standard that is important and treasured by an individual. Values can be influenced by various factors (i.e., education, culture, religion, and personal experiences). It influences an individual’s attitude and behavior.

We acquire and change our values by the experiences we have. Therefore, we acquire new values and may change old ones as influenced by the people we interact with, our education, age, marital status, health and economic status, number of children, and sometimes by politics.

Values are strengthened by repetition and by making it a way of life. These enhance our personal growth and development, and as affirmed by other people.

Examples of values are values that an individual put on honesty, integrity, honor, higher education, responsible parenthood.

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

Attitude is the observable, outward expression of one’s belief and value. Examples of attitudes are:

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

HOW CLIENT’S VALUES AFFECTS DECISION-MAKING

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

Different people may have similar or different values, depending on their experience, education, environment, social exposure, religion, and culture. Values may change through the years but adequate information, exposure, experience, and education may help other people develop desirable values. So that if an individual is given adequate and appropriate information

about certain conditions, situations, or practices, he or she will be guided through modeling to adopt new values. This can be true in making decisions regarding family planning.

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

- Rural mothers still prefer bigger families, while urban women are conditioned to have smaller families.
- When the availability of family planning methods is made public through mass media, there is increase in the number of clients who go to the clinic for services.
- Due to high value on health, adverse rumors and misinformation are feared by most clients.
- Better quality means higher acceptance by clients of family planning services.
- Health worker advice plays a vital role in client choices. Health workers are typically their first contact. The majority of clients' decisions are affected to a great extent when a health worker promotes family planning. Clients are likely to make voluntary decisions.
- Accessibility of service center and the availability of a contraceptive method in a nearby clinic make clients more likely to avail themselves of family planning services.

RESPONSIBILITY OF THE COUNSELOR IN CLIENT'S DECISION-MAKING

Clients have values, beliefs and experiences which shape their attitude towards family planning. It is the counselor's responsibility to help clients examine their attitudes and values, and understand the reason for their choices to make it suitable to their values and priorities.

FACTORS INFLUENCING FP DECISION-MAKING

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

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

KEY LEARNING POINTS

- Understanding our own values can help us better understand and respect the values of the client.
- Reflecting on our own values can help us set limits so we do not influence our clients by sharing our own personal views.
- There are many factors that influence client's decisions. We must remember that these are the same factors that affect OUR decision-making but influence us in different ways.

SESSION 2
INFORMED CHOICE and VOLUNTARISM

LEARNING OBJECTIVES

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

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

NARRATIVE

RIGHTS OF THE CLIENT

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

- **Information** – Clients have the right to accurate, appropriate, understandable, and

clear information related to reproductive health and sexuality, and to health overall. Informational materials for clients need to be available in all parts of the health care facility.

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

QUALITY OF CARE

The provision of quality Family Planning services is the main goal of the Philippine Family Planning Program. This quality of care is important to all service providers and service facilities whether public or private. But how do you know if the service you deliver is of quality?

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

The other aspect of quality services is the ability of the service provider to deliver and provide these services. As such, the delivery of quality services is influenced by a number of factors which the service provider is exposed to. This includes the quality of their work environment, the information and training they receive, and the equipment and supplies available to them.

The Needs of the Health Care Staff

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

Health care staff need:

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

INFORMED CHOICE

Informed choice requires full information about the risks and benefits of the methods available.

Informed choice involves effective access to information on reproductive choices and to the necessary counseling, services, and supplies that help individuals choose and use appropriate family planning methods.

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

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

Five Major Components of Informed Choice

- Provision of information to couples and individuals on reproductive choices, including counseling concerning pregnancy, breast-feeding, and infertility.
- Provision of counseling to ensure comprehension of information and to assist with decision-making.
- Provision of appropriate information on a range of family planning methods, including their advantages, disadvantages, and on accessing services and supplies.
- Provision of comprehensive information on the correct usage of the client's chosen method.
- Efforts to ensure that a range of methods is available to the user either through the service provider or through referral to another agency.

Informed choice increases client satisfaction in using a method, decreasing reservations or fears of possible side effects.

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

VOLUNTARISM

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

Compliance to Informed Choice and Voluntary Decision Principle

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

Key Points of the Principle	Clarification/Interpretation	Illustrative Examples (Case scenario)
Service providers and Barangay Health Workers (BHWs) should not be subject to quotas and targets	A quota or target is a predetermined number of births, FP acceptors, or acceptors of a particular method that service provider or BHWs is assigned or required to achieve. Indicators for planning, budgeting and reporting are exempted.	A community health worker is required to bring three BTL and five IUD acceptors to the clinic each month.
There will be no payment of incentives, bribes, gratuities or financial rewards to (1) any individual in exchange for becoming an FP acceptor, or (2) personnel for achieving a quota	The restriction on provider payment is based on achieving a quota or target expressed as a "predetermined number".	(1) Clinic Z provides a week's worth of rice to new FP acceptors. (2) Dr. X in his regular work for the DOH, normally performs 75 female sterilizations per

Key Points of the Principle	Clarification/Interpretation	Illustrative Examples (Case scenario)
or target.		month. He is told that he will be paid an extra Php 200.00 for each month in which he performs 100 or more sterilizations.
No person shall be denied any right or benefit based on their decision not to accept FP.		A community-based food program requires participants to use a method of FP in order to receive the food. Post-abortal women with complications needing appropriate services are required to accept FP methods in order to receive post-abortion services.
Comprehensible information about benefits and risks of the chosen method, including conditions that might render the method in advisable (i.e., contraindications) plus side effects shall be provided. This requirement may be satisfied through counseling, brochures, posters, or package inserts.	Provide comprehensive information on the range of methods and services or information about where they can be obtained.	In a busy health center with one provider, FP clients are routinely given pills and have IUDs inserted without any explanation about common side effects or warning signs of complications. There are no educational posters on the walls, no brochures available, and no health talks given.

INFORMED CONSENT

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

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

Importance of Informed Consent

a. Among clients who prefer temporary or spacing methods:
   - Ensures the clients receive the information they need to make informed, well-considered decision regarding fertility.
   - Ensures that the client make the decision of their own free will.
   - Helps to assure satisfied and well-informed clients.
   - Reduces the incidence of regrets, thus enhancing program's acceptability and prestige.

b. Among clients who have decided to undergo surgical contraception:

- Diminishes regret after the surgical procedure.
- Impresses upon clients that they are making an important and irrevocable decision.
- Serves as evidence of the client's request and can protect against charges of induced or uninformed sterilization.

SESSION 3

TYPES OF COMMUNICATION IN FP/RH

LEARNING OBJECTIVES

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

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

NARRATIVE

DEFINITION OF INFORMATION-GIVING, MOTIVATION AND COUNSELING

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

Some examples of information-giving:

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

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

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

can attract the interest of the general public or a target audience. Motivational messages are made up of information emphasizing the benefits of a method being promoted. No special setting is required for these activities.

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

Some samples of motivational messages:

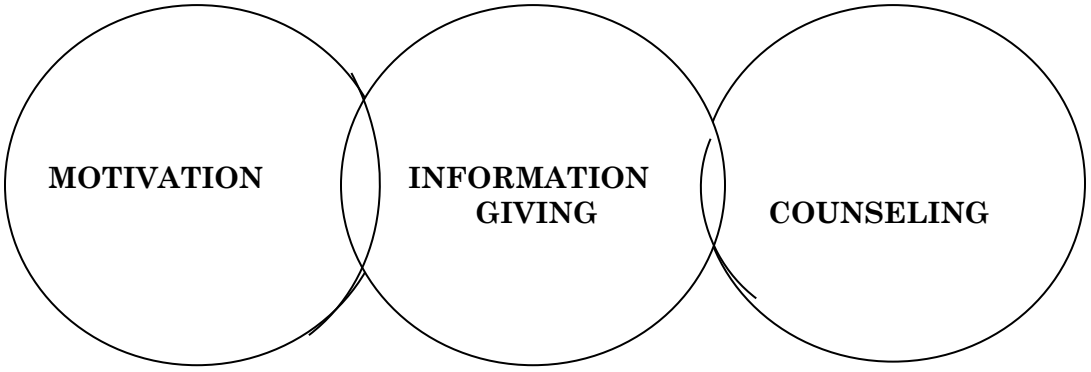
- billboard that promotes the use of specific brand of contraception
- advertisements in a men's magazine that promotes the use of condoms to prevent pregnancy and STI transmission.

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

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

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

TYPES OF FAMILY PLANNING COMMUNICATION DIAGRAM



TYPES OF FAMILY PLANNING COMMUNICATION

TYPE OF COMMUNICATION	GOAL	CONTENT	DIRECTION	BIAS	LOCATION
MOTIVATION OR PROMOTION	Influence an individual or group to adopt a certain practice or behavior	Advantages of family planning and the methods	One-way	Biased	Any-where
INFORMATION-GIVING	Provide facts	Facts about family planning and the methods	One-way	May be Biased	Any-where
COUNSELING	Assist the client make a free & informed decision	Facts, client's needs, situation, opinion, and feelings	Two-way	Not biased	Private

SESSION 4
EFFECTIVE COMMUNICATION SKILLS

LEARNING OBJECTIVES

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

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

NARRATIVE

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

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

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

NON-VERBAL COMMUNICATION

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

TONE OF VOICE

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

ASKING QUESTIONS

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

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

Questions can be used to:

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

There are three types of questions that a family planning counselor can use:

- Closed questions

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

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

- Open Questions

  These types of questions have many possible answers. They can encourage the client to talk about her or his thoughts, feelings, knowledge, and beliefs. These questions often begin with "how" or "what". The following are examples of open questions.

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

  Note: "Why " questions may be intimidating or seem judgmental. It is preferable to use "what" as in "what are your reasons for ….. " or

  "What makes you think …."

- Probing questions

  Probing questions help a counselor clarify the client's responses to open-ended questions. An example of a probing question is "Can you tell me how your friend's experience has made you feel about using DMPA?"

There is some overlap between open-ended question and probing questions. The

difference between these types of questions is clearer in actual discussions with clients when they appear in context. Probing questions follow open questions. Some additional examples are:

- ❖ "You said that you were concerned about the potential bleeding associated with DMPA. How would you feel about a method that does not cause menstrual disturbances?"

- ❖ "You told me that your husband wants to use a reliable method of contraception. What are your thoughts about bilateral tubal ligation?"

ACTIVE LISTENING

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

PARAPHRASING AND CLARIFYING

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

- **Paraphrasing** is restating the client's message simply. Counselors use paraphrasing to make sure that they have understood what a client said and to let the client know that they are trying to understand his or her basic message. Paraphrasing supports the client and encourages him or her to continue speaking.

  Example: *Client:* " I want to use the IUD, but my sister said that it an travel around your body and stick to the baby's head."

  Counselor: " You have some questions because of what you have heard about the IUD, and you want to find out what is true."

  Guidelines for Paraphrasing:

  1. Listen to the client's basic message
  2. Restate to the client a simple summary of what you believe is the basic message. Do not add any new idea.
  3. Observe a cue or ask for response from the client that will confirm or deny the accuracy of the paraphrase.
  4. Do not restate negative images clients may have made about themselves in a way that confirms this perception. For example, if the client says "I feel stupid asking this," it is not proper to say "You feel ignorant"

- **Clarifying** is making an educated guess about the client's message for the client to confirm or deny. Like paraphrasing, clarifying is a way of making sure the client's message is understood. The counselor uses clarifying to clear up confusion if a client's response are vague or not understandable.

  Example: Client: "I am using the pill and like it, but my sister says that with DMPA I do not need to remember to take anything"
  Counselor: "Let me see if I understand you. You are thinking about switching from the pill to DMPA, because DMPA would be more convenient for you."

  Guidelines for clarifying:

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

USING SIMPLE LANGUAGE

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

SESSION 5

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

LEARNING OBJECTIVES

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

1. Explain the G-A-T-H-E-R approach to counseling.
2. Describe each step in the G-A-T-H-E-R approach to counseling.

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

NARRATIVE

A simplified concept in family planning counseling is **GATHER**. The acronym stands for **greet, ask/assess, tell, help, explain,** and **return** for follow-up or **referral**. This is merely a suggested guide of steps and topics to cover while the provider and client engage in an interactive two-way discussion of the client's needs and risks. The steps help the client go through the process of learning, weighing choices, making decisions and carrying out these decisions. In the role of helping the client choose a method, the counselor uses a specific set of skills and knowledge for

each step.

GATHER provides a useful framework, but this does not mean that it must be followed exactly or in sequential order during the counseling session. Good counseling is flexible. The counseling process depends on the needs and situation of the client, so that the length and the content of these steps vary.

GATHER is an acronym which stands for the six steps of family planning counseling.

The acronym serves as a guide for the counselor as she performs counseling.

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

GATHER stands for:

- **G:** Greet the client
- **A:** Ask the client about herself, Assess her knowledge, needs and risks (including risks for sexually-transmitted infections like HIV/AIDS)
- **T:** Tell the client about family planning methods based on her needs and knowledge
- **H:** Help the client choose a method
- **E:** Explain how to use the method
- **R:** Return for follow-up and Refer for services

THE "G" (GREET) STEP

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

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

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

THE "A" (ASK/ASSESS) STEP

The **A** step which is the second step in the GATHER technique **asks** clients about themselves and **assesses** their reproductive needs, family planning knowledge, STI risks, and relation with

partner..

The tasks of the “A” step are:

- Ask the client about self (use FP form I). This will include:
    - General data
    - Medical/OB-Gyne History
    - Physical Examination
- Check if there are any existing medical conditions that will not warrant the use of a specific FP method.
- Assess the client’s reproductive need
    - Ask client when she/he plans to have their next baby
    - Client’s reproductive need can be classified into 3 categories

METHODS	Reproductive Need		
	Short Term (<3 yr)	**Long Term (≥3 yrs)**	**Permanent (no more children)**
	Condom, LAM, NFP, Pills, DMPA, IUD, Implant	NFP, pills, DMPA, IUD, Implant	BTL, Vasectomy, DMPA, IUD, Implant

- Ask client’s knowledge and previous use of FP
    - What do you know about FP?
    - Have you used any method in the past? If yes, what method and for how long? Are you satisfied with the method? If no, why?
    - Correct any misconceptions if there are.
- Assess client’s STI Risks
    - Find out if the client knows or suspects that her / his partner may be engaging in sex with other partners or if the client herself / himself might have other partners by asking indirect questions beginning with
        - ✓ How is your relationship with your husband / wife / partner? Or ask:
        - ✓ Have you or your partner ever been treated for STIs in the past?

- For a woman, ask:
    - Do you have any of the following?

- ✓ Unusual discharge from your vagina?
- ✓ Itching or sores in or around your vagina?
- ✓ Pain or burning sensation

- For a man, ask:
  - Do you have any of the following?
    - ✓ Pain or burning sensation
    - ✓ Open sores anywhere in your genital area?
    - ✓ Pus coming from your penis?
    - ✓ Swollen testicles or penis?
- If answer is YES to any of the questions above, refer the client for treatment. Talk to the client about the use of condom.
- Assesses for Violence Against Women (VAW) – you may ask the following questions
  - How is your relationship with your husband or partner?
  - Does she know about your coming here in the clinic?
  - Is he willing to cooperate or support you in using FP method?

  For any indication of VAW, refer client to the nearest Women's Crisis Center.
- Assess the possibility of pregnancy. The provider can be reasonably sure that the woman is not pregnant if:
  - Her menstrual period started within the last 7 days
  - She gave birth within the last 4 weeks
  - She had an abortion or miscarriage within the last 7 days
  - She gave birth within the last 6 months, is fully breastfeeding, and has not yet had a menstrual period
  - She has not had sexual intercourse since her last menstrual period
  - She uses a modern/reliable family planning method correctly

  Even if she has been using a family method correctly but her last menstrual period is more than 5 weeks ago and she had sex, pregnancy cannot be ruled out. An exception is if she is using a progestin-only injectable.
- If not reasonably sure that the woman is not pregnant, the counselor should ask her about signs of pregnancy.

Early signs of pregnancy	Later signs of pregnancy (more than 12 weeks from last menses)
▪ Late menstrual periods	▪ Larger breasts
▪ Breast tenderness	▪ Darker nipples
▪ Nausea	▪ More vaginal discharge
▪ Vomiting	▪ Enlarging abdomen
▪ Weight gain	▪ Movements of the baby
▪ Always tired	
▪ Mood changes	
▪ Changed eating habits	
▪ Urinating more often	

- If the woman has had several of these signs, she may be pregnant.
- If the woman's answer or the physical examination cannot rule out pregnancy, she can either:
    - Have a pregnancy test; or,
    - Wait until her next menstrual period before starting a method that should not be given during pregnancy.
- Assess the client's condition using the FP Service Record to identify the health status of the client and abnormal conditions he/she may have. Findings of this assessment may then be looked up in the WHO Medical Eligibility Criteria to determine suitability of the client for using the chosen method.
- Category 3 and 4 conditions indicate that the method cannot be provided.

Revisit Clients

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

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

THE "T" (TELL) STEP

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

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

The tasks under the T step are:

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

THE "H" (HELP) STEP

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

- Ask the clients if there is anything they did not understand; repeat information as needed.
- Ask client what additional information is needed to help her / him make a decision.
- Ask clients what method they heard about during the "tell" step that interests them the most.
- Determines client's suitability for his/her chosen method using the specific MEC Checklist for the chosen FP method.
- Asks the clients how they think they will tolerate possible side effects of the chosen method.
- If the client decides not to use a method, tell the client about:
    - Possibility of pregnancy
    - Availability of pre-natal services

- Assure the client that they can return to see you at any given time should they decide to use a FP method.

THE "E" (EXPLAIN) STEP

After a thorough assessment of the client during the "**A**" step, telling the client about appropriate family planning methods during the "**T**" step and helping the client to choose a method in the "**H**" step, the client finally chooses a method she can use. The counselor then provides the method and explains, the "**E**" step, how to use the method.

The main tasks of the E step are the following:

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

Revisit Clients

Ask clients to tell you how she/he uses the present method and the warning signs for the method.

Repeat instructions on how to use the method and/or the warning signs if what client said were incomplete or in correct.

THE "R" (REFER/REVISIT) STEP

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

Routine and emergency follow-up are defined as:

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

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

client's satisfaction and safety while using the chosen method.

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

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

The tasks of the R step are:

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

During return/follow-up visits, the counselor:

- Reviews the chart for the details of the health history
- Asks the client how s/he feels with the method and if s/he has any questions.
- If s/he is having any problems with the method, assesses the nature of the problem and discusses possible solutions.
- If the problem is a side-effect, assesses how severe it is and offers suggestions for managing it or refers the client for treatment.
- If the client is not using the method any more, asks why not (it may be due to problems related to misunderstanding, side-effects or supply).
- If the client still wishes to continue using a contraceptive, answers her/his questions and provides information that will enable her/him to continue with a contraceptive of choice.
- If the client is still using the method, determines if it is being used correctly. Asks the client how s/he is using the method. Re-enforces instructions on the correct use of the method, if necessary.
- Ensures that the client receives re-supplies and an appropriate examination, if necessary.

- Assists the client in selecting another contraceptive method if the client is not satisfied with a method, if her/his situation has changed, or if the method is no longer safe.
- If the client wishes to become pregnant, helps her to stop her method and provides information on the return of fertility. Emphasizes the importance of antenatal care which the midwife can provide.

Bear in mind that especially for revisit clients, counseling should be conducted again, using the appropriate GATHER steps. The tasks enumerated above may fall under the different steps of the GATHER Approach.

MODULE 3: INFECTION PREVENTION IN CONTRACEPTIVE SUBDERMAL IMPLANT SERVICES

MODULE OVERVIEW

Correct infection prevention techniques during the provision of FP services is crucial to the safety of both clients and service providers. The purpose of this module is for service providers to practice appropriate infection prevention techniques.

MODULE OBJECTIVES

At the end of this module, participants will be able to understand the appropriate infection prevention practices to reduce the risk of disease transmission during the provision of FP services.

MODULE SESSIONS

Session 1: The Disease Transmission Cycle and Infection Prevention Definitions

Session 2: Infection Prevention Measures

SKILLS TRAINING COURSE IN CONTRACEPTIVE SUB-DERMAL IMPLANT INSERTION AND REMOVAL MODULE 3 INFECTION PREVENTION	

SESSION 1

THE DISEASE TRANSMISSION CYCLE

OBJECTIVES

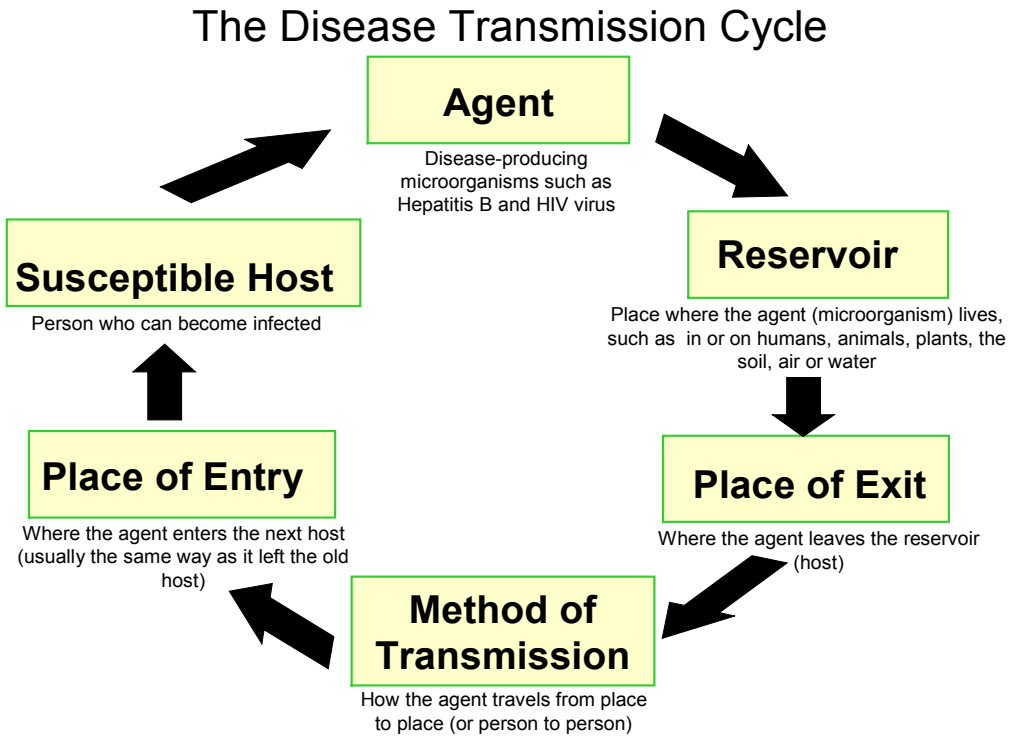
At the end of the session, participants will be able to:

1. Discuss the disease transmission cycle.
2. Explain infection prevention as it relates to family planning service provision.
3. Define infection prevention terms and processes.

NARRATIVE

THE DISEASE TRANSMISSION CYCLE

Infection prevention in family planning refers to the prevention of the spread of infection during the provision of FP services. It aims to protect both the clients and providers from the spread of infectious diseases. Infection prevention procedures are simple, effective and inexpensive.



- The **agent** refers to the infectious microorganisms (germs) which can cause disease such as:

    - Bacteria = staphyloccus, Clostridia tetani which causes tetanus
    - Viruses = Hepatitis B, HIV
    - Fungi and parasites
- Where the agent lives is the **reservoir**. This can be humans, animals, plants, soil, air and water. In humans, the reservoir is usually, the blood, body fluids, and tissues.
- The **place of exit** is the manner by which the agent leaves the reservoir and is transmitted from place to place or person to person. The mode of transmission could be through:
    - Contact – direct transfer of microorganisms through touch, sexual intercourse, fecal/oral transmission and droplets.
    - Vehicle – materials that serves as a means of transfer of the microorganisms. This can be blood (HIV, HBV) water (cholera, shigella), food (salmonella) or instruments and other items used during the procedures.
    - Airborne – carried by air currents (measles, TB)
    - Vector – invertebrate animals can transmit microorganisms (mosquito for malaria and yellow fever)
- The **place of entry** is the manner by which the agent enters another host. Usually, the mode of entry is the same way that the agent left the old host. The organisms can be passed through mucous membranes or broken skin, such as cuts and scratches, and puncture wounds from needle sticks with used needles.
- The next person who gets infected is the **susceptible host**.

To prevent diseases caused by the agent (organisms that cause infection), the cycle must be broken at any point. Breaking the cycle at any point requires infection prevention measures which will be discussed in more detail later.

DEFINITION OF TERMS

Protective barriers are physical, mechanical or chemical processes which help prevent the spread of infectious microorganisms from client to client, clinic staff to client and vice versa due to lack of infection prevention practices or from contaminated instruments or equipment. Infection prevention relies on barriers between the host and microorganisms.

AseCSIs and **aseptic technique** are procedures used in health care settings to describe the combination of efforts made to prevent entry of microorganisms into any area of the body where they are likely to cause infection. The goal of aseCSIs is to reduce microorganisms on animate (living) surfaces (skin and tissue) and inanimate objects (surgical instruments) to a safe level or to eliminate the microorganisms completely.

AntiseCSIs is the prevention of infection by killing or inhibiting the growth of microorganisms on skin and other body tissues through a chemical agent (antiseptic). One example is the use of Povidone-Iodine applied as an antiseptic solution on the cervix before IUD insertion.

Decontamination is the process that makes inanimate (non-living) objects safer for handling by staff before cleaning, using antiseptics like 0.5% Chlorine solution. Such objects include large objects (e.g., examination tables) and surgical instruments and gloves contaminated with blood or body fluids (example in BTL or vasectomy instruments).

Cleaning is the process of physically removing all visible blood, bodily fluids, or foreign material such as dust or soil from skin or inanimate objects. Wash or scrub with a brush with liquid soap or detergent and water. Avoid bar soap or powdered soap, which can stay on the equipment. Rinse and dry. While cleaning, wear utility gloves and personal protective equipment-goggle, mask, apron and enclosed shoes.

Disinfection is the process that eliminates most, but not all, disease-causing microorganisms from inanimate objects. High-level disinfection (HLD), through boiling, by steaming or with chemicals such as chlorine, gluteraldehydes, formaldehydes and peroxides- eliminates most microorganisms except some bacterial endospores. HLD is done with instruments or supplies such as vaginal specula, uterine sounds and gloves for pelvic examinations.

Sterilization is the process that kills all infectious microorganisms, including bacterial endospores, with a high-pressure steam autoclave, a dry-heat oven, chemicals or radiation. Sterilize instruments such as scalpels and needles that touch tissue beneath the skin.

SESSION 2
INFECTION PREVENTION MEASURES

OBJECTIVES

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

1. Explain the principle of standard precautions.
2. Discuss the "protective barriers" which disrupt the transmission of infection such as:
    - Handwashing
    - Using gloves
    - Using antiseptics
    - Processing instruments and other items
    - Proper management of wastes
3. Develop a plan to ensure proper waste management in their respective facilities.

NARRATIVE

STANDARD PRECAUTIONS

Standard Precautions are designed for the safety and care of all people in a health care facility – whether a hospitalized patient, a woman receiving IUD services, or a health care worker.

Because many people with blood-borne viral infections (e.g., hepatitis B [HBV] or C [HCV], HIV) do not feel or look ill, standard precautions are to be applied consistently, regardless of the (known or unknown) health status of those who are providing or receiving care.

When applied consistently, standard precautions act as protective barriers between microorganisms and individuals, and are considered a highly effective means of preventing the spread of infection.

The following considerations and actions help to form such barriers, as well as provide the means for implementing the standard precautions:

- **Consider every person** (client or staff) as potentially infectious and susceptible to infection.
- **Wash hands –** the most important procedure for preventing cross-contamination (person to person or contaminated object to person).

- **Wear gloves** (on both hands) before touching anything wet broken skin, mucous membranes, blood or other body fluids (secretions and excretions), soiled instruments, and contaminated waste materials-or for performing invasive procedures.
- **Use physical barriers** (protective goggles, face masks, and aprons) if splashes and spills of blood or other body fluids are possible (e.g., when cleaning instruments and other items).
- **Use antiseptic agents** for cleansing skin or mucous membranes before surgery, cleaning wounds, or doing hand rubs or surgical hand scrubs with an alcohol-based antiseptic product.
- **Use safe work practices** such as not recapping or bending needles, safely passing sharp instruments, and suturing (when appropriate) with blunt needles.
- **Safely dispose of infectious waste materials** to protect those who handle them and prevent injury or spread of infection to the community.
- Finally, **process instruments, gloves, and other items** after use by first decontaminating and thoroughly cleaning them, and then either sterilizing or high-level disinfecting (HLD) them, using recommended procedures. Again, in the context of IUD services, HLD is the recommended method of final processing.

PROTECTIVE BARRIERS

Having a physical, mechanical or chemical "barrier" between microorganisms and an individual (i.e., client, patient, and health worker) is an effective means of preventing the spread of disease. The barrier serves to break the disease transmission cycle.

Protective barriers are designed to prevent the spread of infection from person to person, and from equipment, instruments, and environmental surfaces to people and vice versa.

Barriers include the following:

1. Handwashing
2. Wearing gloves
3. Using antiseptic solutions
4. Processing of instruments

HANDWASHING

Handwashing is the SIMPLEST, BASIC and MOST IMPORTANT infection prevention procedure in any clinic. It removes many microorganisms from the skin, helping to prevent transmission of infection from person to person.

1. **When to do handwashing**

   Before

   - the day's work
   - examining a client
   - administering injections or drawing blood
   - performing a procedure (IUD insertion & removal or pelvic exam);
   - handling clean, disinfected, or sterilized supplies for storage
   - putting on sterile gloves
   - going home

After

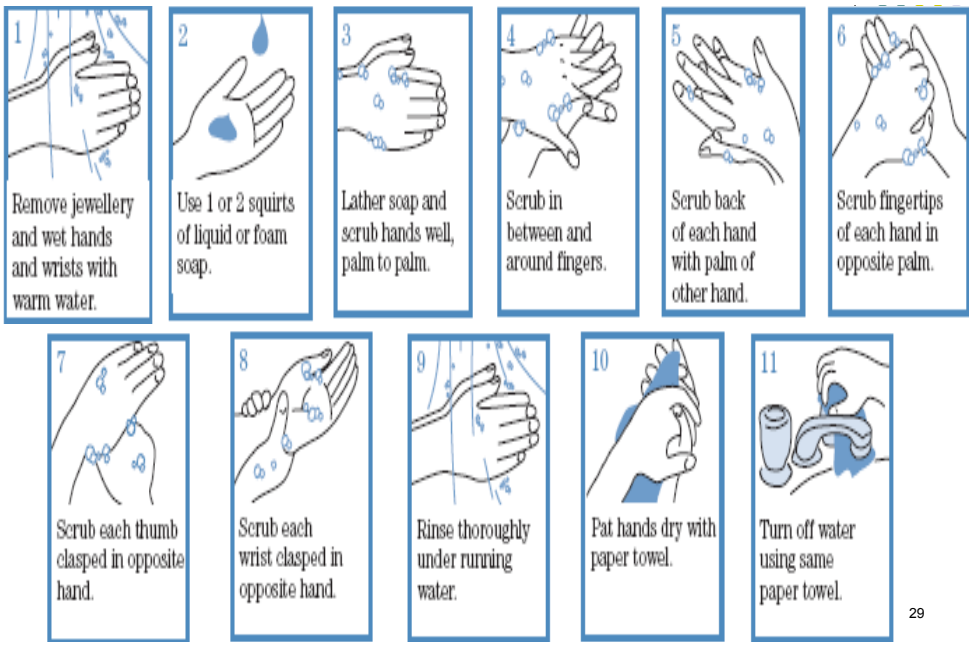
- any situation in which the hands may be contaminated, such as handling instruments or touching body secretions or excretions
- examining a client
- removing gloves
- personal use of toilet
- blowing nose, sneezing, or coughing

2. Supplies needed for hand washing:

- Clean water (water may be running or from a bucket, but it must be clean)
- Soap (bar or liquid)
- Soap dish that drains and keeps the soap dry (bar or liquid)
- Clean, dry towel
- Plastic container with faucet.

3. Steps of Handwashing

- Remove jewelry and wet hands and wrists with water.
- Use 1 or 2 squirts of liquid or foam soap.
- Lather soap and scrub hands, palm to palm.
- Scrub in between and around fingers.
- Scrub back of each hand with palm of the other hand.
- Scrub fingertips of each hand in opposite palm.
- Scrub each thumb clasped in opposite hand.
- Scrub each wrist clasped in opposite hand.
- Rinse thoroughly under running water.
- Turn off water using paper towel.



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Handwashing Tips

Important considerations during hand washing:

- If there is no running water, use a dipper (tabo) to pour water on the hands at the beginning and when rinsing.
- Position the hands and wrists downward as you wet them so that the water flows down.
- If using bar soap, rinse the soap before putting it back in the soap dish.
- Avoid touching the sink as it is probably contaminated.
- Wash hands for 15 - 30 seconds.
- Point hands down when rinsing them with running water.
- Air-dry hands or dry with an unused, dry portion of a clean cotton towel not used by others.
- Use the towel or a paper towel to turn off the faucet.
- If water is not available, 70% of isopropyl alcohol can be used if hands are not visibly soiled.

USING GLOVES

Gloves are used to protect the health care provider from contact with potentially infectious substances and to protect the client or patient from infections that might be present on the skin of the health care provider.

The Three Kinds of Gloves

1. Surgical gloves – used when contact with the blood streak or with tissue under the skin like for surgical procedures, pelvic examination or women in labor.
2. Single use examination gloves – used when there will be contact with intact mucous membranes or when the primary purpose of gloving is to reduce the provider's risk of exposure (i.e. routine pelvic

examination). These gloves should be disposed after one use.

3. Utility or heavy duty household gloves – used for handling contaminated items, medical or chemical waste and performing housekeeping activities.

ANTISEPTICS

Antiseptics are chemicals, which kill or inhibit many, though not all, microorganisms while causing little damage to tissue. Cleaning the client's skin with antiseptic solution is an important infection prevention measure.

Antiseptic solutions should be used in the following situations:

- Skin or vaginal preparations for procedures such as mini-laparotomy, laparoscopy, vasectomy, IUD insertion, and injections
- Hand washing with 70% alcohol before touching clients who are unusually susceptible to infection (e.g., newborns or immune suppressed persons).

Note:

- Alcohol should never be used on mucous membranes because it irritates the membranes.
- Antiseptics should not be used as disinfectants.

COMMONLY USED ANTISEPTICS

Iodine and Iodophor Solutions

Povidone-iodine is the most common iodophor and is available globally.

Note: Iodophors manufactured for use as antiseptics are not effective for disinfecting inorganic objects and surfaces. These iodine solutions have significantly less iodine than chemical disinfectants (Rutala 1996).

Iodophors have a broad spectrum of activity. They kill vegetative bacteria, mycobacterium, viruses and fungi; however, they require up to 2 minutes of contact time to release free iodine, which is the active chemical. Once released the free iodine has rapid killing action.

70% Alcohol Solutions

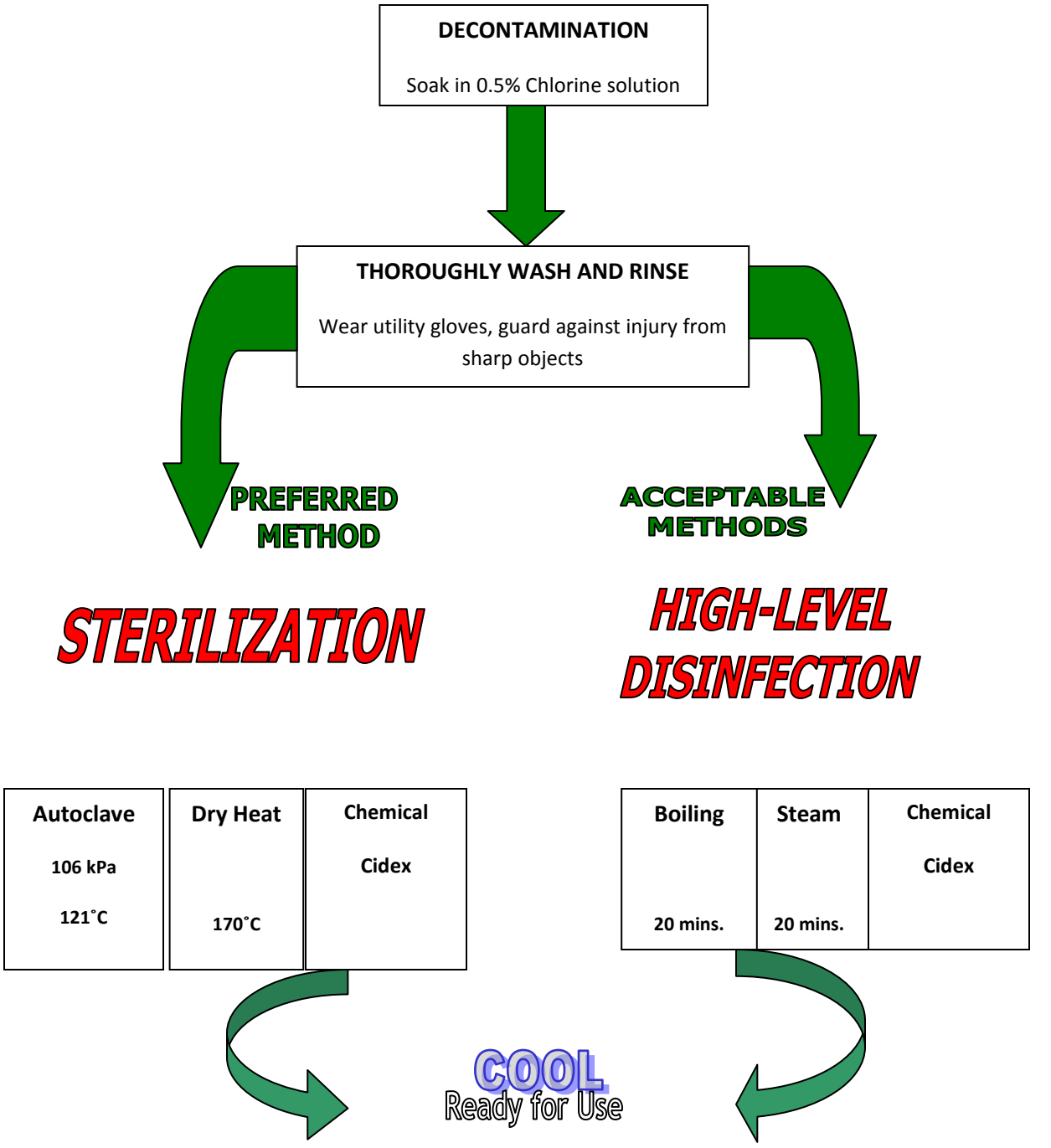
Alcohol functions well to inhibit the growth and reproduction of many microorganisms, including bacteria, fungi, protozoa, and viruses.

Alcohol is a good solvent that dissolves and carries away non-organic impurities that are responsible for things like odor. Its antiseptic action does cause a burning sensation on open flesh, as anyone who has ever used alcohol to clean a wound can testify.

PROCESSING OF INSTRUMENTS

- Proper processing of instruments is critical for reducing infection transmission during clinical procedures.
- The 4 steps for processing instruments and other items include:
  1. decontamination
  2. cleaning

3. sterilization (preferred) or high-level disinfection (acceptable)
4. use or storage



Wrapped sterile packs can be stored for up to one week. Unwrapped items should be stored in a sterile or high-level disinfected container with a tight fitting lid or used immediately.

PREPARING DECONTAMINATING SOLUTION

From concentrated 5% chlorine solution

Parts of water/part of chlorine

%concentrated chlorine - 1

%desire chlorine concentration

5 – 1 = 9 parts water/part of water

.5

1 part chlorine in 9 parts water

From concentrated chlorine granules containing 30% chlorine

Grams of chlorine powder or granules/ liter of water

%desired concentration x 1000

%concentrate of granules

.5 x 1000 = .0166 x 1000 = 16.7 gms/liter

30

17 grams of 30% chlorine granules/powder in 1 liter of water

USE AND DISPOSAL OF SHARPS

In health care settings, injuries from needles and other sharp items are the most common cause of infections from blood-borne pathogens. It is important therefore that sharps are handled with care and to dispose them properly after use. Below is the list of instances when health care providers can be injured by sharps:

- When health care workers recap, bend, or break hypodermic needles.
- When health care workers are stuck by a person carrying unprotected sharps
- When sharps show up in unexpected places, like between linens
- During procedures in which they use many sharps, cannot see their hands, or are working in a small, confined space (like during gynecologic procedures)
- When health care providers handle and dispose of waste that contains used sharps.
- When clients move suddenly during injections

GIVING INJECTIONS

To prevent injuries when giving injections, the following recommendations are considered:

- Always warn the client before giving an injection
- Always use new or properly processed needle and syringe for every injection.
- Steps for giving injections:
    - Wash injection site with soap and water if the area is visibly dirty

- Swab the area with antiseptic (alcohol solution) in circular motion starting from the intended injection site going outward.
- Allow the alcohol to dry for better efficacy.
- Inform client that you are about to inject

RECAPPING NEEDLES

- Whenever possible, dispose of needles immediately without recapping them.
- But if recapping is necessary, follow the "one hand technique"

1. Place the cap on a flat surface and remove hand from the cap
2. With one hand, hold the syringe and use the needle to scoop up the cup.
3. When the cap covers the needle completely, use the other hand to secure the cap on the needle hub. Be careful to hold the cap at the bottom only (near the hub).

WASTE MANAGEMENT

Healthcare waste is defined as the total waste stream from a healthcare facility. Most of it (75-90%) is similar to domestic waste, examples of which are paper, plastic packaging, glass, cartons/boxes, etc. that have not been in contact with patients.

A smaller proportion (10-25%) is infectious waste that requires special treatment because of the risks that it poses both to human health and the environment. Exposure to this waste can result in disease or injury.

The **purpose** of proper waste management:

- Prevents the spread of infections to clinic personnel, clients, visitors and the community.
- Reduces the risk of accidental injury to staff, clients, and community.
- Reduces bad odors.
- Attracts fewer insects and animals which may be vectors of infectious agents.
- Reduces the possibility of the soil or ground water contamination with chemicals or microorganism.

TYPES OF WASTES

1. **General waste**

   These are non-hazardous wastes that pose no risk of injury or infections. These are similar in nature to household trash. Examples are: paper, boxes, packaging materials, bottles, plastic containers, and food-related trash.

2. **Hazardous medical waste**

   Hazardous wastes generated in the rural health unit and birthing homes are classified as:

   a) Infectious – all wastes that are susceptible to contain pathogens (or their toxins) in sufficient concentration to cause diseases to a potential host. e.g. excreta, tissue swabs, blood bags, dressings, etc

   b) Pathological – consist of human tissues or fluids e.g. body parts, blood, blood products and other body fluids, placentas, and product of conception, materials containing fresh or dried blood or body

fluids such as bandages, and surgical sponges.

c) Pharmaceutical - these are expired, unused, and contaminated pharmaceutical products, drugs, vaccines that are no longer needed. It also includes discarded items used in handling pharmaceuticals such as bottles, or boxes with residue, gloves, masks, connecting tubings, and drug vials.

d) Chemicals - these are the discarded solid, liquid, and gaseous chemicals used in cleaning, housekeeping, and disinfecting procedures.

e) Sharps - items that could cause cuts, puncture wounds, including hypodermic and suture needles, scalpel blades, blood tubes, infusion sets, and other glass items that have been in contact with potentially infectious materials (such as glass slides and coverslips)

f) Pressurized containers – consist of full or emptied containers or aerosol cans with pressurized liquid gas or powdered materials

Since the disposal of medical waste is frequently a problem, it is useful to develop a medical waste management plan and a staff be assigned the responsibility of waste disposal.

THE FOUR ASPECTS OF HAZARDOUS (MEDICAL) WASTE MANAGEMENT

The management of waste must be consistent from the point of generation to the point of final disposal. The path between these two points can be segmented into four steps.

1. Sorting or segregation and containerization

Only a small percentage of the waste generated by a healthcare facility is medical waste that must be specially handled to reduce the risk of infections or injury. Therefore, sorting the waste at the point at which it is generated can greatly reduce the amount that needs special handling.

The correct segregation/sorting of waste at the point of generation relies on a clear identification of the different categories of waste and the separate disposal of the waste in accordance with the categorization chosen. To encourage segregation at source, reusable containers with plastic liners of correct size and thickness are placed as close to the point of generation as possible. They should be properly color coded.

Black plastic lining for general, dry, non-infectious waste

Green plastic lining for general, wet, non-infectious waste

Yellow for infectious/pathological waste.

Needles and other sharps pose the greatest risk of injury, and should be disposed of in special sharps containers such as heavy cardboard boxes, tin cans with lid and plastic bottles.

2. Handling

Handle medical waste as little as possible before disposal. When waste containers are ¾ full, the liners are closed with plastic strings and are placed in larger containers at the interim storage areas. Always wear heavy utility gloves when handling medical waste. Always wash your hands after handling wastes and after removing your gloves.

3. Interim storage

In order to avoid both the accumulation and decomposition of waste, it must be collected on a regular daily basis. Waste should never be stored in the facility for more than one or two days.

If it is necessary to store medical waste on-site before final disposal, waste should be placed in an area that is minimally accessible to clinic staff, clients and visitors.

4. Final disposal

General wastes, similar to household waste, can be collected by the regular municipal garbage collector and transported into the final dump sites.

Solid Medical Waste

There are three options for the disposal of solid medical waste: burning waste, burying waste, and transporting waste to an off-site disposal site.

In our country burning waste is not applicable because of the Clean Air Act. So the remaining options are:

a.) burying, that is if there is a space at the back of one's facility to dig a pit;

b.) and transporting waste to an off-site disposal site. This is done by the waste collector of hospital medical wastes.

Building and using a waste-burial pit

1. Choose an appropriate site that is at least 50 meters away from any water source to prevent contamination of water source. The site should have proper drainage, be located downhill from the wells, be free of standing water, and be in an area that does not flood. The site should not be located on land that will be used for agriculture or development.
2. Dig a pit 1 to 2 meters wide and 2 to 5 meters deep. The bottom of the pit should be 1.8 meters above water table.
3. Fence in the area to keep out animals, scavengers, and children.
4. Keep waste covered. Every time waste is added to the pit, cover it with a 10 to 30cm layer of soil.
5. Seal the pit when the level of waste reaches 30 to 50 cm of the surface of the ground. Fill the pit with dirt, seal it with concrete and dig another pit.

Liquid medical waste

The following are the procedures when disposing liquid medical wastes:

1. Carefully pour liquid waste down a sink, drain or flushable toilet.
2. Before pouring liquid waste down a sink, drain, or toilet, consider where the drain empties. It is hazardous for liquid waste to run through open gutters that empty onto the grounds of the facility.
3. Rinse the sink, drain, or toilet thoroughly with water to remove residue waste – again avoid splashing. Clean these areas with s disinfectant cleaning solution at the end of the day or more frequently if heavily soiled.
4. Decontaminate the container that held the liquid waste by filling it with 0.5% chlorine solution for 10 minutes before washing.
5. Wash your gloved hands after handling liquid waste before removing gloves.

MODULE 4: CLIENT ASSESSMENT

MODULE OVERVIEW

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

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

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

MODULE OBJECTIVES

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

MODULE SESSIONS

Session 1:	The use of FP Service Form 1 in Client Assessment
Session 2:	WHO Medical Eligibility Criteria for Contraceptive Use

SKILLS TRAINING COURSE IN CONTRACEPTIVE SUB-DERMAL IMPLANT INSERTION AND REMOVAL **Module 4** **CLIENT ASSESSMENT**	

SESSION 1

THE FP SERVICE FORM 1 IN CLIENT ASSESSMENT

LEARNING OBJECTIVES

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

1. Define client assessment.
2. Explain the purpose of client assessment in FP.
3. Describe the steps of FP client assessment.
4. Describe the FP Service Form 1 with its components.
5. Demonstrate use of the FP Service Formn 1.
6. Explain the guidelines on physical examination in FP service provision.
7. Enumerate the steps in physical examination of FP clients.
8. Explain the purpose of laboratory examination in FP service provision.
9. Describe commonly performed laboratory examination in FP service provision.

NARRATIVE

CLIENT ASSESSMENT

CLIENT ASSESSMENT is the very first stage in the provision of FP services to prospective FP method acceptor. It consists of steps undertaken to determine the health status of a client particularly his/her eligibility for contraceptive use.

Data about the client's health are gathered through medical history taking, physical examination, and needed laboratory examinations which are analyzed to see if the client is in good health or needs further evaluation and management and / or referral.

It is a MUST that all clients who attend FP/ RH clinics undergo assessment.

SPECIFIC STEPS IN CLIENT ASSESSMENT

The following are the steps in client assessment. Note that for each step, client comfort and privacy should always be considered.

1. Prepare the client.
    a. Greet her cordially and allow her to seat comfortably;
    b. Establish good rapport with the client;
    c. Establish the purpose of the visit;
    d. Explain to the client procedures to be performed (including physical and /or laboratory examinations, if needed.)
    e. Encourage the client to ask questions openly.
2. Take and record client's health history using the Family Planning Service Record Form 1 (FP Form1)
3. Discuss with the client the:
    a. Findings based on the history.

b. Need to perform further examination like physical and/or laboratory examination, if necessary.

c. Need for referral for laboratory examinations or further management, if necessary.

d. Need and schedule of follow-up visit(s)

In assessing FP clients:

- Only those procedures that are essential as recommended by the WHO (Applicability of procedures and examinations for contraceptive use) should be performed.
- Additional examinations (i.e., physical or laboratory) are performed to validate abnormal findings during client assessment

  Example: It is not necessary to do a physical examination complete with a pelvic exam on a client requesting for a condom. However, if there is a complaint of urethral discharge, a pelvic exam and collection of urethral discharge for smear should be performed. In this case, the additional examinations are performed because of the signs of infection and not for determining his suitability for using the condom.

CLIENT HISTORY-TAKING

Client history-taking is the process of gathering data by interviewing the client about his/her past and present medical/reproductive health status.

Obtaining the client's history during the initial visit is important in identifying his/her needs and factors or conditions that may affect his/her suitability for using FP method(s). It is, therefore, the responsibility of the service provider to be able to elicit such information prior to the provision of a method.

Client history-taking enables the service provider to:

1. Assess the client's reproductive health status and identify the RH needs of the client.
2. Identify risk factors or areas for precaution in the use of an FP method.
3. Properly record and verify data gathered in FP Form1

FP Form 1

The FP Form 1 lists the possible illnesses relevant to possible FP method use. Family Planning visits are not due to illness, thus the following items should be asked on the context of FP method use whether initial or follow up visits.

A. Personal Data

1. Complete name of client
2. For proper identification and documentation, take complete name of client including middle name. Note that under the present Family Code of the Philippines, an unmarried pregnant woman (this includes live-in partners) retains her maiden name.
3. Name of husband/partner/guardian
   - This is in of cases of emergencies or for purposes of guardianship or consent.
4. Client's age, sex, marital status, date and place of birth
5. Religion, occupation, average family monthly income
   - To determine client's preferences and practices
   - To determine financial capacity for needed examinations, feasibility of using cheaper forms/methods

6. Educational attainment
    - To be able to adjust level of instruction and communication
    - To determine ability to follow complicated instructions/ precautions
7. Address
    - To be able to determine if client can have good follow up or visit clients when necessary
    - In cases of emergencies

B. Medical History

This includes the following information:

- Past illnesses
- Accidents/Injuries
- Allergies
- Immunizations
- Habits (smoking, drinking, substance abuse, etc.)

C. Family History

This includes the following information:

- Health status of immediate family members and living relatives
- Risk factor for heart disease and hypertension

D. Reproductive History

1) <u>Menstrual History</u>

- Menarche = age of onset of menstruation
- LMP (Last Menstrual Period) = first day of last menstrual period, including the usual number of days of menstrual flow, character of flow (scanty, moderate, or heavy), and accompanying symptoms
- PMP (Previous Menstrual Period) = first day of menstrual period prior to the mentioned LMP. This is important to establish accuracy of mentioned LMP, and to establish regularity or irregularity of menstrual periods.)
- Usually, this is the best time to inform clients that "regularity" of menstrual flow is not based on the menstrual flow occurring every same day or week of every month. Rather, it is based on the number of days between the two LMPs (first day of two menstrual periods). The normal average interval number of days is 25-35 days.

  For example, it may happen that a woman with the following menstrual periods will appear to have very irregular menses but is actually having her menses regularly:

  - 2nd week of January (say, Jan. 7);
  - 1st week of February (Feb. 2);
  - Then again in February but in the last week (Feb. 28);
  - Then in the third week of March (March 21).

2) <u>OB History</u>

Completing the OB score is one way of evaluating the obstetric history of the client which provides information relevant to FP method use (birth spacing and/or birth limiting). The **OB score** measures

of gravidity (G), parity (P) of a woman. **Gravidity (G)** refers to number of pregnancies borne by the mother, irrespective of the pregnancy outcome. **Parity (P)** refers to the number of pregnancies reaching viability (>20 weeks AOG). Other relevant information needed are:

- Full-term pregnancies
- Preterm pregnancies
- Abortions or miscarriages (ectopic/ molar)
- Current living children

3) FP History

- FP method currently being used
  - Duration of use
  - Satisfaction with use
- FP method previously used
  - Duration of use
  - Reason/s for discontinuation or shifting
- Reproductive goals/ intents
  - Desired number of children
  - To limit or to space

4) Risk for Sexually-Transmitted Infections (STIs)

The following are reasons for assessing an FP client's risk for STIs:

- FP clients are sexually active people who need to know about factors which put them at risk for STIs.
- If the client is likely to get STIs, the client needs a supply of condoms and counseling about risks, symptoms, and treatment. Counseling includes correct and consistent use of condoms.
- FP clients with a high individual risk for STIs may need to be referred to facilities providing STI services (i.e., counseling and/or treatment).
- IUD should not be provided to clients with high risks for STI.

A basic screening history for STI should be included in the history-taking which should include the following:

1. Presence of abnormal vaginal and or urethral discharge
2. Abnormal vaginal bleeding with the last two menstrual periods
3. Pain or burning sensation during urination
4. History of genital tract problem such as vaginal discharge, ulcers or skin lesions around the genital area
5. Partner of client who have been treated for a genital tract problem in the last three months
6. More than one sex partner in the last two months and/or their sex partner having other sex partner/s

When faced with clients who complain of side effects and complications, or who have reproductive

concerns, the following information should be obtained:

1. Present complaint or concern
2. Onset, nature, and duration of present complaint or concern
3. Accompanying symptoms and precipitating/aggravating factors
4. Measures or medications taken to relieve symptoms and precipitating/ aggravating factors
5. Prior consult or medications

PHYSICAL EXAMINATION

Purpose of a Physical Examination

By evidence, a general physical examination is not necessary at all times in ensuring the SAFE USE of an FP method. The WHO Applicability of procedures serves as a guide that will tell which of the procedures or examinations may be necessary.

Physical examination when necessary will also help the FP service provider to:

- Confirm conditions suspected or noted during the client history-taking
- Evaluate the health of the client while she uses an FP method to make sure she has not developed conditions which need precautions to the use of the contraceptive method
- Confirm complications from side effects which may have arisen from the use of an FP method;

There are only two appropriate timing for performing physical examination and the reasons for each.

Timing of Physical Examinations

- During the INITIAL visit to confirm medical conditions identified in history taking
- AS NEEDED or whenever there is an indication, complaint, or unusual symptom/s related to the use of an FP method

There are basically four general steps in conducting a general physical examination:

1. **Take vital signs**
    a. Blood Pressure
    b. Pulse Rate
    c. Respiratory Rate
    d. Temperature
2. **Prepare client**
    a. Making the client comfortable
    b. IF doing an internal exam: Asking client to void/empty bladder and wash perineum
    c. Assuring privacy and confidentiality; and
    d. Explaining the procedures or what is going to happen and why
3. **Prepare needed instruments and supplies**
    a. Prepare the instruments and supplies ahead of the actual PE especially when there is no knowledgeable assistant around.
4. **Conduct the physical examination**

a. If the health provider is a male, the female client may request a companion during the conduct of the physical examination.

There are two golden rules to remember when conducting the physical examination:

a. Proceed from head to toe.

b. Inspect first, palpate later.

Other physical examination that may be done when necessary and these are;

Breast Examination – According to the applicability in WHO MEC a breast exam does not contribute to the safe and effective use of any contraceptive method. However, in the light of providing quality reproductive health care, a breast examination can be done during initial visit of new clients and yearly as part of a general checkup.

Abdominal Examination

1. Abdominal examination is done to check for tenderness, organ enlargements, or masses.
2. Tenderness in one or both lower quadrants may suggest the presence of pelvic inflammatory disease (PID).
3. In non-pregnant women, the uterus is not palpable by this examination. An abdominal mass may suggest tumor or malignancy.

Pelvic Examination

1. Pelvic examination is done to detect any pelvic abnormality or pathologic condition that may be a precaution to the use of a specific FP method (e.g., IUD, BTL).
2. It is also done to obtain specimen/s for laboratory examination/s, which may be necessary in providing RH/FP care. These examinations include:
    a. Pap smear
    b. Wet vaginal smear for trichomoniasis, moniliasis, or bacterial vaginosis
    c. Gram staining for gonorrhea and chlamydia

LABORATORY EXAMINATION

In some cases, findings in the history taking or physical examination (PE) may have to be confirmed or worked out through the use of selected laboratory tests.

Laboratory tests are **NOT ALWAYS REQUIRED** (refer to WHO Applicability chart) but are performed when needed. Every FP service provider must be familiar with these tests and how to interpret their results so that s/he is knowledgeable about: (1) when to request the tests; and (2) how these tests can help him/her best manage the client's case.

There are laboratory examinations that are essential and should be done as part of the assessment of the client's reproductive health.

Laboratory examinations are determined depending on the symptoms or findings during the client history taking and the physical examination. The results are compared with the established normal standards for a particular test, age group, and sex. This will also help the service provider to:

- Confirm changes or abnormalities identified in the client's history and PE
- Assess the health status of the client and response to management

Hemoglobin determination

Hemoglobin determination will tell whether a person has anemia or not.

The normal ranges for hemoglobin depend on the age and, beginning in adolescence, the sex of the person. The normal ranges are:

- Adult males: 14-18 gm/dl
- Adult women: 12-16 gm/dl

Other Laboratory Examinations

There are other laboratory examinations requested in FP/RH services:

- Wet Smear - to find the causative agent of existing vaginitis- monilia, trichomonas or gardnerella
- Gram Stain - to determine the microorganism causing the STI- gonococci or chlamydia
- Pap Smear – cervical secretions collected examined under a microscope in order to look for pre-malignant or malignant changes
- Acetic Acid – abnormal cells may be identified by applying acetic acid to areas of suspected cervical lesions

SESSION 2

WHO MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE

LEARNING OBJECTIVES

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

1. Explain the WHO-Medical Eligibility Criteria and its use
2. Describe the WHO MEC Checklist for the Different FP methods
3. Demonstrate the proper use of WHO-MEC Wheel
4. Explain the applicability of various procedures or tests in providing FP methods
5. Use the checklist on how to be reasonably sure if the woman is not pregnant

NARRATIVE

The WHO MEC is an available reference tool for assessing clients on their eligibility for initiating and continuing the use of a specific contraceptive method based on certain criteria developed from evidence based standards.

The WHO MEC gives recommendations based on the latest clinical evidence available on the safety of the methods for people with certain health conditions. On the basis of these recommendations, possible conditions of clients wanting to initiate or continue using a contraceptive method are classified under one of the following four categories listed below.

Four Categories

The four categories of the WHO MEC are:

Category 1: A condition for which there is NO RESTRICTION on the use of contraceptive method. PROVIDE the METHOD.

Category 2: A condition where THE ADVANTAGES of using the method generally OUTWEIGH the theoretical or proven RISKS. This indicates that the method can be GENERALLY used, but that CAREFUL FOLLOW-UP may be required.

Category 3: A condition where the THEORETICAL OR PROVEN RISKS usually OUTWEIGH the ADVANTAGES of using the method. Use of this method IS NOT RECOMMENDED UNLESS OTHER MORE APPROPRIATE METHODS ARE NOT AVAILABLE or ACCEPTABLE.

Category 4: A condition, which represents an UNACCEPTABLE HEALTH RISK if the contraceptive method is used. DO NOT PROVIDE the method.

Category	With clinical judgment	With limited clinical judgment
1	Use method in any circumstances	Yes (Use the method)
2	Generally use the 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	

Below are the Summary Tables for each of the specific methods

Simplified MEC Categories for Permanent Methods

Category	Eligibility Criteria
A (Accept)	There is no medical reason to deny sterilization to a person with this condition.
C (Caution)	The procedure is normally conducted in a routine settling, but with extra preparation and precautions.
D (Delay)	The procedure is delayed until the condition is evaluated and/or corrected. Alternative temporary methods of contraception should be provided.

S (Special/ Refer)	The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anesthesia, and other backup medical support. For these conditions, the capacity to decide on the most appropriate procedure and anesthesia regimen is also needed. Alternative temporary methods of contraception should be provided if referral is required or there is otherwise any delay.

Simplified MEC Categories for Fertility Awareness Based Methods

Category	Eligibility Criteria
A (Accept)	There is no medical reason to deny the particular FAB method to a woman in this circumstance.
C (Caution)	The method is normally provided in a routine setting, but with extra preparation and precautions. For FAB methods, this usually means that special counseling may be needed to ensure correct use of the method by a woman in this circumstance.
D (Delay)	Use of this method should be delayed until the condition is evaluated or corrected. Alternative temporary methods of contraception should be offered.
NA	Not applicable

WHO MEC Wheel for Contraceptive Use

The WHO MEC Wheel contains the medical eligibility criteria for starting use of FP methods. It is an abridged version of the Medical Eligibility Criteria for Contraceptive Use, 3rd edition (2004). It guides FP service providers to determine if a woman presenting with a known medical or physical condition is suitable for safely and effectively using various FP methods.

The wheel includes recommendations on initiating use of six common types of contraceptives:

1. Combined pills (low dose combined oral contraceptives, with 35 $\leq$ ethinylestradiol)
2. Combined injectable contraceptives (Cyclofem and Mesigyna)
3. Progestin-only pills
4. Progestgen-only injectables, DMPA (a 3-monthly injectable) and NET-EN (a 2-monthly injectable)
5. Progestogen-only implants (Jadelle, and Implanon)
6. Copper-bearing IUD

The guidance in the wheel applies to initiation of FP methods. Recommendations for continuation of method use, when a woman develops a medical condition while using the method can be found in the MEC guideline.

Applicability of various procedures or test for contraceptive use

Some examinations or procedures may be done before providing a method of contraception. Those with known medical problems or other special conditions may need additional examinations or tests before being deemed appropriate candidates for a particular method of contraception.

The Applicability of various procedures or tests for contraceptive use is part of the WHO Medical Eligibility Criteria for Contraceptive Use, Third Edition, 2004. It focuses on the relationship of the procedures or tests to the safe initiation of a contraceptive method. They are not intended to address the appropriateness of these examinations or tests in other circumstances. Fro example, some of the procedures or tests that are not deemed necessary for safe and effective contraceptive use may be appropriate for good preventive health care or for diagnosing or assessing suspected medical conditions.

The Applicability Chart below shows the required exams for selected methods. Check the WHO MEC Tool (see table below) on what physical and/or laboratory examinations are recommended for safe and effective use of specific FP methods.

For most FP methods, there is no need for examinations.

Table 13. Applicability* of various procedures or tests for contraceptives methods.

Specific Situation	COC	CIC	POP	POI	Im-plants	IUD	Con-dom	Diaphragm cervical cap	Spermi-cides	BTL	Vasecto my
Breast exam by provider	C	C	C	C	C	C	C	C	C	C	NA
Pelvic/Genital exam	C	C	C	C	C	A	C	A	C	A	A
Cervical cancer screening	C	C	C	C	C	C	C	C	C	C	NA
Routine lab tests	C	C	C	C	C	C	C	C	C	C	C
Hemoglobin test	C	C	C	C	C	B	C	C	C	B	C
STI risk assessment: Med Hx & PE	C	C	C	C	C	A[1]	C[2]	C[2]	C[2]	C	C
STI/HIV screening: Lab tests	C	C	C	C	C	B[1]	C[2]	C[2]	C[2]	C	C
BP Screening	[3]	[3]	[3]	[3]	[3]	C	C	C	C	A	C[4]

Source: WHO Medical Eligibility Criteria for Contraceptive Use, Third Edition, 2004

*** Class A** = essential and mandatory in all circumstances for safe and effective use of the contraceptive method

Class B = contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context. The risk of not performing an examination or test should be balanced against the benefits of making the FP methods available.

Class C = does not contribute substantially to safe and effective use of the contraceptive method.

Notes

The Medical Eligibility Criteria for Contraceptive Use, Third Edition, 2004 states that:

[1] If a woman has a very high individual likelihood of exposure to gonorrhea or chlamydial infection, she should generally not have an IUD inserted unless other methods are not available or not acceptable. If she has current purulent cervicitis or gonorrhea or chlamydial infection, then she should not have an IUD inserted until these

conditions are resolved and she is otherwise medically eligible.

[2] Women at high risk of HIV infection should not use spermicides containing nonoxynol-9. Using diaphragms and cervical caps with nonoxynol-9 is not usually recommended for women at high risk of HIV infection unless other more appropriate methods are not available or not acceptable. The contraceptive effectiveness of diaphragms and cervical caps without nonoxynol-9 has been insufficiently studied and should be assumed to be less than that of diaphragms and cervical caps with nonoxynol-9.

[3] It is desirable to have blood pressure measurements taken before initiation of COCs, CICs, POPs, POIs, and implants. However, blood pressure measurements are unavailable in many settings, pregnancy morbidity and mortality risks are high, and hormonal methods among the few methods widely available. In such settings, women should not be denied the use of hormonal methods simply because their blood pressure cannot be measured.

[4] For procedures performed using local anesthesia with ephedrine.

How to determine that a woman is NOT pregnant

A woman should not use an FP method while she is pregnant except for condoms which should be used when protection against STI.

A health provider can usually tell if a woman is not pregnant by asking the following questions. Pregnancy test and physical examination are usually not needed.

It is reasonably certain that a woman is not pregnant if:

- Her menstrual period started within the last 7 days.
- She gave birth within the last 4 weeks.
- She had an abortion or miscarriage within the last 7 days.
- She gave birth within the last 6 months, is breastfeeding often, and has not yet had a menstrual period
- She has not had vaginal sex since her last menstrual period.
- If she has had sex since her last menstrual period, she used a reliable family planning method correctly and her last menstrual period is less than 5 weeks ago.

If the woman has had sex and her last period was 5 weeks ago or more pregnancy can not be ruled out, even if she used effective contraception consider early signs of pregnancy.

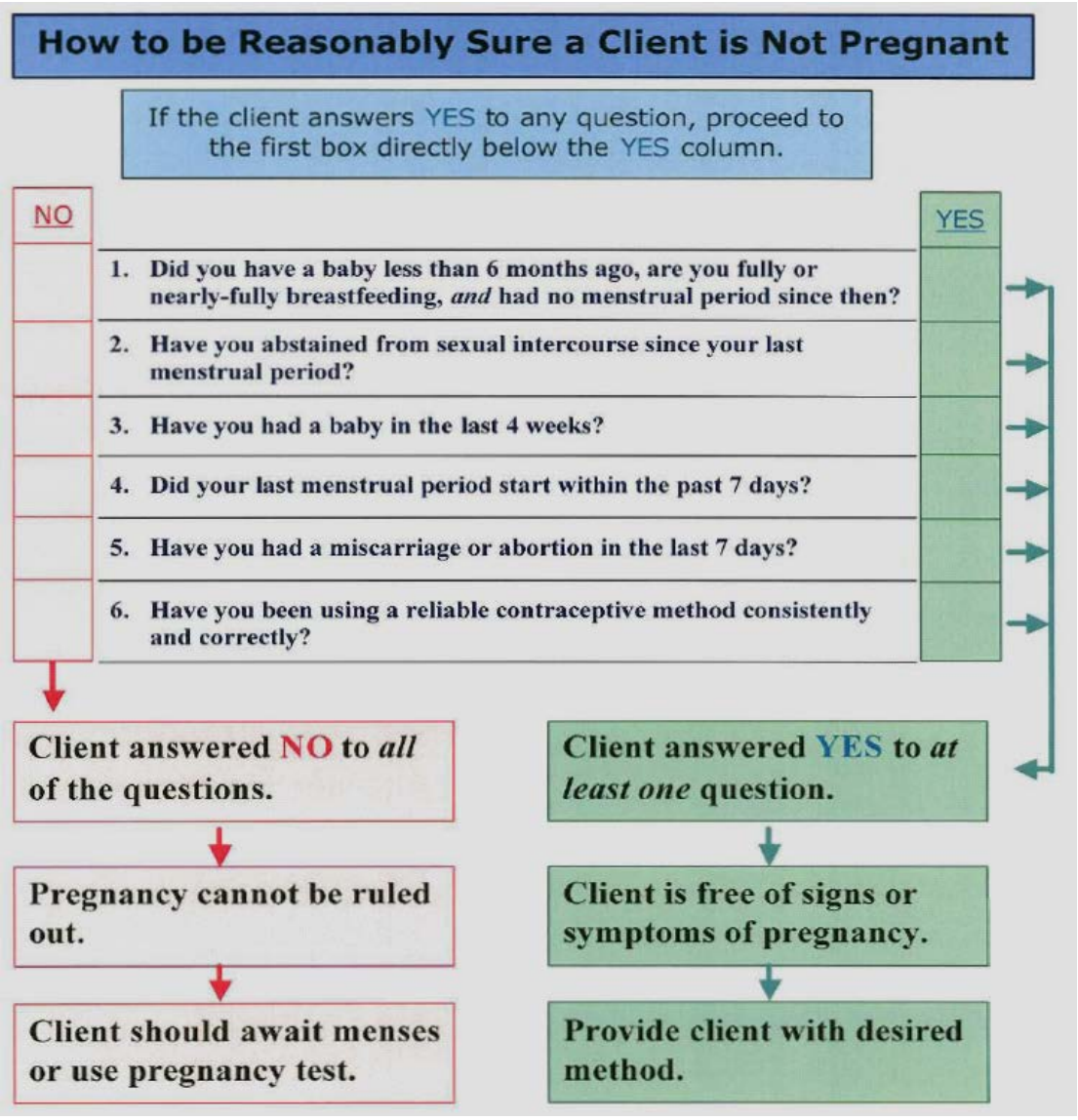
- Late menstrual period
- Breast tenderness
- Nausea
- Vomiting
- Weight change
- Frequent tiredness
- Mood changes
- Changed eating habits
- Frequent urination

Late Signs of Pregnancy: (*If it has been more than 12 weeks since her last menstrual period)*

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

If she exhibited several of these signs, she may be pregnant. Confirm by doing a physical examination.

- If her answers cannot rule out pregnancy, she should either have a laboratory pregnancy test, if available, or wait until her next menstrual period before starting a method. Give her condoms to use until then, with instructions and advice on how to use them.



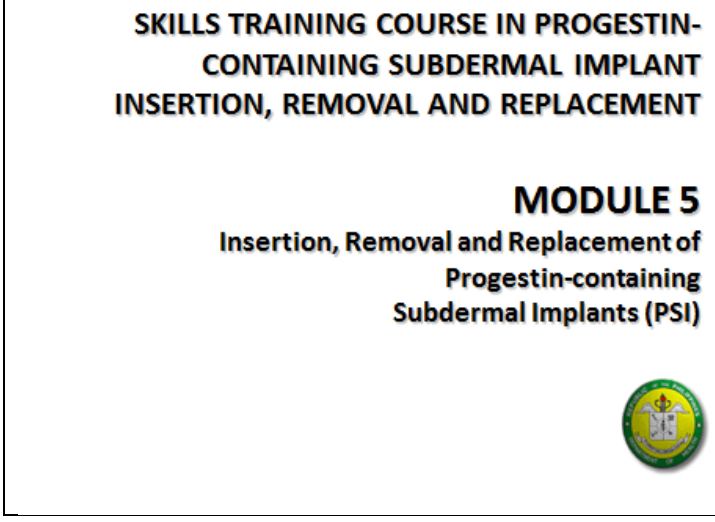
MODULE 5: Insertion, Removal and Replacement of the Progestin-containing Subdermal Implants (PSI)

Learning Objectives:
1. Discuss the Guidelines in Progestin-containing Subdermal Implant Insertion, Removal and Replacement
2. Discuss the Different Steps in the Insertion, Removal and Replacement of PSI guided by A Skills Performance Checklist
3. Demonstrate how to insert, remove and replace the PSI

Methodology:
Illustrated Lecture
Demonstration and Return Demonstration
Video Presentation

Time Allotment: 3 hours

Advance Preparation:
Laptop Computer with DVD Player and LCD
Projection Screen
Arm Model

Learning Objectives

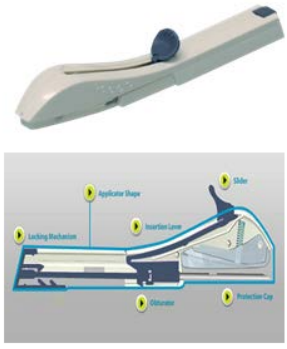
- Discuss the Guidelines in Progestin-containing Subdermal Implant Insertion, Removal and Replacement
- Discuss the Different Steps in the Insertion, Removal and Replacement of PSI guided by a Skills Performance Checklist
- Demonstrate how to insert, remove and replace the PSI

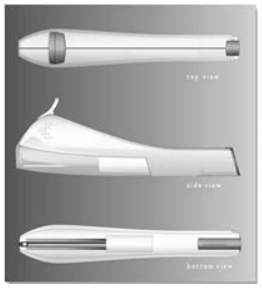
MATERIALS

Materials and equipment needed for PSI Insertion:

1. Examining table for the woman to lie on;
2. Soap for washing the arm;
3. Ballpoint pen or marker;
4. Antiseptic solution;
5. Local anesthetic (1 or 2% lidocaine without epinephrine).
6. Sterile gloves
7. One bowl for the antiseptic soaked cotton balls
8. Syringe (5 or 10 ml) and 5 cm- (2-inch) long needle (G22)
9. PSI Rods loaded in the applicator in its sterile package
10. Ordinary Band-Aid or gauze with surgical tape;
11. Gauze and compresses

DELIVERY SYSTEM OF SINGLE-ROD PSI





WHEN TO START PROVIDING PSI

- **IMPORTANT: A woman can start using PSI anytime she wants if it is reasonably certain she is not pregnant.**
- **To be reasonably certain she is not pregnant, use the Pregnancy Checklist (as discussed in Client Assessment)**

The Client is Having Menstrual Cycles or Switching from a Non-hormonal Method

- **If she is starting within 5 days after the start of her monthly bleeding**
  - **No need for back up method**
- **If it is more than 5 days after the start of her monthly bleeding, she can have the CSI inserted anytime it is reasonably certain she is not pregnant.**
  - **Use back up method for the first 7 days after insertion**
- **If she is switching from an IUD, she can have the CSI inserted immediately.**

The Client is Switching from a Hormonal Method

- **PSI can be inserted immediately, if she is using the hormonal method consistently and correctly or if it is reasonably certain she is not pregnant.**
  - **No need to wait for the next monthly bleeding.**
  - **No need for back up method.**
- **If she is switching from an injectable (DMPA), she can have the PSI inserted when the repeat injection would have been given.**
  - **No need for back up method.**

7

The Client is Fully or Nearly Fully Breastfeeding **Less than 6 months after delivery:** • **If she gave birth less than 6 weeks ago, delay insertion until at least 6 weeks after delivery** • **If her monthly bleeding has not returned, she can have the PSI inserted anytime between 6 weeks and 6 months.** – **No need for a back up method.** • **If her monthly bleeding has returned, she can have the PSI inserted as for women having menstrual cycles.**	
The Client is Fully or Nearly Fully Breastfeeding **More than 6 months after delivery:** • **If her monthly bleeding has not returned, she can have the PSI inserted anytime it is reasonably certain she is not pregnant.** – **Use back up method for the first 7 days after insertion.** • **If her monthly bleeding has returned, she can have the PSI inserted as for women having menstrual cycles.**	
The Client is Partially Breastfeeding **Less than 6 weeks after delivery:** • **Delay insertion until at least 6 weeks after giving birth** **More than 6 weeks after delivery:** • **If her monthly bleeding has not returned, she can have the PSI inserted anytime it is reasonably certain she is not pregnant.** – **Use back up method for the first 7 days after insertion.** • **If her monthly bleeding has returned, she can have the PSI inserted as for women having menstrual cycles.**	

The Client is NOT Breastfeeding

Less than 4 weeks after delivery:

- **She can have the PSI inserted anytime.**
  - **No need for a back up method.**

More than 4 weeks after delivery:

- **If her monthly bleeding has not returned, she can have the PSI inserted anytime it is reasonably certain she is not pregnant.**
  - **Use back up method for the first 7 days after insertion.**
- **If her monthly bleeding has returned, she can have the PSI inserted as for women having menstrual cycles.**

The Client has NO Monthly Bleeding

(Not related to delivery or Breastfeeding)

- **She can have the PSI inserted anytime it is reasonably certain she is not pregnant.**
  - **Use a back up method for the first 7 days after insertion.**

After a Miscarriage

- **PSI can be inserted immediately. If PSI is inserted within 7 days after a miscarriage, no need for a back up method**
- **If it is more than 7 days after a miscarriage, she can have the PSI inserted anytime it is reasonably certain she is not pregnant.**
  - **Use a back up method for the first 7 days after insertion.**

13

TIMING OF INSERTION

PREVIOUS METHOD	TIMING OF INSERTION
NONE; New Acceptor; no menstrual irregularities	Day 1-5 of Cycle
Combined Hormonal Contraceptives	During pill-free week or 4th week or during intake of inactive (brown) tablets
POP	Any day during treatment
DMPA/POI	When next injection is due
IUD	Same day as removal of IUD
After a Miscarriage	Any day; If more than 7 days later, use back up for the first 7 days after insertion
Post-partum: Breastfeeding	6 weeks
Post-partum: Not Breastfeeding	4 weeks
Immediate Post-partum	Right after delivery (US/UK Standards)

VIDEO OF PSI INSERTION

15

Show video of PSI insertion

GUIDELINES ON PSI INSERTION

- **Explain the insertion procedure to the client and encourage her to ask questions, taking time to clarify any issues or concerns she may raise.**
- **Verify Informed Consent**
- **Prepare all the instruments and medical supplies**
- **Check the implant package for completeness of contents and expiration**

16

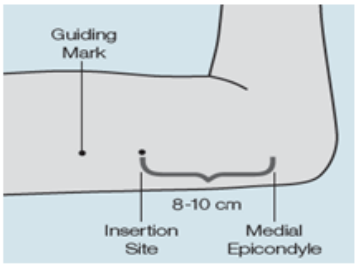
PROCEDURE OF PSI INSERTION

- **Insertion of the PSI should be performed under aseptic conditions, and only by a service provider who is familiar with the procedure.**
- **Encourage the woman to wash her entire arm with soap and water**
- **Wash your hands and dry with a clean towel**
- **The PSI should be inserted just under the skin, in the subdermal region.**

17

PROCEDURE OF PSI INSERTION

– **To minimize the risk of neural or vascular damage, the PSI should be inserted at the inner side of the non-dominant upper arm about 8-10 cm above the medial epicondyle of the humerus.**



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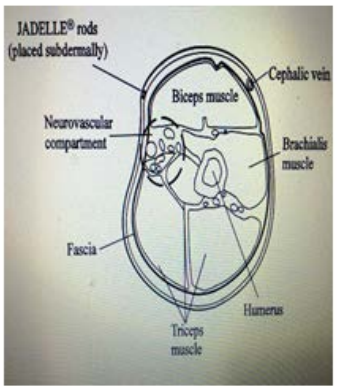
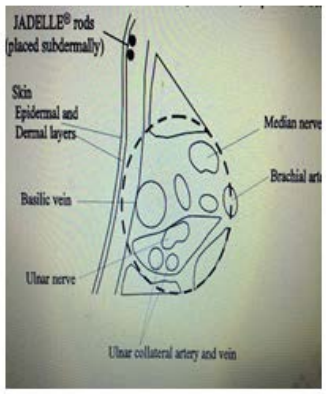
PLACEMENT OF PSI SUBDERMALLY





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TOO DEEP PSI INSERTION

May cause:

- **Neural damage (paresthesia)**
- **Vascular damage.**
- **Migration of the implant (due to intramuscular or fascial insertion or in rare cases with intravascular insertion)**
- **Non-palpable implant difficult to localize and/or remove**

20

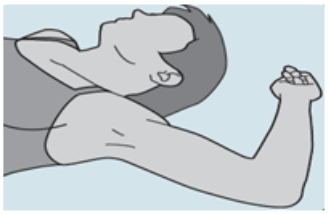
PROCEDURE OF PSI INSERTION

- **It is recommended that the provider be in a seated position during the entire insertion so that the insertion site and the movement of the needle just under the skin can be clearly seen from the side.**

21

PROCEDURE OF PSI INSERTION

- **Have the client lie on her back with her non-dominant arm (the arm which the woman does not use for writing) turned outwards and bent at the elbow, so that her hand is positioned next to her head.**



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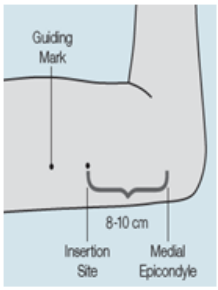
PROCEDURE OF PSI INSERTION

- **Make two marks: the insertion site where the implant will be inserted, and the second, a few centimeters proximal to the first mark.**

- **This second mark will later serve as a direction guide during insertion.**



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PROCEDURE OF PSI INSERTION

- Don your sterile gloves.
- Place a sterile drape or the glove wrapper under the woman's arm
- Clean the insertion site with a disinfectant or antiseptic solution in a circular motion, covering a wide area around the insertion site.

24

PROCEDURE OF PSI INSERTION

- Anesthetize with 2 ml of lidocaine (1% or 2%) applied just under the skin along the 'insertion canal'.
- To prevent local anesthetic toxicity, the total dose should not exceed 10ml (10grams/liter) of a 1% local anesthetic without epinephrine.
- Wait for 3 minutes for anesthesia to take effect.

25

PROCEDURE OF PSI INSERTION

- **Remove the sterile disposable applicator carrying the PSI from its blister.**
- **Ensure that the sterility of the applicator is not compromised.**

26

PROCEDURE FOR THE RADIO-OPAQUE PSI INSERTION

27

Show the videos on PSI insertion

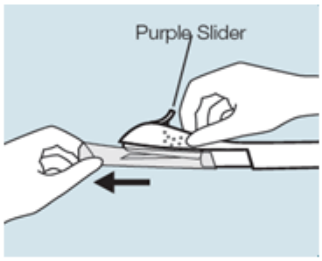
PROCEDURE OF PSI INSERTION

- Hold the applicator in an upright position, 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.
- If the cap does not come off easily, the applicator should not be used.

28

PROCEDURE OF PSI INSERTION

- Check the tip of the needle for the presence of the white colored implant.
- Do not touch the purple slider until you have fully inserted the needle subdermally, as it will retract the needle and prematurely release the implant from the applicator.



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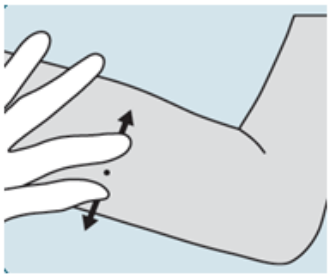
PROCEDURE OF PSI INSERTION

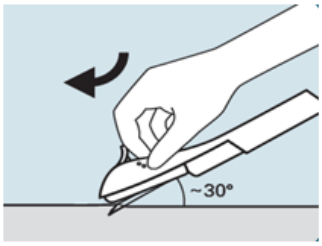
- With your free hand, stretch the skin around the insertion site with thumb and index finger.



30

PROCEDURE OF PSI INSERTION

- Puncture the skin with the tip of the needle angled at about 20° relative to the skin surface .



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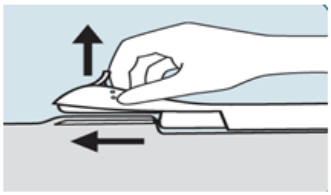
PROCEDURE OF PSI INSERTION

- **Release the skin being stretched with the other hand.**

32

PROCEDURE OF PSI INSERTION

- **As soon as the bevel of the needle is inserted into the skin, lower the applicator to a horizontal position.**
- **While lifting the skin with the tip of the needle, slide the needle to its full length.**
  - You may feel slight resistance but do not exert excessive force.
  - If the needle is not inserted to its full length, the implant will not be inserted properly.
  - You can best see movement of the needle if you are seated and are looking at the applicator from the side and not from above. In this position, you can clearly see the insertion site and the movement of the needle just under the skin.



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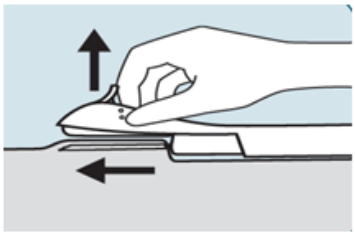
PROCEDURE OF PSI INSERTION

- Keep the applicator in the same position with the needle inserted to its full length.
- If needed, you may use your free hand to keep the applicator in the same position during the following procedure.



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PROCEDURE OF PSI INSERTION

- Unlock the purple slider by pushing it slightly down.
- Move the slider fully back until it stops.
- The implant is now in its final subdermal position, and the needle is locked inside the body of the applicator.

35

Immediately After PSI Insertion

- After retraction of the applicator, have a sterile gauze or cotton ball ready to be applied at the insertion site.
- Always verify the presence of the implant in the women's arm immediately after insertion by palpation.
- Have the woman palpate the implant as well.

36

Immediately After PSI Insertion

- Apply sterile gauze/adhesive bandage with a pressure bandage to prevent bruising.
- Fill out the User Card and hand it over to the subject to facilitate removal of the implant later on.
- The applicator is for single use only and must be adequately disposed of, in accordance with local regulations for the handling of bio-hazardous waste.

37

POST-INSERTION GUIDELINES

- Place a note in the client's record indicating the location of the rod, the type of rod, and specify any unusual events that may have occurred during insertion.
- A drawing showing the approximate location of the rod in the client's arm may be helpful
- Instruct the client regarding wound care and schedule a follow up visit (after 1 week and between 3 to 6 months, then yearly for well – women check up).

38

POST-INSERTION GUIDELINES

- Advise the client about care of the insertion site:
  - Keep the area dry and clean for at least 24 hours
  - Keep the elastic/pressure bandage in place for about 48 to 72 hours, and the adhesive bandage for about 3 to 5 days.
  - There may be bruising, swelling or tenderness at the insertion site for a few days. Reassure her that this is normal
  - Routine work can be resumed immediately
  - Provide client with wound care instructions and date of follow up

39

POST-INSERTION INSTRUCTIONS/GUIDELINES

- Advise the client about common side effects that contraceptive implant users may experience, including:
  - headaches
  - acne
  - weight change
  - breast tenderness
  - abdominal discomfort
  - mood changes and
  - nausea.

40

POST-INSERTION INSTRUCTIONS/GUIDELINES

- Advise the client that she may opt to have the implant removed at anytime if:
  - She is desirous of pregnancy
  - She is intolerant of the side effects
  - She wishes to have it replaced after 3 years
  - She has a co-morbid or medical condition that warrants discontinuation of the hormonal contraceptive

41

REMOVAL OF THE PROGESTIN-CONTAINING SUBDERMAL IMPLANT

42

REQUIREMENTS FOR PSI REMOVAL

- Examining table for the woman to lie on (optional) with arm support or side table;
- Soap for washing the arm;
- Ballpoint pen or marker;
- Sterile (or clean), dry surgical drape;
- Bowl containing cotton balls soaked with antiseptic solution;
- Pair of sterile surgical gloves;
- Local anesthetic (1 or 2% lidocaine);
- Syringe (5 or 10 ml) and 2.5–4 cm (1–1½ inches) long needle (22-gauge);
- Scalpel with #11 blade;
- 1 curved mosquito forceps;
- 1 tissue forceps (optional);
- Band-Aid or sterile gauze with surgical tape;
- Sterile gauze and compresses; and

43

LOCALIZING THE PSI BEFORE REMOVAL

- Review the client's user card to determine site of previous insertion
- Localization is an essential component of the insertion and removal process.
- Palpation is the first step in the localization process.
- Always localize by palpation prior to removal.

44

GUIDELINES IN PSI REMOVAL

- Removal of the PSI should be performed only by a service provider who is familiar with the procedure.
- Indications for removal
  - Patient request
  - Medical indication
  - At the end of 3 years of use

45

GUIDELINES IN PSI REMOVAL

- Counsel the patient thoroughly prior to removal of the PSI.
- If the woman does not wish to become pregnant, another contraceptive method should be started immediately (return to fertility may be very rapid).
- Removal of deeply inserted implants should be conducted with caution in order to prevent damage to deeper neural or vascular structures in the arm and be performed by trained service providers .

46

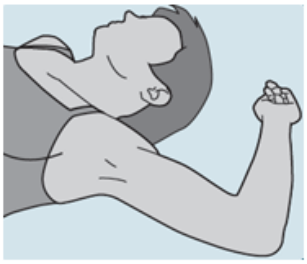
PROCEDURE OF PSI REMOVAL

- Explain the insertion procedure to the client and encourage her to ask questions, taking time to clarify any issues or concerns she may raise.
- Verify informed consent
- Prepare all the instruments and medical supplies.
- Encourage the client to wash her entire arm
- Wash your hands and dry with a clean towel.
- The precise location of the implant should be indicated on the User Card.

47

PROCEDURE OF PSI REMOVAL

- Have the woman lie down on her back, with her arm flexed, and the hand positioned close to her head, exposing the area where the implant is located.



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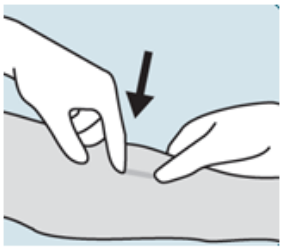
PROCEDURE OF PSI REMOVAL

- Locate the implant by palpation and mark the distal end.
- Push down the proximal tip to fix the implant; a bulge may appear indicating the distal end of the implant.



49

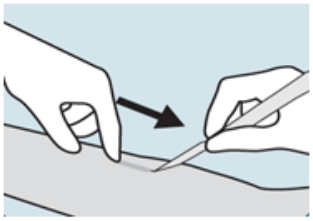
PROCEDURE OF PSI REMOVAL

- Don your sterile gloves.
- Place a sterile drape or glove wrapper under the client's arm
- Clean the area surrounding the intended incision site with a disinfectant or antiseptic solution in a circular motion, covering a wide area around the intended incision site.

50

PROCEDURE OF PSI REMOVAL

- Push down the proximal tip to fix the implant; a bulge may appear indicating the distal end of the implant.
- Make a longitudinal incision of about 2 mm over the distal tip of the implant, parallel to the long axis of the implant



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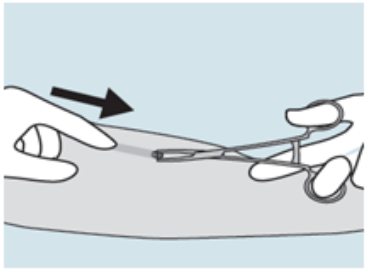
PROCEDURE OF PSI REMOVAL

- Gently push the implant towards the incision until the tip is visible. Grasp the implant with forceps and remove it.



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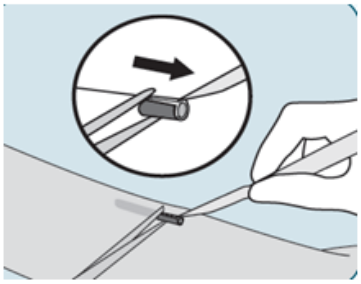
PROCEDURE OF PSI REMOVAL

- If the tip of the implant is not visible, there might be formation of fibrotic tissue around the implant.
- The fibrotic tissue can be split by continuing to cut towards the distal tip with the scalpel blade, until the tip is clearly visible.
- Remove the implant with a forceps.
- Alternatively, the fibrotic tissues may be dissected with your curved mosquito forceps, while holding the proximal end steady.

53

PROCEDURE OF PSI REMOVAL

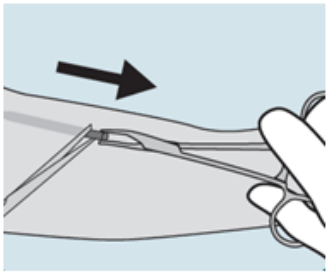
- If the tip of the implant is not visible, gently insert the forceps into the incision and grasp the implant.



54

PROCEDURE OF PSI REMOVAL

- With a second forceps, carefully dissect the tissue around the implant.
- The implant can then be removed.



55

IMMEDIATELY AFTER PSI REMOVAL

- Press on the incision site with an antiseptic-soaked sterile cotton ball.
- Close the incision with an adhesive bandage or sterile gauze.
- Apply elastic/pressure bandage over it to prevent bruising.
- Show the client the implant that has been removed, ensuring completeness.

56

IMMEDIATELY AFTER PSI REMOVAL

- If the woman would like to continue using the PSI, a new implant may be inserted immediately after the old implant is removed (see "How to replace the PSI").
- If the woman does not wish to continue using the PSI and does not want to become pregnant, another contraceptive method should be recommended.

37

POST-REMOVAL INSTRUCTIONS/GUIDELINES

- Document in the client's record the removal process, indicating the site from which it was removed, and specify any unusual events that may have occurred during removal.
- A drawing showing the approximate location of the incision site in the client's arm may be helpful.

38

POST-REMOVAL INSTRUCTIONS/GUIDELINES

- Instruct the client regarding wound care and schedule a follow up visit.
- Advise the client about care of the insertion site:
  - Keep the area dry and clean for at least 24 hours
  - Keep the elastic/pressure bandage in place for about 48 to 72 hours, and the adhesive bandage for about 3 to 5 days.
  - There may be bruising, swelling or tenderness at the insertion site for a few days. Reassure her that this is normal.
  - Routine work can be resumed immediately.

59

REPLACEMENT OF THE PROGESTIN-CONTAINING SUBDERMAL IMPLANT

60

GUIDELINES IN PSI REPLACEMENT

- Replacement of the PSI should only be performed under aseptic conditions and only by a service provider who is familiar with the insertion and removal procedure.
- Immediate replacement can be done after removal of the previous implant as described in **"How to remove the PSI"**.
- The procedure to replace the PSI is similar to the insertion procedure described in the section **"How to Insert the PSI."**

61

PROCEDURE IN PSI REPLACEMENT

- **The new implant can be inserted in the same arm, and often through the same incision from which the previous implant was removed.**
- **If the same incision is being used, the instructions below must also be taken into account.**
- **The small incision of the removal procedure can be used as the entrance for the needle of the new applicator.**
- **Additional anesthetic (~1.5 to 2 mL) will need to be placed along the implant tract.**
- **During replacement, inserting the needle to its full length is crucial; failure to do so will result in a partly visible implant in the removal incision in the skin.**

62

PROCEDURE IN PSI REPLACEMENT

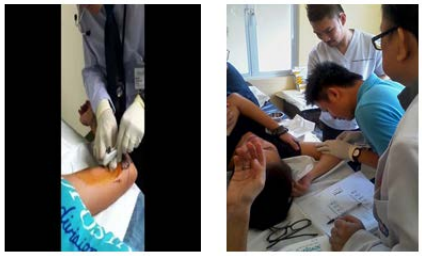
- If there was fibrotic tissue encountered during the removal process, the implant to be inserted for replacement may need to be inserted at a different angle from the previous implant "canal".

63

PROCEDURE IN PSI REPLACEMENT

- It must be noted that replacement with a new implant will move the location of the rod a few millimeters higher up in the arm.
- It is recommended to switch arm insertion sites after two implant insertions.
- The used implant and all other materials used must be adequately disposed of, in accordance with Infection Prevention practices.

64

DEMO AND RETURN DEMO WITH ARM MODEL 	At this point, inform participants that they will be divided into groups in order to practice implant insertion and removal on arm models
DEMO AND RETURN DEMO WITH ACTUAL CLIENT 	

PREPARING THE CLIENT:

1. Provide comprehensive counseling to each client.
2. Ensure that the client understands method advantages, as well as the side effects of irregular bleeding, amenorrhea, and possible delayed return of ovulation.
3. Explain the procedure to the client.
4. Encourage the client to ask questions.
5. Show supplies and materials that will be used.
6. Reassure client before and after implant insertion.

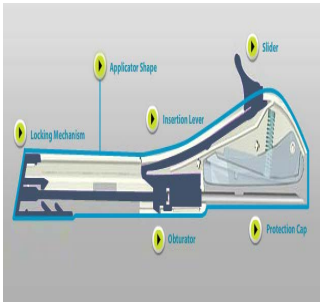
MATERIALS REQUIRED:

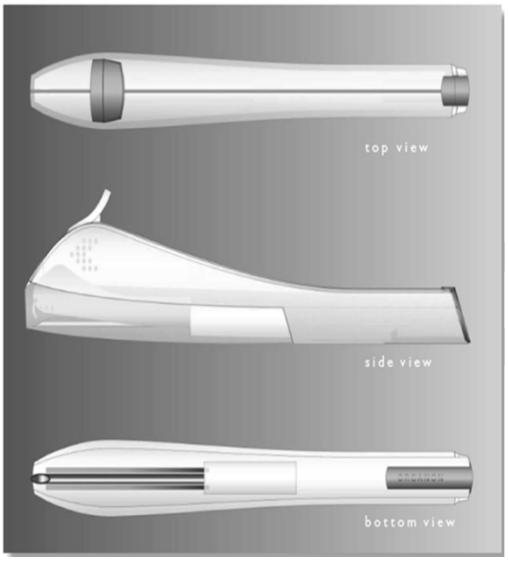
The following materials and instruments will be needed for the insertion of the Progestin-containing Subdermal Implant:

- An examination table for the patient to lie on.
- Sterile surgical drapes or wrapper of the sterile gloves
- Sterile gloves
- Bowl with antiseptic-soaked cotton balls
- Sterile marker (optional).
- Local anesthetic (1 or 2% lidocaine solution)
- 3 or 5 mL syringe with needle
- Sterile gauze or adhesive bandage with medical tape

- Elastic pressure bandage.

DELIVERY SYSTEM OF THE RADIO-OPAQUE IMPLANT:

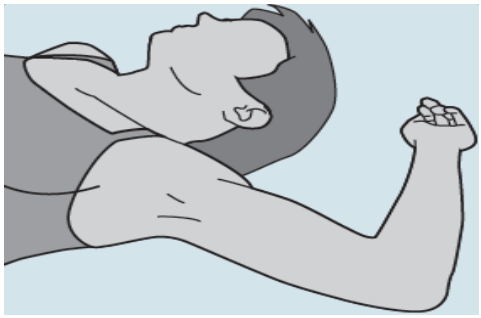




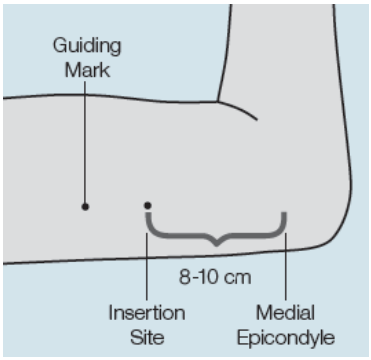
How to Insert the Progestin-containing Subdermal Implant:

- Explain the insertion procedure to the client and encourage her to ask questions, taking time to clarify any issues or concerns she may raise.
- Verify Informed Consent
- Prepare all the instruments and medical supplies
- Check the implant package for completeness of contents and expiration
- Insertion of the PSI should be performed under aseptic conditions, and only by a service provider who is familiar with the procedure.
- Encourage the woman to wash her entire arm with soap and water
- Wash your hands and dry with a clean towel
- The PSI should be inserted subdermally, just under the skin
    - The procedure used for insertion of the PSI is opposite to giving an injection. When inserting the PSI the obturator must remain fixed while the cannula

(needle) is retracted from the arm. For normal injections the plunger is pushed and the body of the syringe remains fixed.
    - To minimize the risk of neural or vascular damage, the PSI should be inserted at the inner side of the non-dominant upper arm about 8-10 cm above the medial epicondyle of the humerus.
    - If the PSI is inserted too deeply (intramuscular or in the fascia), this may cause neural or vascular damage. Too deep insertions have been associated with paresthesia (due to neural damage) and migration of the implant (due to intramuscular or fascial insertion), and in rare cases with intravascular insertion.
    - Moreover, when the implant is inserted too deeply, it may not be palpable and the localization and/or removal can be difficult later on.
- It is recommended that the provider be in a seated position during the entire insertion so that the insertion site and the movement of the needle just under the skin can be clearly seen from the side.
- Have the client lie on her back with her non-dominant arm (the arm which the woman does not use for writing) turned outwards and bent at the elbow, so that her hand is positioned next to her head.



• Make two marks: the insertion site where the implant will be inserted, and the second, a few centimeters proximal to the first mark. This second mark will later serve as a direction guide during insertion.

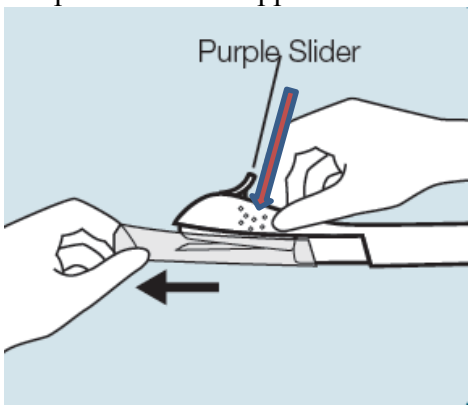


- Don your sterile gloves.
- Place a sterile drape or the glove wrapper under the woman's arm
- Clean the insertion site with a disinfectant or antiseptic solution in a circular motion, covering a wide area around the insertion site.

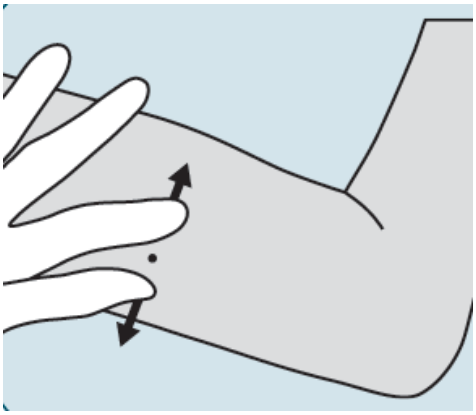
• Anesthetize with 2 ml of lidocaine (1% or 2%) applied just under the skin along the 'insertion canal'. To prevent local anesthetic toxicity, the total dose should not exceed 10ml (10grams/liter) of a 1% local anesthetic without epinephrine. Wait for 3 minutes for anesthesia to take effect.
• Remove the sterile disposable applicator carrying the PSI from its blister. Ensure that the sterility of the applicator is not compromised.

Insertion of the Radio-opaque Implant:

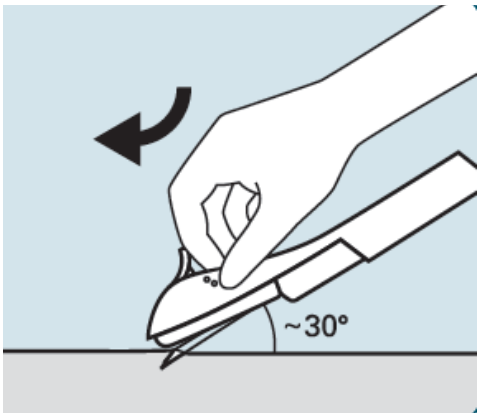
- Hold the applicator in an upright position, just above the needle, at the textured surface area. Remove the transparent protection cap by sliding it horizontally in the direction of the arrow away from the needle. If the cap does not come off easily, the applicator should not be used.
- Check the tip of the needle for the presence of the white colored implant. Do not touch the purple slider until you have fully inserted the needle subdermally, as it will retract the needle and prematurely release the implant from the applicator.



- With your free hand, stretch the skin around the insertion site with thumb and index finger.

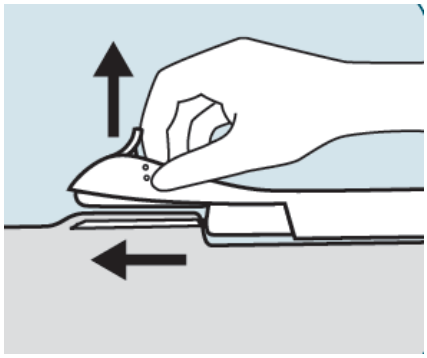


- Puncture the skin with the tip of the needle angled at about 20^{o} relative to the skin surface .

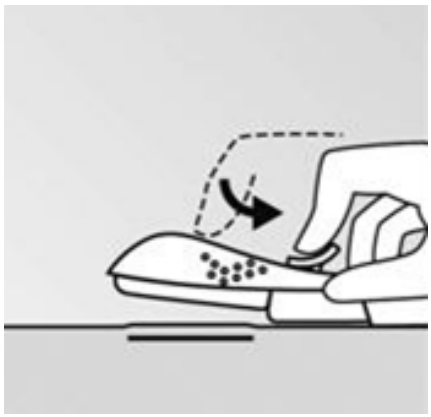


- Release the skin being stretched with the other hand.

- As soon as the bevel of the needle is inserted into the skin, lower the applicator to a horizontal position. While lifting the skin with the tip of the needle, slide the needle to its full length. You may feel slight resistance but do not exert excessive force. If the needle is not inserted to its full length, the implant will not be inserted properly. You can best see movement of the needle if you are seated and are looking at the applicator from the side and not from above. In this position, you can clearly see the insertion site and the movement of the needle just under the skin.



- Keep the applicator in the same position with the needle inserted to its full length. If needed, you may use your free hand to keep the applicator in the same position during the following procedure. Unlock the purple slider by pushing it slightly down. Move the slider fully back until it stops. The implant is now in its final subdermal position, and the needle is locked inside the body of the applicator. The applicator can now be removed. If the applicator is not kept in the same position during this procedure or if the purple slider is not completely moved to the back, the implant will not be inserted properly.



Immediately after Insertion

- After retraction of the applicator, have a sterile gauze or cotton ball ready to be applied at the insertion site.
- Always verify the presence of the implant in the women's arm immediately after insertion by palpation. Have the woman palpate the implant as well.
- Apply sterile gauze/adhesive bandage with a pressure bandage to prevent bruising.
- Fill out the User Card and hand it over to the subject to facilitate removal of the implant later on.
- The applicator is for single use only and must be adequately disposed of, in accordance with local regulations for the handling of biohazardous waste.

Post-Insertion Instructions/Guidance:

- Place a note in the client's record indicating the location of the rod, the type of rod, and specify any unusual events that may have occurred during insertion. A drawing showing the approximate location of the rod in the client's arm may be helpful
- Instruct the client regarding wound care and schedule a follow up visit (after 1 week and between 3 to 6 months, then yearly for well – women check up).
- Advise the client about care of the insertion site:
    - Keep the area dry and clean for at least 24 hours
    - Keep the elastic/pressure bandage in place for about 48 to 72 hours, and the adhesive bandage for about 3 to 5 days.
    - There may be bruising, swelling or tenderness at the insertion site for a few days. Reassure her that this is normal
    - Routine work can be resumed immediately
    - Provide client with wound care instructions and date of follow up
- Advise the client about common side effects that contraceptive implant users may experience, including headaches, acne, weight change, breast tenderness, abdominal discomfort, mood changes and nausea.
- Advise the client that she may opt to have the implant removed at anytime if:
    - She is desirous of pregnancy
    - She is intolerant of the side effects
    - She wishes to have it replaced after 3 years
    - She has a co-morbid or medical condition that warrants discontinuation of the hormonal contraceptive

How to Remove the Progestin-containing Subdermal Implant

Sterile instruments and supplies to be prepared for removal

- Bowl with antiseptic-soaked cotton balls
- Sterile surgical gloves
- Sterile drape or wrapper of sterile gloves
- 3- or 5-ml syringe with needle
- 1% or 2% lidocaine anesthetic without epinephrine
- Sterile scalpel with surgical blade no.12 or 15
- Curved mosquito forceps/dissecting forceps - 2 pcs
- Bandage adhesive or gauze with surgical tape
- Elastic bandage (1 ½ inch width)

For implant replacement: new sterile contraceptive implant in sterile package

Localizing the PSI Before Removal

- Review the client's user card to determine site of previous insertion
- Localization is an essential component of the insertion and removal process. Palpation is the first step in the localization process.
- Always localize by palpation prior to removal.

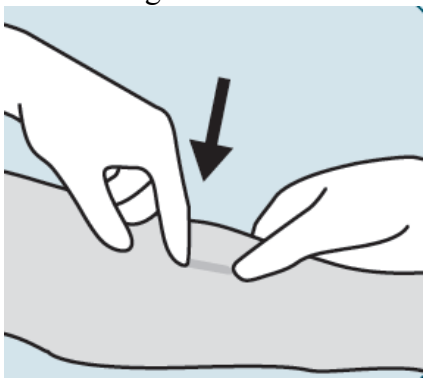
Removing the PSI

- Removal of the PSI should be performed only by a service provider who is familiar with the procedure.
- Indications for removal
    - Patient request
    - Medical indication
    - At the end of 3 years of use
- If the woman does not wish to become pregnant, another contraceptive method should be started immediately (return to fertility may be very rapid).
- Counsel the patient thoroughly prior to removal of the PSI.
- Removal of deeply inserted implants should be conducted with caution in order to prevent damage to deeper neural or vascular structures in the arm and be performed by trained service providers .

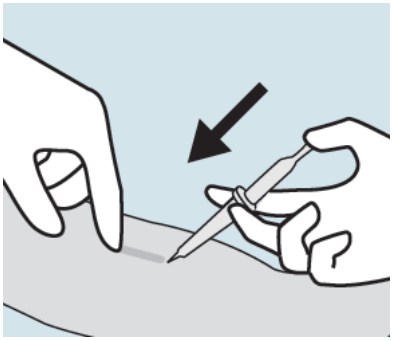
How to Remove the Implant

- Explain the insertion procedure to the client and encourage her to ask questions, taking time to clarify any issues or concerns she may raise.
- Verify informed consent
- Prepare all the instruments and medical supplies.
- Encourage the client to wash her entire arm
- Wash your hands and dry with a clean towel.
- The precise location of the implant should be indicated on the User Card.
- Have the woman lie down on her back, with her arm flexed, and the hand positioned close to her head, exposing the area where the implant is located.

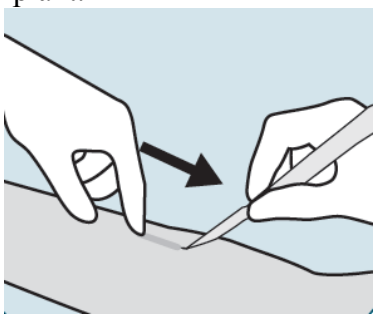
- Locate the implant by palpation and mark the distal end. Push down the proximal tip to fix the implant; a bulge may appear indicating the distal end of the implant.



- Don your sterile gloves.
- Place a sterile drape or glove wrapper under the client's arm
- Clean the area surrounding the intended incision site with a disinfectant or antiseptic solution in a circular motion, covering a wide area around the intended incision site.
- Keeping the implant fixed by pressing on the proximal end to fix it in place, anesthetize the arm with 0.5-1 ml lidocaine (1% or 2%) at the site of incision, just beneath the distal end of the implant. Apply the anesthetic under the distal tip of the implant. Application above the implant makes the skin swell, which may cause difficulty in locating the implant. Wait for 3 minutes for anesthesia to take effect.

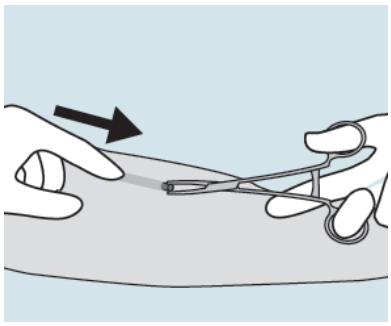


- Push down the proximal tip to fix the implant; a bulge may appear indicating the distal end of the implant. Make a longitudinal incision of about 2 mm over the distal tip of the implant, parallel to the long axis of the implant.

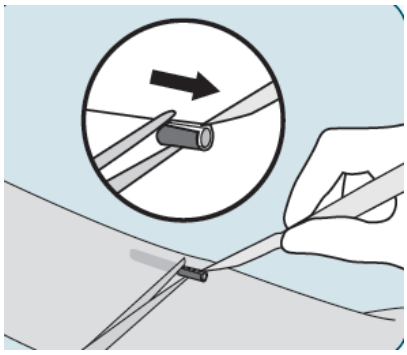


- Gently push the implant towards the incision until the tip is visible. Grasp the implant with

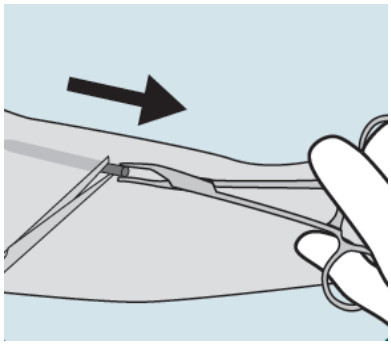
forceps and remove it.



- If the tip of the implant is not visible, there might be formation of fibrotic tissue around the implant. The fibrotic tissue can be split by continuing to cut towards the distal tip with the scalpel blade, until the tip is clearly visible. Remove the implant with a forceps. Alternatively, the fibrotic tissues may be dissected with your curved mosquito forceps, while holding the proximal end steady.
- If the tip of the implant is not visible, gently insert the forceps into the incision and grasp the implant.



- With a second forceps, carefully dissect the tissue around the implant. The implant can then be removed.



- As soon as the entire implant is removed, press on the incision site with an antiseptic-soaked sterile cotton ball.
- Close the incision with an adhesive bandage or sterile gauze.
- Apply elastic/pressure bandage over it to prevent bruising.
- Show the client the implant that has been removed, ensuring completeness.
- If the woman would like to continue using the PSI, a new implant may be inserted immediately after the old implant is removed (see **"How to replace the PSI"**).
- If the woman does not wish to continue using the C and does not want to become pregnant,

another contraceptive method should be recommended.

Post-removal guidelines

- Document in the client's record the removal process, indicating the site from which it was removed, and specify any unusual events that may have occurred during removal. A drawing showing the approximate location of the incision site in the client's arm may be helpful
- Instruct the client regarding wound care and schedule a follow up visit.
- Advise the client about care of the insertion site:
    - Keep the area dry and clean for at least 24 hours
    - Keep the elastic/pressure bandage in place for about 48 to 72 hours, and the adhesive bandage for about 3 to 5 days.
    - There may be bruising, swelling or tenderness at the insertion site for a few days. Reassure her that this is normal
    - Routine work can be resumed immediately
- If the client is not desirous of pregnancy but does not wish replacement with a new implant, provide counseling on family planning options.

How to Replace the PSI

- Replacement of the PSI should only be performed under aseptic conditions and only by a service provider who is familiar with the insertion and removal procedure.
- Immediate replacement can be done after removal of the previous implant as described in **"How to remove the PSI."**
- The procedure to replace the PSI is similar to the insertion procedure described in the section **"How to Insert the PSI."**
- The small incision of the removal procedure can be used as the entrance for the needle of the new applicator.
- Additional anesthetic (~1.5 to 2 mL) will need to be placed along the implant tract.
- During replacement, inserting the needle to its full length is crucial; failure to do so will result in a partly visible implant in the removal incision in the skin.
- If there was fibrotic tissue encountered during the removal process, the implant to be inserted for replacement may need to be inserted at a different angle from the previous implant "canal".
- It must be noted that replacement with a new implant will move the location of the rod a few millimeters higher up in the arm. It is recommended to switch arm insertion sites after two implant insertions.
- The used implant and all other materials used must be adequately disposed of, in accordance with local regulations for the handling of bio-hazardous waste.

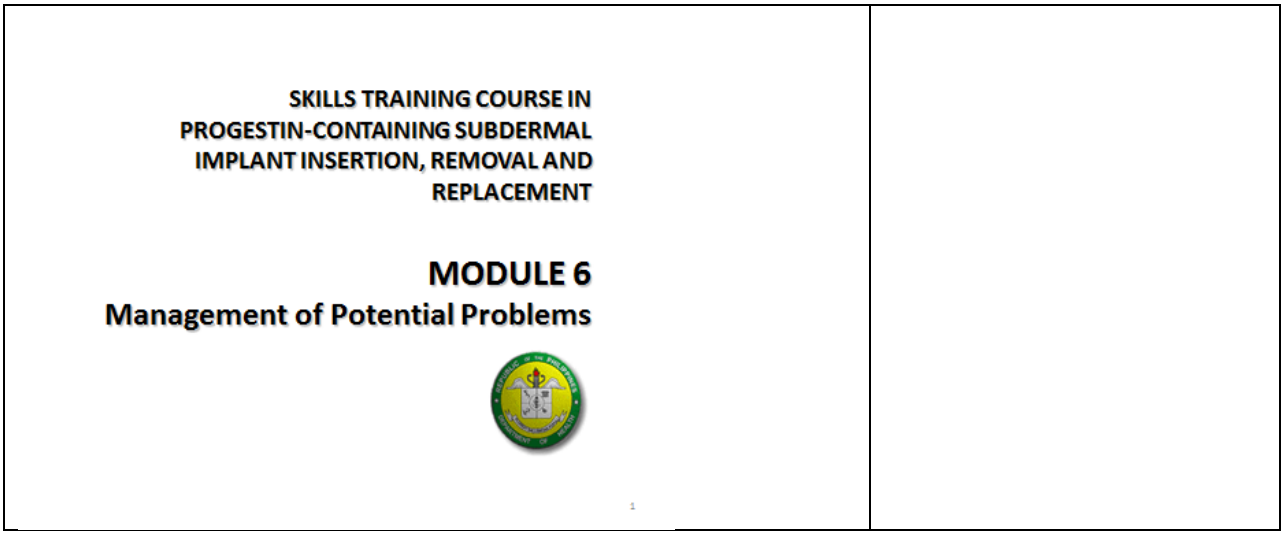
MODULE 6: MANAGEMENT OF POTENTIAL PROBLEMS RELATED WITH THE USE OF THE CONTRACEPTIVE SUBDERMAL IMPLANT

OVERVIEW

Potential problems resulting contraceptive implant provision and use range from minor side effects to potentially serious complications. The incidence of these problems is low and serious complications are even rare. Though rare, the service provider must be aware of these potential complications resulting from contraceptive implants and know how to manage these.
These complications are preventable.

LEARNING OBJECTIVES

1. Discuss the PSI in terms of its:
   - possible side effects
   - potential health risks or complications
2. Discuss the different management options pertaining to contraceptive subdermal implant side effects and complications



OVERVIEW

- **Potential problems resulting contraceptive implant provision and use range from minor side effects to potentially serious complications.**
- **The incidence of these problems is low and serious complications are even rare.**
- **Though rare, the service provider must be aware of these potential complications resulting from contraceptive implants and know how to manage these.**
- **These complications are preventable.**

LEARNING OBJECTIVES

- **Discuss the PSI in terms of its:**
  - **possible side effects**
  - **potential health risks or complications**
- **Discuss the different management options pertaining to PSI side effects and complications**

3

SIDE EFFECT

- **A consequence of a procedure, contraceptive method or medication other than that intended;**
- **Does not require exceptional intervention, but it may require attention and management which is usually limited to re-assurance that no undue harm is expected.**

COMPLICATION

- **Requires intervention or management beyond what was planned or what is normally provided during the actual PSI provision or use.**

5

POSSIBLE SIDE EFFECTS

- **LOCAL REACTIONS AT INSERTION SITE**: bruising and tenderness, scarring, skin discoloration, expulsion, infection
- **NAUSEA/DIZZINESS/VOMITING**
- **CHANGES IN MENSTRUAL PATTERN**: amenorrhea, vaginal spotting, inter-menstrual bleeding, heavy or prolonged bleeding
- **DYSMENORRHEA**
- **WEIGHT CHANGES**
- **ACNE**
- **EXCESSIVE HAIR GROWTH OR HAIR LOSS**
- **MOOD CHANGES OR LOSS OF LIBIDO**
- **ABDOMINAL PAIN**

INCIDENCE OF ADVERSE EVENTS AND RATES OF DISCONTINUATION

Adverse Events

Adverse Events
thought to be related to IMPLANON® in >5% of women

WHO preferred term	AE %	Discontinuation %
Headache	15.3	1.6
Weight increase	11.8	2.3
Acne	11.4	1.3
Breast pain	10.2	< 1
Emotional lability	5.7	2.3
Abdominal pain	5.2	< 1

7

PREVENTION OF REACTIONS AT INSERTION SITE

- **If recommended infection prevention practices are followed, problems with healing of the insertion site are infrequent.**
- **Therefore, with adequate attention to pre-insertion skin preparation, use of aseptic technique, and correct placement of the rods, the risk of infection should be very low.**

8

LOCAL SKIN REACTIONS

- Some **bruising and tenderness** at the insertion site is common.
- Because the incision is small, insertion does not leave a noticeable **scar** in most women.
- In some women, however, **darkening of the skin** over the insertion site occurs.

9

OTHER LOCAL REACTIONS

- **Expulsion** of PSI rods is uncommon.
  - This problem occurs most often when the ends are too close to the incision, or when infection is present
- **Migration/Breakage of the implant**: Once inserted, they will not move around or break inside the arm.

10

INFECTION AT INSERTION SITE

- **Check area of insertion for infection (pain, heat, and redness), pus or abscess**
  - If there is infection (not abscess), wash area with soap and water and give appropriate oral antibiotic for 7 days.
- **Do not remove rods. Ask client to return after 1 week.**
- **If no improvement, remove rods and insert a new set in the other arm or help client choose another method.**

11

INFECTION AT INSERTION SITE

- **If there is abscess:**
  - Prep with antiseptic.
  - Incise and drain.
  - Remove rods.
  - Perform daily wound care.
  - Give oral antibiotics for 7 days.
- **Insert new set in the other arm or help client choose another method.**

12

NAUSEA/VOMITTING/ DIZZINESS/MILD HEADACHE

- **Check for pregnancy by checking symptoms, performing a pelvic examination (speculum and bimanual), and a pregnancy test (if indicated and available).**
- **If pregnant, manage accordingly;**
- **If not pregnant, reassure that this is not a serious problem and usually disappears with time.**
- **Mild headache may require intake of analgesics.**

13

CHANGES IN MENSTRUAL PATTERN

INCIDENCE:

- **Menstrual irregularity:** universal or seen in all women who use the implant; ranging from amenorrhea, vaginal spotting, heavy or prolonged bleeding

MANAGEMENT:

- Reassure the client that breakthrough bleeding and spotting are common

14

AMENORRHEA

- **Reassure the client that amenorrhea is an expected side effect, and that she can expect menstrual cycles to return to normal within 6 months of discontinuing the implant.**
- **Amenorrhea occurs in about 7% of LNG implants users in the first year and decreases thereafter.**
- **Amenorrhea for 6 weeks or more, especially after a pattern of regular menses, may signal pregnancy and should be evaluated:**
  - Check for pregnancy (intrauterine or ectopic) by history, checking symptoms and performing a pelvic examination (speculum and bimanual) or a pregnancy test, if indicated and available.

15

DYSMENORRHEA

INCIDENCE:

- **Seen in 40% of women having natural menstrual cycles.**
- **In 88% of these women, the pain disappears or is significantly reduced during Implant use.**
- **In 2% of Implant users, dysmenorrhoea becomes worse.**

MANAGEMENT:

- **ANALGESICS – of any kind; dosage depending on severity of symptom**

16

WEIGHT CHANGES

INCIDENCE:

- **Studies have shown an increase of 2.6% in body weight over a two year period of Implant use.**

MANAGEMENT

- **Review diet and counsel on diet modification and exercise.**

17

ACNE

INCIDENCE:

- **The incidence of acne is similar in the general population (24%)**
- **Of women who suffered from acne in their natural cycles, 58% noted an improvement with implant use.**
- **Acne occurred for the first time in 14% of women using the implant.**

MANAGEMENT:

- **Recommend cleaning face twice a day and avoiding use of heavy facial creams.**
- **Counsel as appropriate, especially if stress is a factor.**
- **If condition is not tolerable, help client choose another (non-hormonal) method.**

18

Excess Hair Growth or Hair Loss

INCIDENCE:

- **Alopecia** - Seen in 1-2% of implant users;
- Pre-existing conditions such as excess facial or body hair might be worsened by implants use.

MANAGEMENT:

- Review history, before and after insertion
- Hair changes usually are not excessive, may improve over time, and do not require implant removal unless client requests it after counseling.

19

DEPRESSION

(MOOD CHANGES OR LOSS OF LIBIDO)

- Depression or loss of libido may be associated with progestins;
- If the client thinks her depression has worsened while using contraceptive implants, help her choose another method;
- If there are changes in her life that could affect her mood or sex drive including changes in her relationship with her partner, give her emotional support as necessary.
- If her mood changes are serious to entertain major depression, refer for proper psychological care.

20

ABDOMINAL PAIN

- Enlarged ovarian follicles or follicular cysts sometimes have been implicated to cause lower abdominal pain among women using implants as well as those using other progestin-only contraceptives.
- Most women, however, are not aware of them, and they are discovered only incidentally on pelvic examination.
- Because they disappear on their own in the vast majority of women, treatment is not required unless they become symptomatic.
- Surgical treatment may be required if there would be gradual enlargement, torsion, or rupture of these cysts

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POTENTIAL COMPLICATIONS

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POTENTIAL COMPLICATIONS

- SEVERE HEADACHE
- SEVERE HYPERTENSION
- UNRESOLVED PROLONGED OR HEAVY VAGINAL BLEEDING
- OVARIAN CYST
- PREGNANCY
- MASTALGIA OR BREAST INFECTION
- VASCULAR CHANGES (including HOT FLASHES)
- UNRESOLVED INFECTION
- NON-PALPABLE IMPLANT

23

PREVENTION OF POTENTIAL COMPLICATIONS

- **Careful screening of clients**
- **Adherence to infection prevention practices**
- **Provision by trained and skilled health personnel**
- **Following post-insertion follow-up guidelines especially in the advent of warning signs**

24

WARNING SIGNS

- **Severe headaches**
- **Heavy bleeding: twice as much and twice as long or is bothersome**
- **Severe lower abdominal pain**
- **Signs of pregnancy**
- **Unresolved swelling or inflammation at insertion site**
  - **Would require further evaluation and management**

25

HEADACHE

(Especially with Blurred Vision)

- Ask if there has been a change in pattern or severity of headaches since insertion of implants.
- Perform physical examination, measure BP.
- Examine as appropriate:
  - Eyes (fundoscopic)
  - Neurologic system
- If headaches are mild, treat with analgesics (aspirin, ibuprofen, paracetamol or other analgesics) and reassure.
  - Re-evaluate after 1 month if mild headaches persist.

26

HEADACHE

(Especially with Blurred Vision)

- If headaches have changed since starting implants (i.e., numbness or tingling accompanied by loss of speech, visual changes or blurred vision) remove implants and help client choose another (non-hormonal) method.

27

HYPERTENSION

(≥160/100 mmHg)

- Ask if this is the first time anyone has told her that she has high blood pressure.
  - Allow 15 minutes rest, then repeat BP reading.
- Counsel client that a mild increase in BP (< 160/100) does not require removal of implants unless she requests it.
- If requested, help the client choose another method.

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HYPERTENSION

(160/100 mmHg)

- In addition, tell her that high BP usually goes away within 1–3 months.
  - Take BP monthly to be sure it returns to normal.
  - If after 3 months it has not returned to normal, refer for further evaluation.
- If BP > 160/100 or she has arterial vascular problems (e.g., heart attack, stroke, kidney failure, or retinopathy), the implants should be removed.
  - Help her choose another (non-hormonal) method

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VASCULAR CHANGES

(including Hot Flashes)

- Assess for possible cardiovascular disease (CVD)
- Also, check:
  - BP
  - Heart for irregular beats (arrhythmias)
- If there is evidence of CVD, refer for further evaluation.
- Low-dose progestins do not increase the risk of CVD; therefore, removal of implants is not necessary unless the client requests it

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PROLONGED VAGINAL BLEEDING

Incidence:

- Irregular (< 15 day interval) bleeding as well as prolonged spotting or bleeding (8 days or more) are common and expected in LNG implant users - over 65% experienced this during the first year (Sivin 1988).
- In ETG implant users, 20% of women reported frequent and/or prolonged bleeding.
- In addition, moderate menstrual bleeding more than twice as long as a normal menses occurs in 20-30% of implants users during the first 3-6 months.

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PROLONGED VAGINAL BLEEDING

Management:

- For a woman with prolonged spotting or moderate bleeding, the first approach should be counseling and reassurance.
- It should be explained that in the absence of other causes (e.g., cervicitis or cervical polyp) this type of bleeding is not harmful, even if prolonged for several weeks.
- Furthermore, these prolonged bleeding or spotting episodes typically become lighter and shorter in succeeding months.

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Management of Prolonged Vaginal Bleeding

- If, after reassurance, the woman is still unhappy with the irregular bleeding, but wants to continue using implants, a short course (1–3 cycles) of COCs may be tried using:
  - A low-dose COCs (30–35 µg EE) once daily for 21 days (Technical Guidance Working Group[TGWG], 1994).

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Management of Prolonged Vaginal Bleeding

- If COCs are not appropriate for personal or medical reasons, try:
  - Ibuprofen (or another NSAID) up to 800 mg three times daily for 5 days (Technical Guidance Working Group [TGWG] 1994).
  - Mefenamic acid 500 mg three times a day after meals when irregular bleeding starts. (*A Global Handbook for Providers 2011, part of the WHO Family Planning Connerstone).*

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Rationale for Treatment Regimen

- **Combined oral contraceptive**s control or stop bleeding by rebuilding the endometrium.
  - Combined oral contraceptives, which also contain a progestin, are preferred over estrogens (either 20–50 µg EE or 1.25 mg conjugated estrogens) because they are more effective (Alvarez-Sanchez et al. 1996).
  - Furthermore, both EE and conjugated estrogen are expensive and seldom available.
- **Ibuprofen**, which blocks prostaglandin synthesis, decreases uterine contractions and blood flow to the endometrium (Angle, Huff and Lea 1991).

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Management of Heavy Bleeding

- **Heavy bleeding (twice as long or twice as much as normal) is very uncommon with implants but** usually can be managed with low-dose COCs (with or without ibuprofen).
  - If the irregular bleeding continues or starts after several months of normal cycles, some underlying condition unrelated to the implant may be the cause and a thorough investigation is necessary.
- **If the bleeding is not reduced in 3–5 days or is much heavier** (one or two pads or cloths per hour):
  - Determine whether there are other causes for the uterine bleeding.
  - Give 2 low-dose COC pills per day for the remainder of the cycle (at least 3–7 days), followed by 1 cycle (1 pill per day) of COCs.
  - Alternatively (if available), give a 50 µg EE-containing COC or 1.25 mg conjugated estrogen for 14–21 days

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Management of Heavy Bleeding

- **Note: Check to be sure vaginal bleeding has decreased within 3 days.**
  - If COCs or estrogens fail to correct the bleeding problem, the implants may need to be removed for medical reasons (excessive bleeding) or due to the client's wishes (Technical Guidance Working Group [TGWG] 1994).
- Do **not perform a D&C unless another medical condition (e.g., endometrial polyp or incomplete** abortion) is suspected.
  - If uterine evacuation is necessary, manual vacuum aspiration, not D&C, is the preferred method for emptying the uterine cavity.
- For anemia, give nutritional advice on the need to increase iron intake.
  - Use oral iron treatment (one tablet containing at least 100 mg elemental iron, $FeSO_4$, daily for 1–3 months) if hemoglobin = 9g/dl or hematocrit = 27.

37

BREAST FULLNESS OR TENDERNESS (MASTALGIA)

CHECK BREASTS FOR:

- Lumps or cysts, and
- Discharge or galactorrhea (leakage of milk-like fluid), if not breastfeeding.

- **If she is breastfeeding and breast/s is/are tender, examine for breast infection**
  - **If there is breast infection, use warm compresses, advise to continue breastfeeding and give antibiotics as appropriate.**
  - **If breast(s) is not infected, recommend a bra that provides additional support or suggest pain reliever.**

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BREAST FULLNESS OR TENDERNESS (MASTALGIA)

- If pregnant, manage accordingly
- If not pregnant, do not remove rods unless client requests it after counselling.

- If physical examination shows lump or discharge suspicious for cancer (e.g., firm, non-tender or fixed and which does not change during menstrual cycle), refer for diagnosis.
  - If no abnormality, reassure.

- For any of the above conditions, do not remove rods unless client requests it after counseling.

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PREGNANCY

- **If intrauterine pregnancy is confirmed**:
  - counsel client regarding removal of implant and assure her that the small dose of progestin to which she was exposed will have no harmful effect on the fetus.

- If **miscarriage (spontaneous abortion) occurs**, it is not necessary to remove the implants.

- If **ectopic pregnancy is suspected:**
  - **refer at** once for complete evaluation and prompt management.

- Do **not give hormonal treatment (COCs) to** induce withdrawal bleeding. It is not necessary and usually is not successful.

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THROMBOSIS

- Although the clinical relevance of the finding for etonogestrel used as a contraceptive in the absence of an estrogenic component is unknown, **the implant should be removed in the event of a thrombosis.**
- **Implant removal should also be considered in case of long-term immobilization due to surgery or illness.**
- Although the CSI is a progestogen-only contraceptive, it is recommended to assess factors which are known to increase the risk of venous and arterial thromboembolism.
- Women with a history of thrombo-embolic disorders should be made aware of the possibility of a recurrence.

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EXPOSURE IN THE EVENT OF PREGNANCY

- The use of CSIs is not indicated during pregnancy.
  - If pregnancy occurs during use of the CSI, the implant should be removed.
  - Animal studies have shown that very high doses of progestagenic substances may cause masculinization of female fetuses.
- Extensive epidemiological studies have revealed **neither an increased risk of birth defects** in children born to women who used oral contraceptives (OCs) prior to pregnancy, nor of a teratogenic effect when OCs were inadvertently used during pregnancy.

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DRUG INTERACTION

- 5% of reported pregnancies during use of CSIs have been due to drug interactions. As with any hormonal contraceptive the efficacy of progestin-containing subdermal implants may be affected by concomitant use of CYP 450 enzyme inducing drugs including:
  - Phenytoin
  - Phenobarbital
  - Primidone
  - Carbamazepine
  - Rifampicin
- IMPLANON may possibly also be affected by:
  - Oxcarbazepine
  - Topiramate
  - Felbamate
  - Griseofulvin
  - The herbal remedy St John's wort
  - And other CYP 450 enzyme inducers

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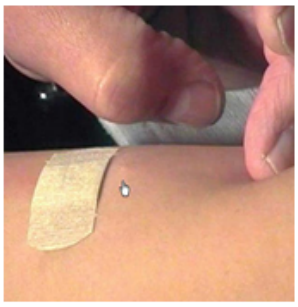
LOCALIZATION OF IMPLANT

- Localization is a critical part of the PSI insertion and removal process. Always verify the location of the implant through palpation immediately after insertion and prior to removal.
- The localization process begins with palpation. If the implant is clearly and easily palpable, the localization process is complete.



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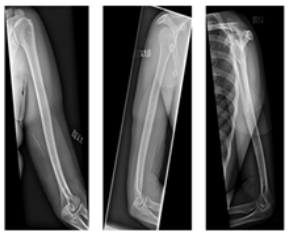
LOCALIZATION OF NON-PALPABLE IMPLANT

If unable to palpate an implant immediately following insertion:

- Do X-ray of the upper arm as quickly as possible; preferably immediately following the insertion procedure.
- The patient may need to use backup contraception if the presence of the implant is not immediately verified.
- If more information is needed, consider additional documentation via **ultrasound, CT scan or MRI.**



45

LOCALIZATION OF NON-PALPABLE IMPLANT

- Localization of the Implant is a critical aspect of the removal process. **Do not attempt to remove an impalpable implant!**
- Before initiating the removal procedure, the health care provider should consult the User Card for the location of the implant.
- At removal, you may encounter implants that were:
  - Inserted after the launch of IMPLANON NXT and are radiopaque.
  - Inserted before the launch of IMPLANON NXT and are non-radiopaque.
- The selection of the most appropriate imaging technique to be used to locate an impalpable implant depends on whether or not the implant is radiopaque.

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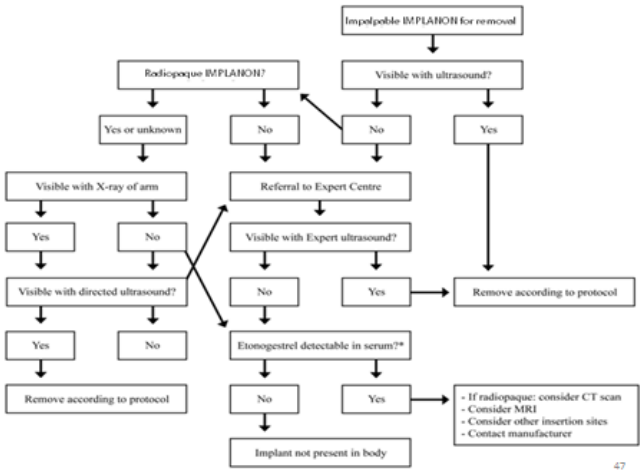

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IMAGING METHODS

- The imaging method that will be effective in locating an implant that cannot be palpated will depend on the type of implant that has been used.

- **Two-Dimensional X-ray**
  - When utilizing this approach, refer the patient to a radiologist. Describe the size, shape and likely location of the implant (right or left upper arm, etc.).
- **CT Scan**
  - Refer the patient to a radiologist and explain the size, shape and likely location of the implant. Ask for exact localization (depth and tissue layer) information.
  - Ask for a marker on the patient's arm that relates to the CT scan pictures and indicate that the marker is required for removal purposes. Remove deeply inserted implants under live ultrasound guidance.

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IMAGING METHODS

- **Ultrasound**
  - The radiopaque PSI appears as a sharp acoustic shadow below the implant in the transverse position and a small echogenic spot (2 mm) when viewed in transverse position.
  - Important to use linear array transducer.
  - Transducer frequency above 10 MHz.
  - Consider this method for removal of deep implants.

- **MRI**
  - The radiopaque PSI appears as a hypodense area.
  - Important to differentiate from blood vessels.
  - Can be followed through images for 40 mm.

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MANAGEMENT

- After localization of a non-palpable implant, consider conducting removal with ultrasound guidance.
- Removal of deeply inserted implants should be conducted with caution in order to prevent damage to deeper neural or vascular structures in the arm and should be performed only by health care providers who are familiar with the anatomy of the arm.
- **Exploratory surgery without knowledge of the exact location of the implant is strongly discouraged.**
- Appropriate imaging should verify the location of most implants.

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CASE STUDIES

SIDE EFFECT

- Defined as a consequence of a procedure, contraceptive method or medication other than that intended;
- Does not require exceptional intervention, but it may require attention and management which is usually limited to re-assurance that no undue harm is expected.

COMPLICATION

- Requires intervention or management beyond what was planned or what is normally provided during the actual contraceptive implant provision or use.

POSSIBLE SIDE EFFECTS

- LOCAL REACTIONS AT INSERTION SITE: bruising and tenderness, scarring, skin discoloration, expulsion, infection
- NAUSEA/DIZZINESS/VOMITING
- CHANGES IN MENSTRUAL PATTERN: amenorrhea, vaginal spotting, inter-menstrual bleeding, heavy or prolonged bleeding
- DYSMENORRHEA
- WEIGHT CHANGES
- ACNE
- EXCESSIVE HAIR GROWTH OR HAIR LOSS
- MOOD CHANGES OR LOSS OF LIBIDO

- ABDOMINAL PAIN

PREVENTION OF REACTION AT INSERTION SITE

- If recommended infection prevention practices are followed, problems with healing of the insertion site are infrequent.
- Therefore, with adequate attention to pre-insertion skin preparation, use of aseptic technique, and correct placement of the rods, the risk of infection should be very low.

LOCAL SKIN REACTIONS

- Some **bruising and tenderness at the insertion site** is common.
- **Scarring:** Because the incision is small, insertion does not leave a noticeable scar in most women.
- In some women, however, **darkening of the skin over the insertion** site occurs.
- Expulsion of PSI rods is uncommon.
    - This problem occurs most often when the ends are too close to the incision, or when infection is present
- **Migration/Breakage of the implant**: Once inserted, they will not move around or break inside the arm.

1. INFECTION AT INSERTION SITE

- Check area of insertion for infection (pain, heat, and redness), pus or abscess
    - If infection (not abscess), wash area with soap and water and give appropriate oral antibiotic for 7 days.
    - Do not remove rods. Ask client to return after 1 week.

- If no improvement, remove rods and insert a new set in the other arm or help client choose another method.
- **If there is an abscess:**
    - Prep with antiseptic.
    - Incise and drain.
    - Remove rods.
    - Perform daily wound care.
    - Give oral antibiotics for 7 days.
- Insert new set in the other arm or help client choose another method.

2. NAUSEA/DIZZINESS/VOMITTING/MILD HEADACHE

- Check for pregnancy by checking symptoms, performing a pelvic examination (speculum and bimanual), and a pregnancy test (if indicated and available).
- If pregnant, manage accordingly;
- If not pregnant, reassure that this is not a serious problem and usually disappears with time.
- Mild, intolerable headache may require intake of analgesics.

3. CHANGES IN MENSTRUAL PATTERN

- **Menstrual irregularity:** universal or seen in all women who use the implant; ranging from amenorrhea, vaginal spotting, heavy or prolonged bleeding

- Reassure the client that breakthrough bleeding and spotting are common and will return to normal in 3-6 months

4. AMENORRHEA

- Reassure the client that amenorrhea is an expected side effect, and that she can expect menstrual cycles to return to normal within 6 months of discontinuing the implant.
- Amenorrhea occurs in about 7% of LNG implants users in the first year and decreases thereafter.
- Amenorrhea for 6 weeks or more, especially after a pattern of regular menses, may signal pregnancy and should be evaluated:
- Check for pregnancy (intrauterine or ectopic) by history, checking symptoms and performing a pelvic examination (speculum and bimanual) or a pregnancy test, if indicated and available.

5. DYSMENORRHEA

- Seen in 40% of women having natural menstrual cycles.
- In 88% of these women, the pain disappears or is significantly reduced during Implant use.
- In 2% of implant users, dysmenorrhoea becomes worse.
- May be managed by analgesics of any kind; dosage depending on severity of symptom

6. WEIGHT CHANGES

- Studies have shown an increase of 2.6% in body weight over a two year period of Implant use.
- Review diet and counsel on diet modification and exercise.

7. ACNE

- The incidence of acne is similar in the general population (24%). Of women who suffered from acne in their natural cycles, 58% noted an improvement with implant use. Acne occurred for the first time in 14% of women using the implant.
- Recommend cleaning face twice a day and avoiding use of heavy facial creams. Counsel as appropriate, especially if stress is a factor. If condition is not tolerable, help client choose another (non-hormonal) method.

8. EXCESS HAIR GROWTH OR HAIR LOSS

- **Alopecia** - Seen in 1-2% of implant users;
- Pre-existing conditions such as excess facial or body hair might be worsened by implants use.
- Review history, before and after insertion. Hair changes usually are not excessive, may improve over time, and do not require implant removal unless client requests it after counselling.

9. MOOD CHANGES OR LOSS OF LIBIDO

- Depression or loss of libido may be associated with progestins. If the client thinks her depression has worsened while using contraceptive implants, help her choose another method;

- If there are changes in her life that could affect her mood or sex drive including changes in her relationship with her partner, give her emotional support as necessary. If her mood changes are serious to entertain major depression, refer for proper psychological care.

10. ABDOMINAL PAIN

- Enlarged ovarian follicles or follicular cysts sometimes have been implicated to cause lower abdominal pain among women using implants as well as those using other progestin-only contraceptives. Most women, however, are not aware of them, and they are discovered only incidentally on pelvic examination.
- Because they disappear on their own in the vast majority of women, treatment is not required unless they become symptomatic. Surgical treatment may be required if there would be gradual enlargement, torsion, or rupture of these cysts.

POTENTIAL COMPLICATIONS:

- SEVERE HYPERTENSION
- UNRESOLVED PROLONGED OR HEAVY VAGINAL BLEEDING
- OVARIAN CYST
- PREGNANCY
- MASTALGIA OR BREAST INFECTION
- VASCULAR CHANGES (including HOT FLASHES)
- UNRESOLVED INFECTION
- NON-PALPABLE IMPLANT

HOW TO PREVENT COMPLICATIONS?

- Careful screening of clients
- Adherence to infection prevention practices
- Provision by trained and skilled health personnel
- Following post-insertion follow-up guidelines especially in the advent of warning signs

WARNING SIGNS OF POSSIBLE COMPLICATIONS THAT WARRANT REFERRAL OR FURTHER EVALUATION:

- Severe headaches
- Heavy bleeding: twice as much and twice as long or is bothersome
- Severe lower abdominal pain
- Signs of pregnancy
- Unresolved swelling or inflammation or infection at insertion site

1. HEADACHE

- Ask if there has been a change in pattern or severity of headaches since insertion of implants.
- Perform physical examination, measure BP.
- Examine as appropriate:
  - Eyes (fundoscopic)
  - Neurologic system
- If headaches are mild, treat with analgesics (aspirin, ibuprofen, paracetamol or other analgesics) and reassure.

- Re-evaluate after 1 month if mild headaches persist.
- If headaches have changed since starting implants (i.e., numbness or tingling accompanied by loss of speech, visual changes or blurred vision) remove implants and help client choose another (non-hormonal) method.

2. HYPERTENSION (≥160/100 mmHg)

- Ask if this is the first time anyone has told her that she has high blood pressure.
  - Allow 15 minutes rest, then repeat BP reading.
- Counsel client that a mild increase in BP (< 160/100) does not require removal of implants unless she requests it.
- If requested, help the client choose another method.

3. VASCULAR CHANGES (including Hot Flashes)

- Assess for possible cardiovascular disease (CVD)
- Also, check:
  - BP
  - Heart for irregular beats (arrhythmias)
- If there is evidence of CVD, refer for further evaluation.
- Low-dose progestins do not increase the risk of CVD; therefore, removal of implants is not necessary unless the client requests it

4. PROLONGED VAGINAL BLEEDING

- Irregular (< 15 day interval) bleeding as well as prolonged spotting or bleeding (8 days or more) are common and expected in LNG implant users - over 65% experienced this during the first year. In PSI users, 20% of women reported frequent and/or prolonged bleeding. In addition, moderate menstrual bleeding more than twice as long as a normal menses occurs in 20-30% of implants users during the first 3-6 months.
- For a woman with prolonged spotting or moderate bleeding, the first approach should be counseling and reassurance. It should be explained that in the absence of other causes (e.g., cervicitis or cervical polyp) this type of bleeding is not harmful, even if prolonged for several weeks. Furthermore, these prolonged bleeding or spotting episodes typically become lighter and shorter in succeeding months.
- If, after reassurance, the woman is still unhappy with the irregular bleeding, but wants to continue using implants, a short course (1–3 cycles) of COCs may be tried using:
  - A low-dose COCs (30–35 µg EE) once daily for 21 days.
  - If COCs are not appropriate for personal or medical reasons, try:
    - Ibuprofen (or another NSAID) up to 800 mg three times daily for 5 days (Technical Guidance Working Group [TGWG] 1994).
    - Mefenamic acid 500 mg three times a day after meals when irregular bleeding starts. (*A Global Handbook for Providers 2011, part of the WHO Family Planning Connerstone).*

5. HEAVY BLEEDING

- Heavy bleeding (twice as long or twice as much as normal) is very uncommon with implants but usually can be managed with low-dose COCs (with or without ibuprofen).
  - If the irregular bleeding continues or starts after several months of normal cycles,

some underlying condition unrelated to the implant may be the cause and a thorough investigation is necessary.

- If the bleeding is not reduced in 3–5 days or is much heavier (one or two pads or cloths per hour):
  - Determine whether there are other causes for the uterine bleeding.
  - Give 2 low-dose COC pills per day for the remainder of the cycle (at least 3–7 days), followed by 1 cycle (1 pill per day) of COCs.
  - Alternatively (if available), give a 50 µg EE-containing COC or 1.25 mg conjugated estrogen for 14–21 days **Note: Check to be sure vaginal bleeding has decreased within 3 days.**
- If COCs or estrogens fail to correct the bleeding problem, the implants may need to be removed for medical reasons (excessive bleeding) or due to the client's wishes (Technical Guidance Working Group [TGWG] 1994).
- Do **not perform a D&C unless another medical condition (e.g., endometrial polyp or incomplete** abortion) is suspected.
  - If uterine evacuation is necessary, manual vacuum aspiration, not D&C, is the preferred method for emptying the uterine cavity.
- For anemia, give nutritional advice on the need to increase iron intake.
  - Use oral iron treatment (one tablet containing at least 100 mg elemental iron, FeSO4, daily for 1–3 months) if hemoglobin = 9g/dl or hematocrit = 27.

6. BREAST FULLNESS OR HEAVINESS (MASTALGIA)

CHECK BREASTS FOR:

- Lumps or cysts, and
- Discharge or galactorrhea (leakage of milk-like fluid), if not breastfeeding.
- If she is breastfeeding and breast(s) is tender, examine for breast infection
  - If there is breast infection, use warm compresses, advise to continue breastfeeding and give antibiotics as appropriate.
  - If breast(s) is not infected, recommend a bra that provides additional support or suggest pain reliever.
- If pregnant, manage accordingly
- If not pregnant, do not remove rods unless client requests it after counselling.
- If physical examination shows lump or discharge suspicious for cancer (e.g., firm, non-tender or fixed and which does not change during menstrual cycle), refer for diagnosis.
  - If no abnormality, reassure.
- For any of the above conditions, do not remove rods unless client requests it after counselling.

7. PREGNANCY

- **If intrauterine pregnancy is confirmed**:
  - counsel client regarding removal of implant and assure her that the small dose of progestin to which she was exposed will have no harmful effect on the fetus.
- If **miscarriage (spontaneous abortion) occurs**, it is not necessary to remove the implants.
- If **ectopic pregnancy is suspected:**
  - **refer at once** for complete evaluation and prompt management.

- Do **not give hormonal treatment (COCs) to** induce withdrawal bleeding. It is not necessary and usually is not successful.

8. NON-PALPABLE/MISSING IMPLANT

- Localization of the Implant is a critical aspect of the removal process. **Do not attempt to remove a non-palpable implant!**
- Before initiating the removal procedure, the health care provider should consult the User Card for the location of the implant.
- At removal, you may encounter implants that were:
  - Inserted after the launch of IMPLANON NXT and are radiopaque.
  - Inserted before the launch of IMPLANON NXT and are non-radiopaque.
- The selection of the most appropriate imaging technique to be used to locate an impalpable implant depends on whether or not the implant is radiopaque.
- The imaging method that will be effective in locating an implant that cannot be palpated will depend on the type of implant that has been used.
- **Two-Dimensional X-ray**
  - When utilizing this approach, refer the patient to a radiologist. Describe the size, shape and likely location of the implant (right or left upper arm, etc.).
- **CT Scan**
  - Refer the patient to a radiologist and explain the size, shape and likely location of the implant. Ask for exact localization (depth and tissue layer) information.
  - Ask for a marker on the patient's arm that relates to the CT scan pictures and indicate that the marker is required for removal purposes. Remove deeply inserted implants under live ultrasound guidance.
- **Ultrasound**
  - The radiopaque PSI appears as a sharp acoustic shadow below the implant in the transverse position and a small echogenic spot (2 mm) when viewed in transverse position.
  - Important to use linear array transducer.
  - Transducer frequency above 10 MHz.
  - Consider this method for removal of deep implants.
- **MRI**
  - The radiopaque PSI appears as a hypodense area.
  - Important to differentiate from blood vessels.
  - Can be followed through images for 40 mm.

- After localization of a non-palpable implant, consider conducting removal with ultrasound guidance.
- Removal of deeply inserted implants should be conducted with caution in order to prevent damage to deeper neural or vascular structures in the arm and should be performed only by health care providers who are familiar with the anatomy of the arm.
- **Exploratory surgery without knowledge of the exact location of the implant is strongly discouraged.**
- Appropriate imaging should verify the location of most implants.

<u>COURSE EVALUATION:</u> This is to be administered to all workshop participants immediately after the last session of the training.

COURSE EVALUATION

1. Strongly Agree 2. Agree 3. Not Sure 4. Disagree 5. Strongly disagree

A. Objectives are:

	1	2	3	4	5
a. Relevant to the course					
b. Relevant to my work setting					
c. Specific and reasonable					
d. Attained					

B. Content was:

	1	2	3	4	5
a. Consistent with objectives					
b. Properly organized or sequence					
c. Adequately discussed					

C. Workshops/ Exercises were:

	1	2	3	4	5
a. Consistent with objectives					
b. Properly organized or sequenced					
c. Adequately discussed					

Please give your rating by putting a check on the box using the following scale:
1- Excellent; 2-Very good; 3-Good; 4-Fair; 5- Poor

D. Administration:

	1	2	3	4	5
1. The quality of the accommodation.					
2. The quality of food.					
3. The quality of food service.					
4. The overall rating for the venue staff.					
5. The facilitation of handouts/exercise materials.					
6. The degree of service by the administrative staff (registration, facilitation of participants needs)					

E. What aspects of the course did you? (Use back for more space)

a. Like best

b. Like least

F. What did the teacher or training team do that were? (Use back for more space)

a. Most helpful

b. Least helpful

G. What suggestions can you give to improve this training program?(Use back for more space

MODULE 7: POST-TRAINING FOLLOW-UP AND MONITORING OF CONTRACEPTIVE SUBDERMAL IMPLANT

PREPARATORY ACTIVITIES

1. **One month prior to visit**

   Ensure that communication (i.e., letter followed by phone call, if possible) with the head of the trainee's facility, the trainee's supervisor and the trainee to inform them of:

   - Purpose of the visit which may be but not be limited to:
     - To determine if the trainee-service provider is able to competently perform the skills taught during the Contraceptive Implant Training on Insertion and Removal
     - To provide trainee with technical assistance, as necessary.
     - To identify problems the trainee may have in applying the knowledge and skills learned.
     - To assist the trainee in finding solutions to these problems.
   - Date of the visit
   - What the trainee needs to prepare: FP Form 1 of FP clients provided services since after the course, Target Client List, CDLMIS Inventory Report, Referral slips, BHS Summary Table (green book) and the RHU Summary Table (blue book)
   - Arrange for availability of client(s) during the visit.

2. **Two weeks prior to visit**
   - Obtain confirmation of the scheduled visit
   - Prepare materials you will need, such as:
     - Performance monitoring checklist (2 copies)
     - Copy of the letter previously sent informing her of your visit
     - Copy of the action plan (developed during the course)
3. **Immediately prior to the visit**
   - Prepare for travel arrangements

4. **Plan to be on time for the site visit**

DURING THE FOLLOW-UP

1. **Conduct a courtesy call on the head of the facility.**
   - Explain the purposes of the follow-up visit which are:
     - To determine if the trainee-service provider is able to competently perform the skills taught during the course.
     - To provide trainee with technical assistance, as necessary.
     - To identify problems the trainee may have in applying the knowledge and skills learned.
     - To assist the trainee in finding solutions to these problems.

2. Arrange to interview the trainee's immediate supervisor.

The following are some informal interview questions the trainer can ask the supervisor:

- Did training improve the trainee's work attitude and performance?
- Is the trainee able to effectively provide FP services (e.g., counseling, provision of implants)?
- Has there been an increase in the FP client load (esp Implant) of the clinic after the trainee's training?
- Has there been an improvement in the quality of services provided by the trainee? In what way?
- Has there been a change in the infection prevention practices in the clinic and as practiced by the trainee? In what way?
- Has the trainee been involved in activities to improve the quality of FP services in the facility (e.g., work planning activities, forecasting and allocation of commodity needs, accomplishment of reports, resource mobilization)?
- Were the changes in the trainee's performance and attitude worth the time invested in training?
- Based on his/her observations in the trainee's change of behavior, knowledge, and attitude, what suggestions would he/she have towards improvement of the course?
- Did training correct the problem or meet the need for which the training program was designed?
- What recommendations does he/she have for future trainees of the course?

3. Interview the trainee and observe his/her performance

- Review the action plan developed during the course. Determine the extent to which the trainee has implemented the action plan.
- Find out whether he/she is able to apply the concepts (e.g., infection prevention, informed consent and voluntarism, managing for quality) and provide FP services as learned in the course.
- Validate performance with records: FP Form 1 of FP clients provided services since after the course, Target Client List, CDLMIS Inventory Report (DTUR, Brgy. Inventory Worksheet), Referral slips, BHS Summary Table (green book) and the RHU Summary Table (blue book)
- If trainee expresses not being able to apply fully the concepts and skills learned in the course, ask for the constraints he/she is encountering. Include these as part of the "Issues" that need to be addressed.
- COACH the midwife to reinforce the critical skills learned during training by:
    - Reviewing with her the performance monitoring checklist as the basis of the

evaluation. Ask her if there are any tasks in the checklist she finds difficult to perform.

- Observing performance on counseling and infection prevention practices.

  Note: Do a role play if no client is available during the visit.

- Checking and assisting her, as needed, on the accomplishment of appropriate forms, as needed.
- Providing feedback by commending her on tasks that were performed well followed by recommendations for improvement.
- Asking what additional assistance she may need to improve her performance.
- Arrange for schedule of return visit if trainee has not performed satisfactorily and to check if recommendations are implemented.

- Provide feedback on the comments of the supervisor.
- Process the observations by listing items rated as "2" in the "Good Points" portion. Those rated as "1" and "0" under the "Issues" heading. For each of the issues, discuss recommendations for improvement and the agreed time frame for completion of the recommended activities.
- Thank the trainee for his/her cooperation.

4. Conduct an exit conference with the supervisor/head of facility.

- Present a summary of the results of the trainee observation and assistance they can provide in improving the trainee's performance.

AFTER THE FOLLOW-UP VISIT

- Prepare the report.
- Send copies of the report to appropriate agencies.

LEVELS OF TRAINING EVALUATION FOR LAPM:

EVALUATION LEVEL	PURPOSE	EVALUATION INSTRUMENTS/TOOLS	TIME TO GATHER DATA
Level 1 – REACTION	**Measures how the trainees felt about the training or learning experience (e.g. course objectives and expectations are met, mastery of the subject**	• **Course Evaluation Questionnaire** • **Recap**	**During and right after the training**

	matter by the speaker, conduciveness of the training venue, etc.)		
Level 2- LEARNING	**Measures knowledge, attitude and/or skills gained by the trainees**	• **Pre- and post-test** • **Skills Performance Checklist**	**At the start, during and right after the training**
Level 3- BEHAVIORAL	**Measures extent to which trainees applied the learning in their workplace or organization**	• **Action Plan** • **Post-training Monitoring Checklist** • **Observation** • **Interview with Supervisor and/or peer**	**3, 6 and 12 months after the training**
Level 4- IMPACT	**Measures the long-term effects of training on the organization, community or society**	• **Visit Interviews** • **Cost-benefit Analysis**	**3 to 5 years after the training**

TOOLS:

I. POST-TRAINING CHECKLIST FORMS including:

A. FACILITY INSPECTION FORM (included in each of the checklists for the different LAPM methods)

B. COMPLIANCE TO INFORMED CHOICE AND VOLUNTARISM PRINCIPLE FORM (incorporated in the individual checklists), and

C. COUNSELING SKILLS PRACTICE CHECKLIST (included in the FPCBT I Checklist and in method-specific counselling for each of the LAPM)

II. SKILLS PERFORMANCE CHECKLIST ON CONTRACEPTIVE IMPLANT

III. SUPERVISOR INTERVIEW FORM (incorporated in the method checklist)

IV. TRAINEE INTERVIEW FORM (incorporated in the method checklist)

V. CLIENT INTERVIEW FORM

METHODOLOGY:

1. ACTION PLAN REVIEW
2. FACILITY INSPECTION (Physical Set-up, Flow, Supplies, Forms, etc.)
3. ACTUAL INTERVIEW (Supervisor, Trainee and Client)
4. SKILLS OBSERVATION USING PERFORMANCE CHECKLIST FOR INDIVIDUAL LAPM

SKILLS CHECKLIST ON PROGESTIN-CONTAINING SUBDERMAL IMPLANT INSERTION AND REMOVAL

This checklist may be used during the clinical phase of the training to determine whether the trainee has reached a level of competency in performing the skill and during the post-training monitoring to determine the progress of the trainee with the newly acquired skill. The trainee should have a copy of the checklist so that he/she would know what is expected of him/her.

Date of Assessment:_____ Course

Date:_____

NAME OF

PARTICIPANT_____

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

Key: 2= Yes 1= Yes, but needs improvement 0= No NA= Not applicable	**2**	**1**	**0**	**NA**
PRE-INSERTION TASKS				
1. Conducts method-specific counseling.				
2. **Ensures that the client understands and accepts the possible side effects of the Implant.**				
3. **Explains the insertion procedure to the client.**				
4. **Encourages the client to ask questions and responds to her questions.**				
5. **Listens attentively to client's response and concerns.**				
6. **Reassures the client that the materials used for implant insertion are sterile.**				
7. Verifies Informed Consent				
8. Washes hands thoroughly with soap and water.				

Key: 2= Yes 1= Yes, but needs improvement 0= No NA= Not applicable	2	1	0	NA
9. Encourages the woman to wash her entire arm with soap and water				
10. Prepares equipments and supplies				
11. Checks implant for contents and expiration.				
12. Allow client to lie on her back with her non-dominant arm (the arm which she does not use for writing) turned outwards and bent at the elbow				
13. Marks the insertion site. (To minimize neural or vascular damage, insert implant at the inner side of the non-dominant upper arm about 8-10 cm above the medial epicondyle of the humerus)				
14. Cleans the insertion site with a disinfectant/antiseptic				
15. Anesthesizes site with an anesthetic spray or with a 2 mL of 1 or 2% lidocaine applied just under the skin along the "insertion canal", Wait for ~3 minutes for the anesthetic to take effect				
16. Removes the sterile disposable applicator carrying the implant from its blister				
17. Hold the applicator in an upright position				
FOR RADIO-OPAQUE IMPLANT				
18. Removes the transparent protection cap.				
19. Keeps finger away from the purple slider				
20. Checks the tip of the needle for the presence of the white rod				
21. Stretches the skin around the insertion site with thumb and index finger				
22. Punctures the skin with the tip of the needle slightly angled at about 20 degrees				
23. Releases the skin				

Key: 2= Yes 1= Yes, but needs improvement 0= No NA= Not applicable	2	1	0	NA
24. Lowers the skin to a horizontal position				
25. While lifting the skin, gently inserts the needle to its full length (NO force should be exerted. The needle should be inserted parallel to the skin to ensure that the implant is inserted superficially just under the skin)				
26. Keeps the applicator parallel to the surface of the skin. (When the implant is placed deeply, parasthesia and migration of the implant may occur. Moreover, removal may be difficult later)				
27. Unlocks the purple slider and moves this fully back until it stops				
28. Removes/retracts the applicator				
After Retraction of the Applicator				
29. Applies sterile gauze/cotton ball at the insertion site				
30. Palpates the presence of the implant underneath the skin				
31. Lets the client palpate the implant herself				
32. Applies adhesive bandage or sterile gauze				
33. Washes hands and dries with a clean dry towel				
34. Discards the applicator and other materials accordingly				
35. Fills out the user card and hands it over the client				
POST-INSERTION				
36. **Applies elastic/pressure bandage over insertion site**				
37. Advises client about wound care and time of removal for adhesive bandage and elastic/pressure bandage				

Key: 2= Yes 1= Yes, but needs improvement 0= No NA= Not applicable	2	1	0	NA
38. Advises clients about common side effects and provides re-assurance about what are normal side effects and what should require prompt/immediate consult				
39. Hands over card with wound care and schedule for follow-up consult				
IMPLANT REMOVAL				
40. Reviews the User Card presented by the client to determine the exact location of the implant as previously inserted				
41. Prepares equipments and supplies				
42. Does hand washing and puts on sterile gloves				
43. Palpates the presence of the implant underneath the skin and marks the distal end				
44. Explains the removal procedure to the client				
45. Encourages the client to ask questions and addresses her concerns				
46. Verifies the consent for removal				
47. Encourages the client to wash her entire arm				
48. Instructs the client to lie down on her back and flex the arm so that the arm is positioned near her head, exposing the area where the implant is located				
49. Washes hands and dries them with a clean dry towel				
50. Dons sterile gloves				
51. Places a sterile drapes or glove's wrapper under the client's arm				
52. Washes the area or site and applies a disinfectant/antispetic				

Key: 2= Yes 1= Yes, but needs improvement 0= No NA= Not applicable	2	1	0	NA
53. Anesthesizes the arm with 0.5-1 mL of 1 or 2% lidocaine at the site of incision, beneath the distal end of the implant				
54. Pushes down the proximal tip to fix the implant; and feels for the bulge that indicates the distal end of the implant				
55. Makes a longitudinal incision of about 2 mm on the skin over the distal tip of the implant				
56. Gently pushes the implant towards the incision until the tip is visible				
57. Grasps the implant with forceps (mosquito) and removes it				
58. If the tip of the implant is not visible due to fibrosis, splits the fibrosis by continuing to cut towards the distal tip using a scalpel blade, until the tip is clearly visible and removes the implant with a forcep				
59. If the tip of the implant is not visible, gently inserts the forcep into the incision and grasps the implant; With a second forcep, carefully dissects the tissue around the implant and removes the implant				
60. Presses on the incision site with an antiseptic-soaked sterile cotton ball				
61. Closes the incision with adhesive bandage or sterile gauze				
62. Shows the client the complete implant that has been removed				
63. If the client is for re-insertion of a new implant, provides a new implant; If she is not desirous of pregnancy but does not wish replacement with a new implant, provides another contraceptive method.				
64. Washes hands and dries them with a clean dry towel				
65. Attends to proper biohazard waste disposal.				
POST-REMOVAL				

Key: 2= Yes 1= Yes, but needs improvement 0= No NA= Not applicable	**2**	**1**	**0**	**NA**
66. **Applies elastic/pressure bandage over removal site**				
67. Advises client about appropriate wound care and time of removal of adhesive bandage and elastic/pressure bandage				
68. Schedules client for a follow-up consult				

COMMENTS/RECOMMENDATIONS:

_____

_____

Trainer's Name and Signature: _____ Date:_____

QUESTIONS AND ANSWERS ON PROGESTIN-CONTAINING CONTRACEPTIVE SUBDERMAL IMPLANTS

1. **Do users of implants require follow-up visits?**

   No. Routine periodic visits are not necessary for implant users. Annual visits may be helpful for other preventive care, but they are not required. Of course, women are welcome to return at any time with questions.

2. **Can implants be left permanently in a woman's arm?**

   Leaving the implants in place beyond their effective lifespan is generally not recommended if the woman continues to be at risk of pregnancy. The implants themselves are not dangerous, but as the hormone levels in the implants drop, they become less and less effective.

3. **Do implants cause cancer?**

   No. Studies have not shown increased risk of any cancer with use of implants.

4. **How long does it take to become pregnant after the implants are removed?**

   Women who stop implants can become pregnant as quickly as women who stop non hormonal methods. Implants do not delay the return of a woman's fertility after they are removed. The bleeding pattern a woman had before she used implants generally returns after they are removed. Some women may have to wait a few months before their usual bleeding pattern returns.

5. **Do implants cause birth defects? Will the fetus be harmed if a woman accidentally becomes pregnant with implants in place?**

   No. Good evidence shows that implants will not cause birth defects and will not otherwise harm the fetus if a woman becomes pregnant while using implants or accidentally has implants inserted when she is already pregnant.

6. **Can implants move around within a woman's body or come out of her arm?**

   Implants do not move around in a woman's body. The implants remain where they are inserted until they are removed. Rarely, a rod may start to come out, most often in the first 4 months after insertion. This usually happens because they were not inserted well or because of an infection where they were inserted. In these cases, the woman will see the implants coming out. Some women may have a sudden change in bleeding pattern. If a woman

notices a rod coming out, she should start using backup method and return to the clinic at once.

7. Do implants increase the risk of ectopic pregnancy?

No. On the contrary implants greatly reduce the risk of ectopic pregnancy. Ectopic pregnancies are extremely rare among implant users. The rate of ectopic pregnancy among women with implants is 6 per 100,000 women per year. The rate of ectopic pregnancy among women in the United States using no contraceptive method is 650 per100,000 women per year.

On the very rare occasions that implants fail and pregnancy occurs, 10 to 17 of every 100 of these pregnancies are ectopic. Thus, the great majority of pregnancies after implants fail are not ectopic. Still, ectopic pregnancy can be life-threatening, so a provider should be aware that ectopic pregnancy is possible if implants fail.

8. Do implants change women's mood or sex drive?

Generally, no. Some women using implants report these complaints. The great majority of implants users do not report any such changes, however, and some report that both mood and sex drive improve. It is difficult to tell whether such changes are due to the implants or to other reasons. There is no evidence that implants affect sexual behavior.

9. Should heavy women avoid implants?

No. These women should know, however, that they need to have their PSI replaced sooner to maintain a high level of protection from pregnancy. In studies of the 6-rod levonorgestrel implants, pregnancy rates among women who weighed 70-79 kg were 2 per 100 women in the sixth year of use. Such women should have their implants replaced, if they wish, after 5 years. Among women who used levonorgestrel implants and who weighed 80 kg or more, the pregnancy rate was 6 per 100 in the fifth year of use. These women should have their implants replaced after 4 years. Studies of etonogestrel implants have not found that weight decreases effectiveness within the lifespan approved for this type of implant.

10. What should be done if an implant user has as ovarian cyst?

The great majority of cysts are not true cysts but actually fluid-filled structures in the ovary (follicles) that continue to grow beyond the usual size in a normal menstrual cycle. They may cause some mild abdominal pain, but they only require treatments if they grow abnormally large, twist, or burst. These follicles usually go away without treatment.

11. Can a woman work soon after having implants inserted?

Yes, a woman can do her usual work immediately after leaving the clinic as long as she does not bump the insertion site or get it wet.

12. Must a woman have a pelvic examination before she can have implants inserted?

No. Instead asking the right questions can help the provider be reasonably certain she is not pregnant (see Pregnancy Checklist). No condition that can be detected by a pelvic examination rules out use of implants.

13. How soon after implant insertion can a couple have unprotected intercourse?

The section on Timing of Insertion gives the provider an overview of the time in a woman's cycle the implant should be inserted, depending on what FP method she is coming from. If it is reasonably certain that she is not pregnant, or if the implant in inserted according to the guidelines on switching FP methods, no back up method is necessary. However, if there are any deviations to these guidelines, it is recommended that the couple uses a barrier method for 7 days after insertion.

SAMPLE PRE-TEST/POST-TEST QUESTIONS

Instructions: Write the letter of the single BEST answer to each question in the blank next to the corresponding number on the attached answer sheet.

Counselling

_____ 1. For a woman in good health, a contraceptive method is BEST selected by the:
a. Woman herself
b. Physician providing health services to the woman
c. Woman's husband

_____2. Which of the following is the MOST important components of contraceptive counselling?
a. Identifying and addressing the client's contraceptive concerns
b. Obtaining formal consent for the procedure from the client
c. Describing adverse side effects to the client

_____3. Which of the following may help a woman feel more confident about using contraceptive subdermal implants?
a. Telling her that you think it's the best method.
b. Comparing the effectiveness and side effects of contraceptive implants to other methods.
c. Stating that 98% of women using contraceptive experience no side effects and continuation rate is also over 90%.

_____4. If inserted within the first days of menses, contraceptive implants are effective in preventing pregnancy:
a. Within 24 hours
b. Within 7 days
c. After the next menstrual period

Indications, Precautions, and Client Assessment

_____5. Contraceptive implants are a preferred method for a woman who:
a. Wants to become pregnant in a couple of years or more.
b. Does not want any more children.
c. Are reassured by having regular menstrual cycles indicating that they are not pregnant.

_____6. A woman who has a past history of deep vein thrombophlebitis:
a. Cannot use contraceptive implants (category 4)
b. Can use contraceptive implants if there are no other available FP options (category 3)
c. Can use contraceptive (category 2)

_____7. Which of the following is a condition requiring further evaluation before inserting contraceptive subdermal implants?
a. Diabetes (controlled)
b. Hypertension (on medication)
c. Unexplained vaginal bleeding

_____8. Which of the following MUST be included with screening a potential contraceptive implants client?

a. A complete medical history, general examination, and pelvic examination
b. A pelvic examination only if indicated, for example, to rule out pregnancy
c. Basic laboratory tests for hemoglobin, total lipids, and liver function tests

Infection Prevention

_____9. In order to reduce the risk of infection, prior to insertion or removal of contraceptive implant:

a. Prepare the surgical site with antiseptic only.
b. Clean the surgical site with soap and water followed by antiseptic.
c. Prepare the site with an antiseptic and give a 3-day course of antibiotics.

_____10. Other than sterilization, another acceptable method for processing surgical (metal) instruments used for contraceptive implants removal is:

a. Decontaminate, clean, and then boil for 30 minutes.
b. Soak for 20 minutes in Chlorhexidine.
c. Decontaminate, wash and scrub instruments, then boil them for 20 minutes.

_____11. Which of the following steps MUST be completed FIRST in order to minimize the risk of staff contracting hepatitis B or HIV/AIDS during the cleaning process?

a. Rinse in water and scrubbed with a brush before disinfecting by boiling.
b. Soak in 0.5% chlorine solution for 10 minutes before cleaning.
c. Soak overnight in 8% formaldehyde.

Method Provision (Insertion and Removal)

_____12. After completing insertion of the implants, you are able to see the tip of one rod at the incision. Which of the following actions are MOST important under these circumstances?

a. Remove that rod and close the incision.
b. Close the incision tightly over that rod.
c. Remove that rod and reinsert it.

_____13. Contraceptive subdermal implants that have been inserted into the fat under the skin:

a. May be easier to remove.
b. May be less effective because the hormone is released more slowly from the implants.
c. May be difficult to remove.

_____14. A woman who has used the two-rod implant for 5 years wants another set inserted. The first set of implants was inserted close to her left elbow. During removal you find thick, fibrous tissue sheaths around them. Which of the following steps is MOST appropriate under these circumstances?

a. Tell her that she cannot use the two-rod implant again.
b. Place the two new rods in the other arm.
c. Place the two new rods in the same site where you removed the old implants.

_____15. What is the MOST important first step to do to facilitate removal of two-rod implants after counselling the client?

a. Advise her to thoroughly wash her arm that has the implant.
b. Provide 5 cc of local anesthesia over the implants.
c. Palpate her arm that has the implants and mark where the tips of the rods are felt.

_____16. Single-rod implants are effective for:

a. 3 years.
b. 5 years.
c. 7 years.

_____17. What is one of key step in preparation for single-rod insertion?

a. Ensure that sterile gloves are available in the correct size.
b. Visually verify the presence of the single-rod tip inside the needle.
c. Carefully load the single rod into the needle respecting sterile technique.

_____18. When inserting the PSI needle, the angle must be:

a. 35 °
b. 25°
c. Not more than 20°

_____19. What is the next step during PSI insertion after the rod is inserted under the skin?

a. Remove the needle while applying pressure on the rod
b. Verify the presence of the rod under the skin though gentle palpation
c. Pull the purple slider all the way back

_____20. The two-rod implants are effective for:

a. 3 years.
b. 5 years.
c. 7 years.

Follow-Up, Side Effects, and Other Problems

_____21. A woman who has used the two-rod implants for 2 months has had irregular bleeding during this time. She asks you what to do. Which of the following counselling statements is BEST under these circumstances?

a. Have the two-rod implants removed to stop the bleeding, and put her on oral contraception to provide normal cycles.
b. Reassure her that irregular bleeding is common and usually becomes less of a problem over time.
c. Do tests for hemoglobin and hematocrit, and provide her with ferrous sulfate and monthly injections of B12 for 3 months.

_____22. A potential side effect of contraceptive implants use is:

a. Heavy vaginal discharge between menstrual periods.

b. Amenorrhea or spotting for 3 months or longer.
c. Increased risk of developing diabetes.

_____23. What is a common menstrual change with single-rod implant users?
a. Amenorrhea in about 20% of users
b. Irregular menses in the first 3 months of use but then return to regular cycles
c. Dysmenorrhea increases among 77% of users

_____24. The contraceptive implants user MUST return to the clinic if she has:
a. Pus and bleeding at the insertion site.
b. Weight gain of more than 4 kg.
c. Irregular bleeding or spotting.

_____25. Which drug MAY reduce effectiveness of contraceptive implants?
a. Erythromycin
b. Phenytoin (Dilantin)
c. Thorazine

ANSWER KEY TO THE QUESTIONS
Instructions: Write the letter of the single BEST answer to each question in the blank next to the corresponding number on the attached answer sheet.

Counselling
__A__ 1. For a woman in good health, a contraceptive method is BEST selected by the:
a. Woman herself
b. Physician providing health services to the woman
c. Woman's husband

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b. Comparing the effectiveness and side effects of contraceptive implants to other methods.
c. Stating that 98% of women using contraceptive experience no side effects and continuation rate is also over 90%.

__A__4. If inserted within the first days of menses, contraceptive implants are effective in preventing pregnancy:
a. Within 24 hours
b. Within 7 days

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Indications, Precautions, and Client Assessment

__A__5. Contraceptive implants are a preferred method for a woman who:
a. Wants to become pregnant in a couple of years or more.
b. Does not want any more children.
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a. Cannot use contraceptive implants (category 4)
b. Can use contraceptive implants if there are no other available FP options (category 3)
c. Can use contraceptive (category 2)

__C__7. Which of the following is a condition requiring further evaluation before inserting contraceptive subdermal implants?
a. Diabetes (controlled)
b. Hypertension (on medication)
c. Unexplained vaginal bleeding

__B__8. Which of the following MUST be included with screening a potential contraceptive implants client?
a. A complete medical history, general examination, and pelvic examination
b. A pelvic examination only if indicated, for example, to rule out pregnancy
c. Basic laboratory tests for hemoglobin, total lipids, and liver function tests

Infection Prevention

__B__9. In order to reduce the risk of infection, prior to insertion or removal of contraceptive implant:
a. Prepare the surgical site with antiseptic only.
b. Clean the surgical site with soap and water followed by antiseptic.
c. Prepare the site with an antiseptic and give a 3-day course of antibiotics.

__C__10. Other than sterilization, another acceptable method for processing surgical (metal) instruments used for contraceptive implants removal is:
a. Decontaminate, clean, and then boil for 30 minutes.
b. Soak for 20 minutes in Chlorhexidine.
c. Decontaminate, wash and scrub instruments, then boil them for 20 minutes.

__B__11. Which of the following steps MUST be completed FIRST in order to minimize the risk of staff contracting hepatitis B or HIV/AIDS during the cleaning process?
a. Rinse in water and scrubbed with a brush before disinfecting by boiling.
b. Soak in 0.5% chlorine solution for 10 minutes before cleaning.
c. Soak overnight in 8% formaldehyde.

Method Provision (Insertion and Removal)

__C__12. After completing insertion of the two-rod implants, you are able to see the tip of one rod at the incision. Which of the following actions are MOST important under these circumstances?

a. Remove that rod and close the incision.
b. Close the incision tightly over that rod.
c. Remove that rod and reinsert it.

__C__13. Contraceptive subdermal implants that have been inserted into the fat under the skin:

a. May be easier to remove.
b. May be less effective because the hormone is released more slowly from the implants.
c. May be difficult to remove.

__B__14. A woman who has used the two-rod implants for 5 years wants another set inserted. The first set of implants was inserted close to her left elbow. During removal you find thick, fibrous tissue sheaths around them. Which of the following steps is MOST appropriate under these
circumstances?

a. Tell her that she cannot use the two-rod implants again.
b. Place the two new rods in the other arm.
c. Place the two new rods in the same site where you removed the old implants.

__C__15. What is the MOST important first step to do to facilitate removal of the two-rod implants after counselling the client?

a. Advise her to thoroughly wash her arm that has the implant.
b. Provide 5 cc of local anesthesia over the implants.
c. Palpate her arm that has the implants and mark where the tips of the rods are felt.

__A__16. Single-rod implants are effective for:

a. 3 years.
b. 5 years.
c. 7 years.

__B__17. What is one of key step in preparation for PSI insertion?

a. Ensure that sterile gloves are available in the correct size.
b. Visually verify the presence of the single-rod tip inside the needle.
c. Carefully load the single rod into the needle respecting sterile technique.

__C__18. When inserting the single-rod needle, the angle must be:

a. 35 °
b. 25°
c. Not more than 20°

__C__19. What is the next step during PSI insertion after the rod is inserted under the skin?

a. Remove the needle while applying pressure on the rod
b. Verify the presence of the rod under the skin though gentle palpation

c. Pull the purple slider all the way back

__B__20. The two-rod implants are effective for:
a. 3 years.
b. 5 years.
c. 7 years.

Follow-Up, Side Effects, and Other Problems

__B__21. A woman who has used the two-rod implants for 2 months has had irregular bleeding during this time. She asks you what to do. Which of the following counselling statements is BEST under these circumstances?
a. Have the two-rod implants removed to stop the bleeding, and put her on oral contraception to provide normal cycles.
b. Reassure her that irregular bleeding is common and usually becomes less of a problem over time.
c. Do tests for hemoglobin and hematocrit, and provide her with ferrous sulfate and monthly injections of B12 for 3 months.

__B__22. A potential side effect of contraceptive implants use is:
a. Heavy vaginal discharge between menstrual periods.
b. Amenorrhea or spotting for 3 months or longer.
c. Increased risk of developing diabetes.

__A__23. What is a common menstrual change with single-rod implant users?
a. Amenorrhea in about 20% of users
b. Irregular menses in the first 3 months of use but then return to regular cycles
c. Dysmenorrhea increases among 77% of users

__A__24. The contraceptive implants user MUST return to the clinic if she has:
a. Pus and bleeding at the insertion site.
b. Weight gain of more than 4 kg.
c. Irregular bleeding or spotting.

__B__25. Which drug MAY reduce effectiveness of contraceptive implants?
a. Erythromycin
b. Phenytoin (Dilantin)
c. Thorazine