UNIT 1

OPENING, FEEDBACK AND CREATING A CONDUCIVE ENVIRONMENT AND INTRODUCTION TO CLINICAL PRACTICE
Session One

Welcome and Registration
Session Objectives

At the End of This Session, Trainees Will Be Able To:

List the names of all participants
Assess participants’ knowledge at entry level to the training.
Give an overview of the training
Welcome and Registration
- Registration
- Welcoming Remarks
Introductory Exercise

Introduce your self, follow the guide:

- Full names
- Preferred name
- Designation
- Work station and section
- Major jobs performed every day
- Norms and Expectations
Logistics Arrangements

- Accommodation
- Meals
- Per diem / reimbursement of traveling costs
- Transport
- Washrooms
- Selection of group leaders
Pre training knowledge test.
Time allotment – 45 Minutes
TRAINING GOAL

To enable service providers to educate, counsel, screen, provide long acting FP methods, manage side effects, complications and other health needs.
By the end of the training trainees will be able to:

- Conduct client education to promote FP method use.
- Counsel individual clients / couple to help them make an appropriate informed choice of FP method and other health services.
- Screen clients for implant and IUCD use and other health services.
- Provide clients with FP methods of their choice.
- Manage clients presenting with contraceptive related problems and other health needs.
Participatory Training Methods which will be used during the training

- Lecture discussion.
- Role play
- Demonstration
- Practicum.
- Simulation.
- Small group discussion.
- Brain storming.
- Large group discussion.
- Gallery walk.
- Case study
- Buzzing
Evaluation methods which will be used during the training

- Pre and post knowledge test.
- Skills assessment
- Process review.
- Continues observation and feedback.
JOBS AND TASKS

• Creating demand for **long** term FP method use among individuals including adolescents, couples and community through client education.

• Counseling individuals including adolescents and couples for informed choice of FP methods.

• Initiate and instruct clients on FP short term methods.

• Managing problems related to use of short term FP method use and other health needs.

• Screening clients suitability for family planning method use and other health services.
Session Two

Giving and Receiving Feedback
Session Objectives

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

• State the meaning of feedback
• State purpose of giving and receiving feedback
• Identify feedback skills
• Apply rules for giving and receiving feedback
• Demonstrate ability to give and receive feedback
Definition of Feedback

Feedback is a method of receiving or giving information about behaviour. It is a way of letting the receiver know in timely and descriptive manner how he/she is performing or how the receiver’s behaviour affects the sender/others.
Words Reflecting feelings

• Angry
• Happy
• Excited
• Annoyed
• Demoralized
• Anxious
• Felt good
• Worried
• Felt bad
• Felt like running away
• Felt scolded
• Felt hopeless
Feedback Skills

- Effective Questioning
  - Open ended questions
  - Closed ended questions
  - Probing questions
- Good listening skills
  - Active listening
- Reflection
- Summarizing and paraphrasing
- Praise and encouragement
- Giving information
- Observing non-verbal cues
Rules for giving feedback

• Should be timely
• Should be descriptive, non-judgmental
• Use what, how rather than why…..
• Be clear and straight to the point
• Use specific statements supported by specific examples
• Provide both positive and negative feedback
• Prepare self to give the feedback
Rules Cont.

• Ask for timely feedback
• Do not react angrily or defensively by explaining …“I did it because of……”
• Use what, how and not why? Use I not you
• Seek clarification by paraphrasing or by open-ended questions
• Thank the giver and say what you will do as a result of being given the feedback
Definition of Quality of Care

Quality of care
• Quality of care is doing the right thing, in the right away and at the right time

Quality
• Quality is the type of care which meets clients' rights, having access to range of services, choice, confidentiality, privacy and safety, respect and dignity

Care
• Care is the way clients are treated by the system providing services
10 Clients’ rights

- Right to information {adequate and accurate}
- Right to access
- Right to choice {free decision - whether to use or not}
- Right to safety
- Right to privacy {visual and audible}
- Right to confidentiality
- Right to dignity {courtesy, consideration and attentiveness}
- Right to comfort {comfort when receiving services}
- Right to continuity {for as long as they need services}
- Right to opinion {to express their views}
10 Service Providers Needs

Needs for
1. Training
   - Technical FP skills
   - Communication skills
2. Information
   - On issues related to their duties
3. Supplies and equipment
4. Guidance
   - Clear objectives
5. Infrastructure
6. Back – up
7. Respect
8. Encouragement
   - Stimulus in the development of their potentially and creativity
9. Feedback
   - concerning achievement of guidance
10. Self - expression
Session Three

INTRODUCTION TO CLINICAL PRACTICE
Objectives

At the end of this session, the trainee will be able to:

- Explain the purposes of clinic practice
- Identify the minimum number of practicum objectives/requirements.
- Describe trainer/preceptor/trainee linkage and other roles in ensuring trainees achieve practicum objectives
- Explain how trainees skills acquisition will be monitored and evaluated
INTRODUCTION TO CLINICAL PRACTICE

Purpose of clinic practicum

• To apply theory to practice.
• To gain assistance in strengthening weak skills identified in pre-training skills assessment.
CONT...

• To practice knowledge and skills learnt with guidance from trainers and preceptors.
• To observe trainers and preceptors model positive practice for trainee application during and after training.
• To practice providing IUCD (CuT 380A) and implants in real situations.
Trainer/preceptor roles

- Guide trainees to acquire skills according to standards
- Demonstrate difficult procedures
- Provide a variety of learning opportunities that will ensure trainee achievement
- Identity trainee’s special needs and assist them accordingly
- Manage conflict wisely if any
- Monitor and evaluate trainees skills acquisition and the achievement of objectives
Role of trainees

• Strive to meet objectives and perform skills with very little guidance from trainers and preceptors.
• Read and apply guidelines and standards (e.g. FP procedure) manual during clinical practice.
• Ask for feedback verbally and in writing on skills performance.
Role of trainees....

- Adhere to rules of giving and receiving feedback to ensure that trainer/trainee interactions are productive.
- Make use of feedback given.
- Work as a team
- Use time wisely and take advantage of all opportunities for learning
- Identify and communicate hindrances to learning and jointly solve them with trainers/preceptors
- Draw attention to trainer about potential and actual conflicts
- Seek face-to-face meetings with trainers/preceptors to achieve competence
- Monitor and evaluate trainees’ own skills acquisition
Joint roles

- Ensure client’s safety is not compromised.
- Ensure application and adherence to laid down policy guidelines, standards and procedures.
- Establish and maintain good interpersonal relationships with clinic staff and clients.
END

THANK YOU
Session 1

INFECTION PREVENTION IN FACILITIES
Session Objective

At the End of This Session, Trainees Will Be Able To:

• Mention Infection prevention problems they have in their health care facilities
Session 2

HAND HYGIENE AND OTHER BARRIERS USED IN PREVENTING INFECTION
Session Objectives

At the End of This Session, Trainees Will Be Able To:

– IDENTIFY TYPES OF HAND HYGIENE. STATE WHEN HAND WASHING SHOULD BE DONE.
– Mention other barriers that are used to prevent infection
– Define antiseptic
– Mention antiseptics used in health care facilities.
– Describe how to prepare site before a procedure.
TYPES OF HAND HYGIENE

• ROUTINE HAND WASHING
• HAND ANTISEPSIS
• ALCOHOL HAND RUB
• SURGICAL HAND SCRUB
Protective Barriers

Barriers include the following:

1. Handwashing

2. Wearing gloves, either for surgery, pelvic examinations, IUD insertions, or to protect clinic staff when handling contaminated waste materials or used instruments

3. Using antiseptic solutions for cleaning wounds or preparing the skin prior to surgery

4. Decontamination, cleaning and sterilizing or high-level disinfecting surgical instruments, reusable gloves, and other items
Antisectotics

Antiseptics are chemicals which kill or inhibit microorganisms on animate objects (Living tissue)
Session 3

• Processing Instruments and Other Items
Session Objective

♣ Describe how to process contaminated instruments and other items.
Processing Instruments

DECONTAMINATION
Soak in 0.5% chlorine solution
10 minutes

THOROUGHLY WASH AND RINSE
Wear gloves and other protective barriers (glasses, visors or goggles)

Preferred Methods

STERILIZATION

Chemical
Soak
10-24 hours

Autoclave
106 kPa pressure
(15 lbs./in²)
121°C (250°F)
20 min. unwrapped
30 min. wrapped

Dry Heat
170°C
60 minutes

HIGH-LEVEL DISINFECTION (HLD)

Boil or Steam
Lid on
20 minutes

Chemical
Soak
20 minutes

Acceptable Methods

COOL
(use immediately or store)
Steps Involved in Processing Instruments, and Other Items

1. Decontamination
2. Cleaning
3. High-Level Disinfection
   3.1 HLD by Boiling
   3.2 HLD Using Chemicals
4. Sterilization
   4.1 Dry Heat Sterilization
   4.2 High Pressure Steam (Autoclave)
   4.2 Chemical Sterilization
Session Four

• DISPOSAL OF WASTE AND THE USE OF PEP
Session Objectives

• Explain how to dispose of medical waste
• Outline steps for Post-exposure prophylaxis (PEP)
Safe disposal of other infectious waste

Proper waste management involves the following steps:

- Segregation
- Handling and Storage
- Transport
- Treatment or Destruction
- Final disposal
Steps to Follow Once a Health Provider is Exposed to Blood and Other Body Fluids

Post-exposure prophylaxis (PEP)

• Step 1: Treatment of Exposure Site
• Step 2: Report and Document
• Step 3: Evaluate the Exposure
• Step 4: Evaluate the Exposure Source
• Step 5: Provision of Anti-Retroviral (ARVs) Drugs for PEP
• Step 6: Follow-Up of HPs exposed to HIV
MINISTRY OF HEALD AND SOCIAL WELFARE

REPRODUCTIVE AND CHILD HEALD SECTION

June, 2011
UNIT 3

EDUCATING AND COUNSELING CLIENTS FOR FAMILY PLANNING SERVICES
Session 3.1

Educating Clients on Family Planning
Session Objectives

At the End of This Session, Trainees Will Be Able To:

• Describe how to lead a discussion on conducting FP education
Steps in Conducting and Evaluating Individual, Group, and Community FP Education

- Prepare for Education session
- Establish Rapport
- Conduct Session
- Evaluate the session
- Close the session
Session 3.2

How and Why to Counsel
Session Objectives

• At the End of This Session, Trainees Will Be Able To:
  • Define Counseling and Counseling for Informed Choice.
  • Explain the reasons for family planning counseling and factors influencing counseling outcomes.
  • Demonstrate ability to effectively counsel clients for informed choice.
  • Demonstrate ability to effectively counsel clients for HTSP
  • Demonstrate ability to effectively counsel high risk clients for making voluntary FP decisions
  • Describe ways to integrate FP and HIV services.
Types of Counseling

• Two main types of counselling discussed in this session are:
  • Counselling for informed choice of FP methods
  • Counselling client including high risk to make voluntary decision on FP/RCH services.
Purpose of Counseling for Informed Choice

- Help the client make an informed choice of a family planning method.
- Provide accurate information when a client expresses incorrect ideas.
Guide for explaining Family Planning methods

1. What the method is
2. How it works to prevent pregnancy
3. Effectiveness
4. Advantages including non contraceptive benefits
5. Disadvantages/side effects
6. Who can use
7. Who cannot use
8. Whether prevents STI/HIV/Dual Protection needed
General steps in counselling clients for informed choice of FP methods

• Establish and maintain positive provider/client interpersonal relationship
• Explore clients' situation and reproductive goals and needs
• Explain family planning methods according to the client’s interest and goal
• Help the client choose an appropriate method
HEALTHY TIMING AND SPACING OF PREGNANCY (HTSP)

• HTSP offers reduced risk to women and their children
• After live births
• After miscarriage or abortion
• For adolescents
HTSP gives guidance:

- for the healthiest time to become pregnant
- for healthiest age for first pregnancy
Birth to Pregnancy Interval and Relative Risks for Mothers and Pregnancy

Birth to Pregnancy Interval and Relative Risk (adjusted odds ratio) for Adverse Maternal and Pregnancy Outcomes (risk for miscarriage is that following a live birth)

- Pre-term birth
- Low birth weight
- Maternal Death
- Abortion

Birth to Pregnancy Interval and Relative Risk for Neonates and Infants

Birth to Pregnancy Interval and Relative Risk (adjusted odds ratio) for Neonatal and Infant Mortality

Source: Rutstein 2005.
Maternal Risks by Age of Woman

Risk for Morbidity and Mortality by Age

- Eclampsia
- Puerperal endometritis
- Maternal death

Source: Conde-Agudelo, A. 2002
High Risk Clients

• **Definition:**
• Are those clients whose lives or the lives of their child/children are at risk by pregnancy. A client may be at higher risk for an unintended pregnancy, miscarriage, and maternal or neonatal complications.
Purpose of Counselling High Risk Clients

• Helps to understand the effects of high risk factors on client, children and family

• Helps the client to identify a problem, find a solution and make a decision according to the situation and time

• Allows the client or service provider to ask questions according to the problem identified and provide appropriate information
Different Groups of High Risk Clients

- Too early – woman giving birth when their age is below 20 years
- Too soon – women whose birth interval are less than 2 years
- Too many – women who have had 4 or more pregnancies.
- Too late – women becoming pregnant at 35 years of age and above
Different Groups of High Risk Clients Cont'd

- Breast feeding mothers within 6 months after delivery
- Women with bad obstetric history (BOH)
- Women with chronic medical conditions e.g. diabetic mellitus, heart disease, etc.
- People living with HIV/AIDS
- Adolescents
- Gender based violence victims (rape, incest sexual abuse, physical or emotional violence)
Steps in Counseling High Risk Clients on FP

• Establish and maintain client/provider relationship that will facilitate free flow of information.
• Start to discuss the health risk factor/issue identified.
• Provide information related to the problem.
• Ensure client understands the information provided.
• Help client to make an appropriate decision to solve the problem.
• Close the discussion and start counseling the client on informed choice for family planning.
Integrating HIV and FP

- Clients seeking HIV services and FP services share common needs and concerns
- Often sexually active and fertile
- Are at risk of HIV infection or might be HIV+
- Need to know HIV status
- Need access to contraceptives
- Create programmatic synergies
- Offer opportunities for follow up and support
Factors affecting Sexual and Reproductive Health Issues

- Health/well-being of self, partner, children
- Access to ARV therapy
- Fears related to disclosing HIV status (rejection, violence, financial loss)
- Knowledge about contraceptives (including cultural myths and misconceptions)
- Stigma regarding condom use
- Gender issues/partner opposition
Factors Affecting Method Choice for HIV+ Clients

- Women and couples with HIV may consider:
  - Safety and effectiveness of the method
  - Duration of protection desired
  - Possible side effects
  - Ease of use
  - Cost and access to resupply
  - Effect on breastfeeding (if postpartum)
  - How it may interact with other medications, including ARVs
  - Whether it provides protection from STI/HIV transmission and acquisition
  - Whether partner involvement or negotiation are required
UNIT 4
SCREENING FEMALE AND MALE CLIENTS
FOR FAMILY PLANNING METHOD USE
Objectives

- Explain why screening is performed
- Explain the different categories in the WHO medical eligibility chart
- Explain procedures necessary for different family planning methods
- Describe how to perform pelvic exam
Reasons for screening clients

- To rule out contraindications for the chosen method.
- Some methods require certain screening procedures.
- When the client requests to be examined.
- When the client's history indicates a problem.
- When procedures are done for reproductive health promotion.
<table>
<thead>
<tr>
<th>Classification</th>
<th>With clinical judgment</th>
<th>With limited clinical judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Use method in any circumstances</td>
<td>Yes, Use the method</td>
</tr>
<tr>
<td>2</td>
<td>Generally use: advantages outweigh risks</td>
<td>Yes, Use the method</td>
</tr>
<tr>
<td>3</td>
<td>Generally DO NOT use: risks outweigh advantages</td>
<td>No, DO NOT use the method</td>
</tr>
<tr>
<td>4</td>
<td>Method NOT to be used</td>
<td>No</td>
</tr>
</tbody>
</table>
Selected procedures for Providing Family Planning methods

<table>
<thead>
<tr>
<th>Specific situation</th>
<th>COC</th>
<th>POP</th>
<th>INJECTABLES</th>
<th>IMPLANTS</th>
<th>IUCD</th>
<th>CONDOMS</th>
<th>MIN LAP</th>
<th>VASECTOMY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast examination by provider</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>NA</td>
</tr>
<tr>
<td>Pelvic/genital examination</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A</td>
<td>C</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>NA</td>
</tr>
<tr>
<td>Routine laboratory tests</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
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<tr>
<td>Haemoglobin test</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>B</td>
<td>C</td>
<td>B</td>
<td>C</td>
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<tr>
<td>STI risk assessment: medical history and physical examination</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A*</td>
<td>C</td>
<td>C</td>
<td>C</td>
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<tr>
<td>STI/HIV screening: laboratory tests</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>B*</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Blood pressure screening</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
<td>B*</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>
Selected procedures cont..

- Classification A: Mandatory for method use
- Classification B: Contributes substantially to safe and effective use
- Classification C: Not mandatory for method use.
- Classification N/A: Not applicable
Head to Toe Physical examination – Procedure steps for female clients

- Prepare setting, equipment and materials for physical examination
- Prepare client and self for examination
- Examine client’s head and neck
- Examine the breasts
- Teach client self-breast examination
- Examine the abdomen
- Examine the extremities
- Prepare equipments, client and self for pelvic examination
- Examine the external genitalia
- Perform speculum examination
- Record and share findings
UNIT 5

MENSTRUAL CYCLE
OBJECTIVES

• At the end of this unit the trainee will be able to:
• Describe bleeding days, release of the egg and thickening of the uterus in relationship to the days of the woman’s cycle
• To describe when in the menstrual cycle the woman is fertile
Days 1–5:
Monthly bleeding

Usually lasts from 2–7 days, often about 5 days.

If there is no pregnancy, the thickened lining of the womb is shed. It leaves the body through the vagina. This monthly bleeding is also called menstruation. Contraction of the womb at this time can cause cramps. Some women bleed for a short time (for example, 2 days), while others bleed for up to 8 days. Bleeding can be heavy or light. If the egg is fertilized by a man’s sperm, the woman may become pregnant, and monthly bleeding stops.

Days 1–5

Day 14:
Release of egg

Usually occurs between days 7 and 21 of the cycle, often around day 14.

Usually, one of the ovaries releases one egg in each cycle (usually once a month). The egg travels through a fallopian tube towards the womb. It may be fertilized in the tube at this time by a sperm cell that has travelled from the vagina.

Days 15–28:
Thickening of the womb lining

Usually about 14 days long, after ovulation.

The lining of the uterus (endometrium) becomes thicker during this time to prepare for a fertilized egg. Usually there is no pregnancy, and the unfertilized egg cell dissolves in the reproductive tract.
Probability of Pregnancy from Intercourse Relative to Ovulation

From Dr. Douglas Huber, information from Wilcox et al. 1998. Post-ovulatory aging of the human oocyte and embryo failure.
FERTILE DAYS

- The Woman’s “fertile window” is from day 8 to day 19 of her menstrual cycle.
- Ovulation occurs around day 14 for a woman who has 28 day cycles.
- Women who do not want to become pregnant need protection especially during this “fertile window”
UNIT 6
Contraceptive Implants
Unit 6 Session 1 – Introduction to Contraceptive Implants.

Session Objectives:
By the end of this session, participants will be able to:
Describe the three types of implants
Describe the single and two rod implants
Explain how implants prevent pregnancy
Describe effectiveness of implants
List the characteristics of implants
Correct misunderstanding about implants
Brainstorming

Ask participants what they know about implants

Record responses and discuss
What Are Implants?

Progestin-releasing flexible rods inserted under the skin

Provide long-term pregnancy protection

Second generation implants:

1-rod system,
   effective for 3 years

2-rod system,
   effective for 5 years
Types of Implants
Two Rod Implant
Implants- Mechanism of Action

Suppresses hormones responsible for ovulation

Thickens cervical mucus to block sperm movement
Effectiveness

Percentage of women pregnant in first year of use

- Spermicides
- Female condom
- Standard Days Method
- Male condom
- Oral contraceptives
- DMPA
- IUD (TCu-380A)
- Female sterilization
- Implants

Correcting misunderstanding about implants - case study

Amina is a woman of 30 years and a mother of two children. She comes to your clinic because she wants to have her implant removed. She has heard that women who have had an implant can never have children again.

What would you tell Amina before she spreads this rumour to others?
Session 2

Counseling on Implants
Session Objectives

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

Describe how to counsel clients for implants, including PITC

Demonstrate counseling for implants

Differentiate between side effects and complications
Counseling topics

• Advantages and limitations of hormonal implants compared with other contraceptive methods
• Possible side effects of implants
• Possibility of scarring after removal
• Changes in bleeding pattern
• Best time for insertion
• Insertion and removal techniques
• Possible complications of insertion/removal
• Maximum time of use/removal date
• The possibility to discontinue use any time
• Rapid return of fertility after removal
• Provision of supportive information about implant(s)
Counselling cont'd

COUNSELLING JUST BEFORE INSERTION
Done at appointment made for insertion
Re-confirm method choice,
Possible irritation at location of the implant explained once more.

POST INSERTION COUNSELLING
Explain possible bruising and tenderness first few days after anaesthetic has worn off.
Insertion site kept dry for 24 hours, seek a clinician’s help if any irritation occurs at the site of insertion.
Counselling contd

POST INSERTION COUNSELLING

Provide post-insertion instructions:
- keep arm dry, expect some soreness, bruising

Explain duration of protection and when to return for removal or replacement

Describe other reasons to return:
- pain, heat, or redness at the insertion site, excessive weight gain (may decrease the length of effectiveness)

COUNSELLING PRIOR TO REMOVAL

Recommendations for counseling outlined above apply to the removal of implant and follow up
**Session 3 – Who can use Implants?**

**Session Objectives.**
By the end of this session, participants will be able to:

* Explain indications for using implants*
* Describe screening clients using history and physical examination where necessary*
* Demonstrate how to categorize clients using WHO eligibility criteria*
* Explain use of implants in an HIV positive client*
Who can and cannot use implants

Women can begin using implants:
Without pelvic examination
Without blood tests/other routine laboratory tests
Without cervical cancer screening
Without breast examination
Not having monthly bleeding at the time, and it is reasonably certain she is not pregnant
Medical eligibility criteria guidelines

<table>
<thead>
<tr>
<th>WHO Category</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>breastfeeding after 6 weeks postpartum, heavy smokers, complicated valvular heart disease, endometriosis, endometrial or ovarian cancer, thyroid disorders</td>
</tr>
<tr>
<td>Category 2</td>
<td>blood pressure $\geq 160/100$, history of DVT/PE, diabetes with vascular complications, heavy or prolonged vaginal bleeding patterns, multiple risk factors for CVD</td>
</tr>
</tbody>
</table>

## Medical Eligibility criteria Guidelines

<table>
<thead>
<tr>
<th>WHO Category</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 3</td>
<td>breastfeeding prior to 6 weeks postpartum, acute DVT/PE, unexplained vaginal bleeding, history of breast cancer, severe liver disease and most liver tumors, systemic lupus disease&lt;br&gt;&lt;em&gt;continuation only&lt;/em&gt;: ischemic heart disease, stroke, migraine with aura</td>
</tr>
<tr>
<td>Category 4</td>
<td>current breast cancer</td>
</tr>
</tbody>
</table>

Eligibility Criteria for Implant Use by Women with HIV

Women with HIV or AIDS can use implants without restrictions.

Some ARV drugs reduce blood progestin levels.

Efficacy is not affected because implants provide consistent dose of hormone over time.

Dual method use should be encouraged.

<table>
<thead>
<tr>
<th>WHO Eligibility Criteria</th>
<th>Condition</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-infected</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>AIDS</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>ARV therapy</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

Group Exercise- VIPP cards

Using VIPP cards participants to give examples of special groups of clients who should ideally not use implants.
Each participant is to fill 4 cards with an example on each.
Participants to post the VIPP cards on a flip chart.
Organize similar cards into categories.
Add conditions which have not been mentioned,
Lead discussion.
Session 4

Infection Prevention for Implant Insertion and Removal
Session Objectives
By the end of this session, participants will be able to:
Describe the principles of infection prevention related to implant insertion and removal
Infection Prevention cont.

Decontaminating / Cleaning instruments
Sterilizing instruments in autoclave / with chemicals or, high-level disinfection by boiling, steaming, or chemicals
Disposing of the single-use applicator (for Single Rod Implant) and used disposable syringes / needles
Decontaminating trocar, scalpel, syringe and needle
Disposing of contaminated objects (gauze, cotton)
Decontaminating surfaces (the procedure table, instrument stand)
Infection Prevention

Px to brainstorm on infection prevention procedures for implants

Hand washing with antiseptic soap and water; dry with clean towel or air-dry
Putting on sterile gloves
Cleaning insertion site with antiseptic solution
Use of sterile surgical drape
Giving local anesthetic with disposable syringe
Post Insertion cleaning the area of insertion site
Session 5

Inserting Implant
Session Objectives

At the End of This Session, Trainees Will Be Able To:

Describe the insertion procedure steps of implant/s

Demonstrate the insertion of implants

Demonstrate post insertion instructions to the client

Describe follow-up management of client and manage side effects and other problems
Grab bag Exercise

Explain the appropriate timing (time in menstrual cycle, postpartum, post abortion, etc.) for implant insertion.

Ask Px to each take one slip of paper from the grab bag. Instruct them to match each “situation” with “the appropriate time for insertion.”

Lead discussion based on when in the woman’s life cycle to provide implants.
COMPONENTS OF IMPLANT
POSITIONING

Figure 4

Figure 5

Guiding Mark
Insertion Site

8–10 cm

Medial Epicondyle
NEEDLE INSERTION
NEEDLE POSITION

Figure 8

Figure 9
OBTURATOR PROCEDURE
INJECTING AND CHECKING
**Jadelle and Sino-Implant (II) insertion:**

**Step 1.** Make a small incision with a scalpel or trocar in the skin on the inside of the upper arm. Alternatively, use the trocar to puncture the skin. Insert the tip of the trocar beneath the skin at a shallow angle. Gently advance the trocar superficially under the skin (not shown). *Note:* The trocar has three marks on it. The mark closest to the hub indicates how far the trocar should be introduced under the skin to place the Jadelle implants. The middle mark is not used. The mark closest to the tip indicates how much of the trocar should remain under the skin following placement of the first implant.

**Step 2.** When the trocar has been inserted to the mark closest to the hub, remove the obturator and load the first implant into the trocar, using thumb and forefinger.
**Jadelle and Sino-Implant (II) insertion:**

**Step 3.** Using the obturator to push, gently advance the implant towards the tip of the trocar until you feel resistance. Never force the obturator.

**Step 4.** Holding the obturator stationary, withdraw the trocar to the mark closest to the trocar tip. The implant should be released under the skin at this point. It is important to keep the obturator stationary and to avoid pushing the implant into the tissue. Do not completely remove the trocar until both implants have been placed.

**Step 5.** To place the second implant, align the trocar so that the second implant will be positioned at about a 30° angle relative to the first implant. Repeat steps 3-4. The rods are placed in the shape of a V opening toward the shoulder. Leave a distance of about 5 mm between the incision and the tips of the implants. Remove the trocar.
Demonstration of Insertion of Implants

Demonstrate insertion of implant on an arm model

Let two participants demonstrate insertion of implant on the model and let others observe and critique

Let the participants continue practicing on a model under observation until they are proficient
Session 6

Removing Implants
Session Objectives

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

- Explain indications for removal of implant/s
- Describe implant removal
Indications for removal of implants

- Woman’s preference
- Woman wants to have a baby
- Medical condition
- It is the recommended time for removal
LOCAL ANESTHESIA

Figure a

Figure b
LOCATION, INCISION AND REMOVAL

Figure c  Figure d
Implant removal:

**Step 1.** Make an incision (4 mm for Jadelle and Sino-Implant (II) and 2 mm for Implanon) with the scalpel close to the proximal ends of the implants (below the bottom of the V for Jadelle and Sino-Implant (II), and below the single rod for Implanon). Do not make a large incision.

Push each implant gently towards the incision with the finger. When the tip of the rod is visible, grasp it with the forceps and gently pull out the rod with the forceps. Repeat procedure for the second implant (Jadelle and Sino-Implant (II)).

Sources: Organon 1999 (9), Organon 2005 (10), Population Council 2005 (11), Sivin 2002 (13), and World Health Organization 2007 (17)
ENCAPSULATED IMPLANT
HARD TO RETRIEVE IMPLANT

Figure g

Figure h
HARD TO RETRIEVE IMPLANT cont.
Demonstration of Removal of Implants

Demonstrate removal of implant on an arm model

Let two participants demonstrate removal of implant on the model and let others observe and critique

Let the participants continue practicing on a model under observation until they are proficient
Client Instructions

Keep arm dry
Expect soreness, bruising
Length of pregnancy protection
Have implants removed before they start to lose effectiveness
Come back any time for follow up
Role Play

Ask for 2 volunteers to do a role play. Ask one participant to play the role of the client and the other to play the role of the provider giving post-insertion instructions to the client.

Discuss in large group.
Session 7

Follow up and reasons to return
Session Objectives

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

Describe follow-up and reasons for client to return

Demonstrate the SOAP approach to manage clients with implant side effects, complications and other health problems.
Managing Any Problems using the SOAP Approach

Subjective: It is the history given
Objective: These are findings the provider notes after examining the client
Assessment: Analysis of history and physical examination findings
Plan: Is purely management
Small group work

Divide trainees into 4 groups
Two groups to discuss a set of side effects and their management. Two groups to discuss complications related to implant
Groups to present to the plenary
Lead discussion with reference to section on management of side effects/complications
Complications

Uncommon:
Infection at insertion site (most infections occur within the first 2 months after insertion)
Difficult removal (rare if properly inserted and provider is skilled at removal)
Expulsion of implant (expulsions most often occur within the first 4 months after insertion)
Issues to inquire about at follow up

Has concerns about the method
Ask about major changes in her health/thinks could be pregnant
Has pain, heat, pus, redness at insertion site
Sees rod coming out
Has gained a lot of weight
Wants a child
UNIT 7
Intrauterine Device
(IUCD or IUD)

Copper T-380A
Revitalizing the IUCD in Tanzania
Session 1

Introduction to IUCD
OBJECTIONS:

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

• Describe types of IUCDs
• Describe Cu T380A IUCD
• Explain how CuT380A-IUCD- prevents pregnancy
• Describe effectiveness of CuT380A
• List the characteristics of Cu T 380A IUCD
• Explain how to correct misunderstanding about IUCD
IUCDs Were Once More Popular

Trends in modern method use in Sub-Saharan Africa (unweighted averages)

% contribution of method to modern method mix

- Pill
- IUD
- Injection

Current IUCD Use in Sub-Saharan Africa

- Southern Africa: 1.8%
- Western Africa: 1.3%
- East Africa: 0.6%
- Middle Africa: 0.2%
Copper IUCD

About the IUCD:
- Small flexible plastic frame with copper sleeves and/or wire.
- Works mainly by stopping sperm and egg from meeting.
- Most women can use IUCDs, including women who have never been pregnant.

- Very effective, with little to remember.
- Copper T 380A lasts for 12 years.
- For older women: should be removed 1 year after last menstrual period (menopause).
- Can soon become pregnant when IUCD taken out.

Check for concerns, rumours: “What have you heard about the IUCD?” Explain common myths:
- IUCD does not leave the womb and move around inside the body.
- IUCD does not get in the way during intercourse, although sometimes the man may feel the strings.
- IUCD does not rust inside the body, even after many years.

- Side-effects usually get better after first 3 months
- For STI/HIV/AIDS protection, also use condoms.

Small device that fits inside the womb
- Very effective
- Keeps working up to 12 yrs.
- It can be removed whenever the client wishes
- Very safe
- Might increase menstrual bleeding or cramps
- No protection against STIs or HIV/AIDS
Mechanism of Action of Copper IUCDs

• Primary mechanism is prevention of fertilization
  • Reduces motility and viability of sperm

• Inhibition of implantation is a secondary mechanism

Source: Ortiz, 1996.
Effectiveness


Percentage of women pregnant in first year of use

Rate during typical use

Rate during perfect use

Spermicides
Female condom
Diaphragm w/spermicides
Male condom
Oral contraceptives
DMPA
IUCD (TCu-380A)
Female sterilization
Implants

Fertility Rates in Parous Women After Discontinuation of Contraceptive

Belhadj H, et al.
Misconceptions

• A misconception is a mistaken interpretation of ideas and information. If a misconception is filled with elaborate details and becomes a fanciful story, then it acquires the characteristics of a rumor.
Rumours are unconfirmed stories that are transferred from person to person by word of mouth. Rumors arise when:

- An issue is important to people but has not been explained
- No one available who can clarify or correct
- Original source of rumor is credible
- Client has not received complete or accurate information
- People have spread rumors for political reasons
Brainstorming on Rumours

- Participants to mention some rumours and misconceptions they have heard on IUCD
- Participants and trainer to discuss the strategies for counteracting rumours and misconceptions
Session 2

Counselling for IUCD
Session Objectives

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

Describe how to counsel client on IUCD use.

Demonstrate counseling for IUCD
Possible side-effects

If you choose this method, you may have some side-effects. They are not usually signs of illness.

After insertion:
- Some cramps for several days
- Some spotting for a few weeks

Other common side-effects:
- Longer and heavier periods
- Bleeding or spotting between periods
- More cramps or pain during periods

May get less after a few months
Possible side-effects of IUCD

If you choose this method, you may have some side-effects. They are not usually signs of illness.

After insertion:
- Some cramps for several days
- Some spotting for a few weeks

Other common side-effects:
- Longer and heavier periods
- Bleeding or spotting between periods
- More cramps or pain during periods
- May get less after a few months

Discuss:
- “It can take time for the body to adjust.”
- Different people have different reactions to methods.

- “If these side-effects happened to you, what would you think or feel about it?”
- “What would it mean to you?”
- Discuss any rumours or concerns.
  “Please come back any time you want help or have questions.”
- “It is okay to switch methods any time.”

- For cramps after insertion, can take aspirin, paracetamol, or ibuprofen.

- For longer, heavier and more painful periods, she can take ibuprofen or a similar medication (NOT aspirin).

- Cramps and bleeding usually get less after 3 to 6 months.

Does client understand side-effects? Is she happy to use method?
Role Play exercise

Participants in groups of 3, one to play as a client, one as a counselor, the third to observe, using the observer’s role-play checklist.
Session 3

Who Can and Cannot Use the IUCD
Session Objectives

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

Explain indications and precautions for using CuT380A

Demonstrate how to screen clients for medical eligibility for the copper IUCD

Discuss the use of IUCD for women with HIV

Describe how to assess women for STIs prior to IUCD insertion
Screening for Medical eligibility

- Gave birth more than 48 hours ago/ less than 4 weeks ago
- Infection following childbirth / abortion
- Unusual bleeding between menstrual periods / bleeding after intercourse
- Female conditions / problems (gynecologic or obstetric conditions or problems),
Screening for Medical eligibility

- More than one sexual partner within last 3 months
- Partner has had another sexual partner within the last 3 months
- Having had STI within last 3 months
- Partner has had STI within last 3 months
- HIV-positive and has developed AIDS?
### Category 1 and 2 Examples (not inclusive): Who Can Use Copper IUCDs

<table>
<thead>
<tr>
<th>WHO Category</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>≥20 years, hypertension, deep venous thrombosis, ischemic heart disease,</td>
</tr>
<tr>
<td></td>
<td>migraine headaches, cervical ectopy, breast disease (including breast cancer)</td>
</tr>
<tr>
<td>Category 2</td>
<td>menarche to &lt;20 years, nulliparous, &lt;48 hours postpartum, heavy or prolonged</td>
</tr>
<tr>
<td></td>
<td>bleeding, severe dysmenorrhea, endometriosis, anemia, high risk of HIV</td>
</tr>
</tbody>
</table>

### Category 3 and 4 Examples (not inclusive):

**Who Should Not Use Copper IUCDs**

<table>
<thead>
<tr>
<th>WHO Category</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 3</td>
<td>- 48 hours to &lt;4 weeks postpartum, ovarian cancer/if initiating use, benign trophoblast disease, high individual risk of STIs, AIDS (no ARV treatment or not well on ARVs)</td>
</tr>
<tr>
<td>Category 4</td>
<td>- pregnancy; postpartum/Post abortion sepsis; unexplained vaginal bleeding (prior to eval.); uterine fibroids with cavity distortion; current PID; purulent cervicitis; endometrial or cervical cancer or pelvic TB/if initiating use</td>
</tr>
</tbody>
</table>

Screening for Pregnancy

- Had baby less than 6 months ago, fully or nearly-fully breastfeeding, had no menstrual period since then
- Abstained from sexual intercourse since last menstrual period or delivery
- Had a baby in the last 4 weeks
- Last menstrual period within past 12 days
- Had miscarriage/abortion within past 12 days
- Been using reliable contraceptive consistently and correctly
Who can and cannot use the IUCD

Most women can safely use the IUCD. But usually cannot use IUCD if:

- May be pregnant
- Gave birth recently (more than 2 days ago)
- At high risk for STIs
- Unusual vaginal bleeding recently
- Infection or problem in female organs

Usually, women with any of these conditions should delay insertion or use another method.

- If in any doubt, use pregnancy checklist or perform pregnancy test.
- IUCD should not be inserted between 48 hours and 4 weeks after childbirth because of expulsion risk.
- If at high risk for chlamydia or gonorrhoea infection.

Those at high risk for these STIs include anyone who:
- has more than 1 sex partner without always using condoms;
- has sex partner who may have sex with others without always using condoms.

- Unusual bleeding should be assessed before IUCD insertion.

STI or Pelvic Inflammatory Disease (PID):
- Treat PID, chlamydia, gonorrhoea or purulent cervicitis BEFORE inserting IUCD. Offer to treat partner too.
- Can insert IUCD if client has genital ulcer disease or vaginitis (bacterial vaginosis, trichomonas vaginalis), but check risk for chlamydia or gonorrhoea. Treat infections.

HIV or AIDS:
- If client has HIV, can insert IUCD.
- If client has AIDS, do not insert IUCD. But if client is being treated with antiretroviral drugs and is healthy, can insert IUCD.

Infection after childbirth or abortion:
- Any infections should be fully treated before IUCD insertion.

Cancer in female organs or pelvic tuberculosis (TB):
- Do not insert IUCD if known cervical, endometrial or ovarian cancer; benign or malignant trophoblast disease; pelvic TB.
Who can use Copper IUCD?

Copper-Bearing IUCD is safe/suitable for nearly all women.

- Who can use IUCDs safely and effectively? women who:
  - Have just had abortion (if no evidence of infection)
  - Are breastfeeding
  - Do hard physical work
  - Have had ectopic pregnancy
Who Can Use Copper IUCD (cont.)

• Have had pelvic inflammatory disease (PID)

• Are infected with HIV or with AIDS but on ART and doing well

• Have or have not had children

• Are not married

• Are of any age, including adolescents and women over 40 years old
IUCDs are Safe for Women with HIV

Little difference in complications between IUCD acceptors with and without HIV.

Percentage of women in Kenyan study

### WHO Eligibility Criteria

<table>
<thead>
<tr>
<th>Condition</th>
<th>Category</th>
<th>Initiate</th>
<th>Continue</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-infected</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>AIDS (without ARVs)</td>
<td>3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>ARV therapy (clinically well)</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

- Safe for majority of women with HIV
- Initiation not recommended if woman has AIDS and is not on ARV therapy
- Dual method use should be encouraged

Values clarification exercise on IUCD and HIV

• Post large sign on wall that says NO another on opposite side that says YES.

• Ask questions. Participants to move to YES side or NO side, middle if don’t know.

• Participants explain justification for their position

• Discuss Participants answers/clarify misconceptions about IUCD use for women with HIV or AIDS.
Assessing a Woman for the risk of STIs prior to IUCD insertion

She is at increased individual risk of STIs if:

- Partner has STI symptoms (pus coming from penis, pain or burning during urination, an open sore in the genital area)
- She or a partner diagnosed with an STI recently
- She has had more than one sexual partner recently
- She has a sexual partner with other partners recently
When can Women Begin using the IUCD?

Women can begin using IUCDs:
Without STI testing
Without an HIV test
Without any blood tests or other routine laboratory test
Without cervical cancer screening
Without a breast examination
Session 4

IUCD Infection Prevention
Session Objectives

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

Explain infection prevention procedures necessary for IUCD insertion and removal
Session 5

Providing IUCD
Session Objectives

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

Demonstrate how to load IUCD
Describe the insertion procedure steps
  Demonstrate insertion of IUCD according to Clinical Skills Assessment checklist
Describe how to provide IUCD post-insertion instructions.
Objectives, Cont’d

- Describe follow-up for IUCD Client
- Explain indications for removal of IUCD
- Demonstrate removal of IUCD from a model
Supporting the User: What to Remember

• Instructions
  • Give client an information card or copy of client’s page and explain. Tell her to keep card in a safe place.
  • Copper T 380A lasts for 12 years.
  • For older women, IUCD should be removed 1 year after last menstrual period (menopause) for full protection from pregnancy.

• When to have IUCD taken out
  • Make appointment to check IUCD is still in place and no infection.
  • Encourage her to come back any time to discuss problems, or have the IUCD removed.

• Bleeding changes and cramps are common. Come back if they bother you.
  • Come back for a check-up in 6 weeks or after next menstrual period

• Come back to the clinic if:
  — Missed a menstrual period, or think you may be pregnant
  — Could have an STI or HIV/AIDS
  — IUCD strings seem to have changed length or are missing
  — Bad pain in lower abdomen

Return Signs:
• “These signs mean a doctor or nurse should check if a problem is developing.”
• “I want you to know about them and remember them.”

• She should tell other health care providers that she has an IUCD.

Remember to offer condoms for dual protection!
Last, most important message:
“Come back any time you have questions or want the IUCD removed.”
Supporting the User: IUCD return visit

How can I help?

- Are you happy using the IUCD?
- We can check it for you
- Any questions or problems?

Let’s check:

- For any new health conditions
- Need condoms too?

A pelvic exam may be useful after first menstrual period 6 weeks after insertion.
- Check for partial or complete expulsion, pelvic infection.

IUCD removal: If client is happy with the IUCD, she can keep it until the end of its effectiveness (12 years after insertion for Copper T 380A).
- To help manage side-effects and other problems, go to next page.
- Wants to switch methods?
  “It’s okay to change methods if that is what you decide.”
- Wants to stop family planning? Discuss reasons, consequences, next steps.
- Arrange IUCD removal if client wishes.

Check for any infections or other problems in the reproductive tract.
- She can keep the IUCD in the following circumstances:
  — while unexplained vaginal bleeding is being assessed,
  — receiving treatment for PID or STIs,
  — awaiting treatment of cervical, endometrial, or ovarian cancer,
  — if she returns with HIV (infection) or AIDS (illness): clients with AIDS should be closely monitored for pelvic infection.
- If client returns with pelvic TB, she should have the IUCD removed.
- Check how client is preventing STIs/HIV/AIDS. If not protected, go to Dual Protection tab. Give condoms if needed.

Continuing? Invite her to return any time or when IUCD needs removal.

Switching? Discuss other methods.
IUCD Use for Adolescents

- Appropriate for properly selected and counseled adolescents
  - Insertion may be more difficult in nullips
- Follow-up and side-effect monitoring important
- Encourage use of condoms
- Screen for risk of STIs
Follow up and Reasons to Return

Client should return 6 weeks after insertion

Other reasons to return:
• Has any concerns about the method/whether satisfied
• major changes in her health
Follow up and Reasons to Return, Cont’d

Thinks she could be pregnant
Concerns about bleeding, vaginal discharge, abdominal pain, fever, unable to feel strings, pain on urination, felt plastic of IUCD
Session 6

Managing IUCD Side Effects and Complications
Objectives

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

Describe the SOAP Approach
Describe how to manage problems reported as side effects/complications using SOAP Approach.
Managing Any Problems using the SOAP Approach

Subjective: It is the history given

Objective: These are findings the provider notes after examining the client

Assessment: Analysis of history and physical examination findings

Plan: Is purely management
Differences between side effects and complications

- **Side Effects**
  - **Minor**
  - Lasts for shorter period.
  - Appear after a few days.
  - Disappear spontaneously.

- **Complications**
  - **Severe**
  - Last for longer period or may be permanent.
  - Appear later.
  - Need management otherwise can be harmful/fatal.
Managing IUCD side effects/complications

(small group work)

- Discuss side effects and complications of IUCD.
- Outline management of the side effects.
- Each group to present in plenary and discuss.
IUCDs – Perforations

Very rare: 1 in 1,000 insertions

Risk:

• Linked to skill and experience of provider
• Reduced through supervised training
• Greater for postpartum insertions performed between 48 hours and 6 weeks after delivery