# Appendix A

## Sample Training Agendas

### Agenda for the Training of Providers: Six Days

<table>
<thead>
<tr>
<th>DAY AND TIME</th>
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<tr>
<td><strong>Morning</strong></td>
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<td>1 hour, 20 mins.</td>
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<td><strong>Total time</strong></td>
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<tr>
<td></td>
<td><strong>Lunch Break</strong></td>
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<tr>
<td><strong>Afternoon</strong></td>
<td>After-Lunch Warm-Up²</td>
<td>15 mins.</td>
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<td></td>
<td>4 Who Are Our Clients?</td>
<td>1 hour, 30 mins.</td>
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<td>Daily Warm-Up</td>
<td>15 mins.</td>
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<td></td>
<td>6 Bringing in the Client Perspective</td>
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<tr>
<td><strong>Afternoon</strong></td>
<td>10 Ensuring Optimal Communication</td>
<td>2 hours, 50 mins.</td>
</tr>
<tr>
<td></td>
<td>Daily Wrap-Up</td>
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*continued*
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<tbody>
<tr>
<td><strong>Day 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Morning</strong></td>
<td>Daily Warm-Up</td>
<td>15 mins.</td>
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<td></td>
<td>11 Addressing Misconceptions</td>
<td>1 hour</td>
</tr>
<tr>
<td></td>
<td>12 Filling Clients’ Knowledge Gaps</td>
<td>1 hour, 45 mins.</td>
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<td><strong>Afternoon</strong></td>
<td>14 Exploring Clients’ Sexual Relationships</td>
<td>1 hour, 35 mins.</td>
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<td></td>
<td>15 The Risk Continuum</td>
<td>55 mins.</td>
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<tr>
<td></td>
<td>Daily Wrap-Up</td>
<td>15 mins.</td>
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<td></td>
<td><strong>Total time</strong></td>
<td><strong>3 hours</strong>¹</td>
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<tr>
<td><strong>Day 4</strong></td>
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<tr>
<td><strong>Morning</strong></td>
<td>Daily Warm-Up</td>
<td>15 mins.</td>
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<td></td>
<td>16 Risk Assessment: Improving Clients’ Perception of Risk</td>
<td>50 mins.</td>
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<tr>
<td>Day 5</td>
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<tr>
<td>Morning</td>
<td>Daily Warm-Up</td>
<td>15 mins.</td>
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<td></td>
<td>21 Strengthening Partner Communication and Negotiation</td>
<td>55 mins.</td>
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1 All “total times” include time for a 15-minute break. Trainers will decide when to schedule these breaks, based on local preferences.

2 An after-lunch warm-up is scheduled for the first day, to help “break the ice” and encourage communication among participants. You can select one of your favorite warm-ups for this session. There are no other after-lunch warm-ups scheduled on the following days, because all of the after-lunch sessions are highly interactive and include group activities. If you want to conduct additional warm-ups after lunch, you will need to adjust the schedule and extend the time allotted for the afternoon sessions.
## Agenda for the Training of Providers: Five Days

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Appendix A
Appendix B

Precourse and Postcourse Knowledge Assessment
Precourse and Postcourse Knowledge Assessment

Number: _______________________________  Date: _________________

1. Which of the following is **not** required for a client to be able to make an informed choice?
   a. Service provider’s recommendation
   b. Availability of appropriate information
   c. Voluntary decision-making process
   d. Availability of adequate service options

2. Which one of the following is **not** a principle of good client-provider interaction?
   a. Providing the client’s preferred method
   b. Using and providing memory aids
   c. Giving all the available information about all reproductive health issues
   d. Providing information on fewer topics, which are directly relevant to the client’s expressed needs, concerns, and circumstances.

3. Which one of the following statements about counseling is **incorrect**?
   a. Counseling is one of the safeguards of clients’ right to informed choice.
   b. Counseling about side effects scares clients away and decreases method continuation.
   c. Counseling enables clients to use their chosen method correctly.
   d. Clients who receive the method they want are more likely to continue using it.

4. Which one of the following statements about counseling is **correct**?
   a. New clients with a method in mind should be given full information about all methods.
   b. New clients with no method in mind should receive information on all methods that respond to their expressed needs.
   c. Satisfied return clients do not need counseling.
   d. Dissatisfied return clients should be discouraged from discontinuing their method.

5. Which one of the following is **incorrect** about counseling?
   a. Assessing and addressing the needs of the client is more important than following the steps of REDI or any other counseling framework.
   b. Clients have the right and responsibility to make decisions and carry them out.
   c. The steps of REDI or any other counseling framework have to be followed in sequential order for a successful counseling session.
   d. An important role for family planning (FP) counselors is to assist clients in anticipating and strategizing about how to overcome the barriers that might prevent them from implementing their decisions.
Appendix B

6. Which one of the following is correct?
   a. The counselor should not discuss sexuality with clients unless the client raises the issue.
   b. The counselor should inform the client that certain sexual practices are right or that some are wrong.
   c. Sexuality is mostly about sexual intercourse.
   d. The counselor should explore clients’ sexual practices and relationships.

7. Which one of the following is incorrect in describing the communication between clients and healthcare staff?
   a. Body language and tone of voice are as important as words in conveying messages.
   b. Praise and encouragement should be used to encourage clients to continue talking.
   c. Counselors should use only open-ended questions in order to get information from the client as quickly as possible.
   d. Opinions and feelings of clients are best elicited by open-ended questions.

8. Client says, “People say injection makes cancer.”
   Provider says, “I see you are concerned about it.”
   Which communication technique has the provider used here?
   a) paraphrasing b) reflecting c) clarification d) active listening

9. Which of the following is incorrect about giving information to clients?
   a. Information should be tailored to clients’ needs.
   b. First the counselor should explore what the client already knows.
   c. The counselor should start with the method used most frequently in the country.
   d. The counselor should check whether the client understands the information given during the counseling session.

10. Which one of the following statements is incorrect when discussing sexuality with clients?
    a. Counseling should start with discussion of sexuality first, because it is the basis and reason for FP and for transmission of sexually transmitted infections (STIs).
    b. The counselor should warn the client that personal and sensitive questions might be asked during counseling.
    c. The client should be assured of confidentiality.
    d. The clients’ sexual relationships should be explored to the extent that the client is comfortable revealing information about them.
11. Which of the following statements is incorrect?
   a. Condoms offer less protection against other STIs than against HIV.
   b. Anal sex is riskier than vaginal sex for transmission of HIV and other STIs.
   c. Someone with an STI, particularly an ulcerative STI such as syphilis or chancroid, is more likely to become infected with HIV if exposed.
   d. Men who are not circumcised are less likely to become infected with HIV if they are exposed than are men who are circumcised.

12. Which of the following statements is incorrect?
   a. Counselors should help clients consider their risk for HIV and other STIs while choosing a FP method.
   b. Married women’s sense of safety from contracting HIV and other STIs might be false.
   c. Self risk assessment for STIs complements but does not replace risk assessment conducted jointly by the client and provider.
   d. STI risk assessment needs to be done only with clients who belong to groups at high risk.

13. Which one of the following statements is incorrect?
   a. Women with a history of an STI in the last two months can generally use an IUD.
   b. Clients with AIDS who are well and on treatment (e.g., antiretroviral therapy) can continue using the IUD.
   c. Breastfeeding women who are six weeks to six months postpartum should not use combined oral contraceptives.
   d. Breastfeeding women generally should not use progestin-only injectables (such as depot medroxyprogesterone acetate (DMPA) within the first six weeks postpartum.

14. Which one of the following is not among the information elements of informed consent for permanent methods?
   a. Temporary methods of contraception are available to the client and his or her partner.
   b. The procedure to be performed on the client is a surgical procedure.
   c. The client can have the procedure reversed if he or she decides to have children again.
   d. The procedure does not protect the client or the partner from infection with HIV or other STIs.

15. Which one of the following is not among the tasks of a counselor after the client makes a decision?
   a. Assisting the client in making a concrete and specific plan for carrying out the decision
   b. Helping the client perceive his or her risk for HIV and other STIs
   c. Identifying and practicing skills that will be needed by the client
   d. Developing strategies to overcome the barriers identified with the client
Appendix B

16. Which of the following cannot be considered as a form of dual protection?
   a. The use of a condom (male or female) alone for both pregnancy and STI prevention
   b. Mutual monogamy between uninfected partners, combined with a contraceptive method
   c. The use of a condom plus another contraceptive method for extra protection against pregnancy
   d. Emergency contraception

17. Which one of the following is not a part of the services for satisfied return clients?
   a. Checking how satisfied the client is with the FP method
   b. Inquiring if the client is using the method correctly
   c. Telling the client about the side effects of the method that he or she is using
   d. Providing resupply or follow-up services (like checking the IUD)

18. Mark the statements that reflect the incorrect management of side effects or problems.
   a. Amenorrhea seen with progestin-only injectables (like DMPA) should be treated with a cycle of combined oral contraceptives so that the client can have regular periods again.
   b. For clients using combined oral contraceptives, mild side effects can be relieved by switching to a lower-dose pill or a progestin-only pill.
   c. When an IUD client is diagnosed with an STI, the IUD can stay in place during the treatment.
   d. In case of a pregnancy of less than 13 weeks gestation with an IUD in place, the IUD should be removed if its strings are visible.

19. Mark the statement that is incorrect.
   a. Clients who come back frequently to switch methods should be discouraged from doing so.
   b. Clients who want to discontinue their method should be offered the option of switching to another FP method.
   c. When a client brings up a misconception or rumor during counseling, the provider should explain why it is not true and give the correct information.
   d. The provider should give full information on side effects to a new FP client, regardless of whether the client asks.

20. For this question, review the activities below and write the phase of REDI to which the activity corresponds in the space provided at the end of the activity (R for Rapport Building; E for Exploration; D for Decision Making; and I for Implementing the Decision).
   a. Help the client consider how his or her family might react to his or her choice of actions. _____
   b. Offer ideas for improving communication and negotiation with the client’s partner. _____
Precourse and Postcourse Knowledge Assessment: Key

Number: ___________________________ Date: _______________

1. Which of the following is **not** required for a client to be able to make an informed choice? (Session 2)
   a. Service provider’s recommendation
   b. Availability of appropriate information
   c. Voluntary decision-making process
   d. Availability of adequate service options

2. Which one of the following is **not** a principle of good client-provider interaction? (Session 2)
   a. Providing the client’s preferred method
   b. Using and providing memory aids
   c. **Giving all the available information about all reproductive health issues**
   d. Providing information on fewer topics, which are directly relevant to the client’s expressed needs, concerns, and circumstances.

3. Which one of the following statements about counseling is **incorrect**? (Session 3)
   a. Counseling is one of the safeguards of clients’ right to informed choice.
   b. Counseling about side effects scares clients’ away and decreases method continuation.
   c. Counseling enables clients to use their chosen method correctly.
   d. Clients who receive the method they want are more likely to continue using it.

4. Which one of the following statements about counseling is **correct**? (Session 4)
   a. New clients with a method in mind should be given full information about all methods
   b. **New clients with no method in mind should receive information on all methods that respond to their expressed needs**
   c. Satisfied return clients do not need counseling
   d. Dissatisfied return clients should be discouraged from discontinuing their method

5. Which one of the following is **incorrect** about counseling? (Session 8)
   a. Assessing and addressing the needs of the client is more important than following the steps of REDI or any other counseling framework.
   b. Client’s have the right and responsibility to make decisions and carry them out.
Appendix B

c. The steps of REDI or any other counseling framework have to be followed in sequential order for a successful counseling session.

d. An important role for FP counselors is to assist clients in anticipating and strategizing about how to overcome the barriers that might prevent them from implementing their decisions.

6. Which one of the following is correct? (Session 9)
   a. The counselor should not discuss sexuality with clients unless the client raises the issue.
   b. The counselor should inform the client that certain sexual practices are right or that some are wrong.
   c. Sexuality is mostly about sexual intercourse.
   d. The counselor should explore clients’ sexual practices and relationships.

7. Which one of the following is incorrect in describing the communication between clients and healthcare staff? (Session 10)
   a. Body language and tone of voice are as important as words in conveying messages.
   b. Praise and encouragement should be used to encourage clients to continue talking.
   c. Counselors should use only open-ended questions in order to get information from the client as quickly as possible.
   d. Opinions and feelings of clients are best elicited by open-ended questions.

8. Client says “People say injection makes cancer.” (Session 10)
   Provider says “I see you are concerned about it.”
   Which communication technique has the provider used here?
   a) paraphrasing   b) reflecting   c) clarification   d) active listening

9. Which of the following is incorrect about giving information to clients? (Session 12)
   a. Information should be tailored to clients’ needs.
   b. First the counselor should explore what the client already knows.
   c. The counselor should start with the method used most frequently in the country.
   d. The counselor should check whether the client understands the information given during the counseling session.

10. Which one of the following statements is incorrect when discussing sexuality with clients? (Session 14)
   a. Counseling should start with discussion of sexuality first, because it is the basis and reason for FP and for transmission of sexually transmitted infections (STIs).
   b. Counselor should warn the client that personal and sensitive questions might be asked during counseling.
c. The client should be ensured of confidentiality.

d. Clients’ sexual relationships should be explored to the extent the client is comfortable revealing.

11. Which of the following statements is incorrect? (Session 15)
   a. Condoms offer less protection against STIs than against other HIV.
   b. Anal sex is riskier than vaginal sex for transmission of HIV and other STIs.
   c. Someone with an STI, particularly an ulcerative STI such as syphilis or chancroid, is more likely to become infected with HIV if they are exposed.
   d. Men who are not circumcised are less likely to become infected with HIV if exposed than are men who are circumcised.

12. Which of the following statements is incorrect? (Session 16)
   a. Counselors should help clients consider their risk for HIV and other STIs while choosing a FP method.
   b. Married women’s sense of safety from contracting HIV and other STIs might be false.
   c. Self risk assessment for STIs complements but does not replace risk assessment conducted jointly by the client and provider.
   d. STI risk assessment needs to be done only with clients who belong to groups at high risk.

13. Which one of the following statements is incorrect? (Session 17)
   a. Women with a history of an STI in the last two months can generally use an IUD.
   b. Clients with AIDS who are well and on treatment (e.g., ARVs) can continue using the IUD.
   c. Breastfeeding women who are six weeks to six months postpartum should not use combined oral contraceptives.
   d. Breastfeeding women generally should not use progestin-only injectables (such as DMPA) within the first six weeks postpartum.

14. Which one of the following is not among the information elements of informed consent for permanent methods? (Session 18)
   a. Temporary methods of contraception are available to the client and his or her partner.
   b. The procedure to be performed on the client is a surgical procedure.
   c. The client can have the procedure reversed if he or she decides to have children again.
   d. The procedure does not protect the client or the partner from infection with HIV or other STIs.
15. Which one of the following is not among the tasks of a counselor after the client makes a decision? (Session 19)
   a. Assisting the client in making a concrete and specific plan for carrying out the decision
   b. Helping the client perceive his or her risk for HIV and other STIs.
   c. Identifying and practicing skills that will be needed by the client
   d. Developing strategies to overcome the barriers identified with the client

16. Which of the following cannot be considered as a form of dual protection? (Session 20)
   a. The use of a condom (male or female) alone for both pregnancy and STI prevention
   b. Mutual monogamy between uninfected partners, combined with a contraceptive method
   c. The use of a condom plus another contraceptive method for extra protection against pregnancy
   d. Emergency contraception

17. Which one of the following is not a part of the services for satisfied return clients? (Session 22)
   a. Checking how satisfied the client is with the FP method
   b. Inquiring if the client is using the method correctly
   c. Telling the client about the side effects of the method that he or she is using
   d. Providing resupply or follow-up services (like checking the IUD)

18. Mark the statements that reflect the incorrect management of side effects or problems. (Session 23)
   a. Amenorrhea seen with progestin-only injectables (like DMPA) should be treated with a cycle of combined oral contraceptives so that the client can have regular periods again.
   b. For clients using combined oral contraceptives, mild side effects can be relieved by switching to a lower-dose pill or a progestin-only pill.
   c. When an IUD client is diagnosed with an STI, the IUD can stay in place during the treatment.
   d. In case of a pregnancy of less than 13 weeks gestation with an IUD in place, the IUD should be removed if its strings are visible.

19. Mark the statement that is incorrect. (Session 24)
   a. Client, who come back frequently to switch methods should be discouraged from doing so.
   b. Clients who want to discontinue their method should be offered the option of switching to another FP method.
c. When a client brings up a misconception or rumor during counseling, the provider should explain why it is not true and give the correct information.

d. The provider should give full information on side effects to a new FP client, regardless of whether the client asks.

20. For this question, review the activities below and write the phase of REDI to which the activity corresponds in the space provided at the end of the activity (R for Rapport Building; E for Exploration; D for Decision Making; and I for Implementing the Decision).

a. Help the client consider how his or her family might react to his or her choice of actions. **D**

b. Offer ideas for improving communication and negotiation with the client’s partner. **I**

c. Ask about the client’s relationships and behaviors that might put him or her at risk for an unintended pregnancy or a sexually transmitted infection. **E**

d. Assure the client of confidentiality. **R**
Appendix B
Appendix C

Daily Warm-Ups and Daily Wrap-Ups
Daily Warm-Ups

Facilitator’s Objectives

• To help the participants refocus on their participation in the workshop
• To review the previous day’s discussions and learning in terms of the client’s perspective
• To preview the day’s sessions and learning objectives

Time

15 minutes

Materials

• Flipchart paper, markers, and tape

Session Outline

<table>
<thead>
<tr>
<th>Training Activities</th>
<th>Methodology</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Welcome/Logistics</td>
<td></td>
<td>2 mins.</td>
</tr>
<tr>
<td>B. Icebreaker</td>
<td></td>
<td>5 mins.</td>
</tr>
<tr>
<td>C. Review of Previous Day</td>
<td>Discussion/presentation</td>
<td>8 mins.</td>
</tr>
</tbody>
</table>

Advance Preparation

1. Prepare to conduct your favorite icebreakers or other warm-up activities in a five-minute timeframe. Short games, songs, or physical activities can help participants get energized and focused on being back in the workshop setting and interacting with fellow participants. You can also ask the participants to lead the group in songs or short group activities.

2. Starting from the second day of the workshop, prepare one or two questions to ask the participants to help them think about the profiled clients’ perspectives, based on the previous day’s sessions and discussions. For example, on the day after the sessions on the topics of introducing the topic of sexuality with clients, using language that clients can understand, or using visual aids, you might ask the “clients” (i.e., those participants selected to assume the role of the client on that day) the following relevant questions:

   ✴ How did you feel when the “providers” (the participants who were playing the role of the provider) here were discussing sexuality? Describe your feelings.

   ✴ How would you feel if they spoke to you about sexuality?

   ✴ How would you like them to discuss these issues with you?

   ✴ How did you feel when you heard words about reproductive organs and sexual practices?
Appendix C

Similar questions can be asked about rights to family planning services and methods, attitudes and beliefs, and clients’ reactions to any of the exercises on counseling skills and steps later in the training.

In addition, general questions such as the following can be asked:

- How did you feel yesterday in this room as you observed these “providers”?  
- What do you think about what they are doing here?  
- How do you feel about the training they are going through?

3. For more information on how to use client portraits, see the Introduction for Trainers and Program Planners and Session 6: Bringing in the Client Perspective.

4. Starting from the fourth day of the workshop, prepare situation cards to reflect a change in each client’s situation. The idea is to allow for the discussion of topics not covered so far in the discussions. These might include discontinuing a method, desiring to have a child, worrying about a rumor, getting married, getting divorced, having vaginal discharge, hearing about HIV and AIDS, complaining of a side effect of a method, having a problem using a method (e.g., missed pills), having a partner who objects to use of family planning, or wanting to switch methods. Situation cards will be needed for Sessions 19, 21, 22, and 24. In those sessions, there are sample situation cards that you can use and more instructions and examples on how to use them. You might choose to give out the situation cards during the morning warm-up, when you assign new participants to client portraits, or you can give out the situation cards at the beginning of the sessions in which they will be used.

5. Decide how to preview the day’s sessions.
Daily Warm-Up Activities

Activity A. Welcome and Logistics (2 minutes)
1. Welcome the participants back to the workshop.
2. Make announcements and address any “housekeeping” or logistical issues that need to be discussed.

Activity B. Icebreaker (5 minutes)
Conduct a short icebreaker.

Activity C. Review of Previous Day (8 minutes)
1. Briefly review the sessions of the previous day.
2. Call on the participants who were assigned to the five client roles the previous day. Introduce them to the large group by just telling their names. (Note: For day 2, there will not be any client role assigned from the previous day, and the reporting on clients’ experiences will start on day 3.)
3. To help the participants think about the profied clients’ perspectives, ask them the prepared question(s) based on the previous day’s sessions (see Advance Preparation).
4. Preview the day’s sessions (as you determined during Advance Preparation).
5. Assign client roles to new participants for the rest of the day. This group will report on their experience as the “client” during the following day’s warm-up. (Note: You may give the situation cards to the newly assigned participants for days 4 and 5 at this point.)

Training Tip
When assigned to a client role, participants tend to report on what problem they were experiencing and what happened. Discourage them from telling the story, and ask them to talk about their feelings and thoughts.

Training Tip
• The numerous role plays and practice sessions in this curriculum focus on the knowledge, attitudes, and skills of the participant who is playing the provider. But equally important learning can happen for the person who is playing the client. Role playing the client involves thinking about a client as a whole person and being able to understand how the lives of clients outside the facility influence communication within the service-delivery setting.
• Thinking about the client’s perspective can help providers identify similarities between themselves and their clients. Paying attention to similarities between clients and providers can be as helpful as noticing the differences, because the things that we share help build a bridge of understanding and communication between clients and providers.
Daily Wrap-Ups

Facilitators’ Objectives

- To recap the information and ideas covered during the day
- To identify one thing that each participant could do in his or her work to apply what he or she learned today
- To provide feedback to the facilitator about how well the workshop is going, issues that remain unclear, and ways to improve the workshop

Time

15 minutes

Materials

- Flipchart paper, markers, and tape

Session Outline

<table>
<thead>
<tr>
<th>Training Activities</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Discussion</td>
<td>15 mins.</td>
</tr>
</tbody>
</table>

Advance Preparation

1. Before the first wrap-up session, create a flipchart entitled “Needs More Discussion.”
2. *Optional*: Create a flipchart entitled “How Can I Apply in My Work What I Have Learned Today?”
Daily Wrap-Up Activities

Activity A. Discussion (15 minutes)

1. Briefly review the topics covered in the day’s sessions.
2. Ask the participants the following question (encourage everyone to say something, but do not write their responses on a flipchart):
   ✴ What was the most important thing you learned from today’s sessions?
3. Post the flipchart entitled “Needs More Discussion.” Ask if there are any areas that remain unclear or that need more discussion. Note these areas on the flipchart.
4. Ask the participants the following question:
   ✴ What suggestions do you have for making things go well tomorrow?
   Do not write their answers on a flipchart, but thank the participants for their comments and note that you will try to follow their recommendations as much as possible.

ー Training Tip

• After the first day, the “Needs More Discussion” flipchart will be revisited each day. Before asking if any areas remain unclear from the day, briefly review the list from the preceding days and ask which (if any) areas have been covered adequately by now. These can be crossed out; the others will remain on the list.
• Try to address the unclear issues at some point during the workshop. These wrap-up sessions are not intended to be used for that purpose, unless you find that there is enough time at the end of the day to do so.

5. Option A: Post the flipchart entitled “How Can I Apply in My Work What I Have Learned Today?” Then ask the participants:
   ✴ What is one thing that you could do when you get back to your work site to apply what you learned from today’s sessions?
   List the participants’ responses on the flipchart. Do not write the same answers more than once, but make tally marks alongside each to indicate how many times each answer was given.
Option B: Tell participants to open the last page of their notebooks and write their answers to the following question on that last page. Then ask the participants:

- What is one thing that you could do when you get back to your work site to apply what you learned from today’s sessions?

Tell them to make sure they write the answers in a place where they will be able to find later. They will need their answers on the last day of the workshop.

Training Tip

Save the “How Can I Apply…” flipchart sheets from each day. At the end of the workshop, during Session 26, refer back to these sheets to help the participants start working on their action plans.

When you ask for one idea from each participant about how to apply what he or she has learned, a participant might have an idea to which everyone else will say, “Yes, I would do the same thing.” While such a response could in theory be accurate and significant, encourage people to think independently. Thus, on the first day, you might put participants into pairs to discuss this issue briefly and ask each pair to report. If you feel that this is not necessary to get a range of answers, then brainstorming works well too.

Training Tip

This daily recap is meant to help the participants focus on realistic changes they can make immediately (i.e., as soon as they return to work) to enhance their communications and counseling with clients.

Too often, trainings end with action plans that never get applied because participants identify potential changes that are too many or too big, or that require the approval of others before they can happen. By asking the participants in this training to identify one thing in each day’s learning that they really think they can do when they return to their work site, we hope to provide a foundation for real and lasting change and for application of the ideas and approaches presented in this training.

It is important to be realistic about what is expected from providers. We often talk about providers and what is expected of them as if they were superhuman and should be able to provide quality counseling to all clients at all times, even under the most adverse conditions. This daily exercise encourages providers to have more realistic expectations, which should help them avoid becoming discouraged about implementing the approaches they learn in training.
Appendix D

The Difference That Counseling Makes
(PowerPoint Presentation)
## The Difference That Counseling Makes

### What Is Counseling?

Counseling is:
- Two-way communication between a client and a health care staff member for the purpose of confirming or facilitating a decision by the client or of helping the client address problems or concerns.

### Counseling Tasks

During counseling, health care staff:
- Help clients assess their health care and informational and emotional support needs
- Provide personalized information (i.e., appropriate to clients’ identified problems and needs)
- Help clients make their own informed and voluntary decisions by enabling them to weigh the options
- Help clients plan how to carry out that decision effectively (by identifying possible barriers and developing skills and strategies to overcome them)
- Answer questions and address concerns

### Two Experts in the Room

**Knowledge of:**
- Healthy timing and spacing of pregnancy (HTSP)
- FP methods and services available
- Other RH areas and services

**Skills:**
- Build trust
- Empathize with clients
- Communicate
- Assess needs
- Tailor information to clients’ needs
- Help clients weigh options and decide

**Thoughts, Feelings, and Opinions about:**
- Fertility plans
- Past experience
- Relationship with partners
- Social circumstances
- Sexual relationships
- Other unexpressed needs
### The Difference That Counseling Makes (continued)

| Why Is Counseling Important? |  |
|------------------------------|  |
| - It protects clients’ right to informed and voluntary decision making. |  |
| - It is an essential element of quality services. |  |
| - It is a key determinant of the adoption and continuation of family planning. |  |
| - It helps clients implement their reproductive health decisions. |  |

| What Does Effective Counseling Do for FP Clients? |  |
|-------------------------------------------------|  |
| Effective counseling:                            |  |
| - Enables clients to choose a method that suits their needs |  |
| - Enables clients to use their chosen method correctly |  |
| - Informs and prepares clients for side effects |  |
| - Enables clients to continue using an FP method with satisfaction as long as they want it |  |
| - Enables clients to reach and maintain their reproductive health goals |  |

| Supporting Choice: Increased Continuation |  |
|-------------------------------------------|  |
| - Use of contraception is highest when people have access to a range of contraceptive methods. |  |
| - Counseling about side effects significantly increases continuation. |  |
| - FP continuation increases when providers are respectful and responsive. |  |
| - Clients who receive the method they want are more likely to continue use. |  |
| - Increased continuation contributes more to contraceptive prevalence than does an increase in new users. |  |

| Telling Clients about Side Effects |  |
|----------------------------------|  |
| - Not knowing about side effects is a major reason for discontinuing pills and injectables. |  |
| - Counseling about side effects increases continuation. |  |

Appendix D

The Difference That Counseling Makes (continued)

Counseling for Side Effects Reduces Early Discontinuation

Effect of Structured Counseling* on Injectable Continuation

FP Continuation Increases When Providers Are Respectful, Responsive

Clients Who Receive the Method They Want Are More Likely to Continue Use
The Difference That Counseling Makes (continued)

### Consequences of Poor Counseling

<table>
<thead>
<tr>
<th>Effect</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improper method use</td>
<td>Unwanted pregnancy</td>
</tr>
<tr>
<td>Fear and dissatisfaction with side effects</td>
<td>Discontinuation</td>
</tr>
<tr>
<td>Failure to recognize serious warning signs</td>
<td>Health risks</td>
</tr>
<tr>
<td>Dissatisfaction with services or method</td>
<td>Dropout</td>
</tr>
<tr>
<td></td>
<td>Poor word of mouth</td>
</tr>
<tr>
<td></td>
<td>Low utilization</td>
</tr>
</tbody>
</table>

### However...

The Reality Often Falls Short of the Ideal

### Under What They Call “Counseling”...

Many providers often:
- Fall to explore clients’ concerns, preferences, and informational needs
- Provide inappropriate or incomplete information or information overload
- Provide little or no preparation for side effects

### Many Providers:

- Believe they know what is best for clients
- Direct the choice of FP methods
- Lack:
  - Good communication skills
  - A client-centered approach
  - Knowledge needed for effective counseling
  - Comfort in discussing sexual and reproductive health
  - Adequate management and supervisory support
- Tell, tell, and tell ...(they tend to do most of the talking)
Appendix D

The Difference That Counseling Makes (continued)

Remember:
There Are Two Experts in the Room

Source: JHU/CCP Photo
Appendix E

Counseling Skills Observation Guide
Counseling Skills Observation Guide

Instructions: This observation guide was developed for use by trainers/supervisors, to regularly observe family planning (FP) counselors in their program and provide ongoing support. The trainer/supervisor, marks the following scores according to the performance level for each client-provider interaction observed:

- 2 = Competently performed (step performed correctly)
- 1 = Needs improvement (step performed partially or incorrectly)
- 0 = Step omitted (step not done)
- NA = Not applicable

Any area that is scored less than 2 needs improvement (except when it is not applicable).

For a more complete description of each task, the trainer/supervisor, can use the “Learning Guides for FP Counseling Skills; New Clients, Satisfied Return Clients, Dissatisfied Return Clients” in the Participant Handbook Appendix B. The supervisor completes one form for each provider observed over one or more observations or supervisory visits.

Name: ________________________________  Service Site: __________________

Supervisor: ____________________________  Date(s): ___________________

<table>
<thead>
<tr>
<th>REDI: TASKS DURING CLIENT/PROVIDER INTERACTION</th>
<th>Clients/Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

**Rapport Building** (Items 3, 5, 6, 7, and 8 should be observed during all phases of REDI. Please mark scores for them only after observing the entire counseling session.)

1. Did the provider greet the client politely, according to local custom? [ ]
2. Did the provider offer the client a seat? [ ]
3. Did the provider ensure **privacy** throughout the session, with no interruptions? [ ]
4. Did the provider explain that he or she asks personal and sometimes embarrassing questions of all clients to better help them select and use FP and stress that everything is **confidential** (i.e., that no one outside the counseling room will learn what is discussed)? [ ]
5. Did the provider **ask open-ended questions** to encourage the client to speak? [ ]
6. Did the provider **listen** to the client without interruptions? [ ]
7. Did the provider give correct information to the client, using clear and simple language to ensure **informed choice**? [ ]
8. Did the provider use visual aids (brochures, flipcharts, contraceptive samples, posters, etc.)? [ ]
### REDI: TASKS DURING CLIENT/PROVIDER INTERACTION

<table>
<thead>
<tr>
<th>Exploration</th>
<th>Clients/Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Did the provider ask the client questions to identify the type of visit? (Circle type of client and go to the appropriate category of client below.)</td>
<td>1</td>
</tr>
<tr>
<td>• New client with a method in mind</td>
<td></td>
</tr>
<tr>
<td>• New client with no method in mind</td>
<td></td>
</tr>
<tr>
<td>• Satisfied return client with no problems (routine follow-up visit or resupply)</td>
<td></td>
</tr>
<tr>
<td>• Dissatisfied return client/client with problem/side effects/concerns</td>
<td></td>
</tr>
</tbody>
</table>

**FOR NEW CLIENTS ONLY:** If return client, skip to 15

10. Did the provider ask about the client’s past experience with FP and assess the client’s knowledge about FP?

11. Did the provider ask questions about:
   - The client’s sexual relationship(s) and habits?
   - Communication with partner(s) about sex, FP, and sexually transmitted infections (STIs), including HIV and AIDS?
   - Support from partner and family to use FP?
   - Possible domestic violence?
   - Socioeconomic circumstances?

12. Did the provider explain STI/HIV prevention and help the client perceive his or her risks for STI/HIV transmission?

13. Did the provider give appropriate information to the client based on the client’s needs (i.e., tailored to the need of the client)?

14. Did the provider screen client for FP use according to standard (medical conditions and history)?

**FOR RETURN CLIENTS ONLY:** If new client, skip to 18

15. Did the provider ask if the client has any problems or concerns with the method?

16. Did the provider ask about possible changes in client’s life?
   - New health-related problems or concerns
   - New partner(s)/possible exposure to STIs/HIV
   - Change in fertility plans

**FOR DISSATISFIED RETURN CLIENTS ONLY:** If satisfied return client, skip to 18

17. Did the provider appropriately address the concerns or problems raised by the client and help the client to develop possible solutions?
### Counseling Skills Observation Guide (cont.)

**REDI: TASKS DURING CLIENT/PROVIDER INTERACTION**

<table>
<thead>
<tr>
<th>Decision Making</th>
<th>Clients/Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Did the provider help the client consider his or her different options or reconfirm his or her choice?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>• Select an FP method based on correct knowledge about side effects, health benefits, and health risks of suitable methods, considering her/his preferences and needs for FP and STI/HIV prevention (<em>new client with no method in mind</em>)</td>
<td></td>
</tr>
<tr>
<td>• Reconfirm her choice of method based on correct knowledge about its side effects, health benefits, and health risks, including the level of STI/HIV protection it offers (<em>new client with a method in mind AND satisfied return client</em>)</td>
<td></td>
</tr>
<tr>
<td>• Options related to discontinuation and method switching (<em>dissatisfied return client</em>)</td>
<td></td>
</tr>
</tbody>
</table>

| Implementing the Decision (the provider often does not need to cover all of these tasks with satisfied return clients) |                                    |
| 19. Did the provider help the client make a plan for implementing the decision by asking about next steps and the timeline for implementation? |                                    |
| 20. Did the provider help the client consider ways to overcome potential barriers to implement his or her decision(s)? |                                    |
| 21. Did the provider ensure that the client has adequate knowledge and skills to implement the decision(s) (e.g., how to use the method, condom demonstration/practice, communication and negotiation skills, provision of information about safer sex practices) |                                    |
| 22. Did the provider ensure that the client understands what follow-up is required (return visits, referral, and/or resupply)? |                                    |
| 23. Did the provider ensure that the client understands what the possible side effects of the method are and what to do about side effects? |                                    |
| 24. Did the provider ensure that the client knows the warning signs of the method and that he or she needs to return to the facility immediately if he or she experiences warning signs? |                                    |
| 25. Did the provider assure the client that he or she is welcome to return to the facility any time that he or she has concerns or problems or thinks he or she might prefer to switch to another method? |                                    |

**TOTAL**

**Additional comments:**
Appendix E

Counseling Skills Observation Guide

*Instructions:* This observation guide was developed for use by supervisors and staff to regularly observe family planning (FP) counselors in their program and provide ongoing support. It is based on the GATHER counseling framework.

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating per client-provider interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General skills and establishment of positive client-provider interaction</strong></td>
<td></td>
</tr>
<tr>
<td>Demonstrates respect for the client; does not judge the client</td>
<td></td>
</tr>
<tr>
<td>Shows friendliness by smiling</td>
<td></td>
</tr>
<tr>
<td>Ensures privacy in the consultation room</td>
<td></td>
</tr>
<tr>
<td>Uses simple and clear language</td>
<td></td>
</tr>
<tr>
<td>Asks open-ended questions</td>
<td></td>
</tr>
<tr>
<td>Asks the client to paraphrase, as necessary, to ensure that the client</td>
<td></td>
</tr>
<tr>
<td>understands his or her questions and explanations</td>
<td></td>
</tr>
<tr>
<td>Encourages the client to ask question and express concerns</td>
<td></td>
</tr>
<tr>
<td>Answers all of the client’s questions</td>
<td></td>
</tr>
<tr>
<td>Indicates throughout the consultation that he or she is listening to the client</td>
<td></td>
</tr>
<tr>
<td>Paraphrases the client to ensure understanding of the client’s message</td>
<td></td>
</tr>
<tr>
<td>Does not interrupt the client unless absolutely necessary</td>
<td></td>
</tr>
<tr>
<td>Greets the client with respect and kindness, introduces himself or herself, and offers the client a seat</td>
<td></td>
</tr>
<tr>
<td>Asks what he or she can do for the client; determines the purpose of the visit</td>
<td></td>
</tr>
<tr>
<td>Explains what will happen during the visit</td>
<td></td>
</tr>
<tr>
<td>Assures the client of the confidentiality of all information that is shared</td>
<td></td>
</tr>
<tr>
<td>Encourages and responds to the client’s questions</td>
<td></td>
</tr>
</tbody>
</table>
### Observation Guide (cont.)

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Rating per client-provider interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Asks the client about himself/herself and his or her concerns</strong></td>
<td></td>
</tr>
<tr>
<td>Assists the client in:</td>
<td></td>
</tr>
<tr>
<td>• Clarifying his or her reproductive health needs, concerns, and problems</td>
<td></td>
</tr>
<tr>
<td>• Asking questions</td>
<td></td>
</tr>
<tr>
<td>• Determining decisions or actions that the client needs or wants to make during this visit</td>
<td></td>
</tr>
<tr>
<td><strong>Obtains the client’s medical and social history (as appropriate to the client’s needs and concerns, using the checklist for the corresponding service):</strong></td>
<td></td>
</tr>
<tr>
<td>• Asks simple and brief questions</td>
<td></td>
</tr>
<tr>
<td>• Explains terms as need</td>
<td></td>
</tr>
<tr>
<td>• Explains the routine nature and purpose of risk-assessment questions regarding pregnancy, sexually transmitted infections (STIs), and HIV or AIDS, among others</td>
<td></td>
</tr>
<tr>
<td><strong>Asks about the client’s:</strong></td>
<td></td>
</tr>
<tr>
<td>• Reproductive health plans (desired number of children, spacing of births, etc.)</td>
<td></td>
</tr>
<tr>
<td>• Perception of risk (regarding pregnancy or STIs, and HIV and AIDS)</td>
<td></td>
</tr>
<tr>
<td>• Risk behaviors as pertinent to the client’s concerns (e.g., pregnancy and STIs and HIV)</td>
<td></td>
</tr>
<tr>
<td>• Other health, interpersonal, or social concerns</td>
<td></td>
</tr>
<tr>
<td>• Feelings about his or her concerns, risks, etc. (as appropriate)</td>
<td></td>
</tr>
<tr>
<td>Explains the purpose of the questions (as appropriate)</td>
<td></td>
</tr>
<tr>
<td>Looks at the client while the client or service provider speaks</td>
<td></td>
</tr>
<tr>
<td>Encourages and responds to the client’s questions</td>
<td></td>
</tr>
<tr>
<td><strong>Tells the client information appropriate to his or her sexual and reproductive health (SRH) needs and knowledge</strong></td>
<td></td>
</tr>
<tr>
<td>Begins the discussion with the client’s preference or most urgent need</td>
<td></td>
</tr>
<tr>
<td>Asks what the client already understand about his or her SRH situation and desired course of action</td>
<td></td>
</tr>
<tr>
<td>Tailors information to the client’s needs, knowledge, and personal situation</td>
<td></td>
</tr>
<tr>
<td>Uses words familiar to the client</td>
<td></td>
</tr>
<tr>
<td>Uses appropriate information, education, and communication materials in an effective manner</td>
<td></td>
</tr>
<tr>
<td>Asks open-ended questions to verify client’s understanding of important information</td>
<td></td>
</tr>
<tr>
<td>Encourages and responds to the client’s questions</td>
<td></td>
</tr>
<tr>
<td>Corrects false information and rumors, as needed</td>
<td></td>
</tr>
</tbody>
</table>
## Task/Activity

### Helps client to make decisions to meet his or her SRH needs

<table>
<thead>
<tr>
<th>Help</th>
<th>Rating per client-provider interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through active listening, including asking open-ended questions, helps the client:</td>
<td></td>
</tr>
<tr>
<td>• Take “ownership” of his or her problem and responsibility for his or her decisions</td>
<td></td>
</tr>
<tr>
<td>• Identity options and the pros and cons of each</td>
<td></td>
</tr>
<tr>
<td>• Make decisions based on weighing pros and cons of all options (including side effects and the possibility of complications), relative to the client’s values and social context</td>
<td></td>
</tr>
<tr>
<td>• Act on decisions taken:</td>
<td></td>
</tr>
<tr>
<td>▶ By asking concrete, specific questions about steps to be taken</td>
<td></td>
</tr>
<tr>
<td>▶ By encouraging the client in terms of steps taken</td>
<td></td>
</tr>
<tr>
<td>Confirms the client’s decision</td>
<td></td>
</tr>
<tr>
<td>Assists the client to identity:</td>
<td></td>
</tr>
<tr>
<td>• Possible barriers to implementing the decision</td>
<td></td>
</tr>
<tr>
<td>• Ways to overcome these barriers</td>
<td></td>
</tr>
<tr>
<td>Helps the client practice skills (e.g., communication skills) to overcome barriers (if appropriate)</td>
<td></td>
</tr>
<tr>
<td>For the client who declines treatment or chooses not to practice any behavior change:</td>
<td></td>
</tr>
<tr>
<td>• Explains possible complications or consequences of unmanaged condition or unchanged behavior</td>
<td></td>
</tr>
<tr>
<td>• Offers his or her services if the client wishes to use them later</td>
<td></td>
</tr>
</tbody>
</table>

### Explains instructions for managing SRH problems/implementing decisions

<table>
<thead>
<tr>
<th>Explain</th>
<th>Rating per client-provider interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explains how to use the chosen method or treatment option</td>
<td></td>
</tr>
<tr>
<td>Reviews common side effects, the warning signs or symptoms of more serious complications, and what to do if they occur</td>
<td></td>
</tr>
<tr>
<td>Provides written instructions and reviews them with the client</td>
<td></td>
</tr>
<tr>
<td>Asks open-ended questions to verify the client’s understanding of important information</td>
<td></td>
</tr>
<tr>
<td>Encourages and responds to the client’s questions</td>
<td></td>
</tr>
</tbody>
</table>

### Return visit/referral

<table>
<thead>
<tr>
<th>Return visit/referral</th>
<th>Rating per client-provider interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sets up follow-up visit, as needed</td>
<td></td>
</tr>
<tr>
<td>Invites the client to come back at any time for any reason</td>
<td></td>
</tr>
<tr>
<td>Refers the client for needed or requested services unavailable onsite</td>
<td></td>
</tr>
<tr>
<td>Thanks the client for coming</td>
<td></td>
</tr>
</tbody>
</table>
# Appendix F

## Family Planning Cue Cards

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Timing and Spacing of Pregnancy (HTSP)</td>
<td>F.3</td>
</tr>
<tr>
<td>Pregnancy Checklist</td>
<td>F.5</td>
</tr>
<tr>
<td>Combined Oral Contraceptives (COCs)</td>
<td>F.7</td>
</tr>
<tr>
<td>Progestin-Only Pills (POPs)</td>
<td>F.9</td>
</tr>
<tr>
<td>Emergency Contraceptive Pills (ECPs)</td>
<td>F.11</td>
</tr>
<tr>
<td>Progestin-Only Injectables</td>
<td>F.13</td>
</tr>
<tr>
<td>Monthly Injectables</td>
<td>F.15</td>
</tr>
<tr>
<td>Implants</td>
<td>F.17</td>
</tr>
<tr>
<td>Copper-Bearing Intrauterine Device (IUD)</td>
<td>F.19</td>
</tr>
<tr>
<td>Levonorgestrel Intrauterine Device (LNG-IUD)</td>
<td>F.21</td>
</tr>
<tr>
<td>Female Sterilization</td>
<td>F.23</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>F.25</td>
</tr>
<tr>
<td>Male Condom</td>
<td>F.27</td>
</tr>
<tr>
<td>Female Condom</td>
<td>F.29</td>
</tr>
<tr>
<td>Spermicides</td>
<td>F.31</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>F.33</td>
</tr>
<tr>
<td>Fertility Awareness Methods</td>
<td>F.35</td>
</tr>
<tr>
<td>Lactational Amenorrhea Method (LAM)</td>
<td>F.37</td>
</tr>
<tr>
<td>Postpartum Family Planning</td>
<td>F.39</td>
</tr>
<tr>
<td>Postabortion Family Planning</td>
<td>F.41</td>
</tr>
<tr>
<td>Family Planning for People Living with HIV</td>
<td>F.43</td>
</tr>
</tbody>
</table>
**HEALTHY TIMING AND SPACING OF PREGNANCY (HTSP)**


Discuss reproductive intentions with your clients whenever there is an opportunity—do they wish to delay or space the births of children, or do they want to limit the number of children they have?

<table>
<thead>
<tr>
<th>During antenatal care (checkups before delivery)</th>
<th>During postabortion care</th>
</tr>
</thead>
<tbody>
<tr>
<td>During postpartum care (checkups after delivery)</td>
<td>During services related to sexually transmitted infections (STIs) and HIV and AIDS</td>
</tr>
<tr>
<td>During well-baby clinics and services for children under 5 (such as immunizations)</td>
<td>During youth services</td>
</tr>
<tr>
<td>During family planning (FP) services (especially services for engaged couples, HIV-positive women who wish to become pregnant, newlyweds, young couples, married couples with children, single mothers, and women who have experienced a miscarriage or abortion)</td>
<td>During men’s health services</td>
</tr>
<tr>
<td></td>
<td>During community outreach</td>
</tr>
</tbody>
</table>

The following information is not relevant for those clients who have completed their family size and wish to use a contraceptive method or procedure to limit. Be sure to establish what the client’s reproductive intentions are before discussing healthy timing and spacing.

**What is healthy timing and spacing of pregnancy?**

Healthy timing and spacing of pregnancy (HTSP) is a way of achieving healthier pregnancies and deliveries and reducing pregnancy-related risks to the health of the mother and babies. HTSP has 3 **key messages** that should be discussed with couples and individuals “taking into consideration health risks and benefits and other circumstances such as their age, fecundity, fertility aspirations, access to health care services, child-rearing support, social and economic circumstances, and personal preferences.” Those key messages are:

- **After a live birth:**
  To achieve the healthiest pregnancy outcomes, couples can use an effective FP method of choice continuously for at least 2 years, but not more than 5 years after the last birth, before trying to become pregnant again.

- **After a miscarriage or abortion:**
  To achieve the healthiest pregnancy outcomes, couples can use an effective FP method of choice continuously for at least 6 months after a miscarriage or abortion, before trying to become pregnant again.

- **For adolescents:**
  To achieve the healthiest pregnancy outcomes, adolescents need to use an effective FP method of their choice continuously until they are 18 years of age before trying to become pregnant.
HEALTHY TIMING AND SPACING OF PREGNANCY (HTSP) (cont.)

What happens when HTSP messages are not taken into consideration?

• **When pregnancies are too close together:**
  - Less than 24 months from the last live birth to the next pregnancy:
    ◦ Newborns can be born too soon, too small, or with a low birth weight.
    ◦ Infants and children may not grow well and are more likely to die before the age of 5.
  - Less than 6 months from the last live birth to the next pregnancy:
    ◦ Mothers may die in childbirth.
    ◦ Newborns can be born too soon, too small, or with a low birth weight.
    ◦ Infants and children may not grow well and are more likely to die before the age of 5.

• **When pregnancies are too far apart (more than 5 years):**
  - Mothers are at a higher risk of developing preeclampsia, a potentially life-threatening complication of pregnancy.
  - Newborns can be born too soon, too small, or with a low birth weight.

• **When pregnancies occur too soon (less than 6 months) after a miscarriage or abortion:**
  - Mothers are at a higher risk of developing anemia or premature rupture of membranes.
  - Newborns can be born too soon, too small, or with a low birth weight.

• **When first pregnancies occur to adolescents less than 18 years old:**
  - Adolescents are at a higher risk of developing pregnancy-induced hypertension, anemia, and prolonged or obstructed labor.
  - Newborns may die, be born too soon, too small, or with a low birth weight.
  - Additionally, the potential health risks associated with short pregnancy spacing intervals and/or having a pregnancy too early in life are exacerbated for women who already have pre-existing health problems, such as HIV, anemia, malnutrition, malaria, tuberculosis, heart disease, and diabetes.

Counseling clients for HTSP

1. Explain the HTSP messages to clients clearly, in language that they understand
2. Explain that to time and space pregnancies, the couple can use an effective FP method of their choice
3. Mention the wide range of FP methods available to the couple, including fertility awareness-based methods
4. Explain how to obtain and use FP methods
5. Emphasize the health, social, and economic benefits of practicing HTSP
6. Remind the clients that HTSP benefits the whole family and the community
7. Encourage clients to ask questions and share the information with partners, family members, and friends
PREGNANCY CHECKLIST

How to be Reasonably Sure a Client is Not Pregnant

Ask the client questions 1–6. As soon as the client answers YES to any question, stop, and follow the instructions.

1. Did you have a baby less than 6 months ago, are you fully or nearly fully breastfeeding, and have you had no menstrual period since then? YES

2. Have you abstained from sexual intercourse since your last menstrual period or delivery? YES

3. Have you had a baby in the last 4 weeks? YES

4. Did your last menstrual period start within the past 7 days (or within the past 12 days if you are planning to use an IUD)? YES

5. Have you had a miscarriage or abortion in the past 7 days? YES

6. Have you been using a reliable contraceptive method consistently and correctly? YES

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

If the client answered YES to at least one of the questions and she is free of signs or symptoms of pregnancy, provide client with desired method.
## COMBINED ORAL CONTRACEPTIVES (COCs)

**Note:** The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

### What Are Combined Oral Contraceptives?
- Combined oral contraceptives (COCs) are pills that are taken once a day to prevent pregnancy. They contain the hormones estrogen and progestin.
- COCs are also called “the Pill,” low-dose combined pills, oral contraceptive pills (OCPs), and oral contraceptives (OCs).
- COCs work primarily by preventing the release of eggs from the ovaries (ovulation).

### How Effective Are COCs?
The effectiveness of COCs depends on the user:
- As commonly used, in the first year, about 8 pregnancies occur per 100 women using COCs.
- When no pill-taking mistakes are made, in the first year, less than 1 pregnancy occurs per 100 women using COCs (3 per 1,000 women).
- **Return of fertility after COCs are stopped:** No delay
- **Protection against sexually transmitted infections (STIs):** None

### Side Effects, Health Benefits, and Health Risks

#### Side Effects (which are temporary and not dangerous)
- Changes in bleeding patterns, including:
  - Lighter bleeding and fewer days of bleeding, irregular bleeding, infrequent bleeding, no monthly bleeding
- Headaches
- Dizziness
- Nausea
- Breast tenderness
- Weight change
- Mood changes
- Acne (can improve or worsen, but usually improves)
- Increase in blood pressure (by a mm Hg)

#### Health Benefits
Help protect against:
- Pregnancy
- Cancer of the lining of the uterus (endometrial cancer)
- Cancer of the ovary
- Symptomatic pelvic inflammatory disease
May help protect against:
- Ovarian cysts
- Iron deficiency anemia
Reduce incidence of:
- Menstrual cramps
- Menstrual bleeding problems
- Painful ovulation
- Excess hair on face or body
- Symptoms of polycystic ovarian syndrome (irregular bleeding, acne, excess hair on face or body)
- Symptoms of endometriosis (pelvic pain, irregular bleeding)

#### Health Risks and Their Warning Signs
Very rare:
- Blood clot in deep veins of legs or lungs (deep vein thrombosis or pulmonary embolism). Warning signs include a sharp pain in the leg or abdomen.

Extremely rare:
- Stroke—Warning signs include severe headache with vision problems.
- Heart attack—Warning signs include severe chest pain or shortness of breath.

COCs and cancer:
- Research findings about COCs and breast cancer are difficult to interpret. Current users of COCs and those who have used COCs within the past 10 years are more likely to be diagnosed with breast cancer, but the cancers are less advanced than cancers diagnosed in other women.
- Use of COCs for 5 years or more appears to speed development of persistent HPV infection into cervical cancer. Only a very small number of such cancers are thought to be associated with COC use.

### Why Some Women Say They Like COCs
- They are controlled by the woman.
- They can be stopped at any time, without a provider’s help.
- They do not interfere with sex.

### Correcting Misunderstandings
- COCs do not build up in a woman’s body.
- COCs do not collect in the stomach; instead, they dissolve each day.
- Women do not need a “rest” from taking COCs.
- COCs must be taken every day, whether or not a woman has sex that day.
- COCs do not make women infertile.
- COCs do not cause birth defects or multiple births.
- COCs do not change women’s sexual behavior.
- COCs do not disrupt an existing pregnancy.
### COMBINED ORAL CONTRACEPTIVES (COCs) (cont.)

#### Who Can Use COCs?
Women of any reproductive age or parity can use COCs, including women who:
- Have or have not had children
- Are not married
- Are of any age, including adolescents and women over 40 years old
- Have just had an abortion or miscarriage
- Smoke cigarettes—if under 35 years old
- Have anemia now or had in the past
- Have varicose veins
- Are infected with HIV, whether or not taking antiretroviral medications

#### Who Cannot Use COCs?
Women who have the following conditions (contraindications) cannot use COCs:
- Breastfeeding fully (or nearly fully) a baby less than 6 months old
- Having had a baby in the last 3 weeks
- Having a current or history of breast cancer
- Having a liver tumor, liver infection, or cirrhosis, or having developed jaundice while using COCs
- Being age 35 or older and smoking
- Having blood pressure 140/90 mmHg or higher
- Having current gallbladder disease
- Having diabetes for more than 20 years, or damage to arteries, vision, kidneys or nervous system caused by diabetes
- Having current or history of stroke, blood clot in legs or lungs, heart attack or serious heart problems
- Migraines with aura or migraines without aura at age 35 or older
- Taking medications for seizures (barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, or rifampicin)
- Planning major surgery that will keep her from walking for 1 week

#### When to Start Using COCs?
- Any time (during the menstrual cycle) it is reasonably certain that the client is not pregnant (see cue card titled Pregnancy Checklist)
- Within 5 days after the start of her monthly bleeding
- Immediately when stopping IUD or another hormonal method. No need to wait for her next monthly bleeding.
- Postpartum:
  - 6 months after giving birth if using LAM
  - At 6 weeks if partially breastfeeding
  - At least after 3 weeks if not breastfeeding (on days 21–28)
  - Beyond those dates, pregnancy has to be ruled out.
- Postabortion (after induced abortion or miscarriage), immediately or within 7 days

#### How Are COCs Used?
- The client should always take 1 pill each day.
- For 28-pill packets (21 hormonal pills and 7 reminder pills containing iron)—When the client finishes 1 packet, she should take the first pill from the next packet on the very next day.
- For 21-pill packets—After the client takes the last pill from 1 packet, she should wait 7 days and then take the first pill from the next packet.
- If the client forgets to take a pill or pills (all instructions for pills containing 30–35 µg estrogen):
  - Missed 1 or 2 hormonal pills or started a new pack 1 or 2 days late—Take a hormonal pill as soon as possible and then continue taking pills daily, 1 each day.
  - Missed 3 or more hormonal pills in the first 2 weeks or started a pack 3 or more days late—Take a hormonal pill as soon as possible and continue taking pills daily, 1 each day. Use a back-up method (condoms or abstain from sex) until you have taken hormonal pills for 7 days in a row. If missed 3 or more pills in the third week, finish the hormonal pills in your current pack and start a new pack the next day. You should not take the 7 nonhormonal pills. Use a back-up method for 7 days. You may miss a period. This is okay.
  - Missed 1 or more of any nonhormonal pills—Throw the missed pills away. Take the rest of the pills as usual, 1 each day. Start a new packet as usual on the next day.
- For pills with 20 _g of estrogen or less, women missing 1 pill should follow the same guidance as missing 1 or 2 30–35 _g pills. Women missing 2 or more pills should follow the same guidance as missing 3 or more 30–35 _g pills.
- The client should also be told about the warning signs for health risks (see on first page).
**PROGESTIN-ONLY PILLS (POPs)**

**Note:** The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers. Baltimore and Geneva;* and WHO. 2004. *Medical eligibility criteria for contraceptive use. 3rd ed.* Geneva. For more detailed guidance, please refer directly to these volumes.

**What Are Progestin-Only Contraceptive Pills?**
Progestin-only pills (POPs) are pills that are taken once a day to prevent pregnancy.
- Unlike COCs, POPs, do not contain any estrogen, and therefore they can be used throughout breastfeeding and by women who cannot use methods with estrogen.
- POPs are also called “minipills” and progestin-only oral contraceptives.
- POPs work primarily by:
  - Thickening cervical mucus (this blocks sperm from meeting an egg)
  - Disrupting the menstrual cycle, including preventing the release of eggs from the ovaries (ovulation)

**How Effective Are POPs?**
Effectiveness depends on the user. For breastfeeding women:
- As commonly used, about 1 pregnancy per 100 women using POPs over the first year.
- When taken everyday, less than 1 pregnancy per 100 women using POPs over the first year (3 per 1,000).
- They are less effective for women not breastfeeding: as commonly used, 3–10 pregnancies per 100 women and when pills are taken every day, less than 1 pregnancy per 100 women (9 per 1,000 women). Women not breastfeeding should take pills at the same time every day (no later than 3 hours) for pills to be effective.
- *Return of fertility after POPs are stopped: No delay*
- *Protection against sexually transmitted infections (STIs): None*

### Side Effects, Health Benefits, and Health Risks

**Side effects (which are temporary and not dangerous)**
- Changes in bleeding patterns including:
  - Frequent bleeding, irregular bleeding, infrequent bleeding, prolonged bleeding, no monthly bleeding, and, for breastfeeding women, lengthened postpartum amenorrhea
- Headaches
- Dizziness
- Mood changes
- Breast tenderness
- Abdominal pain
- Nausea
- For women not breastfeeding, enlarged ovarian follicles.

**Health Benefits and Health Risks**
Help protect against risks of pregnancy.

### Why Some Women Say They Like POPs
- Can be used while breastfeeding
- Can be stopped any time without a provider’s help
- Do not interfere with sex
- Controlled by the woman

**Correcting Misunderstandings**
Progestin-only pills:
- Do not cause a breastfeeding woman’s milk to dry up.
- Must be taken every day, whether or not a woman has sex that day. They don’t require a “rest” period between packs.
- Do not make women infertile.
- Do not cause diarrhea in breastfeeding babies.
- Reduce the risk of ectopic pregnancy.
- Do not build up in a woman’s body. That’s why they have to be taken everyday to maintain their effectiveness.
- Do not cause birth defects.

### Who Can Use POPs?
Women of any reproductive age or parity can use POPs, including women who:
- Are breastfeeding (starting as soon as 6 weeks after childbirth)
- Have or have not had children
- Are not married
- Are of any age, including adolescents and women older than 40
- Have just had an abortion, miscarriage, or ectopic pregnancy
- Smoke cigarettes, regardless of age or number of cigarettes smoked
- Have anemia now or had in the past
- Have varicose veins
- Are infected with HIV, regardless of whether they are taking antiretroviral medications

Women can begin using POPs without a pelvic examination, without any blood tests or other routine laboratory tests, without cervical cancer screening, without a breast examination and even when a woman is not having monthly bleeding at the time (as long as it is reasonably certain that she is not pregnant—see cue card titled Pregnancy Checklist).
## PROGESTIN-ONLY PILLS (POPs) (cont.)

### Who Cannot Use POPs?

Women who have the following conditions cannot use POPs:
- Breastfeeding a baby less than 6 weeks old
- Liver tumor, liver infection, or cirrhosis
- Current serious problem with blood clots in legs or lungs
- Taking medications for seizures (barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate) or tuberculosis (rifampicin)
- Current or history of breast cancer

### When to Start Using POPs?

- **Any time** it is reasonably certain that the client is not pregnant. See Pregnancy Checklist cue card.
- **No monthly bleeding**—Any time it is reasonably certain that the client is not pregnant. A back-up method needed for the first 2 days of taking pills.
- **Immediately when switching from copper-bearing IUD or another hormonal method**, if the client has been using the previous method consistently and correctly. No need to wait for next monthly bleeding.
- **The day after the client finishes taking emergency contraceptive pills.**
- **Having menstrual cycles or switching from a nonhormonal method**—within 5 days after the start of her monthly bleeding and no back-up method; or more than 5 days after the start of monthly bleeding—any time it is certain that the client is not pregnant, and a back-up method is used for the first 2 days of taking pills.

### Postpartum:

- **Fully or nearly fully breastfeeding**—Six weeks after giving birth, and any time between 6 weeks and 6 months, if her monthly bleeding has not returned.
- **Partially breastfeeding**—At 6 weeks after giving birth; if less than 6 weeks and monthly bleeding has returned, a back-up method should be used until 6 weeks have passed since giving birth; if more than 6 weeks and monthly bleeding has not returned, any time it is reasonably certain that she is not pregnant, and a back-up method should be used for the first 2 days.
- **Breastfeeding and monthly bleeding has returned**—As advised for women having menstrual cycles.
- **Not breastfeeding**—Any time within 4 weeks after giving birth; beyond 4 weeks and monthly bleeding has not returned, then any time it is reasonably certain that client is not pregnant, plus a back-up method should be used for the first 2 days of taking pills; if monthly bleeding has returned, then as advised for women having menstrual cycles.

### Postabortion (after abortion or miscarriage)—

- Immediately or within 7 days, no back-up method is needed; more than 7 days after, any time it is reasonably certain that client is not pregnant, and a back-up method should be used for the first 2 days of taking pills.

### How Are POPs Used?

- The client should always take 1 pill each day. When she finishes 1 packet, she should take the first pill from the next packet on the very next day. There is no wait between packets.
- **IMPORTANT**: It is best to take the pill at the same time each day, if possible. This helps remembering and ensures effectiveness. Taking a pill more than 3 hours late increases the risk of pregnancy.
- If the client *forgets to take a pill or pills* or *is 3 or more hours late taking a pill*:
  - **Having monthly bleeding (including those who are breastfeeding)**: She should take 1 pill as soon as possible, continue taking the pills as usual, 1 each day and use a back-up method for the next 2 days. If she had sex in the past 5 days, she can also consider taking emergency contraceptive pills (ECP).
  - **Breastfeeding AND no monthly bleeding**: She should take 1 pill as soon as possible and continue taking the pills as usual, 1 each day. This may mean that she takes 2 pills at the same time or on the same day.
- The client should also be told about the **warning signs for complications**, such as severe abdominal pain (a warning sign for ectopic pregnancy).
EMERGENCY CONTRACEPTIVE PILLS (ECPs)

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. Family planning: A global handbook for providers. Baltimore and Geneva; and WHO. 2004. Medical eligibility criteria for contraceptive use. 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Emergency Contraceptive Pills (ECPs)?

• Emergency contraceptive pills (ECPs) are pills that contain a progestin alone, or a progestin and an estrogen together—hormones like the natural hormones progesterone and estrogen in a woman’s body. ECPs help to prevent pregnancy when taken up to 5 days after unprotected sex. The sooner they are taken, the better.
• ECPs are sometimes called “morning after” pills or postcoital contraceptives.
• They provide an opportunity for women to start using an ongoing family planning method.
• ECPs work primarily by preventing or delaying the release of eggs from the ovaries (ovulation). They do not work if a woman is already pregnant.
• Use of copper-bearing IUDs for emergency contraception is described on the Copper-Bearing Intrauterine Device cue card.

What Pills Can Be Used as Emergency Contraceptive Pills?

• A special ECP product with the progestin levonorgestrel
  ◦ 1.5 mg of levonorgestrel in a single dose
• A special ECP product with estrogen and levonorgestrel
  ◦ 0.5 mg levonorgestrel + 0.1 mg ethinyl estradiol, followed with same dose 12 hours later.
• Progestin-only pills with levonorgestrel or norgestrel
  ◦ 1.5 mg levonorgestrel in a single dose or 3 mg norgestrel in a single dose
• Combined oral contraceptives with estrogen and a progestin (levonorgestrel, norgestrel, or norethindrone)
  ◦ 0.5 mg levonorgestrel + 0.1 mg ethinyl estradiol followed with same dose 12 hours later
  ◦ 1 mg norgestrel + 0.1 mg ethinyl estradiol followed with same dose 12 hours later
  ◦ 2 mg norethindrone + 0.1 mg ethinyl estradiol followed with same dose 12 hours later

When Should ECPs Be Taken?

• As soon as possible after unprotected sex. The sooner ECPs are taken after unprotected sex, the better they prevent pregnancy.
• ECPs can prevent pregnancy when taken any time up to 5 days after unprotected sex.

How Effective Are ECPs?

• If 100 women each had sex once in the second or third week of the menstrual cycle without using contraception, 8 would likely become pregnant.
• If all 100 women used progestin-only ECPs, 1 would likely become pregnant.
• If all 100 women used estrogen and progestin ECPs, 2 would likely become pregnant.
• Return of fertility after taking ECPs: No delay (A woman can become pregnant immediately after taking ECPs. Taking ECPs will not protect a woman from pregnancy from acts of sex after she takes ECPs—not even on the next day. To stay protected from pregnancy, women must begin to use another contraceptive method at once.)
• Protection against sexually transmitted infections (STIs): None

Side Effects, Health Benefits, and Health Risks

### Side Effects (which are temporary and not dangerous)

• Changes in bleeding patterns, including:
  ◦ Light vaginal bleeding for 1–2 days after taking ECPs
  ◦ Monthly bleeding that starts earlier or later than expected

### In the week after taking ECPs:

• Nausea
• Abdominal pain
• Fatigue
• Headache
• Breast tenderness
• Dizziness
• Vomiting (less frequent with progestin-only formulations)

### Health Benefits

Help protect against risks of pregnancy.

### Health Risks

None
### Why Some Women Say They Like ECPs
- Offer a second chance at preventing pregnancy
- Are controlled by the woman
- Reduce seeking out abortion in the case of contraceptive errors or if contraception is not used
- Can have on hand in case an emergency arises

### Correcting Misunderstandings
Emergency contraceptive pills:
- Do not cause abortion.
- Do not cause birth defects if pregnancy occurs.
- Are not dangerous to a women’s health.
- Do not promote sexual risk-taking.
- Do not make women infertile.

### Who Can Use ECPs?
All women can use ECPs safely and effectively, including women who cannot use ongoing hormonal contraceptive methods. Tests and examinations are not necessary for using ECPs. They may be appropriate for other reasons—especially if sex was forced.

### Who Cannot Use ECPs?
Because of the short-term nature of their use, there are no medical conditions that make ECPs unsafe for any woman.

### When Can ECPs Be Used?
ECPs can be used at any time within 5 days after unprotected sex. The sooner after unprotected sex that ECPs are taken, the more effective they are. ECPs can be used any time a woman is worried that she might become pregnant. For example, after:
- Sex was forced (rape) or coerced
- Any unprotected sex
- Contraceptive mistakes, such as:
  - Condom was used incorrectly, slipped, or broke.
  - Fertility awareness method was used incorrectly (e.g., couple failed to abstain or to use another method during the fertile days).
  - Man failed to withdraw, as intended, before he ejaculated.
  - Woman missed 3 or more combined oral contraceptive pills, or starts a new pack 3 or more days late, or is too late for a repeat injection.
  - IUD has come out of place.

### How Are ECPs Used?
- The client takes the pills at once, or if she is using the 2-dose regimen, she takes the next dose in 12 hours.
- Women who have had nausea with previous ECP use or with the first dose of a 2-dose regimen can take antinausea medication.
- If the woman vomits within 2 hours after taking ECPs, she should take another dose. (She can use anti-nausea medication with this repeat dose.) If vomiting continues, she can take the repeat dose by placing the pills high in her vagina. If vomiting occurs more than 2 hours after taking ECPs, she does not need to take any extra pills.
- No routine return visit is required

### Counseling Clients:
- **Explain:**
  - How to take the pills
  - Most common side effects and what to do if they occur (especially nausea and vomiting)
  - That ECPs will not protect the client from pregnancy for any future sex acts—even the next day.
- **Discuss** ongoing contraception options and, if the client is at risk, protection from STIs and HIV
  - If the client does not want to start a contraceptive method now, give her condoms or oral contraceptives in case she changes her mind and invite her to come back any time if she wants another method.
  - *Invite the client* to come back for any questions or problems or if she wants to switch to another method, if she experiences any major change in her health status, or if she thinks she might be pregnant.
## PROGESTIN-ONLY INJECTABLES

**Note:** The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

### What Are Progestin-Only Injectables?
- To prevent pregnancy, a shot is given into the muscle (intramuscular injection) every 2 or 3 months, depending on the type of injectable. The 2-monthly injectable contains norethisterone enantate (NET-EN—Noristerat®, Syngestal®), and the 3-monthly injectables contain depot medroxyprogesterone acetate (DMPA—Depo-Provera®, Megestron®, Petogen®).
- Progestin-only injectable contraceptives contain no estrogen. Therefore, they can be used throughout breastfeeding and by women who cannot use methods with estrogen.
- Progestin-only injectables work primarily by preventing the release of eggs from the ovaries (ovulation).
- A new subcutaneous formulation of DMPA has been developed specifically for injection into the tissue just under the skin (subcutaneously). Called DMPA-SC, this new formulation will be available in prefilled syringes and will contain 30% less hormone than typical DMPA (104 mg instead of 150 mg). Thus, it may cause fewer side effects, with an injection every 3 months which clients can deliver themselves. It has been approved in the United States under the name “Depo-subQ provera 104.”

### How Effective Are Progestin-Only Injectables?
- As commonly used, injectables have a failure rate of 3 pregnancies per 100 women over the first year of use.
- When women have injections on time, the failure rate is less than 1 pregnancy per 100 women over the first year (3 per 1,000 women).
- **Return of fertility after progestin-only injectables are stopped:** An average of about 4 months longer for DMPA and 1 month longer for NET-EN than with most other methods.
- **Protection against sexually transmitted infections (STIs):** None

### Side Effects, Health Benefits, and Health Risks

<table>
<thead>
<tr>
<th><strong>Side Effects (which are temporary and not dangerous)</strong></th>
<th><strong>Health Benefits</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Changes in bleeding patterns including:</td>
<td><strong>DMPA:</strong></td>
</tr>
<tr>
<td>- With DMPA first 3 months: irregular bleeding,</td>
<td>- Helps protect against</td>
</tr>
<tr>
<td>prolonged bleeding</td>
<td>- Risks of pregnancy</td>
</tr>
<tr>
<td>- With DMPA at 1 year: no monthly bleeding,</td>
<td>- Cancer of the lining of uterus (endometrial cancer)</td>
</tr>
<tr>
<td>infrequent bleeding, irregular bleeding</td>
<td>- Uterine fibroids</td>
</tr>
<tr>
<td>- NET-EN affects bleeding patterns less than DMPA.</td>
<td>- May help protect against</td>
</tr>
<tr>
<td>Fewer days of bleeding in the first 6 months and</td>
<td>- Symptomatic pelvic inflammatory disease</td>
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<tr>
<td>less likely to cause no bleeding after 1 year</td>
<td>- Iron deficiency anemia</td>
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<tr>
<td>- Weight gain (about 1–2 kg per year)</td>
<td>- Reduces:</td>
</tr>
<tr>
<td>- Headaches</td>
<td>- Sickle cell crisis among women with sickle cell</td>
</tr>
<tr>
<td>- Dizziness</td>
<td>- anemia</td>
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<tr>
<td>- Abdominal bloating and discomfort</td>
<td>- Symptoms of endometriosis (pelvic pain, irregular</td>
</tr>
<tr>
<td>- Mood changes</td>
<td>- bleeding)</td>
</tr>
<tr>
<td>- Less sex drive</td>
<td><strong>NET-EN:</strong></td>
</tr>
<tr>
<td>- Loss of bone density</td>
<td>- Helps protect against</td>
</tr>
<tr>
<td></td>
<td>- iron deficiency anemia</td>
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<tr>
<td></td>
<td>- May also offer many of the health benefits as DMPA</td>
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</tbody>
</table>

**Health Risks**
None

### Correcting Misunderstandings
- Progestin-only injectables: Can stop monthly bleeding, but this is not harmful. It is similar to not having monthly bleeding during pregnancy. Blood is not building up inside the woman.
- Do not disrupt an existing pregnancy.
- Do not make women infertile.
- Do not cause birth defects.

### Why Some Women Say They Like Progestin-Only Injectables
- Do not require daily action
- Do not interfere with sex
- Private: No one else can tell that a woman is using contraception
- No monthly bleeding (for many women)
- May help women to gain weight
PROGESTIN-ONLY INJECTABLES (cont.)

Who Can Use Progestin-Only Injectables?
Women of any reproductive age or parity, including women who:
• Have or have not had children, or are not married
• Are of any age, including adolescents and women older than 40
• Are breastfeeding (starting as soon as 6 weeks after childbirth)
• Have just had abortion or miscarriage
• Smoke cigarettes, regardless of age or number of cigarettes smoked
• Are infected with HIV, whether or not they are taking antiretroviral medications

Women can begin using progestin-only injectables without a pelvic examination, without any blood tests or other routine laboratory tests, without cervical cancer screening, without a breast examination, and even when the woman is not having monthly bleeding at the time (as long as it is reasonably certain that she is not pregnant—see Pregnancy Checklist cue card).

Who Cannot Use Progestin-Only Injectables?
Women who have the following conditions:
• Breastfeeding a baby less than 6 weeks old
• Active liver disease (severe cirrhosis of the liver, a liver infection, or liver tumor)
• Systolic blood pressure 160 or higher or diastolic blood pressure 100 or higher
• Diabetes for more than 20 years or with damage to the arteries, vision, kidneys, or nervous system
• History of heart attack, heart disease due to blocked or narrowed arteries, or stroke or current blood clot in the deep veins of the leg or in the lung
• Unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition.
• Current or history of breast cancer

When to Start Using Progestin-Only Injectables?
• At any time that it is reasonably certain that the client is not pregnant (If it has been more than 7 days since the last monthly bleeding started, a back-up method [such as abstinence, male or female condoms, spermicides, or withdrawal] is needed for the next 7 days.)
• Having menstrual cycles or switching from a nonhormonal method: If within 7 days after the start of monthly bleeding, there is no need for a back-up method. If more than 7 days after the start of monthly bleeding, a back-up method is needed for the first 7 days after the injection.
• Switching from another hormonal method: Immediately, if the client has been using the previous method consistently and correctly. There is no need to wait for a first period and no need for a back-up method. The day after, when the client finishes taking emergency contraceptive pills; a back-up method is needed for the first 7 days after the injection.
• No monthly bleeding (not related to childbirth or breastfeeding): Any time it is reasonably certain that the client is not pregnant. A back-up method is needed for the first 7 days after the injection.
• Postabortion (after abortion or miscarriage): Immediately or within 7 days. No back-up method needed. Beyond 7 days, any time it is reasonably certain the client is not pregnant; a back-up method is needed for the first 7 days after injection.
• Postpartum:
  ◦ Fully or nearly fully breastfeeding: Six weeks after giving birth, and any time between 6 weeks and 6 months if her monthly bleeding has not returned. If more than 6 months, need to be certain that she is not pregnant, and a back-up method is needed for the first 7 days after the injection.
  ◦ Partially breastfeeding: At 6 weeks after giving birth; if more than 6 weeks and monthly bleeding has not returned, any time it is reasonably certain that the client is not pregnant; a back-up method is needed for the first 7 days after injection.
  ◦ Breastfeeding and monthly bleeding has returned: As advised for women having menstrual cycles.
  ◦ Not breastfeeding: Any time, within 4 weeks after giving birth; beyond 4 weeks and monthly bleeding has not returned, any time it is reasonably certain that the client is not pregnant; a back-up method is needed for the first 7 days after the injection. If monthly bleeding has returned, as advised for women having menstrual cycles.

How Are Progestin-Only Injectables Used?
• The client should not massage the injection site, should be told the name of the injection, and should return in 3 months (13 weeks) for her next DMPA injection and in 2 months (8 weeks) for NET-EN on the day agreed upon.
• The repeat injection for DMPA and NET-EN can be given up to 2 weeks early, or up to 2 weeks late without the need for additional contraceptive protection, but it is best to return on time.
• If the client is more than 2 weeks late for the DMPA or NET-EN repeat injection, she can have the injection, if it is reasonably certain that she is not pregnant. She will need to use a back-up method for the first 7 days after the injection. She may consider emergency contraception if she has had unprotected sex in the past 5 days.
MONTHLY INJECTABLES

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. Family planning: A global handbook for providers. Baltimore and Geneva; and WHO. 2004. Medical eligibility criteria for contraceptive use. 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Monthly Injectables?
• Monthly injectables contain 2 hormones—a progestin and an estrogen—like the natural hormones progesterone and estrogen in a woman’s body. (Combined oral contraceptives also contain these 2 types of hormones.) They are administered by intramuscular injection once a month.
• Monthly injectables also are called combined injectable contraceptives (CICs). Information in this cue card applies to medroxyprogesterone acetate + estradiol cypionate (MPA/E2C, which is marketed under the trade names Cyclofen®, Ciclofen®, Ciclofemina®, Cyclo-Provera®, Femmina®, Lunelle®, Lunella®, and Novafem®) and to norethisterone enanthate + estradiol valerate (NET-EN/E2V, which is marketed under the trade names Mesigyna® and Norigynon®). It may also apply to older formulations, about which less is known. The most widely available CICs are Cyclofen® (25 mg depot-medroxyprogesterone acetate and 5 mg estradiol cypionate) and Mesigyna® (50 mg norethindrone enanthate and 5 mg estradiol valerate).
• Monthly injectables work primarily by preventing the release of eggs from the ovaries (ovulation).

How Effective Are Monthly Injectables?
• As commonly used, the failure rate is about 3 pregnancies per 100 women over the first year.
• When women have injections on time, the failure rate is less than 1 pregnancy per 100 women over the first year (5 per 10,000 women).
• Return of fertility after injections are stopped: An average of about 1 month longer than with most other methods.
• Protection against sexually transmitted infections (STIs): None

Side Effects, Health Benefits, and Health Risks

Side Effects (which are temporary and not dangerous)
• Changes in bleeding patterns, including:
  • Lighter bleeding and fewer days of bleeding, irregular bleeding, infrequent bleeding, prolonged bleeding, no monthly bleeding
• Weight gain
• Headaches
• Dizziness
• Breast tenderness

Health Benefits and Health Risks
Long-term studies of monthly injectables are limited, but researchers expect that their health benefits and health risks are similar to those of combined oral contraceptives (see the cue card Combined Oral Contraceptives, Health Benefits and Health Risks).

Why Some Women Say They Like Monthly Injectables
• Private; no one else can tell that a woman is using contraception
• Do not require daily action
• Injections can be stopped at any time
• Good for spacing births

Correcting Misunderstandings
Monthly injectables:
• Can stop monthly bleeding, but this is not harmful. It is similar to not having monthly bleeding during pregnancy. Blood is not building up inside the woman’s body.
• Are not in experimental phases of study. Government agencies have approved them.
• Do not make women infertile.
• Do not cause early menopause.
• Do not cause birth defects or multiple births.
• Do not cause itching.
• Do not change women’s sexual behavior.

Who Can Use Monthly Injectables?
Women of any reproductive age and parity, including women who:
• Have or have not had children, or are not married
• Are of any age, including adolescents and women older than 40
• Have just had an abortion or miscarriage
• Smoke any number of cigarettes and are younger than 35
• Smoke fewer than 15 cigarettes daily and are older than 35
• Have anemia now or had anemia in the past
• Have varicose veins
• Are infected with HIV, whether or not they are taking antiretroviral medications

Women can begin using monthly injectables without a pelvic examination, without any blood tests or other routine laboratory tests, without cervical cancer screening, without a breast examination, and even when a woman is not having monthly bleeding at the time (as long as it is reasonably certain that she is not pregnant—see Pregnancy Checklist cue card).
MONTHLY INJECTABLES (cont.)

Who Cannot Use Monthly Injectables?
Women who have the following conditions (contraindications):
• Fully or nearly fully breastfeeding a baby less than 6 months old
• Partially breastfeeding a baby less than 6 weeks old
• Have had a baby in the last 3 weeks
• Smoking 15 or more cigarettes a day and being age 35 or older
• Serious active liver disease (jaundice, active hepatitis, severe cirrhosis, liver tumor); women with mild cirrhosis or gall bladder disease can use monthly injectables.
• Systolic blood pressure 140 mm Hg or higher or diastolic blood pressure 90 or higher
• Diabetes for more than 20 years or damage to her arteries, vision, kidneys, or nervous system caused by diabetes
• Current or history of stroke, blood clot in legs or lungs, heart attack, or serious heart problems
• Current or history of breast cancer
• Migraines with aura or migraines without aura at age 35 or older
• Planning major surgery that will keep her from walking for 1 week or more

When to Start Using Monthly Injectables?
• Any time it is reasonably certain that the client is not pregnant. If it has been more than 7 days since menstrual bleeding started, a back-up method (such as abstinence, male or female condoms, spermicides, or withdrawal) is needed for the next 7 days.
• Having menstrual cycles or switching from a nonhormonal method: If within 7 days after the start of monthly bleeding, there is no need for a back-up method. If more than 7 days after the start of monthly bleeding, a back-up method is needed for the first 7 days after the injection.
• Switching from another hormonal method, immediately if the client has been using the previous method consistently and correctly. No need to wait for a first period. No need for a back-up method. After using emergency contraceptive pills (ECPs), the same day as the client finishes taking pills; a back-up method is needed for the first 7 days after the injection.
• No monthly bleeding: Any time when it is reasonably certain that the client is not pregnant; a back-up method is needed for the first 7 days after the injection.
• Postabortion (after abortion or miscarriage): Immediately or within 7 days. No back-up method is needed. Beyond 7 days after abortion or miscarriage, any time it is reasonably certain as the client is not pregnant; a back-up method is needed for the first 7 days after the injection.
• Postpartum:
  ◦ Fully or nearly fully breastfeeding—6 months after giving birth or when breast milk is no longer the baby’s main food, whichever comes first. After 6 months and if her monthly bleeding has not returned, any time it is reasonably certain that the she is not pregnant, along with using a back-up method for the first 7 days after the injection. If more than 6 months and monthly bleeding has returned, as advised for women having menstrual cycles.
  ◦ Partially breastfeeding—At 6 weeks after giving birth, at the earliest. After 6 weeks and if her monthly bleeding has not returned, any time it is reasonably certain that the she is not pregnant, along with using a back-up method for the first 7 days after the injection. If more 6 weeks and her monthly bleeding has returned, as advised for women having menstrual cycles.
  ◦ Not breastfeeding—On days 21–28 after giving birth (within fourth week). If more than 4 weeks after giving birth and her monthly bleeding has not returned, any time it is reasonably certain that the she is not pregnant, along with using a back-up method for the first 7 days after the injection. If more than 4 weeks and her monthly bleeding has returned, as advised for women having menstrual cycles.

How Are Monthly Injectables Used?
• The injection should be given every 4 weeks.
• The client should not massage the injection site, and she should be told the name of the injection.
• Subsequent injections can be given up to 7 days earlier and 7 days later than the scheduled injection day.
• For ease of use, the injections can be scheduled for the same day of each month.
• If the client comes more than 7 days late, she should abstain from sex or use condoms, spermicides, or withdrawal until she can get an injection. She can also consider emergency contraceptive pills if she has had unprotected sex in the past 5 days.
• The client should also be told about the warning signs for health risks (see the cue card on Combined Oral Contraceptives).
## IMPLANTS

**Note:** The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. Family planning: A global handbook for providers. Baltimore and Geneva; and WHO. 2004. Medical eligibility criteria for contraceptive use. 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

### What Are Implants?
- Implants are small plastic rods or capsules, each about the size of a matchstick, that release a progestin like the natural hormone progesterone in a woman's body. A specifically trained provider performs a minor surgical procedure to place the implants under the skin on the inside of a woman's upper arm.
- Implants do not contain estrogen, and so they can be used throughout breastfeeding and by women who cannot use methods containing estrogen.
- There are many types of implants: Jadelle consists of 2 rods and lasts 5 years; Implanon consists of 1 rod and lasts 3 years. (Studies are underway to see if it lasts 4 years); Norplant consists of 6 capsules and is labeled for 5 years of use (large studies found it effective for 7 years); Sinoplant consists of 2 rods and lasts 5 years.
- Implants work primarily by thickening cervical mucus (which blocks the sperm from meeting an egg) and by disrupting the menstrual cycle, including preventing the release of eggs from the ovaries (ovulation).

### How Effective Are Implants?
- Pregnancy rates are less than 1 pregnancy per 100 women using implants over the first year (5 per 10,000 women).
- Pregnancy risk continues beyond first year of use. Over 5 years of Jadelle use, the rate is about 1 pregnancy per 100 women; over 3 years of Implanon use, the rate is less than 1 pregnancy per 100 women (1 per 1,000 women); over 7 years of Norplant use, the rate is about 2 pregnancies per 100 women.
- Jadelle and Norplant implants begin to lose effectiveness sooner in heavier women.
- Return of fertility after implants are removed: No delay
- Protection against sexually transmitted infections (STIs): None

### Side Effects, Health Benefits, and Health Risks

<table>
<thead>
<tr>
<th>Side effects (which are temporary and not dangerous)</th>
<th>Health Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Changes in bleeding patterns including:</td>
<td>• Help protect against</td>
</tr>
<tr>
<td>◦ In first several months, lighter bleeding and fewer days of bleeding, Irregular bleeding that lasts more than 8 days, irregular bleeding, no monthly bleeding</td>
<td>◦ Risks of pregnancy</td>
</tr>
<tr>
<td>◦ After about 1 year, lighter bleeding and fewer days of bleeding, irregular bleeding, infrequent bleeding</td>
<td>◦ Symptomatic pelvic inflammatory disease</td>
</tr>
<tr>
<td>• Headaches</td>
<td>◦ Uterine fibroids</td>
</tr>
<tr>
<td>• Abdominal pain</td>
<td>◦ May help protect against</td>
</tr>
<tr>
<td>• Acne (can improve or worsen)</td>
<td>◦ Iron deficiency anemia</td>
</tr>
<tr>
<td>• Weight change</td>
<td><strong>Complications and Their Warning Signs</strong></td>
</tr>
<tr>
<td>• Breast tenderness</td>
<td>Uncommon:</td>
</tr>
<tr>
<td>• Dizziness</td>
<td>• Infection at insertion site (mostly within the first 2 months)—Warning signs include arm pain and pus or bleeding at the insertion site.</td>
</tr>
<tr>
<td>• Mood changes</td>
<td>• Difficult removal (rare if properly inserted and the provider is skilled at removal)</td>
</tr>
<tr>
<td>• Nausea</td>
<td>Rare:</td>
</tr>
<tr>
<td>• Enlarged ovarian follicles</td>
<td>• Expulsion of implant (mostly within the first 4 months)</td>
</tr>
</tbody>
</table>

### Why Some Women Say They Like Implants
- Do not require the user to do anything once they are inserted
- Prevent pregnancy very effectively for many years
- Convenient
- Do not interfere with sex

### Correcting Misunderstandings
- Implants: Stop working once they are removed. Their hormones do not remain in a woman’s body.
- Can stop monthly bleeding, but this is not harmful. It is similar to not having monthly bleeding during pregnancy. Blood is not building up inside the woman.
- Substantially reduce the risk of ectopic pregnancy.
- Do not make women infertile.
- Do not move to other parts of the body.
**IMPLANTS (cont.)**

### Who Can Use Implants?
Women of any reproductive age or parity, including women who:
- Have or have not had children, or are not married.
- Are of any age, including adolescents and women older than 40.
- Have just had an abortion, a miscarriage, or an ectopic pregnancy.
- Smoke cigarettes, regardless of age or number of cigarettes smoked.
- Are breastfeeding (starting as soon as 6 weeks after childbirth).
- Have anemia, now or in the past.
- Have varicose veins.
- Have HIV infection, whether or not they are taking antiretroviral medications.

Women can begin using implants without a pelvic examination, without any blood tests or other routine laboratory tests, without cervical cancer screening, without a breast examination, and even when a woman is not having monthly bleeding at the time (as long as it is reasonably certain that she is not pregnant—see the Pregnancy Checklist cue card).

### Who Cannot Use Implants?
Women cannot use implants if they have the following conditions:
- Breastfeeding a baby less than 6 weeks old
- Serious active liver disease (jaundice, active hepatitis, severe cirrhosis, liver tumor)
- Current problem with a blood clot in legs or lungs
- Unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition
- Taking medications for seizures (barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate) or tuberculosis (rifampicin)
- Current or history of breast cancer

### How Are Implants Used?
- Implants are inserted and removed by trained health care providers. Insertion takes a few minutes.
- The woman receives an injection of local anesthetic under the skin to prevent pain in her arm.
- The implant(s) are inserted through an incision made on the inside of the upper arm. Implanon does not require an incision. It is inserted through its applicator. The woman stays fully awake throughout the procedure.
- The incision is closed with an adhesive bandage.
- Stitches are not needed.
- For removal, the same steps of injection and incision are completed, and the provider pulls out the implants with the help of an instrument. The client may feel slight pain or soreness for a few days after removal. Stitches are not needed. An adhesive bandage is used to close the incision.
- The client should also be told about the **warning signs for complications** (see the first page).

### When to Start Using Implants?
- **Any time** it is reasonably certain that the client is not pregnant. (See Pregnancy Checklist cue card.)
- **No monthly bleeding**—Any time it is reasonably certain that the client is not pregnant. A back-up method is needed for the first 7 days after insertion.
- Immediately when **switching from another hormonal method**, if the client has been using the previous method consistently and correctly. No need to wait for next monthly bleeding. No need for a back-up method.
- **After taking emergency contraceptive pills (ECPs)**, within the first 7 days (5 days for Implanon) after next monthly bleeding, or any time it is reasonably certain the client is not pregnant. Will need to use a back-up method or the pill the day after taking ECPs, until implant insertion.
- **Menstruating or switching from nonhormonal method**, within 7 days (5 for Implanon) after start of monthly bleeding and no back-up method, or more than 7 days after start of monthly bleeding—any time it is certain client is not pregnant; use back-up method for first 7 days after insertion.
- **Postpartum:**
  - **Fully or nearly fully breastfeeding**—Six weeks after giving birth, and any time between 6 weeks and 6 months, if her monthly bleeding has not returned. If more than 6 months after giving birth and her monthly bleeding has returned, any time it is reasonably certain that she is not pregnant; a back-up method should be used for the first 7 days after insertion.
  - **Partially breastfeeding**—At 6 weeks after giving birth; if more than 6 weeks and monthly bleeding has not returned, any time it is reasonably certain that she is not pregnant; a back-up method should be used for the first 7 days.
  - **Breastfeeding, monthly bleeding has returned**—As advised for women with menstrual cycles.
  - **Not breastfeeding**—Any time within 4 weeks after giving birth; If beyond 4 weeks and monthly bleeding has not returned, any time it is reasonably certain that she is not pregnant; a back-up method is needed for the first 7 days of taking pills. If monthly bleeding has returned, as advised for women having menstrual cycles.
- **Postabortion** (after abortion or miscarriage)—If immediately after or within 7 days, no back-up method is needed. If more than 7 days after, any time it is reasonably certain that she is not pregnant; a back-up method is needed for the first 7 days after insertion.
# COPPER-BEARING INTRAUTERINE DEVICE (IUD)

**Note:** The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. Family planning: A global handbook for providers. Baltimore and Geneva; and WHO. 2004. Medical eligibility criteria for contraceptive use. 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

## What Is the Intrauterine Device (IUD)?
- The IUD is a small, flexible plastic device with copper sleeves or wire around it. A specially trained health care provider inserts it into a woman’s uterus through her vagina and cervix. Almost all types of IUDs have 1 or 2 strings, or threads, tied to them. The strings hang through the cervix into the vagina.
- The most commonly used IUD in family planning programs is the copper-bearing TCu-380A IUD, which is effective for up to 12 years of use. Other copper-bearing IUDs are the MLCu-375 (Multiload) and Nova T, which are effective for 5 years.
- The IUD works primarily by causing a chemical change that damages sperm and egg before they can meet.

## How Effective Are IUDs?
- IUDs are highly effective in providing long-term, reversible contraception. For the TCu-380A, the pregnancy (failure) rate during the first year of use is less than 1 pregnancy for 100 women (6–8 per 1,000 women). Over 10 years of IUD use, the failure rate is about 2 pregnancies per 100 women.
- **Return to fertility after IUD is removed:** No delay
- **Protection against sexually transmitted diseases (STIs):** None

## Side Effects, Health Benefits, and Health Risks

### Side Effects (which are temporary and not dangerous)
Changes in bleeding patterns (especially in the first 3–6 months), including:
- Prolonged and heavy monthly bleeding
- Irregular bleeding
- More cramps and pain during monthly bleeding

### Health Benefits
- Helps protect against risks of pregnancy.
- May help protect against cancer of the lining of the uterus (endometrial cancer).

### Health Risks and Warning Signs
- **Uncommon:** May contribute to anemia if a woman already has low iron blood stores before insertion and the IUD causes heavier monthly bleeding.
- **Rare:** Pelvic inflammatory disease (PID) may occur if the woman has chlamydia or gonorrhea at the time of IUD insertion. Warning signs include increasing or severe pain in the lower abdomen, pain during intercourse, unusual vaginal discharge, fever, chills, nausea, and/or vomiting.

### Complications
- **Rare:** Puncturing (perforation) of the wall of the uterus by the IUD or an instrument used for insertion may occur. This usually heals without treatment.

### Why Some Women Say They Like the IUD
- Highly effective protection from pregnancy
- Long-lasting
- Relatively inexpensive at the start, and no further costs
- Does not require the user to do anything once the IUD is inserted

### Correcting Misunderstandings
- Intrauterine devices:
  - Rarely lead to PID after insertion.
  - Do not increase the risk of contracting STIs, including HIV.
  - Do not increase the risk of miscarriage when a woman becomes pregnant after IUD removal.
  - Do not make women infertile.
  - Do not cause birth defects.
  - Do not cause cancer.
  - Do not move to the heart or brain.
  - Do not cause discomfort or pain for the woman during sex.
  - Do not require a “rest period” after several years of use.
  - Substantially reduce the risk of ectopic pregnancy.

## Who Can Use an IUD?
Most women can use IUDs safely and effectively, including women who:

- Have or have not had children, or are not married
- Are of any age, including adolescents and women older than 40
- Have just had an abortion or miscarriage (if there is no evidence of infection)
- Are breastfeeding

Women can begin using an IUD without STI testing, without an HIV test, without any blood tests or other routine laboratory tests, without cervical cancer screening, and without a breast examination.
### COPPER-BEARING INTRAUTERINE DEVICE (IUD) *(cont.)*

#### Who Cannot Use an IUD?

The IUD should not be used by women who have the following conditions:

- Gave birth more than 48 hours ago but less than 4 weeks ago
- Had an infection following childbirth or abortion
- Experienced unexplained vaginal bleeding suggesting pregnancy or an underlying medical condition
- Have female conditions or problems (gynecologic or obstetric conditions or problems), such as genital cancer or pelvic tuberculosis
- Have current cervical, endometrial, or ovarian cancer
- Have AIDS and are clinically not well or are not using antiretroviral therapy (If the woman is at risk of HIV or is infected with HIV but does not have AIDS, she can use an IUD; if a woman who has an IUD in place develops AIDS, she can keep the IUD.)
- Are at very high individual risk for chlamydial infection or gonorrhea *(see below)*
- Might be pregnant

#### Assessing a client’s risk of STIs; 

Women who are at *high individual risk* of infection should not have an IUD inserted. Steps to take:

1. Tell the client that a woman who faces a very high individual risk of some STIs usually should not use an IUD.
2. Ask the woman to consider her own risk and to think about whether she might have an STI. Risky situations include: a sexual partner with STI symptoms (pus coming from penis, pain or burning during urination, open sore in the genital area); she or a sexual partner diagnosed with an STI recently; and she or her sexual partner having had more than 1 sexual partner recently. The provider also can mention other high-risk situations that exist locally.
3. Ask if she thinks she is a good candidate for an IUD or would like to consider other methods.

#### When Can the IUD Be Inserted?

- **Having menstrual cycles:** If starting within 12 days after start of monthly bleeding, there is no need for a back-up method. If it is more than 12 days after the start of monthly bleeding, client can have IUD inserted whenever it is reasonably certain she is not pregnant; there is no need for a back-up method.
- **Switching from another method:** Immediately, if client has been using previous method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. There is no need to wait for next monthly bleeding. There is no need for a back-up method.
- **For emergency contraception:** Within 5 days after unprotected intercourse. After taking emergency contraceptive pills (ECPs), the same day that she finishes taking ECPs. There is no need for a back-up method.
- **No monthly bleeding:** Any time, if it can be determined she is not pregnant. There is no need for a back-up method.
- **Postpartum:**
  - Any time within 48 hours of giving birth (requires a provider with specific training in postpartum insertion), or 4 weeks after giving birth (in all other cases)
  - **Fully or nearly fully breastfeeding:** If monthly bleeding has not returned any time between 4 weeks and 6 months after giving birth; if more than 6 months after giving birth, any time it is reasonably certain she is not pregnant. There is no need for a back-up method.
  - **Partially breastfeeding or not breastfeeding:** If more than 4 weeks since giving birth and monthly bleeding has not returned, if it can be determined she is not pregnant. There is no need for a back-up method.
  - **Breastfeeding and monthly bleeding has returned:** As advised for women having menstrual cycles.
- **Postabortion** *(after abortion or miscarriage):*
  - Immediately or within 12 days, if no infection is present. No back-up method is needed. Beyond 12 days after abortion or miscarriage, any time it is reasonably certain she is not pregnant. No back-up method is needed. If infection is present, after infection has completely cleared. IUD insertion after a second-trimester abortion or miscarriage requires specific training. If specifically trained health care provider is not available, insertion should be delayed until 4 weeks after abortion or miscarriage.

#### How Are IUDs Used?

- IUDs are inserted and removed by trained health service providers. The client should be told the type of the IUD, the date to return, for how long it protects from pregnancy, and when it will need to be removed or replaced.
- For insertion, to assess the client’s eligibility for the IUD, the provider first conducts a bimanual exam, followed by the speculum exam to inspect the vagina and the cervix). The provider cleans the cervix and then holds the cervix by closing the tenaculum. Then the provider passes the uterine sound through the cervix to measure the depth and position of the uterus. Finally, the provider inserts the IUD slowly through the cervix and cuts its strings at 3 cm.
- The client can expect some cramping and pain for a few days after insertion. She can use ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever, as needed. Also, she can expect some bleeding or spotting immediately after insertion. This may continue for 3–6 months.
- A follow-up visit after her first monthly bleeding or 3–6 weeks following insertion is recommended.
- If the client wants, the client can check the IUD strings to confirm that her IUD is in place.
- The client should also be told about the warning signs for health risks and complications *(see the first page)* and to return to the clinic if she feels the strings are missing or feels the hard plastic of an IUD that has come out.
- For removal, the provider inserts a speculum to see the IUD and its strings, cleans the cervix and the vagina with an antiseptic, asks the woman to take slow, deep breaths to relax, and using a narrow forceps pulls the IUD strings slowly.
# LEVONORGESTREL INTRAUTERINE DEVICE (LNG-IUD)

**Note:** The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

## What Is the Levonorgestrel Intrauterine Device (LNG-IUD)?
- The LNG-IUD is a T-shaped plastic device that steadily releases small amounts of levonorgestrel each day. (Levonorgestrel is a progestin widely used in implants and oral contraceptive pills.) It is effective for 5 years.
- A specifically trained health care provider inserts it into a woman’s uterus through her vagina and cervix.
- The LNG-IUD is also called the levonorgestrel-releasing intrauterine system (LNG-IUS) or the hormonal IUD. It is marketed under the brand names *Mirena* and *LevoNova*. Other IUDs are available with progesterone (*Progestasert*) and other progestins, such as etonogestrel. Information provided in this cue card pertains to the LNG-IUD, but it may be applicable to other hormonal IUDs.
- The LNG-IUD works primarily by suppressing the growth of the lining of uterus (endometrium).

## How Effective Is the LNG-IUD?
- The LNG-IUD’s failure rate is less than 1 pregnancy per 100 women over the first year (2 per 1,000 women). Over 5 years of LNG-IUD use, the failure rate is less than 1 pregnancy per 100 women (5 to 8 per 1,000).
- **Return to fertility after LNG-IUD is removed:** No delay
- **Protection against sexually transmitted diseases (STIs):** None

## Side Effects, Health Benefits, and Health Risks

### Side Effects (which are temporary and not dangerous)
- Changes in bleeding patterns (especially in the first 3–6 months), including:
  - Lighter bleeding and fewer days of bleeding
  - Infrequent bleeding, Irregular bleeding
  - No monthly bleeding
  - Prolonged bleeding
- Acne
- Headaches
- Breast pain or tenderness
- Nausea
- Weight gain
- Dizziness
- Mood changes
- Ovarian cysts

### Health Benefits
- Helps protect against risks of pregnancy and iron deficiency anemia.
- May help protect against pelvic inflammatory disease (PID).

### Health Risks:
None

### Complications:
**Rare:** Puncturing (perforation) of the wall of the uterus by the LNG-IUD or an instrument used for insertion may occur. This usually heals without treatment.

## Who Can Use the LNG-IUD?
Nearly all women can use the LNG-IUD safely and effectively.

## Who Should Not Use the IUD?
The LNG-IUD should not be used by women who have the following conditions:
- Gave birth less than 4 weeks ago
- Infection following childbirth or abortion
- Unexplained vaginal bleeding suggesting pregnancy or an underlying medical condition
- Female conditions or problems (gynecologic or obstetric conditions or problems) such as genital cancer or pelvic tuberculosis
- Known current cervical, endometrial or ovarian cancer
- AIDS and clinically not well or are not on antiretroviral therapy (If she is at risk of HIV or infected by HIV but does not have AIDS, she can use an LNG-IUD. If a woman who has an LNG-IUD in place develops AIDS, she can keep the LNG-IUD.)
- Very high individual risk for chlamydial infection or gonorrhea *(see Assessment of Individual Risk on the Copper-Bearing IUD cue card)*
- Might be pregnant
- Current blood clot in the deep veins of legs or lungs
- Serious active liver disease (jaundice, active hepatitis, severe cirrhosis, liver tumor)
- Current or history of breast cancer
LEVONORGESTREL INTRAUTERINE DEVICE (LNG-IUD) (cont.)

When Can the LNG-IUD Be Inserted?

- **Having menstrual cycles or switching from a nonhormonal method:** If starting within 7 days after the start of her monthly bleeding, no back-up method is needed. If it is more than 7 days after the start of her monthly bleeding, she can have the LNG-IUD inserted any time it is reasonably certain she is not pregnant. A back-up method is needed for the first 7 days after insertion.
- **Switching from a hormonal method:** Immediately, if she has been using the previous method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for next monthly bleeding. No back-up method is needed.
- **After taking emergency contraceptive pills (ECPs):** The LNG-IUD can be inserted within 7 days after the start of the client’s next monthly bleeding or any other time it is reasonably certain that the client is not pregnant. A back-up method is needed until the LNG-IUD is inserted.
- **No monthly bleeding:** Any time it can be determined she is not pregnant; a back-up method is needed for the first 7 days after insertion.
- **Postpartum:**
  - **Fully or nearly fully breastfeeding:** If monthly bleeding has not returned any time between 4 weeks and 6 months after giving birth. No back-up method is needed. If more than 6 months after giving birth and her monthly bleeding has not returned, any time it is reasonably certain she is not pregnant; a back-up method is needed for the first 7 days after insertion.
  - **Partially breastfeeding or not breastfeeding:** If more than 4 weeks since giving birth and her monthly bleeding has not returned, LNG-IUD can be inserted anytime it can be determined she is not pregnant. A back-up method is needed for the first 7 days after insertion.
  - **Breastfeeding and monthly bleeding has returned:** As is advised for women having menstrual cycles.

- **Postabortion** (after abortion or miscarriage): Insert immediately, or within 7 days if no infection is present; no back-up method is needed. Beyond 7 days after abortion or miscarriage, insert any time it is reasonably certain she is not pregnant; no back-up method is needed. If infection is present, insert after infection has completely cleared. LNG-IUD insertion after second-trimester abortion or miscarriage requires specific training. If specifically trained health care provider is not available, insertion should be delayed until after 4 weeks following the abortion or miscarriage.

How Is LNG-IUD Used?

- LNG-IUDs are inserted and removed by trained health service providers. The client should be told the type of the LNG-IUD, the date to return, for how long it protects from pregnancy, and when it will need to be removed or replaced.
- **For insertion,** to assess the client’s eligibility for the IUD, the provider first conducts a pelvic exam (a bimanual exam, followed by the speculum exam to inspect the vagina and the cervix). The provider cleans the cervix and then holds the cervix by closing the tenaculum. Then the provider passes the uterine sound through the cervix to measure the depth and position of the uterus. Finally the provider inserts the LNG-IUD slowly through the cervix and cuts its strings at 3 centimeters. After the insertion the client can rest on the examination table until she feels ready to get dressed.
- The client should return within the first 3 months to make sure that the LNG-IUD is in the right place.
- **If she wants** the client can check the LNG-IUD strings to confirm that her LNG-IUD is in place.
- **The client should also be told about the warning signs for complications** (see the first page) and to return to the clinic if she feels the strings are missing or feels the hard plastic of an LNG-IUD that has come out.
- **For removal,** the provider inserts a speculum to see the LNG-IUD and its strings. After cleaning the cervix and the vagina with an antiseptic solution, the provider asks the woman to take slow, deep breaths to relax, and using a narrow forceps pulls the LNG-IUD strings slowly.
**FEMALE STERILIZATION**

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers*. Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use*. 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

**What Is Female Sterilization?**
- Permanent contraception for women who will not want more children.
- The 2 surgical approaches most often used:
  - **Minilaparotomy** involves making a small incision in the abdomen, and the fallopian tubes are brought to the incision to be cut or blocked.
  - **Laparoscopy** involves inserting a long thin tube with a lens in it into the abdomen through a small incision. This laparoscope enables the doctor to see and block or cut the fallopian tubes in the abdomen.
- Also called tubal sterilization, tubal ligation, voluntary surgical contraception, tubectomy, bi-tubal ligation, tying the tubes, minilap, and “the operation.”
- Works because the fallopian tubes are blocked or cut. Eggs released from the ovaries cannot move down the tubes, and so they do not meet sperm. It is immediately effective.

**How Effective Is Sterilization?**
- Less than 1 pregnancy per 100 women over the first year after having the sterilization procedure (5 per 1,000).
- Over 10 years of use: About 2 pregnancies per 100 women (18 to 19 per 1,000).
- *Fertility does not return because sterilization generally cannot be stopped or reversed.* The procedure is intended to be permanent. Reversal surgery is difficult, expensive, and not available in most areas. When performed, reversal surgery often does not lead to pregnancy.
- *Protection against sexually transmitted infections (STIs):* None

**Side Effects, Health Benefits, and Health Risks**

<table>
<thead>
<tr>
<th>Side Effects</th>
<th>Health Benefits</th>
<th>Health Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Helps protect against risks of pregnancy and pelvic inflammatory disease (PID).</td>
<td>Uncommon to extremely rare: Complications of surgery and anesthesia</td>
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<tr>
<td></td>
<td>May help protect against ovarian cancer</td>
<td><strong>Complications of Surgery</strong></td>
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<td>Uncommon to extremely rare: Serious complications are uncommon and death due to procedure or anesthesia is extremely rare. The risk of complications with local anesthesia is significantly lower than with general anesthesia. Complications can be kept to a minimum if appropriate techniques are used and if procedure is performed in an appropriate setting.</td>
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**Why Some Women Say They Like Female Sterilization**
- No side effects
- No need to worry about contraception again
- Easy to use, nothing to do or remember

**Correcting Misunderstandings**
Female sterilization:
- Does not make women weak
- Does not cause lasting pain in back, uterus, or abdomen.
- Does not remove a woman’s uterus or lead to a need to have it removed.
- Does not cause hormonal imbalances.
- Does not cause heavier bleeding or irregular bleeding or otherwise change women’s menstrual cycles.
- Does not cause any changes in weight, appetite, or appearance.
- Does not change women’s sexual behavior or sex drive.
- Substantially reduces the risk of ectopic pregnancy.

**Who Can Have Female Sterilization?**
With proper counseling and informed consent, any woman can have female sterilization safely, including women who:
- Have no children or few children or are not married
- Do not have husband’s permission
- Are young
- Just gave birth (within the last 7 days)

Women can have female sterilization without any blood tests or routine laboratory tests, without cervical cancer screening and even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant (see cue card titled *Pregnancy Checklist*).

**Who Cannot Have Female Sterilization?**
*No medical condition prevents a woman from using female sterilization.* Some medical conditions may limit when, where, or how the female sterilization procedure should be performed. In such situations one should use **caution, delay** the procedure or make **special** arrangements.
- **Caution** means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition (e.g., past PID, previous abdominal or pelvic surgery, hypothyroidism, moderate iron deficiency anemia).
### Appendix F

**FEMALE STERILIZATION (cont.)**

**Delay** means postpone female sterilization. These conditions must be treated and resolved before female sterilization can be performed. The client should be given a back-up method* to use until the procedure can be performed (e.g., current pregnancy, pelvic inflammatory disease, malignant trophoblast disease, active viral hepatitis).  

**Special** means special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anesthesia, and other back-up medical support (e.g., AIDS, endometriosis, severe cirrhosis of the liver).

For a complete list of medical conditions that necessitate caution, delaying of the procedure, and making special arrangements, see the *Family Planning: A Global Handbook for Providers* or see WHO Medical Eligibility Criteria, 2004.

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### When Can Female Sterilization Be Performed?

- **Having menstrual cycles or switching from another method**—If procedure is performed within 7 days after the start of her monthly bleeding, no need to use another method before the procedure. If it is more than 7 days after the start of her monthly bleeding, she can have the procedure any time it is reasonably certain she is not pregnant.

- **No monthly bleeding**—Any time it is reasonably certain she is not pregnant.

- **After using emergency contraceptive pills (ECPs)**, woman can have sterilization procedure done within 7 days after the start of her next monthly bleeding or, any other time it is reasonably certain she is not pregnant. She should be given a back-up method or oral contraceptives to start the day after she finishes taking the ECPs, to use until she can have the procedure.

- **After childbirth (Postpartum):**
  - Immediately or within 7 days after giving birth, if she has made a voluntary, informed choice in advance.
  - Any time 6 weeks or more after childbirth, if it is reasonably certain she is not pregnant.

- **After abortion or miscarriage (postabortion)**
  - Within 48 hours after uncomplicated abortion, if she has made a voluntary, informed choice in advance.

### How Is Female Sterilization Performed?

- **The client should be counseled and have decided before the procedure if signs of infection are present.**
  - The vagina, through the cervix, and into the uterus, the provider raises each of the 2 fallopian tubes so they are closer to the incision. This may cause discomfort. Through the incision, the provider grasps the tubes and occludes them, by tying and cutting them or by closing them with a clip or ring. The incision is then closed with stitches and covered with an adhesive bandage.

- **Laparoscopy** starts with the insertion of a special needle into the woman’s abdomen. Through the needle, the provider inflates (insufflates) the abdomen with gas or air. The provider makes a small incision (about 1 cm) and inserts a long, thin tube (laparoscope) with which to visualize the tubes. Then another instrument is inserted through the laparoscope to close the fallopian tubes by applying a clip or ring or by using electric current (electrocoagulation) to block the tube. The provider then removes the instrument and the laparoscope, the gas or air is let out, and the provider closes the incision with stitches and covers it with an adhesive bandage. A laparoscope is not used in the immediate postpartum period because of the risk of injury to the large vascular uterus.

- **Local anesthesia is safer than spinal, epidural, or general anesthesia.** Let the client leave the clinic or hospital sooner (in a few hours), allows faster recovery, and makes it possible to perform female sterilization in more facilities.

- **After the procedure**, the client is observed for 2–6 hours at the clinic or hospital. She receives instructions on what to do after she leaves. She should:
  - Rest for 2 days and avoid vigorous work and heavy lifting for a week.
  - Keep the incision clean and dry for 1–2 days.
  - Not have sex for at least 1 week.

- **The client should be told about the warning signs of complications of surgery, such as:**
  - Bleeding, pain, pus, heat, swelling, or redness of the wound that becomes worse or does not go away
  - High fever (greater than 38°C/101°F)
  - Fainting, persistent light-headedness, or extreme dizziness in the first 4 weeks

- **The client should return within 7 days to have the incision site checked and any stitches removed, and any time soon after the procedure if signs of infection are present.**
Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Is Vasectomy?
- Vasectomy is permanent contraception for men who will not want more children.
- Through a puncture or small incision in the scrotum, the provider locates each of the 2 tubes that carry sperm to the penis (vas deferens) and cuts or blocks it by cutting and tying it closed or by applying heat or electricity (cautery).
- Vasectomy is also called male sterilization and male surgical contraception.
- Vasectomy works by closing off each vas deferens, keeping sperm out of semen. Semen is ejaculated, but it cannot cause pregnancy.
- There is a 3-month delay in vasectomy’s taking effect. Therefore, the man or couple must use condoms or another contraceptive method for 3 months after vasectomy.

How Effective Is Vasectomy?
- Where men cannot routinely have their semen examined to see if it still contains sperm, pregnancy rates are about 2 or 3 per 100 women over the first year after their partners have had a vasectomy. Where men can have their semen examined after vasectomy, pregnancy rates are less than 1 per 100 women over the first year after their partners have had vasectomies (2 per 1,000).
- Some pregnancies occur within the first year because the couple does not use condoms or another effective method correctly and consistently in the first 3 months, before the vasectomy is fully effective.
- Over 3 years of use: About 4 pregnancies per 100 women
- *Fertility does not return because vasectomy generally cannot be stopped or reversed.* The procedure is intended to be permanent. Reversal surgery is difficult, expensive, and not available in most areas. When performed, reversal surgery often does not lead to pregnancy.
- Protection against sexually transmitted infections (STIs): None

Side Effects, Health Benefits, and Health Risks

Complications of Surgery
- **Uncommon to rare:** Severe scrotal or testicular pain that lasts for months or years
- **Uncommon to very rare:** Infection at the incision site or inside the incision (uncommon with conventional incision technique; very rare with no-scalpel technique)
- **Rare:** Bleeding under the skin that might cause swelling or bruising (hematoma)

Correcting Misunderstandings
- Vasectomy: Does not remove the testicles. In vasectomy, the tubes carrying sperm from the testicles are blocked. The testicles remain in place.
- Does not decrease sex drive.
- Does not affect sexual function. A man’s erection is as hard, it lasts as long, and he ejaculates the same as before.
- Does not cause a man to grow fat or become weak, less masculine, or less productive.
- Does not cause any diseases later in life.
- Does not prevent transmission of STIs, including HIV.

Why Some Women Say They Like Vasectomy
- Safe, permanent, and convenient
- Fewer side effects and complications than many methods for women
- Man takes responsibility for contraception—takes burden off woman
- Increases enjoyment and frequency of sex
Who Can Have a Vasectomy?
With proper counseling and informed consent, any man can have a vasectomy safely, including men who:
- Have no children or few children
- Are not married
- Do not have wife’s permission
- Are young
- Have sickle cell disease
- Are at high risk of HIV or other STI infection
- Are infected with HIV, whether or not on antiretroviral medications

In some of these situations, especially careful counseling is important to make sure the man will not regret his decision.

Men can have a vasectomy without any blood tests or routine laboratory tests, without having their blood pressure checked, without a hemoglobin test, without having their cholesterol or liver function checked, and even if they cannot have their semen examined by microscope later to see if there are still sperm in it.

Who Cannot Have a Vasectomy?
No medical condition prevents a man from using vasectomy. Some medical conditions may limit when, where, or how the vasectomy procedure should be performed. In such situations, one should use caution, delay the procedure, or make special arrangements.
- Caution means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition (e.g., previous scrotal injury, large varicocele or hydrocele, undescended testicle [one side only], diabetes, depression).
- Delay means postpone vasectomy. These conditions must be treated and resolved before vasectomy can be performed. The client should be given a back-up method* to use until the procedure can be performed (e.g., active STI, scrotal skin infection, a mass in the scrotum, systemic infection).
- Special means that special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anesthesia, and other back-up medical support (e.g., hernia in the groin, undescended testicles [both sides], AIDS, coagulation disorders [blood fails to clot]).

For a complete list of medical conditions that necessitate caution, delaying of the procedure, and making special arrangements, see the sources cited on the front of this cue card.

When Can Vasectomy Be Performed?
Vasectomy can be performed any time a man requests it (if there is no medical reason to delay).

How Is Vasectomy Performed?
- The client should be counseled and have decided after having fully understood the 7 points of informed consent (see Participant Handbook, p. 109).
- Male sterilization is performed through either no-scalpel vasectomy (NSV) or conventional vasectomy. NSV is the preferred method, because it uses a smaller puncture instead of incisions, it causes less pain and bruising, recovery time is shorter, and it reduces the operating time. Based on the approach used, the client should be told about what to expect during the procedure and how to prepare for the procedure.
- The man receives an injection of local anesthetic in his scrotum to prevent pain. He stays awake throughout the procedure.
- In NSV, the skin is punctured with a special instrument and each vas deferens is reached and occluded through the puncture. As the puncture is so small, it can be covered with adhesive bandage.
- In conventional vasectomy, the clinician makes 1–2 cm incision(s) in the scrotal skin. Through the incision(s), each vas deferens is reached and occluded. The skin is then closed with stitches.

Both conventional vasectomy and NSV are performed almost exclusively under local anesthesia only.
- After the procedure, the client receives clear instructions about postoperative care. Following the procedure, the client can leave within a few hours, often in less than 1 hour. He should:
  - Rest for 2 days, if possible
  - Apply cold compresses on the scrotum for the first 4 hours, if possible
  - Wear snug underwear or pants for 2–3 days
  - Not have sex for at least 2–3 days
  - (If his wife is not using an effective contraceptive,) use condoms to use for 3 months, until sperm are cleared from his system.
  - Return in 3 months for semen analysis, if available

- The client should be told about the warning signs of complications of surgery, such as:
  - Bleeding, pain, pus, heat, swelling, or redness in the genital area that becomes worse or does not go away
# MALE CONDOM

**Note:** The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

## What Are Male Condoms?
- A male condom is a thin sheath usually made of rubber (latex) that is placed on an erect penis before intercourse. It is the only method of contraception that also provides protection from sexually transmitted infections (STIs), including HIV.
- Male condoms are also called rubbers, “raincoats,” “umbrellas,” skins, and prophylactics, and are known by many different brand names.
- Male condoms form a barrier that keeps sperm out of the vagina, preventing pregnancy; they also keep infections in semen, on the penis, or in the vagina from infecting the other partner.

## How Effective Are Condoms?
Effectiveness depends on the user. The risk of pregnancy is greatest when condoms are not used with every act of intercourse.

- As commonly used, the failure rate is about 15 pregnancies per 100 women whose partners use male condoms over the first year.
- When used correctly with every sex act, the male condom has a failure rate of about 2 pregnancies per 100 women whose partners use male condoms over the first year.
- **Return of fertility after use of condoms is stopped:** No delay
- **Protection against HIV and other STIs:**
  - When used consistently and correctly, the male condom prevents 80–95% of HIV transmission that would have occurred without condoms.
  - Condoms reduce the risk of becoming infected with many STIs when used consistently and correctly.
    - ⇒ They are most effective for preventing STIs spread by discharge, such as HIV, gonorrhea, and chlamydia.
    - ⇒ They reduce the risk of becoming infected with STIs spread by skin-to-skin contact, such as herpes and human papillomavirus.

## Side Effects, Health Benefits, and Health Risks

<table>
<thead>
<tr>
<th>Side Effects</th>
<th>None</th>
</tr>
</thead>
</table>

**Health Benefits**
- Condoms help protect against:
  - Risk of pregnancy
  - STIs, including HIV
  - They may help protect against conditions caused by STIs:
    - Recurring pelvic inflammatory disease and chronic pelvic pain
    - Cervical cancer
    - Infertility (male and female)

**Health Risks**
- **Extremely rare:** Severe allergic reaction (among people with latex allergy)

## Why Some Men and Women Say They Like Male Condoms
- No hormonal side effects
- Can be used as a temporary back-up method
- Can be used without seeing a health care provider
- Are sold in many places and are generally easy to obtain
- Help protect against both pregnancy and STIs, including HIV

## Correcting Misunderstandings
Male condoms:
- Do not make men sterile, impotent, or weak, or decrease their 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 many married couples. They are not only for use outside of marriage.

## Who Can Use Male Condoms?
All men and women can safely use male condoms, except for those with severe allergy to latex rubber. Also, condoms can be used by:
- Men and women needing a temporary method while waiting for a regular one
- Couples needing a back-up method
- Men and women who have intercourse infrequently
- Couples who need contraception immediately
- Couples in which either partner has more than 1 sexual partner, even if using another method
## MALE CONDOM (cont.)

### When to Start Using Male Condoms?
Use of male condoms can start any time the client wants.

### How Are Male Condoms Used?
**IMPORTANT:** Whenever possible, show the client how to put on a condom. Use a model of a penis, if available, or some other item, like a banana, to demonstrate.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
</table>
| 1. | **Use a new condom for each sex act.**  
- Check the condom package. Do not use if torn or damaged.  
- Tear open the package carefully. Do not use finger nails, teeth or anything that could damage the condom. |
| 2. | **Before any physical contact, place the condom on the tip of the erect penis with the rolled side out.**  
- For the most protection, put the condom before the penis makes any genital, oral or anal contact. |
| 3. | **Unroll the condom all the way to the base of the erect penis.**  
- The condom should unroll easily. Forcing it on could cause it break during use.  
- If the condom does not unroll easily, it may be on backwards, damaged, or too old. Throw it away and use a new condom.  
- If the condom is on backwards and a new one is not available, turn it over and unroll it onto penis. |
| 4. | **Immediately after ejaculation, hold the rim of the condom in place and withdraw the penis while it is still erect.**  
- Withdraw the penis.  
- Slide the condom off, avoiding spilling semen.  
- If having sex again or switching from one sex act to another, use a new condom. |
| 5. | **Dispose of the used condom safely.**  
- Wrap the condom in its package and put it in the rubbish or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing. |

Also:  
- Explain about use of emergency contraceptive pills (ECPs), in case there are errors in condom use.  
- Discuss skills and techniques for negotiating condom use with partners.
## FEMALE CONDOM

**Note:** The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

### What Are Female Condoms?
- Female condoms are sheaths, or linings, made of thin, transparent, soft plastic film that fit loosely inside a woman’s vagina.
  - They have flexible rings at both ends. One ring, at the closed end, helps the woman to insert the condom, and the ring at the open end holds part of the condom outside the vagina.
  - They are lubricated inside and out with a silicone-based lubricant.
- Different brand names of female condoms include FC Female Condom, Reality, Femidom, Dominique, Femy, Myfemy, Protectiv, and Care. In some countries, latex female condoms may be available.
- They work by forming a barrier that keeps sperm out of the vagina, preventing pregnancy; they also keep infections in the semen, on the penis, or in the vagina from infecting the other partner.

### How Effective Are Female Condoms?
Effectiveness depends on the user. The risk of pregnancy is greatest when condoms are not used with every act of intercourse.
- As commonly used, the failure rate for the female condom is 21 pregnancies per 100 women over the first year of use.
- When used correctly with every sex act, female condoms have a failure rate of about 5 pregnancies per 100 women over the first year.
- **Return of fertility after use of female condom is stopped:** No delay
- **Protection against HIV and other sexually transmitted infections (STIs):** Female condoms reduce the risk of infection with STIs, including HIV, when used correctly with every sex act.

### Side Effects, Health Benefits, and Health Risks

<table>
<thead>
<tr>
<th>Side Effects</th>
<th>Why Some Women Say They Like Female Condoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Women can initiate their use.</td>
</tr>
<tr>
<td>Health Benefits</td>
<td>Female condoms have a soft, moist texture that feels more natural during sex.</td>
</tr>
<tr>
<td>Female condoms help protect against</td>
<td>Female condoms protect against pregnancy and STIs, including HIV.</td>
</tr>
<tr>
<td>Risk of pregnancy</td>
<td>The outer ring provides added sexual stimulation for some women.</td>
</tr>
<tr>
<td>STI, including HIV</td>
<td>Female condoms can be used without the need to see a health care provider.</td>
</tr>
<tr>
<td>Health Risks</td>
<td>Why Some Men Say They Like Female Condoms</td>
</tr>
<tr>
<td>None</td>
<td>Female condoms can be inserted ahead of time so that use does not interrupt sex.</td>
</tr>
<tr>
<td>Correcting Misunderstandings</td>
<td>They are not tight or constricting like male condoms.</td>
</tr>
<tr>
<td>Female condoms:</td>
<td>They do not dull the sensation of sex, like male condoms do.</td>
</tr>
<tr>
<td>Cannot get lost in the woman’s body.</td>
<td>Female condoms do not have to be removed immediately after ejaculation.</td>
</tr>
<tr>
<td>Are not difficult to use, but correct use needs to be learned.</td>
<td>-</td>
</tr>
<tr>
<td>Do not have holes that HIV can pass through.</td>
<td>-</td>
</tr>
<tr>
<td>Are used by many married couples; they are not only for use outside marriage.</td>
<td>-</td>
</tr>
<tr>
<td>Do not cause illness in a woman because they prevent semen or sperm from entering her body.</td>
<td>-</td>
</tr>
</tbody>
</table>

### Who Can Use Female Condoms?
Any women can use female condoms. No medical conditions prevent the use of this method.

### When to Start Female Condoms?
Female condom use can begin anytime the client wants.
### How Are Female Condoms Used?

**IMPORTANT:** Whenever possible, show the client how to insert the female condom. Use a model or picture, if available, or your hands to demonstrate. You can create an opening similar to a vagina with one hand and show how to insert the female condom with the other hand. Basic steps and important details are of using a female condom are as follows.

<table>
<thead>
<tr>
<th>Step</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Use a new female condom for each act of intercourse.</td>
<td></td>
</tr>
<tr>
<td>• Check the condom package. Do not use the product if the packaging is torn or damaged.</td>
<td></td>
</tr>
<tr>
<td>• If possible, wash your hands with mild soap and clean water before inserting the condom.</td>
<td></td>
</tr>
<tr>
<td>2. Before any physical contact, insert the condom into the vagina.</td>
<td></td>
</tr>
<tr>
<td>• The female condom can be inserted up to 8 hours before sex. For the most protection, insert the condom before the penis comes into contact with the vagina.</td>
<td></td>
</tr>
<tr>
<td>• Choose a position that is comfortable for insertion—squat, raise one leg, sit, or lie down.</td>
<td></td>
</tr>
<tr>
<td>• Rub the sides of the female condom together to spread the lubricant evenly.</td>
<td></td>
</tr>
<tr>
<td>• Grasp the ring at the closed end, and squeeze it so that it becomes long and narrow.</td>
<td></td>
</tr>
<tr>
<td>• With the other hand, separate the outer lips (labia) and locate the opening of the vagina.</td>
<td></td>
</tr>
<tr>
<td>• Gently push the inner ring into the vagina as far up as it will go. Insert a finger into the condom to push it into place. About 2–3 cm of the condom and the outer ring should remain outside the vagina.</td>
<td></td>
</tr>
<tr>
<td>3. Ensure that the penis enters the condom and stays inside the condom.</td>
<td></td>
</tr>
<tr>
<td>• The man or woman should carefully guide the tip of his penis inside the condom—not between the condom and the wall of the vagina. If his penis goes outside the condom, withdraw and try again.</td>
<td></td>
</tr>
<tr>
<td>• If the condom is accidentally pulled out of the vagina or pushed into it during sex, put the condom back in place.</td>
<td></td>
</tr>
<tr>
<td>4. After the man withdraws his penis, he should hold the outer ring of the condom, twist it to seal in fluids, and gently pull it out of the vagina.</td>
<td></td>
</tr>
<tr>
<td>• The female condom does not need to be removed immediately.</td>
<td></td>
</tr>
<tr>
<td>• Remove the condom before standing up, to avoid spilling semen.</td>
<td></td>
</tr>
<tr>
<td>• If the couple has sex again, they should use a new condom.</td>
<td></td>
</tr>
<tr>
<td>• Reuse of female condoms is not recommended.</td>
<td></td>
</tr>
<tr>
<td>5. Dispose of the used condom safely.</td>
<td></td>
</tr>
<tr>
<td>• Wrap the condom in its package and put it in the rubbish or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing.</td>
<td></td>
</tr>
</tbody>
</table>

**Also:**

- Explain about use of emergency contraceptive pills (ECPs), in case there are errors in condom use.
- Discuss skills and techniques for negotiating condom use with partners.
**SPERMICIDES**

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

**What Are Spermicides?**
- Spermicides are sperm-killing substances inserted deep in the vagina, near the cervix, shortly before sex.
  - Nonoxynol-9 is most widely used spermicide.
  - Others include benzalkonium chloride, chlorhexidine, menfegol, octoxynol-9, and sodium docusate.
- Spermicides are available in foaming tablets, melting or foaming suppositories, cans of pressurized foam, melting film, jelly, and cream. Jellies, creams, and foam from cans can be used alone, with a diaphragm, or with condoms. Films, suppositories, and foaming tablets or suppositories can be used alone or with condoms.
- Spermicides work by causing the membrane of sperm cells to break, killing them or slowing their movement. This keeps sperm from meeting an egg.

**How Effective Are Spermicides?**
The effectiveness of spermicides depends on the user. The risk of pregnancy is greatest when spermicides are not used with every act of intercourse.
- Spermicides are one of the least effective family planning methods.
- As commonly used, spermicides have a failure rate of about 29 pregnancies per 100 women over the first year.
- When used correctly with every act of intercourse, spermicides have a failure rate of about 18 pregnancies per 100 women over the first year.
- Return of fertility after spermicides are stopped: No delay
- Protection against sexually transmitted infections (STIs): None. Frequent use may increase risk of HIV infection.

<table>
<thead>
<tr>
<th>Side Effects, Health Benefits, and Health Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Side Effects (which are temporary and not dangerous)</strong></td>
</tr>
<tr>
<td>• Irritation in or around the vagina or penis</td>
</tr>
<tr>
<td>• Vaginal lesions</td>
</tr>
<tr>
<td><strong>Health Benefits</strong></td>
</tr>
<tr>
<td>Help protect against risk of pregnancy.</td>
</tr>
<tr>
<td><strong>Health Risks</strong></td>
</tr>
<tr>
<td>• Uncommon: Urinary tract infection, especially when spermicides are used 2 or more times a day</td>
</tr>
<tr>
<td>• Rare: Frequent use of nonoxynol-9 may increase risk of HIV infection.</td>
</tr>
<tr>
<td><strong>Why Some Women Say They Like Spermicides</strong></td>
</tr>
<tr>
<td>• Controlled by the woman</td>
</tr>
<tr>
<td>• No hormonal side effects</td>
</tr>
<tr>
<td>• Increase vaginal lubrication</td>
</tr>
<tr>
<td>• Can be used without seeing a health care provider</td>
</tr>
<tr>
<td>• Can be inserted ahead of time, so they do not interrupt sex</td>
</tr>
<tr>
<td><strong>Correcting Misunderstandings</strong></td>
</tr>
<tr>
<td>Spermicides:</td>
</tr>
<tr>
<td>• Do not reduce vaginal secretions or make women bleed during sex.</td>
</tr>
<tr>
<td>• Do not cause cervical cancer or birth defects.</td>
</tr>
<tr>
<td>• Do not protect against STIs.</td>
</tr>
<tr>
<td>• Do not change men’s or women’s sex drive or reduce sexual pleasure for most men.</td>
</tr>
<tr>
<td>• Do not stop women’s monthly bleeding.</td>
</tr>
</tbody>
</table>
**SPERMICIDES (cont.)**

### Who Can Use Spermicides?
Spermicides are safe and suitable for nearly all women.

### Who Cannot Use Spermicides?
All women can safely use spermicides, except for those who:
- Are at high risk for HIV infection
- Have HIV infection
- Have AIDS

### When to Start Using Spermicides?
Spermicides can be started at any time the client wants.

### How Are Spermicides Used?
- Spermicides should be inserted before sex.
  - **Foam or cream:** Any time less than 1 hour before sex.
  - **Tablets, suppositories, jellies, film:** Between 10 minutes and 1 hour before sex.
- The client checks the expiration date and washes her hands with mild soap and clean water, if possible.
- The client applies the spermicide by:
  - **Foam or cream:** Shaking can of foam hard, squeezing spermicide from the can or tube into a plastic applicator, inserting the applicator deep into the vagina, near the cervix, and pushing the plunger.
  - **Tablets, suppositories, jellies:** Inserting the spermicide deep into the vagina, near the cervix, with an applicator or with fingers.
  - **Film:** Folding film in half and inserting with dry fingers (or else the film will stick to the fingers and not the cervix).
- The client should insert additional spermicide before each act of vaginal sex.
- Douching is not recommended, because it will wash away the spermicide and will also increase the risk of STIs. If the client must douche, she should wait for at least 6 hours after sex before doing so.
- Explain about emergency contraceptive pills (ECPs), in case the spermicide is not used at all or is not used properly.
Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers*. Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use*. 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

### What Is the Diaphragm?
- The diaphragm is a soft latex cup that covers the cervix. It is placed deep in the vagina before sex. The rim contains a firm, flexible spring that keeps the diaphragm in place.
- The diaphragm comes in different sizes and requires fitting by a specifically trained provider.
- This method requires correct use with every act of intercourse for greatest effectiveness.
- The diaphragm is used with spermicidal cream, jelly, or foam to improve its effectiveness.
- The diaphragm blocks sperm from entering the cervix; spermicides kill or disable sperm. Both keep sperm from meeting an egg.

### How Effective Is the Diaphragm?
The effectiveness of the diaphragm depends on the user. The risk of pregnancy is greatest when the diaphragm with spermicides is not used with every act of intercourse.
- As commonly used, the diaphragm has a failure rate of about 16 pregnancies per 100 women over the first year.
- When used correctly with every act of intercourse, the diaphragm has a failure rate of about 6 pregnancies per 100 women over the first year.
- Return of fertility after use of the diaphragm is stopped: No delay
- Protection against sexually transmitted infections (STIs): The diaphragm may provide some protection against certain STIs, but clients should not rely on it for STI prevention.

### Side Effects, Health Benefits, and Health Risks

#### Side Effects (which are temporary and not dangerous)
- Irritation in or around the vagina or penis
- Vaginal lesions

#### Health Benefits
- Helps protect against risks of pregnancy
- May help protect against certain STIs (chlamydia, gonorrhea, pelvic inflammatory disease, trichomoniasis)
- Cervical precancer and cancer

#### Health Risks
- **Common to uncommon**: Urinary tract infection
- **Uncommon**: Bacterial vaginosis, candidiasis
- **Rare**: Increased risk of HIV infection, from frequent use of nonoxynol-9
- **Extremely rare**: Toxic shock syndrome

### Why Some Women Say They Like the Diaphragm
- Controlled by the woman
- No hormonal side effects
- Can be inserted ahead of time, so does not interrupt sex

### Correcting Misunderstandings
Diaphragms:
- Do not affect the feeling of sex. (A few men report feeling the diaphragm during sex, but most do not.)
- Cannot pass through the cervix, and cannot go into the uterus or otherwise get lost in the woman’s body.
- Do not cause cervical cancer.

### Who Can Use the Diaphragm?
Nearly all women can use the diaphragm safely and effectively.

### Who Cannot Use the Diaphragm?
Women cannot use the diaphragm if they:
- Have had a baby or a second-trimester abortion in the past 6 weeks.
- Are allergic to latex rubber.
- Are at high risk for HIV infection.
- Have an HIV infection.
- Have AIDS.

### When to Start Using the Diaphragm?
A client can begin using the diaphragm any time she wants, except within 6 weeks of a full-term delivery or a second-trimester spontaneous or induced abortion.
### How Is the Diaphragm Used?

A pelvic examination is needed before starting use. The provider determines the correct diaphragm size and checks that it fits properly and does not come out easily. With a properly fitted diaphragm, the client should not be able to feel anything inside her vagina, even when she walks or when she has intercourse.

**IMPORTANT:** Whenever possible, show the woman the location of the pubic bone and cervix with a model or picture. Explain that the diaphragm is inserted behind the pubic bone and covers cervix.

<table>
<thead>
<tr>
<th>Step</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 1.   | Squeeze a spoonful of spermicidal cream, jelly, or foam into the diaphragm and around the rim.  
• Wash hands with mild soap and clean water if possible.  
• Check the diaphragm for holes, cracks, or tears by holding it up to the light.  
• Check the expiration date of the spermicide and avoid using any beyond its expiration date.  
• Insert the diaphragm less than 6 hours before having sex. |
| 2.   | Press the rim together; push the diaphragm into the vagina as far as it goes.  
• Choose a position that is comfortable for insertion—squatting, raising one leg, sitting, or lying down. |
| 3.   | Feel the diaphragm to make sure that it covers the cervix.  
• Through the dome of the diaphragm, the cervix feels like the tip of the nose.  
• If the diaphragm feels uncomfortable, take it out and insert it again. |
| 4.   | Keep the diaphragm in place for at least 6 hours after sex.  
• Keep the diaphragm in place at least 6 hours after having sex, but no longer than 24 hours.  
• Leaving the diaphragm in place for more than 1 day may increase the risk of toxic shock syndrome. It can also cause a bad odor and vaginal discharge.  
• For multiple sex acts, make sure that the diaphragm is in the correct position, and insert additional spermicides in front of the diaphragm before each act. |
| 5.   | To remove the diaphragm, slide a finger under the rim to pull it down and out.  
• Wash hands with mild soap and clean water, if possible.  
• Insert a finger into the vagina until the rim of the diaphragm is felt.  
• Gently slide a finger under the rim and pull the diaphragm down and out. Use care not to tear the diaphragm with a fingernail.  
• Wash the diaphragm with mild soap and clean water, and dry it after each use. |

Also:
• Explain emergency contraceptive pill (ECP) use, in case the diaphragm moves out of place or is not used properly.  
• Explain when to replace the diaphragm (when it gets thin, develops holes, or becomes stiff, or about every 2 years).
**FERTILITY AWARENESS METHODS**

*Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. Family planning: A global handbook for providers. Baltimore and Geneva; and WHO. 2004. Medical eligibility criteria for contraceptive use. 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.*

<table>
<thead>
<tr>
<th>What Are Fertility Awareness Methods?</th>
<th>Side Effects and Health Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>“Fertility awareness” means that a woman knows how to tell when the fertile time of her menstrual cycle starts and ends. (The fertile time is when she can become pregnant.)</em></td>
<td>None</td>
</tr>
<tr>
<td><em>This approach is also called periodic abstinence or natural family planning. These methods can be used alone or in combination and can be grouped into:</em></td>
<td><strong>Correcting Misunderstandings</strong></td>
</tr>
<tr>
<td>◦ <strong>Calendar-based methods.</strong> These methods involve keeping track of days of the menstrual cycle to identify the start and end of the fertile time. Examples: <em>Standard days method</em> and <em>calendar rhythm method.</em></td>
<td>Fertility awareness methods:</td>
</tr>
<tr>
<td>◦ <strong>Symptoms-based methods.</strong> These methods depend on observing signs of fertility.</td>
<td></td>
</tr>
<tr>
<td>⇒ Cervical secretions: When a woman sees or feels cervical secretions, she may be fertile.</td>
<td>• Can be very effective if used consistently and correctly.</td>
</tr>
<tr>
<td>⇒ Basal body temperature (BBT): A woman’s resting body temperature goes up slightly near the time of ovulation (release of an egg), when she could become pregnant.</td>
<td>• Do not require literacy or advanced education.</td>
</tr>
<tr>
<td>⇒ Examples: Two-Day Method, BBT method, ovulation method, and the symptothermal method</td>
<td>• Do not harm men who abstain from sex.</td>
</tr>
<tr>
<td>• Fertility awareness methods require partner’s cooperation for abstaining or using another method on fertile days.</td>
<td>• Do not work when a couple is mistaken about when the fertile time occurs, such as thinking it occurs during monthly bleeding.</td>
</tr>
<tr>
<td>• Fertility awareness methods work primarily by helping a woman know when she could become pregnant. The couple prevents pregnancy by avoiding unprotected vaginal sex during these fertile days—usually by abstaining or by using condoms or a diaphragm. Some couples use spermicides or withdrawal, but these are among the least-effective methods.</td>
<td><strong>Why Some Women Say They Like Fertility Awareness Methods</strong></td>
</tr>
<tr>
<td>• Clients should be told about emergency contraceptive pills (ECPs), in case there are errors in identifying fertile days.</td>
<td>• Have no side effects.</td>
</tr>
<tr>
<td><strong>How Effective Are Fertility Awareness Methods?</strong> Effectiveness depends on the user. Pregnancy risk is greatest when couples have unprotected sex on the fertile days.</td>
<td>• Do not require procedures and usually do not require supplies.</td>
</tr>
<tr>
<td>• As commonly used, periodic abstinence has a failure rate in the first year of about 25 pregnancies per 100 women.</td>
<td>• Help women learn about their bodies and fertility.</td>
</tr>
<tr>
<td>• Pregnancy rates with correct and consistent use vary for different types of fertility awareness methods—5 pregnancies per 100 women over the first year of use of the standard days method, 9 per 100 women over the first year of use of the calendar rhythm method, 4 per 100 women over the first year of use of the Two-Day method, 1 per 100 women over the first year of use of the basal body temperature (BBT) method, 3 per 100 women over the first year of use of the ovulation method, and 2 per 100 women over the first year of use of the symptothermal method.</td>
<td>• Allow some women to adhere to their religious or cultural norms about contraception.</td>
</tr>
<tr>
<td>• <em>Return of fertility after fertility awareness methods are stopped:</em> No delay</td>
<td>• Can be used to identify fertile days by both women who want to become pregnant and women who want to avoid pregnancy.</td>
</tr>
<tr>
<td>• <em>Protection against sexually transmitted infections (STIs):</em> None</td>
<td><strong>Who Can Use Calendar-Based Methods and Symptoms-Based Methods?</strong></td>
</tr>
<tr>
<td><strong>Delay</strong>—The woman recently gave birth or is breastfeeding, recently had an abortion or miscarriage, is having irregular vaginal bleeding, is using drugs that may delay ovulation)</td>
<td>All women can use calendar-based methods. No medical conditions prevent the use of these methods, but some conditions can make them harder to use effectively and necessitate using caution or delaying their use. Caution means that additional or special counseling may be needed to ensure correct use of the method. Delay means that use of a particular fertility awareness method should be delayed until a condition is evaluated or corrected.</td>
</tr>
<tr>
<td><strong>Caution</strong>—Menstrual cycles have just started or have become less frequent or stopped due to older age.</td>
<td><strong>Calendar-Based Methods</strong></td>
</tr>
<tr>
<td><strong>Delay</strong>—The woman recently gave birth or is breastfeeding, recently had an abortion or miscarriage, is having irregular vaginal bleeding, is using drugs that may delay ovulation</td>
<td>• Caution—Menstrual cycles have just started or have become less frequent or stopped due to older age.</td>
</tr>
<tr>
<td><strong>Caution</strong>—The woman recently gave birth or is breastfeeding, has an acute condition that raises her body temperature [for BBT and symptothermal methods], is having irregular vaginal bleeding, is experiencing abnormal vaginal discharge, or is using drugs that may affect cervical secretions, raise body temperature, or delay ovulation.</td>
<td>• Delay—The woman recently gave birth or is breastfeeding, recently had an abortion or miscarriage, is having irregular vaginal bleeding, is using drugs that may delay ovulation</td>
</tr>
</tbody>
</table>
## FERTILITY AWARENESS METHODS (cont.)

**When to Start Using Fertility Awareness Methods?**
Once trained, a woman or couple usually can begin using fertility awareness methods at any time.

- **Having regular menstrual cycles**—Any time of the month. No need to wait for the next monthly bleeding.
- **No monthly bleeding**—Calendar-based methods cannot be used. Delay symptoms-based methods until monthly bleeding returns.
- **After childbirth** (whether or not breastfeeding)—Delay standard days method until woman has had 3 menstrual cycles; she can start symptothermal methods once normal secretions have returned.
- **After miscarriage or abortion**—Delay standard days method until the start of woman’s next monthly bleeding. Start symptothermal methods immediately, with special counseling and support.
- **When switching from a hormonal method**—Delay standard days method until the start of her next monthly bleeding. Start symptothermal methods in the next menstrual cycle after stopping a hormonal method.
- **After taking emergency contraceptive pills**—Delay standard days method until the start of her next monthly bleeding. Start symptothermal methods once normal secretions have returned.

**How Are Symptoms-Based Methods Used?**

### Two-Day Method
(If the woman has a vaginal infection or another condition that changes cervical mucus, the Two-Day method will be difficult to use.) The woman checks for cervical secretions every afternoon and/or evening, on fingers, underwear, or tissue paper or by sensation in or around the vagina. As soon as she notices any secretions of any type, color, or consistency, she considers herself fertile that day and the following day. The couple avoids unprotected sex or uses condoms on days of heavy bleeding that makes mucus difficult to observe. Between the end of monthly bleeding and the start of secretions, the couple can have unprotected sex, but not on 2 days in a row. (Avoiding intercourse on the second day allows time for semen to disappear and for cervical mucus to be observed.) As soon as she notices any secretions, the woman considers herself fertile and avoids unprotected sex. She continues to check her cervical secretions each day. The secretions have a “peak day”—the last day that they are clear, slippery, stretchy, and wet. She will know this has passed when, on the next day, her secretions are sticky or dry, or she has no secretions at all. She continues to consider herself fertile for 3 days after that peak day and avoids unprotected sex. The couple can have unprotected sex on the 4th day after her peak day and until her next monthly bleeding begins.

### Basal Body Temperature (BBT) Method
(If a woman has fever or other changes in body temperature, the BBT method will be difficult to use.) The woman takes her body temperature at the same time each morning before she gets out of bed and before she eats anything. She records her temperature on a special graph. She watches for her temperature to rise slightly—0.2° to 0.5°C (0.4° to 1.0°F)—around the time of ovulation (usually about midway through the menstrual cycle). The couple avoids vaginal sex, or uses condoms or a diaphragm on each day that she considers herself fertile and the following day. The couple can have unprotected sex again after the woman has had 2 dry days (days without secretions of any type) in a row.

### Symptothermal Method
Users identify fertile and nonfertile days by combining BBT and ovulation method instructions. Women may also identify the fertile time by other signs such as breast tenderness and ovulatory pain (lower abdominal pain or cramping around the time of ovulation). The couple avoids unprotected sex between the first day of monthly bleeding and either the fourth day after peak cervical secretions or the third full day after the rise in temperature (BBT), whichever happens later. Some women who use this method have unprotected sex between the end of monthly bleeding and the beginning of secretions, but not on 2 days in a row.

**Ovulation Method** *(also known as the Billings method or cervical mucus method):*
(If a woman has a vaginal infection or another condition that changes cervical mucus, this method may be difficult to use.) The woman checks every day for any cervical secretions on her finger, underwear, or tissue paper or by sensation in the vagina. The couple avoids unprotected sex on days of heavy bleeding that makes mucus difficult to observe. Between the end of monthly bleeding and the start of secretions, the couple can have unprotected sex, but not on 2 days in a row. (Avoiding intercourse on the second day allows time for semen to disappear and for cervical mucus to be observed.) As soon as she notices any secretions, the woman considers herself fertile and avoids unprotected sex. She continues to check her cervical secretions each day. The secretions have a “peak day”—the last day that they are clear, slippery, stretchy, and wet. She will know this has passed when, on the next day, her secretions are sticky or dry, or she has no secretions at all. She continues to consider herself fertile for 3 days after that peak day and avoids unprotected sex. The couple can have unprotected sex on the 4th day after her peak day and until her next monthly bleeding begins.

**Standard Days Method (SDM)**
Can be used if most of the cycles in a year are between 26 to 32 days long. A woman keeps track of the days of her menstrual cycle, counting the first day of monthly bleeding as day 1. Avoids unprotected sex or uses condoms or a diaphragm on days 8–19 that are considered fertile days for all users of the SDM. The couple can have unprotected sex on all other days of the cycle. They can use color-coded beads or calendar as memory aid.

**Calendar Rhythm Method**
Before relying on this method, a woman records the number of days in each menstrual cycle for at least 6 months. The first day of monthly bleeding is always counted as day 1. The woman estimates the fertile time by subtracting 18 from the length of her shortest recorded cycle. This tells her the estimated first day of her fertile time. Then she subtracts 11 days from the length of her longest recorded cycle. This tells her the estimated last day of her fertile time. The couple avoids unprotected sex or uses condoms or a diaphragm during the fertile time. She updates these calculations each month, always using the 6 most recent cycles.
## LACTATIONAL AMENORRHEA METHOD (LAM)

**Note:** The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

### What Is LAM?
- The lactational amenorrhea method (LAM) is a temporary family planning method based on the natural effect of breastfeeding on fertility. (“Lactational” means related to breastfeeding. “Amenorrhea” means not having monthly bleeding.) LAM provides contraception for the mother and the best approach for feeding for the baby.
- LAM is effective as long as all 3 of the following conditions are met:
  - The mother’s monthly bleeding has not returned.
  - The baby is fully or nearly fully breastfed, and is fed often, day and night.
  - The baby is less than 6 months old.
- “Fully breastfeeding” includes both exclusive breastfeeding (the infant receives no other liquid or food, not even water, in addition to breast milk) and almost-exclusive breastfeeding (the infant receives vitamins, water, juice, or other nutrients once in a while in addition to breast milk).
- “Nearly fully breastfeeding” means that the infant receives some liquid or food in addition to breast milk, but the majority of feedings (more than three-fourths of all feeds) are breast milk.
- LAM works primarily by preventing the release of eggs from the ovaries (ovulation). Frequent breastfeeding temporarily prevents the release of the natural hormones that cause ovulation.

### How Effective Is LAM?

*Effectiveness depends on the user:* With LAM, the risk of pregnancy is greatest when a woman cannot fully or nearly fully breastfeed her infant.

- As commonly used, LAM has a failure rate of about 2 pregnancies per 100 women in the first 6 months after childbirth.
- When used correctly, LAM has a failure rate of less than 1 pregnancy per 100 women in the first 6 months after childbirth.
- *Return of fertility after LAM is stopped:* This depends on how much the woman continues to breastfeed.
- *Protection against sexually transmitted infections (STIs):* None

### Side Effects, Health Benefits, and Health Risks

<table>
<thead>
<tr>
<th>Side Effects</th>
<th>Health Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Health Benefits**

- LAM helps protect against the risk of pregnancy.
- LAM encourages the best breastfeeding patterns, with health benefits for both mother and baby.

**Why Some Women Say They Like LAM**

- It is a natural family planning method.
- LAM supports optimal breastfeeding, providing health benefits for the baby and the mother.
- There is no direct cost for family planning or for feeding the baby.

**Correcting Misunderstandings**

- LAM:
  - Is highly effective when a woman meets all 3 criteria.
  - Can be used by a woman with viral hepatitis.
Who Can and Cannot Use LAM?
All women can safely use LAM, but a woman in the following circumstances may want to consider other contraceptive methods:

- Has HIV infection, including AIDS (Important: Women who are infected with HIV or who have AIDS can use LAM. Breastfeeding will not make their condition worse. There is a chance, however, that mothers with HIV will transmit HIV to their infants through breastfeeding—5–20 of every 100 infants breastfed by mothers with HIV will become infected. Women taking antiretroviral medications [ARVs] can use LAM. In fact, ARV treatment during the first weeks of breastfeeding may reduce the risk of HIV transmission through breast milk. Rapid weaning also decreases the risk of HIV transmission. She should stop breastfeeding over 2 days to 3 weeks. Replacement feeding poses no risk of HIV transmission. Replacement feeding is recommended for the first 6 months after childbirth if—and only if—replacement feeding is acceptable, feasible, affordable, sustainable, and safe. If replacement feeding cannot meet these 5 criteria, exclusive breastfeeding for the first 6 months is the safest way to feed the baby, and it is compatible with LAM.)
- Is using certain medications during breastfeeding (including mood altering drugs, reserpine, ergotamine, antimetabolites, cyclosporine, high doses of corticosteroids, bromocriptine, radioactive drugs, lithium, and certain anticoagulants)
- The newborn has a condition that makes it difficult to breastfeed (including being small-for-date or premature and needing intensive neonatal care, being unable to digest food normally, or having deformities of the mouth, jaw, or palate)

When to Start Using LAM?
The woman should start breastfeeding immediately (within 1 hour) or as soon as possible after the baby is born. LAM can be initiated at any time within 6 months after childbirth if the woman has been fully or nearly fully breastfeeding her baby since birth and her monthly bleeding has not returned.

How Is LAM Used?
- **Ask the mother these 3 questions:**
  - Has your monthly bleeding returned?
  - Are you regularly giving the baby other food besides breast milk or allowing long periods without breastfeeding, either day or night?
  - Is your baby more than 6 months old?
    - If the answer to all of these 3 questions is no, she can use LAM.
- An ideal pattern is feeding on demand (that is, whenever the baby wants to be fed) and at least 10–12 times a day in the first few weeks after childbirth and 8–10 times a day thereafter, including at least once at night in the first months. Daytime feedings should be no more than 4 hours apart, and nighttime feedings should be no more than 6 hours apart.
- She should start giving other foods in addition to breast milk when the baby is 6 months old. At this age breast milk can no longer fully nourish a growing baby.
POSTPARTUM FAMILY PLANNING


What Is Postpartum Family Planning?
Postpartum family planning is the initiation of family planning method use within the 6 weeks following childbirth. There are important considerations in helping pregnant women and new mothers decide how they will avoid pregnancy after childbirth. These are:

• **Timing of counseling:** Ideally, family planning counseling should start *during antenatal care*. This allows sufficient time for clients to be counseled and to make their decisions free of the stress associated with the delivery. It also helps to ensure that clients can receive their method of choice immediately after giving birth or just following *(immediate postpartum)*—e.g., the postpartum IUD or female sterilization. Usually, it is not appropriate to counsel the client *just before delivery*. In this case, the stress that she is experiencing may impair sound decision making. The provider has the responsibility to confirm that such clients are making an informed, voluntary, and sound decision. If there are signs of stress, counseling and the client’s decision making should be postponed. The next appropriate opportunity for counseling the client is *after delivery* but before the client leaves the facility. At this point, it may be too late to provide the client’s method of choice during or at the end of the delivery or procedure, but this may help to ensure that the client gets his or her method of choice before discharge or returns later to get it at *follow-up*.

• **Healthy timing and spacing of pregnancy (HTSP) messages:** To achieve healthiest pregnancy outcomes for the baby and the mother, a woman should wait until her baby is at least 2 years old before trying to become pregnant again. See the HTSP cue card for details.

• **Breastfeeding status:** Since about 99% of women breastfeed their infants for some period of time, providers need to consider the impact of contraceptive methods on breast milk, breastfeeding, and infant health when helping clients choose a method. Within this context, the following 3 points should be taken into consideration when discussing use of contraceptive methods after childbirth:
  ◦ All women should be encouraged to breastfeed.*
  ◦ Breastfeeding should continue when use of a family planning method is initiated.
  ◦ The family planning method should not have any adverse effects on breastfeeding or infant health.

• **Return of fertility:** To make an informed decision, a woman needs to know when she will become fertile again following childbirth.
  ◦ If not fully or nearly fully breastfeeding, she is able to become pregnant as soon as 6 weeks after childbirth.
  ◦ If fully or nearly fully breastfeeding, she is able to become pregnant as soon as 6 months postpartum (see the LAM cue card).

For maximum protection, a woman should not wait until the return of monthly bleeding to start a contraceptive method, but should instead start as soon as guidance allows (see table below).

* Detailed breastfeeding guidance for HIV-positive women is provided in Handout 15-C of the Participant Handbook, p. XX.

### Earliest Time That a Woman Can Start a Family Planning Method after Childbirth

<table>
<thead>
<tr>
<th>Family Planning Method</th>
<th>Fully/Nearly Fully Breastfeeding</th>
<th>Partially/Not Breastfeeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lactational amenorrhea method (LAM)</td>
<td>Immediately</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>Immediately or during partner’s pregnancy†</td>
<td></td>
</tr>
<tr>
<td>Male or female condoms</td>
<td>Immediately</td>
<td></td>
</tr>
<tr>
<td>Spermicide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copper-bearing IUD</td>
<td>Within 48 hours, otherwise wait 4 weeks</td>
<td></td>
</tr>
<tr>
<td>Female sterilization</td>
<td>Within 7 days, otherwise wait 6 weeks</td>
<td></td>
</tr>
<tr>
<td>LNG-IUD</td>
<td>4 weeks after childbirth</td>
<td></td>
</tr>
<tr>
<td>Diaphragm</td>
<td>6 weeks after childbirth</td>
<td></td>
</tr>
<tr>
<td>Fertility awareness methods</td>
<td>Start when normal secretions have returned (symptoms-based methods) or when she has had 3 regular menstrual cycles (calendar-based methods). This is later for breastfeeding women than for those who are not breastfeeding.</td>
<td></td>
</tr>
<tr>
<td>Progestin-only pills</td>
<td>6 weeks after childbirth‡</td>
<td>Immediately if not breastfeeding; 6 weeks after childbirth if partially breastfeeding</td>
</tr>
<tr>
<td>Progestin-only injectables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implants</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

† If a man has a vasectomy during the first 6 months of his partner’s pregnancy, it will be effective by the time she delivers her baby.
‡ Earlier use is not usually recommended unless other, more appropriate methods are not available or not acceptable.
### POSTPARTUM FAMILY PLANNING (cont.)

**Counseling Clients for Postpartum Family Planning**

<table>
<thead>
<tr>
<th><strong>During Antenatal Care (Check-Ups before Delivery)</strong></th>
<th><strong>During Postpartum Care (Check-Ups after Delivery)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Emphasize the importance of breastfeeding, which benefits both mothers and newborns.</td>
<td>• Provide counseling about the benefits of delaying the next pregnancy for 2 years (HTSP)</td>
</tr>
<tr>
<td>• Explain the benefits for future births of healthy timing and spacing of pregnancy (HTSP)</td>
<td>• Emphasize the benefits of breastfeeding, which can delay the next birth if the infant is exclusively breastfed</td>
</tr>
<tr>
<td>• Discuss family planning methods, including:</td>
<td>• Explain that using exclusive breastfeeding as a temporary family planning method (LAM) protects women from pregnancy for up to 6 months</td>
</tr>
<tr>
<td>▶ LAM</td>
<td>• Discuss when to start using family planning methods (including when to switch from LAM to another method)</td>
</tr>
<tr>
<td>▶ Methods that can be started during or immediately after delivery (IUD, female sterilization)</td>
<td>• Discuss ways of reducing risk of HIV and STI transmission</td>
</tr>
<tr>
<td>▶ Methods that can be used while breastfeeding and afterwards</td>
<td></td>
</tr>
<tr>
<td>▶ Discuss ways of reducing transmission risk of HIV and other sexually transmitted infections (STIs)</td>
<td></td>
</tr>
</tbody>
</table>

Invite the client to come back for any questions or problems, when she thinks she is ready to start using a method, to switch from LAM to another family planning method, or if she has any problems with the method she has just started using.
POSTABORTION FAMILY PLANNING

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. Family planning: A global handbook for providers. Baltimore and Geneva; and WHO. 2004. Medical eligibility criteria for contraceptive use. 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes and to the method-specific cue cards.

What Is Postabortion Family Planning?
Access to family planning counseling and methods is an important aspect of postabortion care, to ensure that women are able to avoid a future unplanned pregnancy or successfully achieve a planned pregnancy following a miscarriage. Important considerations in helping women avoid pregnancy in this period include:

• Timing of counseling: Postabortion clients have particular needs related to their personal circumstances—their recent pregnancy, in this case—(e.g., worries, stress, pain they may be experiencing, hurry to return home). The provider needs to assess the best timing for family planning counseling for these clients. For postabortion clients, counseling before the procedure can only be an option if the client is not under stress. Usually, counseling the client just before a procedure to address abortion complications is not appropriate. In this case, sound decision making may be impaired by the stress the client is experiencing. If there are signs of stress, the counseling and decision making of the client should be postponed. The next appropriate opportunity to counsel the client is after the procedure to address abortion complications, but before the client leaves the facility. At this point, it may be too late to provide the client’s method of choice immediately at the end of the procedure (e.g., an IUD), but this may help ensure that the clients get their method of choice predischarge or return later to get it at follow-up.

• Timing of pregnancy: To achieve the healthiest pregnancy outcomes for the baby and the mother, the woman should wait at least 6 months after a miscarriage or abortion before trying to become pregnant again. See the cue card on Healthy Timing and Spacing of Pregnancy (HTSP) for details.

• Return of fertility: Fertility returns very quickly postabortion. A woman can become pregnant as early as within the first 2 weeks following a first-trimester miscarriage or abortion, and within 4 weeks after a second-trimester abortion. Therefore, she needs protection from pregnancy almost immediately.

For maximum protection, a woman should not wait until her next monthly bleeding to start a contraceptive method, but instead she should start as soon as guidance allows (see table on page F-42).

Counseling Clients for Postabortion Family Planning

Before Abortion Procedure
• Explain the benefits of healthy timing and spacing of pregnancy for expected newborns (HTSP)
• Discuss family planning methods, including:
  ◦ Methods that can be started immediately after the procedure (see table above)
  ◦ IUD (which can be inserted after a procedure to address abortion complications, providing there is no infection present)
  ◦ Back-up method options for methods that can be provided later
• Discuss ways of reducing risk of HIV and sexually transmitted infection (STI) transmission

After Abortion Procedure
• Provide counseling about the benefits of delaying the next pregnancy for 2 years (HTSP)
• Discuss family planning methods (see table above):
  ◦ When to start using them
  ◦ Back-up method options for methods that can be provided later
• Discuss ways of reducing risk of HIV and STI transmission

Invite the client to come back for any questions or problems, when she thinks she is ready to start using a method, or if she has any problems with the method she has just started using.
### Earliest Time That a Woman Can Start a Family Planning Method after Abortion/Miscarriage

<table>
<thead>
<tr>
<th>Family Planning Method</th>
<th>When to Start</th>
<th>Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral contraceptives (combined or progestin-only)</td>
<td>Immediately</td>
<td></td>
</tr>
<tr>
<td>Injectables (combined or progestin-only)</td>
<td>Immediately</td>
<td></td>
</tr>
<tr>
<td>Implants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combined patch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male or female condom</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combined vaginal ring</td>
<td>Immediately</td>
<td>Once any injury to the genital tract is healed.</td>
</tr>
<tr>
<td>Spermicide</td>
<td>Immediately</td>
<td></td>
</tr>
<tr>
<td>Cervical cap</td>
<td>Immediately</td>
<td></td>
</tr>
<tr>
<td>Diaphragm</td>
<td>Immediately</td>
<td>Once any injury to the genital tract is healed. Must be refitted after uncomplicated first-trimester miscarriage. After uncomplicated second-trimester miscarriage, use should be delayed 6 weeks.</td>
</tr>
<tr>
<td>IUDs</td>
<td>Immediately</td>
<td>Provided there is no infection and any injury to the genital tract is healed. IUD insertion after a second-trimester abortion requires a specially trained provider.</td>
</tr>
<tr>
<td>Female sterilization</td>
<td>Immediately</td>
<td>Provided there is no infection any injury to the genital tract is healed. Must be decided upon in advance, not while the woman is sedated, under stress, or in pain.</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>Any time, regardless of the timing of miscarriage or abortion</td>
<td></td>
</tr>
<tr>
<td>Fertility awareness methods</td>
<td>Delay until there are no noticeable secretions or bleeding related to injury or infection.</td>
<td>Provided there is no infection any injury to the genital tract is healed. For calendar-based methods, delay until the woman has had at least one monthly bleed after all such secretions and bleeding has stopped.</td>
</tr>
</tbody>
</table>
FAMILY PLANNING FOR PEOPLE LIVING WITH HIV


People living with HIV:
• Can enjoy a healthy sexual life (see “Ways of lowering risk”)
• Have options for preventing unwanted pregnancy and further transmission of HIV (See “Contraceptives for clients with STIs, HIV, and AIDS” as well as Dual Protection in Handout 20 in the Participant Handbook.)
• Can have a healthy baby (See “Thinking about pregnancy,” next page)

Ways of Lowering Risk
• Mutual faithfulness—Two partners faithful to each other
• Limited number of sexual partners
• Safer sex—For example, using condoms or avoiding penetrative sex
  ◦ Examples of acts with no risk: Pleasuring self, massage, hugging, kissing on lips
  ◦ Examples of low-risk acts: vaginal or anal intercourse using condom, oral sex (safer with condoms or other barrier)
  ◦ Examples of high-risk acts: anal intercourse without a condom, vaginal intercourse without a condom
  ◦ These apply whether client’s partner(s) is/are same or opposite sex.

• Early treatment of sexually transmitted infections (STIs) and avoidance of sex if client or partner has an STI
• Not having sex—Need to be prepared to use condoms if client returns to sexual activity

Contraceptives for Clients with STIs, HIV, and AIDS
People with STIs, with HIV and AIDS, or on ARV therapy can start and continue to use most contraceptive methods safely. There are a few limitations, however. See the table below and each cue card on contraceptive methods for more information and for considerations for clients with HIV, including those taking ARV medications.
• Male and female condoms are the only methods that prevent both pregnancy and infection. It is important to use them correctly with every act of vaginal or anal intercourse.
• All hormonal methods (combined and progestin-only pills, injectables, implants) can be safely used. Rifampicin taken for tuberculosis usually reduces the effectiveness of contraceptive pills and implants. Some antiretrovirals (protease inhibitors and nonnucleoside reverse transcriptase inhibitors [NNRTIs]) may lower the effectiveness of hormonal methods. This is not known for sure. (Nucleoside reverse transcriptase inhibitors [NRTIs] are not a concern.)
• Fertility awareness-based methods can be safely used. In case of infection that causes vaginal discharge or fever, fertility awareness-based methods may be difficult to use.
• The lactational amenorrhea method (LAM) risks passing HIV to the baby. Women with HIV should be counseled to choose the feeding option that best suits their situation. (Important: Women who are infected with HIV or who have AIDS can use LAM. Breastfeeding will not make their condition worse. There is a chance, however, that mothers with HIV will transmit HIV to their infants through breastfeeding—5–20 of every 100 infants breastfed by mothers with HIV will become infected. Women taking antiretroviral medications [ARVs] can use LAM. In fact, ARV treatment during the first weeks of breastfeeding may reduce the risk of HIV transmission through breast milk. Rapid weaning also decreases the risk of HIV transmission. She should stop breastfeeding over 2 days to 3 weeks. Replacement feeding poses no risk of HIV transmission. Replacement feeding is recommended for the first 6 months after childbirth if—and only if—replacement feeding is acceptable, feasible, affordable, sustainable, and safe. If replacement feeding cannot meet these 5 criteria, exclusive breastfeeding for the first 6 months is the safest way to feed the baby, and it is compatible with LAM.)
• For IUDs, female sterilization, vasectomy, and spermicides, there are special considerations (see table, page F-44).

In general, contraceptives and ARV medications do not interfere with each other. It is not certain whether some antiretroviral medications make low-dose hormonal contraceptives less effective. Even if they do, condom use can make up for that.
**FAMILY PLANNING FOR PEOPLE LIVING WITH HIV** *(cont.)*

Special Family Planning Considerations for Clients Who Have STIs, Who Have HIV, or Who Are Receiving Antiretroviral Therapy (ART)

<table>
<thead>
<tr>
<th>METHOD</th>
<th>HAS STI</th>
<th>HAS HIV OR AIDS</th>
<th>RECEIVES ART</th>
</tr>
</thead>
</table>
| Intrauterine Device      | Do not insert an IUD in a woman who is at very high individual risk for gonorrhea and chlamydia, or who currently has gonorrhea, chlamydia, purulent cervicitis, or pelvic inflammatory disease (PID). (A current IUD user who becomes infected with gonorrhea or chlamydia or who develops PID can safely continue using an IUD during and after treatment.) | • A woman with HIV but not AIDS can have an IUD inserted.  
• A woman with AIDS should not have an IUD inserted unless she is clinically well on ARV therapy. (A woman who develops AIDS while using an IUD can safely continue using the method.) | Do not insert an IUD if the client is not clinically well. |
| Female Sterilization     | If the client has gonorrhea, chlamydia, purulent cervicitis, or PID, delay sterilization until the condition is treated and cured. | Delay sterilization if the client is currently ill with an AIDS-related illness. |                       |
| Vasectomy                | If the client has a scrotal skin infection, an active STI, balanitis, epididymitis, or orchitis, delay sterilization until the condition is treated and cured. | Delay sterilization if the client is currently ill with an AIDS-related illness. |                       |
| Spermicides              | Can be safely used, including when used with diaphragm or cervical cap | Should not be used if the client is at high risk of HIV, is infected with HIV, or has AIDS. |                       |

**Thinking about Pregnancy: What the Client Needs to Know**

*It’s your decision about getting pregnant.*

Pregnancy risks and risks of infecting the baby are not as high as many people think.

**Risks to baby:**

• If the mother is living with HIV, the baby may get HIV during pregnancy, childbirth, or breastfeeding (3 out of 10 babies). Most babies do not get infected. Treatment lowers this risk to 1 of 10 babies who will get infected.

• If the mother is living with HIV, there is greater chance of stillbirth, premature birth, or low birth weight.

**Risks to mother:**

• HIV infection increases the risk of childbirth complications such as fever and anemia, particularly with delivery by caesarean section.

• Pregnancy will not speed up the course of HIV infection, but it is best to avoid pregnancy in some health situations (see under “What the client needs to consider before getting pregnant”).

**Risks to partner:**

• If the woman is uninfected and her partner is infected, she may have to risk getting HIV to become pregnant.

• If the man is uninfected and the woman is infected, he can avoid HIV risk by using artificial insemination.

**What the Client Needs to Consider before Getting Pregnant**

**Her health now:**

• *Pregnancy is possible*, if her health is good, if her CD4 count is greater than 200 (consider starting women with CD4 counts of 200–350 on antiretrovirals before pregnancy), if she is at clinical Stage 1 or 2 (where CD4 count is not available), if she is on prophylaxis to prevent opportunistic infections or is on antiretrovirals (if eligible), and if she has no sign or symptoms of tuberculosis.

• If pregnancy may cause problems now, delay pregnancy and reevaluate later (e.g., if her health is worsening, if her CD4 count is less than 200, if her tuberculosis status is unknown, if she is taking no prophylaxis to prevent opportunistic infections, or if she is in her first 6 weeks of antiretrovirals).

• Pregnancy is not a good idea now if her health is poor (e.g., if she is in clinical Stage 3 or 4, if she is on tuberculosis treatment, if her CD4 count is less than 100, or if she is waiting to start antiretrovirals).

**Medical care for her and her baby:** Are services available? Where?

**Her partner’s support:**

• Has she got a steady partner? Does her partner know her HIV status?

• Is her partner supportive, and will her partner help with the baby? Does her partner know his own status or is he willing to be tested? What is her partner’s health status?

**Family support:**

• Is her family supportive? Or would they reject a child with HIV? Are family members close by, and can they help?

**Telling others her HIV status:**

• Has she told others? Is she planning to? Who cannot be told?

**Feeding her baby:** Is she able to feed her infant in the recommended way to lower the chances of transmitting HIV?
Appendix G

Participant Workshop Evaluation Form
Participant Workshop Evaluation Form

Please answer all sections of this evaluation form, using the reverse side for comments, if needed. Your responses will assist the training organizers in determining what modifications, if any, should be made to this program.

I. Overall Evaluation

Select the choice that best reflects your overall evaluation of this training:

____ Very good   ____ Good    ____ Fair    ____ Poor    ____ Very poor

II. Achievement of Objectives

The general objectives of the training are to ensure that you have the knowledge, attitudes, and skills necessary to carry out the key tasks of family planning (FP) counseling. For each objective (below), please circle the number that reflects the degree to which you feel that objective was achieved (or the task described in the objective was mastered):

- 5 = totally achieved
- 4 = mostly achieved
- 3 = somewhat achieved
- 2 = hardly achieved
- 1 = not at all achieved

For any objectives given a rating of 1, 2, or 3, please indicate in the Comments/Suggestions column why you feel that it was somewhat, hardly, or not at all achieved, and please offer any suggestions you might have to improve it.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain the importance of quality, client-centered counseling for family planning uptake and continuation</td>
<td>5</td>
</tr>
<tr>
<td>2. Effectively communicate with clients</td>
<td>5</td>
</tr>
<tr>
<td>3. Assess clients' individual FP needs, knowledge, and concerns, and fulfill their needs for information, services, and emotional support</td>
<td>5</td>
</tr>
<tr>
<td>4. Identify the key decisions clients need to make or confirm, and assist them through this process by considering various options and their consequences</td>
<td>5</td>
</tr>
<tr>
<td>5. Assist clients in carrying out their FP decisions, including making a plan for implementation and coping with side effects</td>
<td>5</td>
</tr>
<tr>
<td>6. Identify the barriers to conducting “ideal” counseling and develop a plan to overcome them in your own practice setting</td>
<td>5</td>
</tr>
</tbody>
</table>

Comments/Suggestions:

<table>
<thead>
<tr>
<th>Score</th>
<th>Comments/Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
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<tr>
<td>3</td>
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<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
III. Other Aspects of the Workshop

For each of the following questions, check the response that best represents your opinion. Please add any other comments you have.

1. How relevant to your work was the overall workshop?
   - Extremely Well
   - Mostly
   - Moderately
   - Minimally
   - Not at all

   What aspects of the workshop were most relevant to your work? Why?

   What aspects of the workshop were least relevant to your work? Why?

   Additional comments:

2. How well did the course content meet your expectations?
   - Totally
   - Mostly
   - Moderately
   - Minimally
   - Not at all

   Comments:

3. How well did the overall training methods contribute to achieving the workshop objectives?
   - Extremely Well
   - Mostly
   - Moderately
   - Minimally
   - Not at all

   Comments:

The most effective training methods were: (please check below)
- Illustrated lectures (presentations)
- Question and answer
- Large-group discussion
- Small-group work
- Role plays
- Case studies
- Games
- Other: _____________ (Please specify)

The least effective training methods were: (please check below)
- Illustrated lectures (presentations)
- Question and answer
- Large-group discussion
- Small-group work
- Role plays
- Case studies
- Games
- Other: _____________ (Please specify)
4. How well did the materials (session handouts in Participant Handbook, FP cue cards) distributed in the workshop contribute to your learning?

- Extremely Well
- Mostly
- Moderately
- Minimally
- Not at all

Comments:

Which materials were most useful?

*For the next two questions, please refer to your agendas for the names of the sessions (topics) in this workshop.*

5. Which three sessions were the *most* useful, and why?

a) 

b) 

c) 

6. Which three sessions were the *least* useful, and why?

a) 

b) 

c) 

7. What was the most important new information or skill you learnt?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

8. What knowledge or skill needs were not met?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Appendix G

9. What did you think about the length of the course?
_________________________________________________________
_________________________________________________________
_________________________________________________________

10. What did you think about the depth of the course topics? Please explain.
_________________________________________________________
_________________________________________________________
_________________________________________________________

11. Please check any of the following that you feel could have improved the workshop.
    _____ a. Use of more realistic examples and applications
    _____ b. More time to become familiar with theory and concepts
    _____ c. More time to practice skills and techniques
    _____ d. More effective group interaction
    _____ e. More effective training methods: __________ (please specify)
    _____ f. Concentration on a more limited and specific topic
    _____ g. Consideration of a broader and more comprehensive topic:
            ________________ (please specify)
    _____ h. Other: __________ (please specify)

Comments:
Appendix H

Provider Interview Form
Outcome Evaluation Using Provider Interviews

The true test of the success of family planning (FP) counseling training is whether the participants begin conducting such counseling at their service sites and how well they do it. This appendix and appendixes G and I offer tools for evaluating the outcome of this training through observation of client-provider interaction, interviews with providers, and anonymous interviews with clients. All three perspectives should be considered to get a complete picture of the possible impact of the training on providers and clients. As noted in the “Training Evaluation” section of the Introduction for Trainers and Program Planners, trainers should determine the evaluation plan with program planners and site administrators before conducting the course.

The Provider Interview Form gives a template for exploring the individual provider’s perspective on how well he or she has been able to apply what he or she learned in the training and on what challenges have been encountered. It is meant to complement the information provided in the Counseling Skills Observation Guide and to answer the question “Why not?” if the provider is not implementing FP counseling up to standards. It also requests suggestions for improving the training.

Who Can Conduct Outcome Evaluation?

Because competency in counseling is evaluated through observation of counseling and through interviews with participants and clients, such evaluations are necessarily somewhat subjective. To make the observation process as consistent as possible from one evaluation to another, the same individuals should conduct the evaluations each time, and these evaluators should be competent in the skills being evaluated. The trainers should not conduct the evaluations, although they can help orient local evaluators to the desired outcomes of the training.

When Should Provider Interviews Be Conducted?

Because provider interviews reflect on the providers’ experience following the training, it should only be carried out at the time of the posttraining observations.

Specific Instructions

- The evaluator should fill out one form for each provider interviewed.
- To encourage candor in the provider’s comments, the interviewer must maintain confidentiality. Therefore, the provider’s name should not be recorded on the form. The site name also should not be recorded on the form because there might be only one provider interviewed at any site, and this would allow the individual provider to be identified.
- The evaluator should compile a summary of the providers’ interviews after at least four have been conducted in at least two sites. The summary should be shared only with supervisors, site or program managers, and a representative of the training team. This should be explained to the provider before the interview is started.
Appendix H

If the provider answers Question 1 by saying he or she has “not found it appropriate to initiate reproductive health counseling with clients,” make notes on why this is so, and then skip to Question 5 and complete the rest of the interview. Questions 5 through 8 ask specific questions about problems that have been encountered, and these questions would definitely be relevant for a trainee who has not done any reproductive health (RH) counseling with clients.
Provider Interview Form

Interviewer: ___________________________________________ Date: ________________

Instructions

Obtain a copy of the participant’s action plan (from Session 26 of the training) ahead of time (for Question 7).

Introduce yourself. Explain the following points to the service provider:

• The purpose of the counseling training that you participated in was intended to improve your counseling skills to address the range of clients’ reproductive health (RH) needs and concerns.

• The purpose of this interview is to learn how you have been able to apply your training to the provision of RH services, the challenges you might have encountered in doing so, and how the training might be modified to better prepare participants for counseling tasks in RH service provision.

• Many of the questions are open-ended questions that enable you (the service provider) to share your responses and reactions without being confined to a predetermined range of answers.

• The results of this interview with you and other participants will be shared with program managers, supervisors, and trainers to make improvements at your work site and in the training itself. If there is only one trainee from your work site, it might be difficult (if not impossible) to ensure confidentiality. However, candor will be appreciated and will yield the most helpful responses.

Questions

Check off the service provider’s response to each question, or fill in with additional explanation, as appropriate.

1. What has been your experience in counseling clients using the REDI framework?

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

(If the provider has not yet used the REDI counseling framework, ask him or her to explain why not and go to Question 2.)

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________
Appendix H

2. What do you do to establish rapport and trust with clients?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

3. What has been the reaction of clients when you have initiated discussion on sexuality with them? (check as many as apply)
   a. Clients seem to have welcomed the discussions (have been open and interested in discussing their issues).
   b. Clients have seemed uncomfortable but have answered questions when asked.
   c. Clients have been mostly closed or resistant to discussing anything beyond the primary reason they came to the facility.

4. Consider the various areas of counseling that were emphasized in the training.
   a. Helping clients identify and address their individual FP/RH needs, including the social and sexual context
      • Describe your approach.
      _______________________________________________________________________
      _______________________________________________________________________
      _______________________________________________________________________
      • How effective do you feel this approach has been? Explain.
      _______________________________________________________________________
      _______________________________________________________________________
      _______________________________________________________________________
      • What obstacles have you encountered in using this approach?
      _______________________________________________________________________
      _______________________________________________________________________
      _______________________________________________________________________
      • What have you done when confronted by these obstacles? What support or assistance do you need?
      _______________________________________________________________________
      _______________________________________________________________________
b. Giving essential information to clients

- Describe your approach.

- How effective do you feel this approach has been? Explain.

- What obstacles have you encountered in using this approach?

- What have you done when confronted by these obstacles? What support or assistance do you need?

c. Helping clients perceive or determine their own and their partners’ risk of unintended pregnancy or HIV and other sexually transmitted infections (STIs)

- Describe your approach.

- How effective do you feel this approach has been? Explain.

- What obstacles have you encountered in using this approach?
Appendix H

- What have you done when confronted by these obstacles? What support or assistance do you need?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

d. Helping clients reduce their risk for HIV and other STIs
- Describe your approach.

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

- How effective do you feel this approach has been? Explain.

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

- What obstacles have you encountered in using this approach?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

- What have you done when confronted by these obstacles? What support or assistance do you need?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

e. Helping clients make their own decisions
- Describe your approach.

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

- How effective do you feel this approach has been? Explain.

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
• What obstacles have you encountered in using this approach?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

• What have you done when confronted by these obstacles? What support or assistance do you need?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

\textit{f. Helping clients implement their own decisions}

• Describe your approach.

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

• How effective do you feel this approach has been? Explain.

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

• What obstacles have you encountered in using this approach?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

• What have you done when confronted by these obstacles? What support or assistance do you need?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

\textit{g. Helping clients communicate with a partner about FP/RH issues or concerns}

• Describe your approach.

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
Appendix H

• How effective do you feel this approach has been? Explain.

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

• What obstacles have you encountered in using this approach?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

• What have you done when confronted by these obstacles? What support or assistance do you need?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

5. Remind the provider that the general objective of the training was to enable participants to carry out the following tasks:

- Effectively communicate with clients
- Assess clients’ individual FP needs, knowledge, and concerns, and fulfill their needs for information, services, and emotional support
- Identify the key decisions clients need to make or confirm, and assist them through this process by considering various options and their consequences
- Assist clients in carrying out their FP decisions, including making a plan for implementation and coping with side effects.

Ask him or her to consider the following questions in terms of his or her ability to carry out these tasks.

a. In what ways has REDI been useful in carrying out these counseling tasks (i.e., the tasks listed above)?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

b. What problems have you encountered in applying REDI?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
6. What types of clients, clients’ attitudes, or clients’ behaviors do you find most challenging in FP counseling?
   a. In what ways are they challenging to you?

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

   b. What do you do when confronted by these clients, attitudes, or behaviors?

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

7. How would you describe your progress in implementing your action plan?

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

   a. What obstacles have you encountered in implementing your action plan?

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

   b. What success have you had in overcoming these obstacles? What additional support or assistance do you need?

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

8. What suggestions do you have for improving the training to better prepare participants to carry out the tasks of integrated RH counseling?

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
Appendix I

Client Interview Form
Outcome Evaluation Using Client Interviews

The true test of the success of family planning (FP) counseling training is whether the participants begin conducting such counseling at their service sites and how well they are doing it. This appendix, along with Appendix E (Counseling Skills Observation Guide) and Appendix H (Provider Interview Form), and offers a tool for evaluating the outcome of this training through observation of client-provider interaction, interviews with providers, and anonymous interviews with clients. All three perspectives should be considered to get a complete picture of the possible impact of the training on providers and clients. As noted in the “Training Evaluation” section of the Introduction for Trainers and Program Planners, trainers should determine the evaluation plan with program planners and site administrators before conducting the course.

The Client Interview Form included here is to be used to gather feedback from clients about their perception of the quality of the counseling services they have received. Again, it is best used in conjunction with the Counseling Skills Observation Guide and Provider Interview Form.

Who Can Conduct Outcome Evaluation?

Because competency in counseling is evaluated through observation of counseling and through interviews with participants and clients, such evaluations are necessarily somewhat subjective. To make the observation process as consistent as possible from one evaluation to another, the same individuals should conduct the evaluations each time, and these evaluators should be competent in the skills being evaluated. The trainers should not conduct the evaluations, although they can help orient local evaluators to the desired outcomes of the training.

When Should Client Interviews Be Conducted?

Client interviews can be conducted both before and after the training, to get some sense of the clients’ perceptions of change over time. Because other factors might influence the quality of care and clients’ perceptions of it, changes in quality (from the client’s perspective) cannot be directly attributed to the training. However, these interviews might yield valuable insights into the client’s experience, which can be addressed in future trainings or training follow-up.

How Can This Information Be Used?

The results of this outcome evaluation can be used in many ways:

- **Program planners and administrators** will want to know whether the training had the desired effect on service delivery (i.e., establishing effective FP counseling services). If it did not, evaluations provide clues about what the barriers are and whether they are related to training or can be traced to other aspects of service delivery.

- **Providers** will want to know how clients respond to this approach to counseling and how they can improve their skills.

- **Trainers** will want to know whether their training approaches were effective in imparting appropriate knowledge, attitudes, and skills for effective FP counseling and how these approaches can be strengthened.
Appendix I

Specific Instructions

- The client’s name should not be recorded on the interview form, to maintain confidentiality and to encourage the client to be comfortable giving feedback that he or she might believe is critical of the provider or the service site.

- The site name *should* be recorded, however, because this feedback will be valuable to providers and supervisors at each site.

- The evaluator should compile a summary of the providers’ interviews after at least four have been conducted in at least two sites. Copies of this summary should be given to providers and supervisors at each site and to a representative of the training team.
Interviewer: ___________________________________________ Date: ________________

Site: _______________________________________________________________________

Instructions
Introduce yourself to the client and explain the following:

• You are interviewing clients about their experience in seeking and obtaining reproductive health and family planning services at this facility.

• The purpose of your interviewing clients is to get feedback about their perceptions of the quality of services they received. This will enable facility staff to continue to improve the quality of their services.

• In this context, you would like to ask the client some questions about the services he or she just received. The client’s answers will be “yes” or “no.” You will not be asking any questions about the client himself or herself.

• To help facility personnel improve, it is important that the client be frank about his or her impressions. The client’s feedback will be anonymous—that is, no names will be connected with his or her responses.

• Participation is completely voluntary, and their choice to participate or not will not affect their access to care at this facility.

• The client may refuse to answer any of the questions and may choose to stop participating at any time.

• Ask the client for his or her permission to be interviewed for this purpose.

• This will take about 15 to 20 minutes.

If the client agrees, proceed with the interview using the following questions. Record the client’s answers in the spaces provided. Check the column “NA” if the question is not applicable to the client you are interviewing.

<table>
<thead>
<tr>
<th>CLIENT INTERVIEW FORM</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>General skills and establishment of positive client-provider interaction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In general, did the staff with whom you met:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Show you respect (did not judge you, what you think, or what you have done)?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ensure your privacy in the consultation room?</td>
<td></td>
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</tr>
<tr>
<td>Talk in a language and use terms that you could easily understand?</td>
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<td></td>
</tr>
<tr>
<td>Ask you to repeat some of the explanations to reinforce your understanding?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listen to you without interrupting and show interest in what you had to say?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encourage you to talk about yourself and to ask questions?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Answer your questions clearly?</td>
<td></td>
<td></td>
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</tbody>
</table>
### Appendix I

<table>
<thead>
<tr>
<th>CLIENT INTERVIEW FORM (cont.)</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rapport building</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><em>Did the staff with whom you met:</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welcome you with kindness and with respect?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make you feel comfortable?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Introduce himself or herself?</td>
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<tr>
<td>Ask what he or she could do for you?</td>
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<tr>
<td>Explain why he or she would be asking sensitive and personal questions?</td>
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<tr>
<td>Assure you that whatever you said would not be shared with others?</td>
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<tr>
<td>Explain what would happen during the visit?</td>
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<tr>
<td><strong>Exploration</strong></td>
<td></td>
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<tr>
<td><em>Did the staff with whom you met:</em></td>
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<tr>
<td>Ask you about:</td>
<td></td>
<td></td>
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<tr>
<td>- Your sexual relationships?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- How you communicate with your partner (or partners) about sexuality, family planning, HIV, and other sexually transmitted infections (STIs)?</td>
<td></td>
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<tr>
<td>- Previous pregnancies and the outcomes of those pregnancies?</td>
<td></td>
<td></td>
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<tr>
<td>- Use of family planning methods, including condoms?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Own HIV and STI history</td>
<td></td>
<td></td>
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<tr>
<td>- Knowledge of your partner’s (or partners’) history of HIV or STIs?</td>
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<tr>
<td>Ask you what you know about:</td>
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<tr>
<td>- Family planning?</td>
<td></td>
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<tr>
<td>- HIV?</td>
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<td></td>
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<tr>
<td>- Other STIs?</td>
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<tr>
<td>Provide you with information about any of the above (as appropriate)?</td>
<td></td>
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<tr>
<td>Explain your possible risks for:</td>
<td></td>
<td></td>
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<tr>
<td>- HIV and other STIs?</td>
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<tr>
<td>Help you determine your (or your partner’s) risk for:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- HIV or other STI transmission?</td>
<td></td>
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<tr>
<td>Ask you about other health needs or concerns?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLIENT INTERVIEW FORM (cont.)</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----</td>
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</tr>
<tr>
<td><strong>Decision making</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><em>Did the staff with whom you met:</em></td>
<td></td>
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<tr>
<td>Explain the importance of making your own decisions?</td>
<td></td>
<td></td>
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<tr>
<td>Ask if you already made a decision?</td>
<td></td>
<td></td>
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<tr>
<td>Help you consider all of your options?</td>
<td></td>
<td></td>
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<tr>
<td>Help you consider the advantages and disadvantages of each option (including common side effects of family planning methods being considered)?</td>
<td></td>
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<tr>
<td>Help you consider how your partner or family might react to your choice of options?</td>
<td></td>
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<tr>
<td>Help you confirm or make the decision that you feel best fits your medical and personal circumstances?</td>
<td></td>
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<tr>
<td>Help you receive the service or method you wanted or understand why a different option would be considered better for you?</td>
<td></td>
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<tr>
<td><strong>Implementing the decision</strong></td>
<td></td>
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<tr>
<td><em>Did the staff with whom you met:</em></td>
<td></td>
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<tr>
<td>Encourage you to think about how you would put your decisions into practice?</td>
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<td></td>
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<tr>
<td>Ask you:</td>
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<tr>
<td>o How you would communicate your plan to your partner?</td>
<td></td>
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<tr>
<td>o Whom you could count on to support you in your decision?</td>
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<tr>
<td>o Who might create obstacles for you, and what you can do about that if it happens?</td>
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<tr>
<td>o To offer ideas for improving communication and negotiation with your partner?</td>
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<tr>
<td>Help you make an alternate plan if this one does not work out?</td>
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<tr>
<td>Demonstrate how to use a condom (if applicable) and have you repeat the demonstration to reinforce your understanding?</td>
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<tr>
<td>Give you samples of condoms and tell you where and how to obtain more?</td>
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<tr>
<td>Give clear instructions about how to use the medical treatment recommended for you or the family planning method that you chose?</td>
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<tr>
<td>Invite you back for a follow-up visit (for ongoing support with decision making, negotiation, or condom use, as appropriate)?</td>
<td></td>
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<td></td>
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<tr>
<td>Tell you about other services available elsewhere and how to access them?</td>
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</tr>
<tr>
<td>Were you happy with the service you received?</td>
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<td></td>
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<tr>
<td>Would you refer a friend or relative to this service provider?</td>
<td></td>
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</tr>
<tr>
<td>What other comments would you like to share that we have not covered in these questions?</td>
<td></td>
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</tbody>
</table>

Is there anything that the provider could have done differently to better meet your needs? (If the client says “yes,” ask for his or her suggestions and write those here.)
Appendix J

Contraceptive Technology Update (CTU)
(PowerPoint Presentation)
Contraceptive Technology Update (CTU): What’s New Out There, and What Are the Implications?

Roy Jacobstein, M.D., M.P.H.
EngenderHealth
James Shelton, M.D., M.P.H.
USAID
Our Challenge

“In health care, invention is hard, but dissemination is harder”* 

“Mastering the generation of good changes is not the same as mastering the use of good changes”*

Appendix J

Outline of Presentation

I. World Health Organization (WHO) evidence-based guidance for contraceptive use (Medical Eligibility Criteria)

II. Latest information/thinking/new developments about FP methods
Appendix J

WHO’s Evidence-Based Guidance for Contraceptive Use

I. Contraceptive Technology Update (CTU) (continued)
Medical Eligibility Criteria for Contraceptive Use (MEC, 2004)

- Covers 19 methods, 120 medical conditions
- ~ 1700 recommendations on who can use various contraceptive methods
- Gives guidance to programs and providers for clients with medical problems or other special conditions
- Informs national guidelines, policies, and standards with best available evidence
- Helps reduce medical policy and practice barriers
- Helps lead to improved quality and use of FP methods and services
What Question Is Answered by the MEC?

In the presence of a given condition or client characteristic (e.g., STIs or HIV and AIDS), can a particular FP method be used?

And with what degree of caution or restriction, as reflected in four classification categories or gradations based on risks/benefits?
### WHO Medical Eligibility Criteria, Classification Categories

<table>
<thead>
<tr>
<th>Classification Category</th>
<th>With Clinical Judgment</th>
<th>With Limited Clinical Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No restriction: Use method in any circumstances</td>
<td>Yes Use the method</td>
</tr>
<tr>
<td>2</td>
<td>Generally use: Benefits generally outweigh risks</td>
<td>Yes Use the method</td>
</tr>
<tr>
<td>3</td>
<td>Generally do not use: Risks outweigh benefits</td>
<td>No Do not use the method</td>
</tr>
<tr>
<td>4</td>
<td>Unacceptable health risk: Method is not to be used</td>
<td>No Do not use the method</td>
</tr>
</tbody>
</table>
II. New Findings and Thinking about Specific FP Methods
Methods to Be Considered:

1. Sterilization (female sterilization/vasectomy)
2. IUD
3. Implant
4. Injectable
5. Emergency contraception
6. Standard days method
1A. Female Sterilization
Female Sterilization

- Highly effective, comparable to vasectomy, implant, IUD
- Risk of failure (pregnancy), while low:
  - Continues for years after the procedure (18.5/1000 at 10 years; almost 2/100)
  - Does not diminish with time
  - Is higher in younger women
- No medical condition absolutely restricts a woman's eligibility for sterilization
1B. Vasectomy
No-Scalpel Vasectomy (NSV): Characteristics

- Small puncture; *vas deferens* is pulled through skin
- Very safe; few restrictions
- Minor complications (post-operative and chronic pain, infection and bleeding): 5-10%
- Less with NSV than with incisional technique
- Major morbidity/mortality rare
- No adverse long-term effects
- NSV not "new" (1972)—yet only got to 51% in U.S. in 2004
Vasectomy (cont.)

Effectiveness is comparable to female sterilization, implant, IUD.

Not effective immediately—WHO recommends use of back-up method for 3 months after procedure (i.e., no longer “... or 20 ejaculations”).

Failure (pregnancy) is commonly quoted at from 0.2–0.4%, but rates as high as 3–5% have been reported. This has counseling implications...
2. IUD (TCu 380A)
IUD: Effectiveness and Safety

■ Highly effective, comparable to sterilization
  – “Reversible sterilization”
    • 12–13 yrs with TCu (FDA labels for 10)
    • Cheaper and easier to provide than sterilization
    • Quickly and easily reversible, with immediate return to fecundability

■ Very safe for almost all women (including: postpartum, postabortion, or interval; breastfeeding; HIV-infected; young; nulliparous; women who cannot use hormonal methods)
IUD: Other Considerations

- More service cadres can provide (because it is nonsurgical)
- Good for both “spacers” and “limiters”
- Greater availability = greater choice
- Good option for HIV-positive women
- Most cost-effective method (after 2 years), yet …
- “The IUD has the worst reputation of all methods … except among those using it.”
Not Only Clients Have "Myths": Latest Evidence about Providers’ Concerns

The “Big Three” provider concerns:

1. Pelvic Inflammatory Disease (PID)
2. Infertility
3. HIV and AIDS

New evidence is reassuring

Challenge: “dissemination,” “acceptance,” appropriate behavior change by providers
Concern: Does IUD Cause PID?

- We know the IUD needs an accomplice—sexually transmitted organisms such as *Chlamydia* and *gonococcus* (i.e., PID is not caused by the device itself or by its string)

- 2 possible mechanisms, raises 2 questions:
  - Q 1: Risk from IUD insertion process? &/or
  - Q 2: Risk from postinsertion bacterial exposure (i.e., does having IUD in place facilitate later PID)?
Risk of PID: Very Low and Far Lower Than Many Providers Erroneously Believe

PID Incidence Rate by Time Since Insertion

Source: Farley et al, 1992, in FHI 2004
But What About Risk of PID in High-Prevalence STI Settings?

- Perhaps WHO data included only low-risk women? (study done in Thailand and Latin America)
- What about in low-resource settings, where STI testing is not feasible?
- But no prospective studies exist, thus we need to (can only) estimate risks
Modeling the Attributable Risk*

High-Risk Setting of 10% Cervical Infection

**Simple Screening Questions**

- Only 1 in 667 would get PID from IUD (1.5 cases/1000) 0.15%

**No Screening**

- Only 1 in 333 would get PID from IUD (3 cases/1000) 0.30%

* Shelton, Lancet 2001
Summary: Emerging View on IUD and PID

- Insertion process, due to presence of sexually transmitted bacteria, increases short-term risk of PID in some women (those at high risk of STIs)
- IUD does not appear to facilitate development of PID in postinsertion period
- Overall risks are very small
- Even in high-STI settings, risks appear small (and much smaller than typically believed)
- Our challenge: These facts are not widely known; and it is hard to change preexisting “truths.”
Concern: Does IUD Use Cause Infertility?
Evidence: IUD Not Associated with Infertility*

- Mexico study of nulligravid infertile and primigravid women: no difference
- Similar patterns of previous Cu-IUD use
- Blood tests for chlamydial antibodies: Infertile women—twice the % of antibodies
- Thus, real infertility “culprit” is not IUD but Chlamydia trachomatis (and gonococcus)
- IUD and infertility link: *immeasurable* and “not of public health significance”

Contraceptive Technology Update (CTU) (continued)

Concern: Is IUD Use by HIV-Infected Women Safe? Evidence: Yes

- Cohort studies in Kenya
- Compared HIV-infected and noninfected women using IUDs
- Findings: Same low rates of overall (7–10%) and infectious (0.2–2%) complications
- Conclusion: HIV does not appear to increase risk of IUD-related adverse events, inc. PID

Morrison et al., *Br J Obstet Gynaecol* 2001
Concern: IUD in HIV-Positive Woman Might Raise Risk for HIV-Negative Male Partner

- Ancillary study to Kenyan cohort
- Asks: Does presence of IUD increase cervical shedding of HIV? (Increased shedding is a proxy for increased risk of being infective.)
- Finds cervical shedding of HIV is not increased with IUD use
- Inferential conclusion: IUD use by HIV-positive women appears safe for HIV-negative partner

Richardson et al., *AIDS* 1999
## Changes in the WHO MEC for Use of Copper IUD in HIV/AIDS Clients

<table>
<thead>
<tr>
<th>HIV/AIDS</th>
<th>2nd Ed. Category</th>
<th>2004 Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Risk of HIV</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>HIV-infected</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>AIDS</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Clinically well on ARV therapy</td>
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<td>2</td>
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</tbody>
</table>
### Overview: Current (2004) Medical Eligibility Criteria for IUD Use in Clients with STIs or HIV/AIDS

<table>
<thead>
<tr>
<th>Category</th>
<th>Initiation</th>
<th>Continuation</th>
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<td>3</td>
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</table>

- **Increased general risk of STI (high prevalent setting)**
- **High individual risk of STI**
- **Current chlamydial or GC infection, or purulent cervicitis**
- **HIV positive**
- **AIDS**
- **AIDS and clinically well on ARV**
Progesterone-Releasing Intrauterine Systems (IUS)

- Mirena®—continuous release of a small amount of the progestin, levonorgestrel (same hormone in Norplant and Jadelle)
- Effective 5 years; failure rate in 1 year: ~0.1–0.2%
- Same benefits and side effects of progestins
- May reduce menstrual cramps and flow
- Reduced flow may reduce iron deficiency anemia
- Foundations considering supporting it
- USAID: too expensive, trying to develop generic
Appendix J

3. Implant (Norplant, Jadelle, Implanon)
Norplant vs. Jadelle vs. Implanon

**Norplant (6 capsules)**
- 216 mg LNG

**Jadelle (2 rods)**
- 150 mg LNG

**Implanon (1 rod)**
- 68 g etonogestrel (ENG, 3-ketodesogestrel)

---

**Silastic medical adhesive**

**Silastic tubing**

**Levonorgestrel**
- 36 mg free crystals
- 75 mg crystals in silicone copolymer

**EVA copolymer rod covered by a thin EVA membrane**

**68 mg ENG embedded in EVA copolymer**

34 mm

43 mm

2.4 mm
Comparison of Norplant®, Jadelle®, and Implanon®

Norplant®
- 6 capsules
- Effective 7 yrs
- 1-yr. failure: 0.05% (1 in 20,000); 5-yr. failure 1.6%
- Regulatory approval in 62 countries
- Insertion time: 4.3 min (0.8–18.0)
- Removal time: 10.2 min (1.3–50m)
- Cost: $27

Jadelle®
- 2 rods
- Effective 5 years
- 1-yr. failure: 0.05% (1 in 20,000); 5-yr. failure 1.1%
- Regulatory approval in 11 countries
- Insertion time: 2 min
- Removal time: 4.9 min ± 3.5 minutes
- Cost: $29

Implanon®
- 1 rod
- Effective 3 years
- Regulatory approval in 25 countries
- Insertion time: 1.1 min (0.03–5.0)
- Removal time: 2.6 min (0.2–20.0)
- Cost: comparable; AID RFA out now

[Sinoplan: $5]
4. Injectable
Injectable: Names, Lengths, Content

- Progestin-only injectables:
  - Depot-medroxyprogesterone acetate (DMPA; Depo-provera; Megestron®)
    - 150 mg given intramuscularly every three months
    - also subcutaneous formulation, lower dose (104 mg); CBD ...
  - NET-EN: norethindrone (or norethisterone) enanthate, Noristerat®) given every two months

- Combined injectable contraceptives (progestin plus estrogen)—given monthly:
  - Cyclofem® (MPA, 25 mg plus estradiol, 5 mg)
  - Mesigyna® (50 mg Norethindrone enanthate, plus 5 mg estradiol)
Depo-Provera

- Women of any age and parity can use it (MEC Cat. 1, age 18–45; Cat. 2, if younger or older)
- Start first 7 days after LMP, or can use any time reasonably sure woman not pregnant
- Usable immediately postpartum if not breastfeeding; or 6th week postpartum if breastfeeding
- Usable immediately postabortion
- No association of Depo use with HIV acquisition (2005, FHI/NICHD Study)
- Bone density: WHO consultation, July 2005
Contraceptive Technology Update (CTU) (continued)

Depo in CBD

- Important growth area for contraception
- FHI/STC study in Uganda with CRHWs
  - Comparing CRHWs vs. nurses in clinics
  - Quality similar
  - Second injection slightly better for CRHWs
Appendix J

Depo in Unject (continued)
5. Standard Days Method (SDM)  

Simple Fertility-Based Awareness-Based Approach to Family Planning
Determining the Fertile Window

Day 8

Day 19
Standard Days Method

- Identifies days 8–19 of the cycle as fertile
- Is appropriate for women with menstrual cycles between 26 and 32 days long
- Helps a couple plan or prevent pregnancy by knowing which days they should or should not have unprotected sex
Standard Days Method

Is used with CycleBeads®, a color-coded string of beads that can help a woman:

- Track her cycle days
- Know when she is fertile
- Monitor her cycle length
## Contraceptive Failure of User-Directed Methods

### % of women who became pregnant during 1st year of use

<table>
<thead>
<tr>
<th>Method</th>
<th>Correct Use</th>
<th>Typical Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Method</td>
<td>85</td>
<td>85</td>
</tr>
<tr>
<td>Spermicides</td>
<td>18</td>
<td>29</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Condom</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Oral Contraceptive</td>
<td>0.3</td>
<td>8</td>
</tr>
<tr>
<td>Standard Days Method</td>
<td>5</td>
<td>12</td>
</tr>
</tbody>
</table>

Source: Adapted from Contraceptive Technology, 18th edition, 2004
Contraceptive Technology Update (CTU) *(continued)*

SDM - What does it cost?

- Less expensive than most other methods (only IUD is less per CYP)*
- Counseling takes about 20 minutes
- Training: in-service contraceptive updates, preservice curricula
- USAID working with manufacturer to ensure best price, efficient procurement and delivery for CycleBeads
- CycleBeads can be included in IEC budgets for bilaterals, centrally funded projects
- Technical assistance from AWARENESS (Georgetown Institute for Reproductive Health)

6. Emergency Contraception (EC)
What Is Emergency Contraception (EC)?

- Method of preventing pregnancy after unprotected sexual intercourse
- Mechanism of action: Predominantly and probably only affects ovulation.
- Hormones of regular oral contraceptives, used:
  - In a special higher dosage
  - Within 120 hours (5 days) of unprotected sex
- EC pills (ECPs) do not interrupt an established pregnancy
- (IUDs can also be used for up to 7 days after unprotected sex)
- Not RU-486
Types of ECPs

- **Progestin-only OCs** – in preferred regimen, **one dose** of 1.5 mg levonorgestrel (or can be in 2 doses of 0.75mg, 12 hrs apart) _88% reduction in risk_ (1/100 will get pregnant); less side effects (nausea and vomiting) than with COCs, 6% vs 23%

- **Combined OCs**: 2 doses of pills containing ethinyl estradiol (100 mcg) & levonorgestrel (0.5 mg) _taken 12 hrs apart _75% reduction in risk_ (2/100 vs. 8/100 will get pregnant)
ECPs Are Most Effective When Taken Early

Percentage of pregnancies prevented

- **up to 24 hours***: Progestin-only
- **25-48 hours***: Progestin-only, Combined
- **49-72 hours***: Progestin-only, Combined

* Timing refers to when regimen initiated