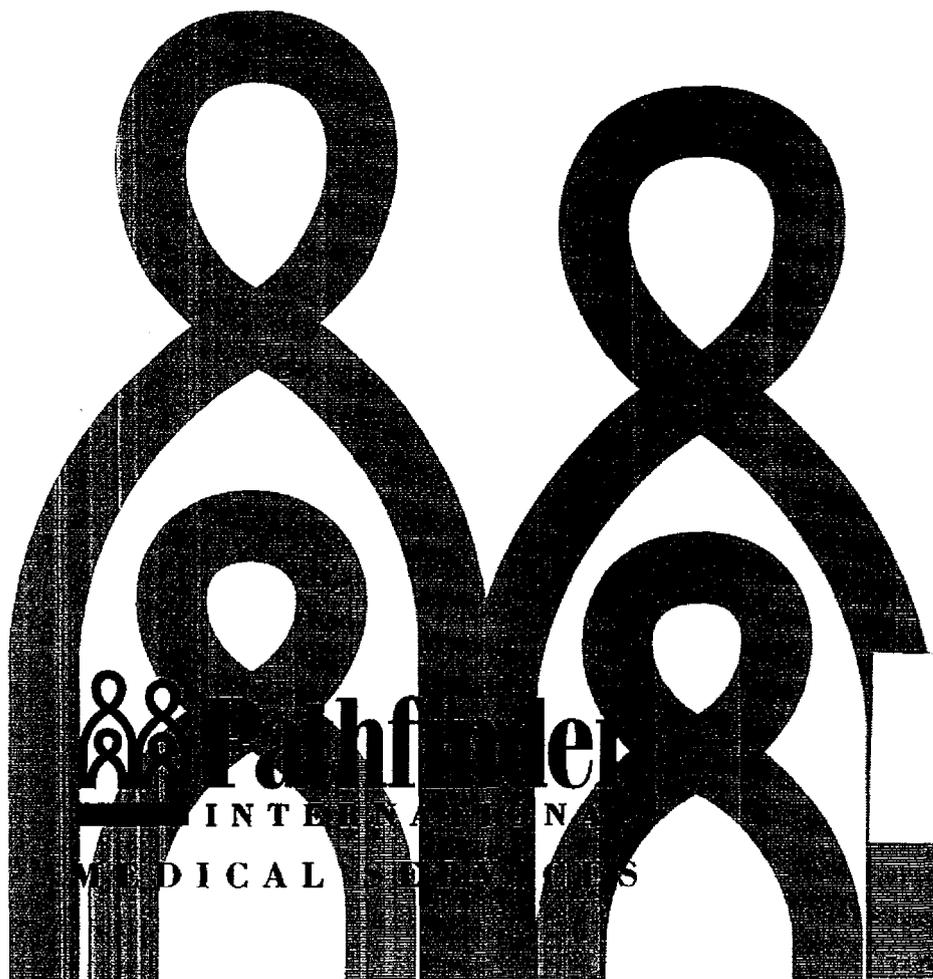


- PN-ART-647-

A comprehensive training course



Spide

Comprehensive
Reproductive Health and Family Planning
Training Curriculum

**MODULE 6:
DMPA INJECTABLE
CONTRACEPTIVE**

Cathy Solter
Medical Services
Pathfinder International
August 1996

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The entire comprehensive training curriculum was used to train service providers in 1995 under this cooperative project which included Pathfinder International, IPAS, AVSC International, and the Vietnamese Ministry of Health. Individual modules were used to train service providers in Nigeria (DMPA), Azerbaijan (VSC), Kenya (Infection Prevention), and Iran (VSC). Feedback from these trainings has been incorporated into the training curriculum to improve its content, training methodologies, and ease of use.

The process for this development of this DMPA module began with the reintroduction of DMPA in the Philippines in 1994. The Philippines Department of Health and colleagues set an example of how a systematic, well thought-out strategy, using well developed training materials that stressed counseling and were barrier-free, could successfully introduce an injectable as a part of the contraceptive method mix. After its use as part of the comprehensive curriculum in Vietnam, the DMPA module was modified to include NET-EN and was used to train 2,800 service providers as part of a social marketing project in collaboration with Population Services International and the Society for Family Health in 1996 in Nigeria.

With the help of colleagues at Pathfinder International, this curriculum has been improved, expanded, and updated to its present form. Thanks are due to: Douglas Huber and Betty Farrell, who provided technical support and input; Penelope Riseborough, who provided technical editing and guidance on printing and publication; Tim Rollins, who designed, formatted, and edited the document, and coordinated the process; Anne Read, who designed the cover; and Joan DeLuca, who entered hundreds of corrections and reproduced millions of corrected pages. Participants in the Reproductive Health Project, and the development of this curriculum for its initial use in Vietnam, include the following:

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NOTES TO THE TRAINER

PURPOSE

This training manual is designed for use as part of the comprehensive family planning and reproductive health training of service providers. It is designed to be used to train physicians, nurses and midwives.

This manual is designed to actively involve the participants in the learning process. Thus, sessions include simulation skills practice, case studies, role plays, discussions, and clinical practice, using objective knowledge, attitude, and skills checklists.

DESIGN

The training manual consists of 15 modules:

1. Introduction/Overview
2. Infection Prevention
3. Counseling
4. Combined Oral Contraceptives and Progestin-only Pills
5. Emergency Contraceptive Pills
6. DMPA Injectable Contraceptives
7. Intrauterine Devices
8. Lactational Amenorrhea and Breastfeeding Support
9. Condoms and Spermicides
10. Voluntary Surgical Contraception
11. MVA for Treatment of Incomplete Abortion
12. Reproductive Tract Infections
13. Postpartum/Postabortion Contraception
14. Training of Trainers
15. Quality of Care

Included in each module is a set of knowledge assessment questions, skills checklists, trainer resources, participant materials, training evaluation tools, and a bibliography.

SUGGESTIONS FOR USE

- The modules are designed to provide flexibility in planning, conducting, and evaluating the training course.
- The curriculum is designed to allow trainers to formulate their own training schedule, based on results from the training needs assessments.
- The modules can be used independently of each other.
- The modules can also be lengthened or shortened depending on the level of

training and expertise of the participants.

- In order to foster changes in behavior, learning experiences have to be in the areas of knowledge, attitudes, and skills. In each module, the overall objective, general, and specific objectives are presented in terms of achievable changes in these three areas.
- Training references and resource materials for trainers and participants are identified.
- The training design section includes the content to be covered and the training methodologies to be used.
- Additionally, a section of the *Notes to the Trainer* contains a discussion of the effective use of demonstration/return demonstration in training.
- Each module is divided into a *Trainer's Module* and an *Appendix* section.
- The *Trainer's Module* presents the information in two columns:
 1. *Content*: This section contains the necessary technical information.
 2. *Training/Learning Methods*: This section contains the training methodology (i.e., lecture, role play, discussion, etc.) used to convey the technical information most effectively.
- The *Appendix* section contains:
 1. a Participant Reaction Form
 2. Pre- and Post-tests
 3. Participant Handouts
- The *Participant Handouts* are referred to in the *Training/Learning Methods* sections of the curriculum and include a number of different materials and exercises, ranging from recapitulations of the technical information from the *Content* of the module to role play descriptions, skills checklists, and case studies.
- The *Participant Handouts* should be photocopied for the trainees and distributed to them in a folder or binder to ensure that they are kept together as a technical resource after the training course has ended.
- Transparencies have been prepared where they are called for in the text. These should be copied onto clear overheads for display during the training sessions.
- The *Participant Reaction Form* should also be copied to receive the trainees' feedback in order to improve future training courses.

To ensure appropriate application of learning from the classroom setting to clinical practice, Clinical Practicum sessions are an important part of this training. For consistency in the philosophy of client's rights, the following should be shared with participants, in preparation for their clinical practicum experiences:

CLIENT'S RIGHTS DURING CLINICAL TRAINING

The rights of the client to privacy and confidentiality should be considered at all times during a clinical training course. When a client is undergoing a physical examination it should be carried out in an environment in which her/his right to bodily privacy is respected. When receiving counselling, undergoing a physical examination, or receiving surgical contraceptive services, the client should be informed about the role of each individual inside the room (e.g., service provider, individuals undergoing training, supervisors, instructors, researchers, etc.).

The client's permission must be obtained before having a clinician-in-training/participant observe, assist with or perform any services. The client should understand that s/he has the right to refuse care from a clinician-in-training/participant. Furthermore, a client's care should not be rescheduled or denied if s/he does not permit a clinician-in-training/participant to be present or provide services. In such cases, the clinical trainer or other staff member should perform the procedure. Finally, the clinical trainer should be present during any client contact in a training situation.

Clinical trainers must be discreet in how coaching and feedback are given during training with clients. Corrective feedback in a client situation should be limited to errors that could harm or cause discomfort to the client. Excessive negative feedback can create anxiety for both the client and clinician-in-training.

It can be difficult to maintain strict client confidentiality in a training situation when specific cases are used in learning exercises such as case studies and clinical conferences. Such discussions always should take place in a private area, out of hearing of other staff and clients, and be conducted without reference to the client by name (AVSC, "Tips for Trainers-8," September 1994; **NSV Trainer's Manual**).

DEMONSTRATION TECHNIQUE

The Five-Step Method of Demonstration and Return Demonstration is a training technique useful in the transfer of skills. The technique is used to make sure that participants become proficient in certain skills. It can be used to develop skills in IUD insertion, pill dispensing, performing a general physical examination, performing a breast or pelvic examination, etc. In short, it can be used for any skill which requires a demonstration. The following are the "five steps."

1. **Overall Picture:** Provide participants with an overall picture of the skill you are helping them develop and a skills checklist. The overall picture should include why the skill is necessary, who needs to develop the skill, how the skill is to be performed, etc. Explain to the participants that these necessary skills are to be performed according to the steps in the skills checklist, on models in the classroom and practiced until participants become proficient in each skill and before they perform them in a clinical situation.
2. **Trainer Demonstration:** The trainer should demonstrate the skill while giving verbal instructions. If an anatomical model is used, a participant or co-trainer should sit at the head of the model and play the role of the client. The trainer should explain the procedure and talk to the role playing participant as s/he would to a real client.
3. **Trainer/Participant Talk-Through:** The trainer performs the procedure again while the participant verbally repeats the step-by-step procedure.

Note: The trainer does **not** demonstrate the wrong procedure at any time. The remaining participants observe the learning participant and ask questions.

4. **Participant Talk-Through:** The participant performs the procedure while verbalizing the step-by-step procedure. The trainer observes and listens, making corrections when necessary. Other participants in the group observe, listen, and ask questions.
5. **Guided Practice:** In this final step, participants are asked to form pairs. Each participant practices the demonstration with their partner. One partner performs the demonstration and talks through the procedure while the other partner observes and critiques using the skills checklist. The partners should exchange roles until both feel competent. When both partners feel competent, they should perform the procedure and talk-through for the trainer, who will assess their performance using the skills checklist.

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UNIT 1: DMPA AS A METHOD

INTRODUCTION:

Depot Medroxyprogesterone Acetate (DMPA; Trade Name: Depo-Provera; the Upjohn Company) is a highly effective reversible contraceptive method. DMPA is approved for use in more than 100 countries, and more than 10 million couples throughout the world use an injectable contraceptive. This training course is designed to prepare providers to safely administer DMPA to family planning clients.

UNIT TRAINING OBJECTIVE:

To prepare providers to safely provide injectable hormones in a clinic or community-based service delivery setting.

SPECIFIC LEARNING OBJECTIVES:

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

1. Discuss the characteristics of DMPA.
2. State the effectiveness and safety of DMPA as compared to other methods.
3. Discuss the mechanism of action of DMPA.
4. Enumerate at least five advantages and five disadvantages of DMPA.
5. Name at least three non-contraceptive benefits of DMPA.
6. Name at least three indications for the use of DMPA.
7. Identify the precautions and other considerations to the use of DMPA.
8. List the common side effects of DMPA as well as possible complications.
9. Discuss the timing of the first injection.

SIMULATED SKILL PRACTICE:

- Timing of Injection

CLINICAL PRACTICUM OBJECTIVES:

During the clinical practicum, participants will be able to:

- Conduct counseling for injectable hormone use,
- Inject clients with an injectable hormone using aseptic technique, and
- Complete MIS forms for injectable hormone provision.

TRAINING/LEARNING METHODOLOGY:

- Lecturette and Discussion
- Brainstorming through use of flash cards

MAJOR REFERENCES AND TRAINING MATERIALS:

- Philippine Family Planning Program: The Family Planning Service, Training for Service Providers on Provision of DMPA as a Contraceptive Method, DOH/UNFPA, 1994.
- Lande, R., "New Era for Injectables," Population Reports, Series K, Number 5, Baltimore, August 1995.
- Liskin, L.S. and Quillin, W.F. "Long-acting progestins: promise and prospects." Population Reports, Series K, Number 2, Baltimore, May 1983.

RESOURCE REQUIREMENTS:

- Overhead projector
- Transparencies and pens
- Newsprint paper
- Marking pens
- Tape
- Flashcards (5" by 15")

EVALUATION METHODS:

- Pre-test

TIME REQUIRED: 3 hours

MATERIALS FOR TRAINERS TO PREPARE IN ADVANCE:

1. Transparencies on:
 - Unit Objectives (Transparency 1.1)
 - Characteristics of DMPA (Transparency 1.2)
 - Effectiveness (Transparency 1.3)
 - Safety (Transparency 1.4)
 - Precautions and Other Considerations (Transparency 1.5)
2. Participant Handouts
3. Copies of pre-test and post-test for each participant.
4. Slips of paper with the following topics written on them:
 - Advantages of DMPA
 - Disadvantages of DMPA
 - Indication for the use of DMPA
 - Non-contraceptive benefits of DMPA

Unit 1: Introduction

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Specific Objectives</p> <ol style="list-style-type: none"> 1. Discuss the characteristics of DMPA. 2. State the effectiveness and safety of DMPA as compared to other methods. 3. Discuss the mechanism of action of DMPA. 4. Enumerate at least 5 advantages and 5 disadvantages of DMPA. 5. Name at least 3 non-contraceptive benefits of DMPA. 6. Name at least 3 indications for the use of DMPA. 7. Identify the precautions and other considerations to the use of DMPA. 8. List the common side effects of DMPA as well as possible complications. 9. Discuss the timing of the first injection. 	<p>Administer the pre-test. Upon review of responses, note units and objectives requiring specific attention.</p> <p>To introduce Unit 1, display transparency on "Specific Objectives." Discuss each objective with participants (Px).</p> <p>Distribute flash cards and ask Px to write down their experiences (what they have seen or heard) with DMPA. Ask Px to display flash cards containing their experiences on one side of the board.</p>

Specific Objective #1: Discuss the characteristics of DMPA.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Characteristics of DMPA</p> <p>DMPA or medroxyprogesterone acetate (also called Depo-Provera) is a three month injectable contraceptive containing a synthetic progestin which resembles the female hormone progesterone. Each dose contains 150 mg of the hormone, which is released slowly into the blood stream from the site of intramuscular injection and provides the client/user with a safe and highly effective form of contraception.</p>	<p>Discussion (45 min.):</p> <p>Using a transparency, discuss the nature, effectiveness and safety of DMPA.</p> <p>Show a sample of DMPA.</p> <p>Encourage Px to ask questions.</p>

Specific Objective #2: State the effectiveness and safety of DMPA as compared to other methods.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Effectiveness of DMPA</p> <p>DMPA is a highly effective contraceptive method. With a standard regimen, pregnancy rates are usually lower than one per 100 woman years for DMPA (see Population Reports, "New Era for Injectables," K-5, August 1995). Injectables are comparable in effectiveness to Norplant® implants, TCU 380A IUD, and voluntary sterilization.</p> <p>Unplanned pregnancies are rare because injectables suppress ovulation in the great majority of cycles and because a woman needs only to obtain the next injection at the right time in order to assure continued effectiveness. Since DMPA does not require daily use there is less chance for user error. The standard regimen is 150 mg given every three months.</p> <p>Several different regimens of DMPA have been used. In a recent randomized trial of two DMPA doses, none of the women receiving the standard 150 mg dose conceived, but the pregnancy rate among women receiving 100 mg every three months was only 0.44 per 100 woman-years (n=268). With higher doses and a longer injection interval—250 to 450 mg every six months—pregnancy rates have ranged from 0 to 3.6 per 100 woman-years. The only standard regimen currently in use is 150 mg given every three months.</p>	<p>(See Px Handout 1.1.)</p>

Specific Objective #2: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Note: <i>Using the correct technique so the dose will be absorbed at the correct rate is critical to contraceptive effectiveness. The DMPA vial must be shaken to suspend the DMPA in the solution, but not so vigorously that the liquid becomes frothy. The injection must be aseptically given deep into the muscle and the injection site should not be massaged because this accelerates absorption.</i></p> <p>Safety of DMPA</p> <p>DMPA is a very safe contraceptive. Like other progestin-only contraceptives, it can be used by women who want a highly effective contraceptive, including women who are breastfeeding or who are not eligible to use estrogen-containing combined oral contraceptives. More than 10 million couples throughout the world are using an injectable contraceptive in more than 100 countries.</p> <p>The United States Food and Drug Administration (USFDA) approved DMPA for contraceptive use in October 1992. Studies by the World Health Organization (WHO) give reassurance that DMPA presents no overall risks for cancer, congenital malformations, or infertility. This research has evaluated more than 3 million woman-months of DMPA use. The research found:</p> <ul style="list-style-type: none"> • DMPA, like oral contraceptives, exerts a strong protective effect against endometrial cancer. • No overall increased risk of breast cancer with DMPA use. 	<p>(See Px Handout 1.2.)</p>

Specific Objective #2: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Safety (cont.)</p> <ul style="list-style-type: none"> • No relation between ovarian cancer and the use of DMPA. (Researchers had expected that DMPA would protect women against ovarian cancer as oral contraceptives do.) • DMPA was not found to affect the risk of developing liver cancer in areas where hepatitis B is endemic. <p>Further research results include:</p> <ul style="list-style-type: none"> • DMPA does not appear to increase a woman's risk of developing invasive cervical cancer, even after a period of 10 years. • DMPA does not cause any clinically significant changes in blood pressure or on the coagulation of the fibrinolytic system affecting thrombosis. • Studies of "in utero exposure to DMPA" found no differences in the health, growth, sexual development, aggression, physical activity, or sex role identity of teenage children exposed in utero to DMPA as compared to other children. • The use of DMPA does not permanently inhibit fertility, although it takes a woman four months longer to become pregnant after discontinuing DMPA than after discontinuing COCs, IUDs, or barrier methods. <p>Note: WHO studies have reported a small increased risk of cancer in young women who were using DMPA, however it is not clear whether or not the studies were biased due to methodological problems. The risk for breast cancer in young women is very low; therefore, no special precaution is needed.</p>	

Specific Objective #3: Discuss the mechanism of action of DMPA.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Primary Mechanism of Action</p> <p>1. <u>Inhibits Ovulation</u> - After a 150 mg injection of DMPA, ovulation does not occur for at least 14 weeks. Levels of the follicle stimulating hormone (FSH) and luteinizing hormone (LH) are lowered and an LH surge does not occur.</p> <p>Secondary Mechanisms of Action</p> <p>2. <u>Thickens the Cervical Mucus</u> - the cervical mucus becomes thick, making sperm penetration difficult.</p> <p>3. <u>Thins the Endometrial Lining</u> - As a result of the high progestin and low estrogen levels, the endometrium changes, making it unfavorable for implantation. However, due to the changes in the cervical mucus and anovulation, fertilization is extremely unlikely to occur.</p>	<p>Discussion (10 min.):</p> <p>Ask for a volunteer to discuss how DMPA prevents pregnancy. Discuss each mechanism of action to supplement the response of the Px.</p> <p>(See Px Handout 1.3.)</p>

Specific Objective #4: Enumerate at least 5 advantages and 5 disadvantages of DMPA.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Advantages of DMPA</p> <ul style="list-style-type: none"> • Highly effective • Safe • Long acting (three months) • Protects against endometrial and possibly ovarian cancer • Does not interfere with sexual intercourse • One of the most private and confidential methods • Convenient and easy to use (does not require a daily routine or supplies) • Not user dependent • Can be provided by a non-physician • Completely reversible (an average of 4 months delay in return to fertility after discontinuing DMPA) • Suitable for women who are not eligible to use an estrogen containing contraceptive • Suitable for breastfeeding women (after 6 weeks postpartum) • Provides immediate postpartum (in non-breastfeeding women) or postabortion contraception • Reduces the risk of pelvic inflammatory disease • Provides protection against anemia (hemoglobin levels rise in most women) • The prolonged absence of menses is an advantage for many women • May be used by women at any age or parity if they are at risk of pregnancy • Protects against ectopic pregnancy since ovulation does not occur • Reduces the symptoms of endometriosis (DMPA is sometimes used to treat endometriosis) 	<p>Group Exercise (10 min.):</p> <p>Divide Px into small groups. Ask a representative of each group to pick a piece of paper with a topic on it, which the group will discuss and prepare to present. (Use this activity with advantages of DMPA, disadvantages of DMPA, indications for the use of DMPA, and the non-contraceptive benefits of DMPA.)</p> <p>Plenary (20 min.):</p> <p>Ask groups to present their outputs. Summarize the output of each group and supplement as needed.</p> <p>(See <i>Px Handout 1.4.</i>)</p>

Specific Objective #4: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Disadvantages of DMPA</p> <ul style="list-style-type: none"> • There are menstrual changes for almost all women. Irregular, prolonged bleeding, or spotting usually occurs during the first two to six months of use. Bleeding diminishes and usually stops after nine to twelve months of use. Over half the women using DMPA will experience amenorrhea within twelve months of use. Amenorrhea can be an advantage if women are fully informed that this is not harmful. • Increased appetite causing weight gain for some women (0.5 kg, on the average, in the first year). • Delay in return of fertility after discontinuing DMPA. Pregnancy is delayed four months longer than after discontinuing other contraceptives, such as oral contraceptives or IUDs. This is because residual levels of DMPA exist for several months after the end of the contraceptive protection from the last injection. DMPA is completely reversible and does not cause infertility. • Since DMPA is long acting, it cannot easily be discontinued or removed from the body if a complication occurs or if pregnancy is desired. • DMPA does not provide protection against STDs/HIV. 	<p>(See Px Handout 1.5.)</p>

Specific Objective #5: Name at least 3 non-contraceptive benefits of DMPA.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Non-contraceptive Benefits of DMPA</p> <ul style="list-style-type: none"> • Reduces frequency of fibroids • Reduces frequency of ovarian cysts • Protects against ectopic pregnancy (since ovulation does not occur) • Reduces the incidence of pelvic inflammatory disease • Relieves premenstrual tension • Prevents anemia caused by blood loss or deficiency (hemoglobin levels rise in most women) • It reduces the symptoms of endometriosis (DMPA is sometimes used to treat endometriosis) • Reduces sickle-cell crises in women with sickle-cell anemia • Decreases the frequency of epileptic seizures in women with epilepsy 	<p>See Specific Objective #4 (page 9)</p>

Specific Objective #6: Name at least 3 appropriate users of DMPA.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Appropriate Users of DMPA</p> <p>DMPA is appropriate for any woman who:</p> <ul style="list-style-type: none"> • Desires an effective long-acting, reversible contraceptive. • Prefers a method that does not require any preparation before intercourse. • Wants a convenient method. • Is breastfeeding and wants to use a hormonal method. • Does not want partners or others to know she is using a contraceptive method. • Desires the convenience of not having to keep contraceptive methods at home. • Has problems of compliance with oral contraceptives. • Cannot use an estrogen-containing contraceptive. • Has completed her family size, but does not desire sterilization. 	<p>See Specific Objective #4 (page 9)</p> <p>(See <i>Px Handout 1.6.</i>)</p>

Specific Objective #7: Identify the precautions and other considerations to the use of DMPA.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Precautions and Other Considerations</p> <p>There is only one primary precaution to the use of DMPA:</p> <ul style="list-style-type: none"> • Pregnancy, either known or suspected (This means do not give DMPA.) <p>There are secondary precautions to the use of the method:</p> <ul style="list-style-type: none"> • Undiagnosed abnormal vaginal bleeding • Breast cancer, known or suspected • Amenorrhea not related to pregnancy or lactation • Heart disease • Acute liver or gallbladder disease <p>(This means the client should be referred to a physician for further evaluation.)</p> <p>There are several other considerations to the use of DMPA:</p> <ul style="list-style-type: none"> • Diabetes Mellitus • Hypertension <p>(This means DMPA may be given, but the client should be followed more closely.)</p> <p>Note: Women who are breastfeeding should wait until 6 weeks postpartum before using DMPA.</p>	<p>Discussion (30 min.):</p> <p>Show a transparency of the contraindications, precautions and other considerations to the use of DMPA and discuss them.</p>

Specific Objective #8: List the common side effects of DMPA as well as possible complications.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Common Side Effects</p> <p>The following are side effects sometimes associated with DMPA. (The management of these side effects will be covered in Unit 2.)</p> <ul style="list-style-type: none"> • Spotting and light bleeding • Moderate bleeding • Amenorrhea • Weight gain <p>In rare cases, women may experience:</p> <ul style="list-style-type: none"> • Headaches • Mood changes • Nausea • Abdominal bloating • Breast tenderness <p>Complications</p> <p>In rare cases, heavy bleeding may occur.</p>	<p>Discussion (30 min.):</p> <p>Refer to the flash cards you placed on the board earlier. If they include any side effects, refer to these. Otherwise, ask Px to enumerate and discuss possible side effects. Supplement as needed.</p> <p>(See <i>Px Handout 1.7.</i>)</p>

Specific Objective #9: Discuss the timing of the first injection.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Timing of the First Injection</p> <p>Q. When can DMPA be given? (Note: Please see Px Handout 1.9: <i>How to Be Reasonably Sure the Woman is Not Pregnant</i>)</p> <p>A. DMPA may be given at any time when the woman is not pregnant:</p> <ul style="list-style-type: none"> • During the first seven days after the start of menses. • Immediately or within 14 days following a spontaneous or induced abortion (immediately following abortion is generally preferred for the woman's convenience). • Immediately postpartum or up to 28 days after delivery if the woman is not breastfeeding (because postpartum women don't ovulate for at least 28 days). • Between six weeks and six months for fully breastfeeding women whose menses have not returned postpartum. (Full breastfeeding is a reliable method of contraception up to six months postpartum if a woman has not menstruated.) Full breastfeeding means: Intervals between feeds should not exceed 4 hours during the day, 6 hours at night, and supplementation should not exceed 5 - 15% of all feeding episodes, preferably fewer. (DMPA is generally not given before an infant is six weeks old, because of the theoretical concern that the liver of the neonate may not be mature enough to metabolize DMPA.) • When a woman has not had intercourse since her last menses and cannot, therefore, be pregnant. • When a woman is reliably using another effective method of contraception (COCs, IUD, barrier). 	<p>Learning Game (30 min.):</p> <p>Ask for 5 volunteers. Give each volunteer a flash card. On each flash card is a "time" when it is appropriate to initiate DMPA. Ask each volunteer to discuss the "time" on her card. Supplement the discussion as needed.</p> <p>(See Px Handouts 1.8 and 1.9.)</p>

UNIT 2: MANAGEMENT OF SIDE EFFECTS AND COMPLICATIONS

INTRODUCTION:

The correct management of complications and side effects associated with DMPA is very important in ensuring the continuation of use. In this unit the participants, together with the facilitator, will identify the common side effects and complications related to the use of DMPA, give explanations as to the cause/nature of the side effects and complications, and discuss their management. In Unit 2, the participants will demonstrate how they will manage the side effects or complications based on prepared case studies.

UNIT TRAINING OBJECTIVE:

To develop the capabilities of participants to manage the side effects and complications related to DMPA use.

SPECIFIC LEARNING OBJECTIVES:

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

1. Manage DMPA side-effects.
2. Explain how to improve the quality of service by overcoming barriers to DMPA.

SIMULATED SKILL PRACTICE:

- Case studies

CLINICAL PRACTICUM OBJECTIVES:

During the clinical practicum, participants will:

- Manage cases of irregular vaginal bleeding,
- Manage cases of amenorrhea,
- Manage cases of weight gain, and
- Manage cases of mood changes.

TRAINING/LEARNING METHODOLOGY:

- Lecturette
- Discussion
- Case Studies

MAJOR REFERENCES AND TRAINING MATERIALS:

- Philippine Family Planning Program: The Family Planning Service, Training for Service Providers on Provision of DMPA as a Contraceptive Method, DOH/UNFPA, 1994.
- Hardee, K., Huber, D., McIntyre, S., Phillips, A., Proposed Strategy for the Introduction of DMPA into the Philippine Family Planning Program, DOH/USAID, 1993
- Program for International Training in Health, Guidelines for Clinical Procedures in Family Planning, A Reference for Trainers, Second Edition, University of North Carolina at Chapel Hill, 1993
- Interagency Guidelines Working Group, Recommendations for Updating Selected Practices in Contraceptive Use: Results of a Technical Meeting, 1994.
- Liskin L. S. and Quillin, W.F. Long-acting progestins: promise and prospects. Population Reports, Series K, Number-2, Baltimore, May 1983.

RESOURCE REQUIREMENTS:

- Handouts
- Flash cards of "Complications and Side Effects" developed in Unit 1
- Case studies
- Masking tape
- Marking pens

TIME REQUIRED: 2 hours

MATERIALS FOR TRAINERS TO PREPARE IN ADVANCE:

1. Transparency on the objectives of the unit (Transparency 2.1)
2. Participant handouts
3. Copies of the case studies

Unit 2: Introduction

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Introduction</p> <p>Your success in helping your client understand the cause/nature of side effects and complications related to DMPA and how well you manage such cases will largely determine the client's satisfaction and continuing use of the method. Management can be done by nurses and midwives following the suggested guidelines. If the problem is not responding to the recommended treatment, refer the client to a physician.</p> <p>When side effects are not well managed, many women stop using DMPA due to fear and misunderstanding.</p> <p>On very rare occasions allergic reactions have occurred immediately following an injection of DMPA. However, when side effects occur they usually occur weeks or months following the injection of DMPA.</p>	<p>Introduce the topic by reviewing the objectives of the unit. Post the flash cards of side effects and complications which were developed during Unit 1.</p>

Specific Objective #1: Manage DMPA Side Effects.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Menstrual Changes</p> <p>Menstrual changes occur in almost all women using DMPA. Episodes of unpredictable irregular bleeding and spotting lasting 7 days or more are common during the first months of use. During the first year of use only about 10% of DMPA users have normal menstrual cycles. With increasing duration of use, the frequency and length of episodes of bleeding and spotting decrease, and amenorrhea becomes more common. Approximately 50% of women using DMPA for 1 year report amenorrhea. The following side effects may be encountered:</p> <p><u>Spotting or Light Bleeding</u> This is lighter than regular menstruation and is not harmful, even if it persists for several weeks. Usually, all that is needed is counseling and reassurance. A pelvic examination to rule out other causes of bleeding might reassure the client, but it is not medically indicated unless the history suggests the bleeding is not related to DMPA. Vitamins or iron may be prescribed if you feel the client is weak or anemic. Reassure the client that she can come for consultation anytime for any problem.</p> <p>If the woman is dissatisfied even after reassurance you may give 14-21 low dose or medium dose combined oral contraceptives and instruct her to take one each day. (The client should be screened to make sure there are no precautions to the use of COCs.) As an alternative you may give her next injection up to four weeks early (this temporarily reduces bleeding). Reschedule her next injection for three months later. Bleeding episodes become lighter and shorter in succeeding months.</p>	<p>Lecturette (30 min.):</p> <p>Using the flash cards and the narrative give a lecturette on the possible side effects and complications which might be associated with DMPA. The lecturette should include the nature and explanation of the side effects and complications.</p> <p>Discussion (30 min.):</p> <p>Lead a group discussion on how to manage the common side effects and complications identified on the flash cards. Encourage the active participation of the Px.</p> <p>(See Px Handout 2.1.)</p> <p>(Training/Learning methods continued on next page.)</p>

Specific Objective #1: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p><u>Moderate Bleeding</u> Moderate bleeding is equivalent to a menstrual period, except that it is longer in duration, and may last up to twice as long as a client's normal menstruation.</p> <p>If a woman has moderate bleeding, reassure her that this is normal and expected for up to 25-30% of women in the first three to six months of use. Bleeding periods become shorter and lighter over time. If counseling and reassurance are not sufficient for the woman, you may consider giving 14-21 low dose or medium dose, combined oral contraceptives and instruct her to take one each day. (The estrogen in COCs helps rebuild the endometrium and reduces bleeding.) World Health Organization (WHO) studies show that 92% of the DMPA bleeding episodes will stop within 14 days after giving the estrogen in standard 50 mg COCs, compared with 75% who did not receive estrogens. Therefore, estrogens were 68% effective in stopping bleeding episodes which would have otherwise continued. Alternatively, 14-21 days of Premarin (1.25 mg daily) or ibuprofen (200 to 400 mg every four hours until bleeding subsides or up to seven days) may be given. (Ibuprofen blocks prostaglandin synthesis and thus decreases uterine bleeding.) You may also give the next injection up to four weeks early in order to decrease uterine bleeding temporarily. Irregular or prolonged bleeding may occur again after any of these measures, until amenorrhea is established, usually after nine or more months of use.</p> <p><u>Heavy Bleeding</u> Heavy bleeding is greater than regular menstruation and more prolonged. Heavy bleeding is rare. Rule out pregnancy (including ectopic pregnancy), abortion, reproductive tract infection (RTI), cancer, and other gynecological problems.</p>	<p>Group Exercise (30 min.):</p> <p>Divide the Px into 3 groups. Ask one Px from each group to close her/his eyes and choose a case study. Allow the groups 30 minutes to discuss their case and prepare a plan for managing the case. The following should be included in the plan:</p> <ol style="list-style-type: none"> 1) Information to be obtained when taking a history and the rationale for each question, 2) Steps included in the physical examination and the rationale for each, 3) Differential diagnosis, and 4) Management of the case, including treatment, counseling messages, follow-up, and referral if indicated. <p>(See Px Handout 2.2.)</p>

Specific Objective #1: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p><u>Heavy Bleeding</u> (Cont.) You should give low-dose combined oral contraceptives (one tablet per day) or another form of estrogen for 14-21 days. If bleeding is especially heavy, or bleeding is not reduced, you should refer the woman to a doctor, who can do the following:</p> <ol style="list-style-type: none"> 1. Evaluate the woman for other possible causes of uterine bleeding. 2. After a full evaluation, give two COCs (double the estrogen dose) per day for three to seven days, followed by one COC for 11-14 days. 3. Give an injectable estrogen, estradiol cyprionate, 5 mg intramuscular, if bleeding is very heavy. If not effective within 24 hours the dose may be repeated once. <p>Very heavy bleeding with DMPA is rare, about one woman in every 1000-2000. A dilation and curettage (D & C) should <u>not</u> be done unless some other condition exists. Some providers may add methergine for treating heavy DMPA-related bleeding, similar to treatment for puerperal bleeding. Use of methergine should be limited to 0.2 mg taken orally, three to four times per day for two or three days. The effectiveness of methergine in reducing heavy DMPA-related bleeding is not documented, and this treatment should not be relied upon as a regular means of controlling DMPA-related bleeding.</p> <p><u>Amenorrhea</u> 40 - 50% of women will stop menstruating at some point during the first 12 months of DMPA use. With continuous DMPA use, 75 - 80% of women will eventually stop menstruating. This is the most common reason for discontinuation. Women must be counseled to understand that this is normal and expected during use of DMPA. Like lactational amenorrhea, there are no harmful effects of</p>	

Specific Objective #1: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p><u>Amenorrhea (Cont.)</u> DMPA amenorrhea, and there can be health benefits, such as improvement in anemia.</p> <ol style="list-style-type: none"> 1. Give reassurance that amenorrhea is normal and expected during DMPA use. 2. Amenorrhea during DMPA use, like amenorrhea with breastfeeding, is not harmful and can benefit the woman by preventing anemia. 3. A pregnancy test is not needed because of the high effectiveness of DMPA. 4. The woman should not fear that amenorrhea will lead to infertility or a premature menopause. Fertility returns the same after stopping DMPA whether or not she was amenorrheic. 5. Do <u>not</u> give estrogen treatment to induce withdrawal bleeding. This is usually not successful unless two or three cycles of oral contraceptives are given (which is not recommended). <p><u>Weight Gain</u> The weight gain associated with DMPA use is due to an increase in appetite. Weigh the client. Ask client about eating and exercise habits. Counsel the client that fluctuations of one to two kg can occur. If the weight gain is less than 2.4 kg (5 lbs.) reassure her that this is not significant. If the weight gain is more than this, counsel the client on diet and exercise. If the weight gain is unacceptable, counsel the client and help her choose another method.</p> <p><u>Headaches</u> Headaches can be psychological or due to other conditions not necessarily related to DMPA use. Ask if there has been a change in pattern or severity of headaches since beginning DMPA. Determine whether the client has purulent nasal discharge and tenderness in the sinus area. Ask whether she has ever had high blood pressure. Refer for treatment of sinusitis if present; continue</p>	

Specific Objective #1: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p><u>Headaches (Cont.)</u> DMPA. Regardless of history, check blood pressure (BP). If elevated, repeat BP. If the reading is normal, continue DMPA injections. If systolic BP is 190 or higher, or diastolic BP is 110 or higher, wait another week before giving the next injection and refer the client as appropriate. If the BP is over 160/90, repeat BP on two more occasions over the next 2 weeks. If the BP remains over 160/90, refer the client for treatment.</p> <p>Note: DMPA has very little or no effect on blood pressure.</p> <p>If the headaches are definitely worse with injectables, counsel the client and help her choose a non-hormonal method.</p> <p><u>Mood Changes</u> Mood Changes, especially depression, may sometimes be associated with DMPA use. Ask the client about possible causes, such as family, financial or social problems. Ask if mood changes have increased since going on DMPA. Counsel accordingly and follow-up during her next return visit. If no other cause is found and the depression has worsened during DMPA use, counsel client on the use of another method.</p> <p><u>Nausea</u> Nausea is rare with DMPA. Rule out possible causes such as anemia, high or low blood pressure, low blood sugar, pregnancy, viral illness, intestinal parasites or neurologic disease. If nausea is slight, continue using DMPA. If the nausea is severe and the client attributes it to the use of DMPA, counsel her on the use of another method (even though nausea is seldom due to DMPA).</p>	

Specific Objective #2: Explain how to improve the quality of service by overcoming barriers to DMPA.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>The following are selected procedural questions in the delivery of DMPA.</p> <p>1. WHEN CAN THE FIRST DMPA INJECTION BE GIVEN (INTERVAL)? HOW SOON DOES IT BECOME EFFECTIVE? IS A BACK-UP METHOD NEEDED?</p> <p>DMPA may be given within the first seven days of the menstrual cycle or anytime you can be reasonably sure the client is not pregnant.</p> <p>If injectable progestins are begun on or after the seventh day of the menstrual cycle in a woman who is at risk of pregnancy, a back-up method or abstinence may be advised. Although there is good reason to believe the effect on cervical mucus will promptly provide contraceptive protection within 24 hours, it may be prudent to consider a back-up method for up to seven days.</p> <p>Rationale Although ovulation can occur as early as day 10 of the menstrual cycle, this is rare. Fertile ovulation is very uncommon before day 12. Intercourse five days before ovulation may have as much as a 5% chance of resulting in pregnancy; however, since experts believe there are few ovulations before day 13, there is only a very small chance that intercourse on day seven of the cycle could result in pregnancy.</p> <p>In general, use of DMPA within the first seven days after the woman's normal menses would assure that the probability of the woman being already pregnant, or becoming pregnant, is extremely low. One study reports a slight increase in pregnancy rates starting on day eight.</p> <p>Although DMPA has no known teratogenic effects, fetal exposure should be avoided. In addition, one study has suggested that <i>in utero</i> exposure may increase the risk of low birth weight babies.</p>	<p>Lecturette (30 mins.):</p> <p>Give a short lecturette describing how to improve the quality of services by overcoming barriers to DMPA. Try to involve Px in a discussion about overcoming barriers to DMPA. Ask which are contrary to standard procedures right now and how some of these barriers might be overcome.</p> <p>(See Px Handout 2.3.)</p>

Specific Objective #2: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>It is probable that DMPA effectively thickens cervical mucus within 24 hours. Consistent with this theory, progestin-only pills have been shown to produce a thickened mucus with low sperm penetration within three to four hours after pill ingestion. Natural progesterones also cause cervical mucus to become scant, thick, and sticky--decreasing or inhibiting sperm penetration--usually within 24 hours, but sometimes within 48 hours. Clinical observations also support this finding.</p> <p>DMPA consistently inhibits ovulation.</p> <p>2. WHEN CAN THE FIRST DMPA INJECTION BE GIVEN POSTPARTUM?</p> <p><u>For Breastfeeding Women:</u> If the woman chooses to rely on the Lactational Amenorrhea Method (LAM), start injectable progestins when her menses returns (Note: In breastfeeding women, bleeding in the first 56 days [eight weeks] postpartum is NOT considered "menstrual" bleeding, because it is not preceded by ovulation) or when the woman is no longer fully or nearly fully breastfeeding or at six months postpartum, whichever comes first. If she does not want to rely on LAM, ideally wait at least six weeks postpartum to initiate DMPA.</p> <p><u>For Non-Breastfeeding Women:</u> The first DMPA injection can be given immediately postpartum and whenever the service provider can be reasonably sure that the client is not pregnant.</p> <p>Rationale Risk of pregnancy during lactational amenorrhea is very low: <2% in the first six months postpartum if fully breastfeeding; <7% in first 12 months.</p>	

Specific Objective #2: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Wait to initiate DMPA until a breastfeeding woman is at least six weeks postpartum, due to concerns that the immature neonatal liver may have a decreased capacity to metabolize exogenous steroids. Studies have not detected any effects on the health or growth of breastfed babies of women who begin using DMPA at six weeks postpartum.</p> <p>3. IS DMPA APPROPRIATE FOR USE IMMEDIATELY POSTABORTION?</p> <p>Yes, DMPA is appropriate for use immediately post-abortion (spontaneous, unsafe or induced), in any trimester, and should be initiated within the first seven days postabortion (or any time you can be reasonably sure the client is not pregnant).</p> <p>Rationale Fertility returns almost immediately postabortion (spontaneous, unsafe or induced): within two weeks for first trimester abortion and within four weeks for second trimester abortion. Within six weeks after an abortion, 75% of women have ovulated. While there may be a theoretical concern of increased thrombogenic effect with COC-use in the first week postabortion, there is no known clinical thrombogenic effect of DMPA; therefore, it can be safely used immediately postabortion (after a spontaneous, unsafe or induced abortion).</p> <p>4. ARE THERE ANY AGE/PARITY RESTRICTIONS ON DMPA USE?</p> <p>No. However, young and/or childless women in particular need to understand that, on average, it takes a woman four months longer to become pregnant after discontinuing DMPA than after discontinuing COCs, IUDs, or barrier methods.</p>	

Specific Objective #2: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>DMPA may be used by women through menopause. Risks for use of DMPA for older women appear minimal.</p> <p>For young adults, some evidence suggests that use of DMPA within two years of menarche may pose an additional long-term risk for osteoporosis. However, for those adolescents age 15 and under, for whom DMPA is the most appropriate method, the benefits of the method generally outweigh the risks.</p> <p>Rationale After discontinuing DMPA, about 50% of women conceive by seven months (i.e., 10 months after the last injection). After discontinuing other methods, 50% of women conceive in three months. Residual amounts of DMPA will remain in circulation for about seven to nine months after an injection, at which time serum levels of DMPA become undetectable. By about two to three years after discontinuation of DMPA, the proportion of women who have conceived is virtually the same as for those who have discontinued use of other methods.</p> <p>DMPA confers many non-contraceptive benefits including decreased menstrual blood loss, as well as protection against endometriosis, acute PID, and ectopic pregnancy and, of particular importance to older women, protection against endometrial cancer. DMPA may also inhibit intravascular sickling, an additional benefit to women at risk for sickle cell disease. Other effects which may be attributed to DMPA use include a slight increase in weight and slight (non-clinically significant) alterations in plasma lipid profiles. A theoretical risk of osteoporosis is currently under study.</p> <p>Regarding young adults, the suppression of ovulation with DMPA results in low estrogen levels, and estrogen is necessary for the development and maintenance of strong bones (to prevent osteoporosis). The peak strength (density) of spinal bone is reached by girls</p>	

Specific Objective #2: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>around age 16; the greatest increase in bone density occurs in the first two years post-menarche. Thus, some evidence suggests that a hypoestrogenic state, within the first two years after menarche, may increase the risk of osteoporosis later in life, particularly for women with other risk factors for osteoporosis (e.g., women who are small-boned, underweight, not black, smokers or malnourished).</p> <p>5. WHAT IS THE PREFERRED SITE OF A DMPA INJECTION?</p> <p>Both the arm (deltoid) and the gluteal muscle are acceptable. The deltoid is generally more acceptable to the client and has easier access for service providers, however, the client's preference should be taken into consideration. The DMPA injection is deep intra-muscular and the injection site should not be massaged.</p> <p>Rationale In order to be effective, DMPA needs to be released slowly over time. Massaging at the site of DMPA injection increases immediate absorption, which could result in decreased effectiveness.</p> <p>6. IS THERE A NEED FOR A REST PERIOD AFTER A CERTAIN PERIOD OF USE OF DMPA, AND IS THERE A MAXIMUM RECOMMENDED DURATION OF USE?</p> <p>No, there is no need for a rest period. DMPA may be used for as long as a woman wishes to avoid pregnancy.</p> <p>Rationale There is no cumulative effect of DMPA; the time required to clear the drug from the body is the same after multiple injections as after a single injection.</p>	

Specific Objective #2: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>7. SHOULD DMPA BE DISCONTINUED BECAUSE OF EXTENDED AMENORRHEA?</p> <p>No, there is no medical reason to discontinue. The client should be reassured that amenorrhea with DMPA is common, is not harmful, and may be beneficial (i.e., decreased anemia). The question of whether DMPA may be related to osteoporosis is under study. In theory, this may be a particular concern for older women. (See p. 27 concerning DMPA before age 16.)</p> <p>Rationale The likelihood of amenorrhea increases with increased duration of progestin-only injectable use (50% at end of first year, two-thirds of women by end of second year of use). Women who are counseled about this possible side effect will be less concerned if they experience extended amenorrhea. Extended amenorrhea resulting from use of DMPA is due to endometrial atrophy. There is no risk of endometrial hyperplasia. In fact, DMPA is protective against endometrial cancer.</p> <p>8. HOW MUCH GRACE PERIOD IS THERE FOR SUBSEQUENT DMPA INJECTIONS?</p> <p>For DMPA, on a three month schedule, it is acceptable to give the next injection:</p> <ul style="list-style-type: none"> • up to two weeks late and possibly up to four weeks late • DMPA may be given up to four weeks early (although this is not ideal) <p>If a client comes in after the grace period, advise her that delays in obtaining DMPA injections increase the risk of pregnancy and <i>in utero</i> exposure to DMPA. It is acceptable to give the DMPA injection if you can reasonably assure that she is not pregnant; although there is good reason to believe the effect on cervical mucus will provide contraceptive protection within 24 hours, it might be prudent to consider a back-up</p>	

Specific Objective #2: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>method for up to seven days. Reschedule the next injection for three months.</p> <p>Rationale DMPA blood levels consistently remain high enough to maintain contraceptive effect through three months post-injection and the pregnancy risk at four months post-injection is extremely low (and DMPA has no known teratogenic effects, although one study has suggested <i>in utero</i> DMPA exposure may possibly increase risk of low birth weight babies).</p> <p>It has been shown that the time it takes for progestin levels to be insufficient for contraception may vary somewhat from population to population. Studies show that Thai women seem to metabolize DMPA rapidly. Additionally, weight has also been show to have an independent influence on progestin levels (in heavier women, the contraceptive effects last longer).</p> <p>9. IF A WOMAN COMPLAINS OF HEAVIER MENSES AND/OR PROLONGED BLEEDING, IS THERE A MEDICAL BASIS FOR DISCONTINUING DMPA INJECTIONS?</p> <p>Not usually. Irregular and prolonged bleeding episodes are common and expected in the first three to six months of use.</p> <p>a) For prolonged spotting or moderate bleeding (equivalent to normal menstruation but longer in duration), the first approach should be counseling and reassurance. It should be explained that in the absence of evidence for other diseases, irregular bleeding commonly occurs in the first few months of DMPA use. If counseling and reassurance are not sufficient for the woman and she wishes to continue the method, the following management approaches may be tried:</p> <ul style="list-style-type: none"> • short term (for 7 to 21 days) COCs or estrogen • ibuprofen (or presumably, similar non-steroidal anti-inflammatories) 	

Specific Objective #2: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • if the previous injection was given more than 4 weeks ago, giving another injection at this time may be effective <p>b) Heavy bleeding (greater than normal menstruation) is uncommon; it can usually be controlled by administration of increased doses of COCs (or estrogen). Some women will require stopping injectable progestins due to medical reasons for excessive bleeding or due to the client's preference.</p> <ul style="list-style-type: none"> • If suspected, abnormal conditions which cause prolonged or heavy bleeding should be evaluated and treated as appropriate. • Some prolonged or heavy bleeding may fail to be corrected and injections may need to be discontinued. • Evaluate and address anemia if indicated. Give nutritional advice on the need to increase the intake of iron containing foods. • Do not perform uterine evacuation unless another medical condition is suspected. (Vacuum aspiration is generally the preferred method of uterine evacuation.) <p>Rationale The number of bleeding days decreases with months of injectable progestin use. Management of prolonged or heavy bleeding may be achieved by:</p> <ul style="list-style-type: none"> • rebuilding endometrium with COCs/estrogen • by ibuprofen (which blocks prostaglandin synthesis and thus decreases uterine bleeding) • accelerating the arrival of amenorrhea with another injection (there is evidence that bleeding decreases with a subsequent injection) 	

Specific Objective #2: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>10. CAN DMPA BE SAFELY INITIATED AND RESUPPLIED BY NON-PHYSICIANS?</p> <p>Yes. DMPA (including immediate postpartum injection in non-lactating women and postabortion injection) can be safely administered by any adequately trained service provider, such as nurses, midwives, pharmacists, CBD workers, etc.</p> <p>Rationale Nurses, midwives, and other community health workers can be appropriately trained to initiate and resupply injectable progestins.</p> <p>11. SHOULD DMPA INJECTABLES BE PROVIDED IF INFECTION PREVENTION MEASURES CANNOT BE FOLLOWED?</p> <p>No. All sites providing DMPA injectable contraceptives should consistently follow basic infection prevention measures, including:</p> <ul style="list-style-type: none"> a) Handwashing b) Aseptic technique (including cleaning the DMPA injection site) c) Sterile needles and syringes (single-use, disposable needles/syringes are preferred) d) If sterilization of reusable needles/syringes is impossible, decontamination with bleach followed by high-level disinfection—if correctly executed—may be used e) Safe disposal of single-use needles/syringes 	

Specific Objective #2: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Rationale Because injecting a steroid contraceptive, such as DMPA, penetrates the protective skin barrier, careful aseptic technique must be followed to prevent infection. One type of infection associated with this procedure is an injection abscess, commonly caused by normal skin flora (staph and strep). Thorough skin preparation done before the DMPA injection will remove most microorganisms from the client's skin which helps prevent cellulitis (skin infection) and abscess formation at the injection site.</p> <p>Another concern is the increasing problem of transmission of hepatitis B and AIDS viruses to clients, health care providers, and clinic staff, especially cleaning and housekeeping personnel. To minimize this risk, whenever possible, single-use (disposable) needles and syringes should be used.</p> <p>If reusable needles and syringes are used, they should be decontaminated immediately after use by soaking in 0.5% chlorine solution or another locally available and approved disinfectant. These practices, when combined with the proper disposal of single-use needles and syringes, protect clinic staff, especially cleaning and housekeeping personnel, from contracting hepatitis B or AIDS following accidental needle sticks. Following decontamination, reusable needles and syringes should be thoroughly cleaned and finally sterilized or high-level disinfected.</p>	

Unit 2: Conclusion

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
	<p>Synthesize the session by emphasizing the importance of being able to manage side effects and complications related to the use of DMPA in order to ensure continuation of use of the method.</p>

UNIT 3: COUNSELING DMPA CLIENTS

INTRODUCTION:

This unit is designed to help health workers who are the "frontliners" in providing information and services to family planning clients. Cognizant that counseling is one of their vital roles, major consideration is given to their preparation. This unit provides FP trained physicians, nurses and midwives with the essential skills, knowledge and desirable attitudes to be able to appropriately counsel DMPA clients **to make an informed choice and to continue to use the method successfully.**

This unit aims to help family planning service providers **foster the attitudes of thoroughness, empathy, caring, respect, honesty and confidentiality while they counsel DMPA acceptors** with side effects or complications and provide assistance to clients whose use of their chosen method is affected by myths, rumors and misconceptions.

MODULE TRAINING OBJECTIVE:

To develop and enhance the counseling skills of family planning workers providing DMPA.

SPECIFIC LEARNING OBJECTIVE:

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

1. Discuss the importance of counseling for DMPA clients.
2. Explain the principles of counseling.
3. Discuss the key points to be included in the counseling session.
4. Explain the role of values and attitudes in counseling.
5. Discuss the necessary skills (CLEAR ROLES) and steps (GATHER) necessary for effective counseling.
6. Demonstrate the skills, techniques and principles used to effectively counsel clients and dispel rumors and misconceptions, while showing respect, honesty and confidentiality during the classroom role play.
7. Demonstrate how to counsel clients considering DMPA as a contraceptive method.

TRAINING/LEARNING METHODOLOGY:

- Lecturette
- Discussion
- Role play
- Questions
- Games
- Individual Reflection
- Demonstration

Unit 3: Introduction

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Introduction</p> <p>As with all other methods the support and introduction of DMPA should be client-focused and emphasize quality of care and informed choice. With DMPA, thorough and accurate counseling is critical to client satisfaction.</p> <p>Remember that client counseling does not end with the first visit. Drop-outs usually occur because the service provider has not continued to counsel and support her client when she is experiencing a side effect such as irregular bleeding or amenorrhea.</p> <p>In most cases what the provider needs to give is reassurance, attention and a listening ear. Show genuine interest and concern and encourage the client to come back anytime she has any questions, concerns or complaints.</p>	<p>Introduce the topic by reviewing the unit's objectives.</p> <p>Brainstorming (10 min.):</p> <p>Draw from the Px their ideas regarding the rationale of this module by asking, "Why is counseling necessary for DMPA clients?" List their responses on the board and supplement their answers. Introduce the topic by explaining the objectives of the unit and the importance of counseling DMPA clients (see narrative). Evaluate this exercise by observing the Px responses to brainstorming comments.</p>

Specific Objective #1: Discuss the importance of counseling for DMPA clients.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Importance of DMPA Counseling</p> <p>It is critical that clients receive accurate information. Providers must be able and willing to assist women who are experiencing side effects or those who have concerns about the safety of DMPA through counseling. It is very important to create confidence and share knowledge, so that the client returns to you with questions if necessary. This increases client satisfaction and client continuation.</p> <p>Women often tolerate expected side effects, but they may discontinue the method if a side effect that they do not expect occurs. Women who do not receive information about side effects are twice as likely to discontinue using the method.</p> <p>Purpose of DMPA Counseling</p> <ul style="list-style-type: none"> • Assist clients to adopt new contraceptive practice • Prepare clients for potential side effects and their management • Support clients during side effects and their management • Enable clients to protect themselves from STDs • Support clients to successfully use injectable hormones • Assist clients to select and successfully use another method if she wishes when injectables are no longer appropriate or acceptable 	<p>(See <i>Px Handout 3.1.</i>)</p>

Specific Objective #2: Explain the principles of counseling.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Principles of Counseling</p> <p>1. <i>Acceptance</i>: Respect the client, whatever her circumstances. This enables the counselor to be understanding of the meaning and causes of her behavior and leads to interaction with the client that is non-judgmental; it also means recognizing the capacities and limitations of the client.</p> <p>2. <i>Individualization</i>: Recognize and understand each person's unique qualities; this requires the provider to know the specifics in every client's situation. Try to understand.</p> <p>3. <i>Confidentiality</i>: The client has a right to expect that her family planning needs will be kept confidential and that the clinician will not discuss her situation inappropriately or with other clients within earshot.</p> <p>4. <i>Controlled Emotional Involvement</i>: Be sensitive and responsive to the client's feelings without being emotionally involved.</p>	<p>Discussion (20 min.): Use the responses in the session and discuss the importance of counseling and the key points to be included in the counseling session. Trainer should observe the accuracy of Px's contributions to the discussion. (See <i>Px Handout 3.2</i>.)</p> <p>Good Counselor/Bad Counselor: An Experiential Learning Exercise (30 min.): Explain that provider attitudes toward clients has an effect on the quality of counseling and ultimately the quality of care provided to clients. We are now going to do an activity that will help us identify those important attitudes and explore how they relate to counseling family planning clients.</p> <ol style="list-style-type: none"> 1. Instruct the Px to close their eyes and think about a time that they went to a friend, relative, teacher or clergy member to discuss a problem and that person did not help them at all. 2. Ask them to reflect on that situation and write down exactly what that person did (specific actions or attitudes) that was not helpful, or that hindered the resolution of the problem. 3. Once completed, ask Px to share their lists. Write their responses on a flipchart. <p>Possible responses might include: ordered, ignored, directed, scolded, minimized, moralized, preached, made fun of, judged, criticized, insulted, shamed, was distracted.</p>

Specific Objective #2: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>5. <i>Non-Judgmental Attitude:</i> Do not have pre-conceived ideas or draw premature conclusions about the client; do not allow personal biases/prejudices to effect the relationship.</p> <p>6. <i>Self-Determination:</i> The client should determine what her needs are and how they should be met; the counselor does not decide for her, does not manipulate her opinions, but guides her to be able to look at her needs objectively, understand the choices or alternatives open to her, and their implications and consequences.</p>	<p>4. Now ask Px to think of a time that they went to someone with a problem, and that person helped them resolve the problem.</p> <p>5. Again, ask them what that person did to assist them in resolving the problem.</p> <p>6. Record responses on a flip chart.</p> <p>Possible responses might include: did not judge, gave me undivided attention, asked questions, did not impose his/her opinion, validated my concern, did not give advice, helped me to make my own decision, respected confidentiality, listened, showed respect.</p> <p>7. Relate this experience and the Px's responses to our role as FP counselors.</p> <p>8. Ask Px the following questions: How did it feel to go to a trusted person with a problem, only to receive no help? How does this relate to our work as family planning counselors? What are the principles we need to keep in mind when we meet clients?</p> <p>Closing:</p> <ul style="list-style-type: none"> • Continue discussion concerning principles of counseling. • Draw from Px the qualities of a good counselor. • Write responses on board and let them explain each briefly. • Supplement discussion. • Summarize the whole session and draw learning insights.

Specific Objective #3: Discuss the key points to be included in the counseling session.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Key points in DMPA Counseling</p> <p>Client counseling for DMPA must include some key points:</p> <ul style="list-style-type: none"> • Range of FP choices available • Advantages/disadvantages of each method, including DMPA • Bleeding irregularities and amenorrhea • Slow return to fertility • Other possible side effects • Need to receive follow-up injections every three months • Returning to clinic if there are problems • Lack of protection from HIV/STDs • Information for breastfeeding mothers • Finding out whether amenorrhea is culturally acceptable or not acceptable 	<p>Lecturette (15 min.):</p> <p>Be sure to include the important points that make up part of any counseling session:</p> <ul style="list-style-type: none"> • Range of FP choices available • Advantages/disadvantages of each method, including DMPA • Bleeding irregularities and amenorrhea • Return to fertility • Need to receive follow-up injections every 3 months • Other possible side effects • Returning to clinic if there are problems • Risk of HIV/STDs • Information for breastfeeding mothers <p>(See <i>Px Handout 3.3.</i>)</p>

Specific Objective #4: Explain the role of values and attitudes in counseling.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Survey of Sexual Attitudes: Agree? Disagree?</p> <ol style="list-style-type: none"> 1. Women should be virgins when they marry. 2. Birth control should be available for married people only. 3. The average woman wants sex less often than the average man. 4. Family Planning is against the culture. 5. Most people who contract STDs have had many sexual partners. 6. Vasectomy should not be considered by a man who has only one or two children or who is under the age of 35. 7. The choice of sterilization should be entirely voluntary. 8. Men enjoy sex without love more than women do. 9. Easy availability of birth control encourages sexual activity, especially among young people. 10. Using family planning is not a good idea before the wife has had her first child. 11. It is not unusual for people to be in love with more than one person at a time. 12. I would hesitate to marry someone with whom I had not had sexual intercourse. 13. Parents should not allow their daughters as much sexual freedom as they allow their sons. 14. Adolescents who have had children should be allowed to go to school. 15. Marital infidelity is equally acceptable or unacceptable for both sexes. 16. A child should be given sex education in school. 	<p>Introduce the topic by saying: "Our values and attitudes are often so ingrained that we are unaware of them until we are confronted with a situation that challenges them. By understanding our own values, we are better able to appreciate and respect the various experiences that shape the values of our clients. Let us now do an exercise that will help us explore our values surrounding contraception and sexuality."</p> <p>(See <i>Px Handout 3.4.</i>)</p> <p>Survey of Sexual Attitudes Game (45 min.):</p> <ol style="list-style-type: none"> 1. Tape papers labeled "Agree" and "Disagree" to opposite walls of the room. 2. Read a statement from the sheet "Survey of Sexual Attitudes" and ask Px to go and stand by the sign that best represents their feeling. Encourage them to be honest in their answers and to stand by their opinion even if they see their friends and colleagues have a different opinion.

Specific Objective #4: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Survey of Sexual Attitudes (Cont.)</p> <ol style="list-style-type: none"> 17. Prostitutes provide a useful social service. 18. Religion is a strong obstacle to acceptance of FP. 19. STDs are common among poor illiterates. 20. STDs are rarely seen in FP clinics because the clients are married women. 21. Women who are not married should not use injectable hormones for contraception. 22. Women with no children should not use injectable hormones for contraception. 23. Injectable hormones should be used by adolescents. 24. Injectable hormones should be used only by women who have had at least 3 children. 	<p>Survey of Sexual Attitudes Game (Cont.)</p> <ol style="list-style-type: none"> 3. Remind Px that there are no right or wrong answers to statements. After each statement, ask one or two Px from each side to explain why they agree or disagree with the statement. Repeat for a few statements as time allows. 4. Remember that it is not the role of a trainer to agree or disagree with any statement, but to affirm and validate all opinions expressed. 5. Process the game by asking these questions: <ol style="list-style-type: none"> a) Did any of your responses surprise you? b) How did people respond to different statements? c) How do you feel about other people's responses? Why? <p>Possible responses to b and c: Defensive, ambivalent, judgmental, angry, afraid to express opinion.</p>

Specific Objective #5: Discuss the necessary skills (CLEAR ROLES) and steps (GATHER) necessary for effective counseling.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Skills for Effective Counseling</p> <p>Both verbal and nonverbal communication skills are crucial in the counseling process. The acronyms "CLEAR" and "ROLES" help providers remember appropriate behaviors (both verbal and nonverbal) during counseling.</p> <p>Appropriate Verbal Behaviors Clarify Listen Encourage Acknowledge Reflect and Repeat</p> <p>Appropriate Nonverbal Behaviors Relax Open and Approachable Lean toward Client Eye Contact Sit straight and Smile</p> <p>Counseling Process Thorough and accurate counseling is the most critical element to client satisfaction. Giving the clients complete, accurate and clear information about DMPA will make the method and potential side effects more widely accepted.</p> <p>Service providers must have the competence and skills in counseling women who either want to use DMPA or want information about the various FP methods.</p> <p>Bearing in mind the six steps in the counseling process ("GATHER") the following points should be taken into consideration:</p>	<p>Large Group Discussion (30 min.): Inform Px that there are skills that service providers should possess to be effective in counseling clients for DMPA. Relate the definitions of values and attitudes, as illustrated by the last exercise, to show how they have an impact on service delivery of injectables.</p> <p>Ask Px what they think are the skills needed by service providers. Write their responses on the board and let them explain each skill. Validate their responses by writing the skills on a transparency. Describe each skill. Ask volunteers to discuss and give examples of the applications of these skills.</p> <p>Summarize and supplement discussion and draw learning insights.</p> <p>Inform Px that the counseling process involves a series of activities done in a systematic way to resolve a clients needs or problems. To maintain a smooth flow in the process there are six elements which should be included.</p> <p><i>(See Px Handout 3.5.)</i></p>

Specific Objective #5: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>G - <i>greet the client</i> in a friendly, warm, respectful, and helpful way. Create confidence, develop rapport, and make them feel at ease.</p> <p>A - <i>ask clients</i> about their needs and reproductive goals. Know your clients. Obtain a history using standard forms. If you need to ask the client about sensitive matters, wait until she feels at ease with you.</p> <p>T - <i>tell the client</i> about her choices for family planning. Tell your client about DMPA. When giving information about DMPA (or any other method) the following should be made clear: mechanism of action, effectiveness, side effects, return to fertility, and follow-up appointments.</p> <p>H - <i>help the client to choose a method.</i> Help your client choose a method by making her consider the suitability of each method to her health and lifestyle. Let your client do the talking. Allow her plenty of time to ask questions and express concerns. If your client chooses DMPA help her feel confident that she has opted for an effective, safe and convenient FP method.</p> <p>E - <i>explain the correct use of the method.</i> Explain how DMPA is used. It is given by deep intramuscular injection in the arm or buttocks. The site of the injection should not be massaged.</p> <p>R - <i>repetition</i> of the method instructions by the client to help assess clarity of communication and <i>return</i> to the clinic in 3 months time and every 3 months thereafter. It is wise to give clients an appointment card on which is written the date of the next injection. Tell the clients they may visit the clinic anytime as needed for concerns or problems.</p>	<p>Large Group Discussion (Cont.):</p> <p>To help the provider easily recall the elements, the acronym GATHER can be used.</p> <p>Ask Px if they have encountered this term before in their previous training. If the answer is yes, ask for volunteers to spell out the acronym and ask them to delineate each letter.</p> <p>Write the responses on the board and comment on the demonstration.</p> <p>If their are Px who are not familiar with this material, supplement this further.</p> <p>Encourage all Px to share in the discussion. Synthesize the activity and draw learning insights.</p> <p>(See Px Handout 3.6.)</p>

Specific Objective #6: Demonstrate the skills, techniques and principles used to effectively counsel clients and dispel rumors and misconceptions while showing respect, honesty and confidentiality during the classroom role play.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Rumors</p> <p>Rumors are unconfirmed stories that are transferred from one person to another by word of mouth. Rumors may spread faster if they are relayed over the media (radio, TV or newspapers).</p> <p>Misconceptions</p> <p>Misconceptions are mistaken notions or a wrong understanding of an idea. If a misconception is embellished with elaborate details and becomes a fanciful story, then it acquires the characteristics of a rumor.</p> <p>Word of Mouth Game</p> <p>The point of this exercise is to show that as information passes from one person to another, it is changed and distorted.</p>	<p>Explain to Px that in the previous sessions, we have reviewed both attitudes important for family planning counselors, the skills necessary to provide good counseling, and the steps of a counseling session. However, without practice, observation and feedback we will not be sure that we are able to put this information into practice. In this session, we will have the chance to put together all we have learned and practice counseling DMPA clients, but before practice we will discuss rumors.</p> <p>Brainstorming (10 min.):</p> <p>Ask Px to come up with a definition for the word Rumor. Process their answers, and, if necessary, supplement from the narrative.</p> <p>Go through the same process for the word Misconception.</p> <p><i>(See Px Handout 3.7.)</i></p> <p>Word of Mouth Game: Rumors and Misinformation (20 min.):</p> <ol style="list-style-type: none"> 1. Divide the group in half. Tell one half to stand in a line facing the center of the room. The other half should form a line facing the first group, but out of hearing distance. 2. Tell the end person in each group the following story:

Specific Objective #6: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
	<p><i>"I went to the clinic last week, because I have been having trouble sleeping, and because I have a rash. I had to wait a long time. When I finally saw a nurse, she had lots of questions about my eating habits, evening activities, hobbies. Then, while I was there, I remembered that it was almost time for my next DMPA injection. The nurse asked me if I was happy using DMPA and if I had noticed any side effects. She thought my problems might be related."</i></p> <ol style="list-style-type: none"> 3. Ask the two people you have told the story to whisper it to the next person in line. The listener should then whisper it to the next person who has not heard the story, and so on. 4. Tell Px they may talk until it is their turn to listen to the story. Then they must listen. 5. When the last person in each line has heard the story, have each repeat it out loud. Then read the story you told them. 6. Ask the group: How did the story change? Why? How does this apply to the spread of rumors and misinformation?

Specific Objective #6: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Effective Ways to Counteract Rumors</p> <p>Correcting rumors and misconceptions is one of the important tasks of service providers. It is not enough to simply tell clients that what they have heard of is not true. Some effective ways to counteract rumors about any method are:</p> <ul style="list-style-type: none"> • Find out where the rumor comes from and talk with people who started it or repeated it. Check whether there is some basis for the rumor. Determine the underlying fear to which the rumor relates. • Use strong, solid scientific data to counteract misinformation. Explain the facts. • Clarify information with the use of demonstrations and visual aids. • Give examples of satisfied users, if they are willing to have their names used. This kind of personal example is most convincing. • Find out what else the client needs to know in order to have confidence in the method. • Always tell the truth. Never try to hide side effects or problems that might occur. 	<p>Effective Ways to Counteract Rumors Lecturette (15 min.):</p> <p>Give a brief lecturette using the narrative on "Effective Ways to Counteract Rumors."</p> <p>Brainstorming</p> <p>Ask Px to identify some rumors they have heard about DMPA and the possible underlying reasons for these.</p> <p>Write these rumors on the board. Save them. Drawing on these examples, have Px generalize the major causes of FP myths and rumors.</p> <p>(See Px Handout 3.8.)</p> <p>Possible responses might include:</p> <p>Inadequate information, misinformation (either through intentional or accidental distortion of truth), cultural and personal values appear to conflict with concept of FP.</p> <p>Explain to Px that to counteract rumors effectively, counselors need to understand the cause of the rumor, and explain why the rumor is not true and what the truth is. When possible, the counselor should demonstrate or give specific examples which counteract the rumor. Ask Px to think about resources, such as satisfied users and people who are influential in the community, who would be valuable in combatting rumors and how these people could be used. Ask Px what they can do if they don't know the answer to a question a client asks.</p>

Specific Objective #6: Continued

<p>CONTENT Knowledge/Attitudes/Skills</p>	<p>Training/Learning Methods (Time Required)</p>
	<p>Small Group Exercise (15 min.):</p> <p>Divide the Px into small groups if time permits; if not, have the large group do the exercise together. Divide the rumors among the groups. Ask each group to come up with the ways to combat the rumors they have.</p> <p>Plenary (15 min.):</p> <p>Ask each group to present and ask whether any solutions can be added.</p> <p>Congratulate Px on their presentations. Remind them that counteracting rumors and misconceptions is just one aspect of counseling clients. Next Px will have a chance to demonstrate the other counseling skills they have learned.</p> <p>Counseling Role Plays (30 min.):</p> <p>Divide Px in teams of three. In each team, one person will play the client, one person the counselor and the third person will observe. Assign each team one of the counseling situations found in <i>Px Handout 3.9</i>, but only allow the Px who is playing the "client" to see the case study. If the group is large there may be some overlap. Ask the "client" and the "counselor" to role play the counseling session and the observer to comment on the role play.</p> <p>The "Counselor" (who has not been told the situation) must identify the client's feelings and determine the client's situation in order to assist the client in the decision making process. The "Counselor" must demonstrate respect, caring, honesty and confidentiality.</p>

Specific Objective #6: Continued

<p>CONTENT Knowledge/Attitudes/Skills</p>	<p>Training/Learning Methods (Time Required)</p>
	<p>Counseling Role Plays (cont.):</p> <p>Ask the Observer to use the "Observer's Guide" to critique each role play.</p> <p>(See Px Handout 3.10.)</p> <p>Process the role play by asking the client and counselor to give their impressions and/or reactions to the exercise and ask the observers to make comments based on what they wrote in their "Observer's Guide."</p> <p>Reassign the "rumors" and have the "counselors" and "clients" exchange roles.</p> <p>The trainer may interrupt the role plays at critical times to point out problems in the exchange and identify possible solutions.</p> <p>To summarize the session, remind the Px of the following: "The counselor must recognize and respond to each client as a unique person with attitudes, values, and experiences reflected in his or her personal situation. The counselor must recognize the individual informational needs of each client."</p> <p>Congratulate Px on their active participation.</p>

Specific Objective #7: Demonstrate how to counsel clients considering DMPA as a contraceptive method.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Key Counseling Points:</p> <p>Introduction of a new contraceptive requires much programmatic preparation. One of the most essential is that element which deals with communicating with potential users. Counseling for DMPA requires more time and effort from you, as clients respond to promotion/communication campaigns. You will need to answer their questions, and the questions of your colleagues. And you will need to screen and counsel very carefully to prepare women and their families for side effects associated with this method.</p> <p>DMPA clients need to know, at a minimum, the following:</p> <p>Informed Choice/Method Specific Counseling:</p> <ul style="list-style-type: none"> • Tell woman about all other methods available so that she genuinely understands all the options and can choose a method based on full and factual information. This includes the benefits and risks of each. • Determine what she knows about DMPA, how she learned about it, what has she heard, what are her expectations from this method? Correct any unrealistic expectations about injections. • Probe for and discuss with client local myths and rumors. Common myths and rumors include that DMPA causes irreversible infertility, causes cancer, or causes deformed babies. Correct any myths or rumors about injections. Clinicians may need to address these myths with colleagues as well as clients. 	<p>Trainer Presentation followed by role play (30 min.):</p> <p>Trainer to discuss content having Px follow using the Learning Guide.</p> <p><i>(See Px Handouts 3.11 and 3.12.)</i></p> <p>Following content review, hand out and review briefly (if necessary):</p> <ul style="list-style-type: none"> • Role plays • Learning Guide for DMPA Counseling • Counseling Skills Observers Role Play Checklists • Checklist for DMPA Counseling skills <p>Divide PX into small groups charged with demonstrating method-specific, pre-injection, post-injection and return visit counseling.</p> <p>Trainer to facilitate analysis of role play and productive group discussion.</p>

Specific Objective #7: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Explain in language the woman will understand (keep it simple):</p> <ul style="list-style-type: none"> • Benefits and risks of DMPA • DMPA is an injection which must be given every 12 weeks (three months). This requires she come to see the doctor/clinic every three months. • DMPA may be given at any time, but it is preferable to give it during the first seven days of the menstrual cycle. If the client does not receive the injection in the first seven days of her cycle, she will need to use a back-up method such as a condom or spermicide or abstain from intercourse for 24 hours following the first injection. After that, the injection will protect her very effectively from pregnancy. • The injection is safe and effective, but there are possible side effects. Remember, however that giving clients a long list of side effects which they are unlikely to experience might discourage them from using the method. Common side effects could include: <ul style="list-style-type: none"> • Irregular periods, spotting between periods, or no periods for several months at a time, or no periods at all after the first three or four injections. Explore with woman how she may feel if she does not have any periods for several months. Will this worry her? Might she feel its unnatural and bad for her health? (In fact, amenorrhea helps prevent anemia.) The clinician should deal with all concerns a woman is likely to have in regard to these questions. Reassure her that her periods will resume after discontinuing DMPA. 	

Specific Objective #7: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • Heavy/prolonged periods, especially in the first two to three months of use. This is uncommon and can be managed, but may pose social or family life problems in Hindu/Muslim cultures. (Explore with woman how she feels about this, how prolonged bleeding or frequent spotting may affect her daily life, etc.) (The physiology of menstruation may have to be explained if anxiety and fears about bleeding irregularities are expressed.) • Client may experience weight gain or mild headaches. • Client may experience mood changes or feel somewhat depressed at times. • There is a delay of several months in the return to fertility following the last injection of DMPA. • DMPA does not protect her from STDs, including HIV. If she is at risk, she can use DMPA but also must be counseled to use condoms (as does any client using any method who is at risk). <p>If after screening it is determined that DMPA is physically/medically appropriate for the client, that she, has been fully informed and counseled about DMPA, and has made the decision to use this method, prepare and administer injection.</p> <p>Repeat Information After Providing Injection:</p> <p>Injection is effective immediately if she is within the first 7 days of her menstrual cycle; if she is not, she must use back-up method for next 24 hours (condoms/spermicide or abstain from intercourse). <i>Provide her with condoms.</i> Reassure her she can come back to see you/clinic at any time if she experiences any side effects/problems; she should not wait for the next injection to resolve problems.</p>	

Specific Objective #7: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Tell her if she doesn't like the injection, or side effects are too troublesome, she can change to another method more appropriate for her.</p> <p>Tell her she can be up to two weeks late for her next injection and still be effectively protected from pregnancy. Injections may also be given up to four weeks early. However, stress that it is better if she receives her injections on time, every three months.</p> <p>Give her a definite return appointment (date/time).</p> <p>Follow-up Visit:</p> <ul style="list-style-type: none"> • Discuss with client her experience so far with DMPA; any complaints, side effects. • Repeat history checklist • Check BP and weight. <p>If the client is satisfied:</p> <ul style="list-style-type: none"> • Give next injection • Give supportive counseling to ensure tolerance of menstrual irregularities • Remind client of next visit • Plan for return visit <p>If the client developed side effects:</p> <ul style="list-style-type: none"> • Perform physical, pelvic, and lab exams as needed • Reassure the client and offer supportive counseling • Manage the condition according to the Explanation and Management of DMPA Side Effects Table (Participant Handout 2.1) • If provider cannot manage the condition, refer client to a physician or service point • Advise client to use back-up method • Give injection if client is fully recovered • If the client is dissatisfied with method, help her choose another method. 	

Specific Objective #7: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>If she is more than two weeks late for her next injection:</p> <ul style="list-style-type: none"> • Examine client for possible pregnancy. • Advise client to use back-up method until next period, or give one cycle of COCs and instruct her to return for repeat exam in one month. • If negative for pregnancy, administer injection during this second visit. • If any precautions have developed, counsel for selection of another method (except for irregular vaginal bleeding). 	

UNIT 4: PROVISION OF DMPA

INTRODUCTION:

This unit is intended to assist the FP service provider in the provision of DMPA as a contraceptive method. While some sessions may appear to be very basic for health workers (like giving the actual injection), a review of the procedure and the additional information on post injection care is relevant in light of developments regarding HIV/AIDS.

UNIT TRAINING OBJECTIVE:

To develop skills in the provision of DMPA in relation to screening clients, administering the injection, post-injection care and infection prevention.

SPECIFIC LEARNING OBJECTIVES:

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

1. Demonstrate knowledge, skills, and attitudes appropriate in screening prospective DMPA acceptors using a checklist.
2. Discuss logistical considerations for provision of DMPA services.
3. Explain the procedures to be followed in giving a DMPA injection.
4. Perform actual injection procedures.
5. Explain the instructions given to a client after the injection.
6. Discuss infection prevention for DMPA use.

SIMULATED SKILL PRACTICE:

- Injection procedures
- Infection prevention procedures

CLINICAL PRACTICUM OBJECTIVES:

By the end of the unit, participants will be able to demonstrate the skills and knowledge necessary for administering a DMPA injection and for performing infection prevention procedures.

TRAINING/LEARNING METHODOLOGY:

- Lecture
- Discussion
- Role play
- Demonstration and return demonstration
- Group discussion
- Brainstorming

MAJOR REFERENCES AND TRAINING MATERIALS:

- Philippine Family Planning Program: The Family Planning Service, Training for Service Providers on Provision of DMPA as a Contraceptive Method, DOH/UNFPA, 1994.
- Tietjen, L., Cronin, W., McIntosh, N., Infection Prevention for Family Planning Service Programs, Essential Medical Information Systems, Inc., Durant OK, 1992.
- Hardee, K., Huber, D., McIntyre, S., Phillips, A., Proposed Strategy for the Introduction of DMPA into the Philippine Family Planning Program, prepared for the Department of Health and the USAID/Manila.
- USAID, Depo-Provera: Next Steps, "Depo-Provera information packet for HPNs," a proposed design, Aug. 20, 1993.

RESOURCE REQUIREMENTS:

- Copies of screening checklist
- Syringes, needles, vials, cotton and alcohol
- Glass of milk
- Disinfectant (chlorine powder or bleach)
- Disinfector (boiling type)
- Containers for disposable needles and for decontamination
- Model for injection (or substitute, e.g. an orange, etc.)
- Whiteboard and markers
- Transparencies and pens
- Overhead projector
- Copies of FP Clinical Standards Manual

TIME REQUIRED: 3 hours

MATERIALS FOR TRAINERS TO PREPARE IN ADVANCE:

1. Transparencies on:
 - the objectives of the unit (Transparency 4.1)
 - preparation of the client prior to the injection (Transparency 4.2)
 - post-injection instructions (Transparency 4.3)
2. Materials and supplies for the sessions, including equipment necessary for decontamination, cleaning, high-level disinfection and disposal of needles
3. Select a participant to review the narrative and ask Px to be prepared to demonstrate the decontamination, cleaning and high-level disinfection (or sterilization) of reusable syringes and needles.
4. Participant handouts, including DMPA checklist
5. Purchase a supply of fruit (such as oranges or apples) or vegetables (like eggplant) for Px to practice giving injections.

Specific Objective #1: Demonstrate knowledge, skills and attitudes appropriate in screening prospective DMPA acceptors using a checklist.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>A physical examination is always an important part of good reproductive health care, but recent scientific studies have shown it is not required for the provision of DMPA.</p> <p>DMPA is a very safe contraceptive with very few precautions, so a screening checklist is a good tool for exploring the appropriateness of DMPA for the client.</p> <p>Tell Px that aside from the DMPA screening checklist, the FP client record used by their clinic should also be completed.</p> <p>Note: The screening checklist is not a replacement for the FP Client Service Record, which should be filled out for every client attending the clinic. The FP Client Service Record is not provided in this training module; it is a record-keeping form, which may vary from clinic to clinic, used to track all pertinent information on an individual client. Service providers may consider attaching the filled-in screening check list or recording the responses after using it where there is a difference between the two documents.</p>	<p>DMPA Screening Checklist (45 min):</p> <p>Introduce the objectives of this unit and display on transparency.</p> <p>Distribute <i>Participant Handout 4.1: Sample DMPA Screening Checklist</i>. Inform Px that when they use this checklist in their clinics, it should be attached to the client record. Ask for a volunteer to discuss the checklist and explain why each item should be included in the checklist.</p> <p>For example: Q: Are you breastfeeding a baby less than six weeks of age? A: This question is included because DMPA should be given to a woman between six weeks and eight to twelve weeks after delivery if they are fully breastfeeding. DMPA is not given earlier than six weeks to allow for the establishment of lactation.</p> <p>Divide the Px into pairs, asking each pair to practice role play screening a client using the checklist. Discuss this activity with the whole group, asking the following questions:</p> <ol style="list-style-type: none"> 1. Did anyone encounter any difficulties? 2. Can you imagine any difficulties you might encounter when you actually do this? 3. What will you do if a client answers "yes" to any of the questions? (Stress referral to a physician or counseling for another method.)

Specific Objective #2: Discuss logistical considerations for provision of DMPA services.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Logistical Considerations</p> <p>Certain packaging, storage, and equipment concerns must be considered and accounted for when integrating DMPA into FP service delivery programs:</p> <p><i>Packaging for DMPA:</i></p> <ul style="list-style-type: none"> • 1 cc glass vial, each vial containing enough DMPA for one injection • 100 vials per distribution box • 105 2 ml disposable sterile syringes with affixed 21, 22, or 23 gauge needles are provided with each distribution box. <p><i>Shelf Life for DMPA:</i></p> <p>The DMPA made by Upjohn in Belgium is labeled with a shelf-life of five years. DMPA made by Upjohn in the US is currently labeled for a shelf-life of two and a half years. The two products are the same; the shelf-life of the US product will gradually be extended over a period of years (use the manufacturer's instructions as a guide for determining "extension period of shelf life").</p> <p><i>Special Considerations:</i></p> <ul style="list-style-type: none"> • DMPA requires a sterile syringe and a 21 - 23 gauge needle for administration. Ample supplies must be available. • Care must be taken to ensure syringes and needles are not removed from DMPA stocks for the administration of other drugs. • Syringes and needles are manufactured for single-use only and must be safely disposed of (in a sharps container, for example) following DMPA administration. Attempts to re-sterilize needles and syringes may diminish their integrity, resulting in potentially unsafe or ineffective administration. 	<p>(See <i>Px Handouts 4.2 and 4.3.</i>)</p>

Specific Objective #2: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p><i>Special Considerations (Cont.):</i></p> <ul style="list-style-type: none"> • Storage conditions are critical to product stability; particle size in aqueous suspensions like DMPA can change with temperature fluctuations. These changes can affect drug efficacy. Follow manufacturer's storage recommendations. • Because DMPA is a suspension, the colloid may separate. Shaking the vial should return the suspension to a milky white color. • Careful monitoring of the amount of DMPA use in the field is needed, especially since the real programmatic demand is unknown. • The normal visual indicators for quality control of injectable drugs should be applied, e.g., physical damage to carton or product; broken seals; foreign matter inside vial or syringe package; leakage or "caking" of ingredients. 	

Specific Objective #3: Explain the procedures to be followed in giving a DMPA injection.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Injection Procedures</p> <p><i>Preparing Equipment, Supplies and Materials:</i> Prepare the supplies and materials needed for the procedure before the physical examination, so that the client does not have to wait very long on the examining table. Assemble the following equipment needed for injection:</p> <ul style="list-style-type: none"> • DMPA vial • Sterile syringe & needle • Cotton wool • Locally available antiseptic to use to clean skin <p>If needles and syringes are to be used more than once they must be decontaminated, cleaned and sterilized after each use.</p> <p><i>Preparing the Client:</i></p> <ul style="list-style-type: none"> • Provide comprehensive counseling for each and every client. • Ensure that the client understands method advantages, as well as the side effects of irregular bleeding, amenorrhea, and possible delayed return of ovulation. • Explain the procedure to the client. • Encourage the client to ask questions to reduce apprehension and anxiety. • Show her the supplies and materials that will be used. • Explain that the syringes and needles are sterile. • Reassure the client before and after the injection. <p><i>Dosage of DMPA:</i> The usual dosage for DMPA is 150 mg in 1 ml to be given by deep intramuscular (IM) injection every three months.</p>	<p>Discussion (15 min.):</p> <p>Ask two volunteers to share with the class their experience in giving IM injections, reminding them to focus on the following:</p> <ul style="list-style-type: none"> • Preparing supplies and materials • Preparing the client • Techniques for administering injections • Post-injection care <p>Tell the other Px to listen carefully and note down deficiencies in the procedures outlined by the two volunteers. Ask Px to give any deficiencies they noted. List these on the board. Discuss how to correct each one.</p> <p>Lecturette (15 min.):</p> <p>Present the procedures for giving injections. Display a transparency to illustrate the main points.</p> <p>(See Px Handout 4.4.)</p>

Specific Objective #3: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Steps in Administering a DMPA Injection</p> <ol style="list-style-type: none"> 1. Wash hands thoroughly with soap and water and air dry them or use a clean towel. 2. Check vial for contents/dosage. 3. Roll the vial back and forth between the palms of your hands to mix the solution or shake it lightly. Don't shake the vial vigorously, as it will become foamy. Failure to mix the solution will permit some of the drug to remain as sediment in the vial, resulting in an inadequate dose and possibly lower contraceptive effectiveness. 4. If using a pre-packaged sterile syringe and needle, open the sterile packet. If using a boiled needle and syringe, remove the needle and syringe from the covered container with dry, boiled forceps, pick-ups or tongs. Use a 21 - 23 gauge needle, 1 - 1.5 inches in length with a 2 - 5 ml syringe. <p>Note: Never use a syringe which has not been high-level disinfected or sterilized between each use. Studies have shown that changing only the needle and not the syringe between clients can result in the transmission of hepatitis B virus.</p> <ol style="list-style-type: none"> 5. Attach the needle to the syringe by holding the base (hub) of the needle and the barrel of the syringe. 6. Turn the vial containing the DMPA upside down and draw 1 cc (containing 150 mg of DMPA) into the syringe. Use the same needle you will use for the injection. 	<p>(See Px Handout 4.5.)</p>

Specific Objective #3: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Note: Do not leave one needle inserted in the vial cap for multiple uses. This practice is dangerous because it provides a direct route for bacteria to enter the medicine vial and contaminate the fluid between each use.</p> <p>7. Disinfect/clean the skin at the site of the injection with alcohols or other antiseptics removing any visible dirt or soil.</p> <p>8. Allow the antiseptic to dry before giving the injection.</p> <p>9. Administer the injection, aspirate first to ensure that the needle is not in a vein. Inject DMPA deep into the deltoid or gluteal muscle, without massaging the site.</p> <p>Note: Both the deltoid (arm) and gluteal (buttocks) muscles are acceptable sites for injection. Client preference should be taken into consideration. The deltoid site is generally more accessible to service providers and more acceptable to clients.</p> <p>10. Instruct the client not to massage the area after the injection. Massaging may speed the release of progestin and thus shorten the period of efficacy. It may also disperse the DMPA so that it is not properly absorbed.</p> <p>11. Wash hands again.</p>	

Specific Objective #4: Perform injection procedures.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Post-Injection Care:</p> <p>For information on disposal of syringes and needles or decontaminations, cleaning and high level disinfection of needles and syringes, refer to Specific Objective #6.</p>	<p>Demonstration and Return Participant Demonstrations (30 min.):</p> <p>Proceed to a demonstration and return demonstration in the preparation of supplies, equipment and the client and the technique of administration using a fruit or vegetable. Ask each Px to give a return demonstration on the actual injection procedures.</p> <p>(See Px Handout 4.6.)</p>

Specific Objective #5: Explain the instructions given to a client after the injection.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Post-Injection Instructions to Client</p> <p>Inform all clients of the following:</p> <p><i>When the injection takes effect:</i> The injection takes effect immediately if it is given between day one and day seven of the client's cycle counting first day of menses as day 1. When it is given after day seven a backup method should be used for 24 hours.</p> <p><i>What if she returns early or late?</i> The next injection may be given up to two weeks after the scheduled date without concern for reduced effectiveness in case the client was unable to return on the appointed date. The prolonged presence of DMPA in the body gives a two week "grace" period during which she is still protected against pregnancy. A pregnancy test is not needed.</p> <p>Instruct the client that if she is more than two weeks late, she should abstain from sexual intercourse or reliably use an additional method until she returns. If you are reasonably assured that she was not at risk of pregnancy, you may give her the next injection. If you are unsure, do a sensitive pregnancy test or ask her to use another method of contraception, and have her return in one month. After one month you may determine if she is free of pregnancy, and if so, you may give her the next injection.</p> <p>The next injection may be given up to four weeks early, if the woman cannot return at the scheduled time. Giving the next injection early is also one form of managing prolonged bleeding or spotting, when this occurs within four weeks of the next scheduled visit.</p>	<p>Lecturette/Discussion (45 min.):</p> <p>With the aid of transparencies, discuss post-injection instructions. After the lecturette, ask volunteers to demonstrate post-injection instructions in a role play using a hypothetical clinic situation.</p> <p>Role Play Instructions</p> <p>Ask other Px to observe the role play and note down their reactions. Process the role play. Ask Px if the volunteers were able to demonstrate effectively post-injection instructions, including the following:</p> <ul style="list-style-type: none"> • Content • Clarity of information • Delivery • Behavior during role play • Other observations

Specific Objective #5: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p><i>When should the client return?</i> Instruct the client to return in three months for her next injection. Tell her that she may return anytime that she has questions or problems.</p> <p>Tell her to come back at once if she experiences any of the following signs or symptoms which might indicate a serious condition which may or may not be related to injectable contraceptive use:</p> <ul style="list-style-type: none"> • heavy vaginal bleeding • excessive weight gain • headaches • severe abdominal pain <p><i>Follow-up Visits:</i> Instructions for follow-up visits are covered in Unit 5. It is essential to make clients understand the importance of returning faithfully every three months for their injections. Give the client a card or slip of paper with the date of her next scheduled visit. Explain the date and make sure that your client understands.</p> <p>Note: To make sure your client understands all of the above instructions, ask her to repeat them.</p>	

Specific Objective #6: Discuss infection prevention for DMPA use.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Disposal of Contaminated Items</p> <p>After completing each injection of DMPA, staff should properly dispose of any contaminated objects, including gauze, cotton or other waste items. Single-use needles and syringes should be placed in a puncture-proof container made of cardboard, metal or glass. Intravenous fluid containers make good "sharps" containers. To prevent needlestick accidents, single-use needles and syringes should not be recapped, bent or broken prior to disposal. An ideal way to dispose of needles is to put them in a plastic bottle, (an alcohol bottle for example) filled with chlorine solution. Bury the bottle when it is full where it is unlikely to be dug-up or disturbed.</p> <p>Processing Reusable Needles and Syringes</p> <p>Whenever possible, disposable needles and syringes should be used. When reusable needles and syringes are used they should be decontaminated, cleaned, rinsed and sterilized or high-level disinfected. The following steps should be followed:</p> <p><i>Decontamination:</i></p> <ul style="list-style-type: none"> • Prepare 0.5% chlorine bleach solution. (For example, if 3.5% chlorine bleach is used, mix one part bleach with six parts water; if 5.0% chlorine bleach is used, mix one part bleach with nine parts water. Another alternative is to mix 7 grams of calcium hypochlorite [70% available chlorine] in 1 liter of water.) • Wearing protective gloves, rinse the needle and syringe in cold water. • Draw chlorine solution into the syringe and squirt it back into the bowl of chlorine solution. Repeat five times. 	<p>Sources of Infection: Discussion (15 min.) Ask Px to think back and remember the information they have learned on the provision of DMPA. Using brainstorming elicit from Px possible ways a client can be infected. Write these on the board. Do the same for ways that the care provider can be infected.</p> <p>(See Px Handout 4.7.)</p> <p>Ways of Preventing Infection: Brainstorming (15 min.): For each possible source of infection ask Px to come up with a way of preventing the infection from occurring. Supplement their answers.</p> <p>Disposal of Needles and Syringes: Using the narrative, give a lecturette and demonstration on the proper disposal of needles and syringes. Ask Px for suggestions about what containers are available in their clinics for the proper disposal of needles.</p>

Specific Objective #6: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p><i>Decontamination (Cont.):</i></p> <ul style="list-style-type: none"> • Submerge the syringe and needle in the solution for 10 minutes. <u>Do not submerge metal for more than 20 minutes as this causes rapid rusting.</u> • Remove items and rinse. <p><i>Cleaning:</i></p> <ul style="list-style-type: none"> • Using protective gloves, disassemble the needle and syringe. • Using soap and water, remove any visible "soil." • Rinse with clean water. <p><u><i>Sterilizing or High-Level Disinfection</i></u></p> <p><i>Heat Sterilization:</i></p> <ul style="list-style-type: none"> • Wet the lumen of the needle before sterilizing. • Heat items at 121°C at 15 lbs/in² of pressure. • Heat items for 20 minutes if unwrapped; 30 minutes if wrapped. • Remove the items only when they are dry. Remove the items using handling forceps and store in a covered container. <p><i>High-Level Disinfection:</i></p> <ul style="list-style-type: none"> • Instruments must be covered completely by water during boiling. • Do not add anything to pot after water begins to boil. • Boil for 20 minutes in a pot with a lid (start timing when water begins to boil). • Air dry before use or storage and store in a covered, previously high-level disinfected container, or • Soak for 20 minutes in 8% formaldehyde or a glutaraldehyde and rinse well in water that has been boiled for 20 minutes. • Air dry before use or storage. 	<p>Decontamination, Cleaning and Sterilization/High-Level Disinfection of Reusable Needles and Syringes:</p> <p>Mention to Px that although the FP program is currently supplying disposable needles and syringes, not every clinic may have these available all of the time.</p> <p>Ask the Px you have selected to demonstrate the proper decontamination, cleaning, and sterilization or high-level disinfection of reusable needles and syringes.</p> <p>Elicit comments and suggestions from other Px.</p>

UNIT 5: RETURN VISITS AND FOLLOW-UP

INTRODUCTION:

This unit deals with the return visit of DMPA clients for subsequent injections and the follow-up of clients who are defaulting and discontinuing their injections.

UNIT TRAINING OBJECTIVE:

To develop skills in providing services to returning clients and the follow-up of defaulters and drop-outs.

SPECIFIC LEARNING OBJECTIVES:

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

1. Discuss and demonstrate the steps/services given to a client during her return clinic visit.
2. Differentiate a DMPA defaulter from a drop-out.
3. Identify clients' reasons for defaulting and discontinuing DMPA.
4. Discuss strategies to follow-up defaulters and drop-outs.
5. Demonstrate skills in managing returning clients, conducting home visits of defaulters and drop-outs, and managing drop-outs who return to the clinic.

SIMULATED SKILL PRACTICE:

- Demonstrate steps of a client return visit
- Demonstrate steps in managing returning clients, defaulters, and drop-outs

TRAINING/LEARNING METHODOLOGY:

- Lecture
- Discussion
- Role play
- Group work
- Game

MAJOR REFERENCES AND TRAINING MATERIALS:

- Philippine Family Planning Program: The Family Planning Service. Training for Service Providers on Provision of DMPA as a Contraceptive Method, DOH/UNFPA, 1994.

RESOURCE REQUIREMENTS:

- Chalkboard
- Transparencies
- Overhead projector
- Pens
- Newsprint paper
- Flash cards

EVALUATION METHODS:

- Post-test

TIME REQUIRED: 2 hours 30 minutes

MATERIALS FOR TRAINERS TO PREPARE IN ADVANCE:

1. Transparency on the unit objectives (Transparency 5.1)
2. Copies of the post-test for each participant
3. Four sets of flash cards with procedure for follow-up
4. Flash cards with objectives of home visit

Specific Objective #1: Discuss and demonstrate the steps/services given to a client during her return clinic visit.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Return Visit</p> <p>Using DMPA as a method requires clients to return to the clinic every three months (90 days) for the next injection. Every client should be advised during counseling and during post-injection instructions about the importance of returning to the clinic on her scheduled date and should be given an appointment card or slip of paper with the date of the appointment written on it.</p> <p>Steps Performed during Follow-Up</p> <p>During each follow-up visit the care provider should perform the following procedures or steps:</p> <p><i>Interviewing the Client:</i></p> <ul style="list-style-type: none"> • Ask the client whether both she and her partner are satisfied with the method. • Ask if they have any questions, problems, or concerns. • Ask if the client has encountered any side effects such as menstrual irregularities. • Take and record BP and weight. <p><i>Satisfied Client:</i></p> <ul style="list-style-type: none"> • If the client is satisfied with the method and has no contraindications or precautions to continued use, give the client her next injection. • Give supportive counseling and continued reassurance to help ensure a high tolerance for menstrual irregularities. • Remind client to return to the clinic on the scheduled date, or any time if she has problems (e.g., side effects) or any condition that may cause dissatisfaction with the method. • Plan for return or next visit. 	<p>Introduction</p> <p>Bridge this session with the session given earlier on post-injection instructions, stressing the importance of returning to the clinic for another injection.</p> <p>(See Px Handout 5.1 and 5.2.)</p> <p>Group Exercises (45 min.)</p> <p>Divide Px into 4 groups. Give each group a set of flash cards with the steps/procedures for follow-up written on them. Ask each group to complete the following:</p> <ol style="list-style-type: none"> 1. What questions would you ask the client? 2. If the client is satisfied with the method, what steps would you take? 3. If the client is not satisfied with the method, what would you do? 4. What should you do if the client is early or late for her injection? <p>Allow 15 min. for group work. Ask each group to present their answers for 5-10 min.</p>

Specific Objective #1: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p><i>If the client has experienced a complication or side effect:</i></p> <ul style="list-style-type: none"> • If client has developed a complication or troublesome side effect, examine her and gather information about what she experienced. • Reassure and provide further counseling. • Manage the condition according to the instructions in Unit 2. • If it is beyond your capability to manage, refer client to the physician or to the appropriate service center. • If the next scheduled injection can be given after the management of the condition or as per physician's advice, then give the injection. If not, advise client to use a temporary back-up method and return after she has fully managed/recovered from the side effects or precautions. • If the client finds the method unacceptable due to the developed condition, then help her choose another method. <p><i>What if the Client Returns Early or Late?</i> If the client returns late, the next injection may be given up to two weeks after the scheduled date without concern for reduced effectiveness. The prolonged presence of DMPA in the body gives a two week "grace" period during which she is still protected against pregnancy. A pregnancy test is not needed.</p> <p>If the woman is more than two weeks late, and you are reasonably assured that she is not at risk of pregnancy (e.g., she has abstained or reliably used another method), you may give her the next injection. If you are unsure, do a sensitive pregnancy test or place her on another method of contraception and have her return in one month. After one month you may determine if she is free of pregnancy and if so, you may give the next injection.</p>	

Specific Objective #1: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
If the client comes to the clinic early for her injection, it may be given up to four weeks early. Giving the injection early is also one form of managing prolonged bleeding or spotting, when this occurs within four weeks of the next scheduled visit.	

Specific Objective #2: Differentiate a DMPA defaulter from a drop-out.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Returning to continue injections every three months should be emphasized every time the client visits the clinic. However, some clients still cannot come on schedule and some may stop coming altogether. In this session we will learn how to minimize the problem of method discontinuation.</p> <p>Definition of a Defaulter</p> <p>A defaulter is a DMPA client who does not return to the clinic on her scheduled injection date. (She may be injected within two weeks following her scheduled date or up to four weeks early, although this is not ideal.)</p> <p>Definition of a Drop-out</p> <p>A drop-out is a DMPA acceptor who <u>does not</u> return to the clinic within the two week grace period following the date of her scheduled injection as long as she does not report to another service site for the injection. (After the two week grace period, she must use a back-up method for one month. Once pregnancy has been ruled out, she can be given DMPA.)</p>	<p>Defining DMPA "Defaulters" and "Drop-outs"</p> <p>Brainstorming (15 min.):</p> <p>Divide the Px into 2 groups. Assign 1 group to come up with a definition of defaulter and the other group to come up with a definition of drop-out. Give them 5 minutes to do this. Assign 1 person from each group to write their definition on the board. Supplement if necessary.</p> <p>(See Px Handout 5.3.)</p>

Specific Objective #3: Identify clients' reasons for defaulting and discontinuing DMPA.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Possible Reasons for Defaulting and Remedies</p> <p>Reason 1: Client forgot the date of return appointment and remembered later. Remedy: To help the client remember her next injection date, give her an appointment card or calendar with the date written on it (or circled, if it is a calendar). If no printed card or calendar is available, give her a slip of paper with the appointment written on it. For women who may not be very aware of dates, try to help them remember by linking the appointment date with an important event such as a religious or national holiday or using a person in whom they can confide to remind them.</p> <p>Reason 2: Long distance from the client's home to the clinic or the length of time the client has to wait in the clinic is prohibitive. Remedy: Develop an out-reach project. Go to the client in her home. If the long clinic wait is part of the problem, suggest times for the client to come when the clinic is less busy or develop a plan to reduce client waiting time.</p> <p>Reason 3: Financial reasons (not enough money to pay for transportation to the clinic). Remedy: Deliver the method to the client's doorstep or find out about the possibility of transferring the client to a site near to her home and refer her to it.</p>	<p>Reasons for Defaulting or Dropping Out (30 min.):</p> <p>Brainstorm with Px to elicit reasons for defaulting or discontinuing DMPA. Write their answers on the board. Next, elicit from Px ways to prevent the defaulting or discontinuing from happening. Supplement their answers as needed.</p> <p>(See Px Handouts 5.4 and 5.5.)</p>

Specific Objective #3: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Reason 4: There is no one at home to take care of the children.</p> <p>Remedy: Deliver the method to the client's doorstep, or counsel her for informed choice of other long-term or permanent method. If you have her chosen method, provide it or if not, refer her to a clinic provider that does.</p> <p>Reason 5: Non-availability of clinic staff to give the injection.</p> <p>Remedy: Train all clinicians in the use of DMPA and emphasize the importance of good human relations when working with clients. Start this training as soon as you return from the final training in order to prevent the non-availability of clinic staff for giving the injection according to the guidelines.</p>	
<p>Possible Reasons for Dropping-out and Remedies</p>	
<p>Reason 1: Client's concern over menstrual irregularities or side effects.</p> <p>Remedy: Give client adequate counseling on the safety and effectiveness of DMPA as well as what to expect during DMPA use and information about possible side effects. Most importantly, tell her that these menstrual irregularities are not dangerous and are normal while using DMPA. Counsel the client for informed choice of another family planning method, if necessary.</p>	

Specific Objective #3: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Reason 2: Misconceptions, misinformation or rumors they might have heard about the method.</p> <p>Remedy: Make sure that the initial counseling of the client is adequate and includes information about rumors, misconceptions and misinformation. Use counseling skills to find out the extent of the misconceptions, misinformation or rumors and clear them up.</p>	
<p>Reason 3: Client is not adequately counseled about what to expect during the use of the method.</p> <p>Remedy: Be sure that initial counseling is adequate and repeat counseling during subsequent visits.</p>	
<p>Reason 4: Client is forced to switch to another method because supplies of DMPA are not available.</p> <p>Remedy: Perform regular inventories of supplies of DMPA and make sure requisitioning is done on a timely basis.</p>	
<p>Reason 5: Client wants to have another child.</p> <p>Remedy: Counsel the client on the scientifically recommended spacing of pregnancies and determine if she would be "at risk" as the result of a pregnancy. (Is she too young, too old, or is her pregnancy too soon following her last delivery?) Provide relevant guidance for maintaining health during her next pregnancy. Review health benefits of DMPA and possible delay of return of ovulation after using DMPA. Encourage client to return to you any time she wishes to do so after stopping DMPA.</p>	

Specific Objective #4: Discuss strategies to follow-up defaulters and drop-outs.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Strategies to Follow-up Defaulters and Drop-outs</p> <p>The service provider can use various strategies to follow-up defaulters to remind them that their injection is overdue and to convince drop-outs to resume their injections. Reminder: A woman is entitled to discontinue her injections at any time.</p> <p>The following are several suggestions:</p> <p>Strategy 1: By word of mouth. The provider should send word to the client through her neighbor or friends whom she trusts, reminding her to return to the clinic. This can be done even before the injection is due.</p> <p>Strategy 2: Write a note to the client if she has not come on her due date to remind her that she is expected to return to the clinic within two weeks of the due date.</p> <p>Strategy 3: Contact the client by telephone, either directly or through a neighbor. However, it is important to maintain confidentiality. The provider should only contact the client through a neighbor or friend if the client has given permission to do so.</p> <p>Strategy 4: Use local radio broadcasts to remind clients and the community about the advantages of discontinuing family planning services and to dispel rumors and misconceptions. Solicit satisfied clients and respected community leaders to discuss family planning and DMPA on the local radio broadcast to encourage clients to return.</p>	<p>Strategies for Follow-up:</p> <p>Ask for volunteers to share their strategies for following-up acceptors who do not return for resupply. Elicit more answers from other Px. Synthesize by stressing that these strategies can be used also to follow-up DMPA drop-outs and defaulters.</p> <p>(See <i>Px Handout 5.6.</i>)</p>

Specific Objective #4: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Strategy 5: The service provider or community-based worker should visit the client home to find out why the client has not returned to the clinic.</p> <p>Note: Home visits should not only be done for drop-outs, but for continuing users as well.</p>	

Specific Objective #5: Demonstrate skills in managing returning clients, conducting home visits for defaulters and drop-outs, and managing drop-outs who return to the clinic.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Objectives of a Home Visit</p> <p>There are several things that can be accomplished during a home visit:</p> <ol style="list-style-type: none"> 1. Find out if the client is comfortable and satisfied with the method. 2. Answer questions or concerns she may have. 3. Find out if she has a problem or is experiencing side effects. 4. Reinforce the initial counseling given to the client. <p>Preparing for the Home Visit</p> <p>The service provider should:</p> <ul style="list-style-type: none"> • Review the client's records. • Identify clients for a home visit and purposes for the visit. • Record the names and addresses and scheduled date of injections of those you plan to visit. • Sort clients by location and plan your visits by area. <p>What to Do on a Home Visit</p> <ul style="list-style-type: none"> • Talk to the client personally and in private to establish rapport. • Be patient in determining why the client has not returned to the clinic. • Write down her reasons and transfer your notes to the client record when you return to the clinic. • Answer her queries completely and honestly; show concern for problems she may have. 	<p>Home Visits</p> <p>Discussion (15 min.):</p> <p>Using flash cards, discuss with Px the objectives of a home visit, preparing for a home visit and what to do on a home visit.</p> <p>Role play (15 min.):</p> <p>Ask two volunteers to role play a home visit. After the role play, elicit observations from the other Px on how the "visit" could be improved.</p> <p><i>(See Px Handout 5.7.)</i></p>

Specific Objective #5: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>What to do on a Home Visit (Cont.)</p> <ul style="list-style-type: none"> • Counsel her, emphasizing the importance of returning to the clinic for her injection on her due date, or give the injection at home according to your standard practices. • Set up a date for her return. • If the client fails to return within the grace period, tell her to use another non-hormonal method and set a date for a clinic visit. • If you cannot convince her to return for an injection and if the client wishes to be protected from pregnancy, help her choose another method. <p>If the client is more than two weeks late you may still give the injection if you can establish that the client is not pregnant.</p> <p>Rule out pregnancy by:</p> <ul style="list-style-type: none"> • Taking a careful history • Performing a sensitive pregnancy test • Performing a physical examination <p>However, if you are not sure whether the client is pregnant, counsel her to use a non-hormonal method for a month until you can determine definitely that she is not pregnant.</p>	<p>Managing the Returning Drop Out (15 min.):</p> <p>Call on two other volunteers to depict a clinic situation in the classroom. One Px should act the part of a drop-out client going back to the clinic to reaccept DMPA. The other Px will portray a service provider who will attend to the client.</p> <p>Following the role play, ask for observations from the group, using the following guide questions:</p> <ol style="list-style-type: none"> 1. Did the provider follow the correct steps in providing client care during a return visit? 2. Were the procedures done correctly? 3. Were the instructions given by the provider understood by the client? 4. Did the provider check to make sure the client understood?

Unit 5: Conclusion

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
	<p>Evaluation</p> <p>Review <i>Px Handout 5.8: Competency Based Checklist for Injectables</i>, which summarizes the steps of DMPA provision. This checklist should be used as the basis for assessing Px competence to provide DMPA services.</p> <p>Since this is the end of the module, ask Px to complete the post-test and the Participant Evaluation.</p>

Participant Handout 1.1: Characteristics & Effectiveness of DMPA

Characteristics of DMPA

DMPA or medroxyprogesterone acetate (also called Depo-Provera) is a three month injectable contraceptive containing a synthetic progestin which resembles the female hormone progesterone. Each dose contains 150 mg of the hormone, which is released slowly into the blood stream from the site of intramuscular injection and provides the client/user with a safe and highly effective form of contraception.

Effectiveness of DMPA

DMPA is a highly effective contraceptive method. With a standard regimen, pregnancy rates are usually lower than one per 100 woman years for DMPA (see **Population Reports**, "New Era for Injectables," K-5, August 1995). Injectables are comparable in effectiveness to Norplant® implants, TCU 380A IUD, and voluntary sterilization.

Unplanned pregnancies are rare because injectables suppress ovulation in the great majority of cycles and because a woman needs only to obtain the next injection at the right time in order to assure continued effectiveness. Since DMPA does not require daily use there is less chance for user error. The standard regimen is 150 mg given every three months.

Several different regimens of DMPA have been used. In a recent randomized trial of two DMPA doses, none of the women receiving the standard 150 mg dose conceived, but the pregnancy rate among women receiving 100 mg every three months was only 0.44 per 100 woman-years (n=268). With higher doses and a longer injection interval--250 to 450 mg every six months--pregnancy rates have ranged from 0 to 3.6 per 100 woman-years. The only standard regimen currently in use is 150 mg given every three months.

Note: Using the correct technique so the dose will be absorbed at the correct rate is critical to contraceptive effectiveness. The DMPA vial must be shaken to suspend the DMPA in the solution, but not so vigorously that the liquid becomes frothy. The injection must be aseptically given deep into the muscle and the injection site **should not be massaged** because this accelerates absorption.

Participant Handout 1.2: Safety

Safety of DMPA

DMPA is a very safe contraceptive. Like other progestin-only contraceptives, it can be used by women who want a highly effective contraceptive, including women who are breastfeeding or who are not eligible to use estrogen-containing combined oral contraceptives. More than 10 million couples throughout the world are using an injectable contraceptive in more than 100 countries.

The United States Food and Drug Administration (USFDA) approved DMPA for contraceptive use in October 1992. Studies by the World Health Organization (WHO) give reassurance that DMPA presents no overall risks for cancer, congenital malformations, or infertility. This research has evaluated more than 3 million woman-months of DMPA use. The research found:

- DMPA, like oral contraceptives, exerts a strong protective effect against endometrial cancer.
- No overall increased risk of breast cancer with DMPA use.
- No relation between ovarian cancer and the use of DMPA. (Researchers had expected that DMPA would protect women against ovarian cancer as oral contraceptives do.)
- DMPA was not found to affect the risk of developing liver cancer in areas where hepatitis B is endemic.

Further research results include:

- DMPA does not appear to increase a woman's risk of developing invasive cervical cancer, even after a period of 10 years.
- DMPA does not cause any clinically significant changes in blood pressure or on the coagulation of the fibrinolytic system affecting thrombosis.
- Studies of "in utero exposure to DMPA" found no differences in the health, growth, sexual development, aggression, physical activity, or sex role identity of teenage children exposed in utero to DMPA as compared to other children.
- The use of DMPA does not permanently inhibit fertility, although it takes a woman four months longer to become pregnant after discontinuing DMPA than after discontinuing COCs, IUDs, or barrier methods.

Note: WHO studies have reported a small increased risk of cancer in young women who were using DMPA, however it is not clear whether or not the studies were biased due to methodological problems. The risk for breast cancer in young women is very low; therefore, no special precaution is needed.

Participant Handout 1.3: Mechanism of Action

Primary Mechanism of Action

1. Inhibits Ovulation - After a 150 mg injection of DMPA, ovulation does not occur for at least 14 weeks. Levels of the follicle stimulating hormone (FSH) and luteinizing hormone (LH) are lowered and an LH surge does not occur.

Secondary Mechanisms of Action

2. Thickens the Cervical Mucus - the cervical mucus becomes thick, making sperm penetration difficult.
3. Thins the Endometrial Lining - As a result of the high progestin and low estrogen levels, the endometrium changes, making it unfavorable for implantation. However, due to the changes in the cervical mucus and anovulation, fertilization is extremely unlikely to occur.

Participant Handout 1.4: Advantages of DMPA

Advantages of DMPA

- Highly effective
- Safe
- Long acting (three months)
- Protects against endometrial and possibly ovarian cancer
- Does not interfere with sexual intercourse
- One of the most private and confidential methods
- Convenient and easy to use (does not require a daily routine or supplies)
- Not user dependent
- Can be provided by a non-physician
- Completely reversible (an average of 4 months delay in return to fertility after discontinuing DMPA)
- Suitable for women who are not eligible to use an estrogen containing contraceptive
- Suitable for breastfeeding women (after 6 weeks postpartum)
- Provides immediate postpartum (in non-breastfeeding women) or postabortion contraception
- Reduces the risk of pelvic inflammatory disease
- Provides protection against anemia (hemoglobin levels rise in most women)
- The prolonged absence of menses is an advantage for many women
- May be used by women at any age or parity if they are at risk of pregnancy
- Protects against ectopic pregnancy since ovulation does not occur
- Reduces the symptoms of endometriosis (DMPA is sometimes used to treat endometriosis)

Participant Handout 1.5: Disadvantages and Non-contraceptive Benefits

Disadvantages of DMPA

- There are menstrual changes for almost all women. Irregular, prolonged bleeding, or spotting usually occurs during the first two to six months of use. Bleeding diminishes and usually stops after nine to twelve months of use. Over half the women using DMPA will experience amenorrhea within twelve months of use. Amenorrhea can be an advantage if women are fully informed that this is not harmful.
- Increased appetite causing weight gain for some women (0.5 kg, on the average, in the first year).
- Delay in return of fertility after discontinuing DMPA. Pregnancy is delayed four months longer than after discontinuing other contraceptives, such as oral contraceptives or IUDs. This is because residual levels of DMPA exist for several months after the end of the contraceptive protection from the last injection. DMPA is completely reversible and does not cause infertility.
- Since DMPA is long acting, it cannot easily be discontinued or removed from the body if a complication occurs or if pregnancy is desired.
- DMPA does not provide protection against STDs/HIV.

Non-contraceptive Benefits of DMPA

- Reduces frequency of fibroids
- Reduces frequency of ovarian cysts
- Protects against ectopic pregnancy (since ovulation does not occur)
- Reduces the incidence of pelvic inflammatory disease
- Relieves premenstrual tension
- Prevents anemia caused by blood loss or deficiency (hemoglobin levels rise in most women)
- It reduces the symptoms of endometriosis (DMPA is sometimes used to treat endometriosis)
- Reduces sickle-cell crises in women with sickle-cell anemia
- Decreases the frequency of epileptic seizures in women with epilepsy

Participant Handout 1.6: Appropriate Users and Precautions

Appropriate Users of DMPA

DMPA is appropriate for any woman who:

- Desires an effective long-acting, reversible contraceptive.
- Prefers a method that does not require any preparation before intercourse.
- Wants a convenient method.
- Is breastfeeding and wants to use a hormonal method.
- Does not want partners or others to know she is using a contraceptive method.
- Desires the convenience of not having to keep contraceptive methods at home.
- Has problems of compliance with oral contraceptives.
- Cannot use an estrogen-containing contraceptive.
- Has completed her family size, but does not desire sterilization.

Precautions and Other Considerations

There is only one primary precaution to the use of DMPA:

- Pregnancy, either known or suspected

(This means do not give DMPA.)

There are secondary precautions to the use of the method:

- Undiagnosed abnormal vaginal bleeding
- Breast cancer, known or suspected
- Amenorrhea not related to pregnancy or lactation
- Heart disease
- Acute liver or gallbladder disease

(This means the client should be referred to a physician for further evaluation.)

There are several other considerations to the use of DMPA:

- Diabetes Mellitus
- Hypertension

(This means DMPA may be given, but the client should be followed more closely.)

Note: Women who are breastfeeding should wait until 6 weeks postpartum before using DMPA.

Participant Handout 1.7: Side Effects

Common Side Effects

The following are side effects sometimes associated with DMPA. (The management of these side effects will be covered in Unit 2.)

- Spotting and light bleeding
- Moderate bleeding
- Amenorrhea
- Weight gain

In rare cases, women may experience:

- Headaches
- Mood changes
- Nausea
- Abdominal bloating
- Breast tenderness

Complications

In rare cases, heavy bleeding may occur.

Participant Handout 1.8: Timing of the First Injection

Timing of the First Injection

Q. When can DMPA be given? (**Note:** Please see *How to Be Reasonably Sure the Woman is Not Pregnant Px* Handout 1.9.)

A. DMPA may be given at any time when the woman is not pregnant:

- During the first seven days after the start of menses.
- Immediately or within 14 days following a spontaneous or induced abortion (immediately following abortion is generally preferred for the woman's convenience).
- Immediately postpartum or up to 28 days after delivery **if the woman is not breastfeeding** (because postpartum women don't ovulate for at least 28 days).
- Between six weeks and six months for fully breastfeeding women whose menses have not returned postpartum. (Full breastfeeding is a reliable method of contraception up to six months postpartum if a woman has not menstruated.) Full breastfeeding means: Intervals between feeds should not exceed 4 hours during the day, 6 hours at night, and supplementation should not exceed 5 - 15% of all feeding episodes, preferably fewer. (DMPA is generally not given before an infant is six weeks old, because of the theoretical concern that the liver of the neonate may not be mature enough to metabolize DMPA.)
- When a woman has not had intercourse since her last menses and cannot, therefore, be pregnant.
- When a woman is reliably using another effective method of contraception (COCs, IUD, barrier).

Participant Handout 1.9: How to Be Reasonably Sure the Woman is Not Pregnant

You can be reasonably sure the woman is not pregnant if she has no symptoms (see "History," below) or signs (see "Physical Exam," below) of pregnancy, and:

- has not had intercourse since last normal menses, or
- has been correctly and consistently using another reliable method, or
- is within the first seven days after normal menses, or
- is within four weeks postpartum (for NON-lactating women), or
- is within the first seven days postabortion, or
- is fully breastfeeding, amenorrheic, and less than six months postpartum (see "Relying on Lactational Amenorrhea," below).

History of Symptoms for Pregnancy

- Absent (or altered) menses
- Nausea (with or without vomiting)
- Fatigue (persistent)
- Breast tenderness (and breast enlargement)
- Increased frequency of urination
- Maternal perception of fetal movements (late symptom: 16 to 20 weeks gestation)

Physical exam is seldom necessary, except to rule out pregnancy of greater than six weeks when uterine enlargement begins to be noticeable. Later (around 18 weeks), the fetal heart beat can be heard with a stethoscope and fetal movements can be perceived by the examiner.

Laboratory

In certain settings, pregnancy tests are not very helpful or practical because highly sensitive tests (positive +/- 10 days after conception) are not available or affordable. However, in cases where the possibility of pregnancy is difficult to rule out, a highly sensitive pregnancy test may be helpful, if part of routine clinic practice.

Relying on Lactational Amenorrhea Method (LAM)

The Lactational Amenorrhea Method (LAM) is a highly effective contraceptive method (98% protection during the first six months postpartum in women who are fully or nearly fully¹ breastfeeding and amenorrheic). The effectiveness of LAM in the second six months postpartum is under study.

A service provider can be reasonably sure that a woman is not pregnant if she is still amenorrheic, within the first six months postpartum, fully or nearly fully¹ breastfeeding, and has no clinical signs of pregnancy. When an accurate pregnancy test is not easily available or affordable, and a woman more than six months postpartum requests an IUD² or Norplant® implants or injectables, you can still be reasonably sure she is not pregnant if the woman has kept her breastfeeding frequency high³, and she is still amenorrheic.

It should be noted that bleeding in the first eight weeks (56 days) postpartum is NOT considered "menstrual" bleeding in breastfeeding women.

Source: Technical Guidance/Competence Working Group document Recommendations for Updating Selected Practices in Contraceptive Use: Results of a Technical Meeting, Volume I. Nov. 1994.

¹ "Fully" breastfeeding includes exclusive or almost exclusive breastfeeding (only occasional tastes of foods or water) day and night. "Nearly fully" breastfeeding means that supplemental feedings are given but comprise a minimal part of the infant's diet.

² It is more important to rule out pregnancy before inserting an IUD than before starting hormonal methods because of the risk of septic miscarriage.

³ A woman who breastfeeds 10 times per day or more, or who gives more than 80% of her infant's meals as breastfeeds, is at less risk of being fertile. Breastfeeding before giving each supplement is optimal.

Participant Handout 2.1: Explanation and Management of DMPA Side Effects

Side Effect/ Explanation	Investigation Steps	Management of Side Effect
<p>Spotting or Light Bleeding: This is lighter than regular menstruation and is not harmful, even if it persists for several weeks.</p>	<p>Usually, all that is needed is counseling and reassurance. A pelvic examination to rule out other causes of bleeding might reassure the client, but it is not medically indicated unless the history suggests the bleeding is not related to DMPA.</p>	<p>Vitamins or iron may be prescribed if you feel the client is weak or anemic. Reassure the client that she should come for consultation anytime for any problem. If she is dissatisfied even after reassurance, you may give 14-21 low dose or medium dose combined oral contraceptives and instruct her to take one each day. As an alternative, you may give her next injection up to four weeks early (this temporarily reduces bleeding). Reschedule her next injection for three months later.</p>
<p>Moderate Bleeding: Moderate bleeding is equivalent to a menstrual period, except that it is longer in duration. Moderate bleeding may last up to twice as long as a client's normal menstruation.</p>	<p>No investigation is usually required unless bleeding persists despite management. If this occurs, then rule out pregnancy (including ectopic pregnancy), abortion, reproductive tract infection (RTI), cancer and other gynecological problems.</p>	<p>If a woman has moderate bleeding, reassure her that this is normal and expected for up to 25-30% of women in the first three to six months of use. Bleeding periods become shorter and lighter over time. If counseling and reassurance are not sufficient, consider giving 14-21 low dose or medium dose combined oral contraceptives and instruct her to take one each day. (The estrogen in COCs helps rebuild the endometrium and reduces bleeding.) World Health Organization (WHO) studies show that 92% of the DMPA bleeding episodes will stop within 14 days after giving the estrogen in standard 50 mg COCs. Alternatively, 14-21 days of Premarin (1.25 mg daily) or ibuprofen (200 - 400 mg every 4 hours until bleeding subsides or up to 7 days) may be given. (Ibuprofen blocks prostaglandin synthesis and thus decreases uterine bleeding.) You may also give the next injection up to four weeks early in order to reduce bleeding temporarily. Irregular or prolonged bleeding may occur again after any of these measures until amenorrhea is established, usually after nine months of use.</p>
<p>Heavy bleeding: Heavy bleeding is greater than regular menstruation and more prolonged. Heavy bleeding is rare.</p>	<p>No investigation is usually required unless bleeding persists despite management. If this occurs, then rule out pregnancy (including ectopic pregnancy), abortion, reproductive tract infection (RTI), cancer and other gynecological problems.</p>	<p>You should give low-dose combined oral contraceptives or another form of estrogen for 14-21 days (one tablet per day). If bleeding is especially heavy, or bleeding is not reduced, you should refer the woman to a doctor, who can do the following:</p> <ol style="list-style-type: none"> 1. Evaluate the woman for other possible causes of uterine bleeding. 2. After a full evaluation, double the estrogen dose for three to seven days, followed by one COC for 11-14 days. 3. Give an injectable estrogen, estradiol cypionate, 5 mg intramuscular, if bleeding is very heavy. If not effective within 24 hours the dose may be repeated once. <p>Very heavy bleeding with DMPA is rare, about one woman in every 1000-2000. A dilatation and curettage (D & C) should <u>not</u> be done unless some other condition exists. Some providers may add methergine for treating heavy DMPA bleeding, similar to treatment for puerperal bleeding. Use of methergine should be limited to 0.2 mg taken orally, three to four times per day for two or three days. The effectiveness of methergine in reducing heavy DMPA-related bleeding is not documented, and this treatment should not be relied on as a regular means of controlling DMPA-related bleeding.</p>

Side Effect/ Explanation	Investigation Steps	Management of Side Effect
<p>Amenorrhea: 40 - 50% of women will stop menstruating at some point during the first 12 months of DMPA use. With continuous DMPA use, 75 - 80% of women will eventually stop menstruating. This is the most common reason for discontinuation. Women must be counseled to understand that this is normal and expected during use of DMPA. Like lactational amenorrhea, there are no harmful effects of DMPA amenorrhea, and there can be health benefits, such as improvement in anemia.</p>	<p>Review the client's record to see if she has been receiving her injections as scheduled. If not, rule out pregnancy.</p>	<ol style="list-style-type: none"> 1. Give reassurance that amenorrhea is normal and expected during DMPA use. 2. Amenorrhea during DMPA use, like amenorrhea during breastfeeding, is not harmful and can benefit the woman by preventing anemia. 3. A pregnancy test is not needed because of the high effectiveness of DMPA. 4. The woman should not fear that amenorrhea will lead to infertility or a premature menopause. Fertility returns the same after stopping DMPA whether or not she was amenorrheic. 5. Do <u>not</u> give estrogen treatment to induce withdrawal bleeding. This is usually not successful unless 2 or 3 cycles of oral contraceptives are given (which is not recommended).
<p>Weight Gain: The weight gain associated with DMPA use is due to an increase in appetite.</p>	<p>Ask client about eating and exercise habits. Weigh the client.</p>	<p>Counsel the client that fluctuations of one to two kg may occur. If the weight gain is less than 2.4 kg (5 lbs), reassure her that this is not significant. If the weight gain is more than this, counsel the client on diet and exercise. If the weight gain is unacceptable, counsel the client and help her choose another method.</p>
<p>Headaches: Headaches can be psychological or due to other conditions not necessarily related to DMPA use.</p>	<p>Ask if there has been a change in pattern or severity of headaches since beginning DMPA. Determine whether she has purulent nasal discharge and tenderness in the sinus area. Ask whether she has ever had high blood pressure.</p>	<p>Refer for treatment of sinusitis if present; continue DMPA. Regardless of history, check blood pressure. If it is elevated, repeat BP. If it becomes normal, continue DMPA injections. If systolic BP is 190 or higher, or diastolic BP is 110 or higher, wait another week before giving the next injection and refer the client as appropriate. If the BP is over 160/90, repeat BP on two more occasions over the next two weeks. If the BP remains over 160/90, refer the client for treatment. (Note: DMPA has very little or no effect on blood pressure.) If the headaches are definitely worse with injectables, counsel the client and help her choose a non-hormonal method.</p>
<p>Mood Changes: Mood changes, especially depression, may be associated with DMPA use.</p>	<p>Ask the client about possible causes, such as family, financial or social problems. Ask if mood changes have increased since going on DMPA.</p>	<p>Counsel accordingly and follow-up during her next return visit. If no other cause is found and the depression has worsened during DMPA use, counsel client on the use of another method.</p>
<p>Nausea: Nausea is rare with DMPA.</p>	<p>Rule out possible causes such as anemia, high or low blood pressure, low blood sugar, pregnancy, viral illness, intestinal parasites, or neurologic disease.</p>	<p>If nausea is slight, continue using DMPA. If the nausea is severe and the client attributes it to the use of DMPA, counsel her on the use of another method (even though nausea is seldom due to DMPA).</p>

Participant Handout 2.2: Case Study #1

[CLIENT NAME], a 28 year old, married woman, gravida 2, para 2 from [TOWN/NEIGHBORHOOD] visited [CLINIC NAME] for family planning. After the counseling she chose an injectable method, DMPA. A history was taken and a physical examination was done by the [CLINIC] midwife. No precaution to the use of the method was noted. Her weight was 50 kilos. She was given 150 mg of DMPA, deep I.M. into the deltoid muscle. She was advised to return to the clinic in 3 months, for her next injection. One month later, the client returned to the clinic complaining of on and off spotting which was light to moderate, and dizziness. The client was very much bothered by the spotting and thinking of stopping the method.

A physical examination revealed the following: pale conjunctiva, BP 100/70, pulse rate 88 per minute.

How would you manage this case?

Participant Handout 2.2: Case Study # 2

[CLIENT NAME], a 30 years old, married, gravida 2, para 2 woman from [CLIENT'S TOWN/ NEIGHBORHOOD], a regular patient at the [CLINIC NAME/LOCATION], visited the clinic on November 17 complaining of amenorrhea. [CLIENT NAME] is an acceptor of DMPA and received her fourth injection on October 12. Prior to this visit she was having on and off spotting and she was assured by the nurse at [CLINIC NAME] that this was a normal, expected effect of the method. But now, [CLIENT NAME] is very worried because a friend told her that because she was having amenorrhea she was probably pregnant.

How would you manage this case?

Participant Handout 2.2: Case Study # 3

[CLIENT NAME], a 30 year old married woman, gravida 5, para 5, from [CLIENT HOMETOWN], came to the clinic on November 18 complaining of severe headaches and on and off spotting. [CLIENT NAME] is a DMPA user who received her third injection of DMPA on October 20. During her last visit her record showed that she had gained 2 kg from her initial weight of 55 kg and her BP was 130/90. Prior to this visit, no medication was given and counseling was given by the physician.

How would you manage this case?

Participant Handout 2.3: Barriers to DMPA

1. WHEN CAN THE FIRST **DMPA** INJECTION BE GIVEN (INTERVAL)? HOW SOON DOES IT BECOME EFFECTIVE? IS A **BACK-UP METHOD** NEEDED?

DMPA may be given within the first seven days of the menstrual cycle or anytime you can be reasonably sure the client is not pregnant.

If injectable progestins are begun on or after the seventh day of the menstrual cycle in a woman who is at risk of pregnancy, a back-up method or abstinence may be advised. Although there is good reason to believe the effect on cervical mucus will promptly provide contraceptive protection within 24 hours, it may be prudent to consider a back-up method for up to seven days.

Rationale

Although ovulation can occur as early as day 10 of the menstrual cycle, this is rare. Fertile ovulation is very uncommon before day 12. Intercourse five days before ovulation may have as much as a 5% chance of resulting in pregnancy; however, since experts believe there are few ovulations before day 13, there is only a very small chance that intercourse on day seven of the cycle could result in pregnancy.

In general, use of DMPA within the first seven days after the woman's normal menses would assure that the probability of the woman being already pregnant, or becoming pregnant, is extremely low. One study reports a slight increase in pregnancy rates starting on day eight.

Although DMPA has no known teratogenic effects, fetal exposure should be avoided. In addition, one study has suggested that *in utero* exposure may increase the risk of low birth weight babies.

It is probable that DMPA effectively thickens cervical mucus within 24 hours. Consistent with this theory, progestin-only pills have been shown to produce a thickened mucus with low sperm penetration within three to four hours after pill ingestion. Natural progesterones also cause cervical mucus to become scant, thick, and sticky--decreasing or inhibiting sperm penetration--usually within 24 hours, but sometimes within 48 hours. Clinical observations also support this finding.

DMPA consistently inhibits ovulation.

2. WHEN CAN THE FIRST **DMPA** INJECTION BE GIVEN POSTPARTUM?

For Breastfeeding Women:

If the woman chooses to rely on the Lactational Amenorrhea Method (LAM), start injectable progestins when her menses returns (**Note:** In breastfeeding women, bleeding in the first 56 days [eight weeks] postpartum is NOT considered "menstrual" bleeding, because it is not preceded by ovulation) or when the woman is no longer fully or nearly fully breastfeeding or at six months postpartum, whichever comes first.

Participant Handout 2.3: Barriers to DMPA continued

If she does not want to rely on LAM, ideally wait at least six weeks postpartum to initiate DMPA.

For Non-Breastfeeding Women:

The first DMPA injection can be given immediately postpartum and whenever the service provider can be reasonably sure that the client is not pregnant.

Rationale

Risk of pregnancy during lactational amenorrhea is very low: <2% in the first six months postpartum if fully breastfeeding; <7% in first 12 months.

Wait to initiate DMPA until a breastfeeding woman is at least six weeks postpartum, due to concerns that the immature neonatal liver may have a decreased capacity to metabolize exogenous steroids. Studies have not detected any effects on the health or growth of breastfed babies of women who begin using DMPA at six weeks postpartum.

3. IS DMPA APPROPRIATE FOR USE IMMEDIATELY POSTABORTION?

Yes, DMPA is appropriate for use immediately post-abortion (spontaneous, unsafe or induced), in any trimester, and should be initiated within the first seven days postabortion (or any time you can be reasonably sure the client is not pregnant).

Rationale

Fertility returns almost immediately postabortion (spontaneous, unsafe or induced): within two weeks for first trimester abortion and within four weeks for second trimester abortion. Within six weeks after an abortion, 75% of women have ovulated. While there may be a theoretical concern of increased thrombogenic effect with COC-use in the first week postabortion, there is no known clinical thrombogenic effect of DMPA; therefore, it can be safely used immediately postabortion (after a spontaneous, unsafe or induced abortion).

4. ARE THERE ANY AGE/PARITY RESTRICTIONS ON DMPA USE?

No. However, young and/or childless women in particular need to understand that, on average, it takes a woman four months longer to become pregnant after discontinuing DMPA than after discontinuing COCs, IUDs, or barrier methods.

DMPA may be used by women through menopause. Risks for use of DMPA for older women appear minimal.

Participant Handout 2.3: Barriers to DMPA continued

For young adults, some evidence suggests that use of DMPA within two years of menarche may pose an additional long-term risk for osteoporosis. However, for those adolescents age 15 and under, for whom DMPA is the most appropriate method, the benefits of the method generally outweigh the risks.

Rationale

After discontinuing DMPA, about 50% of women conceive by seven months (i.e., 10 months after the last injection). After discontinuing other methods, 50% of women conceive in three months. Residual amounts of DMPA will remain in circulation for about seven to nine months after an injection, at which time serum levels of DMPA become undetectable. By about two to three years after discontinuation of DMPA, the proportion of women who have conceived is virtually the same as for those who have discontinued use of other methods.

DMPA confers many non-contraceptive benefits including decreased menstrual blood loss, as well as protection against endometriosis, acute PID, and ectopic pregnancy and, of particular importance to older women, protection against endometrial cancer. DMPA may also inhibit intravascular sickling, an additional benefit to women at risk for sickle cell disease. Other effects which may be attributed to DMPA use include a slight increase in weight and slight (non-clinically significant) alterations in plasma lipid profiles. A theoretical risk of osteoporosis is currently under study.

Regarding young adults, the suppression of ovulation with DMPA results in low estrogen levels, and estrogen is necessary for the development and maintenance of strong bones (to prevent osteoporosis). The peak strength (density) of spinal bone is reached by girls around age 16; the greatest increase in bone density occurs in the first two years post-menarche. Thus, some evidence suggests that a hypoestrogenic state, within the first two years after menarche, may increase the risk of osteoporosis later in life, particularly for women with other risk factors for osteoporosis (e.g., women who are small-boned, underweight, not black, smokers or malnourished).

5. WHAT IS THE PREFERRED SITE OF A DMPA INJECTION?

Both the arm (deltoid) and the gluteal muscle are acceptable. The deltoid is generally more acceptable to the client and has easier access for service providers, however, the client's preference should be taken into consideration. The DMPA injection is deep intra-muscular and the injection site **should not be massaged**.

Rationale

In order to be effective, DMPA needs to be released slowly over time. Massaging at the site of DMPA injection increases immediate absorption, which could result in decreased effectiveness.

Participant Handout 2.3: Barriers to DMPA continued

6. IS THERE A NEED FOR A REST PERIOD AFTER A CERTAIN PERIOD OF USE OF DMPA, AND IS THERE A MAXIMUM RECOMMENDED DURATION OF USE?

No, there is no need for a rest period. DMPA may be used for as long as a woman wishes to avoid pregnancy.

Rationale

There is no cumulative effect of DMPA; the time required to clear the drug from the body is the same after multiple injections as after a single injection.

7. SHOULD DMPA BE DISCONTINUED BECAUSE OF EXTENDED AMENORRHEA?

No, there is no medical reason to discontinue. The client should be reassured that amenorrhea with DMPA is common, is not harmful, and may be beneficial (i.e., decreased anemia). The question of whether DMPA may be related to osteoporosis is under study. In theory, this may be a particular concern for older women. (See p. 27 concerning DMPA before age 16.)

Rationale

The likelihood of amenorrhea increases with increased duration of progestin-only injectable use (50% at end of first year, two-thirds of women by end of second year of use). Women who are counseled about this possible side effect will be less concerned if they experience extended amenorrhea. Extended amenorrhea resulting from use of DMPA is due to endometrial atrophy. There is no risk of endometrial hyperplasia. In fact, DMPA is protective against endometrial cancer.

8. HOW MUCH GRACE PERIOD IS THERE FOR SUBSEQUENT DMPA INJECTIONS?

For DMPA, on a three month schedule, it is acceptable to give the next injection:

- up to two weeks late and possibly up to four weeks late
- DMPA may be given up to four weeks early (although this is not ideal)

If a client comes in after the grace period, advise her that delays in obtaining DMPA injections increase the risk of pregnancy and *in utero* exposure to DMPA. It is acceptable to give the DMPA injection if you can reasonably assure that she is not pregnant; although there is good reason to believe the effect on cervical mucus will provide contraceptive protection within 24 hours, it might be prudent to consider a back-up method for up to seven days. Reschedule the next injection for three months.

Rationale

DMPA blood levels consistently remain high enough to maintain contraceptive effect through three months post-injection and the pregnancy risk at four months post-injection is **extremely** low (and DMPA has no known teratogenic effects, although one study has suggested *in utero* DMPA exposure may possibly increase risk of low birth weight babies).

Participant Handout 2.3: Barriers to DMPA continued

It has been shown that the time it takes for progestin levels to be insufficient for contraception may vary somewhat from population to population. Studies show that Thai women seem to metabolize DMPA rapidly. Additionally, weight has also been shown to have an independent influence on progestin levels (in heavier women, the contraceptive effects last longer).

9. IF A WOMAN COMPLAINS OF HEAVIER MENSES AND/OR PROLONGED BLEEDING, IS THERE A MEDICAL BASIS FOR DISCONTINUING DMPA INJECTIONS?

Not usually. Irregular and prolonged bleeding episodes are common and expected in the first three to six months of use.

a) For **prolonged spotting or moderate bleeding** (equivalent to normal menstruation but longer in duration), the first approach should be counseling and reassurance. It should be explained that in the absence of evidence for other diseases, irregular bleeding commonly occurs in the first few months of DMPA use. If counseling and reassurance are not sufficient for the woman and she wishes to continue the method, the following management approaches may be tried:

- short term (for 7 to 21 days) COCs or estrogen
- ibuprofen (or presumably, similar non-steroidal anti-inflammatories)
- if the previous injection was given more than 4 weeks ago, giving another injection at this time may be effective

b) **Heavy bleeding** (greater than normal menstruation) is uncommon; it can usually be controlled by administration of increased doses of COCs (or estrogen). Some women will require stopping injectable progestins due to medical reasons for excessive bleeding or due to the client's preference.

- If suspected, abnormal conditions which cause prolonged or heavy bleeding should be evaluated and treated as appropriate.
- Some prolonged or heavy bleeding may fail to be corrected and injections may need to be discontinued.
- Evaluate and address anemia if indicated. Give nutritional advice on the need to increase the intake of iron containing foods.
- **Do not** perform uterine evacuation unless another medical condition is suspected. (Vacuum aspiration is generally the preferred method of uterine evacuation.)

Rationale

The number of bleeding days decreases with months of injectable progestin use. Management of prolonged or heavy bleeding may be achieved by:

- rebuilding endometrium with COCs/estrogen
- by ibuprofen (which blocks prostaglandin synthesis and thus decreases uterine bleeding)
- accelerating the arrival of amenorrhea with another injection (there is evidence that bleeding decreases with a subsequent injection)

Participant Handout 2.3: Barriers to DMPA continued

10. CAN DMPA BE SAFELY INITIATED AND RESUPPLIED BY NON-PHYSICIANS?

Yes. DMPA (including immediate postpartum injection in non-lactating women and postabortion injection) can be safely administered by any adequately trained service provider, such as nurses, midwives, pharmacists, CBD workers, etc.

Rationale

Nurses, midwives, and other community health workers can be appropriately trained to initiate and resupply injectable progestins.

11. SHOULD DMPA INJECTABLES BE PROVIDED IF INFECTION PREVENTION MEASURES CANNOT BE FOLLOWED?

No. All sites providing DMPA injectable contraceptives should consistently follow basic infection prevention measures, including:

- a) Handwashing
- b) Aseptic technique (including cleaning the DMPA injection site)
- c) Sterile needles and syringes (single-use, disposable needles/syringes are preferred)
- d) If sterilization of reusable needles/syringes is impossible, **decontamination with bleach followed by high-level disinfection**--if correctly executed--may be used
- e) Safe disposal of single-use needles/syringes

Rationale

Because injecting a steroid contraceptive, such as DMPA, penetrates the protective skin barrier, careful aseptic technique must be followed to prevent infection. One type of infection associated with this procedure is an injection abscess, commonly caused by normal skin flora (staph and strep). Thorough skin preparation done before the DMPA injection will remove most microorganisms from the client's skin which helps prevent cellulitis (skin infection) and abscess formation at the injection site.

Another concern is the increasing problem of transmission of hepatitis B and AIDS viruses to clients, health care providers, and clinic staff, especially cleaning and housekeeping personnel. To minimize this risk, whenever possible, single-use (disposable) needles and syringes should be used.

If reusable needles and syringes are used, they should be decontaminated immediately after use by soaking in 0.5% chlorine solution or another locally available and approved disinfectant. These practices, when combined with the proper disposal of single-use needles and syringes, protect clinic staff, especially cleaning and housekeeping personnel, from contracting hepatitis B or AIDS following accidental needle sticks. Following decontamination, reusable needles and syringes should be thoroughly cleaned and finally sterilized or high-level disinfected.

Participant Handout 3.1: Introduction to DMPA Counseling

Introduction

As with all other methods the support and introduction of DMPA should be client-focused and emphasize quality of care and informed choice. With DMPA, thorough and accurate counseling is critical to client satisfaction.

Remember that client counseling does not end with the first visit. Drop-outs usually occur because the service provider has **not** continued to counsel and support her client when she is experiencing a side effect such as irregular bleeding or amenorrhea.

In most cases what the provider needs to give is reassurance, attention and a listening ear. Show genuine interest and concern and encourage the client to come back anytime she has any questions, concerns or complaints.

Importance of DMPA Counseling

It is critical that clients receive accurate information. Providers must be able and willing to assist women who are experiencing side effects or those who have concerns about the safety of DMPA through counseling. It is very important to create confidence and share knowledge, so that the client returns to you with questions if necessary. This increases client satisfaction and client continuation.

Women often tolerate expected side effects, but they may discontinue the method if a side effect that they do not expect occurs. Women who do not receive information about side effects are twice as likely to discontinue using the method.

Purpose of DMPA Counseling

- Assist clients to adopt new contraceptive practice
- Prepare clients for potential side effects and their management
- Support clients during side effects and their management
- Enable clients to protect themselves from STDs
- Support clients to successfully use injectable hormones
- Assist clients to select and successfully use another method if she wishes when injectables are no longer appropriate or acceptable

Participant Handout 3.2: Principles of Counseling

Principles of Counseling

- 1. Acceptance:* Respect the client, whatever her circumstances. This enables the counselor to be understanding of the meaning and causes of her behavior and leads to interaction with the client that is non-judgmental; it also means recognizing the capacities and limitations of the client.
- 2. Individualization:* Recognize and understand each person's unique qualities; this requires the provider to know the specifics in every client's situation. Try to understand.
- 3. Confidentiality:* The client has a right to expect that her family planning needs will be kept confidential and that the clinician will not discuss her situation inappropriately or with other clients within earshot.
- 4. Controlled Emotional Involvement:* Be sensitive and responsive to the client's feelings without being emotionally involved.
- 5. Non-Judgmental Attitude:* Do not have pre-conceived ideas or draw premature conclusions about the client; do not allow personal biases/prejudices to effect the relationship.
- 6. Self-Determination:* The client should determine what her needs are and how they should be met; the counselor does not decide for her, does not manipulate her opinions, but guides her to be able to look at her needs objectively, understand the choices or alternatives open to her, and their implications and consequences.

Participant Handout 3.3: Key Points in Counseling Session

Key points in DMPA Counseling

Client counseling for DMPA must include some key points:

- Range of FP choices available
- Advantages/disadvantages of each method, including DMPA
- Bleeding irregularities and amenorrhea
- Slow return to fertility
- Other possible side effects
- Need to receive follow-up injections every three months
- Returning to clinic if there are problems
- Lack of protection from HIV/STDs
- Information for breastfeeding mothers
- Finding out whether amenorrhea is culturally acceptable or not acceptable

Participant Handout 3.4: Survey of Sexual Attitudes Game

Survey of Sexual Attitudes: Agree? Disagree?

1. Women should be virgins when they marry.
2. Birth control should be available for married people only.
3. The average woman wants sex less often than the average man.
4. Family Planning is against the culture.
5. Most people who contract STDs have had many sexual partners.
6. Vasectomy should not be considered by a man who has only one or two children or who is under the age of 35.
7. The choice of sterilization should be entirely voluntary.
8. Men enjoy sex without love more than women do.
9. Easy availability of birth control encourages sexual activity, especially among young people.
10. Using family planning is not a good idea before the wife has had her first child.
11. It is not unusual for people to be in love with more than one person at a time.
12. I would hesitate to marry someone with whom I had not had sexual intercourse.
13. Parents should not allow their daughters as much sexual freedom as they allow their sons.
14. Adolescents who have had children should be allowed to go to school.
15. Marital infidelity is equally acceptable or unacceptable for both sexes.
16. A child should be given sex education in school.
17. Prostitutes provide a useful social service.
18. Religion is a strong obstacle to acceptance of FP.
19. STDs are common among poor illiterates.
20. STDs are rarely seen in FP clinics because the clients are married women.
21. Women who are not married should not use injectable hormones for contraception.
22. Women with no children should not use injectable hormones for contraception.
23. Injectable hormones should be used by adolescents.
24. Injectable hormones should be used only by women who have had at least 3 children.

Participant Handout 3.5: Skills for Counseling

Skills for Effective Counseling

Both verbal and nonverbal communication skills are crucial in the counseling process. The acronyms "CLEAR" and "ROLES" help providers remember appropriate behaviors (both verbal and nonverbal) during counseling.

Appropriate Verbal Behaviors

Clarify
Listen
Encourage
Acknowledge
Reflect and Repeat

Appropriate Nonverbal Behaviors

Relax
Open and Approachable
Lean toward Client
Eye Contact
Sit straight and Smile

Participant Handout 3.6: The Counseling Process

Counseling Process

Thorough and accurate counseling is the most critical element to client satisfaction. Giving the clients complete, accurate and clear information about DMPA will make the method and potential side effects more widely accepted.

Service providers must have the competence and skills in counseling women who either want to use DMPA or want information about the various FP methods.

Bearing in mind the six steps in the counseling process ("GATHER") the following points should be taken into consideration:

G - *greet the client* in a friendly, warm, respectful, and helpful way. Create confidence, develop rapport, and make them feel at ease.

A - *ask* clients about their needs and reproductive goals. Know your clients. Obtain a history using standard forms. If you need to ask the client about sensitive matters, wait until she feels at ease with you.

T - *tell* the client about her choices for family planning. Tell your client about DMPA. When giving information about DMPA (or any other method) the following should be made clear: mechanism of action, effectiveness, side effects, return to fertility, and follow-up appointments.

H - *help the client to choose a method.*

Help your client choose a method by making her consider the suitability of each method to her health and lifestyle. Let your client do the talking. Allow her plenty of time to ask questions and express concerns. If your client chooses DMPA help her feel confident that she has opted for an effective, safe and convenient FP method.

E - *explain the correct use of the method.*

Explain how DMPA is used. It is given by deep intramuscular injection in the arm or buttocks. The site of the injection should not be massaged.

R - *repetition* of the method instructions by the client to help assess clarity of communication and *return* to the clinic in 3 months time and every 3 months thereafter. It is wise to give clients an appointment card on which is written the date of the next injection. Tell the clients they may visit the clinic anytime as needed for concerns or problems.

Participant Handout 3.7: Rumors and Misconceptions

Rumors

Rumors are unconfirmed stories that are transferred from one person to another by word of mouth. Rumors may spread faster if they are relayed over the media (radio, TV or newspapers).

Misconceptions

Misconceptions are mistaken notions or a wrong understanding of an idea. If a misconception is embellished with elaborate details and becomes a fanciful story, then it acquires the characteristics of a rumor.

Effective Ways to Counteract Rumors

Correcting rumors and misconceptions is one of the important tasks of service providers. It is not enough to simply tell clients that what they have heard of is not true. Some effective ways to counteract rumors about any method are:

- Find out where the rumor comes from and talk with people who started it or repeated it. Check whether there is some basis for the rumor. Determine the underlying fear to which the rumor relates.
- Use strong, solid scientific data to counteract misinformation. Explain the facts.
- Clarify information with the use of demonstrations and visual aids.
- Give examples of satisfied users, if they are willing to have their names used. This kind of personal example is most convincing.
- Find out what else the client needs to know in order to have confidence in the method.
- Always tell the truth. Never try to hide side effects or problems that might occur.

Participant Handout 3.8: Rumors and Misconceptions about DMPA

Rumor	Facts and Realities
A woman who uses DMPA will not be able to get pregnant again.	Most former users of DMPA can expect to become pregnant within a year after their last injection if they do not use another contraceptive. In a large study in Thailand, almost 70% of former DMPA users conceived within the first 12 months following discontinuation. Moreover, 92% conceived within 24 months, compared with 93% of IUD users and 94% of COC users. There is no difference in the time it takes fertility to return between long-term and short-term users and no difference between women with and without amenorrhea.
Injectable contraceptives cause cancer.	Research has clearly proven that DMPA does not cause cancer. In fact, it has been demonstrated that it protects against endometrial cancer. A WHO collaborative study of neoplasia and steroid contraceptives found no overall increased risk of breast cancer, no increased risk of invasive cervical cancer and no increased risk of ovarian or liver cancer.
DMPA causes nausea.	Nausea is <u>not</u> common with injectables. In fact, many women on injectable contraceptives find their appetite becomes stronger.
A woman will not have enough breast milk if she uses DMPA while breastfeeding.	Studies have shown that the amount of breast milk does not decrease when breastfeeding women use DMPA. DMPA has no effect on the composition of breastmilk, initiation or duration of breastfeeding or the growth and development of the infant.
Amenorrhea is bad for the health of women.	Amenorrhea is an expected result of using DMPA because women using DMPA do not ovulate. This kind of amenorrhea is not harmful. It helps prevent anemia and frees women from the discomfort and inconvenience of monthly bleeding.
DMPA causes abnormal or deformed babies.	There is no evidence that DMPA causes any abnormalities in infants. Studies done on infants who were exposed to DMPA while in the womb showed no increase in birth defects. These infants were followed until they were teenagers and the research found that their long-term physical and intellectual development was normal. It is worth noting that before DMPA was recognized as a contraceptive it was used in pregnant women to prevent miscarriage.
Clients need to stop using DMPA and have a "rest" after several injections.	There is no limit to the number of years DMPA can be continuously used. Among healthy women it can be given until menopause, when contraception is no longer needed.
DMPA causes abortion.	DMPA prevents ovulation. If no egg is released, no fertilization takes place--hence, no abortion.
DMPA causes amenorrhea, resulting in pregnancy or a tumor.	(A) There is amenorrhea in pregnancy, but not all amenorrhea is due to pregnancy. The amenorrhea experienced with DMPA use is due to the thinning of the endometrium, resulting from an increased level of progesterone. (B) Amenorrhea may be one of the signs of an existing tumor or cancer of the endometrium or ovary. The amenorrhea experienced with DMPA use is due to the reason given in (A). In fact, DMPA may prevent endometrial and ovarian tumors.
DMPA causes anemia.	During the first 3 - 6 months of DMPA use, irregular bleeding may be experienced in the form of spotting or minimal bleeding. But this usually stops within a few months of continuous use of DMPA. Since the bleeding is minimal, it rarely results in anemia. Anemia which is caused by blood loss or iron deficiency is actually prevented by injectables.

Rumor	Facts and Realities
DMPA causes masculine characteristics in females.	Studies have shown that the use of DMPA will not cause any masculinizing effect.
DMPA will result in retained menses causing blood toxicity.	No menses are formed with DMPA use since it results in an atrophic endometrium.
DMPA will result in a decrease in libido.	There may be other factors that result in a decrease in libido (e.g., anti-hypertensive drugs, exhaustion). However, DMPA has a very minimal effect on libido. On the contrary, the sense of security of not getting pregnant may increase the libido of the client.
Was DMPA banned in the United States because it was not considered safe?	No, in 1992 the U.S. Food and Drug Administration approved DMPA for use as a contraceptive, reversing a 1978 decision because data had accumulated that proved DMPA is a safe contraceptive. The decision to approve DMPA came after an extensive review of the method as well as the unanimous recommendation by an expert advisory medical panel.
Since DMPA has just been approved it is still in the "experimental" stage and the Government should not use it to experiment with.	DMPA as a contraceptive method was developed in the 1960's. It has been approved as a long-acting contraceptive method and is marketed in more than 90 countries. To date, over 30 million women have used DMPA, over 100,000 women have used it for more than 10 years, and currently between 8 and 9 million rely on DMPA for contraceptive protection.
DMPA causes onset of menopause.	DMPA does not affect menopause. The amenorrhea experienced with DMPA only occurs while using DMPA. When a client stops using DMPA, normal menstruation will return.

Participant Handout 3.9: Counseling Role Plays

1. I got the shot 3 months ago, and I am bleeding a lot. I have never bled for 3 weeks at a time like this, and I am scared that I am losing all of my blood. I don't think I should get another shot.
2. I have been getting shots for about nine months now. I don't get my menses anymore. I know the nurse said this might happen, but I am afraid that I will get sick.
3. I have gotten 2 shots. All my friends are scaring me, saying that I will never have another baby, or that if I do, the baby will be born deformed.
4. When informed about all methods available, the client responds, "How can you advise me to get this shot? I have read in the paper that it causes cancer."
5. I have been getting the shot for one year. I have gained 15 pounds! I don't want any more shots.
6. Tell me about this shot. It sounds like a good idea, but my priest says it causes abortion.
7. I have been getting shots for one year. Now I think I am pregnant. How could you have given me a method that would let me become pregnant?
8. I have recently gotten married. I don't want to get pregnant right away, but maybe in 5 - 8 months. Should I use the shot?
9. I used to take the "pill" and it made me very nauseated. Will the injection do that too?
10. I would like to have the injection, but I heard that it causes sexual desire to decrease. Is that true?
11. I read in the paper that the injection was banned in the United States and that it is being used as an "experiment" on [COUNTRY] women. Is this true?

Participant Handout 3.10: Observer's Guide to Counseling Role plays

What to observe:

1. Non-verbal communication/behavior that facilitated the counseling process.
2. Non-verbal communication/behavior that hindered the counseling process (that needs improvement).
3. Counseling principle(s) that was/were clearly illustrated.
4. Counseling principle(s) that was/were not clearly demonstrated.
5. Relevant key points taken up during the counseling session.
6. CLEAR ROLES skills strongly demonstrated.

7. CLEAR ROLES skills that need to be strengthened.

8. How was GATHER applied?

9. Completeness and accuracy of technical control.

10. Do you think the client is satisfied with the session?

11. Do you think the counselor is satisfied with the session?

12. How does the counselor show respect for the client? Caring for the client?
Honesty to the client? Confidentiality toward the client?

Participant Handout 3.11: Key Points of DMPA Counseling

Key Counseling Points:

Introduction of a new contraceptive requires much programmatic preparation. One of the most essential is that element which deals with communicating with potential users. Counseling for DMPA requires more time and effort from you, as clients respond to promotion/communication campaigns. You will need to answer their questions, and the questions of your colleagues. And you will need to screen and counsel very carefully to prepare women and their families for side effects associated with this method.

DMPA clients need to know, at a minimum, the following:

Informed Choice/Method Specific Counseling:

- Tell woman about **all** other methods available so that she genuinely understands all the options and can choose a method based on full and factual information. This includes the benefits and risks of each.
- Determine what she knows about **DMPA**, how she learned about it, what has she heard, what are her expectations from this method? Correct any unrealistic expectations about injections.
- Probe for and discuss with client local myths and rumors. Common myths and rumors include that DMPA causes irreversible infertility, causes cancer, or causes deformed babies. Correct any myths or rumors about injections. Clinicians may need to address these myths with colleagues as well as clients.

Explain in language the woman will understand (keep it simple):

- Benefits and risks of DMPA
- DMPA is an injection which must be given every 12 weeks (three months). This requires she come to see the doctor/clinic every three months.
- DMPA may be given at any time, but it is preferable to give it during the first seven days of her menstrual cycle. If the client does not receive the injection in the first seven days of her cycle, **she will need to use a back-up method** such as a condom or spermicide or abstain from intercourse for 24 hours following the first injection. After that, the injection will protect her very effectively from pregnancy.
- The injection is safe and effective, but there are possible side effects. Remember, however that giving clients a long list of side effects which they are unlikely to experience might discourage them from using the method. Common side effects could include:
 - **Irregular periods, spotting between periods, or no periods** for several months at a time, or no periods at all after the first three or four injections. Explore with woman how she may feel if she does not have any periods for several months. Will this worry her? Might she feel its unnatural and bad for her health? (In fact, amenorrhea helps prevent anemia.) The clinician should deal with all concerns a woman is likely to have in regard to these questions. Reassure her that her periods will resume after discontinuing DMPA.

Participant Handout 3.11: Key Points of DMPA Counseling cont.

- **Heavy/prolonged periods**, especially in the first two to three months of use. This is uncommon and can be managed, but may pose social or family life problems in Hindu/Muslim cultures. (Explore with woman how she feels about this, how prolonged bleeding or frequent spotting may affect her daily life, etc.) (The physiology of menstruation may have to be explained if anxiety and fears about bleeding irregularities are expressed.)
- Client may experience **weight gain** or mild headaches.
- Client may experience mood changes or feel somewhat depressed at times.
- There is a delay of several months in the return to fertility following the last injection of DMPA.
- DMPA does not protect her from STDs, including HIV. If she is at risk, she can use DMPA but also must be counseled to use condoms (as does any client using any method who is at risk).

If after screening it is determined that DMPA is physically/medically appropriate for the client, that she, has been fully informed and counseled about DMPA, and has made the decision to use this method, prepare and administer injection.

Repeat Information After Providing Injection:

Injection is effective immediately if she is within the first 7 days of her menstrual cycle; if she is not, she must use back-up method for next 24 hours (condoms/spermicide or abstain from intercourse). *Provide her with condoms.* Reassure her she can come back to see you/clinic at any time if she experiences any side effects/problems; she should not wait for the next injection to resolve problems.

Tell her if she doesn't like the injection, or side effects are too troublesome, she can change to another method more appropriate for her.

Tell her she can be up to two weeks late for her next injection and still be effectively protected from pregnancy. Injections may also be given up to four weeks early. However, stress that it is better if she receives her injections on time, every three months.

Give her a definite return appointment (date/time).

Participant Handout 3.11: Key Points of DMPA Counseling cont.

Follow-up Visit:

- Discuss with client her experience so far with DMPA; any complaints, side effects.
- Repeat history checklist
- Check BP and weight.

If the client is satisfied:

- Give next injection
- Give supportive counseling to ensure tolerance of menstrual irregularities
- Remind client of next visit
- Plan for return visit

If the client developed side effects:

- Perform physical, pelvic, and lab exams as needed
- Reassure the client and offer supportive counseling
- Manage the condition according to the Explanation and Management of DMPA Side Effects Table (Participant Handout 2.1)
- If provider cannot manage the condition, refer client to a physician or service point
- Advise client to use back-up method
- Give injection if client is fully recovered
- If the client is dissatisfied with method, help her choose another method.

If she is more than two weeks late for her next injection:

- Examine client for possible pregnancy.
- Advise client to use back-up method until next period, or give one cycle of COCs and instruct her to return for repeat exam in one month.
- If negative for pregnancy, administer injection during this second visit.
- If any precautions have developed, counsel for selection of another method (except for irregular vaginal bleeding).

Participant Handout 3.12: Learning Guide for DMPA Counseling Skills

Participant's Name: _____

Clinical Site: _____

Trainer's Name: _____

TASK/ACTIVITY	CASES		
	1	2	3
INITIAL INTERVIEW:			
1. Greet client respectfully			
2. Ask what MCH/FP service she is seeking and respond to any general questions client may have			
3. Provide general information about MCH/FP services and FP methods available			
4. Explain what to expect during clinic visit			
5. Help client to make an informed choice: <ul style="list-style-type: none"> • Explore attitudes or religious beliefs that may favor or rule out one or more methods • Ask client about reproductive goals - space or limit births • Explain contraceptive choices available • Explain benefits/advantages of each • Explain risks/disadvantages of each • Inquire if client has questions and answer questions • Help client make decision about choice of method 			
METHOD SPECIFIC COUNSELING:			
6. Assure necessary privacy			
7. Obtain necessary biographic data (name, address, age, etc.)			
8. If client chooses DMPA: <ul style="list-style-type: none"> • Ask her what she knows about DMPA. Correct any myths/rumors or misinformation • Explain how DMPA works and its effectiveness in preventing pregnancy • Explain the potential side effects of DMPA <ul style="list-style-type: none"> - changes in menstrual periods (irregular/spotting/no periods) - possible delay in return to fertility of on average four months - she may gain weight - she may feel some depression • Explore with client how irregular or increased bleeding may affect her daily life, and if a delay in return to fertility is important to her • Explain what to expect regarding injection, frequency of return visits • Ask client if she has any questions and respond to them 			
9. Screen client for precautions using DMPA Screening Checklist (Px Handout 4.1): <ul style="list-style-type: none"> • Ask all questions on history checklist • Check weight and blood pressure • Record findings 			

TASK/ACTIVITY	CASES		
	1	2	3
METHOD SPECIFIC COUNSELING (continued):			
<p>10. If no precautions, prepare and administer DMPA injection according to following steps/procedure:</p> <p>Step 1: Wash hands Step 2: Check vial for contents/dosage Step 3: Gently shake DMPA vial Step 4: Open sterile package Step 5: Attach needle to syringe Step 6: Draw DMPA into syringe Step 7: Wipe site of injection Step 8: Allow antiseptic to dry Step 9: Administer 150 mg deep IM in deltoid/gluteal Step 10: Do not massage site of injection Step 11: Wash hands</p>			
<p>11. Repeat important instructions to client:</p> <ul style="list-style-type: none"> • DMPA injections take effect immediately if given between day 1 - 7 of menstrual cycle. Otherwise, client must use back-up method or abstain from intercourse for 24 hours following first injection. • Return for next injection in three months. Client may be up to 2 weeks late in returning and still be protected from pregnancy. However, it is better for client to return on time. • Remind client of menstrual changes she may experience and possibility of weight gain • Remind client to inform other health care providers she is on DMPA • Reassure client she may return at any time if she has questions or concerns 			
<p>12. Discuss with client returning immediately if she has any of the following problems:</p> <ul style="list-style-type: none"> • Heavy vaginal bleeding • Excessive weight gain • Headaches • Severe abdominal pain 			
13. Have client repeat back to you important instructions			
14. Give DMPA card with next appointment (time and date)			
15. Document/record the visit according to local clinic guidelines			

TASK/ACTIVITY	CASES		
	1	2	3
RETURN VISIT:			
1. Ask if any problems or complaints			
2. Repeat the history checklist			
3. Check blood pressure and weight			
4. If client is more than one month late, check for pregnancy			
5. If client has developed any precautions, or wants to discontinue DMPA, help her to make an informed choice of another method			
6. If client is satisfied with DMPA method, no precautions exist, and she wishes to continue, give DMPA injection (observing steps/procedure listed in no. 10 above.)			

Comments:

Participant Handout 4.1: Sample DMPA Screening Checklist

Ask the potential DMPA user the following questions:	Yes	No
1. Is your period overdue or are you possibly pregnant?		
If "Yes" to Question #1, DO NOT give DMPA.		
2. Have you missed a period?		
3. Have you been having any abnormal or unexpected bleeding?		
4. Do you have an undiagnosed lump in your breast or an abnormal discharge from your nipple?		
5. Do you have or have you had heart disease?		
6. Do you currently have liver disease?		
If there are any "Yes" answers to Questions #2 - #6, refer the client to a physician for further evaluation.		
7. Do you have diabetes?		
8. Do you have severe high blood pressure? (BP over 180/110)		
If there are any "Yes" answers to Questions #7 - #8, give DMPA, but follow the client more closely.		
9. Are you breastfeeding a baby who is less than six weeks old?		
If "Yes" to Question #9, ask the client to return for her injection when the baby is six weeks old.		

Participant Handout 4.2: Logistical Considerations

Logistical Considerations

Certain packaging, storage, and equipment concerns must be considered and accounted for when integrating DMPA into FP service delivery programs:

Packaging for DMPA:

- 1 cc glass vial, each vial containing enough DMPA for one injection
- 100 vials per distribution box
- 105 2 ml disposable sterile syringes with affixed 21, 22, or 23 gauge needles are provided with each distribution box.

Shelf Life for DMPA:

The DMPA made by Upjohn in Belgium is labeled with a shelf-life of five years. DMPA made by Upjohn in the US is currently labeled for a shelf-life of two and a half years. The two products are the same; the shelf-life of the US product will gradually be extended over a period of years (use the manufacturer's instructions as a guide for determining "extension period of shelf life").

Special Considerations:

- DMPA requires a sterile syringe and a 21 - 23 gauge needle for administration. Ample supplies must be available.
- Care must be taken to ensure syringes and needles are not removed from DMPA stocks for the administration of other drugs.
- Syringes and needles are manufactured for single-use only and must be safely disposed of (in a sharps container, for example) following DMPA administration. Attempts to re-sterilize needles and syringes may diminish their integrity, resulting in potentially unsafe or ineffective administration.
- Storage conditions are critical to product stability; particle size in aqueous suspensions like DMPA can change with temperature fluctuations. These changes can affect drug efficacy. Follow manufacturer's storage recommendations.
- Because DMPA is a suspension, the colloid may separate. Shaking the vial should return the suspension to a milky white color.
- Careful monitoring of the amount of DMPA use in the field is needed, especially since the real programmatic demand is unknown.
- The normal visual indicators for quality control of injectable drugs should be applied, e.g., physical damage to carton or product; broken seals; foreign matter inside vial or syringe package; leakage or "caking" of ingredients.

Participant Handout 4.3: Logistics Monitoring of Injectables

Instructions: Check the appropriate column (Yes or No) to indicate if the logistics requirements for DMPA service provision are met at the service delivery site. Any comments should be noted in the Remarks column.

ITEM	Yes	No	REMARKS
Is the store easily accessible?			
Is there a trained store keeper?			
Is there security against fire, theft, and damage?			
Are lighting and ventilation adequate?			
Is the store kept clean?			
Is insect and rodent infestation controlled?			
Are commodities stored off of the floor and away from the walls?			
Are there enough shelves for all supplies?			
Is the provider able to determine the appropriate quantity to order?			
Are appropriate forms for requisition available?			
Are stock records kept?			
Are stocks used "first to expire, first out"?			
Are supplies adequate?			

Participant Handout 4.4: Injection Procedures

Injection Procedures

Preparing Equipment, Supplies and Materials:

Prepare the supplies and materials needed for the procedure before the physical examination, so that the client does not have to wait very long on the examining table. Assemble the following equipment needed for injection:

- DMPA vial
- Sterile syringe & needle
- Cotton wool
- Locally available antiseptic to use to clean skin

If needles and syringes are to be used more than once they must be decontaminated, cleaned and sterilized after each use.

Preparing the Client:

- Provide comprehensive counseling for each and every client.
- Ensure that the client understands method advantages, as well as the side effects of irregular bleeding, amenorrhea, and possible delayed return of ovulation.
- Explain the procedure to the client.
- Encourage the client to ask questions to reduce apprehension and anxiety.
- Show her the supplies and materials that will be used.
- Explain that the syringes and needles are sterile.
- Reassure the client before and after the injection.

Dosage of DMPA:

The usual dosage for DMPA is 150 mg in 1 ml to be given by deep intramuscular (IM) injection every three months.

Participant Handout 4.5: Steps in Administering a DMPA Injection

Steps in Administering a DMPA Injection

1. Wash hands thoroughly with soap and water and air dry them or use a clean towel.
2. Check vial for contents/dosage.
3. Roll the vial back and forth between the palms of your hands to mix the solution or shake it lightly. Don't shake the vial vigorously, as it will become foamy. Failure to mix the solution will permit some of the drug to remain as sediment in the vial, resulting in an inadequate dose and possibly lower contraceptive effectiveness.
4. If using a pre-packaged sterile syringe and needle, open the sterile packet. If using a boiled needle and syringe, remove the needle and syringe from the covered container with dry, boiled forceps, pick-ups or tongs. Use a 21 - 23 gauge needle, 1 - 1.5 inches in length with a 2 - 5 ml syringe.

Note: Never use a syringe which has not been high-level disinfected or sterilized between each use. Studies have shown that changing only the needle and not the syringe between clients can result in the transmission of hepatitis B virus.

5. Attach the needle to the syringe by holding the base (hub) of the needle and the barrel of the syringe.
6. Turn the vial containing the DMPA upside down and draw 1 cc (containing 150 mg of DMPA) into the syringe. Use the same needle you will use for the injection.

Note: Do not leave one needle inserted in the vial cap for multiple uses. This practice is dangerous because it provides a direct route for bacteria to enter the medicine vial and contaminate the fluid between each use.

7. Disinfect/clean the skin at the site of the injection with alcohols or other antiseptics removing any visible dirt or soil.
8. Allow the antiseptic to dry before giving the injection.
9. Administer the injection, aspirate first to ensure that the needle is not in a vein. Inject DMPA deep into the deltoid or gluteal muscle, without massaging the site.

Note: Both the deltoid (arm) and gluteal (buttocks) muscles are acceptable sites for injection. Client preference should be taken into consideration. The deltoid site is generally more accessible to service providers and more acceptable to clients.

10. Instruct the client **not** to massage the area after the injection. Massaging may speed the release of progestin and thus shorten the period of efficacy. It may also disperse the DMPA so that it is not properly absorbed.
11. Wash hands again.

Participant Handout 4.6: Postinjection Care

Postinjection Instructions to Client

Inform all clients of the following:

When the injection takes effect:

The injection takes effect immediately if it is given between day one and day seven of the client's cycle counting first day of menses as day 1. When it is given after day seven a backup method should be used for 24 hours.

What if she returns early or late?

The next injection may be given up to two weeks after the scheduled date without concern for reduced effectiveness in case the client was unable to return on the appointed date. The prolonged presence of DMPA in the body gives a two week "grace" period during which she is still protected against pregnancy. A pregnancy test is not needed.

Instruct the client that if she is more than two weeks late, she should abstain from sexual intercourse or reliably use an additional method until she returns. If you are reasonably assured that she was not at risk of pregnancy, you may give her the next injection. If you are unsure, do a sensitive pregnancy test or ask her to use another method of contraception, and have her return in one month. After one month you may determine if she is free of pregnancy, and if so, you may give her the next injection.

The next injection may be given up to four weeks early, if the woman cannot return at the scheduled time. Giving the next injection early is also one form of managing prolonged bleeding or spotting, when this occurs within four weeks of the next scheduled visit.

When should the client return?

Instruct the client to return in three months for her next injection. Tell her that she may return anytime that she has questions or problems. Tell her to come back at once if she experiences any of the following signs or symptoms which might indicate a serious condition which may or may not be related to injectable contraceptive use:

- heavy vaginal bleeding
- excessive weight gain
- headaches
- severe abdominal pain

Follow-up Visits:

It is essential to make clients understand the importance of returning faithfully every three months for their injections. Give the client a card or slip of paper with the date of her next scheduled visit. Explain the date and make sure that your client understands.

Note: To make sure your client understands all of the above instructions, ask her to repeat them.

Participant Handout 4.7: Infection Prevention

Disposal of Contaminated Items

After completing each injection of DMPA, staff should properly dispose of any contaminated objects, including gauze, cotton or other waste items. Single-use needles and syringes should be placed in a puncture-proof container made of cardboard, metal or glass. Intravenous fluid containers make good "sharps" containers. To prevent needlestick accidents, single-use needles and syringes should not be recapped, bent or broken prior to disposal. An ideal way to dispose of needles is to put them in a plastic bottle, (an alcohol bottle for example) filled with chlorine solution. Bury the bottle when it is full where it is unlikely to be dug-up or disturbed.

Processing Reusable Needles and Syringes

Whenever possible, disposable needles and syringes should be used. When reusable needles and syringes are used they should be decontaminated, cleaned, rinsed and sterilized or high-level disinfected. The following steps should be followed:

Decontamination:

- Prepare 0.5% chlorine bleach solution. (For example, if 3.5% chlorine bleach is used, mix one part bleach with six parts water; if 5.0% chlorine bleach is used, mix one part bleach with nine parts water. Another alternative is to mix 7 grams of calcium hypochlorite [70% available chlorine] in 1 liter of water.)
- Wearing protective gloves, rinse the needle and syringe in cold water.
- Draw chlorine solution into the syringe and squirt it back into the bowl of chlorine solution. Repeat five times.
- Submerge the syringe and needle in the solution for 10 minutes. Do not submerge metal for more than 20 minutes as this causes rapid rusting.
- Remove items and rinse.

Cleaning:

- Using protective gloves, disassemble the needle and syringe.
- Using soap and water, remove any visible "soil."
- Rinse with clean water.

Participant Handout 4.7: Infection Prevention continued

Sterilizing or High-Level Disinfection

Heat Sterilization:

- Wet the lumen of the needle before sterilizing.
- Heat items at 121°C at 15 lbs/in² of pressure.
- Heat items for 20 minutes if unwrapped; 30 minutes if wrapped.
- Remove the items only when they are dry. Remove the items using handling forceps and store in a covered container.

High-Level Disinfection:

- Instruments must be covered completely by water during boiling.
- Do not add anything to pot after water begins to boil.
- Boil for 20 minutes in a pot with a lid (start timing when water begins to boil).
- Air dry before use or storage and store in a covered, previously high-level disinfected container, **or**
- Soak for 20 minutes in 8% formaldehyde or a glutaraldehyde and rinse well in water that has been boiled for 20 minutes.
- Air dry before use or storage.

**Participant Handout 5.1:
Summary Framework of Activities:
Client Return Visits or Follow-Up**

- 1. Interview the Client**

- 2. Weigh client and take blood pressure if it was high during an earlier visit (over 140/90)**

- 3. If the Client is satisfied:**
 - Give next injection
 - Give supportive counseling to ensure tolerance of menstrual irregularities
 - Remind client of next visit
 - Plan for return visit

If the client developed conditions, side effects or complications:

- Perform physical, pelvic and lab exams as needed
- Reassure the client and offer supportive counseling
- Manage the condition according to Unit 2
- If provider cannot manage the condition, refer client to a physician or service point
- Advise client to use back-up method
- Give injection if client is fully recovered
- If the client is dissatisfied with method, help her choose another method

Participant Handout 5.2: Steps of Return Visit

Return Visit

Using DMPA as a method requires clients to return to the clinic every three months (90 days) for the next injection. Every client should be advised during counseling and during post-injection instructions about the importance of returning to the clinic on her scheduled date and should be given an appointment card or slip of paper with the date of the appointment written on it.

Steps Performed during Follow-Up

During each follow-up visit the care provider should perform the following procedures or steps:

Interviewing the Client:

- Ask the client whether both she and her partner are satisfied with the method.
- Ask if they have any questions, problems, or concerns.
- Ask if the client has encountered any side effects such as menstrual irregularities.
- Take and record BP and weight.

Satisfied Client:

- If the client is satisfied with the method and has no contraindications or precautions to continued use, give the client her next injection.
- Give supportive counseling and continued reassurance to help ensure a high tolerance for menstrual irregularities.
- Remind client to return to the clinic on the scheduled date, or any time if she has problems (e.g., side effects) or any condition that may cause dissatisfaction with the method.
- Plan for return or next visit.

If the client has experienced a complication or side effect:

- If client has developed a complication or troublesome side effect, examine her and gather information about what she experienced.
- Reassure and provide further counseling.
- Manage the condition according to the instructions in Unit 2.
- If it is beyond your capability to manage, refer client to the physician or to the appropriate service center.
- If the next scheduled injection can be given after the management of the condition or as per physician's advice, then give the injection. If not, advise client to use a temporary back-up method and return after she has fully managed/recovered from the side effects or precautions.
- If the client finds the method unacceptable due to the developed condition, then help her choose another method.

Participant Handout 5.2: Steps of Return Visit continued

What if the Client Returns Early or Late?

If the client returns late, the next injection may be given up to two weeks after the scheduled date without concern for reduced effectiveness. The prolonged presence of DMPA in the body gives a two week "grace" period during which she is still protected against pregnancy. A pregnancy test is not needed.

If the woman is more than two weeks late, and you are reasonably assured that she is not at risk of pregnancy (e.g., she has abstained or reliably used another method), you may give her the next injection. If you are unsure, do a sensitive pregnancy test or place her on another method of contraception and have her return in one month. After one month you may determine if she is free of pregnancy and if so, you may give the next injection.

If the client comes to the clinic early for her injection, it may be given up to four weeks early. Giving the injection early is also one form of managing prolonged bleeding or spotting, when this occurs within four weeks of the next scheduled visit.

Participant Handout 5.3: Defaulting and Dropping-Out

Returning to continue injections every three months should be emphasized every time the client visits the clinic. However, some clients still cannot come on schedule and some may stop coming altogether. In this session we will learn how to minimize the problem of method discontinuation.

Definition of a Defaulter

A defaulter is a DMPA client who does not return to the clinic on her scheduled injection date. (She may be injected within two weeks following her scheduled date or up to four weeks early, although this is not ideal.)

Definition of a Drop-out

A drop-out is a DMPA acceptor who does not return to the clinic within the two week grace period following the date of her scheduled injection as long as she does not report to another service site for the injection. (After the two week grace period, she must use a back-up method for one month. Once pregnancy has been ruled out, she can be given DMPA.)

Participant Handout 5.4: Reasons for Defaulting and Remedies

Possible Reasons for Defaulting and Remedies

Reason 1: Client forgot the date of return appointment and remembered later.

Remedy: To help the client remember her next injection date, give her an appointment card or calendar with the date written on it (or circled, if it is a calendar). If no printed card or calendar is available, give her a slip of paper with the appointment written on it. For women who may not be very aware of dates, try to help them remember by linking the appointment date with an important event such as a religious or national holiday or using a person in whom they can confide to remind them.

Reason 2: Long distance from the client's home to the clinic or the length of time the client has to wait in the clinic is prohibitive.

Remedy: Develop an out-reach project. Go to the client in her home. If the long clinic wait is part of the problem, suggest times for the client to come when the clinic is less busy or develop a plan to reduce client waiting time.

Reason 3: Financial reasons (not enough money to pay for transportation to the clinic).

Remedy: Deliver the method to the client's doorstep or find out about the possibility of transferring the client to a site near to her home and refer her to it.

Reason 4: There is no one at home to take care of the children.

Remedy: Deliver the method to the client's doorstep, or counsel her for informed choice of other long-term or permanent method. If you have her chosen method, provide it or if not, refer her to a clinic provider that does.

Reason 5: Non-availability of clinic staff to give the injection.

Remedy: Train all clinicians in the use of DMPA and emphasize the importance of good human relations when working with clients. Start this training as soon as you return from the final training in order to prevent the non-availability of clinic staff for giving the injection according to the guidelines.

Participant Handout 5.5: Reasons for Dropping-Out and Remedies

Possible Reasons for Dropping-out and Remedies

Reason 1: Client's concern over menstrual irregularities or side effects.

Remedy: Give client adequate counseling on the safety and effectiveness of DMPA as well as what to expect during DMPA use and information about possible side effects. Most importantly, tell her that these menstrual irregularities are not dangerous and are normal while using DMPA. Counsel the client for informed choice of another family planning method, if necessary.

Reason 2: Misconceptions, misinformation or rumors they might have heard about the method.

Remedy: Make sure that the initial counseling of the client is adequate and includes information about rumors, misconceptions and misinformation. Use counseling skills to find out the extent of the misconceptions, misinformation or rumors and clear them up.

Reason 3: Client is not adequately counseled about what to expect during the use of the method.

Remedy: Be sure that initial counseling is adequate and repeat counseling during subsequent visits.

Reason 4: Client is forced to switch to another method because supplies of DMPA are not available.

Remedy: Perform regular inventories of supplies of DMPA and make sure requisitioning is done on a timely basis.

Reason 5: Client wants to have another child.

Remedy: Counsel the client on the scientifically recommended spacing of pregnancies and determine if she would be "at risk" as the result of a pregnancy. (Is she too young, too old, or is her pregnancy too soon following her last delivery?) Provide relevant guidance for maintaining health during her next pregnancy. Review health benefits of DMPA and possible delay of return of ovulation after using DMPA. Encourage client to return to you any time she wishes to do so after stopping DMPA.

Participant Handout 5.6: Follow-up Strategies

Strategies to Follow-up Defaulters and Drop-outs

The service provider can use various strategies to follow-up defaulters to remind them that their injection is overdue and to convince drop-outs to resume their injections. **Reminder:** A woman is entitled to discontinue her injections at any time.

The following are several suggestions:

- Strategy 1:** By word of mouth. The provider should send word to the client through her neighbor or friends whom she trusts, reminding her to return to the clinic. This can be done even before the injection is due.
- Strategy 2:** Write a note to the client if she has not come on her due date to remind her that she is expected to return to the clinic within two weeks of the due date.
- Strategy 3:** Contact the client by telephone, either directly or through a neighbor. However, it is important to maintain confidentiality. The provider should only contact the client through a neighbor or friend if the client has given permission to do so.
- Strategy 4:** Use local radio broadcasts to remind clients and the community about the advantages of family planning services and to dispel rumors and misconceptions. Solicit satisfied clients and respected community leaders to discuss family planning and DMPA on the local radio broadcast to encourage clients to return.
- Strategy 5:** The service provider or community-based worker should visit the client home to find out why the client has not returned to the clinic.

Note: Home visits should not only be done for drop-outs, but for continuing users as well.

Participant Handout 5.7: Home Visits

Objectives of a Home Visit

There are several things that can be accomplished during a home visit:

1. Find out if the client is comfortable and satisfied with the method.
2. Answer questions or concerns she may have.
3. Find out if she has a problem or is experiencing side effects.
4. Reinforce the initial counseling given to the client.

Preparing for the Home Visit

The service provider should:

- Review the client's records.
- Identify clients for a home visit and purposes for the visit.
- Record the names and addresses and scheduled date of injections of those you plan to visit.
- Sort clients by location and plan your visits by area.

What to Do on a Home Visit

- Talk to the client personally and in private to establish rapport.
- Be patient in determining why the client has not returned to the clinic.
- Write down her reasons and transfer your notes to the client record when you return to the clinic.
- Answer her queries completely and honestly; show concern for problems she may have.
- Counsel her, emphasizing the importance of returning to the clinic for her injection on her due date, or give the injection at home according to your standard practices.
- Set up a date for her return.
- If the client fails to return within the grace period, tell her to use another non-hormonal method and set a date for a clinic visit.
- If you cannot convince her to return for an injection and if the client wishes to be protected from pregnancy, help her choose another method.

If the client is more than two weeks late you may still give the injection if you can establish that the client is not pregnant.

Rule out pregnancy by:

- Taking a careful history
- Performing a sensitive pregnancy test
- Performing a physical examination

However, if you are not sure whether the client is pregnant, counsel her to use a non-hormonal method for a month until you can determine definitely that she is not pregnant.

Participant Handout 5.8: Competency-Based Checklist for Injectables

Instructions: Check the appropriate column (S = satisfactory, U = unsatisfactory) to indicate whether the service provider satisfactorily performs the task. Any comments may be noted to the right in the "Remarks" column.

TASK/ACTIVITY	S	U	REMARKS
INITIAL CLIENT INTERVIEW			
Greets client			
Offers client a seat			
Assures privacy			
Establishes rapport by asking about client/family			
Uses simple language			
Asks client about reproductive goals			
Counsels client about all methods			
Gives advantages & disadvantages of each method			
Gives effectiveness and safety of each method			
Allows client to choose the method			
If the client chooses injectables, the following tasks should also be performed:			
Obtains necessary information about client's ideas and fears			
Explains how the injectables work			
Explains potential side effects, especially those related to menstrual irregularities			
Explains frequency of return visits			
Ensures that client understands			
Explains what to expect regarding injection			
Encourages client to ask questions			
Uses open-ended questions			

TASK/ACTIVITY	S	U	REMARKS
Displays visual aids			
Shows client the injectable vial			
Encourages client to return to the clinic if there are any questions or concerns			
SCREENING			
Explains procedure to client			
Administers screening checklist			
Takes blood pressure			
Weighs client			
Records findings			
Attaches completed screening checklist to client's record			
Refers client to a physician, only if appropriate			
If client is less than six weeks postpartum and breastfeeding, encourages her to return when the infant is six weeks old			
ADMINISTERING THE INJECTION			
Washes hands with soap and water			
Assembles all materials needed			
Explains procedure to client			
Shows client supplies to be used			
Reassures client			
Allows client to choose injection site			
If using DMPA, gently shakes vial			
Uses sterile technique in assembling syringe			
Completely draws the fluid into the syringe			
Cleans the injection site with antiseptic			
Allows the site to dry before injecting			
Instructs the client not to massage the site			
Inserts the needle deep into the muscle			
Withdraws the plunger			
Injects the contents			

TASK/ACTIVITY	S	U	REMARKS
If appropriate, gives back-up method to the client			
Records information on client's card			
Instructs client when to return			
INFECTION PREVENTION			
Washes hands before and after procedure			
Air dries hands or uses clean towel			
Drops used needle into a bottle of 0.5% chlorine solution			
Does not recap, bend or break needles before disposal			
Disposes of used needles and syringes by burning or burying			
If syringes and needles must be reused the following procedures are followed:			
Decontaminates items in 0.5% chlorine solution			
Cleans items with soap and water and rinses with clean water			
If sterilizing items, wets the lumen of the needle, heats in autoclave at 121° C for 20 minutes if unwrapped or 30 minutes if wrapped			
If high-level disinfecting items, covers items with water and boils for 30 minutes			
Removes items when dry with sterile or HLD forceps			
Stores items in a covered, sterile container			
If this is the client's first visit, the following tasks should be performed and observed:			
Gives appointment card with date			
Gives verbal instructions			
Allows client to repeat instructions			
Instructs client to return early if she has questions or concerns			
Provides back-up method if appropriate			

TASK/ACTIVITY	S	U	REMARKS
If this is a follow-up visit for the client, the following tasks should be performed and observed:			
Asks client about her experience with the method			
Cross checks appointment date			
Checks and records weight			
Records any other relevant information			
Gives satisfied client supportive counseling			
Gives date for return visit			
Examines client who has complaints and takes history			
Reassures and provides further counseling			
Manages side effects appropriately			
Refers client when appropriate			
Helps client choose another method if not satisfied			
If a client returns early, administers DMPA up to 4 weeks early			
If a client returns late, administers DMPA up to 2 weeks late			
If client returns after "grace period," rules out pregnancy before next injection			
Follows-up defaulters or drop-outs			

Transparency 1.1: Unit 1 Objectives

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

1. Discuss the characteristics of DMPA.
2. State the effectiveness and safety of DMPA as compared to other methods.
3. Discuss the mechanism of action of DMPA.
4. Enumerate at least five advantages and five disadvantages of DMPA.
5. Name at least three non-contraceptive benefits of DMPA.
6. Name at least three indications for the use of DMPA.
7. Identify the precautions and other considerations to the use of DMPA.
8. List the common side effects of DMPA as well as possible complications.
9. Discuss the timing of the first injection.

Transparency 1.2: Characteristics of DMPA

DMPA or medroxyprogesterone acetate (also called Depo-Provera) is a three month injectable contraceptive containing a synthetic progestin which resembles the female hormone progesterone. Each dose contains 150 mg of the hormone, which is released slowly into the blood stream from the site of intramuscular injection and provides the client/user with a safe and highly effective form of contraception.

Transparency 1.3: Effectiveness of DMPA

DMPA is a highly effective contraceptive method. With a standard regimen, pregnancy rates are usually lower than one per 100 woman-years for DMPA (see **Population Reports**, "New Era for Injectables," K-5, August 1995). Injectables are comparable in effectiveness to Norplant® implants, TCU 380A IUD, and voluntary sterilization.

Unplanned pregnancies are rare because injectables suppress ovulation in the great majority of cycles and because a woman needs only to obtain the next injection at the right time in order to assure continued effectiveness. Since DMPA does not require daily use there is less chance for user error. The standard regimen is 150 mg given every three months.

Several different regimens of DMPA have been used. In a recent randomized trial of two DMPA doses, none of the women receiving the standard 150 mg dose conceived, but the pregnancy rate among women receiving 100 mg every three months was only 0.44 per 100 woman-years (n=268). With higher doses and a longer injection interval—250 to 450 mg every six months—pregnancy rates have ranged from 0 to 3.6 per 100 woman-years. The only standard regimen currently in use is 150 mg given every three months.

The DMPA vial must be shaken to suspend the DMPA in the solution, but not so vigorously that the liquid becomes frothy. The injection must be aseptically given deep into the muscle and the injection site **should not be massaged** because this accelerates absorption. Using the correct technique so the dose will be absorbed at the correct rate is critical to contraceptive effectiveness.

Transparency 1.4: Safety of DMPA

DMPA is a very safe contraceptive. Like other progestin-only contraceptives, it can be used by women who want a highly effective contraceptive, including women who are breastfeeding or who are not eligible to use estrogen-containing combined oral contraceptives. More than 10 million couples throughout the world are using an injectable contraceptive in more than 100 countries.

The United States Food and Drug Administration (USFDA) approved DMPA for contraceptive use in October 1992. Studies by the World Health Organization (WHO) give reassurance that DMPA presents no overall risks for cancer, congenital malformations, or infertility. This research has evaluated more than 3 million woman-months of DMPA use. The research found:

- DMPA, like oral contraceptives, exerts a strong protective effect against endometrial cancer.
- No overall increased risk of breast cancer with DMPA use.
- No relation between ovarian cancer and the use of DMPA.
(Researchers had expected that DMPA would protect women against ovarian cancer as oral contraceptives do.)
- DMPA was not found to affect the risk of developing liver cancer in areas where hepatitis B is endemic.

Transparency 1.4: Safety of DMPA continued

Further research results include:

- DMPA does not appear to increase a woman's risk of developing invasive cervical cancer, even after a period of 10 years.
- DMPA does not cause any clinically significant changes in blood pressure or on the coagulation of the fibrinolytic system affecting thrombosis.
- Studies of "in utero exposure to DMPA" found no differences in the health, growth, sexual development, aggression, physical activity, or sex role identity of teenage children exposed in utero to DMPA as compared to other children.
- The use of DMPA does not permanently inhibit fertility, although it takes a woman four months longer to become pregnant after discontinuing DMPA than after discontinuing COCs, IUDs, or barrier methods.

Note: WHO studies report a small increased risk of cancer in young women who had recently started DMPA. Breast cancer is uncommon in young women and it is not clear whether bias contributed to the increase. Because the risk remains very low, no special precaution is needed for young women or recent users.

Transparency 1.5: Precautions and Other Considerations

There is only one primary precaution to the use of DMPA:

- Pregnancy, either known or suspected

(This means do not give DMPA.)

There are secondary precautions to the use of the method:

- Undiagnosed abnormal vaginal bleeding
- Breast cancer, known or suspected
- Amenorrhea not related to pregnancy or lactation
- Heart disease
- Acute liver or gallbladder disease

(This means the client should be referred to a physician for further evaluation.)

There are several other considerations to the use of DMPA:

- Diabetes Mellitus
- Hypertension

(This means DMPA may be given, but the client should be followed more closely.)

Note: Women who are breastfeeding should wait until 6 weeks postpartum before using DMPA.

Transparency 2.1: Unit 2 Objectives

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

1. Manage DMPA side-effects.
2. Explain how to improve the quality of service by overcoming barriers to DMPA use.

Transparency 3.1: Unit 3 Objectives

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

1. Discuss the importance of counseling for DMPA clients.
2. Explain the principles of counseling.
3. Discuss the key points to be included in the counseling session.
4. Explain the role of values and attitudes in counseling.
5. Discuss the necessary skills (CLEAR ROLES) and steps (GATHER) necessary for effective counseling.
6. Demonstrate the skills, techniques and principles used to effectively counsel clients and dispel rumors and misconceptions, while showing respect, caring, honesty and confidentiality during the classroom role play.
7. Demonstrate how to counsel clients contemplating DMPA as a contraceptive method.

Transparency 4.1: Unit 4 Objectives

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

1. Demonstrate knowledge, skills, and attitudes appropriate in screening prospective DMPA acceptors with the use of a checklist.
2. Discuss logistical considerations for provision of DMPA services.
3. Explain the procedures to be followed in giving a DMPA injection.
4. Perform actual injection procedures.
5. Explain the instructions given to a client after the injection.
6. Discuss infection prevention for DMPA use.

Transparency 4.2: Preparing the Client for Injection

Preparing Equipment, Supplies and Materials:

Prepare the supplies and materials needed for the procedure before the physical examination, so that the client does not have to wait very long on the examining table. Assemble the following equipment needed for injection:

- DMPA vial
- Sterile syringe & needle
- Cotton wool
- Locally available antiseptic to use to clean skin

If needles and syringes are to be used more than once they must be decontaminated, cleaned and sterilized after each use.

Preparing the Client:

- Provide comprehensive counseling for each and every client.
- Ensure that the client understands method advantages, as well as the side effects of irregular bleeding, amenorrhea, and possible delayed return of ovulation.
- Explain the procedure to the client.
- Encourage the client to ask questions to reduce apprehension and anxiety.
- Show her the supplies and materials that will be used.
- Explain that the syringes and needles are sterile.
- Reassure the client before and after the injection.

Dosage of DMPA:

The usual dosage for DMPA is 150 mg in 1 ml to be given by deep intramuscular (IM) injection every three months.

Transparency 4.3: Postinjection Instructions to Client

Inform all clients of the following:

When the injection takes effect:

The injection takes effect immediately if it is given between day one and day seven of the client's cycle counting first day of menses as day 1. When it is given after day seven a backup method should be used for 24 hours.

What if she returns early or late?

The next injection may be given up to two weeks after the scheduled date without concern for reduced effectiveness in case the client was unable to return on the appointed date. The prolonged presence of DMPA in the body gives a two week "grace" period during which she is still protected against pregnancy. A pregnancy test is not needed.

Instruct the client that if she is more than two weeks late, she should abstain or reliably use an additional method until she returns. If you are reasonably assured that she was not at risk of pregnancy, you may give her the next injection. If you are unsure, do a sensitive pregnancy test or ask her to use another method of contraception, and have her return in one month. After one month you may determine if she is free of pregnancy, and if so, you may give her the next injection.

The next injection may be given up to four weeks early, if the woman cannot return at the scheduled time. Giving the next injection early is also one form of managing prolonged bleeding or spotting, when this occurs within four weeks of the next scheduled visit.

Transparency 4.3: Postinjection Instructions to Client continued

When should the client return?

Instruct the client to return in three months for her next injection. Tell her that she may return anytime that she has questions or problems.

Tell her to come back at once if she experiences any of the following signs or symptoms which might indicate a serious condition which may or may not be related to injectable contraceptive use:

- heavy vaginal bleeding
- excessive weight gain
- headaches
- severe abdominal pain

Follow-up Visits

Instructions for follow-up visits are covered in Unit 5. It is essential to make clients understand the importance of returning faithfully every three months for their injections. Give the client a card or slip of paper with the date of her next scheduled visit. Explain the date and make sure that your client understands.

Note: To make sure your client understands all of the above instructions, ask her to repeat them.

Transparency 5.1: Unit 5 Objectives

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

1. Discuss and demonstrate the steps/services given to a client during her return clinic visit.
2. Differentiate a DMPA defaulter from a drop-out.
3. Identify clients reasons for defaulting and discontinuing DMPA.
4. Discuss strategies to follow-up defaulters and drop-outs.
5. Demonstrate skills in managing returning clients, conducting home visits of defaulters and drop-outs, and managing the drop-outs who return to the clinic.

PROGESTIN-ONLY INJECTABLE CONTRACEPTIVES PRE/POST-TEST

Participant Name: _____

Instructions: Circle the letter(s) of the answer(s) you consider correct, tick off true or false.

1. DMPA is composed of
 - a. estrogen and progesterone
 - b. synthetic progestin medroxyprogesterone acetate derived from the natural hormone progesterone
 - c. norethindrone enanthate
 - d. synthetic estrogen derived from the natural hormone estrogen

2. The principal mechanisms of action of DMPA is to (circle one group of letter(s))
 - a. suppress ovulation
 - b. disables the sperm
 - c. prevent implantation
 - d. thicken cervical mucus
 - e. creates thin, atrophic endometrium
 - f. all of above

3. The **standard** regime (dose and schedule) of DMPA is
 - a. 100 mg every 8 weeks
 - b. 100 mg every 12 weeks
 - c. 150 mg every 8 weeks
 - d. 150 mg every 12 weeks

4. The dose of DMPA depends on
 - a. the age of the client
 - b. weight of the client
 - c. parity of the client
 - d. all of the above
 - e. none of the above

5. DMPA route of administration is
 - a. oral liquid
 - b. sub-cutaneous using 25 gauge 1 inch needle
 - c. intravenous using 24 gauge 1 inch needle
 - d. deep intramuscular using 21-23 gauge and 1 1/2 inch needle
 - e. an implant

6. Some of the disadvantages of DMPA include (circle all that apply)
 - a. frequent bleeding abnormalities
 - b. it can cause permanent infertility
 - c. it often causes nausea
 - d. it does not protect from STDs/HIV
 - e. it is not very effective

7. You may give a subsequent injection without requiring special lab tests or examinations to a woman who returns at (circle all that apply)
 - a. 10 weeks after the previous injection
 - b. 12 weeks after the previous injection
 - c. 14 weeks after the previous injection
 - d. 18 weeks after the previous injection

8. DMPA may be appropriate choice for (circle all that apply)
 - a. woman who wishes to postpone pregnancy for 6 months
 - b. woman over 40, smoker, with estrogen precautions
 - c. breastfeeding woman (less than six weeks postpartum)
 - d. woman taking rifampin
 - e. woman who has recently noticed a lump in her breast
 - f. woman wishing to postpone pregnancy for 2 or more years
 - g. woman wishing to prevent future pregnancies but unable or unwilling to undergo VSC

9. DMPA precautions apply to (circle all you consider a precaution)
 - a. nulliparous woman
 - b. breastfeeding woman (more than six weeks postpartum)
 - c. woman with suspected pregnancy
 - d. woman with benign/malignant liver disease
 - e. woman with undiagnosed vaginal bleeding
 - f. obese woman
 - g. women under age 30 years

10. If a woman comes for her first DMPA injection on day 8 of her menstrual cycle
 - a. she needs to wait for her next menstrual period before receiving DMPA injection
 - b. she is given DMPA but needs to use a backup method for up to 7 days following the injection
 - c. She needs to be given a higher dose of DMPA
 - d. she can be given DMPA injection and do nothing

- c. Because most physicians are very familiar with giving injections, there is no need for training them in how to provide DMPA services True _____ False _____
- d. DMPA may cause permanent infertility if used for over three years True _____ False _____
- e. It is more important to use a new needle than a new syringe with every DMPA injection True _____ False _____
16. Reusable syringes and needles once used may be reused if they have been treated as follows
- decontaminated, cleaned and boiled for 10 minutes
 - decontaminated, cleaned and boiled for 20 minutes
 - sterilized in an autoclave
 - none of above
17. A disposable syringe and needle
- can be reused if boiled for 20 minutes
 - should be recapped before disposal
 - can be used if autoclaved
 - none of the above
18. The vast majority of women who develop DMPA side effects
- must be referred to a specialist
 - can be advised and have side effects managed in the service providers clinic
 - need to discontinue DMPA immediately
 - are probably neurotic and should be discouraged from complaining
19. If a woman using DMPA returns with a complaint of slight bleeding for ten days you would
- refer her immediately to a specialist
 - counsel her that this problem is not harmful and is likely to improve
 - advise her she needs a D & C to investigate the cause
 - advise her to try another method
20. If a woman tells you she has heard that an injectable contraceptive should not be used to space pregnancies because it causes infertility, you could respond
- she is correct. Only women who wish no more future pregnancies can use DMPA
 - she must not listen to silly gossip that comes from uneducated people and must do what the doctor tells her
 - actually, studies conducted with many hundreds of thousands of women who used DMPA show that it does not cause infertility but rather only some delay in return to fertility

(bold = correct)

PROGESTIN-ONLY INJECTABLE CONTRACEPTIVES PRE/POST-TEST

Participant Name: _____

Instructions: Circle the letter(s) of the answer(s) you consider correct, tick off true or false.

1. DMPA is composed of
 - a. estrogen and progesterone
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5. DMPA route of administration is
 - a. oral liquid
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 - c. intravenous using 24 gauge 1 inch needle
 - d. deep intramuscular using 21-23 gauge and 1 1/2 inch needle**
 - e. an implant

6. Some of the disadvantages of DMPA include (circle all that apply)
 - a. **frequent bleeding abnormalities**
 - b. it can cause permanent infertility
 - c. it often causes nausea
 - d. **it does not protect from STDs/HIV**
 - e. it is not very effective

7. You may give a subsequent injection without requiring special lab tests or examinations to a woman who returns at (circle all that apply)
 - a. **10 weeks after the previous injection**
 - b. **12 weeks after the previous injection**
 - c. **14 weeks after the previous injection**
 - d. 18 weeks after the previous injection

8. DMPA may be appropriate choice for (circle all that apply)
 - a. woman who wishes to postpone pregnancy for 6 months
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 - c. breastfeeding woman (less than six weeks postpartum)
 - d. **woman taking rifampin**
 - e. woman who has recently noticed a lump in her breast
 - f. **woman wishing to postpone pregnancy for 2 or more years**
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 - c. She needs to be given a higher dose of DMPA
 - d. she can be given DMPA injection and do nothing

- c. Because most physicians are very familiar with giving injections, there is no need for training them in how to provide DMPA services True _____ False X
- d. DMPA may cause permanent infertility if used for over three years True _____ False X
- e. It is more important to use a new needle than a new syringe with every DMPA injection True _____ False X
16. Reusable syringes and needles once used may be reused if they have been treated as follows
- decontaminated, cleaned and boiled for 10 minutes
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 - sterilized in an autoclave
 - none of above
17. A disposable syringe and needle
- can be reused if boiled for 20 minutes
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 - can be used if autoclaved
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20. If a woman tells you she has heard that an injectable contraceptive should not be used to space pregnancies because it causes infertility, you could respond
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 - she must not listen to silly gossip that comes from uneducated people and must do what the doctor tells her
 - actually, studies conducted with many hundreds of thousands of women who used DMPA show that it does not cause infertility but rather only some delay in return to fertility**

Comprehensive FP/RH Curriculum Participant Evaluation

Module 6: DMPA

Rate each of the following statements as to whether or not you agree with them, using the following key:

- | | |
|---|----------------------------|
| 5 | Strongly agree |
| 4 | Somewhat agree |
| 3 | Neither agree nor disagree |
| 2 | Somewhat disagree |
| 1 | Strongly disagree |

Course Materials

I feel that:

- | | |
|---|-----------|
| • The objectives of the module were clearly defined. | 5 4 3 2 1 |
| • The material was presented clearly and in an organized fashion. | 5 4 3 2 1 |
| • The pre-/post-test accurately assessed my in-course learning. | 5 4 3 2 1 |
| • The competency-based performance checklists were useful. | 5 4 3 2 1 |

Technical Information

- | | |
|--|-----------|
| I learned new information in this course. | 5 4 3 2 1 |
| I will now be able to: | |
| • give a technical overview of DMPA as a method | 5 4 3 2 1 |
| • manage side effects related to DMPA | 5 4 3 2 1 |
| • counsel clients who are considering using DMPA | 5 4 3 2 1 |
| • screen clients and provide DMPA services | 5 4 3 2 1 |
| • follow-up with DMPA users | 5 4 3 2 1 |

Training Methodology

- | | |
|--|-----------|
| The trainers' presentations were clear and organized. | 5 4 3 2 1 |
| Class discussion contributed to my learning. | 5 4 3 2 1 |
| I learned practical skills in the role plays and case studies. | 5 4 3 2 1 |
| The required reading was informative. | 5 4 3 2 1 |
| The trainers encouraged my questions and input. | 5 4 3 2 1 |

Training Location & Schedule

The training site and schedule were convenient.

5 4 3 2 1

The necessary materials were available.

5 4 3 2 1

Suggestions

What was the most useful part of this training? _____

What was the least useful part of this training? _____

What suggestions do you have to improve the module? Please feel free to reference any of the topics above. _____
