• State-of-the-Art Family Planning and Reproductive Health Services • State-of-the-Art Family

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Optimal Birth Spacing and Family Planning Counseling Training Manual

CATALYST
consortium

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ACKNOWLEDGMENTS

The Optimal Birth Spacing Initiative (OBSI) is an activity of the CATALYST Consortium designed to place optimal birth spacing on the global public health agenda by instituting a recommendation for three to five year birth intervals at the policy, programmatic and behavioral levels. The objectives of OBSI are: (1) to create consensus among international organizations and program managers on the strong association between birth intervals of three to five years and improved maternal and child health outcomes; (2) to strengthen health services, provider training and community programs with birth spacing programming; and (3) to empower individuals and families to adopt birth spacing behaviors.

The five members of the Catalyst Consortium are Academy for Educational Development (AED), Pathfinder International, Centre for Development and Population Activities (CEDPA), Meridian Group International and PROFAMILIA/Colombia.

The optimal birth spacing content in this Manual presents all the new research data commissioned by CATALYST. The data show greater mortality and morbidity when birth intervals are less than three years and more than five years. CATALYST also incorporated the finding of focus groups conducted in five countries: Bolivia, Peru, Egypt, India and Pakistan. The focus groups contributed data on behavioral and other factors that prevent women from carrying out their desired birth spacing decisions. This manual integrates both the qualitative and quantitative data that CATALYST has gathered.

Dr. Reynaldo Pareja, CATALYST Behavior Change Communications Senior Advisor, and Dr. Suzanne Knecht, CATALYST Reproductive Health Officer, incorporated current available OBS data into the existing family training manual, along with Elizabeth Miller Pittman, a consultant to CATALYST, who also incorporated the OBSI content and edited the two sources.

Information from two Pathfinder training modules written by Cathy Solter, Director of Technical Services, was used to produce this Family Planning Manual. The modules are part of Pathfinder's Comprehensive Reproductive Health and Family Planning Training Curriculum, They are Module 1, “Introduction to Family Planning and the Health of Women and Children and an Overview of Family Planning Methods”, and Module 3, “Counseling for Family Planning Services”.

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NOTES TO THE TRAINER

PURPOSE

This training manual seeks to present an integrated approach for family planning counselors, including physicians, nurses and midwives, to use when counseling clients in decision making on *optimal birth spacing (OBS)* and family planning. Depending on the needs of the participants, the manual can be used as a three-four day training program, or as part of a longer more comprehensive family planning and reproductive health training of OBS and family planning counselors. Individual sections of the manual can also be adapted for use with community-based, social or auxiliary workers.

The knowledge, skills and attitudes suggested here are applicable for counseling of single and married men and women, adolescents, and others in need of family planning counseling. The manual includes current information on contraceptives integrated with recent research results showing the advantages of a space between births of 3 - 5 years. The intent is that the information will help clients make informed decisions about planning pregnancies in ways beneficial to them for health or other reasons.

Upon completion of trainings that use this manual, the participants will be able to provide effective general, contraceptive method-specific, and follow-up counseling on family planning to clients and their families. They will be able to identify feelings and values that impact the counseling process. They will understand principles and elements of counseling, outside factors that influence the success of counseling, and appropriate responses to the myths and rumors that clients or clients families might have about family planning counseling.

DESIGN

This training manual is designed for dual use: as a counseling training for practitioners already familiar with optimal birth spacing practices and family planning, and as a module to used as part of a more comprehensive family planning training program that includes more detailed information on family planning.

Through the use of a variety of training methodologies, this manual actively involves participants in the learning process by means of case studies, role-playing, and simulation skills practice. The manual includes a Competency-Based Training (CBT) skills checklist to be used after simulation practices. In addition, there are trainer resources, participant materials, training evaluation tools, and a bibliography. There are also knowledge assessment questions for use before and after the training.

PARTICIPANT SELECTION

The manual is targeted at mid-level family planning counselors, such as nurses, nurse midwives, nurse assistants, physicians, and others, who already have skills and training in women's reproductive health. However, managers of health clinics and health programs are also desired participants. Their understanding and support of program goals, challenges, and resource requirements is essential,

USING THE MANUAL

- This manual gives guidance on how to plan, conduct, and evaluate this training course.

- This manual suggests that trainers modify the curriculum and length of training depending on identified participant wishes and levels of expertise.

- The objective of this training manual is to change behaviors through learning experiences that affect participant knowledge, attitudes and skills.

- Trainer and participant training references and resource materials are identified in a bibliography in the Overview.

- This manual is divided into two volumes, the *Trainer's Manual* and the *Participant's Manual*. The *Trainer's Manual* contains the "Training Guide" and the "Appendix."

  - The "Training Guide" presents the information in two columns.

    - The first column, "Content," has technical information.
    - The second column, "Training/Learning Methods," contains the training methodology (lecture, role-play, discussion, etc.) to be used and the time required to complete each activity.
    - References to participant handouts and transparencies occur as both text and symbols in the "training/learning methods" section. The symbols have number designations that refer to specific objectives and the sequence within the specific objectives.

  - The "Appendix" contains:

    - "Participant Handouts"
      - "Transparencies"
      - Tools include the pre- and post-test, Competency-Based Training (CBT)
      - Skills checklists and counseling cue cards.

- The Participant's Manual contains:

  - Participant Handouts" for group exercises, case studies, pre- and post-tests, Competency Based Training (CBT) skills checklists, and a participant evaluation form.

    - "Content" drawn from the *Trainer's Manual* that can be used as reference material by the participant. The material should be photocopied and available by the time training begins. The materials may be given out as indicated in each specific learning objective or at the end of the course when appropriate. Hole-punching the handouts beforehand and providing participants with a 3-ring binder at the beginning of the course can facilitate the organization of handouts as they are distributed throughout the training.

GUIDE TO SYMBOLS

Participant Handout

Transparency

INFORMED CHOICE

In order for a family planning counseling client to make an informed choice about family planning, s/he must be conscious of current and relevant information about family planning choices and their consequences and be able to make a free and independent choice about them. Family planning counseling seeks to provide this information. Proof of "informed choice" may require specific written documentation in some countries and situations.

Being **"informed"** about family planning means that:

- The client is educated about the health and other benefits of a 3-5 year birth interval for the child to be born, the woman, the man and the next child to be born.
- The client is educated about the advantages and disadvantages of family planning methods including harmful side effects.
- The client has and understands current and relevant information on family planning in order to make a conscious decision with respect to his/her own reproductive health.
- The client is self-aware and able to consciously evaluate his/her own needs in order to be able to determine the best method for him or her self with the help of a family planning counselor.

A **"choice"** about family planning means that:

- A client is conscious of a range of family planning methods to choose from.
- A client makes a conscious choice on whether or not and how he or she wishes to be treated with respect to family planning.
- A client makes a conscious and independent decision and can select from available contraceptive methods or medical procedures.

DEMONSTRATION TECHNIQUE

The Five-Step Method of Demonstration and Return Demonstration is a method of training by demonstration. It is used to teach technical skills where circumstances are not appropriate for actual practice. It can be used to develop skills in, for example, inserting an IUD, performing physical examinations including breast or pelvic examinations, or other skills whose development requires a demonstration. The following list outlines the five steps:

1. **Overall Picture:** The trainer identifies and describes the skill or procedure for participants so that they have a clear overall picture of it and provides a skills checklist. The overall picture should include why and when the procedure is necessary, who needs to develop it, and how it is performed. Skills or procedures should be performed following the steps in the skills checklist. Classroom dummies may also be used for practice so that participants become proficient in the procedure before needing to perform it on a human being.

2. **Trainer Demonstration:** The trainer should accompany the demonstration with verbal instruction. If a dummy is used, the participant or co-trainer should sit at its head and role-play the part of the client. The trainer should explain the procedure and talk to the dummy as if it were a live client so that participants will be better prepared for real clinical situations and the potential problems that may arise. The role-player can then speak on behalf of the dummy in response.

3. **Trainer/Participant Talk-Through:** To reinforce the training, the trainer should repeat the demonstration this time allowing a participant to give a step-by-step description of what the trainer is doing.

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

4. **Participant Talk-Through:** A participant then performs the procedure accompanied by a verbal step-by-step description. 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 group in pairs. Each participant practices the demonstration with his/her 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.

DO'S AND DON'TS OF TRAINING

Trainers should ALWAYS keep in mind the following "do’s and don'ts" during any learning session.

DO'S

- **Do** maintain good eye contact
- **Do** prepare in advance
- **Do** involve participants
- **Do** use visual aids
- **Do** speak clearly
- **Do** speak loud enough
- **Do** encourage questions
- **Do** recap at the end of each session
- **Do** bridge one topic to the next
- **Do** encourage participation
- **Do** write clearly and boldly
- **Do** summarize
- **Do** use logical sequencing of topics
- **Do** use good time management
- **Do** K.I.S. (Keep It Simple)
- **Do** give feedback
- **Do** position visuals so everyone can see them
- **Do** avoid distracting mannerisms and distractions in the room
- **Do** be aware of the participants' body language
- **Do** keep the group on focused on the task
- **Do** provide clear instructions
- **Do** check to see if your instructions are understood
- **Do** evaluate as you go
- **Do** be patient

DON'TS

- **Don't** talk to the flip chart
- **Don't** block the visual aids
- **Don't** stand in one spot--move around the room
- **Don't** ignore the participants' comments and feedback (verbal and non-verbal)
- **Don't** read from curriculum
- **Don't** touch participants
- **Don't** shout at participants

COUNSELING FOR FAMILY PLANNING SERVICES

OVERVIEW

INTRODUCTION:

Counseling is one of the critical elements in the provision of *quality* family planning services. Through counseling, providers help clients make and carry out their own choices about reproductive health and family planning, including optimal birth spacing and contraceptive methods. Recent studies have strongly indicated that spacing births three to five years apart greatly improves the survival and health of mothers during the pregnancy and postpartum stages, as well as that of infants during the prenatal, perinatal and postnatal stages of development. Furthermore, a three to five year birth space period gives parents more time to properly care for their other young children and can lessen economic constraints on the family. Once clients have the proper information on optimal birth spacing as well as contraceptive methods, they can make informed decisions regarding their reproductive lives. Good counseling leads to improved client relations. A well-treated client promotes family planning, returns when s/he needs to and continues to use optimal birth spacing and a chosen contraceptive method.

MANUAL TRAINING OBJECTIVE:

To prepare health workers with the necessary knowledge, skills and attitudes to offer effective general, method-specific and follow-up counseling so that clients can make informed decisions about optimal birth spacing and family planning methods.

SPECIFIC LEARNING OBJECTIVES:

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

1. Describe the key messages and major principles of optimal birth spacing (OBS) and family planning (FP).
2. Describe the health benefits of family planning and optimal birth spacing.
3. Explain the relationship between maternal and child mortality and high-risk factors such as maternal age, birth order, and birth interval.
4. Identify their own attitudes, feelings, and values, and how these impact the counseling process.
5. Explain the reasons for family planning counseling and factors that influence the success of counseling.
6. Describe the major principles of counseling.
7. Describe the essential elements and key steps of the counseling process.
8. Identify the effect of verbal and non-verbal interpersonal communication on the counseling process.
9. Review contraceptive methods: description, use, effectiveness, advantages and disadvantages, side effects, and relationship to sexuality.
10. Identify and respond to misconceptions and rumors raised by clients and their

families.
11. Explain the rights of the client.
12. Identify several ways to counsel and motivate men to make responsible choices.
13. Review the counseling modules and identify ways to adapt it appropriately for cultural and environmental factors.
14. Apply principles and steps of counseling in role plays.

SIMULATED SKILL PRACTICE:

Using role plays and cue cards designed for this manual, participants will **practice and demonstrate** their interpersonal communication and counseling skills for speaking with family planning clients and their families. The simulation should include practice responding to misconceptions and rumors about contraceptives; counseling mothers, mothers-in-law, and husbands or partners; educating on general and method-specific family planning; and counseling in follow-up visit for clients using various contraceptive methods.

TRAINING/LEARNING METHODOLOGY:

- Required reading
- Trainer presentation
- Class discussion
- Group exercises
- Role play simulated practice

RESOURCE REQUIREMENTS:

- Overhead projector
- Flipchart
- Markers
- Counseling cue cards for each FP method

EVALUATION METHODS:

- Pre- and post-test
- Observation and assessment during role play simulated practice
- Evaluation
- Direct verbal feedback

TIME REQUIRED:

- Workshop and simulated practice: 3 - 4 days

WORK FOR TRAINERS TO DO IN ADVANCE:

1. Prepare transparencies:
   - Transparency #0.1: Training Objectives
   - Transparency #0.2: Training Schedule
   - Transparency #1.1: Key Messages of Family Planning
   - Transparency #2.1 - 2.5: Statistics related to optimal birth spacing and use of contraceptive methods
   - Transparency #7.1: Elements of a Successful Counseling Session

2. Copy Participant Handouts.

3. Prepare copies of the pre-test and post-test for each participant.

4. Prepare necessary flipcharts, when applicable, before each session begins.

5. Have on hand slips of paper and stick-it notes for exercises such as the introduction, myths.

Note: *Trainers should read* Population Reports No. 35: Counseling Makes a Difference *before the training workshop begins.*

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Introduction

Resource Requirements:

- Markers
- Tape
- Flip chart paper
- Pens/pencils
- Cut-up strips of paper or stick-it notes
- Overhead projector

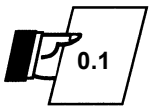
Time Required: 1 hour 40 minutes

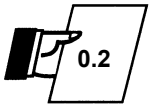
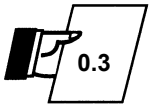
Work for Trainers to Do in Advance:

- Prepare *Participant Handouts 0.1, 0.2, 0.3, 0.4*
- Prepare *Transparencies 0.1, 0.2*
- Make copies of pre-test for participants

Introduction

CONTENT ***Knowledge/Attitudes/Skills***	Training/Learning Methods *(Time Required)*
INTRODUCING TRAINERS AND PARTICIPANTS	**INTRODUCTION OF PARTICIPANTS (20 MIN.):** The trainer(s) should: ►Greet participants and introduce yourself. ►Ask all participants to give their names. ►Divide participants into pairs. ►Ask participants to spend 10 minutes interviewing each other (5 minutes for each interview). Include the trainers in the exercise and pair them with participants. ►Participants may ask any questions that will help them be able to introduce their partner to the rest of the group. ►At the end of 10 minutes, ask each participant to introduce their partner to the rest of the group. **EXPECTATIONS (20 MIN.):**

CONTENT ***Knowledge/Attitudes/Skills***	Training/Learning Methods *(Time Required)*
DEFINE PARTICIPANTS' EXPECTATIONS OF THE COURSE 1. What do you hope to accomplish during this course? 2. Do you anticipate any difficulties during the course? 3. How do you think this training will help you at work?	The trainer should: ► Write the 3 questions separately on 3 pieces of flip chart paper. ► Ask the participants to divide up into groups of 3-4 people (depending on group size) and give each group strips of paper or stick-it notes to write on. ►Give each group 10 minutes to discuss the 3 questions and write their responses on the small pieces of paper. Adhere the responses to the appropriate flip chart paper. ►Review the responses, asking for further clarification as needed. ►Make note of all of the expectations so that you can refer to them throughout the course.
SUGGESTIONS FOR EFFECTIVE PARTICIPATION **DO:** ►Listen. ►Ask a question when you have one. ►Feel free to share an illustration or example. ►Request an example to clarify a point. ►Search for ways in which you can apply a general principle or idea to your work. ►Think of ways you can pass on ideas to your subordinates and co-workers. ►Be skeptical–don't automatically accept everything you hear. ►Participate in the discussion. ►Respect the opinion of others. **DON'T:** ►Try to develop an extreme problem just to prove the trainer doesn't have all the answers. (The trainer doesn't.) ►Close your mind by saying, "This is all fine in theory, but..." ►Assume that all topics covered will be equally relevant to your needs.	**EFFECTIVE PARTICIPATION (10 MIN.):** The trainer should: ►Ask participants for suggestions for effective participation. ►Give participants additional suggestions. ►Ask a participant to record the suggestions of the group. ►Distribute Participants Handout 0.1: Suggestions for Effective Participation. 

CONTENT ***Knowledge/Attitudes/Skills***	Training/Learning Methods *(Time Required)*
►Take extensive notes; the handouts will satisfy most of your needs. ►Sleep during class time. ►Discuss personal problems. ►Dominate the discussion. ►Interrupt.	
TRAINING OBJECTIVES By the end of the training, participants will be able to: 1. Describe the key messages of optimal birth spacing and family planning services. 2. Describe the health benefits of optimal birth spacing and family planning and the negative consequences of not using optimal birth spacing. 3. Explain the relationship between maternal and child mortality and high-risk factors such as maternal age, birth order, and birth interval. 4. Identify their own attitudes, feelings, and values, and how these impact the counseling process. 5. Explain the reasons for family planning counseling and factors that influence the success of counseling. 6. Describe the major principles of family planning counseling. 7. Describe the essential elements and key steps of the family planning counseling process. 8. Identify the impact of verbal and non-verbal interpersonal communication on the counseling process. 9. Review contraceptive methods: description, use, effectiveness, advantages and disadvantages, side effects and relationship to sexuality. 10. Identify and respond to misconceptions and rumors raised by clients and their families. 11. Explain the rights of the client. 12. Identify several ways to counsel and motivate men to make responsible choices. 13. Identify several ways to assess and adapt the counseling process appropriately taking into account cultural and environmental factors. 14. Apply principles and steps of counseling in role plays.	**REVIEW OF TRAINING OBJECTIVES AND SCHEDULE (10 MIN.):** The trainer should: Distribute Participants Handout 0.2: Training Objectives  Display *Transparency 0.1: Training Objectives* and review the objectives with the group, pointing out where their expectations will or can be met. Distribute Participants Handout 0.3: Training Schedule, display Transparency 0.2: Training Schedule and discuss. 
WHERE ARE WE? Starting each day with "Where Are We?" is our opportunity to review the previous days' material, especially the key points of	**TRAINER PRESENTATION: WHERE ARE WE? (10 MIN.):** The trainer should: ►Explain that "Where Are We?" requires the active cooperation of the participants, so be certain to make their role clear.

CONTENT ***Knowledge/Attitudes/Skills***	Training/Learning Methods *(Time Required)*
each session. Each day one participant will be assigned to conduct the exercise. This person should take some time to write down the key points from the day before. The participant who is assigned should briefly present these key points and then ask participants for any additions. **REFLECTIONS** After a full day of activities, we need to take time to look over what we have done and examine what it means to us individually. The "Reflections" activity is an opportunity for the trainers and participants to share feedback on the training activities and to identify areas that need reinforcement or further discussion. Therefore, each day, selected participants forming a housekeeping team will solicit feedback from the other participants during breaks or lunch and then at the end of the day will meet with the trainers to discuss how the day of training went. For the first session of "Reflections," the housekeeping team should ask other Participants the following questions and share responses with the trainers: ►What did I like about today and why? ►What did I not like about today and why? ►What did I learn and experience today that I will be able to use? The housekeeping team may vary the exercise to make it more interesting and less repetitive.	►Explain that the exercise "Where Are We?" will be a regular feature at the beginning of each day during the training session. ►This activity should be used to review the previous days' material, especially the key points of each session. ►Problems identified during the "Where Are We?" session should be resolved before continuing with the day's work (whenever possible), since unresolved issues may hinder the learning process. ►Distribute Participants Handout 0.4: Where Are We and Reflections. 0.4 ►Explain that the "Reflections" activity will be performed at the end of the day's activities. ►Be sure to close each day's activities with a session of "Reflections" on the day. ►Make a note of the participants and trainers' feedback. ►Attempt to address ideas and concerns during the discussion and during the following days' lesson plans. **Housekeeping Teams** ►Organize the participants into groups. ►Explain that each day these groups will be responsible for certain activities related to the training. The groups will be responsible for conducting both the "Reflections" and "Where Are We" exercises. They should also be responsible for getting participants to return on time after breaks and for conducting energizing exercises after breaks or lunch. Other responsibilities may be included, such as providing feedback to the trainers at the end of the day. **PRE-TEST (30 MIN.):** The trainer should: ►Explain to participants that a pre-test will

CONTENT ***Knowledge/Attitudes/Skills***	Training/Learning Methods *(Time Required)*
	be given before the training. ►Explain that the pre-test is used to determine what topics to focus the training on and, when compared with the post-test, to evaluate the training's effectiveness. The post-test taken after the training shows improvement in the participant's knowledge of the subject matter. ►Distribute the pre-test and allow participants 30 minutes to complete the pre-test. ►Using the *Answer Key*, review participants' answers to identify the areas of difficulties. Be sure to focus on these areas during training.

Specific Objective #1: Describe the key messages and major principles of optimal birth spacing (OBS) and Family Planning (FP) services

Resource Requirements:
- Markers
- Flip chart paper
- Overhead projector

Time Required: 45 minutes

Work for Trainers to Do in Advance:
- Prepare *Participant Handouts 1.1*
- Prepare *Transparencies 1.1*

Specific Objective #1

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
KEY MESSAGES OF OPTIMAL BIRTH SPACING AND FP 1. Voluntary optimal birth spacing of 3-5 years and FP are some of the most important **health** measures a couple and a nation can practice to reduce maternal and infant mortality and morbidity. 2. The delay of another birth for at least three years after the last birth profoundly reduces maternal and child morbidity and mortality. 3. The risk of death from pregnancy and childbirth, especially when birth spaces are short, is far greater than the risk of death from contraceptive use. 4. Important barriers to FP in any country include some imposed by a country's medical profession and others that are social, cultural and/or religious. Medical barriers are medical policies, standards and practices which are not scientifically justifiable and which may restrict clients' access to family planning services. Examples of social/cultural/religious barriers include the importance placed on having a male offspring and the prohibition by certain religions to use contraceptives.	**TRAINER PRESENTATION & DISCUSSION (15 MIN.):** The trainer should: ►Display and briefly discuss *Transparency 1.1: Key Messages of FP*, stressing them as the major concepts underlying entire course rationale. ►Discuss each message, one by one, and ask participants what they think is meant by each statement. Do they agree/disagree? Why?

Specific Objective #1

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
PRINCIPLES OF FP SERVICES 1. The cornerstone of a sound FP program is one that incorporates the following five principles: • **Voluntary choice on the part of the client** • **Informed choice** • **Availability of the widest range of FP methods possible** • **The proliferation of optimal birth spacing and contraceptive information to help clients make decisions appropriate for their individual situations: delay first birth, space births 3 - 5 years apart, or limit the number of births** • **Integration into other reproductive health (RH) services** 2. A client has **the right** to make an independent, well-informed, self aware, voluntary decision on a contraceptive method, as long as it is medically safe. Some might argue that if a precaution exists and the client is fully informed of the risks, the client's choice must still be honored by the clinician, although it might be preferable to refer the client to a medically trained health worker for a second opinion to prevent the client from being harmed. 3. **Confidentiality,** the right to have medical information treated in conformity with the medical code of ethics and laws regarding confidentiality of medical information. 4. **Alertness** of health professionals that all sexually active individuals are at some risk for **STDs** including **HIV** and **hepatitis B** and that they have a duty to warn clients that contraceptive methods do not necessarily provide protection from these diseases. For this reason, distribution of **latex condoms** should now be a mainstay of all FP programs. 5. The **involvement of communities and community leaders** in optimal birth spacing and FP programs helps to demystify family planning for those who may benefit from it.	CLASS DISCUSSION (15 MIN.): The trainer should: ►Start discussion by asking participants what they consider to be important principles of FP programming. ►Guide discussion around content, asking individual participants about what s/he thinks about the principles described. ►Explore with those participants who provide FP services their experience in implementing these principles. What are the challenges in implementing them in a busy clinic setting? (Distribute Participants *Handout 1.1: Key Messages and Major Principles of Optimal Birth Spacing and FP*.) DISCUSSION (15 MIN.): The trainer should: ►Discuss the involvement of other parties in FP services. Ask the following questions: a) Is this realistic? b) What are the problems in trying to involve husbands or partners? Mothers-in-law? Where does such involvement compromise the client's confidentiality? Are the rights of the client being taken into account?

Specific Objective #1

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
6. **Health care workers** assume a leadership role in educating clients, community, and special interest groups about health and other benefits of optimal birth spacing and FP. With their professionalism, they can influence decisions about family planning by: • integrating FP into Maternal and Child Health (MCH) services • supporting private-sector OBS/FP initiatives such as social marketing programs • introducing MCH/FP programs in factories, plantations, and other work sites	►Discuss the role of health care workers in client education. Ask the following questions: a) Is this done by participants now? b) How many are/have been involved in community and voluntary FP group activities? c) Do participants think their involvement can make a difference?

Specific Objective #2: Describe the health benefits of optimal birth spacing and family planning

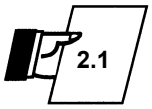
Resource Requirements:
- Markers
- Flip chart paper
- Overhead projector

Time Required: 35 minutes

Work for Trainers to Do in Advance:
- Prepare *Participant Handout 2.1*
- Prepare *Transparencies 2.1 - 2.5*

Specific Objective #2

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
HEALTH/NON-CONTRACEPTIVE BENEFITS *Significant Reduction in Maternal Mortality and Morbidity* • Globally, an estimated 500,000 women die each year from pregnancy and childbirth related causes, including septic abortions. • 90% of maternal mortality deaths occur in Africa and South Asia. • An unpublished WHO study estimates that complications from pregnancy and childbirth are the first or second cause of all deaths occurring in women ages 15-44 in developing countries. • **Major direct causes of death are hemorrhage, complications from unsafe induced abortion, toxemia, obstructed labor, and puerperal infection.** • Multiple and closely spaced pregnancies (less than 3 years between births) lead to and worsen such conditions as anemia, maternal malnutrition, and low birth-weight babies. • Research from Latin America shows that when there is less than 6 months and more than 59 months between the birth of one child and the conception of the next (the interpregnancy interval) women face an increased risk for	**TRAINER PRESENTATION & DISCUSSION (20 MIN.):** The trainer should: ►Display *Transparencies 2.1, 2.2, 2.3, 2.4, and 2.5*. ►Ask the participants: a) What observations can you make based on the transparencies? b) How can FP help reduce maternal mortality? c) How can FP help reduce infant mortality? d) How can optimal birth spacing of 3-5 years affect maternal and infant mortality? ►Using the transparencies, highlight the significant difference that prevention of unwanted

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
interval) women face an increased risk for morbidity and mortality (Conde-Agudelo: 2002) • Compared to a 18-23 month interpregnancy interval, intervals less than 6 months are associated with an increased risk for: maternal death (150%), third trimester bleeding (70%), anemia (30%), premature rupture of membranes (70%) and puerperal endometritis (30%) (Conde-Agudelo: 2002). • Using an optimal birth space of 3 - 5 years and an effective FP method reduces maternal deaths by helping to prevent high-risk pregnancies. • **Maternal deaths can be prevented if unwanted pregnancies are avoided and births are spaced apart at least three years.** *Reduction in Infant and Child Mortality and Morbidity* • Globally, an estimated 14.5 million infants and children under age five die every year, mainly from respiratory and diarrheal diseases complicated by malnutrition. • Studies show that **spacing of births by at least three years could prevent at least 20%** of infant deaths and significantly reduce the devastating morbidity effects suffered by children. In less developed countries (LDCs) (excluding China) 24% of infant deaths were averted when no births occurred before 36 months (Rutstein, 2000). **OTHER HEALTH BENEFITS OF FP** • Studies show that combined oral contraceptives (COCs) provide significant non-contraceptive health benefits. They are known to reduce the incidence of the following diseases and disorders: · Ectopic pregnancy · Ovarian cancer · Endometrial cancer · Ovarian cysts	pregnancies and optimal birth spacing of 3-5 years can make regarding the reduction of maternal and child mortality. (See *Participants Handout 2.1.*)  DISCUSSION (15 MIN.): The trainer should: ►Ask participants to brainstorm a

Specific Objective #2

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
· Benign breast disease · Excessive menstrual bleeding and associated anemia · Menstrual cramping, pain and discomfort • **Spacing births 3 - 5 years apart** also has many possible benefits: economic advantages for the family, increased attention time for young children already born, more time for women in activities outside of childrearing (e.g. further education or work). • **Breastfeeding** protects infants against diarrheal and other infectious diseases, protects the mother from postpartum hemorrhage and is a natural birth spacing method. Spacing births 3 - 5 years apart enables mothers to breastfeed their children longer. • **The use of FP methods** by women with AIDS helps to avoid pregnancy and thus bearing HIV-infected children.	list of other benefits to family planning and optimal birth spacing, including non-contraceptive benefits of specific family planning methods such as the COC and breastfeeding. ►List participant responses on the flipchart and add to their list as necessary.

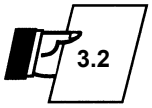
Specific Objective #3: Explain the relationship between maternal and child mortality and high-risk factors of maternal age, birth order, and birth interval

Resource Requirements:
- Markers
- Flip chart paper

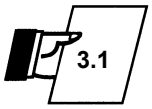
Time Required: 40 minutes

Work for Trainers to Do in Advance:
- Prepare *Participant Handout 3.1, 3.2*
- Insert demographic data into content column and *Participant Handout 3.1*

Specific Objective #3

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
MATERNAL HIGH-RISK FACTORS In many developing countries, the high-risk factors for maternal and infant mortality are referred to as **"Too Young, Too Old, Too Many, Too Close"**. *Age ("Too Young, Too Old")* • In the developing world, pregnancy, and childbirth are the leading causes of death in women under the age of 18 years. • Mothers younger than 18 and older than 35 are at greater risk of prenatal complications and pregnancy-related death. Compared to 20-24 year old mothers, mothers between 15-19 years of age have a 4 times increased risk of death, 4.5 times increased risk of eclampsia, and 3.7 times increased risk of puerperal endometritis. (Conde-Agudelo: 2002) • Studies suggest that if pregnancy could be averted in women under age 20 and over age 35, maternal mortality could be reduced by 8-40%. • In _____, the Maternal Mortality Ratio (MMR) is estimated to be around ____/100,000 live	**SMALL GROUP WORK & DISCUSSION (30 MIN.):** Prior to the session, the trainer should **add the demographic information** for the appropriate country from *Participants Handout 3.2:Demographic Data* into the *Content* column and into *Participants Handout 3.1. Participants Handout 3.2: Demographic Data* may also be distributed to the participants for their information.  The trainer should: ►Divide the participants into 4 groups, each group representing a high-risk factor. ►List the four high-risk factors on flipchart, clarifying, with the participants' input, the meaning of

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*

births; the Infant Mortality Rate (IMR) is estimated to be about ____/1,000 live births.
• Infant mortality is particularly high in babies born to mothers under age 20 and over age 40.
• If childbirth could be postponed until the "too young" mother was old enough, and averted in mothers "too old" and "too ill," the impact on both maternal and infant mortality would be significant.
• Factors that would greatly reduce MMR and IMR in the "safe" age group (20-35) include:
  • Better access to pre- and postnatal care
  • Better access to contraceptive methods to permit child spacing of 3-5 years apart
  • Improved nutrition
  • Better-trained village midwives
  • Improved childbirth and delivery conditions
  • Better access to specialists for management of complications from labor and birth
  • Better facilities for managing complications
 	
Birth Number ("Too Many")
 	
• Studies show that the more children a woman bears, the greater her risk of dying as a result of pregnancy and/or childbirth.
• Women who have had five or more deliveries are more likely to experience problems during pregnancy and labor and to require Caesarean section (which is often not readily available or not performed early enough). The chance of experiencing problems is even greater if births are spaced closely together.
• This group has a significantly higher risk of miscarriage and perinatal mortality than women undergoing their second or third delivery.
 	
Birth Interval ("Too Close")
 	
• Studies have consistently shown a strong, direct relationship between birth intervals and infant/child mortality.
• DHS data from 18 countries in four regions that assessed outcomes of more than 43,000 pregnancies showed that compared to children
	participants' input, the meaning of each category.
	►In their small groups, ask participants to discuss:
	- the factors that contribute to "their situation" (women who have their children too young, too old, too closely spaced or have too many)
	- the relationship between their situation and maternal and infant mortality and morbidity
	►In plenary, ask each group to briefly share their responses
	►Distribute and discuss *Participants Handout 3.1*
	
	 
	
	►Ask participants to think about the devastating effect the death of a mother has on a family.
	
	BRAINSTORM (10 MIN.):
	
	The trainer should:
	
	►Ask participants to identify factors that would help to reduce MMR/IMR.
	►List on flipchart and add to list from content, as necessary.

Specific Objective #3

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
born less than 2 years after a previous birth, children born 3 to 4 years after a previous birth are: - 1.5 times more likely to survive first week of life - 2.2 times more likely to survive 28 days of life - 2.3 times more likely to survive first year - 2.4 times more likely to survive to age five (Rutstein, 2000) • *Transparency 2.5* shows the estimated percent in IMR reduction if all births were spaced by at least two years.	

Specific Objective #4: Participants will be able to identify their own attitudes, feelings, and values, as well as their significance and impact on the counseling process

Resource Requirements:
- Markers
- Flip chart paper

Time Required: 30 minutes

Work for Trainers to Do in Advance:
- Prepare *Participant Handout 4.1*
- Hang up 2 pieces of paper - "Agree" and "Disagree" on opposite walls

Specific Objective #4

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
SURVEY OF SEXUAL ATTITUDES 1. Women should be virgins when they marry. 2. Family planning should be available for married people only. 3. The average woman wants sex less often than the average man. 4. Family planning goes against this country's tradition. 5. Vasectomy should not be considered by a man who has only one or two children or who is under the age of 35. 6. Most people who contract STDs have had many sexual partners. 7. The choice of sterilization should always be voluntary. 8. Men enjoy sex without love more than women do. 9. Easy availability of family planning encourages sexual activity, especially among young people. 10. Using family planning methods 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. Couple should not marry until they have had	**SURVEY OF SEXUAL ATTITUDES GAME (30 MIN.):** The trainer should: 1. Tape papers labeled *Agree* and *Disagree* to opposite walls of the room. 2. Randomly read aloud a statement from the *survey of sexual attitudes* and ask participants to move to the sign that best represents their feelings about the statement. 3. Ask one participant from each group to explain why s/he agrees or disagrees with the statement. 4. Repeat process for a number of statements. 5. End the game by asking the participants:

Specific Objective #4

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
sexual intercourse. 13. Parents should not allow their daughters as much sexual freedom as they allow their sons. 14. Marital infidelity is equally acceptable or unacceptable for both sexes. 15. A child should be given sex education at school. 16. Most pregnancies “just happen,” they are not planned. 17. Abortion is an acceptable form of family planning. 18. Couples should only be allowed two children. 19. Prostitutes provide a useful social service. 20. STDs are more common among poor, illiterate people. 21. The optimal birth spacing time is 3-5 years.	a. Did any of your responses surprise you? b. How did people respond to different statements? c. How did you feel about other peoples' responses? Why? d. What implications do your own feelings and values have on the counseling process? **Possible responses for b and c**: Defensive, judgmental, ambivalent, afraid to express opinion, angry. *(Give participants* Handout #4.1*)* The trainer should: ►Summarize the exercise by saying: ☻People's different experiences often lead them to different conclusions. ☻We must first be aware of our own value systems to ensure that we do not impose our beliefs on our clients. ☻We must learn to respect others' values and beliefs, especially when they come to us for counseling.

Specific Objective #5: Explain the reasons for family planning counseling and factors influencing counseling outcomes

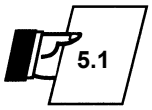
Resource Requirements:
- Markers
- Flip chart paper

Time Required: 1 hour

Work for Trainers to Do in Advance:
- Prepare *Participant Handout 4.1*
- Ask another trainer or participant to assist you with a role play and prepare for it

Specific Objective #5

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
REASONS FOR COUNSELING 1. When the client-provider interaction is positive and **the client feels that s/he was actively involved in the choice of method**, the chances are increased that s/he will: • decide to adopt optimal birth spacing and a family planning method • use the method correctly • continue to use the method • cope successfully with minor side effects • return to see the service provider • not believe myths or rumors and even work to counteract them among family and community 2. A well-informed, well-treated **client** also has **advantages for the service provider** due to: • fewer pregnancies to handle • higher continuation rates • fewer time-consuming minor complaints and side effects • well-treated clients often promote optimal birth spacing and family planning and refer other clients • increased trust and respect between client	**DISCUSSION (15 MIN.):** The trainer should: ►Ask the participants to discuss their ideas regarding: – Why counseling is a vital element of family planning services. – The advantages of a well-informed and well-treated client for service providers. – How counseling affects a client's well-being, optimal birth spacing and continued use of a method. ►List all suggestions on a flipchart and elaborate as necessary from the content list.

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
and provider **FACTORS AND BARRIERS INFLUENCING COUNSELING OUTCOMES** In every client-provider counseling session, many and various factors and barriers influence the outcome of the counseling. These factors and barriers should all be taken into consideration when conducting counseling. *Service Provider Factors* • Provider attitudes and behaviors • Style of provider (mutual participation model vs. authoritarian or provider-controlled model) • Provider knowledge and skills (communication and technical) • Provider method bias • Provider's own value system regarding birth spacing and/or use of contraceptives • Differences in client-provider caste, social class, gender, or education *Client Factors* • Ability to obtain method of choice, or second choice if precautions exist • Client's perceived ability/confidence to negotiate optimal birth spacing and family planning method with partner • Family pressure to get pregnant too soon and too frequently, especially if there is no male child • Misconceptions on false advantages in having children closely together • Level of trust and respect towards provider • Feels privacy and confidentiality are assured • Feels s/he is being treated with respect and dignity *Programmatic Factors* • Lack of a clear norm regarding optimal birth spacing and lack of training of provider in the new norm and its advantages	SMALL GROUP WORK & CLASS DISCUSSION (25 MIN.): The trainer should: ►Divide the participants into 5 small groups and ask them to identify factors that influence the success of family planning counseling and barriers to counseling. ►Assign Group 1 to service-provider factors, Group 2 to client factors, Group 3 to programmatic factors, Group 4 to medical barriers and Group 5 to social/cultural barriers. ►Give some examples of what is meant by a "factor" or barrier in order to help the groups understand their assigned task. ►Have each group present the factors and barriers they have identified on a flipchart. (*Fill in where necessary from factors in content column, and* ***summarize the main points.***) ►For each category, ask participants how the negative factors and barriers can be addressed to better be able to improve the outcomes of family planning counseling. *Distribute Participants* Handout #5.1 

Specific Objective #5

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
new norm and its advantages • Number of methods available • Reliability of method supply (especially in the case of COCs or DMPA) • Privacy and confidentiality of surroundings • Social/cultural needs are met • Overall image of professionalism conveyed by clinic and provider *Medical and Legal Barriers* • Doctors different ideas about the advantages of OBS for the woman, the new born, and the next to be born • Restrictions on who can provide certain clinical methods like the COC/IUD • Some methods only available with doctor's prescription • Clinical guidelines/regulations listing elaborate physical/laboratory exams before agreeing to provide certain methods • Limiting the number of COC cycles dispensed at first and follow-up visits • Requiring that much irrelevant information be included in the client history • Imposing age and parity restrictions on potential clients of injectable contraceptives • Restricting access to non-clinical methods such as condoms and spermicides by offering them only at clinics • Limiting postpartum clients to a choice of condoms or spermicides • Requiring frequent follow-up visits for IUDs *Social/Cultural Barriers* • Cultural privileging of early marriage/early childbearing • Son preference • Mothers-in-law or other family members pressuring for additional speedy pregnancies to get a son • Spousal consent required for some methods • Inability of woman to negotiate with partner	***ROLE PLAY AND DISCUSSION (20 MIN.):*** ***Negotiation Skills*** ►*With another trainer or a volunteer from the group, present 2 short role plays depicting a woman who:* ☹ *is not able to negotiate with her partner regarding the use of optimal birth spacing or a contraceptive method.* ☹ *fears her mother-in-law and cannot find the courage to explain the benefits of spacing births that she learned at her last visit to the clinic.* ►*Divide the participants into 4 groups and ask the first 2 groups to re-work the first role play so the woman can successfully negotiate with her partner and the other 2 groups to rework the second role play so the woman can communicate more openly with her mother-in-law.* ►*Ask each group to present it's play.* ►*Discuss the following:* - *What were the differences between the original and re-worked role plays?* - *What are the elements of good negotiation skills?* - *How can we as service providers encourage women to negotiate with their partners and other family members such as mothers-in-law?*

Specific Objective #6: Describe the major principles of counseling

Resource Requirements:
- Markers
- Flip chart paper

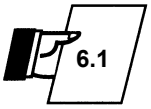
Time Required: 45 minutes

Work for Trainers to Do in Advance:
- Prepare *Participant Handout 6.1*

Specific Objective #6

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
Principles of Counseling 1. Counseling should take place **in a culturally appropriate environment** where client and provider can hear each other, and with sufficient **time** to ensure that all necessary information, client's concerns, and medical requirements are discussed and addressed. 2. **Confidentiality** must be ensured both in the process of counseling and the handling of client records. Treat each client well. Be polite and show respect for each client. 3. It is essential that counseling take place in a **non-judgmental, accepting, and caring atmosphere**. Treat each client well. Be polite and show respect for each new client. 4. The client should be able to understand the **language** the provider uses (e.g., local dialects, simple, culturally appropriate vocabulary, no highly technical medical terminology). Information should not be tailored to the client, but clearly explained. 5. Clinic staff must use good **interpersonal communication** skills, including the ability to question effectively, listen actively, summarize and paraphrase clients' comments or	**SNOW BALL (45 MIN.):** The trainer should: ►Ask participants in pairs to write down what they believe are the fundamental principles of counseling. ►After 5 minutes, ask each pair to join with another pair (making a group of 4) and discuss and combine their lists. ►After another 5 minutes ask each group of 4 to join another group of 4, making groups of 8, and repeat. Continue until all groups are combined. In plenary: ►Briefly relate principles to factors discussed in the group work exercise. ►Pose questions such as: 1. In your current work environment, which principles are followed, and which ones are not? Do you see any problems implementing them?

Specific Objective #6

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
problems, and adopt a non-judgmental, helpful manner. 6. The client should not be overwhelmed with information. The **most important messages should be discussed first** (e.g., what the client must do to practice optimal birth spacing and to use methods correctly and safely) and be brief, simple, and specific. Repeating critical information is the most effective way to reinforce the message. **Repeat, repeat, repeat** but avoid too much information. Too much information makes it hard to remember the important information. 7. Use audiovisual aids and contraceptive samples to help the client better understand his/her chosen method. 8. Always **verify that the client has understood** what has been discussed. Have the client repeat back the most important messages or instructions. 9. Respect the client's choice. Make sure the client is making an informed choice. As long as there is no medical reason against it the client should have the method they want.	2. What can a provider do when the clinic space is not appropriate for counseling? 3. What are some ways to train clinic staff in counseling and interpersonal communication skills and in maintaining confidentiality *Distribute* Participants Handout #6.1. 

Specific Objective #7: Describe the key steps of the counseling process

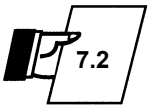
Resource Requirements:
- Markers
- Flip chart paper
- Overhead projector

Time Required: 1 hour 5 minutes

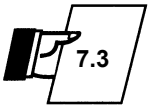
Work for Trainers to Do in Advance:
- Prepare *Participant Handout 7.1, 7.2, 7.3*
- Prepare *Transparency 7.1*
- Review the dialogues
- Prepare role play of counseling session with another trainer or Participants

Specific Objective #7

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
Effective counseling, which results in a well-informed decision and a contented client, can be achieved by following some basic steps in the counseling process. The steps can provide structure to a complex process yet should be adapted to meet each individual client's needs. The following are **elements** of a successful counseling session: 1. Introductions 2. Finding out more/Getting information 3. Providing family planning information 4. Helping in the decision-making process 5. Providing details on a selected method 6. Follow-up **Examples of Tasks Conducted Under Each Step** *Introductions* • Welcome and register client. • Prepare chart/record. • Determine purpose of visit. • Give the client full attention, showing that you	**GROUP EXERCISE (20 MIN.):** The trainer should: ►Hand out a copy of *Dialogue Exercise* from *Participants Handout #7.1* and ask each participant to answer, "Is this dialogue good or bad, and **why?"** 7.1 • Discuss briefly. ROLE PLAY/GROUP DISCUSSION (45 MIN): ►Before the session, the trainer should **prepare a role play of the counseling process** that uses the major steps and tasks listed in the content column. The trainer should play the part of the

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
care for his/her well-being. • Assure the client that all information discussed will be confidential. • Talk in a private place if possible. *Finding out more/Getting information* • Ask the client about her/his wishes. • Write down the client's: age, marital status, number of previous pregnancies and births, number of living children, basic medical history, previous use of family planning methods, history and risk for STDs. • Assess the possible profile of the woman who is a candidate for birth spacing. Not all women who come into the service are the same or have the same situation. An adolescent girl who has been raped is not in the same situation as a woman who has two small children, is married or lives with a partner and does or does not want to have another child within the next two years. Therefore, it is important to find out her present state to determine how best to present optimal birth spacing. • Assess what the client knows about optimal birth spacing and family planning methods. • Provide encouragement to the client by praising her for the information she already knows and for coming to the center to seek out more information. • Ask the client if there is a particular method s/he is interested in. • Discuss any client concerns about risks vs. benefits of modern methods (dispel rumors and misconceptions). *Providing FP information* • Tell the client about optimal birth spacing and the available methods. • Focus on methods that most interest the client, but briefly mention other available methods. • Show/describe how each method works, the advantages and benefits and possible side effects and disadvantages. • Answer client concerns and questions.	counselor and should ask another trainer or participant to volunteer as the client. (Examples of possible scenarios include: - an unmarried, sexually active adolescent who has never used contraceptives but does not want to get pregnant - a married mother of 4 children, all spaced less than 2 years apart who is considering family planning - a married mother of one child seeking to delay her next pregnancy ►Tell the Participants they are going to observe a role play of the counseling process. Ask them to identify the major steps of the counseling process as they observe. ►After the role play, ask Participants for general reactions. ►Ask Participants what major steps of the counseling process they identified, writing each one on flip chart paper. ►After the steps are listed, ask participants to help put them in chronological order, grouping similar responses. ►Give *participants Handout #7.2* and show *Transparency #7.1*, the diagram of the elements of a successful counseling session.  ►Write each major step on a separate flip chart paper. ►Step by step, ask Participants to quickly identify specific tasks within each step and write them on the appropriate flip chart

Specific Objective #7

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
Helping in the decision-making process • Help the client to choose a method. • Repeat information if necessary. • Explain any procedures or lab tests to be performed. • Examine client. • If there is any reason found on examination or while taking a more detailed history that there are precautions for the method, help the client choose another method. *Providing details on a selected method* • Demonstrate/explain how to use the method (how, when, where). • Explain to the client how and when s/he can/should get re-supplies of the method, if necessary. • Provide confidence and encouragement again by complimenting the client on her decision and ability to practice a family planning method. *Follow-up* • At the follow-up or return visit ask the client if s/he is still using the method. • If the answer is yes, ask her/him if s/he is experiencing any problems or side effects and answer her/his questions, solve any problems, if possible. • If the answer is no, ask why s/he stopped using the method and counsel her/him to see if s/he would like to try another method or re-try the same method again. • Make sure s/he is using the method correctly (ask her/him how s/he is using it).	on the appropriate flip chart. ►*Give participants* Handout *#7.3* and complete the exercise by explaining that all of the elements discussed are necessary for "successful" counseling. Successful counseling results in a well-informed decision and a contented client. Effective counseling requires knowledge, skill, sensitivity, and tolerance toward the wishes and differences of all clients. 

Specific Objective #8: Identify elements of effective interpersonal communication (verbal and non-verbal)

Resource Requirements:
- Markers
- Flip chart paper
- Slips of paper

Time Required: 1 hour 15 minutes

Work for Trainers to Do in Advance:
- Prepare *Participant Handout 8.1*
- Prepare slips of paper with different emotions
- Draw basic body on flip chart paper

Specific Objective #8

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
INTERPERSONAL COMMUNICATION Interpersonal communication is the face-to-face process of transmitting information and understanding between two or more people. Face-to-face communication takes place in two forms, **verbal and nonverbal**, and is conscious and unconscious, intentional and unintentional. Nonverbal communication can involve all our senses, while verbal communication is restricted to hearing. Cultural differences make non-verbal communication especially prone to misinterpretation at the conscious and unconscious levels. In counseling, it is especially important to be aware and sensitive to the verbal and nonverbal communication styles of the culture in which you are working. How do the ethnic groups with whom you work talk about reproductive health? What words do they use? Are there certain gestures that are considered insulting? Effective counseling needs to consider all aspects of	**COMMUNICATION EXERCISE (20 MIN.):** The trainer should: ►Give slips of paper with different emotions (defensiveness, anger, pride, fear, sadness, happiness, pain, impatience, disapproval, confusion) to volunteer Participants. ►Ask them to act out the emotion before the group. ►They may use facial expressions and body language, but not words or verbal expressions. ►Other Participants should try to guess the emotion. ►Ask for volunteers and privately assign each of them one of the following emotions (anger, boredom, happiness, frustration, disinterest, impatience, and disapproval). ►Ask each volunteer to read the

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
communication. **Types of Interpersonal Communication** *Verbal Communication* • Refers to **words and their meaning** • Begins and ends with what we say • Is largely conscious and controlled by the individual speaking The use of or reference to local proverbs, stories, or songs, can be a powerful way to convey family planning messages to clients of all ages and can make clients feel more at ease. Counseling, especially with adolescents or clients who do not have a high level of education, can be more effective when language is kept simple and familiar rather than using too many medical terms. *Nonverbal Communication* • Refers to **actions, gestures, behaviors, and facial expressions** which express, without speaking, how we feel • Is complex and largely unconscious • Often reveals to the observant the real feelings or message being conveyed or can be misinterpreted Body posture, eye contact, physical appearance, the use of space (arrangement of desks and chairs), and the amount of time spent waiting in a doctor's office can all communicate a nonverbal message. Generally, verbal and nonverbal communication work together to convey and reinforce a message. If the verbal and nonverbal messages do not match, the message believed is often the one conveyed nonverbally. **Positive nonverbal cues** include those actions and behaviors that show you are being attentive, listening to the needs and concerns of the client and genuinely interested in providing them with	same sentence using tone of voice to convey their emotion. ►Other Participants should attempt to guess the emotion. ►Sentences which can be used are: – Someone will see you soon. – Have you followed the instructions you were given on how to take the pill? Ask participants: ►What conclusions can you draw from doing these 2 activities? ►How do verbal and nonverbal communication styles impact counseling? ►Which nonverbal cues or body language can be used to communicate understanding, support, or helpfulness? GRAFFITI EXERCISE (10 MIN.): The trainer should: ►Tape newsprint to the walls. ►Hand out markers to participants. ►Ask participants to write on the newsprint terms that people in their locales, especially adolescents, use to talk about sex and men's and women's bodies. ►Allow 5 minutes for writing. ►Reconvene the large group. ►Review the terms on the newsprint, adding others that arise during the discussion. ***PROVERB EXERCISE (15 MIN.):*** ►*Draw a big, simple picture of a body on the flipchart.*

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
help. Positive nonverbal messages can be conveyed through your body movements, facial expressions, etc. In some cultures, for example, this might mean leaning toward the client in a way that shows you are listening, maintaining eye contact with the client or nodding your head in encouragement. Negative nonverbal cues **include those actions and behaviors that do not put the client at ease and make her/him feel that you do not care, are not interested, and do not have much concern in his/her wishes. Possible examples of this might include not making or maintaining eye contact, frowning, sitting with arms crossed and glancing frequently at a watch or clock.** When communicating with clients, providers should be cognizant of not only what they say, but how they say it, both verbally and nonverbally. They should also be aware that cultural differences play a significant role in how nonverbal communications are interpreted, and different nonverbal cues may mean completely different things.	►*Ask Participants to quickly say some of the local proverbs/expressions commonly used in their areas. Write them coming out of/next to the body's mouth.* ►*Next ask what sort of daily activities their clients tend to be involved in (farming, cooking, fishing, teaching, childrearing, etc.). Write these around the hands and feet of the body.* ►*Explain how with verbal communication it is important to be able to express family planning information in terms that are familiar to the clients and that one way to do that is to use the experiences and expressions of their clientele.* ►*In pairs or groups of three, ask Participants to brainstorm on how different proverbs, expressions, daily activities could be used to convey family planning information.* ►*Ask each small group to share their ideas with the big group.* **VERBAL/NONVERBAL COMMUNICATION EXERCISE (30 MIN.):** The trainer should: ►Ask the Participants to form pairs. ►One person should talk for five minutes about a personal problem or concern. ►The other should try **nonverbally** to communicate interest, understanding, and help in any way s/he wishes except by speech. ►Have the pairs switch roles and repeat the exercise for five minutes.

Specific Objective #8

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
	►Stop and allow two to three minutes for the pairs to talk freely to each other. ►Discuss the exercise with the entire group. Some questions to raise include: - How did it feel to talk for five uninterrupted minutes? - How did it feel to be prevented from talking? - Did you feel your partner understood you? How did you know? - Did anyone feel helped? Why or why not? - Why is silence so difficult to tolerate? - Give examples of contradictory verbal/nonverbal messages. - What happens when nonverbal behavior does not match verbal messages? - Ask the Participants, "Do we sometimes show negative emotions or feelings to clients during counseling sessions? In what ways?" The objective of this exercise is to make participants aware of nonverbal ways of communicating, particularly when listening to clients, and to demonstrate the power of nonverbal communication. ►*The trainer should sum up the activities, stressing the importance of verbal and nonverbal communication and give participants* Handout #8.1 8.1

Specific Objective #9: Review of contraceptive methods

Resource Requirements:
- Markers
- Flip chart paper
- Information & samples of contraceptive methods

Time Required: 2 hours

Work for Trainers to Do in Advance:
- Prepare *Participant Handout #9.1, 9.2*
- Prepare slips of paper with names of contraceptive methods
- Collect and display available information & samples of contraceptive methods

Specific Objective #9

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
REVIEW OF CONTRACEPTIVE METHODS There are many factors to take into consideration before choosing a contraceptive method. How is it used? What is the effectiveness of the method? What are the advantages and disadvantages? Who is an appropriate candidate for the method? Who should not use the method? Participant Handout 9.1, a review of contraceptive methods, provides detailed information on these questions for each method. **METHODS RELATIONSHIP TO SEXUALITY** Clients' **continued use of a method and level of content** is **often related to** the real or perceived **effect of a method on their sexual practices and enjoyment**. As in the case with minor side effects, one client's idea of a problem may be another's idea of an advantage.	DOCUMENT REVIEW, GAME AND GROUP DISCUSSION (2 HOURS 30 MIN.): ►In plenary, ask Participants to name all the contraceptive methods they know and write these on a flip chart. ►Divide the Participants into pairs and ask them to briefly share with one another what they know about each method, including how it is used, the effectiveness, the advantages and disadvantages, etc. (15 min.) ►Distribute *Participants Handout #9.1*, the matrix of contraceptive methods, and ask Participants to spend 15 minutes reviewing it. 9.1 ►Give each pair a slip of paper with the name of a contraceptive on it.

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
advantage. **If spontaneity is a priority** for a woman or her partner, then **methods, which take action immediately before intercourse, may not be satisfactory** for that couple (e.g., condoms or spermicides). **For many clients, the frequency of sex will be a factor in choosing a method.** Women who are considering hormonal methods or IUDs should consider whether they might be bothered by menstrual changes, if these occur. **If effectiveness is a priority**, then methods such as **COCs, IUD, implants, and injectables** will give the client a greater feeling of security during sex.	They should not let other people know what contraceptive they have been given. ►Using the matrix as well as any other information available, ask participants to prepare a 5-minute presentation on the method (15 min.). ►In plenary, the participants ask the pair questions that have a yes/no response to guess their method. Some sample questions might be: Can the method be used by women who smoke? Can the method affect menstrual bleeding? Can the method be used during the early postpartum period? ►Once the method is identified, the pair gives a short presentation of the method. ►Clarify any questions the participants may have regarding the method. ►Ask participants how, based on their opinions/experiences, the method impacts sexuality. ►Continue the process until all methods have been covered (2 hours). ►Distribute *Participants Handout # 9.2*, Relationship Between Methods and Sexuality. 9.2

Specific Objective #10: Identify and respond to misconceptions and rumors raised by clients and their families

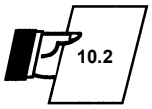
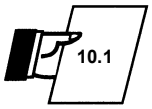
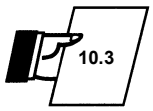
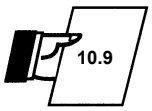
Resource Requirements:
- Markers
- Flip chart paper

Time Required: 1 hour 40 minutes

Work for Trainers to Do in Advance:
- Prepare *Participant Handouts 10.1 - 10.9*
- Review the case study

Specific Objective #10

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
Rumors are **unconfirmed stories** that are **transferred** from one person to another **by word of mouth**. In general, rumors arise when: • an issue is important to people, but has not been clearly explained. • there is nobody available who can clarify or correct the information. • the original source is perceived to be credible. • clients have not been given enough options for contraceptive methods. • people are motivated to spread them for political reasons. A **misconception** is a **mistaken interpretation of ideas or information**. If a misconception is filled with elaborate details and becomes a fanciful story, then it acquires the characteristics of a rumor. Unfortunately, rumors or misconceptions are sometimes spread by health workers who may be misinformed about certain methods or who have religious or cultural beliefs about family planning, which impact their professional conduct. The **underlying causes** of rumors have to do with people's knowledge and understanding of their bodies, health, medicine, and the world	**TRAINER PRESENTATION AND GROUP DISCUSSION (60 MIN.):** The trainer should: ►Ask participants to explain the differences between a rumor and a misconception. ►Write responses on the board and validate answers. ►Cite reasons why rumors and misconception might be believable. ►Ask participants to list some of the most common rumors they have heard about family planning in general; write responses on the board. ►Have participants identify the underlying and immediate causes of some of the rumors they have identified. ►Hand out copies of the case study *Participants Handout #10.2: Underlying and Immediate Causes Of Rumors*.

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
around them. Often, rumors and misconceptions about family planning make rational sense to clients and potential clients. People usually believe a given rumor or piece of misinformation due to **immediate causes** (e.g., confusion about anatomy and physiology). Methods for Counteracting Rumors and Misconception 1. When a client mentions a rumor, **always listen politely. Don't laugh.** 2. **Define** what a rumor or misconception is. 3. **Find out where the rumor came from** and talk with the people who started it or repeated it. Check whether there is some basis for the rumor. 4. **Explain the facts**. 5. **Use strong scientific facts** about family planning methods to counteract misinformation. 6. Always **tell the truth**. Never try to hide side effects or problems that might occur with various methods. 7. **Clarify information** with the use of demonstrations and visual aids. 8. **Give examples of people who are contented users** of the method if they have given informed consent to use of their names. This kind of personal testimonial is most convincing. 9. **Reassure the client** by examining her and telling her your findings. 10. **Counsel** the client about all available family planning methods. 11. Reassure and let the client know that you care by conducting **home visits** if the client has given informed consent to it.	 ►Ask participants to answer the questions found at the end of the case study. ►Give examples of strategies to obstruct rumors and misconceptions. ►Explain the importance of knowing both immediate and underlying reasons for rumors and misconception. (Distribute *Participants Handout #10.1*.)  **GROUP EXERCISE (20 MIN.):** The trainer should: ►Divide the participants into groups. ►Give each group one family planning method--COCs, IUD, DMPA, vasectomy, female VSC. Ask them to identify common rumors and misconceptions about the method and possible ways of combating these. ►Have one of the groups present a rumor. ►Ask participants to identify what the immediate reason could be for its popularity, some of the underlying reasons for the rumor, and how to offset them. ►Distribute *Participants Handouts 10.3-10.9*.  

Specific Objective #10

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
	ROLE PLAY (20 MIN.): The trainer should: ►Ask for two volunteers to role play one of the rumors. ►Have one participant play a client concerned about the rumor, the other play a health worker counteracting the rumor. ►Have participants discuss the role play. If time allows, ask other volunteers to role-play other rumors.

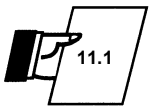
Specific Objective #11: Explain the rights of the client

Resource Requirements:
- Markers
- Flip chart paper

Time Required: 1 hour

Work for Trainers to Do in Advance:
- Prepare *Participant Handout 11.1*
- Review *The Rights of the Client*

Specific Objective #11

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
INTRODUCTION TO RIGHTS OF THE CLIENT There are many reasons why individuals and couples decide to start, continue, or stop practicing family planning: • desire to delay the birth of a first child • to space the birth of children • to ensure only a certain number of children Others may wish to use family planning services not so much for protection from unplanned or unwanted pregnancy, but for other reasons, including a desire to achieve pregnancy or for the protection of their reproductive and sexual health. **Family planning today has as much to do with sexuality and health protection as it does with decisions relating to procreation.** Any member of the community who is of reproductive age should be considered a potential family planning client. Family planning services are a type of preventive health service. **Therefore, the rights of the family planning clients should be seen in the overall context of the rights of the clients of any health services.**	**TRAINER PRESENTATION (15 MIN.):** The trainer should: ►Give a brief lecture on *The Rights of the Client.* The complete text, as written by IPPF, can be found in *Participants Handout #11.1*. **GROUP WORK AND PRESENTATION (45 MIN.):** The trainer should: ►Divide participants into groups or pairs, according to the area or clinic in which they work. ►Provide each pair or group with *Participants Handout #11.1: The Rights of the Client.*  ►Ask each pair or group first to identify what prevents client **rights** from being respected.

Specific Objective #11

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
Program managers and service providers should respect the rights of clients. One kind of client rights (professional rights) has to do with the quality of services and the availability of family planning information, etc. Another set of client rights (legal rights) have to do with informed consent and informed choice. **The following are the basic professional rights of all family planning clients:** 1. **Information:** The right to learn about the benefits and availability of family planning. 2. **Access:** The right to obtain services regardless of sex, creed, color, marital status, or location. 3. **Choice:** The right to decide freely whether or not to practice optimal birth spacing/family planning and to make a conscious, informed, independent choice of methods. 4. **Safety:** The right to be informed about safe and unsafe usage of family planning methods. 5. **Privacy:** The right to choose a private environment for counseling or services. 6. **Confidentiality:** The right to have medical information treated in conformity with the medical code of ethics and laws regarding confidentiality of medical information. 7. **Dignity:** The right to be treated with courtesy, consideration, attentiveness, and cultural sensitivity. 8. **Comfort:** The right to feel comfortable when receiving services. 9. **Continuity:** The right to receive contraceptive services and supplies for as long as needed. 10. **Opinion:** The right to express views on the services offered. In addition to the above professional rights, each client has a set of legal rights, which must be understood and respected by those providing health care services, including family planning counseling services. It is the provider's responsibility to be aware of these rights and how	►Ask them to list specific steps that can be taken to ensure that both professional and legal rights of the client are respected. ►Ask each group to present.

Specific Objective #11

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
they vary in different countries. The failure to take such responsibility is likely to result in the rejection of family planning ideas and principles and of providers who treat such rights carelessly. (**Source**: International Planned Parenthood Federation. *Rights of the client.* London: 1991.)	

Specific Objective #12: Identify several ways to counsel and motivate men to make responsible choices

Resource Requirements:
- Markers
- Flip chart paper

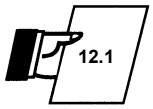
Time Required: 40 minutes

Work for Trainers to Do in Advance:
- Prepare *Participant Handout 12.1*

Specific Objective #12

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
COUNSELING AND MOTIVATING MEN **Men have special counseling needs** and should receive special attention from providers to **motivate them to make responsible choices** regarding reproductive health practices. Just as women often prefer to talk to other women about family planning and sexual issues, **men often prefer to talk to other men** about these issues. **Men's Special Counseling Needs** • Men **need to be encouraged to support** women's **use of family planning methods** or to use family planning themselves (condoms or vasectomy). • Men need to be **informed of all the benefits of optimal birth spacing**: for them and for the health of their partner, existing children and the newborn. • It is **important to talk to YOUNG MEN** (14-18) **about responsible and safe sex** before they become sexually active. • Men **often have less information** or are more likely to be **misinformed** about family planning methods, male and female anatomy,	**GROUP BRAINSTORM, ROLE PLAY AND GROUP DISCUSSION (40 MIN.):** The trainer should: ►Use a flipchart to identify men's special counseling needs with participants. Divide the list into thirds. ►Divide the participants into three groups and have each group conduct a role play of a provider counseling a man (alone or with a woman partner). Group one should incorporate a counseling need from the top third of the counseling needs list, group 2 from the second third and group 3 from the last third of the list. ►Discuss the role plays with the participants, asking them to identify the men's special counseling needs and ideas on how to motivate and counsel men.

Specific Objective #12

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
and reproductive functions because they tend to talk less about these issues than women. • Men seldom discuss the next pregnancy with their partner. They do not talk about pregnancy intervals, and what benefits it could represent for her partner, for the next child to be born, or for him. • Men sometimes feel pressure to get their partner pregnant very soon if the last live birth was a girl in order to "look for/find/get" the desired male son. • Some men feel they are not supposed to "negotiate" sex with a partner. They feel it is their right to simply demand it and get it. • Men are **often more concerned about sexual performance** and desire than women. • Men often have **serious misconceptions and concerns that family planning methods** will **negatively impact their sexual pleasure** and/or **performance**. • Men are often **concerned that women will become promiscuous** if they use family planning. • Many men **do not know how to use condoms correctly**. Providers should always demonstrate correct condom use, using a model, when possible. • Men are often not comfortable going to a health facility, especially if it serves women primarily. Providers should try to go to where men are to discuss family planning whenever possible (e.g., work places, bars, sporting events, etc.).	(Distribute *Participants Handout #12.1*) 

Specific Objective #13: Review the counseling manual and identify ways to adapt the counseling process, appropriately taking into account cultural and environmental factors

Resource Requirements:
- Markers
- Flip chart paper
- Overhead projector

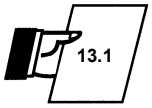
Time Required: 1 hour 5 minutes

Work for Trainers to Do in Advance:
- Prepare *Participant Handout 13.1*
- Prepare *Transparency 0.1*
- Prepare copies of the post-test

Specific Objective #13

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
Adapting the Counseling Process Most **providers will need to adapt the counseling process** to the locale, culture and physical environment they are working in. In some service delivery settings the demand for services is so high that physical, staffing, and time constraints prevent clients from being counseled privately. In other settings, clients actually prefer the group-counseling situation due to cultural factors. The factors that **a provider always has responsibility for** and most control over are: • tolerance, empathy, and supportive attitude • respect for clients • technical knowledge • use of a dynamic style of counseling which responds to individual client needs • belief in and knowledge that birth spacing saves lives and may improve the quality of lives	REVIEW OF COUNSELING TRAINING MANUAL (20 MIN.): ►Ask participants to quickly identify the main themes covered during the training program. ►Display *Transparency 0.1: Training Objectives*. ►For each objective, ask participants to review the topics covered during the training. **BRAINSTORM AND GROUP DISCUSSION (15 MIN.):** The trainer should: ►Divide participants into small groups by clinic, locale or type of facility in which one works (this

Specific Objective #13

CONTENT *Knowledge/Attitudes/Skills*	*TRAINING/LEARNING METHODS* *(Time Required)*
Providers must collaborate with their team of health facility staff to find creative remedies for limitations of space, staff and supplies at less well-equipped facilities. They are also tasked with taking into account client comfort and individual wishes and attempting to address these as completely as possible even in the most rustic of conditions.	will depend on the training group) ►Ask the participants to discuss the pros and cons of the health facility where they work related to the ability to effectively counsel clients about family planning, taking into account cultural factors (e.g., need for privacy versus group interaction, etc.). ►Ask the participants to brainstorm about how they can adapt their own settings to better meet the wishes of clients during the family planning counseling process. ►Ask groups to share, in plenary, a few points discussed in the groups. ►Distribute *Participants Handout #13.1*  **TRAINER SUMMARY AND POST-TEST (30 MIN.):** The trainer should: ►Briefly summarize the main content again and ways to adapt the information to different settings. ►Administer the post-test, emphasizing it as a way to evaluate the training.

Specific Objective #14: Apply principles and steps of counseling in role plays

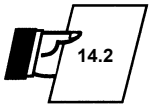
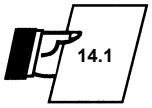
Resource Requirements:
- Markers
- Flip chart paper

Time Required: 2 hours 45 minutes

Work for Trainers to Do in Advance:
- Prepare *Participant Handout 14.1, 14.2*
- Prepare copies of the Competency Based Training Skills Assessment Checklists and cue cards
- Prepare "good" and "bad" role plays of counseling process with another trainer
- Prepare copies of the evaluation

Specific Objective #14

CONTENT Knowledge/Attitudes/Skills	*TRAINING/LEARNING METHODS (Time Required)*
OBJECTIVES OF ROLE PLAY 1. To enable participants to practice interpersonal communication skills and apply the principles and steps of counseling, using counseling cue cards. 2. To serve as a self-evaluation mechanism with which participants can assess her/his knowledge of family planning methods and counseling skills. 3. To enable the trainer to assess objectively participants counseling skills and knowledge of the advantages and disadvantages of optimal birth spacing and family planning methods, using the Counseling Checklist.	TRAINER DEMONSTRATION/SIMULATED PRACTICE/ROLE PLAYS/GROUP FEEDBACK AND DISCUSSION (2.5 HOURS): *Guidelines for Conducting Role Plays* The trainer should: ►Ask another trainer to assist. The two trainers should use role plays to demonstrate examples of "good" and "bad" family planning counseling sessions. ►First have trainers role play a "bad" family planning counseling session. **Note**: *The trainer/participants should **not** demonstrate a wrong procedure at any time.* ►To perform a "good" counseling role play, follow the steps of the counseling process in the correct sequence, so that participants can observe how the process should work. ►Have participants use *Participants Handout #14.2: Observer's Role Play Checklist for*

CONTENT Knowledge/Attitudes/Skills	*TRAINING/LEARNING METHODS (Time Required)*
	Counseling Skills.  ►Ask participants to analyze the demonstrations and provide feedback on positive and negative aspects of it. Have them ask what was missing, what was wrong, and what was incomplete about the information provided. ►After the trainer demonstration, the participants perform role plays, using role plays found in *Participants Handout #14.1* and method-specific checklists and counseling cue cards.  ►Each participant should participate in two or more role plays depending on the trainer. If there is time, the trainer asks the participant to include client instructions found on the back of each cue card in the role play. ►**Each participant is expected to participate actively in the role play process,** as both a player **and** observer, and in group discussions and feedback. ►Divide participants into two groups of equal size for simultaneous role play with one trainer per group. ►Trainers should switch groups after one or two role plays to get as many trainer observations of individual participant counseling skills as possible. ►Each participant should play the role of **counselor** and **client** or client's family member, depending on the role play. ►**Observe and assess each participant** for counseling content, process, and participation in the exercise. ►Allow *actors/players* about 10 minutes to prepare, limit each role play to five or six minutes, and allow about 15 minutes for feedback and analysis of the process and content. ►**Encourage and guide the participants in**

Specific Objective #14

CONTENT Knowledge/Attitudes/Skills	*TRAINING/LEARNING METHODS (Time Required)*
	constructive critique, in analyzing what was good about the way the **counselor** handled the counseling and suggest what could be improved. ►Remind participants not to confuse the actual participant with the **actor's** role, and that feedback and critique must not be personalized. ►The **trainer's role** during feedback/ discussion **should be to stimulate, guide, keep up discussion, and end it when time is up**. ►The trainer may wish to provide general feedback at the end of participant discussion. ►**Upon completion of role plays**, the trainer will need to provide feedback to individual participants, discuss and sign off the Observer's Role Play Checklist with each. ►Summarize the major points observed in the exercise and respond to participant questions with the entire group. TRAINER SUMMARY AND EVALUATION (15 MIN.): ►Briefly summarize objectives of the workshop and review expectations to make sure they were met. ►Distribute and ask participants to fill out the Participation Evaluation Form.

APPENDIX

Participant Handout # 0.1: Suggestions for Effective Participation

DO:

- Listen.
- Ask a question when you have one.
- Feel free to share an illustration or example.
- Request an example to clarify a point.
- Search for ways in which you can apply a general principle or idea to your work.
- Think of ways you can pass on ideas to your subordinates and co-workers.
- Be skeptical–don't automatically accept everything you hear.
- Participate in the discussion.
- Respect the opinion of others.

DON'T:

- Try to develop an extreme problem just to prove the trainer doesn't have all the answers. (The trainer doesn't.)
- Close your mind by saying, "This is all fine in theory, but..."
- Assume that all topics covered will be equally relevant to your needs.
- Take extensive notes; the handouts will satisfy most of your needs.
- Sleep during class time.
- Discuss personal problems.
- Dominate the discussion.
- Interrupt.

Participant Handout # 0.2: Training Objectives

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

1. Describe the key messages and major principles of optimal birth spacing and family planning services.
2. Describe the health benefits of optimal birth spacing and family planning and possible negative consequences of not using optimal birth spacing.
3. Explain the relationship of high risk factors such as maternal age, number of births, and short birth interval to maternal and child mortality.
4. Identify their own attitudes, feelings, and values, and how these impact the family planning counseling process.
5. Explain the reasons for family planning counseling and the factors that influence the success of counseling.
6. Describe the major principles of family planning counseling.
7. Describe the essential elements/steps of the family planning counseling process.
8. Identify the impact of verbal and non-verbal interpersonal communication on the counseling process.
9. Review contraceptive methods: description, use, effectiveness, advantages, disadvantages, side effects, relationship to sexuality.
10. Identify and respond to misconceptions and rumors about contraceptives that clients and families have.
11. Explain the professional rights of the client and that the client may have legal rights as well.
12. Identify several ways men may be counseled and motivated to make responsible family planning choices.
13. Identify several ways to adapt the counseling process appropriately following an assessment of the culture and environment.
14. Apply principles and steps of family planning counseling in role plays.

Participant Handout # 0.3: Training Schedule

******* TO BE DEVELOPED BY TRAINERS IN THE FIELD **********

Participant Handout # 0.4: Where are We and Reflections

Where Are We?

Starting each day with "Where Are We?" is our opportunity to review the previous days' material, especially the key points of each session.

Each day one participant will be assigned to conduct the exercise. This person should take some time to write down the key points from the day before. The participant who is assigned should briefly present these key points and then ask participants for any additions.

Reflections

After a full day of activities, we need to take time to look over what we have done and examine what it means to us individually. The "Reflections" activity is an opportunity for the trainers and participants to share feedback on the training activities and to identify areas that need reinforcement or further discussion. Therefore, each day, selected participants (housekeeping team) will solicit feedback from the other participants during breaks or lunch and then at the end of the day will meet with the trainers to discuss how the day of training went. For the first session of "Reflections," the housekeeping team should ask other participants the following questions and share responses with the trainers:

- What did I like about today and why?
- What did I not like about today and why?
- What did I learn and experience today that I will be able to use?

(The housekeeping team is free to vary the exercise to make it more interesting and less repetitive.)

Participant Handout 1.1: Key Messages and Principles of Optimal Birth Spacing and FP Services

Key Messages of FP

1. Voluntary optimal birth spacing of 3-5 years and FP are some of the most important **health** measures a couple and a nation can practice to reduce maternal and infant mortality and morbidity.
2. Delaying the next birth by at least three years after the previous birth profoundly reduces maternal and child morbidity and mortality.
3. The risk of death from pregnancy and childbirth, especially when birth spaces are too short, is far greater than the risk of death from contraceptive use.
4. In some countries, the medical profession imposes barriers to family planning, in others social, cultural or religious norms or beliefs create barriers. An example of a medical barrier is a medical policy, standard of practice or opinion that differs from that of the family planning counselor thus hindering the ease with which family planning ideas may be put into action regardless of the needs of the client. Examples of social, cultural and religious barriers include the importance of having a male offspring in some cultures even at the expense of the mother's health, and religious prohibitions of modern contraceptive methods.

Principles of FP Services

1. The cornerstone of a sound FP program is one that incorporates the following five principles:
   - **voluntary choice on the part of the client**
   - **informed choice**
   - **availability of the widest range of FP methods possible**
   - **the proliferation of optimal birth spacing and contraceptive information to help clients make decisions appropriate for their individual situations: delay first birth, space births 3 - 5 years apart, or limit the number of births**
   - **integration of family planning with other RH services**
2. A client has **the right** to make an independent, well-informed, self aware, voluntary decision on a contraceptive method, as long as it is medically safe. Some might argue that if a precaution exists and the client is fully informed of the risks, the client's choice must still be honored by the clinician, although it might be preferable to refer the client to a medically trained health worker for a second opinion to prevent the client from being harmed.
3. **Confidentiality,** the right to have medical information treated in conformity with the medical code of ethics and laws regarding confidentiality of medical information.
4. **Alertness** of health professionals that all sexually active individuals are at some risk for **STDs** including **HIV** and **Hepatitis B** and that they have a duty to warn clients that contraceptive methods do not necessarily provide protection from these diseases. For this reason, distribution of **latex condoms** should now be a mainstay of all FP programs.
5. The **involvement of communities and community leaders** in optimal birth spacing and FP programs helps to demystify family planning for those who may benefit from it.

6. **Health care workers** assume a leadership role in educating clients, community, and special interest groups about health and other benefits of optimal birth spacing and FP. With their professionalism, they can influence decisions about family planning by:
   - integrating it into Maternal and Child Health (MCH) services
   - supporting private-sector OBS/FP initiatives such as social marketing programs
   - introducing MCH/FP programs in factories, plantations, and other work sites

Participant Handout 2.1: Health Benefits of Optimal Birth Spacing and Family Planning

HEALTH/NON-CONTRACEPTIVE BENEFITS

Significant Reduction in Maternal Mortality and Morbidity

- Globally, an estimated 500,000 women die each year from pregnancy and childbirth related causes, including septic abortions.
- 90% of maternal mortality deaths occur in Africa and South Asia.
- An unpublished WHO study estimates that complications from pregnancy and childbirth are the first or second cause of all deaths occurring in women ages 15-44 in developing countries.
- **Major direct causes of death are hemorrhage, complications from unsafe induced abortion, toxemia, obstructed labor, and puerperal infection.**
- Multiple and closely spaced births (less than 3 years between births) may lead to and worsen such conditions as anemia, maternal malnutrition, and low birth-weight babies.
- Research from Latin America shows that when there is less than 6 months and more than 59 months between the birth of one child and the conception of the next (the interpregnancy interval) women face an increased risk for morbidity and mortality (Conde-Agudelo: 2002)
- Compared to a 18-23 month interpregnancy interval, intervals less than 6 months are associated with an increased risk for: maternal death (150%), third trimester bleeding (70%), anemia (30%), premature rupture of membranes (70%) and puerperal endometritis (30%) (Conde-Agudelo: 2002).
- Using an optimal birth space of 3 - 5 years and an effective FP method reduces maternal deaths by preventing high-risk pregnancies among women.
- **Maternal deaths can be prevented if unwanted pregnancies are avoided and births are spaced by at least three years.**

Reduction in Infant and Child Mortality and Morbidity

- Globally, an estimated 14.5 million infants and children under age five die every year, mainly from respiratory and diarrheal diseases complicated by malnutrition.
- Multiple worldwide studies show that **spacing of births by at least three years could prevent at least 20%** of these infant deaths and significantly reduce the devastating morbidity effects suffered by these children.
- In LDC countries (excluding China) 24% of infant deaths were averted when no births occurred before 36 months (Rustein, 2000).

OTHER HEALTH BENEFITS OF FP

- Studies show that combined oral contraceptives (COCs) provide significant non-contraceptive health benefits. They are known to reduce the incidence of the following diseases and disorders:
  - Ectopic pregnancy
  - Ovarian cancer
  - Endometrial cancer
  - Ovarian cysts
  - Benign breast disease
  - Excessive menstrual bleeding and associated anemia
  - Menstrual cramping, pain and discomfort
- Spacing births 3 - 5 years apart also has many possible benefits: economic advantages for the family, increased attention time for young children already born, more time for women in activities outside of childrearing (ex. further education or work).
- **Breastfeeding** protects infants against diarrheal and other infectious diseases, as well as protecting mother from postpartum hemorrhage. It is also a natural method for spacing births. Spacing births 3 - 5 years apart enables mothers to breastfeed their children longer.
- **The use of FP methods** by women with AIDS helps to avoid pregnancy and thus bearing HIV-infected children.

Participant Handout 3.1: Maternal High-Risk Factors

MATERNAL HIGH-RISK FACTORS

In many developing countries, the high-risk factors referred to as **"Too Young, Too Old, Too Many, Too Close"** are major culprits of maternal and infant mortality.

Age ("Too Young, Too Old")

- In the developing world, pregnancy, and childbirth are the leading causes of death in women under the age of 18 years.
- Mothers younger than 18 and older than 35 are at greater risk of prenatal complications and pregnancy-related death. Compared to 20-24 year old mothers, mothers between 15-19 years of age have a 4 times increased risk of death, 4.5 times increased risk of eclampsia, and 3.7 times increased risk of puerperal endometritis. (Conde-Agudelo: 2002)
- Studies suggest that if pregnancy could be averted in women under age 20 and over age 35, maternal mortality could be reduced by 8-40%.
- In _____, the Maternal Mortality Ratio (MMR) is estimated to be around /100,000 live births; the Infant Mortality Rate (IMR) is estimated to be about ____/1,000 live births.
- Infant mortality is particularly high in babies born to mothers under age 20 and over age 40.
- If childbirth could be postponed until the "too young" mother was old enough, and averted in mothers "too old" and "too ill," the impact on both maternal and infant mortality would be significant.
- Factors that would greatly reduce MMR and IMR in the "safe" age group (20-35) include:
  - Better access to pre- and postnatal care
  - Better access to contraceptive methods to permit child spacing of 3-5 years apart
  - Improved nutrition
  - Better-trained village midwives
  - Improved childbirth and delivery conditions
  - Better access to specialists for management of complications from labor and birth
  - Better facilities for managing complications

Birth Number ("Too Many")

- Studies show that the more children a woman bears, the greater her risk of dying as a result of pregnancy and/or childbirth.
- Women who have had five or more deliveries are more likely to experience problems during pregnancy and labor and to require Caesarean section (which is often not readily available or not performed early enough). The chance of experiencing problems is even greater if births are too closely spaced together.
- This group has a significantly higher risk of miscarriage and perinatal mortality than women undergoing a second or third delivery.

Birth Interval ("Too Close")

- Studies have consistently shown a strong, direct relationship between birth intervals and infant/child mortality.
- Department of Health Services data from 18 countries in four regions that assessed outcomes of more than 43,000 pregnancies showed that compared to children born less than 2 years after a previous birth, children born 3 to 4 years after a previous birth are:
  -1.5 times more likely to survive first week of life
  - 2.2 times more likely to survive 28 days of life
  - 2.3 times more likely to survive first year
  - 2.4 times more likely to survive to age five (Rutstein, 2000)

- *Transparency 2.5* shows the estimated percent in IMR reduction if all births were spaced by at least two years.

Participant Handout 3.2: Demographic Data

Country	Total Fertility Rate	Contraceptive Prevalence Rate		Maternal Mortality Rate	Infant Mortality Rate
		Total	Modern		
North Africa					
Egypt	3.9	47	45	270	62
West Africa					
Burkina Faso	6.9	8	4	810	94
Cote d'Ivoire	7.4	3	1	---	88
Ghana	5.5	19	9	1000	66
Nigeria	6.5	6	4	800	87
Senegal	6.0	7	5	600	68
East Africa					
Eritrea	---	---	---	---	105
Ethiopia	6.6	4	3	560	120
Kenya	5.4	33	27	170	62
Madagascar	6.1	17	5	570	93
Mozambique	6.6	---	---	300	148
Tanzania	6.3	10	7	340	92
Uganda	7.4	5	3	550	115
Zimbabwe	4.4	48	42	---	53
Middle Africa					
Zaire	6.7	8	3	800	108
South Africa					
Botswana	4.6	33	32	250	41
South Africa	4.4	50	49	84	46
West Asia					
Azerbaijan	2.5	---	7	---	25
Jordan	5.6	40	27	48	34
Turkey	2.3	63	35	150	47
Yemen	7.7	10	6	---	83
South Central Asia					
Bangladesh	4.3	45	36	600	88
India	3.4	41	36	460	79
Iran	6.6	65	45	120	57

Country	Total Fertility Rate	Contraceptive Prevalence Rate		Maternal Mortality Rate	Infant Mortality Rate
		Total	Modern		
Kazakstan	2.3	---	22	---	27
Kyrgyzstan	3.3	---	25	---	29
Nepal	5.1	23	22	830	98
Pakistan	6.1	12	9	500	91
Sri Lanka	2.6	66	44	80	18.4
Tajikistan	4.3	---	15	---	47
Turkmenistan	4.0	---	12	---	46
Uzbekistan	3.8	---	19	---	28
Southeast Asia					
Cambodia	5.8	---	---	500	111
Indonesia	3.0	50	47	450	66
Laos	6.3	---	---	300	102
Philippines	4.1	40	25	100	34
Thailand	2.2	66	64	50	35
Vietnam	3.7	49	37	120	42
East Asia					
China	2.0	83	81	95	44
North America					
United States	2.1	74	69	8	7.5
Central America					
Mexico	3.2	53	45	110	34
South America					
Bolivia	4.8	45	18	600	71
Brazil	3.0	66	56	200	58
Ecuador	3.8	53	41	170	40
Peru	3.5	59	33	300	60
Northern Europe					
United Kingdom	1.8	72	71	100	6.2

Definitions

Total Fertility Rate (TFR):	Average number of children a woman would have assuming current age-specific birth rates.
Contraceptive Prevalence Rate (CPR):	Percent of currently married or "in-union" women of reproductive age (ages 15 to 49) who are using any form of contraception. "Modern" methods include clinic and supply methods such as the pill, IUD, condom, and sterilization. The rates presented in this chart are from demographic information for the years from 1988 - 1994.
Maternal Mortality Ratio (MMR):	Number of deaths of women from pregnancy-related causes per 100,000 live births in one year. The rates presented in this chart are from demographic information for the years 1990 - 1992.
Infant Mortality Rate (IMR):	Infant deaths per 1000 live births.

Source: Population Reference Bureau, 1875 Connecticut Ave., Suite 520, Washington, DC 20009-5728
Tel: (202) 483-1100

Participant Handout # 4.1: Survey of Sexual Attitudes

1. Women should be virgins when they marry.

2. Family planning should be available for married people only.

3. The average woman wants sex less often than the average man.

4. Family planning goes against this country's tradition.

5. Vasectomy should not be considered by a man who has only one or two children or who is under the age of 35.

6. Most people who contract STDs have had many sexual partners.

7. The choice of sterilization should always be voluntary.

8. Men enjoy sex without love more than women do.

9. Easy availability of family planning encourages sexual activity, especially among young people.

10. Using family planning methods 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. Couple should not marry until they have had sexual intercourse.

13. Parents should not allow their daughters as much sexual freedom as they allow their sons.

14. Marital infidelity is equally acceptable or unacceptable for both sexes.

15. A child should be given sex education at school.

16. Most pregnancies “just happen”, they are not planned.

17. Abortion is an acceptable form of family planning.

18. Couples should only be allowed two children.

19. Prostitutes provide a useful social service.

20. STDs are more common among poor, illiterate people.

21. The optimal birth spacing time is 3-5 years.

Participant Handout # 5.1: Reasons for family planning counseling and factors influencing counseling outcomes

REASONS FOR FAMILY PLANNING COUNSELING

1. When the client-provider interaction is positive and **the client feels that s/he was actively involved in the choice of contraceptive method**, the chances are increased that s/he will:
   - decide to adopt optimal birth spacing and a family planning method
   - use the method correctly
   - continue to use the method
   - know the difference between minor side effects and those that require attention
   - return to see the service provider
   - understand the genesis of myths or rumors about contraceptives and be armed to evaluate them independently and help others do so as well

2. A well-informed, well-treated **client** is **advantageous to the service provider** due to:
   - fewer pregnancies to handle
   - higher continuation rates
   - fewer time-consuming complaints about insignificant side effects
   - possible assistance in promoting optimal birth spacing and family planning and referring new clients
   - increased relationships of trust and respect between client and provider

FACTORS AND BARRIERS AFFECTING FAMILY PLANNING COUNSELING

In every client-provider counseling session, many and various factors and barriers influence the outcome of the counseling. These factors and barriers should all be taken into consideration when conducting counseling.

Service Provider Factors

- Provider attitudes and behaviors
- Style of provider (mutual participation model vs. authoritarian or provider-controlled model)
- Provider knowledge and skills (communication and technical)
- Provider method bias
- Provider's own value system regarding birth spacing and/or use of contraceptives
- Differences in client-provider caste, social class, gender, or education

Client Factors

- Ability to obtain method of choice, or second choice if precautions exist
- Ability and confidence in negotiating optimal birth spacing and family planning method with partner

- Pressure from family to get pregnant too soon and too frequently, especially if there is no male child
- Misconceptions on advantages in having children closely together
- Level of trust and respect towards provider
- Feeling that privacy and confidentiality are assured
- Feeling of being treated well and with respect and dignity

Programmatic Factors

- Lack of a clear norm regarding optimal birth spacing and lack of training of provider in the new norm and its advantages
- Number of methods available
- Reliability of supply of chosen method (especially in the case of COCs or DMPA)
- Privacy and confidentiality of surroundings
- Social/cultural needs are met
- Overall image of professionalism conveyed by clinic and provider

Medical Barriers

- Doctors' different opinions on the advantages of OBS or FP for the woman, the new born, and the next to be born
- Restrictions on who is qualified to provide certain clinical methods like the COC/IUD
- Restrictions on who can prescribe some methods and whether or not they should be available without a prescription
- Clinical guidelines and regulations with requirements to fulfill prior to providing a client with certain methods
- Limiting the number of COC cycles dispensed at first and follow-up visits
- Requiring that much irrelevant information be included in the client history
- Imposing age and parity restrictions on potential clients of injectable contraceptives
- Restricting access to non-clinical methods such as condoms and spermicides by offering them only at clinics
- Limiting postpartum clients to a choice of condoms or spermicides
- Requiring frequent follow-up visits for IUDs

Social/Cultural Barriers

- Cultural privileging of early marriage/early childbearing
- Son preference
- Mothers-in-law or other family members pressuring for speedy pregnancies to get a son or to get a lot of children quickly
- Spousal consent required for some methods
- Inability of woman to negotiate with partner

Participant Handout # 6.1: Principles of Counseling

Principles of Counseling

1. Counseling environment should be **culturally appropriate.** An ideal environment is one that the client chooses to go to from the available options. The client and counselor should be able to hear each other. A family planning counseling session should be long enough so that family planning information can be disseminated, the client's concerns can be addressed and medical requirements about family planning services can be reviewed.

2. **Confidentiality** medical information should be treated in conformity with the medical code of ethics and laws regarding confidentiality of medical information. Part of resulting with a well-treated client is respecting the client in confidential matters as well.

3. For family planning counseling to be accepted and successful, it is essential that counseling be **non-judgmental and in an accepting, caring atmosphere**. If a provider does not feel s/he can treat the client well or adequately due to cultural or other constraints, s/he has a professional obligation to refer the client to another family planning counselor.

4. The client should be able to understand the counselor and vice-versa. If possible, counseling should take place in the client's local dialect or a simplified **language** common to both and in culturally appropriate vocabulary that omits confusing and unnecessary technical medical terminology. Information should not be held back or tailored for a client who does not understand, instead, a translator should be found so that the client has all the necessary information to make a well-informed and independent decision.

5. Clinic staff must use good **interpersonal communication** skills, including the ability to question effectively, listen actively, summarize and paraphrase clients' comments or problems, and adopt a non-judgmental, helpful manner.

6. The client should not be overwhelmed with information. The **most important messages should be discussed first** such as, what the client must do to practice optimal birth spacing and to use a chosen contraceptive method correctly and safely. Being brief, simple, and specific, repeat critical information to reinforce the message effectively. **Repeat, repeat, repeat.** At the same time**,** avoid too much irrelevant or unimportant information to avoid obscuring the important information and making it difficult to remember.

7. Use audiovisual aids and contraceptive samples to help the client better understand his/her chosen method.

8. Always **verify that the client has understood** the discussion by having the client repeat back the most important messages or instructions.

9. Respect the client's choice. Verify that the client is making an independent, self-aware, well-informed choice. As long as there is not a medical contraindication, the client should be able to use his/her chosen method. If the family planning counselor does not feel s/he can safely recommend the client's chosen method, then s/he should tell the client so and refer him/her to another family planning counselor.

Participant Handout #7.1: Sample Dialogues

Dialogue 1

Client: I don't want any more children. A friend of mine has an IUD and she is very pleased with it, so I would like one too.

Provider: Yes, we have IUDs here. It's nice to have a client who knows what she wants. The nurse will see you soon to put it in.

Question: Is this dialogue good or bad? Why?

Dialogue 2

Client: I would like to wait before getting pregnant again but my husband is insisting on having another baby right away.

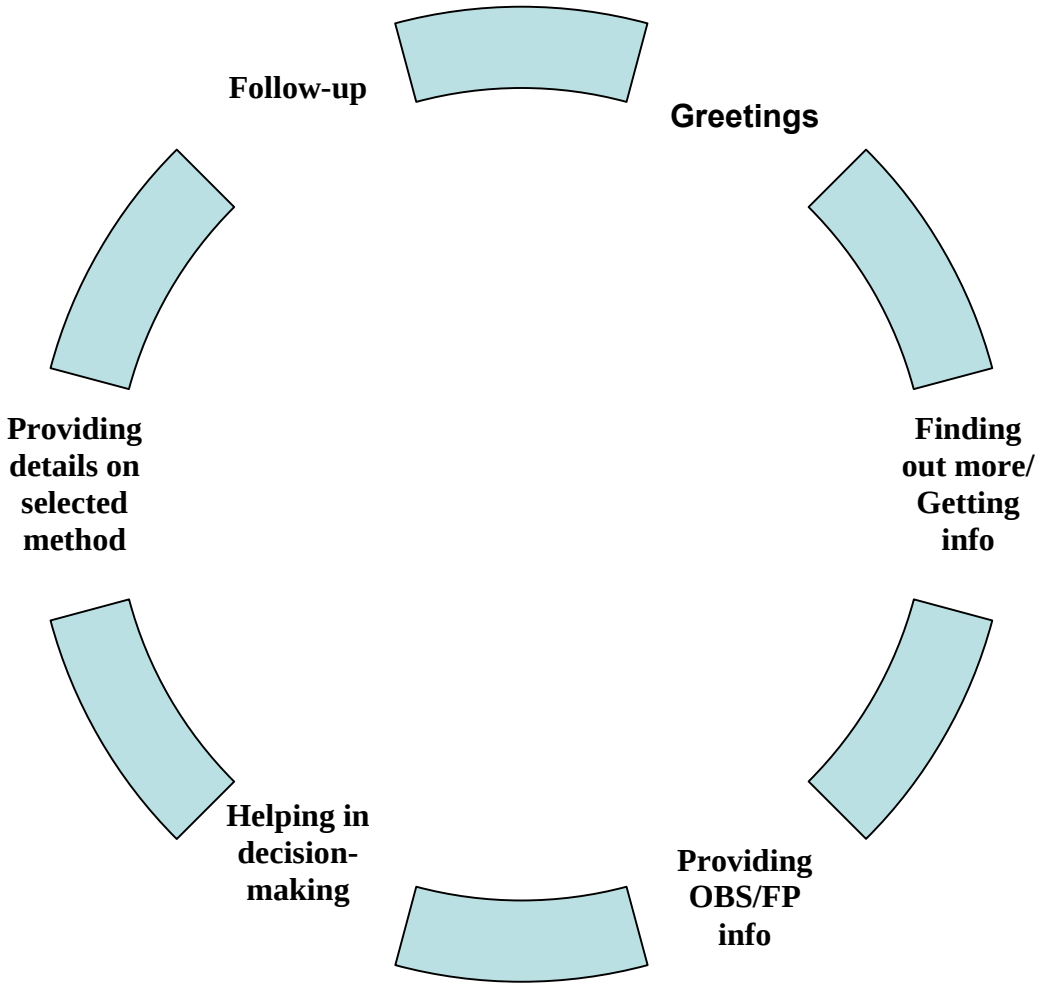
Provider: The best delay you can have is three years after the birth of your last child. How old is your last child?

Client: One year.

Provider: Excellent! You can still wait two more years. The health benefits will be great for you, your one year old and your future newborn. There will also be less economic stress on your family if you wait. Here is a list of all the benefits. Now let's make sure you are using a method that will protect you...

Question: Is this dialogue good or bad? Why?

Participant Handout #7.2: Elements of a Successful Counseling Session



Participant Handout #7.3: Key steps of the counseling process

Effective counseling, resulting in a well-informed decision and a well-treated client, can be achieved by following some basic steps in the counseling process. The steps can provide structure to a complex process yet should be adapted to meet each individual client's needs.

The following are **steps** of a successful counseling session:

1. Introductions
2. Finding out more/Getting information
3. Providing family planning information
4. Helping in the decision-making process
5. Providing details on a selected method
6. Follow-up

Examples of Tasks Conducted Under Each Step

Introductions

- Welcome and register client.
- Prepare chart/record.
- Determine purpose of visit.
- Give clients full attention, showing that you care for their well-being.
- Assure the client that all information discussed will be confidential.
- Talk in a private place if possible.

Finding out more/Getting information

- Ask client about her/his wishes and circumstances.
- Write down the client's: age, marital status, number of previous pregnancies and births, number of living children, basic medical history, previous use of family planning methods, history and risk for STDs.
- Attempt to develop a professional profile of women candidates for family planning or birth spacing. Women may be in vastly different situations, some of which might be outside of the field of family planning counseling and should be referred to other professionals in different fields. For example, an adolescent female rape victim should not be considered to be in the same situation as a woman with children who is married or lives with her partner and wishes to delay pregnancies. Therefore, it is important to find out the client's individual circumstances as they relate to family planning counseling.
- Talk with the client to determine his/her knowledge of optimal birth spacing and family planning methods. In the process be cognizant that in some cultures seeking out family planning information and services may be strongly discouraged.
- Show approval to the client for his/her knowledge about family planning and for seeking out family planning services and encourage the client to seek additional information and services in the future by providing information on such services.
- Ask the client if there is a particular method s/he is interested in.

- Discuss any client concerns about risks vs. benefits of modern methods and shed light on rumors and misconceptions.

Providing FP information

- Tell the client about optimal birth spacing and the available methods.
- Focus on methods that most interest the client, but briefly mention other available methods.
- Show/describe how each method works, the advantages and benefits and possible side effects and disadvantages.
- Answer client concerns and questions.

Helping in the decision-making process

- Help the client to choose a method.
- Repeat information if necessary.
- Explain any procedures or lab tests to be performed.
- Have a trained health professional examine client.
- If there is any reason found on examination or while taking a more detailed history that there are precautions for the method, help the client choose another method.

Providing details on a selected method

- Demonstrate/explain how, when and where to use the method.
- Explain to the client how and when s/he can/should get re-supplies of the method, if necessary.
- Provide confidence and encouragement again by complimenting the client on the decision to practice a family planning method.

Follow-up

- At the follow-up or return visit ask the client if s/he is still using the method.
- If the answer is yes, ask her/him if s/he is experiencing any problems or side effects and answer her/his questions resolving issues, if possible.
- If the answer is no, ask why s/he stopped using the method and counsel her/him to see if s/he would like to try another method or re-try the same method again.
- Make sure s/he is using the method correctly (ask her/him how s/he is using it).

Participant Handout #8.1: Elements of effective interpersonal communication (verbal and non-verbal)

INTERPERSONAL COMMUNICATION

Interpersonal communication is the face-to-face process of transmitting information and understanding between two or more people.

Face-to-face communication takes place in two forms, **verbal and nonverbal**, and is both conscious and unconscious, intentional and unintentional. Nonverbal communication can involve all our senses, while verbal communication is restricted to hearing. Cultural differences make non-verbal communication especially prone to misinterpretation at the conscious and unconscious levels.

In counseling, it is especially important to be aware and sensitive to the verbal and nonverbal communication styles of the culture in which you are working. How do the ethnic groups with whom you work talk about reproductive health? What words do they use? Are there certain gestures that are considered insulting? Effective counseling needs to consider all aspects of communication.

Types of Interpersonal Communication

Verbal Communication

- Refers to **words and their meaning**
- Begins and ends with what we say
- Is largely conscious and controlled by the individual speaking

The use of or reference to local proverbs, stories, or songs, can be a powerful way to convey family planning messages to clients of all ages and can make clients feel more at ease. Counseling, especially with adolescents or clients who do not have a high level of education, can be more effective when language is kept simple and familiar rather than using too many medical terms.

Nonverbal Communication

- Refers to **actions, gestures, behaviors, and facial expressions** which express, without speaking, how we feel
- Is complex and largely unconscious
- Often reveals to the observant the real feelings or message being conveyed or can be misinterpreted

Body posture, eye contact, physical appearance, the use of space (arrangement of desks and chairs), and the amount of time spent waiting in a doctor's office can all communicate a nonverbal message.

Generally, verbal and nonverbal communication work together to convey and reinforce a message. If the verbal and nonverbal messages do not match, the message believed is often the one conveyed nonverbally.

Positive nonverbal cues include those actions and behaviors that show you are being attentive, listening to the needs and concerns of the client and genuinely interested in providing them with help. Positive nonverbal messages can be conveyed through your body movements, facial expressions, etc. In some cultures, for example, this might mean leaning toward the client in a way that shows you are listening, maintaining eye contact with the client or nodding your head in encouragement.

Negative nonverbal cues **include those actions and behaviors that do not put the client at ease and make her/him feel that you do not care, are not interested, and do not have much concern in his/her wishes. Possible examples of this might include not making or maintaining eye contact, frowning, sitting with arms crossed and glancing frequently at a watch or clock.**

When communicating with clients, providers should be cognizant of not only what they say, but how they say it both verbally and nonverbally. They should also be aware that cultural differences play a significant role in how nonverbal communications are interpreted, and different nonverbal cues may mean completely different things.

Participant Handout #9.1: Methods of Contraception

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
Combined Oral Contraceptives (COCs) Available now for over 30 years, COCs are one of the most extensively studied medications in history. They constitute a highly effective and popular family planning method and are safe for use by most women. *Mechanism of Action* COCs contain the hormones estrogen and progestin. Taken orally on a daily basis, the combined action of the two hormones prevents pregnancy chiefly by hampering the production of follicle-stimulating hormone (FSH) and luteinizing hormone (LH), thus suppressing ovulation; by creating a thick cervical mucus, which hampers the transport of sperm; and by creating a thin, atopic endometrium, which deters implantation.	• Reduce dysmenorrhea • Regulate the menstrual cycle • Reduce menstrual flow (which may be useful to anemic women) • Decrease pre-menstrual symptoms • Decrease the risk of severe forms of pelvic inflammatory disease (PID) • Decrease the risk of ectopic pregnancy • Decrease the risk of ovarian and endometrial cancer • Decrease the incidence of functional ovarian cysts • Decrease the rate of benign breast disease • Decrease the incidence of acne • Client controls own fertility • Well researched • Does not interrupt sex • Will not affect lactation after use has been established	• Client-dependent; must be taken every day • Requires regular/dependable supply • COCs may have minor side effects in some clients, such as nausea, headache, or breakthrough bleeding • Women who smoke over 20 cigarettes a day and are over 35 years of age are at high risk for developing cardiovascular disease. • Does not protect from STDs/HIV	COCs may be an appropriate choice for: • Women and couples who want effective, reversible method • Nulliparous women • Women suffering from anemia due to heavy menstrual bleeding • Women with irregular menstrual cycles • Women with history of ectopic pregnancy • Women with family history of ovarian cancer or history of benign, functional ovarian cysts	COCs should not be used by women with the following conditions: • Smoking • Moderate to severe hypertension • Diabetes with vascular disease • Thromboletic disorder • Ischemic heart disease • Valvular heart disease with complications • Major surgery with prolonged immobilization • Stroke • Recurrent migraine headaches with focal neurological symptoms • Unexplained abnormal vaginal bleeding • Breast cancer • Gallbladder disease • Jaundice related to contraceptive use • Active viral hepatitis • Cirrhosis of the liver • Liver tumors • Taking the drugs rifampin, griseofulvin or anticonvulsants for epilepsy

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
Effectiveness **COCs are effective. Their typical pregnancy rate is 8% in one year.** As with any method which is client-dependent, effectiveness rates will vary. **The perfect-use pregnancy rate is 1%.**	• Can be stopped anytime • Easily made available • Highly effective, reversible, easy to use • **Safe for most women**			

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
Emergency Contraceptive Pills (ECP) ECPs are either high- or low-dose combined oral contraceptives or progestin-only pills taken in a specific regimen within 72 hours after unprotected sex in order to avoid an unwanted pregnancy. *Mechanism of Action* The precise mode of action of ECPs is uncertain and may be related to the time it is used in a woman's cycle. ECPs are thought to prevent ovulation, fertilization, and/or implantation. ECPs are not effective once the process of implantation of a fertilized ovum has begun. **ECPs will not cause an abortion** and have no known adverse effects on (the growth and development of) an established pregnancy. *Effectiveness of ECPs* After a single act of unprotected sexual intercourse, the Yuzpe regimen (which contains estrogen and a progestin) reduces the risk of pregnancy by 74%. The	• Well-documented safety • Drug exposure and side effects are of short duration • Readily available (COCs containing EE and LNG) • Convenient and easy to use • Multiple contraceptive mechanisms: prevents ovulation and implantation • Reduce the risk of unwanted pregnancy • Reduce the need for abortions • Appropriate for young adults who may have unplanned sex and who may be less likely than adults to be prepared for a first sexual encounter • Can provide a bridge to the practice of regular contraception	• Do not protect against the transmission of STDs and HIV • Do not provide ongoing protection against pregnancy • Should be used within three days of unprotected intercourse for highest efficacy • May produce nausea and sometimes vomiting • May change the time of the woman's next menstrual period • Are more expensive and less effective than regular contraception • **Could result in increased pregnancy risk if used too frequently**	ECPs are suitable for a woman who experiences: • Unprotected intercourse • Contraceptive accidents (e.g., condom breakage or slippage, dislodged diaphragm, etc.) • Contraceptive use errors (e.g., missed pills, incorrect use of barrier methods, miscalculated safe days with natural family planning method, etc.) • **Sexual assault or other non-consensual intercourse**	ECPs should not be given to women who: • Have a confirmed pregnancy

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
progestin only regimen reduces the risk of pregnancy by 85% **Overall, ECPs are less effective than regular contraceptive methods. Because the ECP pregnancy rate is based on a one-time use, it cannot be directly compared to failure rates of regular contraceptives, which represent the risk of failure during a full year of use. If ECPs were to be used frequently, the failure rate during a full year of use would be higher than those of regular hormonal contraceptives. Therefore, ECPs are inappropriate for regular use.**				
Progestin-only pills (POPs) Like other progestin-only contraceptives (i.e., Norplant implants and DMPA), POPs contain no estrogen. POPs are administered orally while other	• Highly effective when used correctly • Do not affect breastfeeding • Do not increase risk of blood clotting • **Decrease**	• **Must** be taken at **same time** every day • May produce minor side effects, including amenorrhea,	POPs may be an appropriate choice for: • Breastfeeding women who need/want contraception	**POPs should NOT be given to women who:** • Have a confirmed pregnancy • Have unexplained abnormal vaginal bleeding • Currently have breast

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
delivery mechanisms include injections (DMPA), implants (Norplant), IUDs (Progestasert), or vaginal rings. The DMPA injectable has been in use for some 20 years and POPs for about 12. One of the newer progestin methods available is the Norplant implant. *Mechanism of Action* The progestin in POPs prevents pregnancy by suppressing ovulation in many cycles (not all), and by thickening the cervical mucus and creating a thin endometrium, which hampers sperm transport. *Effectiveness* POPs are effective, even though they contain about one-third the progestin in COCs. POPs have a typical pregnancy rate varying from 8-12% (estimated based on lack of specific data). Pregnancies will be fewer in breastfeeding women. However, the effectiveness of POPs is client-dependent; the pill must be taken at the same time every day. It is important for the client to understand that even one pill missed can render the method	**menstrual pain and amount of bleeding**	headaches, weight gain/loss, mood changes, nausea, breast tenderness • Do not prevent ectopic pregnancy • Do not protect against future ovarian cysts • **Do not protect against STDs/HIV**	• Women who experience estrogen-related side effects when using COCs • Women with high blood pressure • Women over 35 who smoke and do not want to use an IUD or VSC • Women with sickle cell anemia	cancer • Have had breast cancer with no evidence of disease the past 5 years • Have severe (decompensated) cirrhosis of the liver • Have active viral hepatitis • Have either benign or malign liver tumors • Have Schistosomiasis with sever fibrosis of the liver • Are taking the antibiotics rifampin (rifampicine) or griseofulvin • Are taking anticonvulsants for epilepsy except valproic acid • Are breastfeeding less than 6 weeks after childbirth

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
ineffective for that cycle. POPs become effective within seven days if begun on the first day of the menstrual cycle. If the POP is started on day two to day five of the cycle, the POPs will not become fully effective until after ovulation for that cycle, and the client should use a back-up method (condom, spermicide, or other non-hormonal method) for two weeks. Clients must be counseled particularly well on these points.				
DMPA DMPA (depo-medroxyprogesterone acetate) contains the hormone progesterone. It is a long-acting method, which slowly releases the hormone, and is given by intramuscular injection required every 12 weeks. *Mechanism of Action* DMPA suppresses ovulation in all cycles, and thickens cervical mucus while creating a thin endometrium, which hampers sperm transport.	• Very effective • Private • Long-term pregnancy prevention but reversible • Does not interfere with sex • No daily pill-taking • Allows some flexibility in return visits. Clients can return as much as 2 to 4 weeks early or late for their next injection • Can be used at any age • Quantity and quality of breast milk are not harmed	• May produce minor side effects, such as light spotting of bleeding, heavy bleeding, amenorrhea or weight gain • Delayed return to fertility (until DMPA levels in body drop) • Requires another injection every 3 months • May cause headaches, breast tenderness, moodiness, nausea, hair loss, less sex drive, and/or acne in some women • Does not protect	DMPA may be an appropriate choice for: • Women who are breastfeeding (as soon as 6 weeks after childbirth) • Smoke cigarettes • Have no children • Are adolescents • Are fat or thin • Have just had abortion or miscarriage Women with these conditions also	DMPA should NOT be given to women who: • Are pregnant • Have severe high blood pressure (greater than 180/110) • Have diabetes with vascular disease or diabetes for more than 20 years • Have current or past Ischemic heart disease • Have had a stroke • Have unexplained abnormal vaginal bleeding • Have current breast cancer or have had past breast cancer with no evidence of disease for 5 years • Have active viral hepatitis • Have severe cirrhosis of the liver

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
Effectiveness DMPA is highly effective, with a pregnancy rate of less than 1%. Studies show that approximately only one woman out of 400 who use DMPA for a year will become pregnant.	not harmed • No estrogen side effects. Does not increase the risk of estrogen-related complications such a heart attack • Helps prevent ectopic pregnancies • Helps prevent uterine fibroids • May help prevent ovarian cancer • For some women, it may help prevent iron-deficiency anemia, reduce epileptic seizures, and make sickle cell crises less frequent and less painful	against sexually transmitted diseases including HIV/AIDS	generally may use DMPA: • Benign breast disease • Mild headaches • Mild or moderate high blood pressure • Iron deficiency anemia • Blood clotting problems • Varicose veins • Valvular heart disease • Irregular menstrual periods • Malaria • Schistosomiasis • Sickle cell disease • Thyroid disease • Uterine fibroids • Epilepsy • Tuberculosis	liver • Have benign or malignant liver tumors • Have schistosomiasis with severe fibrosis of the liver • Are breastfeeding less than 6 weeks after childbirth
Norplant Implants Developed by the Population Council, the Norplant implant system consists of six thin,	• Very effective, even in heavier women • Long-term pregnancy protection (effective	Common side effects include: • Changes in menstrual bleeding, including light	Women who may use Norplant include: • Women who are	Norplant should **NOT** be given to women who: • Have a confirmed pregnancy • Have unexplained abnormal vaginal bleeding

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
flexible silastic capsules, which are inserted just under the skin of the inner upper arm by a trained provider. The capsules contain the progestin levonogestrel, which is released though the capsule walls in a continuous low dose over five years. *Mechanism of Action* Like DMPA, Norplant implants work by consistently suppressing ovulation and by producing a thick cervical mucus, which hampers sperm transport. *Effectiveness* Norplant implants are highly effective, with a pregnancy rate of less than 1% over the course of a year (a figure comparable to VSC.) Norplant implants provide effective protection for five years, after which time its effectiveness diminishes and it should be removed.	up to 5 years) but reversible • No need to do anything at time of sexual intercourse • Nothing to remember: no pill-taking or repeated injections, no repeated clinic visits required • Effective within 24 hours after insertion • Fertility returns almost immediately after capsules are removed • Quality and quantity of breast milk do not seem to be harmed; can be used by nursing mothers starting 6 weeks after childbirth • No estrogen side effects • Helps prevent iron deficiency anemia • Helps prevent ectopic pregnancies • May help prevent endometrial cancer • May make sickle cell crises less frequent and painful	spotting or bleeding between monthly periods, prolonged bleeding, or amenorrhea Possible side effects include: • Headaches • Enlargement of ovaries or of ovarian cysts • Dizziness • Breast tenderness and/or discharge • Nervousness • Nausea • Acne or skin rash • Change in appetite • Weight gain • Hair loss or more hair growth on face Other disadvantages: • Clients cannot start or stop on their own - capsules must be inserted by a specially trained health care provider • Minor surgical procedure required to insert and remove capsules	breastfeeding (as soon as 6 weeks after childbirth) • Smoke cigarettes • Have no children • Are adolescents • Are fat or thin • Have just had abortion or miscarriage Women with these conditions also generally may use Norplant: • Benign breast disease • Mild headaches • High blood pressure • Iron deficiency anemia • Blood clotting problems • Varicose veins • Valvular heart disease • Irregular menstrual periods • Malaria	• Have current breast cancer, or have had breast cancer with no sign of disease the past 5 years • Have active viral hepatitis • Have severe cirrhosis of the liver • Have benign or malignant liver tumors • Have schistosomiasis with severe fibrosis of the liver • Are breastfeeding less than 6 weeks after childbirth

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
	• Insertion only involves minor pain of anesthesia needle.	• Discomfort for several hours up to 1 day after insertion for some women. Removal is sometimes painful and more difficult than insertion • In very rare cases when pregnancy occurs, as many as 1 in 6 is ectopic • Does not protect against sexually transmitted diseases including HIV/AIDS	• Schistosomiasis • Sickle cell disease • Thyroid disease • Benign ovarian tumors or uterine fibroids • Epilepsy • Tuberculosis • Endometriosis • Gallbladder disease • Pelvic inflammatory disease • Sexually transmitted disease • Blood clotting problems	
Female Sterilization (Voluntary Surgical Contraception, VSC) Commonly acknowledged to be quick, easy, safe and effective, female sterilization is the most widely used contraception method worldwide. An estimated 182 million couples have chosen voluntary surgical contraception	• Very effective • Permanent • Nothing to remember, no supplies needed, no repeated clinic visits required • No interference with sex • No effect on breast milk	• Usually painful for several days after the procedure • Uncommon complications of surgery include: Infection or bleeding at the incision, internal infection or bleeding, injury to internal organs,	Women who are safe candidates for sterilization include: • Old or young women • Women with no children • Women who just gave birth (within 7 days)	**Women with the following conditions should delay sterilization:** • Pregnant women • Current thromboembolic disorder • Current ischemic heart disease • Prolonged immobilization or surgery on legs • Unexplained abnormal

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
(VSC) as the means to prevent further pregnancies; 140 million of these were female sterilizations. Services to provide female sterilization have greatly expanded in many countries, making it possible for more women to avail themselves of this procedure. In contrast, the male sterilization procedure, vasectomy, is one of the least known and least used contraceptive methods worldwide. *Mechanism of Action* Female sterilization is a relatively simple and safe surgical procedure. It involves blocking the fallopian tubes by ligation, clips or bands in order to prevent sperm and ovum from uniting. *Effectiveness* This procedure does not affect sexual performance, and it is highly effective. Female sterilization pregnancy rates are less than 1% in the first year and pregnancy is even less frequent in subsequent years. Female sterilization is permanent and must be assumed to be	• No known long-term side effects or health risks • Can be performed just after childbirth • Helps protect against ovarian cancer	anesthesia risks • Very rarely, death due to anesthesia overdose or other complication • In rare cases when pregnancy occurs, it is more likely to be ectopic • Requires physical examination and minor surgery by a specially trained provider • More risky and expensive than vasectomy • Reversal surgery is difficult, expensive, and not usually available • Successful reversal not guaranteed • No protection against sexually transmitted disease, including HIV/AIDS	• Women who are breastfeeding Women with these conditions may also generally have sterilization: • Preeclampsia • Past ectopic pregnancy • Benign ovarian tumors • Irregular or heavy vaginal bleeding patterns, painful menstruation • Vaginitis without purulent cervicitis • Diabetes • Varicose veins • HIV-positive or high risk of HIV or other STD infection • Uncomplicated schistosomiasis • Malaria • Tuberculosis • Cesarean	vaginal bleeding • Cervical cancer (awaiting treatment) • Endometrial or ovarian cancer • Current pelvic inflammatory disease or within the past 3 months • Current gallbladder disease • Active viral hepatitis • Malignant trophoblast disease • Iron deficiency anemia with hemoglobin less than 7 g/dl • Abnormal skin infection • Acute bronchitis or pneumonia • Emergency surgery or surgery for an infectious condition • Systemic infection or gastroenteritis Post partum or postabortion women with the following conditions should also delay sterilization: • Severe preeclampsia/eclampsia • Prolonged rupture of membranes • Severe hemorrhage • Sepsis • Fever during or right after delivery

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
irreversible by the client.			section (surgical delivery) at same time	• Severe trauma to the genital tract • Uterine rupture or perforation • Acute hematometra • Postpartum women, once the first 7 days have passed after birth, should delay the procedure until uterine involution is complete (usually takes around 42 days). The first 7 days after childbirth do not require a delay. **Women with the following conditions should be referred to a special clinic or center:** • Moderate to severe high blood pressure • Diabetes with vascular disease or diabetes for more than 20 years • Valvular heart disease with complications • High risk of HIV infection • Severe cirrhosis of the liver • Chronic asthma • Bronchitis • Emphysema • Lung infection • Fixed uterus • Abdominal wall or umbilical hernia **Women with these conditions should use caution before**

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
				accepting sterilization: • Mild high blood pressure • Hypothyroid • Thalassemia • Sickle Cell disease • Epilepsy • Schistosomiasis with fibrosis of liver • Taking antibiotics rifampin or griseofulvin • Taking anticonvulsants for epilepsy except valproic acid • Past hypertension with blood pressure that cannot be evaluated • Diabetes • Past ischemic heart disease • Valvular heart disease • Stroke • Current breast cancer • Has not become pregnant since pelvic inflammatory disease • Mild cirrhosis of liver • Benign or malignant liver tumors • Uterine fibroids • Obesity • Diaphragmatic hernia • Kidney disease • Elective surgery • Severe nutritional deficiencies
		Common minor short-	Most men can	**Men with the following**

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
Vasectomy Vasectomy is one of the least known and least used contraceptive practices worldwide. However, it is a relatively simple and safe surgical procedure. *Mechanism of Action* Vasectomy involves blocking the vas deferens to prevent sperm from entering semen. The vasa are reached through two small incisions in the scrotum. *Effectiveness* Vasectomy is highly effective; pregnancy rates are less than 1% in the man's partners. An important point to make when counseling for vasectomy is that it takes 20 ejaculations for the man to be free of sperm following a vasectomy; he should use a condom for every act of intercourse until he has had 20 ejaculations. Vasectomy is permanent and should be considered irreversible by the client.	• Very effective • Permanent • Nothing to remember except to use condoms for the first 3 months or 20 ejaculations • No interference with sex • No supplies to get, no repeat clinic visits required • No apparent long-term health risks Compared with female sterilization, it is: • Safer • Slightly more effective • Easier to perform • Less expensive • Able to be tested for effectiveness at any time • Less likely to induce ectopic pregnancy	term side effects include: • Usually uncomfortable for 2 or 3 days • Pain in the scrotum, swelling and bruising • Brief feeling of faintness after procedure Uncommon complications include: • Bleeding or infection at the incision site or inside incision • Blood clots in scrotum Other disadvantages include: • Requires minor surgery by specially trained provider • Not immediately effective. The first 20 ejaculations after vasectomy may contain sperm. The couple must use another contraceptive method for the first 20 ejaculations or the first 3 months-whichever comes first.	have vasectomy, including men of all ages, those who have sickle cell or hereditary anemia; or those who are HIV-positive or at high risk of HIV or other STD infection. **However, vasectomy does NOT prevent a man from passing HIV and other STDs.**	**conditions should delay vasectomy:** • Current STD • Scrotal skin infection • Balanitis • Infection or severe gastroenteritis • Filariasis or elephantiasis • Intrascrotal mass **Men with the following conditions should be referred to special care or center:** • Coagulation disorders • AIDS • Inguinal hernia **Men with the following conditions should use caution:** • Previous scrotal injury or surgery • Large varicocele • Large hydrocele • Cryptorchidism • Diabetes and diabetes with vascular disease or diabetes for more than 20 years

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
		• Reversal surgery is difficult, expensive, and not available in most areas. Success cannot be guaranteed. • No protection against HIV/AIDS or STDs		
Condoms Condoms are contraceptive devices (barrier methods) that cover the penis and prevent sperm from uniting with ovum. In the age of STDs/HIV, condoms have assumed new importance. The condom is the only method (if used correctly) that is known to protect against HIV/AIDS transmission. *Mechanism of Action* Barrier methods physically block or chemically inactivate sperm to prevent it from uniting with the ovum. The condom prevents sperm from entering the vagina. *Effectiveness* Condoms range from fairly effective to highly effective, depending on a number of	• Prevents STDs, including HIV/AIDS, as well as pregnancy, when used correctly during intercourse • Helps protect against conditions caused by STDs- pelvic inflammatory disease, infertility, possible cervical cancer in women, and chronic pain • Can be used to prevent STD infection during pregnancy • Can be used immediately after childbirth • No effect on breast milk • Protects against infection in the uterus	• Latex condoms may cause itching for a few people who are allergic to latex. Also, some people may be allergic to the lubricant on some brands of condoms. • May decrease sensation, making sex less enjoyable • Couple must take time to put condom on erect penis before sex • Supply must be ready even if woman or man is not expecting to have sex • Small possibility that condom will slip off or break during sex • Condoms can weaken if stored too	Men of all ages are good candidates for using condoms	**People should NOT use a condom if:** • They have a severe allergy to latex rubber

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
variables (age of user, frequency of intercourse, use with spermicide, correct and consistent use, etc.). Typical user pregnancy rates are about 12%. Used consistently and correctly, condoms have a pregnancy rate of approximately 3%.	uterus • Safe. No hormonal side effects • Helps prevent ectopic pregnancies • Can be stopped at any time • Offer occasional contraception with no daily upkeep • Easy to keep on hand- little planning involved • Can be used by men of any age • Can be used without seeing a health care provider first • Usually easy to obtain and sold in many places • Enable a man to take responsibility for preventing pregnancy and disease • Often help prevent premature ejaculation	weaken if stored too long or in too much heat, sunlight, humidity, or if used with oil-based lubricants- and then may break during use • A man's cooperation is necessary for a woman to protect herself from pregnancy and disease • Poor reputation. Many people connect condoms with immoral sex, sex outside marriage, or sex with prostitutes • May embarrass people to buy, ask partner to use, put on, take off, or throw away condoms		
Intrauterine Device (IUDs) A popular and very effective method, modern IUDs have been available since the 1960s,	• A single decision leads to effective long-term prevention of pregnancy	Common side effects include: • Menstrual changes • Longer and heavier menstrual periods	Many women can use IUDs even if they: • Smoke cigarettes	**Women with the following should NOT use IUDs:** • Benign or malignant Trophoblast disease • Pelvic tuberculosis

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
with the development of the Lippes Loop. There are two categories of IUDs: unmedicated (inert) and medicated. The Lippes Loop is an example of an unmedicated IUD. Medicated IUDs are those that are either copper-bearing, such as second-generation Copper T 380A (TCu 380A) or the Multiload 375 (MLCu 375), or hormone-releasing, such as the Progestasert. The copper on plastic IUDs increases their effectiveness and extends their effective lifespan. There are several types of IUDs used worldwide. *Mechanism of Action* Recent studies of the IUD indicate that the copper-bearing IUDs' principal mechanism of action (MOA) is to interfere with fertilization. When the IUD is in place, the transport of sperm and eggs through the fallopian tubes is altered, preventing fertilization. IUDs have several other MOAs, including the destruction of sperm and egg secondary to vaseptic inflammatory reaction in the uterus. IUDs, which contain progesterone, also cause the	• Long-lasting. The most widely used, the TCu-380A, lasts at least 10 years. Inert IUDs never need replacement • Very effective. Little to remember • No interference with sex • No hormonal side effects with copper-bearing or inert IUDs • Immediately reversible- no delay in return to fertility • No effect on breast milk • Can be inserted immediately after childbirth or after induced abortion • Can be used through menopause • No interactions with any medicines • Helps prevent ectopic pregnancies	• Bleeding or spotting between periods • More cramps or pain during periods Uncommon side effects: • Severe cramps and pain beyond first 3 to 5 days after insertion • Heavy menstrual bleeding or bleeding between periods, possibly contributing to anemia (more likely with inert IUDs) • Perforation of wall of uterus (very rare if IUD properly inserted) Other disadvantages: • Does not protect against STDs, including HIV/AIDS • Pelvic inflammatory disease (PID) is more likely to follow STD infection if a woman uses an IUD. • Medical procedure, including pelvic exam, needed to insert IUD	• Have just had an abortion or miscarriage (if no evidence of infection) • Take antibiotics or convulsants • Are breastfeeding Women with these condition can also generally use IUDs: • Benign breast disease • Breast cancer • Headaches • High blood pressure • Irregular vaginal bleeding • Blood clotting problems • Varicose veins • Heart disease (disease involving heart valves may require treatment with antibiotics before IUD insertion)	• Distorted uterine cavity • Pregnant women • Unexplained abnormal vaginal bleeding • Cervical cancer (awaiting treatment) • Endometrial or ovarian cancer • Current PID or in last 3 months • Current STD • STD in last 3 months • Increased risk of STDs • HIV infected • High risk of HIV infection • AIDS • After septic abortion • Puerpal sepsis (genital tract infection during first 42 days after childbirth) • Women who have given birth 48 or 4 weeks earlier need a doctor or nurse to make a clinical judgment

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
thickening of cervical mucus, which hampers sperm transport. *Effectiveness* The IUD is highly effective, with different pregnancy rates for the various types. Older, inert IUDs have a pregnancy rate above 2% per year. The newer TCu 380A and MLCu 375 have pregnancy rates of less then 1% per year. IUDs also have a good continuation rate, higher than most other reversible methods.		insert IUD. Occasionally, a women faints during procedure • Some pain and bleeding or spotting may occur immediately after IUD insertion- usually goes away with a day or two • Client cannot stop IUD use on her own. A trained health care provider must remove the IUD for her • May come out of uterus, possibly without the woman's knowing • Does not protect against ectopic pregnancy as well as it protects against normal pregnancy • The woman should check the position of the IUD strings from time to time, requiring that she put her fingers in her vagina. Some women may be unwilling to do this.	• History of stroke • Diabetes • Liver or gallbladder disease • Malaria • Schistosomiasis (without anemia) • Thyroid disease • Epilepsy • Nonpelvic tuberculosis • Uterine fibroids (unless they badly distort the uterine cavity) • Past ectopic pregnancy • Past pelvic surgery	

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
Fertility Awareness Methods Fertility awareness methods are methods that rely on various techniques to identify a woman's fertile days (the days on which she can become pregnant). These methods monitor the various changes and signs that occur in a woman's body during each menstrual cycle, which may indicate when she is fertile and when she is not (the "safe" days). By avoiding intercourse on "unsafe" days, a woman may avoid pregnancy. These methods can work for many women with varying degrees of reliability. However, each requires a considerable degree of instruction and a high level of motivation and commitment on the part of the couple in order to be used successfully. *Mechanism of Action* The simple **Standard Days Method** is based on cycle days. All method users abstain from unprotected intercourse on **days 8-19** of every cycle (both inclusive). Because the standard formula to define the fertile period	• No or low cost • No chemical products/no physical side effects • Immediately reversible • Acceptable to many religious faiths • Responsibility for family planning is shared by both partners • Educates people about women's fertility cycles	• Requires considerable client instruction • Requires high level of client responsibility: women must keep daily records • Couples must cooperate in order to avoid sexual relations during fertile days (about 10-15 days each month), unless a barrier method is used at that time • Women with irregular menstrual periods may be unable to use rhythm or BBT methods • Does not protect against STDs/HIV • Can become unreliable or hard to use if woman has a fever, has a vaginal infection, is breastfeeding, or has any other condition that changes body temperature, cervical mucus, or menstrual cycle length.	Fertility awareness methods may be appropriate for client who: • Will not or cannot use other methods for personal or religious reasons • Has conditions that are a precaution for hormonal or other methods • Finds that using a more effective method is not crucial	Women with the following conditions may find it difficult to use fertility awareness methods and may need to choose a more effective method: • Any medical condition that would make pregnancy especially dangerous • Irregular menstrual cycles, bleeding between periods, heavy or long monthly bleeding • If they are younger women and their periods are just starting • If they are older women and their periods have become irregular or have stopped • If the woman has recently given birth or had an abortion • If she is breastfeeding • If she has any condition that affects ovaries or menstrual bleeding, such as stroke, serious liver disease, hyperthyroid, hypothyroid, or cervical cancer • If she has any diseases or infections that may change cervical mucus,

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
is already established, SDM users do not need to keep records of cycle lengths or do calculations. The probability of becoming pregnant during this "fertile window" varies, from 4% five days before ovulation, to 30% two days before ovulation. For women with cycles between 26 and 32 days the probability of pregnancy with SDM is very low, because women usually ovulate between days 13 and 17 of their cycle; by avoiding unprotected sex day 8 through 19 allows enough time for the gametes to lose their capacity to fertilize or be fertilized. A helpful FP aid is the "necklace" of beads that represent a woman's cycle. Women keep track of where they are in their cycle by moving a rubber ring along the beads, with the fertile days specially colored. **The Basal Body Temperature (BBT)** Method requires the woman to take her own temperature every morning on awaking and record it on a chart over several months. By doing this she can determine her time of ovulation. A drop in the BBT sometimes precedes ovulation by 12 to 24 hours and rises		cycle length. • May be very difficult to practice if woman has more than one partner • After childbirth, may be hard to identify the fertile time until menstrual cycle has become regular again		change cervical mucus, basal body temperature, or menstrual bleeding, such as certain STDs, vaginal infections, or pelvic inflammatory disease in the last 3 months • If she takes any drugs that affect cervical mucus, such as mood-altering drugs, lithium, tricyclic anti-depressants, or anti-anxiety therapies

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
immediately after ovulation, staying elevated slightly (0.2° to 0.5°C) until her next menstrual period. **The Two-Day Method** is an observation-based method. Method users pay attention to the presence of *secretions of any type* at the vulva (mostly cervical secretions) and consider themselves fertile on **1) the days when they have perceived ANY secretions and 2) the day following the presence of any secretions.** To avoid pregnancy, women must avoid unprotected intercourse on those days. Daily, a woman using the Two-Day Method determines her fertility status daily by asking herself 2 questions, "Did I notice any secretions *today*? Did I notice any secretions *yesterday*?" If she answers yes to either or both of these questions, she is probably fertile today. Two-Day method users are taught to consider all secretions noticeable at the vulva as sign of fertility irrespective of color, consistency, etc., to make learning and using the method easier. To avoid potential confusion with seminal fluids deposited the previous evening or morning, users do not take into				

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
account secretions perceived before noon. **The Hypothermal Method (STM)** combines several techniques to predict ovulation. The woman monitors her cervical mucus (as in the Billings Method) and her temperature changes (as in the BBT method), including other signs of ovulation, like breast tenderness, back pain, abdominal pain, and light intermenstrual bleeding. She must abstain from the first sign of wet cervical mucus until her body temperature has remained elevated for three days after the peak day (the last day of clear, slippery mucus) or until the fourth day after the thin mucus is no longer observed, whichever is later. *Effectiveness* Fertility awareness methods have a typical pregnancy rate of about 20% in the first year. Depending on variables such as consistency of use, regularity of menstrual cycles, and user-related factors, consistent and correct use effectiveness can reach 98%. When used in combination with a barrier method, effectiveness is				

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
increased.				
Lactational Amenorrhea Method (LAM) LAM is a family planning method for breastfeeding mothers, which provides natural protection against pregnancy for up to six months after birth and encourages the timely introduction of complementary family planning methods during continued breastfeeding. *Mechanism of Action* LAM is based on the physiological infertility of breastfeeding women. The infant's suckling at the breast sends neural signals to the mother's hypothalamus. This influences the level and rhythm of gonadotropin-releasing hormone (GnRH) secretion. GnRH influences pituitary release of FSH and LH, the hormones responsible for follicle development and ovulation. Hence, breastfeeding results in decreased and disorganized follicular development. Without ovulation, fertilization cannot take place.	• Can be started immediately after delivery • Requires no prescription • Carries no side effects or precautions • Economical • Very convenient • Requires no chemical substances or mechanical devices • Encourages the best breastfeeding patterns • Helps protect infant from diarrhea and other infectious diseases • Counseling for LAM encourages starting a follow-on method at the proper time	• Can only be used during the early postpartum period (first 6 months) • May be difficult for woman to maintain pattern of fully or almost fully breastfeeding • Provides no protection against STDs/HIV	Most women can use LAM safely and effectively, even if they: • Smoke cigarettes • Are young or old • Are fat or thin Women with these conditions can also generally use LAM: • Benign breast disease • Breast cancer • Headaches • High blood pressure • Irregular vaginal bleeding • Blood clotting problems • Varicose veins • Heart disease • Diabetes • Liver or gallbladder disease • Malaria	The following conditions represent unacceptable health risks to the infant while using LAM: • The use of reserpine, ergotamine, antimetabolites, cyclosporine, cortisone, bromoriptine, radioactive drugs, lithium, or anticoagulants The following conditions may prevent breastfeeding: • Sore nipples • Mastitis • Congenital deformity of infant's mouth, jaw, or palate • Infant small for age • Premature birth or neonatal intensive care • Past breast surgery • Certain metabolic disorders

Method Mechanism of Action Effectiveness	Advantages	Disadvantages	Appropriate Users of the Method	Who Should Not Use the Method
Effectiveness If using the LAM technique perfectly, a woman has less than a 2% chance of pregnancy in six months. She must meet the following criteria: • She is less than six months postpartum • She is amenorrheic • She is fully or almost fully breastfeeding Recent clinical trials have confirmed "consistent and correct use" effectiveness rate.			• Sickle cell disease • Thyroid disease • Uterine fibroids • Iron deficiency anemia	

Participant Handout #9.2: Relationship Between Contraceptive Methods and Sexuality

Clients' **continued use of a method and level of content** is **often related to** the real or perceived **effect of a method on their sexual practices and enjoyment**.

As in the case with minor side effects, what one client perceives as a problem may be perceived as an advantage by another client.

If spontaneity is a priority for a woman or her partner, then **methods, which take action immediately before intercourse, may not be satisfactory** for that couple (e.g., condoms or spermicides).

For many clients, the frequency of sex will be a factor in choosing a method.

Women who are considering hormonal methods or IUDs should consider whether they might be bothered by menstrual changes, if these occur.

If effectiveness is a priority, then methods such as **COCs, IUD, implants, and injectables** will give the client a greater feeling of security during sex.

. Participant Handout #10.1: Rumors and Misconceptions

Rumors are **unconfirmed stories** that are **transferred** from one person to another **by word of mouth**. In general, rumors arise when:

- an issue is important to people, but has not been clearly explained.
- there is nobody available who can clarify or correct the information.
- the original source is perceived to be credible.
- clients have not been given enough options for contraceptive methods.
- people are motivated to spread them for political reasons.

A **misconception** is a **mistaken interpretation of ideas or information**. If a misconception is filled with elaborate details and becomes a fanciful story, then it acquires the characteristics of a rumor.

Unfortunately, rumors or misconceptions are sometimes spread by health workers who may be misinformed about certain methods or who have religious or cultural beliefs about family planning, which impact their professional conduct.

The **underlying causes** of rumors have to do with people's knowledge and understanding of their bodies, health, medicine, and the world around them. Often, rumors and misconceptions about family planning make rational sense to clients and potential clients. People usually believe a given rumor or piece of misinformation due to **immediate causes** (e.g., confusion about anatomy and physiology).

Participant Handout #10.1: Rumors and Misconceptions (cont.)

Methods for Counteracting Rumors and Misconception

1. When a client mentions a rumor, **always listen politely. Don't laugh.**
2. **Define** rumor or misconception and give some examples.
3. **Try to determine what kind of incident started the rumor and if it has any validity.** If there is a logical other explanation for the side effect or problem a form of contraception has been rumored to cause, talk with people who started the rumor and attempt to clarify with them their experiences and direct them to the proper health authorities if necessary.
4. **Explain the facts**.
5. **Use strong scientific facts** about family planning methods to counteract misinformation.
6. Always **tell the truth**. Never try to hide side effects or problems that might occur with various methods.
7. **Clarify information** with the use of demonstrations and visual aids.
8. **Give examples of people who are contented users** of the method if they have given informed consent to use of their names. This kind of personal testimonial is most convincing.
9. **Reassure clients** who are experiencing problems and, if necessary, have a qualified health worker examine the client if his/her chosen method requires a physical exam prior to being recommended.
10. **Counsel** the client about all available family planning methods.
11. Reassure and let the client know that you care by conducting **home visits** if the client has given informed consent to it.

Participant Handout #10.2: Immediate and Underlying Causes for Rumors

Dr. Q went to work in a clinic in a small town. As an obstetrician-gynecologist, she was very interested in family planning. Dr Q was pleased to discover that her town had one of the highest pill-acceptance rates in the province. But when she talked to the midwives and nurses, she discovered that they were extremely busy delivering babies and that there were also large numbers of abortions being performed.

Dr. Q decided to check the records of some of the women who came to the clinic. She found that many of the clients who had accepted family planning, and had been given COCs, were the same clients who were coming to the clinic for abortions or prenatal visits!

Dr. Q decided to investigate the reason for this. She compiled a list of COC acceptors who had become pregnant while on the method. Then she asked several village health workers to interview these women to find out how they had been taking their pills. The village health workers reported that some of the women had taken the pill only after sleeping with their husbands.

Dr. Q asked the village health workers to hold a series of health-education classes about the contraceptive pills. The village health workers did this. They explained that the pills did not work unless taken every day. They also explained that it was necessary to have a certain level of hormones circulating in the blood to prevent pregnancy. The health workers also explained what to do when one or two pills were missed.

Over the next several months, Dr. Q monitored pregnancy rates and found no change! She was very frustrated!

One day while she was making a prenatal examination of a pregnant pill acceptor with pre-eclampsia, she asked the woman how she had taken her pills. The woman said that she had taken them only after having sex with her husband. Dr. Q asked why she had taken them that way. The woman said that she didn't sleep with her husband every day, so why did she need pills every day? Dr. Q asked her how she thought the pills worked. The woman said she didn't know, but she supposed they killed the man's "seed."

Dr. Q explained that pills don't kill the "seed," they only prevent eggs from developing in a woman's ovaries. The woman said she didn't understand about eggs being in her ovaries; it was the first time she had heard anything like that--all she knew was that she was pregnant, although she had taken the pill.

Dr. Q began to suspect that the woman did not have the medically correct idea about contraception. She asked the woman how she thought conception occurred. The woman said, "The woman is the vessel and the man plants the seed." Dr. Q asked what the woman's role was. The woman said, "She is merely the place for planting."

Participant Handout #10.2: Immediate and Underlying Causes for Rumors (cont.)

Dr. Q then realized the underlying reason for the village women's confusion and their subsequent failure to take the pills properly. They believed that they could become pregnant any time "the man's seed was planted" and that the pills worked only by killing the seed.

Dr. Q began conducting classes for the health workers on counseling clients on the anatomy and physiology of reproduction. She also included information for them on how to counteract rumors and misinformation.

Questions:

1. Why didn't the explanation given by the village health workers convince the women to take the pills every day?

2. How did Dr. Q discover the underlying reason behind pill use after sex?

3. Taking into account the locality in which you work, use the local language/expressions/proverbs, etc. to counteract the rumor in the story and explain how to use the pill properly.

4. How would you go about finding the immediate and underlying reasons for nonacceptance of family planning in your locality?

Participant Handout #10.3: Rumors and Misinformation about COCs

Rumor or Misinformation	Facts & Realities: Information to Combat Rumors
I only need to take the Pill when I sleep with my husband.	A woman must take her pills every day in order not to become pregnant. (The provider can use an analogy: ask her if someone can be a grandmother and a grandfather at the same time. When she says "no," tell her that pills are like that, too--it is either/or.) Either she takes them every day and she will not become pregnant, or she only takes them sometimes and may become pregnant. Pills only protect against pregnancy if she takes them every day. If she misses one pill, she should take two as soon as she remembers.
I am still protected from pregnancy when I stop taking the Pill if I have been using it long enough.	A woman is only protected for as long as she actually takes the pill every day. (Reinforce this by using an analogy or personal example.)
Pills make you weak.	Sometimes women feel weak for other reasons, but they are also taking the Pill, so they think it is the Pill that causes the weakness. If a woman feels weak, she should keep taking her pills every day and go to see a doctor. Pills do not make a woman weak. A doctor should be seen to try to find out what else is causing weakness in a woman. If a woman were feeling "weak", a pregnancy would almost certainly make her feel much worse than taking the Pill.
The Pill will build up in your body. Pill residues settle in the woman's uterus so that she has to have her uterus cleaned every year in order to prevent the formation of a lump.	It is not possible for pills to accumulate in the body. Pills are swallowed and dissolved in a woman's body just like other medicines and food. The substances in the Pill are absorbed by the digestive system and circulated throughout the body by the blood. (Demonstrate how a pill dissolves in a glass of water.)

Participant Handout #10.3: Rumors and Misinformation about COCs (cont.)

Rumor or Misinformation	Facts & Realities: Information to Combat Rumors
The Pill is dangerous and causes cancer.	Numerous studies have disproved this rumor. The Pill has been used safely by millions of women for over 30 years and been tested more than any other drug. In fact, studies show that the Pill can protect women from some forms of cancer, such as those of the ovary, endometrium, cervix, and breast.
The Pill causes abnormal or deformed babies.	There is NO medical evidence that the Pill causes abnormal or deformed babies. There have always been incidences of abnormalities and birth defects, long before the Pill was invented. Birth defects are usually caused by genetic (e.g., Down Syndrome) or environmental factors (e.g., drugs, exposure to toxic waste and chemicals).
Taking the Pill is the same as having an abortion.	The Pill is taken **to prevent conception**, not to cause an abortion. The pill prevents ovulation so that fertilization cannot occur, preventing a pregnancy (and therefore any chance of an "abortion").
The Pill causes the birth of twins or triplets.	The Pill has no effect on the tendency toward multiple births. The tendency to have twins usually runs in families. That is, if there have been multiple births in either the man's or woman's family, then the chances of having twins are greater. Multiple births may also be triggered by fertility medication or by drugs taken to induce pregnancy.
The Pill prolongs pregnancy. A woman who took the pill before she got pregnant delivered almost two months after her expected date of delivery.	The pill does not prolong pregnancy in any way. An example such as this was probably a simple case of not calculating the date of conception correctly.

Participant Handout #10.3: Rumors and Misinformation about COCs (cont.)

Rumor or Misinformation	Facts & Realities: Information to Combat Rumors
Women who take the Pill for several years need to stop the Pill to give the body a "rest period."	A "rest period" from taking Pills is **not** necessary and a woman may use COCs for as many years as she wants to prevent a pregnancy. A rest period would not be beneficial and would disrupt the woman's preferred and successful method of contraception.
The Pill can't be used following an abortion.	COCs are **appropriate for use immediately post-abortion** (spontaneous or induced), in either the first or second trimester, and should be initiated within the first seven days postabortion, or anytime the provider can be reasonably sure that the client is not pregnant. Ovulation returns almost immediately postabortion: 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. Immediate use of COCs postabortion does **not** affect return to fertility following discontinuation of COCs.
The Pill causes infertility or makes it more difficult for a woman to become pregnant once she stops using it.	Studies have clearly shown that the Pill does not cause infertility or decrease a woman's chances of becoming pregnant once she stops taking it.

Participant Handout #10.4: Rumors and Misinformation about IUDs

Rumor or Misinformation	Facts & Realities: Information to Combat Rumors
The thread of the IUD can trap the penis during intercourse.	The strings of the IUD are soft and flexible, cling to the walls of the vagina and are rarely felt during intercourse. If the string is felt, it can be cut very short, (leaving just enough string to be able to grasp with a forceps). The IUD cannot trap the penis, because it is located within the uterine cavity and the penis is positioned in the vagina during intercourse. The string is too short to wrap around the penis and cannot cause injury to it. (For greater reassurance, use a pelvic model to show how an IUD is inserted or demonstrate with your fingers how it would be impossible for the IUD to trap the penis.)
A woman who has an IUD cannot do heavy work.	Using an IUD should not stop a woman from carrying out her regular activities in any way. There is no correlation between the performance of chores or tasks and the use of an IUD.
The IUD might travel inside a woman's body to her heart or her brain.	There is no passage from the uterus to the other organs of the body. The IUD is placed inside the uterus and unless it is accidentally expelled, stays there until it is removed by a trained health care provider. If the IUD is accidentally expelled, it comes out of the vagina, which is the only passage to the uterus. (Teach the client to feel the string, especially after menstruation, to confirm that it is in place.)
The IUD causes ectopic pregnancy.	There is no evidence that the use of an IUD increases the risk of an ectopic pregnancy. One study (Vessey, et. al., 1979) showed the risk of ectopic pregnancy to be the same for all women (with or without an IUD) at 1.2 cases per 1,000 women per year.

Participant Handout #10.4: Rumors and Misinformation about IUDs (cont.)

Rumor or Misinformation	Facts & Realities: Information to Combat Rumors
A woman who was wearing an IUD became pregnant. The IUD became embedded in the baby's forehead.	The baby is very well protected by the sac filled with amniotic fluid inside the mother's womb. **If a woman gets pregnant with an IUD in place, the health provider should remove the IUD immediately due to the risk of infection.** If for some reason the IUD is left in place during a pregnancy, it is usually expelled with the placenta or with the baby at birth.
The IUD rots in the uterus after prolonged use.	Once in place, if there are no problems, the IUD can remain in place up to 10 years. The IUD is made up of materials that cannot deteriorate or "rot", it simply loses its effectiveness as a contraceptive after 10 years.
An IUD can't be inserted until 12 weeks postpartum.	If health care providers are specially trained, the IUD can be inserted immediately after the delivery of the placenta or immediately following a Cesarean section, or up to 48 hours following delivery. Expulsion rates for postpartum insertion vary greatly, depending on the type of IUD and the provider's technique. Current information indicates that expulsion rates may be higher during the period from 10 minutes to 48 hours after delivery, as compared with the first 10-minute period. To minimize the risk of expulsion, only properly trained providers should insert IUDs postpartum. Use of an inserter for IUD insertion tends to reduce the expulsion rate. After the 48-hour postpartum period, a Copper T may be safely inserted at four or more weeks postpartum. The withdrawal technique for Copper T insertion helps minimize perforations for inserting IUDs four to six weeks postpartum. Other types of IUDs may have different perforation rates.

Participant Handout #10.4: Rumors and Misinformation about IUDs (cont.)

Rumor or Misinformation	Facts & Realities: Information to Combat Rumors
An IUD can't be inserted until 12 weeks postpartum (cont.).	Given the relative lack of information on the other IUDs at four to six weeks, it is advisable to wait until six weeks postpartum for the insertion of IUDs other than the Copper T. It has been shown that IUDs do not affect breast milk and can be safely used by breastfeeding women postpartum.
An IUD can't be inserted after an abortion.	With appropriate technique, the IUD may be inserted immediately postabortion (spontaneous or induced) **if the uterus is not infected**, or during the first seven days postabortion (or anytime you can be reasonably sure the client is not pregnant). Expulsion rates vary greatly, depending both on IUD type and on provider technique. To minimize the risk of expulsion, only providers with proper training and experience should insert IUDs. Clients must be carefully counseled to detect expulsions. Postabortion IUD insertion after 16 weeks' gestation requires special training of the provider for correct fundal placement. If this is not possible, insertion should be delayed for six weeks postabortion.

Participant Handout #10.5: Rumors and Misinformation about Condoms

Rumor or Misinformation	Facts & Realities: Information to Combat Rumors
Using a condom is like taking a shower with a raincoat on.	Many couples are not bothered by condoms. Types of condoms vary widely and a couple should choose a brand that will suit them best and give them the most pleasure.
If a condom slips off during sexual intercourse, it might get lost inside the woman's body.	A condom cannot get lost inside the woman's body, because it cannot pass through the cervix. If the condom is put on properly, it will not slip off. The condom should be rolled down to the base of the erect penis. (If it comes off accidentally, instruct the client to pull it out carefully with a finger, taking care not to spill any semen, which may lead to an unwanted pregnancy.)
There is too much danger of condoms breaking or tearing during intercourse.	Condoms are made of thin but very strong latex rubber and they undergo extensive laboratory tests for strength. (Demonstrate how strong the condom is by blowing it up like a balloon or pulling it over your hand and wrist.) Condoms are meant to be used only once. There is less chance that a condom will break or tear if it is stored away from heat and placed on the erect penis leaving enough space at the tip for the ejaculate. A condom is more likely to break if the vagina is very dry, or if the condom is old (past the expiration date).

Participant Handout #10.6: Rumors and Misinformation about Female Sterilization

Rumor or Misinformation	Facts & Realities: Information to Combat Rumors
A woman who has been ligated loses all desire for sex (becomes frigid) or becomes a sex maniac.	Tubal ligation has no physiological effect on the woman other than that of preventing the egg from being fertilized by sperm. The ovaries will still release eggs and produce hormones, and the woman will still menstruate, but she will no longer get pregnant. The egg released during ovulation will disintegrate and become absorbed by the body. Tubal ligation does not cause a woman to lose or change any of her feminine characteristics.
A woman who has been ligated becomes sickly and unable to do any work.	A woman who has been ligated can resume regular activities as soon as she is free from post-surgical discomfort. It does not affect her ability to work or make her weak or "sick".
A woman who undergoes ligation has to be hospitalized.	There is no need for hospitalization with a female sterilization ligation. The procedure takes approximately 15 minutes. After the operation, the woman should rest for a few hours and then be allowed to go home in the company of a family member.
Ligation shortens the life span of a woman and may cause early menopause.	There is no medical reason for a ligated woman to have a shorter life span--just the opposite, her life will probably be prolonged by preventing unwanted pregnancies. Ligation will not hasten menopause. A ligated woman will continue to ovulate and menstruate (although she will no longer get pregnant) until she naturally reaches menopause.

Participant Handout #10.7: Rumors and Misinformation about Vasectomy

Rumor or Misinformation	Facts & Realities: Information to Combat Rumors
Vasectomy is the same as castration. A man who submits to vasectomy has his manhood taken away. He will become gentle and effeminate. He may even turn into a homosexual. Worst of all, he will no longer enjoy sex.	Vasectomy is not castration. In vasectomy, the vas deferens are cut and tied so that sperm cannot mix with the semen. The semen ejaculated during sexual intercourse no longer contains sperm and will no longer make a woman pregnant. Vasectomy does not interfere with any other physiological functions; neither does it cause any other types of changes. After a vasectomy a man will continue to produce male hormones, be "masculine" and heterosexual. Many men enjoy sex more after a vasectomy because they no longer need to worry about getting a woman pregnant.
Sperm that is not ejaculated during intercourse will collect in the scrotum and cause the scrotum to burst or will cause other problems in the body.	Sperm that is not ejaculated is absorbed by the body. It cannot collect in the scrotum or cause harm to a man's body in any way.

Participant Handout #10.8: Rumors and Misinformation about DMPA

Rumor or Misinformation	Facts & Realities: Information to Combat Rumors
A woman who uses DMPA will never again be able to get pregnant.	Sometimes there is a delay of six to twelve months after the last injection for a woman's fertility to return to normal. In a study in Thailand, almost 70% of former DMPA users conceived within the first 12 months following discontinuation and 90% conceived within 24 months, a percentage comparable to pregnancy rates for the general population.
Injectable contraceptives cause cancer.	Research has clearly proven that DMPA does not cause cancer. In fact, it has been shown to protect against ovarian cancer.
DMPA causes nausea.	Nausea is not common with injectables. In fact, many women on injectable contraceptives find that 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 are using DMPA. DMPA also has no effect on the composition of breast milk, the initiation or duration of breastfeeding, or the growth and development of the infant.
DMPA stops menstrual bleeding (amenorrhea) and that is bad for a woman's health.	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.

Participant Handout #10.8: Rumors and Misinformation about DMPA (cont.)

Rumor or Misinformation	Facts & Realities: Information to Combat Rumors
Women need to stop using DMPA and have a "rest" after several injections.	There is no cumulative effect of DMPA and there is no limit to the number of years DMPA can be used without the need to give the body a "rest." Among healthy women, it can be given until menopause, when contraception is no longer needed. The time needed to clear the drug from the body is the same for multiple injections as for one.
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 in past years, DMPA was used in women to prevent miscarriage.
DMPA causes abortion.	DMPA prevents ovulation. If no egg is released, no fertilization takes place; hence, no pregnancy and no abortion.
DMPA causes amenorrhea, resulting in pregnancy or a tumor.	Amenorrhea is one of the signs of pregnancy, but not all amenorrhea means that a woman is pregnant. The amenorrhea experienced with DMPA use is due to the thinning of the endometrium and is not harmful in anyway. Amenorrhea sometimes is a sign of a tumor or cancer of the endometrium or ovary. However, DMPA amenorrhea is not only "normal," but there is evidence that DMPA may actually <u>help prevent</u> endometrial and ovarian tumors.

Participant Handout #10.8: Rumors and Misinformation about DMPA (cont.)

Rumor or Misinformation	Facts & Realities: Information to Combat Rumors
DMPA causes irregular bleeding, resulting in anemia.	During the first three to six months of DMPA use, irregular bleeding may be experienced in the form of spotting or minimal bleeding. This usually stops within a few months of continuous use of DMPA and rarely results in anemia.
DMPA causes masculine characteristics in females, such as facial hair.	Studies have shown that the use of DMPA will not cause any masculinizing effect, such as facial hair.
DMPA will result in retained menses, causing blood toxicity.	No menses lining is formed with DMPA use, since it results in an atrophic endometrium, so there is nothing to "retain" or cause a problem.
DMPA will result in a decrease in libido.	DMPA sometimes has a slight effect on a woman's libido. However, the sense of security against the risk of pregnancy may increase the libido of the woman.
DMPA is still in the "developmental stage" and women shouldn't be experimented on.	DMPA was developed in the 1960s. Since then, it has been approved as a long-acting contraceptive method and is now marketed in more than 90 countries. To date, over 30 million women have used DMPA, over 100,000 have used it for more than 10 years, and between eight and nine million women currently rely on DMPA for contraceptive protection, without problems.

Participant Handout #10.9: Rumors and Misinformation about Optimal Birth Spacing

Rumor or Misinformation	Facts & Realities: Information to Combat Rumors
It is better to have your children closely spaced while you are young because it is the time the woman's body is the strongest.	Close pregnancies less than 3-year intervals are not good for the woman's body at any age. She has to rest sufficiently in between pregnancies to be strong and healthy for her next pregnancy. This interval will also provide the mother with the time necessary to properly nourish and nurture the last-born child.
It is more convenient to complete the family fast and then opt for permanent methods of birth control.	It is more convenient and beneficial for the whole family that the mother and the children be healthy than closely born. The permanent method can come after the desired number of children is reached.
It is best to have children closely spaced so they can keep each other company.	While the children may be close in age, it can be more demanding on the mother as each child vies for attention to get his/her needs met. Spacing births 3-5 years apart will contribute to a healthier mother and healthier children whose needs can be sufficiently met during their early childhood years.
Closely spaced births demonstrate the man's virility and the woman's ability to conceive and give birth.	When births are spaced at least 3 years apart, it still shows the couple's ability to conceive and give birth. Spacing births is a healthier option for the children and mother and can ease economic pressures on the family.

Participant Handout #11.1: Some Rights of Family Planning Counseling Clients

INTRODUCTION TO SOME CLIENT RIGHTS IMPLICIT IN THE FAMILY PLANNING COUNSELING PROFESSION (PROFESSIONAL RIGHTS)

There are many reasons why individuals and couples decide to start, continue, or stop practicing family planning including: to delay the birth of a first child, to space the birth of children, to ensure only a certain number of children. Others may wish to use family planning services not so much for protection from unplanned or unwanted pregnancy, but for other reasons, including a desire to achieve pregnancy or for the protection of their reproductive and sexual health. **Family planning today has as much to do with sexuality and health protection as it does with decisions relating to procreation.**

Any member of the community who is of reproductive age should be considered a potential family planning client.

Family planning services are a type of preventive health service. **Therefore, the rights of the family planning clients should be seen in the overall context of the rights of the clients of any health services.**

The Rights of Family Planning Counseling Clients

1. Right to Information

The family planning counselor is responsible for fulfilling the client's right to information about family planning. The information should include advantages and disadvantages of both birth spacing and family planning using contraceptives. The client also has a right to know where and how to obtain family planning information and services. All family planning programs should be active in disseminating information at service delivery sites and in communities.

2. Right to Access

Individuals in the community have a right to receive family planning services and information regardless of social status, economic situation, religion, political belief, ethnic origin, marital status, geographical location, or any other group identity. This means a right of access to information, health care providers and health care service-delivery systems.

Family planning programs should take the necessary steps to provide services to all individuals who want them, and, if possible, attempt to aid access to regular health services also.

Participant Handout #11.1: Some Rights of Family Planning Counseling Clients (cont.)

3. Right of Choice

Individuals and couples have the right to a well-informed, independent, conscious choice on whether or not to practice family planning and, if so, which method(s) to use. Family planning programs should assist people in making informed choices by providing unbiased information, education, counseling and a variety of contraceptive methods. Clients should be able to obtain the method they have decided upon if not medically unwise due to contraindications.

An ideas concept of acceptability and appropriateness may change changes with circumstances and the amount and quality of information they have. Therefore, **the right of choice also involves clients' informed decisions about discontinuing and/or switching methods.**

Clients also have a right to choose a location for family planning services and the type of service provider. The selection may depend on locale and type of facility and may include any of the following: a community family planning or health worker, pharmacy, or over-the-counter service as well as hospital, health center, or family planning clinic. Family planning counselors should encourage **governmental and private sector financing for the establishment of alternative service sites** as well**.**

4. Right to Safety of Family Planning Services

Family planning clients have a right to safety of family planning services.

- Clients have a right to protection against negative effects of a contraceptive method on their physical health and mental well being, and family planning counselors have a professional duty to take this into account. In addition, laws protect the client in this regard.
- In cases where pregnancies may be health risks such that birth spacing is medically advisable, and the client chooses to space births using contraceptives, s/he has a right to advice on safe and effective contraceptive methods from the family planning counselor.
- When receiving family planning services, clients also have a right to protection against other health risks posed by certain methods of contraception that either require insertion or change a client's hormonal balance. Some examples might be protection from contracting new infections due to the improperly sterilized conditions or medical equipment. In some LDCs, it may be irresponsible for providers to suggest contraceptive methods that require levels of sterilization that are not possible given the nature of the available facilities.

Participant Handout #11.1: Some Rights of Family Planning Counseling Clients (cont.)

It is the responsibility of the service provider to ensure not only a safe and technically competent quality of service, but also the safety of the facility itself. In addition to making certain that the client is conscious and well informed, ensuring the client's right to safety means assisting the client in making an appropriate choice of contraceptive, screening for contraindications, using the appropriate techniques for providing the method, teaching the client about the proper use of the method, and ensuring proper follow-up. Be aware that clients also have additional rights that are legal rights with regard to the kind of treatment they receive from providers. It is a provider's responsibility to know what these rights are and to be certain to respect them in all instances and in all countries.

Sterilized supplies and a clean facility should be pre-conditions to the delivery of any kind of medical service. All medical complications that a facility is not adequately equipped to resolve should be referred to a different facility. The client should be informed of the reasons for doing so.

5. Right to Privacy

The client has a right to chose a private environment for counseling or family planning services. The conversations between family planning counselors and their clients are protected communications just as are the communications between healthcare workers and their clients and should be treated accordingly with the proper level of professionalism. This does not change depending on the country.

If a physical examination is necessary in the family planning counseling process, conditions should be on a par with conditions of a fully equipped medical facility.

If a client is to be used for experimentation for the purposes of advancing family planning, then a full range of legal rights that are beyond the scope of this document apply to the situation. It would be extremely inadvisable to use LDC clients for such purposes due to the implicit lack of adequate communication. Also, it should be noted that the use of those who are considered to be underage in any country by that country's definition are protected by additional laws, and disregard of those laws would have additional legal consequences for all participants. In all countries, legal rights of the client are the primary concern of any professional healthcare provider or family planning counselor. Those who cannot hold such rights in high regard should not be in the field.

If an invasion of the client's body is anticipated such that a "right to bodily privacy" might be an issue, even fully informed consent from a conscious client may not protect the provider from severe legal consequences. Keep in mind that violation of a client's legal rights will most likely result in a prohibition of the provider's continued practice, if not worse. Some non-western cultures have even stricter laws than those in the West.

A healthcare provider or family planning counselor should seek legal advice before engaging in any of the following activities:

Participant Handout #11.1: Some Rights of Family Planning Counseling Clients (cont.)

- Subjecting a client to a "role play" situation in the process of receiving counseling or undergoing a physical examination.

- Subjected to an invasive exam which is not medically necessary in the presence of a range of individuals undergoing training, supervisors, instructors or researchers.

- Discussing a client's case in the presence of the client and others for training or any other purposes in which the client will be identified.

6. Right to Confidentiality

Clients in any country have a right to have family planning counseling information treated in conformity with the medical code of ethics and laws regarding confidentiality of medical information. The client should be assured that any information s/he provides in the course of family planning counseling would be confidential.

Since some cultures discourage or even prohibit family planning, a breach of this confidentiality could cause the client personal and social problems, which would then be the responsibility of the family planning counselor and would reflect poorly on family planning in general. This is part of the reason why strict conformity with the medical code of ethics and laws regarding confidentiality of medical information is important.

The client has a right to request that his/her records be transferred to another facility. Facilities should be able to comply with such requests and to maintain the confidentiality of records. However, unless such records are released directly to the client, the facility has an added burden to establish that the request was made voluntarily and by the client.

7. Professional Right to Dignity

In the furtherance of family planning, counselors should treat clients courteously, with consideration, and with respect for their dignity and cultural beliefs regardless of education level, social status, or the counselor's own personal feelings and prejudgments. A provider who has personal, gender, marital, social, financial or intellectual prejudices and attitudes associated with the client that may affect his/her ability to make unbiased judgments has a professional responsibility to refer the client to another provider.

8. Professional Right to Comfort

Clients have a right to a level of comfort and adequacy of facilities. Service delivery sites should have proper ventilation, lighting, seating, and toilet facilities in addition to the ability to sterilize the environment and supplies as necessary when necessary. Part of the counselor's responsibility is to see that the facility meets with professional standards and provides for client comfort. If the client is uncomfortable with the facility and other facilities are available, then the client should be so informed.

Participant Handout #11.1: Rights of Family Planning Counseling Clients (cont.)

9. Right of Availability

Clients have a right to receive contraceptive services and supplies for as long as they need them. The services provided to a particular client should not be discontinued except by the informed decision of the client. Access to additional family planning services should not be obstructed because of previous contraceptive choices, and the client should have access to referrals and follow-up service if s/he wishes.

10. Right of Opinion

A client should be able to express his or her own views on the service received without interference. A clients' opinion about the quality of services--whether in the form of thanks or complaint—and suggestion, can be constructive and useful to the program's ongoing efforts to provide good family planning counseling services. If the counselor worries that the client may not wish to express such views openly, the counselor or facility may wish to establish a "suggestions box" so that it can monitor and evaluate responses and reactions to provision of services.

New programs and/or service delivery facilities typically attempt to consider the client wishes even in planning stages. The aim of family planning counseling programs should always be to treat clients well and provide them with information for the purposes of enlightenment and enrichment of choices as appropriate and acceptable to them.

Source: International Planned Parenthood Federation. *Rights of the client.* London: 1991.

Participant Handout #12.1: Counseling and Motivating Men

COUNSELING AND MOTIVATING MEN

Men have different counseling needs since they do not physically bear the burden of pregnancy. They need to be **motivated to make responsible choices** regarding reproductive health practices. Just as women often prefer to talk to other women about family planning and sexual issues, **men often prefer to talk to other men** about these issues.

Men's Special Counseling Needs

- Men **need to be encouraged to support** women's **use of family planning methods** or to use family planning themselves (condoms or vasectomy).
- Men need to be informed of the benefits of optimal birth spacing: for the health of their partner, existing children, the newborn, and for them, especially financially if they support the family.
- It is **important to talk to YOUNG MEN** (14-18) **about responsible and safe sex** before they become sexually active.
- Men **often have less information** or are more likely to be **misinformed** about family planning methods, male and female anatomy, and reproductive functions because they tend to talk less about these issues than women.
- Men seldom discuss the next pregnancy with their partner. They do not talk about pregnancy intervals, and what benefits it could represent for her partner, for the next child to be born, or for him.
- Men sometimes feel pressure to get their partner pregnant very soon especially if the last live birth was a girl in order to "look for/find/get" a boy.
- Some men feel they are not supposed to "negotiate" sex with a partner. They feel it is their right to simply demand it and get it.
- Men are **often more concerned about sexual performance** and desire than women.
- Men often have **serious misconceptions and concerns that family planning methods** will **negatively impact their sexual pleasure** and/or **performance**.
- Men are often **concerned that women will become promiscuous** if they use family planning.
- Many men **do not know how to use condoms correctly**. Providers should always demonstrate correct condom use, using a model, when possible.
- Men are often not comfortable going to a health facility, particularly if it serves primarily women. Providers should try to go to where men are to discuss family planning whenever possible (e.g., work places, bars, sporting events, etc.).

Participant Handout #13.1: Adapting the Counseling Process

Most **providers will need to adapt the counseling process** to the locale, culture and physical environment they are working in.

In some service delivery settings the demand for services is so high that physical, staffing, and time constraints prevent clients from being counseled privately. In other settings, clients actually prefer the group counseling situation due to cultural factors.

The factors that **a provider always has responsibility for** and most control over are:

- tolerance, empathy, and supportive attitude
- respect for clients
- technical knowledge
- use of a dynamic style of counseling which responds to individual client needs
- belief in and knowledge that birth spacing saves lives and may improve the quality of lives and that family planning using contraceptives is a way to achieve birth spacing.

Providers must collaborate with their team of health facility staff to find creative remedies for limitations of space, staff and supplies at less well-equipped facilities. They are also tasked with taking into account client comfort and individual wishes and attempting to address these as completely as possible even in the most rustic of conditions.

Participant Handout #14.1: Role Plays
Counseling for FP Services

Purpose of Role Play Exercise: To provide an opportunity for the participant to practice her/his skills in the process and content of counseling, before working with actual clients.

Instructions:

1. Every participant should be involved in the role-play exercise, either as a player or as an observer.
2. **Players** should meet for 10 minutes before the role play to assign roles, decide and agree on the message or main point the role play is to make, who is going to play what role, what each player is going to say, etc.
3. **Observers** are requested to use the observation form to record their observations. The form is an aid to record observations in a systematic and objective manner and to facilitate concise discussion and feedback following the role plays.
4. While players are preparing, observers are requested to familiarize themselves with the observation form.
5. Suggested time limits (may be changed by trainer to meet the time available):

Instructions:	5 minutes
Player preparation time:	10 minutes
Role play presentation:	5-10 minutes
Feedback and analysis:	15-30 minutes

Role Play #1: A 24 year-old woman with three children comes to see her clinician. She wants to practice some method of family planning. She is not sure about having any more children. She has heard that the IUD causes a lot of bleeding. How will the clinician respond?

Role Play #2: A 20 year-old lactating woman, with a three month-old baby wants to postpone her next pregnancy. Her sister uses the COC and likes that method very much. She says she wants to use the COC. How will the clinician respond?

Role Play #3: A couple in their mid-20s comes to see the clinician. The husband wants to have a male child. The wife wants to postpone her next pregnancy. How will the clinician respond?

Role Play #4: A young couple, accompanied by the husband's mother, comes to see the clinician. The couple has three daughters and wants to postpone their next pregnancy. The mother-in-law insists that they should have another child as soon as possible in order to try for a son. How will the clinician respond?

Role Play #5: A 19 year old, unmarried woman comes to see the clinician. She explains that she and her fiancé are having sexual relations and she is worried about becoming pregnant before she is married. How will the clinician respond?

Participant Handout #14.2: Observer's Role Play Checklist

Participant Handout #14.2: Observer's Role Play Checklist for Counseling Skills

Instructions: Use the checklist to record your observations of the role play. Observe the counseling process as well as content. Note whether the counselor applies the steps/elements of the counseling process discussed in objective 7 (as appropriate to the role play). Does the counselor address the problem adequately? Does s/he address the "client's" concerns? Is the information given correct and complete? What is the client's behavior? How does the "counselor" behave? What nonverbal messages are communicated by client or counselor?

TASK	PERFORMED	
	YES	*NO*
Counselor's Nonverbal Communication:		
Friendly/welcoming/smiling?		
Non-judgmental/receptive?		
Listens attentively/nods head to encourage and acknowledge client's responses?		
Appears rushed/impatient?		
Counselor's Verbal Communication:		
Phrases questions clearly and appropriately? Uses non-technical terms?		
Listens to client's responses closely?		
Answers client's questions?		
Uses language the client can understand?		
Counseling Process and Content:		
Greets the client in a friendly and respectful manner?		
Asks client about self?		
client's needs and concerns?	_____	_____
reproductive goals?	_____	_____
	_____	_____
Provides client information on optimal birth spacing and family planning methods?	_____	_____
informs about optimal birth spacing and all methods available?	_____	_____
asks which method interests client?	_____	_____
asks what client knows about method?	_____	_____
corrects myths/rumors/incorrect information?	_____	_____
describes how method works and its effectiveness?	_____	_____
uses A/V aids during counseling?	_____	_____
describes benefits and risks?	_____	_____
describes potential side effects?	_____	_____
answers client's questions clearly?	_____	_____

Participant Handout #14.2: Observer's Role Play Checklist for Counseling Skills (cont.)

TASK	PERFORMED	
	YES	NO
Counseling Process & Content (continued):		
Helps client to reach an informed decision?		
asks if anything not understood?	_____	_____
asks "what method do you want?"	_____	_____
	_____	_____
Provides more information on the selected method?	_____	_____
explains clearly what client has to do to use method successfully?	_____	_____
instructions to client are complete and clear?	_____	_____
asks client to repeat back instructions?	_____	_____
reminds client of potential minor side effects?	_____	_____
reminds client of danger signs?	_____	_____
explains to client what to do if problems?	_____	_____
Plans a follow-up visit?		
Problem Solving:		
Does "counselor" respond appropriately to the client's needs and problems?		
Is "counselor" convincing on advice given?		
Is advice given/method provided appropriate?		
Does "counselor" treat client/family with respect?		
Is the counseling		
counselor-controlled?	_____	_____
client-controlled?	_____	_____
balanced?	_____	_____
Is "counselor" convincing in her/his role?	_____	_____
Is "client" convincing in her/his role?	_____	_____

Source: Indian Medical Association/Development Associates. *Family Planning Course, Module 2: Counseling for Family Planning Services.* 1994.

Participant Handout #14.2: Observer's Role Play Checklist for Counseling Skills (cont.)

What did you learn from observing this role play?

_____

_____

_____

Please record your comments/observations for feedback to participants (both positive and negative):

_____

_____

_____

_____

Instructions for Competency Based Training (CBT)
Skills Assessment Checklists

Date of Assessment _____ Dates of Training _____

Place of Assessment: Clinic _____ Classroom _____

Name of Clinic Site _____

Name of the Service Provider _____

Name of the Assessor _____

These assessment lists contain detailed steps for service providers to follow in counseling and giving instructions on contraceptive methods. The checklists may be used during training to monitor the progress of the trainee as s/he acquires the new skills, and they may be used during the clinical phase of training to determine whether the trainee has reached a level of competence in performing the skills. Trainers or supervisors may also use the checklist for follow-up or monitoring purposes. The trainee should always receive a copy of the assessment checklist so that s/he may know what is expected of her/him.

Instructions for the Assessor

➔Always explain to the client what you are doing before beginning. Ask for the client's permission to observe.

➔Begin the assessment when the trainee greets the client.

➔Use the following rating scale:

2 = Done according to standards
1 = Needs improvement
N/O = Not observed

➔Continue assessing the trainee throughout the time s/he is with the client, using the rating scale.

➔Observe only and fill in the form using the rating numbers. Do not interfere unless the trainee misses a critical step or compromises the safety of the client.

➔Write specific comments when a task is not performed according to standards.

➔Use the same copy for several observations.

➔When you have completed the observation, review the results with the trainee. Do this in private, away from the client or other trainees.

CBT Skills Assessment Checklist for Counseling

TASK/ACTIVITY	CASES 1	2	3	COMMENTS
GENERAL FP COUNSELING				
Provider ensures that discussion cannot be overheard				
Provider uses visual aids				
PROVIDER'S NONVERBAL COMMUNICATION:				
Friendly/welcoming/smiling/respectful?				
Non-judgmental/receptive?				
Listens attentively/nods head to encourage and acknowledge client's responses?				
Appears rushed/impatient?				
PROVIDER'S VERBAL COMMUNICATION:				
Phrases questions clearly and appropriately? Uses non-technical terms?				
Listens to client's responses closely?				
Answers client's questions?				
Uses language the client can understand?				
COUNSELING PROCESS AND CONTENT:				
Greets the client in a friendly and respectful manner? Welcomes the client and registers her. Provides privacy (both auditory and visual). Determines the purpose of the visit. Assures the client that all information discussed will be confidential.				
Asks client about self? Client's needs and concerns Reproductive goals Past practice of OBS & FP method HIV/STD risk and precautions				
Provides information about FP methods? Tells about OBS and all methods available. Asks which method interests client. Asks what client knows about method. Corrects myths/rumors/incorrect information. Describes how method works and its effectiveness. Uses A/V aids during counseling. Describes benefits and risks. Describes potential side effects. Answers client's questions clearly?				

CBT Skills Assessment Checklist for Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
Helps client to reach an informed decision? Asks if anything not understood. Repeats information if necessary. Asks "what method do you want?" Explains any tests or procedures that will be performed. Examines the client. Screens the client for any medical precautions to the use of the method.				
Provides more information on the selected method? Explains clearly what client has to do to use method successfully. Instructions to client are complete and clear. Asks client to repeat back instructions. Reminds client of potential minor side effects. Reminds client of danger signs. Explains to client what to do if problems. Explains to the client how and when she can get supplies of the method if necessary.				
Plans a follow-up visit? Asks the client if she is still using the method. If she has stopped using the method, discusses the problem and other options. Asks about any problems or side effects she is experiencing. Makes sure she is using the method correctly.				

CBT Skills Assessment Checklist for COC Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
INITIAL INTERVIEW				
See *General Counseling Checklist.*				
METHOD-SPECIFIC COUNSELING				
1. Ensures necessary privacy.				
2. Obtains necessary biographical data (name, address, age, etc.).				
3. If client chooses COCs: Asks her what she knows about COCs. Corrects any myths, rumors or misinformation she may express. Asks if she has used COCs in the past. What was her experience? Gives client a package of COCs to look at and handle. Explains advantages of the COC, including non-contraceptive benefits. Briefly explains how COCs work and the importance of taking it every day. Explains potential common side effects of the COC. Stresses that she may experience some (or possibly none) of these and that they can all be managed: amenorrhea/very scanty periods spotting or breakthrough bleeding (BTB) nausea headaches breast tenderness/fullness mood changes/depression weight gain or weight loss Reassures client that most side effects are not serious and will decrease or stop after about 3 months of use. Responds to any questions or concerns the client may have. Explains that provider will ask her some questions and perform a minimal physical examination to be sure that the COC is medically appropriate.				
4. **Screens client** for COC precautions. Asks all questions on checklist and record responses. Do you think you are pregnant? Have you had any bleeding between periods? Bleeding after intercourse? Any bleeding heavier than usual over the past 3 months? What is your age?				

CBT Skills Assessment Checklist for COC Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
METHOD-SPECIFIC COUNSELING (continued)				
4. Screening continued • Do you smoke cigarettes/use other tobacco products? • Do you have high blood pressure? • Do you have diabetes? • Have you ever had a blood clot in your legs or lungs? • Have you ever had a stroke? • Have you ever been told you have heart disease? • Do you have severe chest pains and unusual shortness of breath? • Do you think you have heart disease? • Do you have breast cancer now or have you been diagnosed in the past? • To your knowledge, do you have any liver disease now? • Have you ever been told you have had a tumor of the liver? • Do you have frequent and severe headaches with blurred vision or temporary loss of vision? • Are you breastfeeding a child less than 6 months old at present? • Are you **fully or almost fully** breastfeeding (no solid food supplements or liquids)? • Have you had a menstrual period since your delivery? (Bleeding in the first 56 days following delivery is not considered a menstrual period.) • Have you ever had a severe pelvic infection with chills, fever, pain in your womb area, and a vaginal discharge? • Do you have any of these symptoms now? **Reassures client of confidentiality and uses judgment concerning the necessity of asking the following questions:** • Do you or your husband/partner have other sex partners? • What medicines do you regularly take? • Are you taking any medicines for seizures/convulsions? Tuberculosis (Rifampin)? Other medications?				

CBT Skills Assessment Checklist for COC Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
METHOD-SPECIFIC COUNSELING (continued)				
5. **If COC is appropriate, gives the following client instructions:** • Start the pill on the first day of your next menstrual period (or on the fifth day of your menstrual period, or use local guidelines for this instruction). If client starts COCs after day five of her cycle, she should use a backup method for the first seven days. Explains to the client that if she forgets to take her pills, she may become pregnant. If she forgets to take her pills, she should do the following: • If she misses one pill, the client should take it as soon as she remembers. Take the next one at the regular time. • If she misses two pills, the client should take two pills as soon as she remembers. She should take two pills the next day, and use a backup method for the next week. The client should finish the packet normally. • If she misses more than two pills, the client should throw away the packet, and start a new one, **and** use backup methods for the next week.				
6. Cautions client that she may feel queasy or nauseated if she takes two pills in one day, but taking two pills reduces her chances of becoming pregnant. Shows client how to use spermicide if she has not previously used it.				
7. Explains other situations in which a back-up method is needed: • *Diarrhea/vomiting*: Start using a back-up method on the first day of diarrhea or vomiting, and use it for at least 7 days after the diarrhea/vomiting is over. Meanwhile, continue to take your pills as usual. • If she is taking certain medications used in the treatment of tuberculosis and seizures (rifampin, phenytoin, carbamazepine).				
8. Stresses the importance of informing other doctors/health workers who may care for her that she is using the COC.				

CBT Skills Assessment Checklist for COC Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
METHOD-SPECIFIC COUNSELING (CONTINUED)				
9. Asks client to repeat back in her own words instructions for when to start the COC, which pill she will begin with, how she will take the second and subsequent pills, and what she will do if she misses a pill or pills.				
10. Explains in a non-alarming way the early pill warning signs, stressing the rarity of these: Severe, constant pain in belly, chest, or legs and very bad headaches that start or become worse after she begins to take COCs. Brief loss of vision, seeing flashing lights, or zigzag lines (with or without bad headaches) Jaundice (skins and eyes look yellow)				
11. Asks client a few questions to ensure that she understands and remembers key instructions.				
12. • Prescribes or provides client with as many COC packets as program guidelines allow. • Prescribes or provides client with at least a three-month supply of spermicide. • Reassures client that she may change the pills or try another method if she does not like these COCs.				
13. Reassures client that provider is available to see her if she has any problems or questions or needs advice.				
14. • Plans for a return visit and gives client a definite return date. • Asks client to bring her pill packets with her on the return visit.				
15. Documents/records the visit according to local clinic guidelines.				
RETURN VISIT COUNSELING				
1. Asks client if she is satisfied with the COC.				
2. Asks if she is having any problems or experiencing any side effects.				
3. Asks client how she is taking the COCs, and to demonstrate with the package she is using.				
4. Repeats the history checklist.				
5. Briefly reviews key messages/instructions concerning missed pills, use of back-up method, and danger signs.				

CBT Skills Assessment Checklist for COC Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
RETURN VISIT COUNSELING (continued)				
6. Asks client to repeat these back.				
7. If the client is satisfied with the COC, is tolerating the COC well, is not experiencing any serious side effects, and no precautions exist: Prescribes/provides client with as many COC packets as program guidelines allow. Provides her with a sufficient supply of condoms, if at risk of STD.				
8. If client wants to discontinue the COC, helps her make an informed choice of another method.				
9. Encourages client to see provider at any time if she has questions or problems.				

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Source: Indian Medical Association/Development Associates. *Family Planning Course Module 3: The Oral Contraceptive Pill.* May 1994.

CBT Skills Assessment Checklist for Condom Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
INITIAL INTERVIEW				
See *General Counseling Checklist.*				
METHOD-SPECIFIC COUNSELING				
1. Ensures necessary privacy.				
2. Obtains necessary biographical data (name, address, age, etc.).				
3. If client chooses condoms: Asks what client knows about condoms, if s/he has ever used in the past, and what was her/his experience Corrects any myth, rumors or incorrect information Asks if there is any resistance from her partner to using the condom. Suggests how to negotiate resistance using the benefits as a win-win situation				
4. Provides basic facts about condoms: How they work and their effectiveness. Repeats advantages of using condoms, alone or with another method. Asks if client or partner has any allergies to latex. Counsels on talking with partner about the use of condoms. Where to obtain/cost. Asks if client has any questions and responds.				
5. Provides specific instructions on how to use condoms correctly: Use at every act of intercourse. Use with spermicide whenever possible. Do not "test" condoms by blowing up or unrolling. Put on when penis is erect. Put on before penis is near or introduced into vagina.				
6. Demonstrates how to put on condom correctly by using a model, banana, or two fingers: Cautions client not to unroll condom before putting on. Shows how to place rim of condom on penis and how to unroll up to the base of penis. Instructs on how to leave half-inch space at tip of condom for semen and to make sure space is not filled with air, as it may burst. Shows how to expel air by pinching tip of condom as it is unrolled (put on).				

CBT Skills Assessment Checklist for Condom Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
METHOD-SPECIFIC COUNSELING (CONTINUED)				
6. Continued Cautions about tearing accidentally with fingernails or rings.				
7. Counsels client on what to do if condom breaks during intercourse: See doctor or clinic where woman can be assessed for emergency contraception, where available.				
8. Has client practice putting on condom, using the model/banana/fingers. Corrects any technique errors.				
9. Counsels client on how to remove penis from vagina with condom intact and no spillage of semen: Hold on to rim of condom while withdrawing. Be careful not to let semen spill into vagina when penis is flaccid.				
10. Discusses use of lubricants and what not to use: No petroleum-based products (mineral/ vegetable/cooking oil, Vaseline, baby-oil, margarine/butter, etc.) Advises, if lubricant is needed, to use a spermicide or glycerin oil. Advises client how to dispose of condoms–by tying it into a knot and throwing it away into a trashcan.				
11. Repeats major condom messages to client: Be sure to have condom before you need it. Use condom with every act of intercourse. Do not use a condom more than once. Do not rely on condom if package is damaged, torn, outdated, dry, brittle or sticky.				
12. Encourages client to should return at any time for advice, more condoms or when s/he wants to use another method.				

CBT Skills Assessment Checklist for Condom Counseling

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Source: Indian Medical Association/Development Associates. *Family Planning Course Module 5: The Lactational Amenorrhea Method and Condoms.* May 1994.

CBT Skills Assessment Checklist for DMPA Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
INITIAL INTERVIEW				
See *General Counseling Checklist.*				
METHOD-SPECIFIC COUNSELING				
1. Assures necessary privacy.				
2. Obtains necessary biographical data (name, address, age, etc.).				
3. If the client has chosen DMPA: Asks what she knows about DMPA. Corrects any myths/rumors or misinformation Explains how DMPA works and its effectiveness in preventing pregnancy Explains the potential side effects of DMPA: changes in menstrual periods (irregular/spotting/no periods) possible delay in return to fertility of on average four months weight gain depression Explores with client how irregular or increased bleeding may affect her daily life, and if a delay in return to fertility is important to her Explains what to expect regarding injection, frequency of return visits Asks client if she has any questions and responds to them				
4. Screens client for precautions using DMPA Screening Checklist: Asks all questions on history checklist. Checks weight and blood pressure. Records findings.				
5. Repeats important instructions to client: DMPA injections take effect immediately if given between days 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. Reminds client of menstrual changes she may experience and possibility of weight gain.				

CBT Skills Assessment Checklist for DMPA Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
METHOD-SPECIFIC COUNSELING (CONTINUED)				
5. Continued Reminds client to inform other health care providers she is on DMPA. Reassures client she may return at any time if she has questions or concerns.				
6. Discusses with client returning immediately if she has any of the following problems: Heavy vaginal bleeding Excessive weight gain Headaches Severe abdominal pain				
7. Asks client to repeat important instructions.				
8. Gives DMPA card with next appointment (time and date).				
9. Documents/records the visit according to local clinic guidelines.				
RETURN VISIT				
1. Asks if there are any problems or complaints.				
2. Repeats the history checklist.				
3. If client has developed any precautions, or wants to discontinue DMPA, helps her to make an informed choice of another method.				
4. If client is more than one month late, checks for pregnancy.				
5. If client is satisfied with DMPA method, no precautions exist, and she wishes to continue, gives DMPA injection.				

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Source: Indian Medical Association/Development Associates. *Family Planning Course Module 6: Progestin-only Contraceptives: DMPA and a Review of Norplant.* May 1994.

CBT Skills Assessment Checklist for ECP Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
1. Greets the client in a friendly, respectful, and helpful way.				
2. Asks client why she has come to the clinic or what makes her think that she needs ECPs. Ensures confidentiality.				
3. Takes a brief medical history, which includes information on dates of unprotected sex and last menstrual period.				
4. Tells the client about ECPs, including how they work, their effectiveness, and the possible side effects.				
5. Allows client to ask questions.				
6. Explains the correct use of ECPs.				
7. Shows client the ECP tablets.				
8. Asks the client to summarize the instructions.				
9. Gives client correct number of ECP tablets.				
10. Explains how to manage possible ECPs side effects: *Nausea*: Reminds client that it is a common side effect. Suggests taking pill(s) with food or vaginal placement of second dose. *Vomiting*: Reassures client that side effect can occur. Suggests taking pill(s) with food or milk, at bedtime, or vaginal placement of second dose. Advises client to repeat the dose if it is vomited within two hours. *Breast tenderness, headaches, or dizziness*: Reminds client the side effects are common and will not last long. Offers aspirin or ibuprofen for discomfort. *Irregular bleeding or spotting*: Reassures client that this is a common side effect and should not last long.				
11. Tells client to return or report to a clinic or hospital if she has any concerns or questions.				
12. Tells client her menstrual period may be a few days early or late, but most likely will be on time. Reminds client to return for a pregnancy test if her menses are more than a week late.				

CBT Skills Assessment Checklist for ECP Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
13. Reminds client that ECPs are not suitable as a regular method of contraception. Asks client if she would like to discuss other methods she can use in the future.				
14. Provides contraceptive information and services or schedules an appointment for another visit to discuss ongoing contraceptive use. Provides referral services and/or STD/HIV prevention information as needed.				
15. Demonstrates a non-judgmental attitude and respect for client throughout ECP service provision.				

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CBT Skills Assessment Checklist for IUDs Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
INITIAL INTERVIEW (CLIENT RECEPTION AREA)				
See *General Counseling Checklist.*				
METHOD SPECIFIC COUNSELING (COUNSELING AREA)				
1. Assures necessary privacy.				
2. Obtains biographic information (name, address, etc.).				
If the client chooses IUDs: Asks her what she knows about IUDs. Corrects any myths, rumors or misinformation she may express. Shows her a sample IUD and where and how it is used. Discusses the advantages and disadvantages of the IUD. Explains how the IUD works and its effectiveness. Explains possible side effects. Explains benign nature of the most common side effects. Discusses client needs, concerns, and fears in a thorough and sympathetic manner. Asks possible reaction of partner to finding out she is using IUD and how to deal with situation.				
4. Screens client carefully to make sure there is no medical condition that would be a problem (completes Client Screening Checklist).				
5. Reviews potential side effects and makes sure that they are fully understood.				
PRE-INSERTION COUNSELING (EXAM/PROCEDURE AREA)				
6. Reviews Client Screening Checklist to determine if the client is an appropriate candidate for the IUD and if she has any problems that should be monitored while the IUD is in place.				
7. Informs client about required physical and pelvic exams.				
8. Checks that client is within seven (7) days of last menstrual period.				
9. Rules out pregnancy if beyond day 7. (Refers if non-medical counselor.)				
10. Describes the insertion process and what the woman should expect during and afterwards.				

CBT Skills Assessment Checklist for IUDs Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
POST-INSPECTION COUNSELING (CONTINUED)				
11 Completes client record.				
12. Teaches client when and how to check for strings.				
13. Discusses what to do if the client experiences any side effects or problems.				
14. Explains the warning signs of potential complications: Abnormal bleeding Abnormal discharge Pain (abdominal or pain with intercourse) Fever Strings missing, shorter or longer				
15. Reminds client of effective life of IUD just provided to her (check IUD package insert for life of that particular IUD).				
16. Assures client she can return to the same clinic at any time to receive advice, medical attention, and, if desired, to the IUD removed.				
17. Asks client to repeat instructions.				
18. Answers client questions.				
REMOVAL COUNSELING				
PRE-REMOVAL COUNSELING (CLIENT RECEPTION AREA)				
1. Greets client in a friendly and respectful manner.				
2. Establishes purpose of visit.				
3. Asks client her reason for removal and answers any questions.				
4. Asks client about her present reproductive goals (does she want to continue spacing or limiting births).				
5. Describes the removal process and what she should expect during removal and afterwards.				
POST REMOVAL COUNSELING				
6. Discusses what to do if client experiences any problems (e.g., prolonged bleeding or abdominal or pelvic pain).				
7. Asks client to repeat instructions.				

CBT Skills Assessment Checklist for IUDs Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
POST REMOVAL COUNSELING (CONTINUED)				
8. Answers any questions.				
9. Reviews general and method-specific information about family planning methods if client wants to continue spacing or limiting births.				
10. Assists client in obtaining new contraceptive method or provides temporary method (barrier) until method of choice can be started.				

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Source: Indian Medical Association/Development Associates. *Family Planning Course Module 9: Intrauterine Contraceptive Devices: Providing Services.* May 1994.

CBT Skills Assessment Checklist for LAM Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
INITIAL INTERVIEW				
See *General Counseling Checklist.*				
METHOD COUNSELING				
1. Assures necessary privacy.				
2. Obtains necessary biographic data.				
3. If client has chosen LAM: Asks her what she knows about breastfeeding as a contraceptive method. Corrects any myths/rumors/misinformation she may have. Asks if she has used breastfeeding in the past for child spacing purposes. Asks what her experience was. Repeats advantages of breastfeeding for baby and mother. Asks if she has any questions and answers these.				
IMMEDIATE POSTPARTUM PERIOD				
4. Counsels client on optimal breastfeeding practices, including: Breastfeeding immediately after delivery to provide colostrum to infant. Breastfeeding on demand, day and night. Breastfeeding on both breasts Avoiding intervals of more than four hours between any two daytime feeds and more than six hours between any two nighttime feeds. Breastfeeding exclusively for the first six months. When supplements are introduced, feeding from breast first and then giving supplement. Avoiding use of pacifiers/bottles/nipples. Breastfeeding even when mother or baby is ill. Encouraging her to maintain sound diet. If separated from baby, expressing and correctly storing milk. Breastfeeding as long as possible.				

CBT Skills Assessment Checklist for LAM Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
METHOD-SPECIFIC COUNSELING (CONTINUED)				
Explains the benefits for the newborn, for her and for the next baby to come if she does not become pregnant until baby is at least two years old. Reinforces how these benefits will be obtained if she uses a contraceptive to avoid getting pregnant. Discusses when to introduce an additional method of contraception. Stresses that when any one of the following conditions occur, client is at risk for pregnancy: When she has a menstrual period. When her baby reaches six months of age. When she starts to give regular supplementary feedings.				
7. Asks client if she has questions and respond to these				
8. Asks client to repeat the three LAM conditions and the most important optimal breastfeeding practices Corrects any misunderstandings.				
9. Reassures client that provider is available to see her if she has any problems, questions or needs advice.				
POSTPARTUM VISIT				
10. If client is **postpartum:** Asks if client is having any breastfeeding difficulties/problems and advises/treats as appropriate.				
11. Takes a history. Asks client: Have you had a menstrual period since the birth of your baby? **Note:** Spotting in the first 56 days is not considered menses. Is your baby more than six months old? Has your baby regularly started taking solid foods or liquids (more than sips of water/ritual foods)?				
12. If answer to all three questions is "no," discusses and teaches client the three conditions under which LAM provides effective contraceptive protection: No menstrual period. Baby is less than six months old. She is fully or nearly fully breastfeeding.				

CBT Skills Assessment Checklist for LAM Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
METHOD-SPECIFIC COUNSELING (CONTINUED)				
RETURN VISIT COUNSELING (CONTINUED)				
1. Asks if any problems or complaints and deals with these as appropriate.				
2. Repeats optimal breastfeeding practices.				
3. Discusses other FP methods complementary to breastfeeding.				
4. Gives return appointment for checkup and eventual adoption of another FP method.				

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Source: Indian Medical Association/Development Associates. *Family Planning Course Module 5: The Lactational Amenorrhea Method and Condoms.* May 1994.

TASK/ACTIVITY	CASES 1	2	3	COMMENTS
INITIAL INTERVIEW				
See *General Counseling Checklist.*				
METHOD-SPECIFIC COUNSELING				
1. Ensures necessary privacy.				
2. Obtains necessary biographical data (name, address, age, etc.).				
3. If the client chooses POPs: Asks her what she knows about POPs. Corrects myths, rumors or misinformation she may express. Ask her if she will have any issues using POPs with her partner and how to deal with them. Asks if she has used POPs in the past. What was her experience? Gives her a package of POPs to look at and handle. Explains advantages of the POP, including non-contraceptive benefits. Briefly explains how the POP works and the importance of taking it **at the same time every day.** Explains that she should continue to the next packet of pills **without any rest** Explains that she should take her pills even when she does not have sex Explains that she may have her menses at any time before the end of the packet. Reminds her that absent menses is also normal with POPs.				
4. Explains what to do if she misses taking one POP: If she is breastfeeding and using POPs for extra protection she is still protected if she misses pill. Take it as soon as she remembers Continue taking pills at the usual time and If she is not breastfeeding or breastfeeding but her menses have returned she should use a back-up method for the next 2 days. Explains what the client should do if she misses taking 2 or more POPs: Take 2 pills as soon as she remembers. Take 2 pills on the next day. Immediately start using a backup method since there is an increased chance of becoming pregnant. If menses does not occur within 4-6 weeks, come to the clinic.				

TASK/ACTIVITY	CASES 1	2	3	COMMENTS
METHOD-SPECIFIC COUNSELING **(CONTINUED)**				
5. Asks client to repeat back in her own words instructions when to start POPs, when to take them and when to use a backup method				
6. Explains potential common side effects of the POPs that she may experience some (or possibly none) of these, and that they can all be managed: Amenorrhea/very scanty periods Spotting or breakthrough bleeding (BTB)				
7. Explains other situations when backup is needed: Diarrhea and vomiting If she is taking certain medications used in the treatment of TB and seizures (rifampin, phenytoin, carbamazepine)				
8. Explains in a non-alarming way the signs that warn a woman that she should seek medical attention: Extremely heavy bleeding (twice as long or twice as much as is usual for her) Any very bad headaches that start or become worse after taking POPs Skin or eyes become unusually yellow She thinks she might be pregnant				
CLIENT SCREENING				
9. **Screens client** for POP precautions. Asks all the questions on the checklist and records responses. Do you have or have you ever had breast cancer? Do you have jaundice, severe cirrhosis of the liver, a liver infection or tumor? (Are her eyes or skin unusually yellow? Are you breastfeeding a baby less than 6 weeks old? Are you taking medicine for seizures? Taking rifampin (rifampicin) or griseofulvin? Do you think you are pregnant?				
10. Reassures client of confidentiality and uses good judgment concerning the necessity of asking the following question: Do you or your husband/partner have other sex partners?				
11. Manages or refers for follow-up any positive findings.				

CBT Skills Assessment Checklist for POPs

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
RETURN VISIT COUNSELING				
1. Asks the client if she is satisfied with POPs.				
2. Asks if she is having any problems taking POPs or experiencing any side effects.				
3. Asks client how she is taking POPs and to demonstrate, using a POP packet.				
4. Repeats the history checklist. If history suggests client has developed a precaution, does an appropriate examination to rule out or verify.				
5. Briefly reviews instructions concerning missed pills, back up, and warning signs.				
6. If she is satisfied with POPs, is not experiencing any serious side effects and no precautions exist, prescribes additional cycles.				
7. Provides her with back-up spermicide and condoms.				
8. If client wants to discontinue POPs, or she is no longer breastfeeding, helps her make an informed choice of another method.				
9. Encourages her to return to the clinic any time she has questions or problems.				

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CBT Skills Assessment Checklist for VSC Counseling

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
INITIAL INTERVIEW				
See *General Counseling Checklist.*				
METHOD-SPECIFIC COUNSELING				
1. Assures necessary privacy.				
2. Obtains necessary biographic data (name, address, age, etc.).				
3. If client chooses VSC, explains in clear and non-technical language: How female sterilization/vasectomy works and its effectiveness in preventing future pregnancies. Explains the permanent nature of VSC and limited chances for reversal. Explains the surgical nature of VSC. Explains the small surgical risk and possibility of failure. Explains that VSC offers no protection from STDs/HIV/AIDS.				
4. Responds to and discusses the client's needs, questions, concerns and fears in a thorough and sympathetic manner. Asks client what s/he knows or has heard about VSC. Probes for myths/rumors and clarifies these in a respectful manner.				
5. Screens client through questioning and history for: Eligibility criteria. Medical conditions that may cause problem during or after VSC surgery.				
6. Assesses and discusses with client her/his decision and feelings about VSC: How long has client been thinking of having female sterilization/vasectomy? Is spouse in agreement with client's decision to have female sterilization/vasectomy? How would client feel if her/his life situation changed, if spouse were to die or divorce, or existing children were to die? Is any pressure being put on client by someone else to have female sterilization/ vasectomy?				

CBT Skills Assessment Checklist for VSC Counseling

TASK/ACTIVITY	CASES 1	CASES 2	CASES 3	COMMENTS
METHOD-SPECIFIC COUNSELING **(CONTINUED)**				
6. Continued Are there any indications that client may later regret having had female sterilization/ vasectomy (young age? marital instability? economic constraints/inducement? not entirely sure?)? Asks client if s/he is absolutely sure of decision and documents response.				
7. Explains to client: Where to go to obtain female sterilization/vasectomy. Writes referral letter/or make appointment for client at VSC Center. Explains in general terms what to expect during and after VSC surgery.				
7. Provides **specific pre-operative instructions:** Fast from midnight (tubectomy). Light breakfast morning of surgery (vasectomy). Bathe and wear clean clothing. Tubectomy clients should not wear nail polish, jewelry/hairpins. Empty bowels morning of surgery. Empty bladder just before surgery. Have someone with her/him to accompany home after surgery.				
9. Provides **specific post-operative instructions:** *For Female Sterilization Client* Rest fully first day; avoid strenuous activity and heavy lifting for seven days. May bathe after 24 hours but must keep incision clean and dry. Do not disturb/remove incision dressing. Avoid intercourse for two weeks or use condoms until next menses. Return to doctor or VSC Center immediately if she experiences: fever, bleeding, pus from incision fainting or dizziness abdominal pain which persists or gets worse If no problems, return to doctor or VSC Center in 7 days for removal of sutures and check-up. Provides client with 20 condoms.				

CBT Skills Assessment Checklist for VSC Counseling

TASK/ACTIVITY	CASES 1	CASES 2	CASES 3	COMMENTS
METHOD-SPECIFIC COUNSELING **(CONTINUED)**				
10. Provides **specific post-operative instructions**: *For Vasectomy Client* Rest fully first day; resume light work after 48 hours. Avoid strenuous activity and heavy lifting for 7 days; may resume normal activities after 7 days including cycling. Take all medications prescribed by VSC Center. May bathe after 24 hours but must keep incision clean and dry. Do not disturb/remove incision dressing or sutures. Abstain from intercourse for two weeks and then use condoms for 20 ejaculations. Explain why condoms are necessary. Return to doctor or VSC Center immediately if he experiences: fever, bleeding, pus from incision site fainting or dizziness excessive scrotal pain which persists or gets worse excessive scrotal swelling or enlargement If no problems, return to doctor or VSC Center in 7 days for removal of sutures and check-up unless this is not required (i.e., if the man has a no-scalpel vasectomy). Provides client with one-month supply of condoms.				
11. Asks client to repeat instructions to ensure understanding.				
FOLLOW-UP VISIT COUNSELING				
1. Inquires of client if there are any problems or complaints.				
2. Reminds vasectomy clients of need to use condoms for at least 20 ejaculations.				
3. Responds to any questions or concerns the client may have.				
4. Reassures client there is no need to return to you or VSC Center unless client has problems or further concerns.				

CBT Skills Assessment Checklist for VSC Counseling

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Source: Indian Medical Association/Development Associates. *Family Planning Course Module 4: Voluntary Surgical Contraception.* May 1994.

Combined Oral Contraceptives (COCs)

What are they?

COCs are tablets containing the hormones estrogen and progestin. A woman takes one tablet daily to prevent pregnancy.

How effective are they?

Typically, among one hundred women using COCs for one year, eight become pregnant. If taken every day, COCs are highly effective. If taken irregularly the risk of pregnancy is much higher.

How do COCs work?

COCs work by preventing the release of the egg from the ovary. Without an egg, a woman cannot become pregnant.

Advantages

- safe
- effective and easy to use
- lighter, regular periods with less cramping
- can become pregnant again after stopping the pill
- don't interfere with sex
- decrease risk of cancer of the female reproductive organs

Disadvantages

- have some side effects
- must be taken every day
- don't protect against sexually transmitted diseases, such as HIV

Possible Side Effects

Most women experience no side effects. Occasionally, women may experience nausea, weight gain, breast tenderness, headaches, unexpected bleeding or spotting, depression, or dizziness.

Combined Oral Contraceptives (COCs) (cont.)

Client Instructions

1. Show the client the pill packet and explain how to take the pills.
   - **Take the first pill on the first day of period or on any of the next four days.**
   - Take one pill every day, at the same time of day.
   - If the client has a 28-day packet, when she finishes one packet, she should take the first pill in the next packet on the next day. If the client has a 21-day packet, she should wait seven days, and then begin the next packet.

2. Explain to the client that if she forgets to take her pills, she may become pregnant. If she forgets to take her pills, she should do the following:
   - If she misses one pill, the client should take it as soon as she remembers. Take the next one at the regular time.
   - If she misses two pills, the client should take two pills as soon as she remembers. She should take two pills the next day, and use a backup method for the next week. The client should finish the packet normally.
   - If she misses more than two pills, the client should throw away the packet, and start a new one, **and** use a back-up method for the next week.

3. Review possible side effects. Most women have no side effects. Occasionally, women may experience nausea, weight gain, breast tenderness, headaches, unexpected bleeding or spotting, depression, or dizziness.

4. Review the reasons why she should return to the care provider:
   chest pain or shortness of breath
   severe headaches (with blurred vision)
   swelling or severe pain in one leg

5. Tell the client to return anytime she has a problem and in time for re-supply.

6. Have the client repeat this information.

Condoms

What are they?

The condom is a thin sheath worn over the erect penis when a couple is having sex. Contraceptive jelly or foam can be used with the condom for added protection against pregnancy.

How effective are they?

Condoms are effective if used consistently and correctly. If one hundred couples used condoms for one year, typically twelve to fifteen of the women might become pregnant. If contraceptive foam or jelly were used with the condom then fewer women would become pregnant.

How do Condoms work?

The condom catches the man's sperm so that no sperm can enter the vagina. When a spermicide is used it actually kills the sperm.

Advantages

- safe
- doesn't require a prescription or medical examination
- effective and easy to use
- helps protect partners from sexually transmitted diseases

Disadvantages

- interrupts the sex act
- may decrease sexual sensitivity in some men and women
- a new condom must be used each time the couple has sex
- a supply of condoms must be available before sex occurs

Possible Side Effects

Most men and women have no side effects. Occasionally a condom may break or slip off during intercourse. Some men or women may have an allergic reaction to latex.

Client Instructions

1. Show the client the condom and explain how to use it.
   - Open the package carefully so the condom doesn't tear.
   - Don't unroll the condom before putting it on.
   - Place the unrolled condom on the tip of the hard penis.
   - Hold the tip of the condom with the thumb and forefinger.
   - Unroll the condom until it covers the penis.
   - Leave enough space at the tip of the condom for the semen.
   - After ejaculation, hold the rim of the condom and pull the penis out of the vagina before it becomes soft.

2. Explain about the care of condoms.
   - Don't apply oil-based lubricants (like baby oil, cooking oil, petroleum jelly/Vaseline, or cold cream) because they can destroy the condom. It is safe to use contraceptive foam or jelly, clean water, saliva, or water-based lubricants.
   - Store condoms in a cool, dry place. Don't carry them near the body because heat can destroy them.
   - Use each condom only once.
   - Use contraceptive foam or jelly to make them more effective.
   - Don't use a condom if the package is broken or if the condom is dry or sticky or the color has changed.
   - Take care to dispose of used condoms properly.

3. Review possible side effects. Most men and women have no side effects. Occasionally men or women can be allergic to condoms or spermicides. If itching, burning, or swelling develop, the client(s) should return to the clinic to discuss another method.

4. Tell the client to return to the clinic:
   - any time there is a problem
   - in time for re-supply
   - if either partner is unhappy with the method
   - if either partner thinks s/he may have been exposed to an STD

Have the client repeat the instructions.

DMPA: The Injectable Contraceptive

What is it?

DMPA is an injection containing the hormone progestin. The injection is given every three months.

How effective is it?

DMPA is highly effective if the injections are given every three months. If one hundred women use DMPA regularly for one year, typically only one of them might become pregnant.

How does DMPA work?

DMPA works by preventing the release of the egg from the ovary. Without an egg, a woman cannot become pregnant.

Advantages

- safe and effective
- lasts for three months
- periods become very light and often disappear after a year of use
- completely reversible, can become pregnant again after stopping DMPA, although there might be a delay of several months
- can be used while breastfeeding
- doesn't interfere with sex
- may improve anemia

Disadvantages

- menstrual pattern will probably change
- increased appetite may cause weight gain
- typically a four-month delay in getting pregnant after stopping DMPA
- doesn't protect against sexually transmitted diseases

Possible Side Effects
Most women initially experience irregular spotting or prolonged light to moderate bleeding. Later, bleeding is likely to be lighter, less frequent, or stop altogether. Some women also experience weight gain or headaches.

DMPA: The Injectable Contraceptive (cont.)

Client Instructions

1. Show the client the vial of DMPA.

2. Explain the use of DMPA.
   - DMPA is given by injection every three months. The client should never be more than two weeks late for her repeat injection. If the client knows that she may not be able to come at the appointed time, she may come up to four weeks early.
   - The injection will take effect immediately if it is given between day one and day seven of her menstrual cycle.
   - If the injection is given after day seven of her cycle, a back-up method should be used for 24 hours.

3. Review possible side effects. Most women initially experience irregular spotting or prolonged light to moderate bleeding. Later bleeding is likely to be lighter, less frequent, or stop altogether. Some women also experience weight gain or headaches.

5. Review the reasons why she should return to the care provider:
   - heavy vaginal bleeding
   - excessive weight gain
   - headaches

6. Tell the client to return anytime she has a problem and in time for her next injection.

7. Have the client repeat this information.

Emergency Contraception Pills (ECPs)

(information is for low-dose combined pills)

What are they?

ECPs are a hormonal method of contraception that can be used to prevent pregnancy following an act of unprotected sexual intercourse.

How effective are they?

After a single use, pregnancy occurs in about two percent of women who use ECPs correctly.

How Do ECPs Work?

ECPs are thought to prevent ovulation and fertilization. They are not effective once the process of implantation of a fertilized ovum has begun.

Advantages

- safe and readily available
- reduces risk of unwanted pregnancy and need for abortions
- appropriate for use after unprotected intercourse (including rape, pressured marital or casual sex, or contraceptive failure)
- can be used by young adults, who are less likely to prepare for a first sexual encounter
- provides a bridge to the practice of regular contraception
- drug exposure and side effects are of short duration

Disadvantages

- don't protect against transmission of STDs and HIV
- don't provide ongoing protection against pregnancy
- must be used within 72 hours of unprotected intercourse
- may change the time of the woman's next period
- inappropriate for regular use (high cumulative pregnancy rate)

Possible Side Effects

Side effects may include nausea, vomiting, spotting, breast tenderness, headache, dizziness, and fatigue.

Emergency Contraception Pills (ECPs) (cont')

(Information is for low-dose combined pills)

Client Instructions

1. Show the client the pills and explain how to use them.
   - Swallow four tablets as soon as convenient, but no later than 72 hours after having unprotected sex.
   - Swallow the second four tablets 12 hours after the first dose.
   - **Important:** if more than 72 hours have passed since client had unprotected sex do not use ECPs.
   - If client vomits within two hours of taking a dose, she should take two tablets as soon as possible. If the vomiting occurs after the first dose, client will still need to take a second dose 12 hours later. (Provider can give client extra pills) To reduce nausea, take the tablets after eating or before bed.

   Instruct the client **not to take any extra emergency contraceptive pills unless vomiting occurs.** More pills will **not** decrease the risk of pregnancy further.

2. Review possible side effects. ECPs often cause temporary side effects such as nausea and vomiting. Sometimes they can cause headaches, dizziness, cramping, or breast tenderness. These side effects generally do not last more than 24 hours.

3. Review what to expect after using ECPs. Women will not see any immediate signs showing whether the ECPs worked. The menstrual period should come on time (or a few days early or late). Tell the client that if her period is more than a week later than expected, or if she has any cause for concern that she should return to the clinic.

4. Instruct the client to return to the clinic when she has her period if she wishes to use a contraceptive method to prevent future pregnancies.

5. Have the client repeat this information.

Intrauterine Device (IUD)

(Information is for the TCu 380A IUD)

What Is It?

An IUD is a small plastic and copper device that is inserted into the uterus to prevent pregnancy.

How effective is it?

If one hundred women use IUDs for a year, typically one will become pregnant.

How does the IUD work?

The IUD works by preventing sperm from joining with the egg.

Advantages

- safe, effective, and long-acting (10 years)
- easy to remove if the client wants to become pregnant
- doesn't interfere with sex
- doesn't interfere with breastfeeding

Disadvantages

- client may feel slight pain during the first few days after IUD insertion
- heavier and/or longer periods, which normally decrease during the first and second years
- doesn't protect against STDs
- not suitable for women with multiple sexual partners or whose partner has other sexual partners

Possible Side Effects

Side effects of the IUD may include cramping and some pain during and immediately after insertion, heavier and longer menstrual flow for the first few months, increased vaginal discharge, and possible infection.

Intrauterine Device (IUD) (cont.)

(Information is for the TCu 380A IUD)

Client Instructions

1. Show the client the IUD and explain how it is inserted.

2. Explain to the client how to check for the strings.

3. Review possible side effects. Side effects of IUD use may include: cramping and some pain during and immediately after insertion, heavier and longer menstrual flow for the first few months, increased vaginal discharge, and possible infection. Heavier and longer bleeding is normal and expected, especially in the first few months. Bleeding usually decreases during the first and second years of IUD use.

4. Explain the warning signs of potential complications:
   - abnormal bleeding
   - abnormal discharge
   - pain (abdominal or pain with intercourse)
   - fever
   - strings missing, shorter, or longer

5. Tell the client to return any time she has a problem. Remind her that the IUD can stay in for up to 10 years.

6. Have the client repeat this information.

Lactational Amenorrhea Method (LAM)

What is it?

The Lactational Amenorrhea Method (LAM) is a temporary family planning method based on the natural infertility resulting from exclusive breastfeeding. ("Lactational" means related to breastfeeding and "Amenorrhea" means not having menstrual bleeding.)

How effective is it?
Effective as commonly used- 2 pregnancies per 100 women in the first 6 months after childbirth.

HOW DOES LAM WORK?

Exclusive breastfeeding causes changes in the woman's hormones that prevent ovulation resulting in no menstruation.

Advantages

- Is effective in preventing pregnancy for up to 6 months.
- Encourages the best breastfeeding patterns, which have health benefits for the mother and baby.
- Can be used immediately after childbirth.
- No need to do anything at the time of sexual intercourse.
- No direct cost for family planning or for feeding the baby.
- No supplies or procedures needed to prevent pregnancy.

Disadvantages

- Short term; can only be used for up to 6 months after delivery.
- Frequent breastfeeding may be difficult for some mothers.
- Does not provide protection against STDs/HIV.
- If the mother has HIV there is some chance that breast milk will pass HIV to the baby.

Possible Side Effects

There are no side effects associated with LAM.

Lactational Amenorrhea Method (LAM) (cont.)

Client Instructions

1. Ask yourself these 3 important questions:

   - Have your menses returned?
   - Are you giving the baby water, liquids or other food besides breast milk or allowing long periods without breastfeeding, either day or night?
   - Is your baby more than 6 months old?

   If the answer to **all** of these questions is no then you can use LAM. Your chance of pregnancy is 1% to 2%.

   If the answer to **any** of the questions is yes you are at risk of getting pregnant. To prevent another pregnancy during the optimal birth spacing period, you should use another method of family planning and continue breastfeeding.

2. For LAM to be effective, you should do the following:

   - Breastfeed exclusively for six months.
   - Breastfeed on demand, day and night (8-12 breastfeeds during a 24-hour period with at least 1 feeding during the night.)
   - Continue breastfeeding even if the mother or the infant becomes ill.

3. You must stop using LAM as your form of contraception if:

   - Your baby reaches 6 months of age ***or***
   - You are having menstrual bleeding ***or***
   - You begin giving the baby supplemental foods.

4. As soon as any one of the conditions mentioned above changes, you must switch to another method of family planning in order to prevent pregnancy and insure you get the benefits of a three-year optimal birth spacing interval and continue breastfeeding for the health of your baby.

Progestin Only Oral Contraceptives (POPs)

What are they?

POPs are tablets containing only a very small amount of one hormone, a progestin. A woman takes one tablet daily to prevent pregnancy. POPs are the best oral contraceptive for breastfeeding women.

How effective are they?

POPs are very effective for breastfeeding women, about 1 pregnancy per 100 women in the first year as commonly used. As commonly used, they are less effective for non-breastfeeding women.

How do POPs work?

POPs work by thickening the cervical mucus, making it difficult for sperm to pass through and by preventing the release of the egg from the ovary in about half of menstrual cycles.

Advantages

- Safe
- Can be used by nursing mothers starting 6 weeks after childbirth
- No estrogen side effects
- Can become pregnant again after stopping the pill
- Don't interfere with sex
- May help prevent benign breast disease, endometrial and ovarian cancer and pelvic inflammatory disease

Disadvantages

- For women not breastfeeding may change menstrual periods
- Must be taken at the same time every day
- Don't protect against sexually transmitted diseases, such as HIV

Possible Side Effects

Amenorrhea, irregular bleeding, or spotting for women not breastfeeding. Less common side effects include headache and breast tenderness.

Progestin Only Oral Contraceptives (POPs) (cont.)

Client Instructions

1. Show the client the pill packet and explain how to take the pills.
   - Take the first pill on the first day of period or on any of the next four days
   - Take one pill every day, at the same time of day
   - Take the pills non-stop, from one packet to another
   - **Do not miss a day**

2. Explain what the client should do if she misses taking one POP:
   - Take it as soon as she remembers
   - Continue taking the next pill at the usual time and
   - Use a back up method for the next 7 days
   - Then continue taking the pills as usual

3. Explain what the client should do if she misses 2 or more POPs:
   - Take 2 pills as soon as she remembers
   - Take 2 pills on the next day
   - Use a backup method for the next 7 days
   - Then continue taking the pills as usual

4. Review possible side effects. Women not breastfeeding may have a change in menstrual periods. Most breastfeeding women have no side effects. Occasionally, women may experience breast tenderness, or headaches.

5. Review the reasons why she should return to the care provider:
   - If she thinks she might be pregnant
   - If she has abdominal pain, tenderness or fainting

6. Tell the client to return anytime she has any worries or a problem and in time for re-supply.

7. Have the client repeat this information.

Female Sterilization

What is it?

Female sterilization is a safe and simple procedure that provides permanent contraception.

How effective is it?

Female sterilization is very effective. If one hundred women are sterilized, only one of them might become pregnant within two years.

How does it work?

The doctor makes a very small cut in the woman's abdomen and then cuts the tube through which the egg passes to get from the ovary to the uterus. This prevents the woman's egg from meeting the man's sperm.

Advantages

- very safe and simple procedure that takes only 15-30 minutes by a trained doctor
- very effective
- permanent
- does not interfere with sex

Disadvantages

- may cause pain at the incision site and lower abdomen for a few days after the procedure
- leaves a small scar
- impossible to reverse

Possible Side Effects

Side effects are unusual following female sterilization. Occasionally, women have bleeding or a wound infection following the procedure.

Client Instructions

1. Discuss the client's decision to be sterilized. How long has she considered it? Has she discussed it with her husband or partner? How would she feel if circumstances change in her life, such as divorce or death of a child or spouse? Does she understand that the method is permanent?

2. Give the client instructions before the procedure.
   - Don't eat or drink anything after midnight the night before the surgery.
   - Bathe the day of surgery and wear clean clothes.
   - Ask someone to bring client home after procedure.
   - Ask a friend or family member to care for children.
   - Don't wear jewelry, nail polish or hairpins.

3. Give the client instructions after the procedure.
   - Rest for a day or two.
   - Don't lift anything heavy or do heavy work for one week after the procedure.
   - Keep the incision clean and dry.
   - May bathe after 24 hours.
   - Expect to feel a little pain in the lower abdomen.
   - May notice bruising or discoloration in the area of the procedure, this is normal.
   - Return to the clinic in one week to have the stitches removed (**note:** the instructions should be modified where absorbable sutures are used).

3. Review possible side effects. Return immediately to the clinic if client experiences fever, bleeding, pus from the incision, or abdominal pain, which doesn't go away or gets worse.

Vasectomy

What is it?

Vasectomy is a minor procedure for men that is done by a doctor. It is permanent sterilization for men who do not want any more children.

How effective is it?

Vasectomy (male sterilization) is very effective. If one hundred men are sterilized only one or fewer of them will cause a pregnancy during the first year after the procedure.

How does it work?

The doctor makes a tiny puncture or cut in the scrotum and then cuts the tubes that carry the sperm from the testes to the penis. After the procedure the man still produces semen, but there are no sperm in it.

Advantages

- very safe and simple procedure that takes about 15-30 minutes by a trained doctor
- very effective
- permanent
- does not interfere with sex

Disadvantages

- may cause some discomfort during and following the procedure
- is not effective immediately
- another method of family planning must be used for several weeks after the procedure until all of the sperm in the tube are expelled
- it is permanent and difficult and expensive to reverse

Possible Side Effects

Side effects are unusual following vasectomy. Occasionally men have swelling and discomfort of the scrotum, bleeding or infection.

Client Instructions

1. Discuss the client's decision to be sterilized. How long has he considered it? Has he discussed it with his wife or partner? How would he feel if circumstances change in his life such as divorce or death of a child or spouse? Does he understand that the method is permanent?

2. Give the client instructions before the procedure.
   - Eat a light breakfast the morning of the procedure.
   - Bathe the day of the surgery and wear clean clothes.
   - Empty bowels the morning of surgery and urinate just before the procedure.
   - Ask someone to accompany client home after the procedure.

3. Give the client instructions after the procedure.
   - Rest for a day or two.
   - Don't lift anything heavy or do heavy work for one week after the procedure.
   - Take all of the medicine given at the clinic.
   - Keep the incision clean and dry.
   - May bathe after 24 hours.
   - May notice bruising in the area of the stitches, this is normal.
   - The stitches will dissolve and don't have to be removed (**note:** *these instructions must be modified if non-absorbable sutures are used or no sutures at all*).
   - Avoid intercourse for 2-3 days and then use condoms for 20 ejaculations.

4. Review possible side effects. Return immediately to the doctor or clinic if there is fever, bleeding, or pus from the incision, dizziness, excessive scrotal pain which persists or gets worse, excessive swelling of the scrotum.

Note: *if semen analysis is available, offer to have sperm analyzed after 15-20 ejaculations*

Transparency # 0.1: Training Objectives

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

1. **Describe** the key messages and major principles of optimal birth spacing and family planning services.

2. **Describe** the health benefits of optimal birth spacing and family planning and the negative consequences of no optimal birth spacing.

3. **Explain** the relationship between maternal and child mortality and high-risk factors of maternal age, birth order, and birth interval.

4. **Identify** their own attitudes, feelings, and values, as well as their significance and impact on the counseling process.

4. **Explain** the reasons for family planning counseling and factors influencing counseling outcomes.

6. **Describe** the major principles of counseling.

7. **Describe** the essential elements/steps of the counseling process.

8. **Identify** the impact of interpersonal communication (verbal and non-verbal) on the counseling process.

9. **Review** contraceptive methods: description, use, effectiveness, advantages and disadvantages (side effects), relationship to sexuality.

10. **Identify** and respond to misconceptions and rumors raised by clients and their families.

11. **Explain** the rights of the client.

12. **Identify** several ways to counsel and motivate men to make responsible choices.

13. **Identify** several ways to assess and adapt the counseling process appropriately taking into account cultural and environmental factors.

14. **Apply** principles and steps of counseling in role plays.

Transparency # 0.2: Training Schedule

******* TO BE DEVELOPED BY TRAINERS IN THE FIELD **********

Transparency # 1.1: Key Messages of FP

Key Messages of FP

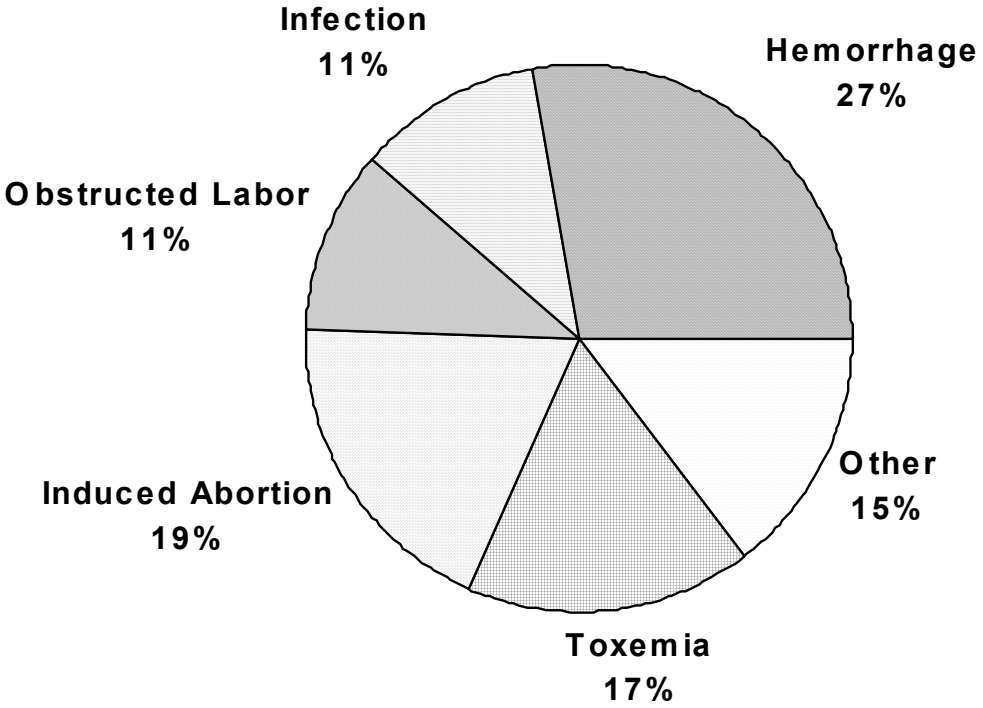
1. Voluntary optimal birth spacing of 3-5 years and FP are some of the most important **health** measures a couple and a nation can practice to reduce maternal and infant mortality and morbidity.

2. The delay of the next birth for at least three years profoundly reduces maternal and child mortality.

3. The risk of death from pregnancy and childbirth, especially when spaces between births are too short, is far greater than the risk of death from contraceptive use.

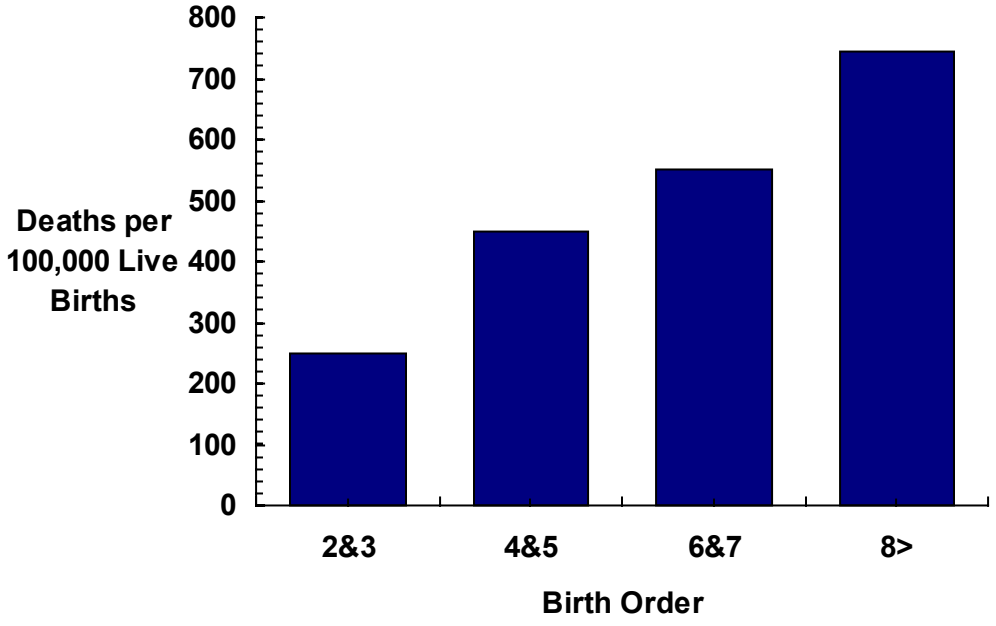
4. Barriers to FP in any country include some imposed by a country's medical profession and others that are social, cultural or religious. Medical policies, standards and practices that conflict with family planning ideas and inhibit a client's access to some types of family planning services are considered to be medical barriers. Examples of social, cultural and religious barriers include the importance in some countries of having a male offspring even at the expense of the mother's health and religious prohibitions of contraceptives.

Transparency 2.1: Causes of Maternal Death in Developing Countries



Source: Family Planning Saves Lives, 2nd ed.
Washington, DC: Population Reference Bureau, 1991, p.9.

Transparency 2.2: Maternal Deaths by Birth Order Matlab, Bangladesh, 1968 - 1970



Source: INTRAH. *Guidelines for Clinical Procedures in Family Planning.* 2nd ed. Chapel Hill, NC: Population Reference Bureau, 1993, p.8.

Transparency 2.3: A Comparison of Death Rates from Pregnancy or Childbirth and from Various Contraceptive Methods

Women's Death Rate from Pregnancy and Childbirth (in one year)	
Region	*Deaths per 100,000 births*
World	390
Africa	640
Asia	420
Caribbean	220
Latin America	270
Developed Countries	30

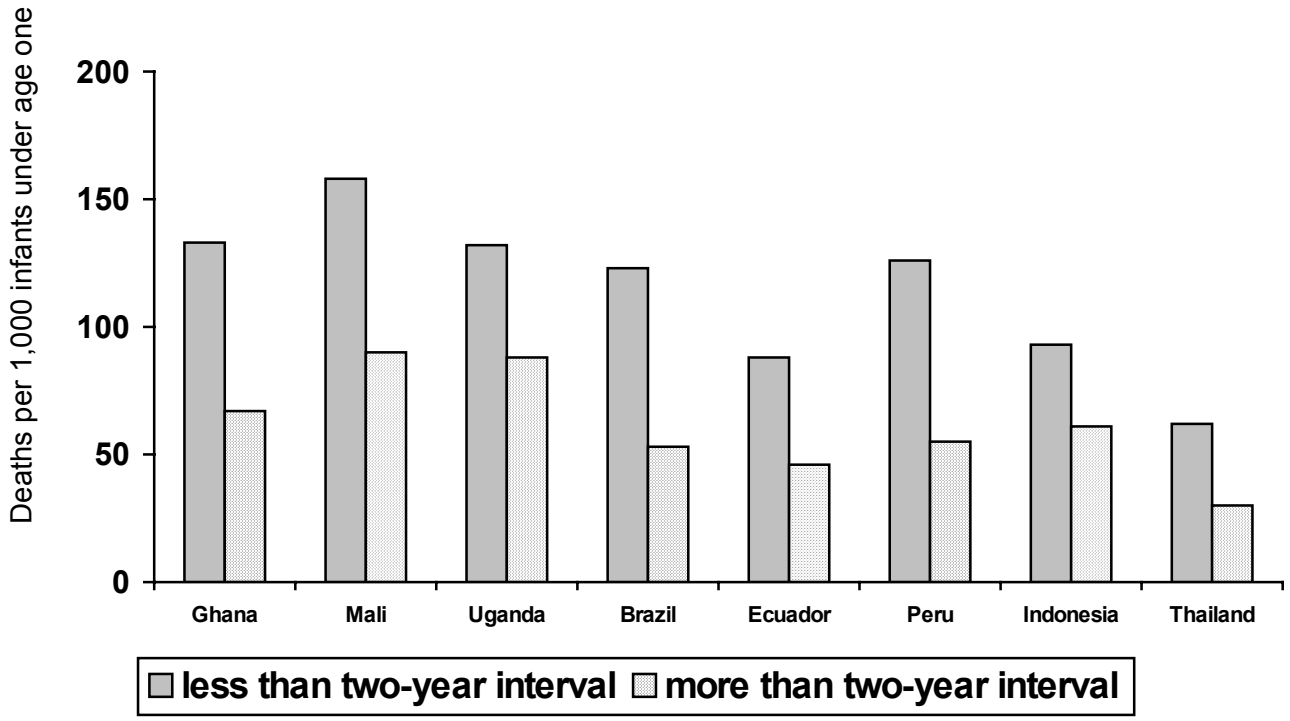
Note: *A woman's lifetime risk of dying from maternal causes is affected by her health status, available medical care, and the number of times she becomes pregnant.*

Women's Death Rate from Using Contraceptives (in one year)	
Method	*Deaths per 100,000 Users*
Oral Contraceptives (nonsmoker)	1.6
Oral Contraceptives (smoker)	6.3
IUD	1.0
Barrier Methods	0.0
Natural Methods	0.0
Female Sterilization	5.0

Note: *The contraceptive risks are based on United States data. At this time, there are no reliable sources of contraceptive risk information for developing countries. These risk estimates do NOT include the risk of death from pregnancy due to method failure. Deaths from female sterilization surgery are virtually zero after the first year.*

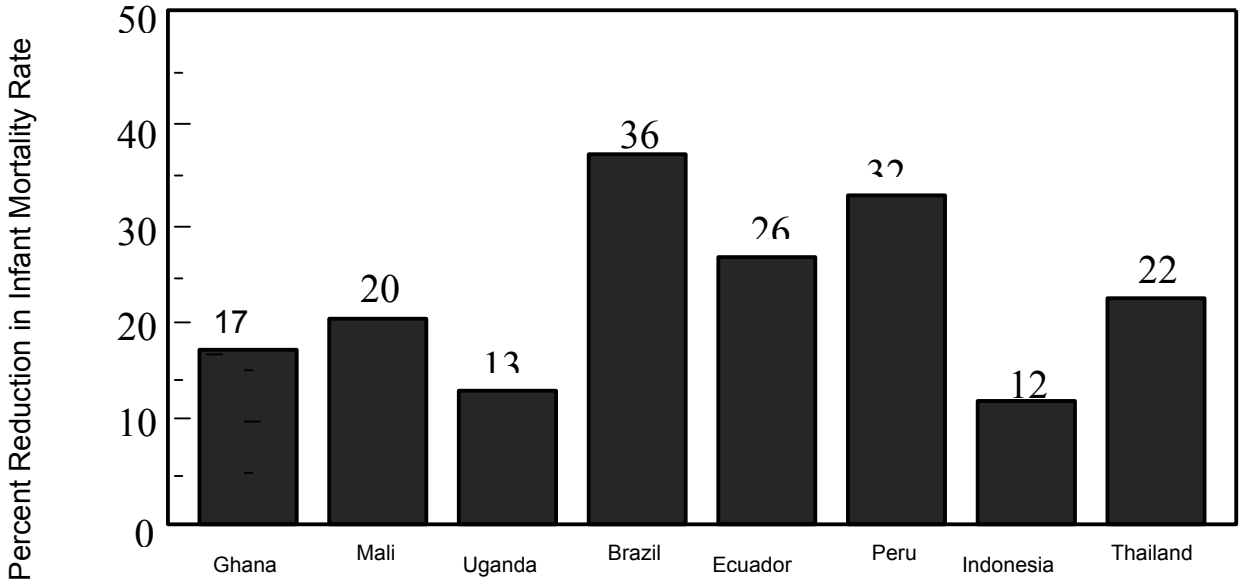
Source: Population Reference Bureau. *Family Planning Saves Lives*. 2nd Ed. (1991) p. 12.

Transparency 2.4: A Comparison of Mortality Rates for Infants Born After Short or Long Intervals



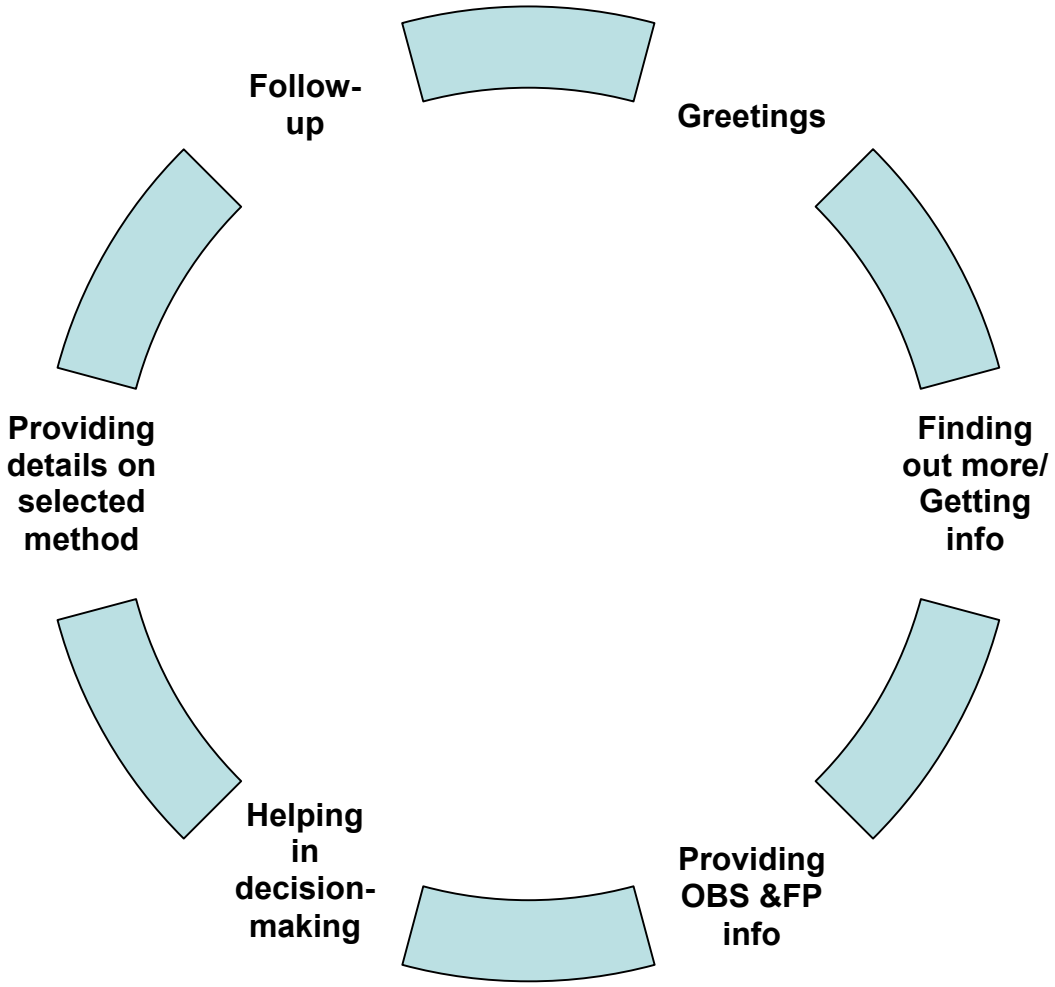
Source: Family Planning Saves Lives. 2nd. ed.
Washington, DC: Population Reference Bureau, 1991,p. 5.

Transparency 2.5: Estimated Percent Reduction in Infant Mortality Rate if All Babies were Born After at least two-year Interval



Source: Family Planning Saves Lives. 2nd Ed.
Washington, DC: Population Reference Bureau, 1991, p. 8.

Transparency #7.1: Elements of a Successful Counseling Session



COUNSELING FOR FAMILY PLANNING
PRE-/POST-TEST

Participant Name _____

Instructions: Circle the letter or letters corresponding with the correct answer (some questions may have more than one correct answer).

1. For most clients, the best family planning method is:
   a. the one that the health provider thinks is best for a particular client.
   b. the one that is most effective.
   c. the one that is most convenient for the provider.
   d. the one that the client chooses after learning about all the available methods.
   e. all of the above.

2. The family planning counseling process may be described as:
   a. a two-way communication process actively involving both the client and the health provider.
   b. a one-way communication process in which the provider asks the questions and the client answers questions.
   c. a one-time process in which a client learns everything about the family planning method chosen.
   d. a process that enables a client to be informed about different methods, ask questions, make an informed choice of a method, and leave the clinic feeling confident about how to use the method correctly.
   e. an ongoing communication process that takes place at every health and family planning service encounter.

1. **Informed choice** means that a family planning client:
   a. has been informed about all methods and agrees to use the contraceptive method the provider recommends.
   b. has been informed about the side effects of the method she has chosen.
   c. has been informed of the benefits of optimal birth spacing for her and her children.
   d. has informed you of the method she wants.
   e. has the right to choose any method she wants based on full information about the benefits of optimal birth spacing, the benefits and risks of all the methods available (including the right not to use any method), and has been counseled on all aspects of the method chosen.

2. An informed consent form signed by the client is required by many institutions for:
   a. COCs
   b. IUD
   c. DMPA
   d. VSC
   e. all of the above

3. Which of the following elements should be incorporated into each counseling session?
    a. Privacy
    b. Confidentiality
    c. Provider method bias
    d. Accepting and non-judgmental clinic staff attitude
    e. Technical jargon
    f. Insufficient time

4. Detailed information about a particular method is usually discussed with a client during:
    a. general FP counseling.
    b. method-specific counseling.
    c. follow-up counseling.
    d. all of the above.

5. Optimal birth spacing:
    a. should be explained by the counselor after the client has already given birth to at least one child.
    b. is 3 - 5 years between births.
    c. is healthier for the mother, existing children, and expected baby.
    d. should be discussed with clients when they are either trying to delay, space or limit births.
    e. should not be discussed with a client until a method of family planning has been chosen.

6. If a client is unsure about or reluctant to choose a FP method, a service provider should:
    a. tell the client which method the provider thinks is best.
    b. not mention a method for which the client is known to have a precaution or one that involves action on part of client.
    c. counsel the client on all the methods available and suggest she think about it and return when she has made a decision.
    d. explore with the client what method would best fit into her daily life, her present family situation, present and future reproductive plans, and her partner's preference, and guide her in her final decision.

7. Which is the best way to correct a rumor about a FP method?
    a. Laugh at the client for believing such a silly rumor.
    b. Politely tell the client the rumor is not true, and lightly brush off the comment.
    c. Politely explain that the rumor is not true and why it is not true.
    d. Ignore the comment.
    e. None of the above.

8. Which of the following are examples of open-ended questions?
    a. Do you want to use the Pill?
    b. How would you feel about using the Pill?
    c. What have you heard about the IUD?
    d. Have you heard of the IUD?
    e. Do you remember what to do if you miss one pill?
    f. Tell me what you will do if you miss one pill.

g. How would you feel about not having any more children?
h. You realize that female sterilization is permanent?

11. List 5 (positive or negative) nonverbal communication cues that may be given by a client:

_____

_____

_____

_____

_____

12. Which of the following are characteristics of **active listening**?
    a. Occasionally paraphrasing or summarizing what the client has said
    b. Looking at the client while s/he is talking
    c. Thinking about what you will say next to the client
    d. Writing or reading notes while the client is speaking
    e. Asking specific questions related to what the client has told you
    f. Interrupting the client
    g. Nodding your head and making encouraging sounds while client is speaking
    h. Filing papers

13. Which of the following are characteristics of **effective questioning**?
    a. Asking more than one question at a time
    b. Asking one question and waiting for an answer
    c. Asking questions that begin with **why**
    d. Phrasing questions to avoid **yes** or **no** answers
    e. Using a tone of voice that indicates interest and concern
    f. Using words to encourage client to keep talking, such as "oh?" and "then?"
    g. Asking leading questions

14. What are the main steps of the counseling process?

    a. _____

    b. _____

    c. _____

    d. _____

    e. _____

    f. _____

15. A client will better understand a method s/he has chosen and remember important instructions on its correct use if:

a. a flipchart, model or other visual aid is used.
b. she is given general information during counseling and a detailed pamphlet to read at home.
c. the instructions are given to her mother-in-law or husband.
d. she is able to handle and/or look at the method chosen (e.g., IUD sample, pill package, DMPA vial)
e. technical **medical** language is used.
f. she is encouraged to ask questions.

16. A client has had an IUD in for three months and now wants to have it removed. What would be the best counseling response?
    a. Explain that it sometimes takes more than three months to get used to the IUD and try to persuade her to keep it for another three months.
    b. Don't ask any questions; remove it and help her choose another method.
    c. Ask her why she wants it removed. If it is to become pregnant, remove the IUD. If not, discuss her reasons and concerns. If she still wants it removed, do so and help her choose another method.

17. A client who has been on the COC for five months has missed at least one pill out of every cycle. She has forgotten to take two pills in her current cycle. She does not want a pregnancy. Would you counsel her to:
    a. devise a system to help her remember to take her pill?
    b. speak with her husband or mother-in-law?
    c. help her choose another effective method which is not so client-dependent?
    d. lecture her on possible consequences and repeat instructions about using a back-up method?
    e. not counsel her: sympathize and do nothing? (After all, it's her life.)

18, **TRUE or FALSE**. Indicate whether the statement is true or false.

___ a. A good counseling session is one in which the service provider leads and controls the discussion.
___ b. It is not particularly important to discuss myths and rumors, because you will be giving the client correct information about the method she will use.
___ c. A spouse or mother-in-law should be encouraged to participate in optimal birth spacing and FP counseling sessions, even if the client does not seem eager to involve them.
___ d. It is acceptable for a provider to persuade a client to use a method that the provider genuinely thinks is better for the client.
___ e. Counseling is more important when the client is illiterate than when the client is highly educated.
___ f. It is only important to visual aids when the client is illiterate.
___ g. Brief, simple, specific messages which are repeated often are a good way to provide instructions for method use.
___ h. The decision to use a particular method must be a voluntary, informed decision made by the client.

COUNSELING FOR FAMILY PLANNING

PRE-/POST-TEST

Participant Name _____

Instructions: **Circle the letter or letters corresponding with the correct answer (some questions may have more than one correct answer).**

1. For most clients, the best family planning method is:
   a. the one that the health provider thinks is best for a particular client.
   b. the one that is most effective.
   c. the one that is most convenient for the provider.
   d. the one that the client chooses after learning about all the available methods.
   e. all of the above.

2. The family planning counseling process may be described as:
   a. a two-way communication process actively involving both the client and the health provider.
   b. a one-way communication process in which the provider asks the questions and the client answers questions.
   c. a one-time process in which a client learns everything about the family planning method chosen.
   d. a process that enables a client to be informed about different methods, ask questions, make an informed choice of a method, and leave the clinic feeling confident about how to use the method correctly.
   e. an ongoing communication process that takes place at every health and family planning service encounter.

3. **Informed choice** means that a family planning client:
   a. has been informed about all methods and agrees to use the contraceptive method the provider recommends.
   b. has been informed about the side effects of the method she has chosen.
   c. has been informed of the benefits of optimal birth spacing for her and her children.
   d. has informed you of the method she wants.
   e. has the right to choose any method she wants based on full information about the benefits of optimal birth spacing, the benefits and risks of all the methods available (including the right not to use any method), and has been counseled on all aspects of the method chosen.

4. An informed consent form signed by the client is required by many institutions for:
   a. COCs
   b. IUD
   c. DMPA
   d. VSC

e. all of the above

5. Which of the following elements should be incorporated into each counseling session?
   a. Privacy
   b. Confidentiality
   c. Provider method bias
   d. Accepting and non-judgmental clinic staff attitude
   e. Technical jargon
   f. Insufficient time

6. Detailed information about a particular method is usually discussed with a client during:
   a. general FP counseling.
   b. method-specific counseling.
   c. follow-up counseling.
   d. all of the above.

7. Optimal birth spacing :
   a. should be explained by the counselor after the client has already given birth to at least one or two children.
   b. is 3 - 5 years between birth of last son/daughter and next birth.
   c. is healthier for the mother, existing children, and expected baby.
   d. should be discussed with clients when they are either trying to delay, space or limit births.
   e. should not be discussed with a client until a method of family planning has been chosen.

8. If a client is unsure about or reluctant to choose a FP method, a service provider should:
   a. tell the client which method the provider thinks is best.
   b. not mention a method for which the client is known to have a precaution or one that involves action on part of client.
   c. counsel the client on all the methods available and suggest she think about it and return when she has made a decision.
   d. explore with the client what method would best fit into her daily life, her present family situation, present and future reproductive plans, and her partner's preference, and guide her in her final decision.

9. Which is the best way to correct a rumor about a FP method?
   a. Laugh at the client for believing such a silly rumor.
   b. Politely tell the client the rumor is not true, and lightly brush off the comment.
   c. Politely explain that the rumor is not true and why it is not true.
   d. Ignore the comment.
   e. None of the above.

10. Which of the following are examples of open-ended questions?
   a. Do you want to use the Pill?
   b. How would you feel about using the Pill?
   c. What have you heard about the IUD?
   d. Have you heard of the IUD?
   e. Do you remember what to do if you miss one pill?

f. Tell me what you will do if you miss one pill.
g. How would you feel about not having any more children?
h. You realize that female sterilization is permanent?

11. List 5 (positive or negative) nonverbal communication cues that may be given by a client:

- Nodding of head/moving head from side to side
- Frowning/smiling/grimacing
- Looking at the floor/ceiling/around the clinic
- Twisting rings or other jewelry/pulling on fingers/rubbing hands
- Maintaining or avoiding eye contact

12. Which of the following are characteristics of **active listening**?
    a. Occasionally paraphrasing or summarizing what the client has said
    b. Looking at the client while s/he is talking
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    d. Phrasing questions to avoid yes or no answers
    e. Using a tone of voice that indicates interest and concern
    f. Using words to encourage client to keep talking, such as "oh?" and "then?"
    g. Asking leading questions

14. What are the main steps of the counseling process?

    a. Introductions

    b. Finding out more/Getting information

    c. Providing family planning information

    d. Helping in the decision-making process

    e. Providing details on a selected method

    f. Follow-up

15. A client will better understand a method s/he has chosen and remember important instructions on its correct use if:
    a. a flipchart, model or other visual aid is used.
    b. she is given general information during counseling and a detailed pamphlet to read at home.
    c. the instructions are given to her mother-in-law or husband.
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    __F__ d. It is acceptable for a provider to persuade a client to use a method that the provider genuinely thinks is better for the client.
    __F__ e. Counseling is more important when the client is illiterate than when the client is highly educated.
    __F__ f. It is only important to use visual aids when the client is illiterate.
    __T__ g. Brief, simple, specific messages, which are repeated often are a good way to provide instructions for method use.
    __T__ h. The decision to use a particular method must be a voluntary, informed decision made by the client.

Participant Evaluation

Counseling for Optimal Birth Spacing and Family Planning

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-tests accurately assessed my in-course learning.	5 4 3 2 1
• the competency-based performance checklist was 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:	
• Provide general counseling to family planning clients.	5 4 3 2 1
• Adapt the counseling process to unique cultural settings.	5 4 3 2 1
• Dispel rumors and misconceptions about family planning.	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. _____

_____

_____

_____

_____

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