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Maternal and Child Health Initiative

Family Planning Training for Primary Health Care Providers

Trainer's Guide

April 2006



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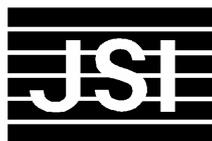


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Family Planning Training Course Schedule

Day 1	Day 2	Day 3	Day 4
9:00-10:50 1. Introduction/ Course Opening (1 hr 50 m)	9:00-9:15 Review of Daily Activities	9:00-9:15 Review of Daily Activities	9:00-9:15 Review of Daily Activities
10:50-11:10 2. Family Planning in the Russian Federation (20 m)	9:15-10:10 8. Natural Family Planning Methods (55 m)	9:15-10:15 14. Voluntary Surgical Contraception (1 hr)	9:15-9:45 20. STIs, HIV/AIDS and Family Planning: Part II (30 m)
	10:10-11:10 9. Barrier Methods of Contraception (1 hr)	10:15-11:10 15. Emergency Contraception (55 m)	9:45-10:15 21. Couples Communication (30 m)
			10:15-11:55 22. Increasing Access to FP Services: Action Plans (1 hr 40 m, incl. break)
11:10-11:25 Break	11:10-11:25 Break	11:10-11:25 Break	Break (during group wk)
11:25-12:20 3. Basic Concepts of Family Planning (55 m)	11:25-12:35 10. Low-dose Combined Oral Contraceptives (1 hr 10m)	11:25-12:25 16. Postpartum Contraception and LAM (1 hr)	11:55-12:30 23. Post-test and Evaluation (35 m)
12:20-13:00 4. Evidence-based Medicine (40 m)		12:25-12:55 17. Postabortion Contraception (30 m)	12:30-13:00 24. Closing (30m)
13:00-14:00 Lunch	12:35-13:35 Lunch	12:55-13:55 Lunch	
14:00-15:15 5. Principles of Counseling (1 hr 15 m)	13:35-14:35 11. Progestin-only Contraceptives (1 hr)	13:55-14:25 18. Adolescent Contraception (30 m)	
	14:35-15:45 12. Intrauterine Devices (1 hr 10 m)	14:25-15:50 19. Counseling Practice Day Three: Role Plays (1 hr 25 m)	
15:15-15:30 Break	15:45-16:00 Break	15:50-16:05 Break	
15:30-16:50 6. Informed Choice: The GATHER Method of Counseling (1 hr 20 m)	16:00-17:40 13. Counseling Practice Day Two: Role Plays (1 hr 40 m)	16:05-17:05 20. STIs, HIV/AIDS and Family Planning: Part I (1 hr)	
16:50-17:30 7. Methods of Contraception: Overview (40 m)			
17:30-17:35 Reflection	17:40-17:45 Reflection	17:05-17:10 Reflection	
Steering Committee	Steering Committee	Steering Committee	

Acronyms

AIDS	Acquired immunodeficiency syndrome
CAR	Crude abortion rate
CMV	Cytomegalovirus
COC	Combined oral contraceptive
CPR	Contraceptive prevalence rate
CPS	Contraceptive prevalence study
DHS	Demographic and Health Survey
DMPA	Depot medroxyprogesterone acetate
ECP	Emergency contraception pills
FP	Family planning
GNP	Gross national product
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
ICPD	International Conference on Population and Development
IEC	Information, education and communication
IMR	Infant mortality rate
IUD	Intrauterine device
JSI	John Snow, Inc.
JSI R&T	John Snow, Inc. Research & Training
LAM	Lactational amenorrhea method
MCHI	Maternal and Child Health Initiative
MMR	Maternal mortality rate
PID	Pelvic inflammatory disease
PMTCT	Prevention of mother to child transmission
POC	Progestin-only contraceptive
POP	Progestin-only pill
QAP	Quality Assurance Project
RH	Reproductive health
RHS	Reproductive Health Survey
SDM	Standard Days Method
SECS	Society for Education on Contraception and Sexuality
SH	Sexual health
STI	Sexually transmitted infection
TAR	Total abortion rate
TFR	Total fertility rate
USAID	United States Agency for International Development
UTI	Urinary tract infection
VSC	Voluntary surgical contraception
WFS	World Fertility Survey
WHO	World Health Organization
WIN	Women and Infants' Health Project
WRA	Women of reproductive age

Introduction to the Trainer's Guide

The *Family Planning Training for Primary Health Care Providers* was developed in 2005 by the Maternal and Child Health Initiative. It is intended to train Russian health providers in international evidence-based practices and standards for family planning services, with an emphasis on counseling.

Who the training is for

This manual is designed for training health care providers to strengthen their knowledge and counseling skills in order to provide quality family planning services, integrating family planning into the broader spectrum of reproductive health care services. Participants can include obstetrician/gynecologists, nurses, midwives, family medicine doctors, general practitioners, feldschers and pediatricians who provide prenatal, delivery, postpartum, breastfeeding, postabortion, well-baby, adolescent and HIV/AIDS care.

The training design will work best for a group of 15 to 25 people.

Goal of the training

To prepare health care providers to offer effective, evidence-based family planning counseling.

Objectives of the training

At the end of the training, health care providers will be able to:

- counsel clients effectively on contraceptive choices.
- provide information on modern contraceptive methods to clients.
- use the skills of family planning counseling for different population groups.
- describe the measures necessary for prevention of sexually transmitted infections and HIV.
- share information on contraceptive methods and family planning counseling skills with other providers at the health facility, and support colleagues in implementation of modern methods and counseling approaches.

The curriculum focuses on client-centered counseling skills. Detailed information on medical technology is provided to participants as reference material, but is not the main focus of the sessions. Participants will have many opportunities to practice family planning counseling in different scenarios.

How the Trainer's Guide is organized

At the beginning of each session, the guide lists:

- learning **objectives** for the session
- **time** required for the session
- **materials** needed
- training **techniques** used
- special **preparation** required, if any

The session plan provides step by step instructions for how to conduct the session. The text of all slides, handouts and flip charts is given in the session plan.

Participants receive a manual containing the main points of each session, as well as readings on these topics. The Participant Manual also contains most of the instructions they will need for group work and other activities (such as case studies). This avoids passing out a lot of handouts during the sessions.

In this Trainer's Guide:

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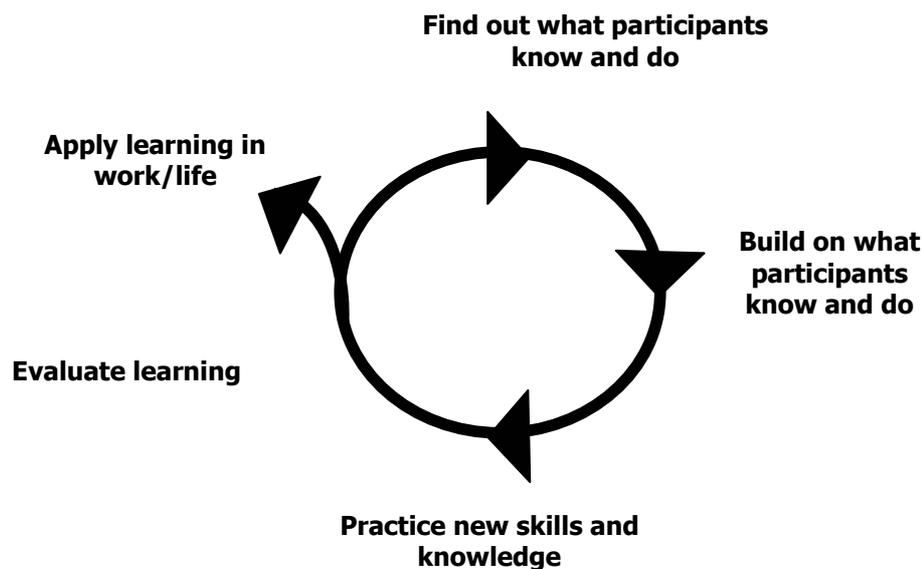
Items provided in the Participant Manual, such as activity Task Sheets and reference articles, are shown in a double-lined box like this.

Information to be written on a flip chart is shown in a box with a dashed line like this.

Methodology

This training is based on the principles of adult learning. Adults learn best when they feel that the topic is relevant to their lives and work, and when they have a chance to apply new skills in a practical setting.

The sessions in the training are based on the **Adult Learning Cycle**, shown below.



1. In each session, the trainer should begin by **finding out what participants already know and do** in regard to the topic. Discussion questions and short activities are included in the session plans to help trainers with this step.
2. Next, the trainer **builds on participants' current knowledge** by presenting new information or assigning them practical activities.
3. The trainer gives participants an opportunity to **practice the new knowledge or skills**, through a hands-on activity or discussion.
4. The trainer concludes the session by **evaluating** what participants have learned about the topic. The session plans include suggested questions or activities to help trainers and participants assess learning. There is also time set aside for a short evaluation activity at the end of each day.
5. After participants leave the training, they should be ready to **apply** their new skills in the real world. The training should prepare them to make this transition by practicing skills in a realistic way.

Adult learning techniques

The following techniques are used in this training.

Brainstorm - This technique encourages active and imaginative input from participants and taps the participants' knowledge and expertise. The trainer's role is to encourage all participants to say the first thing that comes to their minds and to keep ideas flowing quickly. Brainstorming is used to help focus or clarify activities or generate information that can help introduce or direct a topic.

Process - The trainer asks a question on a topic to be investigated. The participants are asked to draw upon personal experience and opinion and to respond with as many ideas as possible. As participants put forward their ideas, each idea is recorded on the board; none are rejected. When the brainstorm is complete, the group analyzes the information collected.

Advantages - It promotes creativity in finding solutions to problems. It is particularly effective for finding what participants know about a topic.

Case study - This technique encourages participants to analyze situations they might encounter and determine how they would respond. A case study is a detailed description of an event, followed by questions for participants to discuss. The case study should be designed in such way that the situation is relevant to participants and they have enough time to read, think and discuss.

Process - The trainer hands out a case study that describes a relevant situation or problem to be addressed. Participants read the case study. Participants are either broken up into small groups to discuss or may stay in the large group to discuss the story. The instructor facilitates discussion.

Advantages - It encourages participants to identify alternative behaviors and solutions to situations and problems they might experience in their work. It can present a great deal of information to which participants can refer as they discuss and answer questions.

Demonstration - This technique allows participants to see how something should be done. A demonstration brings to life information that could be presented in a lecture or discussion. For example, a discussion of how to use a condom may not be nearly as effective as a direct demonstration of how to do it which participants can both see and try for themselves. Health care providers can also use demonstrations with clients.

Process - The trainer should explain the purpose of the demonstration. The trainer demonstrates the procedures or new behavior. Participants are encouraged to ask questions and engage in discussion. The participants practice what has been demonstrated and receive feedback from the trainer.

Advantages – By demonstrating the new skill, participants show whether or not they have correctly understood it. Hands-on practice also makes the new information more memorable.

Gallery walk – This can be a form of brainstorming or a method for small groups to report back their work. Individuals or groups post their work on the classroom walls, creating a “gallery” of work for everyone to review.

Process - Individuals or groups perform a task and present their results in written form on flip charts or pieces of paper. They post their products on the classroom wall. Then all participants are given time to walk around the room and read/review their peers' work. (Optional: Post blank flip charts for participants to write comments about each other's work.) Debrief in plenary to find out what participants noticed and how they reacted to each others' work.

Advantages – This technique is a good way to showcase every participant's work without repetitive group report-backs. It also allows participants to compare different ideas, attitudes or approaches with peers. It allows participants to get up and move around physically.

Presentation and discussion – The lectures used in this training are mostly short presentations to highlight key content. They should incorporate participants' interactions; the trainer should continuously ask questions of participants to elicit information from them rather than lecturing without a break.

Process - Trainer identifies points where participants can be involved through questions and discussion. Practice and time your lecture to make sure that you have not prepared either too little or too much for the time allotted. As you present your lecture, keep an eye on the participants and make sure that you are holding their attention. If people start to lose interest, involve them by asking questions.

Advantages - Lectures can provide detailed, specific information in a short amount of time.

Role plays - This technique encourages participants to explore solutions or practice new skills. It is a small, often unrehearsed drama where participants are given roles to act out. Unlike a drama or play, there is no 'script' or particular words that participant-actors must say, but there is a description of the situation, the positions they should take, what they might do or opinions they should express.

Process - Roles may be set up by the trainer or participants may make up their own roles. The description of a role play can be given orally or by handout. Participants acting in the role play should be given some time to prepare. Trainer facilitates discussion and analysis of what was seen or felt by participants. 'Actors' are given a chance to describe their roles and what they were doing to see if it matches with what participants observed. Participants then discuss how what they saw relates to their own work and situations they encounter.

Advantages - Discussions following the role play can center around the role, opinions, and actions of characters as presented by the participants and thus avoid criticism of the participants themselves. This technique is entertaining as well as educational, and improves participants' skills of expression and observation. Role play is also a good tool for building self-reflection and feedback skills.

Small groups - It is often necessary to break a large training group into small groups to facilitate discussion, problem-solving, or team activities and tasks.

Process - Participants select or are randomly broken into smaller groups. A specific task is assigned to smaller groups. The trainer clearly states the purpose of the task, the time limit, and how the group's work is to be presented. Group members share responsibility for the task and presentation. Following these instructions, the group carries out the task. Then the small groups come back together and present their results to the whole group.

Advantages - The smaller the group, the greater the chance of individual participation. The more small groups you have, the better your chances of coming up with interesting information and more solutions to problems (although the report-back time increases with each additional group).

Pair work – This is a variation on small group work. It is useful as a short, quick way to conduct a simple group work exercise without taking a lot of time forming groups and reporting back.

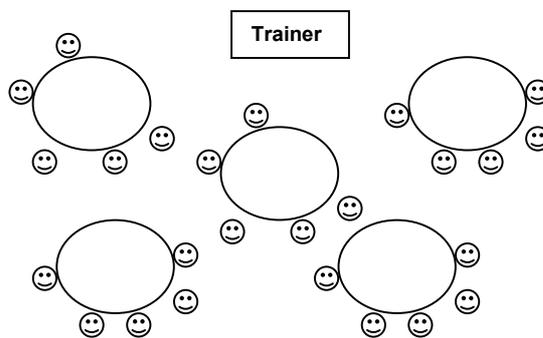
Process – Participants are asked to form pairs with people sitting near them. They are given a very simple, short task (e.g. one question to discuss or one problem to solve). Trainers give them a short time period to carry it out. Then the participants come back together for discussion. The trainer asks for a few pairs to give their answers, and summarizes their responses at the end.

Advantages – This technique takes very little time to set up (participants do not have to move around the room or settle into a group dynamic). It allows participants to contribute who are not comfortable speaking in a larger group. It also generates several answers to a question in a short time.

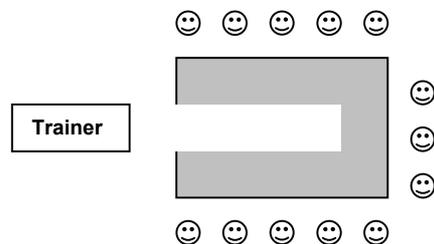
Setting up the training room

The training room should be large enough for all participants, trainers and observers to sit comfortably. To facilitate the interactive training activities, the chairs and tables should be movable (do not choose a training room with fixed auditorium seats). Everyone should be able to see and hear the trainers, the slides, and the other participants. Trainers can set up in a central location, but should move around the room while leading sessions. Two possibilities for setting up on the first day are:

Small group tables: This seating arrangement makes it faster and easier for small groups to work. It can be easily adjusted for different activities.



Horseshoe: If the group is smaller than 20, this seating arrangement makes it easy for everyone to see and talk to each other.



Managing group work

Many sessions in this curriculum include small group work. In some cases, you will be instructed to have participants from the same health facility work together. However, if not otherwise indicated, try to mix up the participants into different groups each time, so that they do not work with the same people repeatedly. It is important to give participants from different health facilities or regions the opportunity to meet each other and share experiences.

Here are some suggested ways to divide the participants into small groups:

- Ask participants to count off according to the number of groups desired. (For example, if forming 5 small groups, ask participants to count off 1-5, then work in groups according to their assigned number.) This technique ensures that people sitting next to their colleagues or friends do not work together.
- Make several "puzzles" by cutting up colored paper or postcards into interlocking pieces (one puzzle per group). Mix up all the puzzle pieces and ask participants to draw a piece at random. Then ask participants to search for the other people whose pieces fit with theirs.
- Ask participants to find others born in the same month (Note: Groups will be different sizes and may have to be adjusted).
- Draw pictures (e.g. an animal, a sun, a star) on post-its and stick one picture on the back of each participant's chair before the activity starts. Use a different picture for each group. Then ask participants to form groups with the other people who have the same picture.

Daily evaluation methods

Evaluating what participants have learned is a critical step in training. Since this training asks health providers to adopt new attitudes, new ways of working together, and new clinical approaches that may be different from their current practice, it is very important to check continually how they are reacting to the new material. As much as possible, trainers should give participants the opportunity to voice their questions, concerns and disagreements with the family planning counseling and contraceptive methods presented. In this way, trainers can identify which topics to spend more time on. This will also give participants an outlet so that they feel that their concerns are being heard.

Five minutes is provided at the end of each day for an evaluation activity. The trainer should select an activity such as one of those listed below.

Review the training objectives: Ask participants to take a blank piece of paper and write their answers to the following:

- On a scale of 1 – 5, (with 5 being "maximum possible,") to what extent were the training objectives met today?
- What suggestions do you have for the next day of this training?

Collect the responses and review them before the next day.

Gallery walk evaluation: To evaluate how effective the day was for participants, ask them to take a few minutes to write their thoughts about these questions. Give each participant one pink card and one green card.

- On the pink card, they should finish this sentence: "One thing I liked today was...."
- On the green card, they should finish this sentence: "One thing I would change for tomorrow is...."

Ask participants to tape their pink cards on one wall, and their green cards on another wall, making a "gallery" of their answers. Then give everyone 5 minutes to read the posted answers. Collect the responses and review them before the next day.

Role play: Ask participants to role-play an illustration of a valuable lesson that they learned today, or ask them to draw a picture of something valuable that they learned during the day, and then to explain it to the group afterward.

Temperature check: This technique helps the trainer find out how participants are feeling. Ask participants to write down one or two words that best describe how they are feeling at that moment and then to share it with the rest of the group if they choose.

Guided imagery: Ask participants to close their eyes and think back to the beginning of the day. Ask them to think about how they arrived at or began the activity you are evaluating. Ask them some of the following questions to give them an opportunity to think about the cognitive, attitudinal, and behavioral aspects of the activity that you are evaluating. Give participants a chance to think about each question as you ask it before moving on to the next question. Participants should think about their answers silently, not saying them aloud. The guided imagery helps them reflect, not analyze.

- What have you felt during the experience? Did your feelings change from the beginning until the end? What surprised you? Were there any disappointments? How about laughter?
- What new skills did you develop? Did you have a chance to practice them? What was that like?
- Was there a piece of new information about [the topic] that you took away from the activity? How would you describe it to someone who was not here?

Physical continuum: Ask participants to think about a statement such as: "I feel confident that I could effectively counsel a woman on postabortion contraception." Ask participants to stand at one end of the room if they strongly agree with the statement, at the other end of the room if they strongly disagree, or to choose a place somewhere in between that represents their feelings. Ask a few participants to discuss why they placed themselves where they did. *Note:* This is a good technique to use when controversial subjects arise, and it is important for everyone to see how everyone else feels or thinks about a topic. It can be used to clarify values or to help people reflect and share their learning.

Paper fight: Ask each person to take a piece of paper and to write a question on it that will help evaluate how well the day's (or course) objectives have been met. (For example, a participant might write "List one advantage and one disadvantage of IUDs.") When each person has written a question, ask them to make a ball out of the paper. Then ask them to stand up, facing one another in equally divided teams.

- Explain that they will "fight" one another with the paper balls, each team throwing the balls at the other team until the trainer says "Stop." The goal is to get as many paper balls on the other team's side as possible.
- When everyone is ready, say, "On your mark, get set, GO!" and watch the paper fight for a few minutes. After about a minute, call "Time!"
- Ask the two teams to collect their paper balls and to count the number that are on both sides. The team with the fewest balls on its side "wins." Instruct the teams to open up their papers and to read the question silently. Then, the "winning" team asks the other team one of the questions, and the other team must correctly answer it to the satisfaction of both teams and the trainer. Continue, with both teams asking and answering questions in turn until all questions have been asked and answered.

Fill in the blank: Read one or more of the statements below, and ask participants to write a few words to finish each statement. Collect the written responses.

- Tomorrow, I hope that the trainer....
- I think we are spending too much time on
- I think we are not spending enough time on....
- At the end of today's session, I felt....

Checking the mood: Post a flip chart with three faces drawn on it. Before they leave the room for the day, ask participants to put a mark below the face that best describes how they feel about the day. Variation: You can leave the flip chart on the wall for the duration of the training, and have participants mark it each day. At the end of the training, review how this "chart" of the participants' feelings changed over time.

			
Day 1			
Day 2			
Day 3			
Day 4			

Materials List

Equipment and materials to be available in all sessions:

- LCD projector and laptop
- At least 2 flip chart stands
- Flip chart paper
- Markers
- Pens
- Tape
- Slides (electronic version)

Manuals and booklets (one per participant):

- Family Planning Training for Primary Health Care Providers: Participant Manual
- Medical Eligibility Criteria for Contraceptive Use*. Third edition. World Health Organization. Geneva: 2004.
- Illustrated Flip Book: "Contraception: How to Prevent an Unwanted Pregnancy." EngenderHealth and the Scientific Center of Obstetrics, Gynecology and Perinatology of the Russian Academy of Medical Sciences, 2003.
- Clinical-Organizational Guidelines on Prevention of HIV Mother-to-Child Transmission*. First Edition. Maternal and Child Health Initiative. Moscow, 2005.

Handouts (one per participant):

- 1. Pre-test
- 2. Action Plan Worksheet
- 3. Post-test
- 4. Final Course Evaluation
- "WHO Medical Eligibility Criteria for Starting Contraceptive Methods" summary table

Cue Cards and other job aids (one set per participant):

- GATHER Method for Counseling Cue Card
- Standard Days Method Cue Card
- Male Condoms Cue Card
- Vaginal Spermicides Cue Card
- Low-dose Combined Oral Contraceptives Cue Card
- Progestin-only Pills Cue Card
- Progestin-only Injectables Cue Card
- Intrauterine Device Cue Card
- Permanent Methods Cue Card
- Emergency Contraception Cue Card
- Postpartum Contraception Cue Card
- Lactational Amenorrhea Method Cue Card
- Postabortion Contraception Cue Card
- How To Tell If A Woman Is Not Pregnant Cue Card
- Screening for Risk of Sexually Transmitted Infections and HIV Cue Card

Sample contraceptive products:

- Male condoms (at least one per participant for demonstration)
- Vaginal spermicides
- Low-dose combined oral contraceptives (21-day and 28-day packets)
- Progestin-only pills
- IUDs

Materials for specific sessions:

- Name tags
- Volunteer Team sign-up sheet (provided in this Trainer's Guide at the end of Session 1: Introductions/Course Opening)
- Closed-question game cards (provided in this Trainer's Guide at the end of Session 5: Principles of Counseling)
- Post-its, index cards or small pieces of paper (at least 60 pieces)
- Model of uterus (if available; otherwise use illustrations in Flip Book "*Contraception: How to Prevent an Unwanted Pregnancy*")
- Male models for condom demonstration (one for every two or three participants)
- Paper napkins
- Basket, bag or envelope
- Role play cards with client cases (provided in this Trainer's Guide at the end of Session 13: Counseling Practice Day Two: Role Plays)
- Role play cards for Day Three (provided in this Trainer's Guide at the end of Session 19: Counseling Practice Day Three: Role Plays)
- HIV Transmission risk cards (provided in this Trainer's Guide at the end of Session 20: STIs, HIV/AIDS and Family Planning)
- Cards for condom negotiation exercise (provided in this Trainer's Guide at the end of Session 21: Couples Communication)
- Couples Campaign sample materials (if available)
- Certificate of Participation for each participant

Optional materials for trainer-selected activities:

Introduction activity (Session 1):

- Map of the Russian Federation or the specific oblast of the training and pushpins or colored stickers, or
- Blank pieces of paper (A4 or half page, 1 per participant), or
- Post-its or small cards of paper (1 per participant), tape

Closing activity (Session 24):

- Spool of thread, or
- Pieces of blank paper (one per person)

1. Introduction/Course Opening

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

- refer to the trainers and other participants by their names.
- compare their expectations with the objectives of the course.
- determine the norms that they will respect during the course.
- describe the schedule of the course.
- evaluate their knowledge of family planning by completing a Pre-test.

Time: 1 hour 50 minutes

Techniques: Presentations, self-test, introduction activity

Materials:

- Handout 1: Pre-test, flip chart with "Parking Place" written on it, name tags, Volunteer Team sign-up sheet, slides

One set of the following for each participant:

- Participant Manual
- Complete set of Cue Cards
- *Medical Eligibility Criteria for Contraceptive Use* (Third edition, World Health Organization, Geneva: 2004)
- Illustrated Flip Book "Contraception: How to Prevent an Unwanted Pregnancy" (EngenderHealth and the Scientific Center of Obstetrics, Gynecology and Perinatology of the Russian Academy of Medical Sciences, 2003)

Optional for introduction exercise:

- *Map of the Russian Federation or the specific oblast of the training, and pushpins or colored stickers (1 per person), **or***
- *Blank pieces of paper (A4 or half page, 1 per person) and colored markers, **or***
- *Post-its or index cards (1 per person), tape*

Preparation:

- Write "Parking Place" on a flip chart and post it on the wall.
- Post the Volunteer Team sign-up sheet on the wall (*provided at the end of this session*).

Activities:

1. Welcome participants (5 min)

Introduce yourself, including your name, position, and professional experience.

Ask your co-trainers to introduce themselves.

If any officials from the program, the host institution/hospital or the government are present, **invite** them to say a few words to welcome the participants.

Tell participants:

- To begin, I will present some brief information about the Maternal and Child Health Initiative.
- This training course in family planning is a key core component of the MCHI project.

Tell participants this information while **showing** these **slides**:

This curriculum for training health providers in family planning is part of the ongoing **Maternal and Child Health Initiative (MCHI)**, which is funded by the United States Agency for International Development (USAID) and has been implemented by John Snow Inc. (JSI) in the Russian Federation since 1999.

MCHI:

- provides technical assistance to the Russian health care system.
- works with major stakeholders to improve maternal and child health by:
 - adopting and integrating internationally-recognized maternal child health standards, protocols and practices into primary health care.

- currently works in 16 Oblasts of the Russian Federation.
- partners with:
 - the Ministry of Health and Social Development of the Russian Federation.
 - multiple Regional Health Care Departments and regional medical facilities.
- the Russian Society of Obstetricians and Gynecologists.

MCHI interventions include:

- client-centered family planning services, especially for postpartum and postabortion clients.
- family-centered maternity care.
- antenatal care.
- exclusive breastfeeding.
- newborn resuscitation.
- essential newborn care.
- youth-friendly services.
- HIV prevention and counseling, with a special emphasis on the prevention of mother-to-child transmission of HIV (PMTCT).

Acknowledge the organizers and donors of the course.

2. Conduct introduction exercise (40 min)

Begin to set a less formal tone for the course by conducting introductions. Encourage the participants to use this opportunity to begin to know one another, and to continue to make connections throughout the training.

Choose an activity (some options are presented below) that allows participants to introduce themselves and share a little about their experience with family planning. Everyone in the room should take part in the activity, including all trainers and observers.

Whatever activity you choose, **do the following**:

Ask participants to introduce themselves by giving the following information. **Show** the list on this **slide**.

- Your name and how you would like to be called.
- The location where you work.
- Your organization and position/job.
- Your experience with family planning and similar training courses (briefly).
- Your expectations for the course.

Choose one of these activities, or a similar one:

- *Option 1:* Draw or ask a participant to draw the map of their district or oblast on a flip chart. Invite each participant to come to the map and indicate with a colored pushpin or sticker the location where he/she works and to introduce him/herself by answering the questions above. At the end of the exercise, you will have a "map of the group."
- *Option 2:* Give each participant a piece of paper and colored markers. Ask each participant to choose a symbol that represents him/her in some way, and to draw it on the paper. The symbol could be something from nature, a plant or animal, a household object, etc. (For example, a cheerful person might choose the sun; a person who loves technology might choose a computer.) Then ask each person to introduce him/herself by answering the questions above, and also by explaining his or her personal symbol.

- *Option 3:* Before the session, write the names of famous romantic couples from literature or history on note cards, and stick one card on the back of each person's chair.
 - a. Ask participants to look at their cards and find their "match."
 - b. Then give participants 5 minutes to interview their partners. They should find out the answers to the questions listed above.
 - c. Bring everyone back together. Go around the room and ask each participant to introduce his/her partner.

While participants are introducing themselves, **write** down their expectations on a **flip chart**.

When everyone is finished, **summarize** the experiences represented in the room, and the most commonly mentioned expectations.

3. Present the goal and objectives of the course (5 min)

Tell participants the goal and objectives of the course while **showing** these **slides**.

Goal of the course: To prepare health care providers to offer effective, evidence-based family planning counseling.

Objectives: By the end of this course, you will be able to:

- counsel clients effectively on family planning choices.
 - provide information on modern contraceptive methods to clients.
 - use the skills of family planning counseling for different population groups.
- describe the measures necessary for prevention of sexually transmitted infections and HIV.
 - share information on contraceptive methods and family planning counseling skills with other providers at your health facility, and support colleagues in implementation of modern methods and counseling approaches.

4. Review expectations for the course (5 min)

Go back to the **flip chart** listing participants' expectations. **Compare** their expectations with the course objectives.

Point out which expectations are likely to be met, and which are likely to be outside the scope of this training.

At the end of the session, **post** the flip chart with participants' expectations on the wall. At the end of the course, you can review the expectations and ask which ones have been met.

5. Explain the key principles on which the course is based (5 min)

Tell participants this information while **showing** these **slides**:

Key principles of the course:

- Access to information and choices about family planning is a human right.
- The health care provider is the key to successful modern family planning services.
- We can provide higher quality family planning services if we base our work on scientific **evidence** about what works best.

- The client should be able to choose a contraceptive method according to his/her needs and preferences.
- Family planning counseling is critical to helping the client make an informed choice of an appropriate method and then use it consistently and correctly.

- For maximum effectiveness, family planning counseling should be integrated into other health care services (antenatal care, postpartum care, well-baby care, STI/HIV care, etc.)
- Health care providers should take every opportunity to share information about modern contraception with clients, with other staff at their health facilities, with people in the community, and with family and friends.

6. Explain the training methodology used in this course (5 min)

Tell participants:

- This training course is based on adult learning principles and methodology.
- We will learn using participatory activities based on problem-solving and drawing on participants' experiences (for example: case studies, role plays, discussions).
- Family planning counseling is also a kind of adult learning situation; the health care provider facilitates the client's learning about contraceptive methods and how to use them, and sometimes how to change his/her behaviors to use contraceptives effectively.

Ask:

- ***Think about a time that you learned something new in your adult years. What helps you to learn, as an adult?***

Listen to several responses.

Then **show** the possible responses on this **slide, pointing out** ideas already mentioned by participants.

Adults learn best when:

- the teacher (or “trainer” or “facilitator”) relates to them as equals.
- they can practice new skills with hands-on activities.
- they can draw on their life experiences to help them learn new skills and acquire new knowledge.
- the training focuses on skills and knowledge that are relevant to their work/life.
- their ideas are respected.
- they have opportunities to reflect on their own learning.

Tell participants:

- Trainers will model these adult learning approaches in this training.
- You should also try to use these approaches when counseling a client, or when teaching a colleague about family planning.

7. Review the schedule for the course (5 min)

Go over the daily schedule, break times, and what topics will be covered on each day.

Tell participants to look at the schedule provided in their **Participant Manuals**.

Tell participants:

- The first day we will cover basic concepts and counseling skills.
- Then we will go through the main contraceptive methods available in the Russian Federation, in order of their effectiveness (traditional, modern, long-acting and permanent).
- On the third and fourth days, we will talk about issues for specific groups of clients: those in need of emergency contraception, postabortion and postpartum clients, adolescents, and those at risk of STI/HIV.
- There will be counseling practice every day. Everyone will have several chances to practice this very important skill.
- On the last day, you will have time to plan for how you will integrate what you have learned here about family planning into your work in your health facilities and communities, by making an Action Plan.

8. Introduce the course manuals and materials (5 min)

Tell participants to look at their **Participant Manuals**.

Tell participants:

- The **Participant Manual** contains the text of all the **slides**. This means you do not have to take detailed notes; you can focus on learning and taking part in activities instead.
- During sessions, you are asked to pay attention to the trainer and participate in discussions, not to just read along in the manual. The manual is for reference unless the trainer asks you to refer to a specific section.
- The **Participant Manual** also includes most of the instructions for group activities. This means there will not be too many handouts. Instead, everything is in one convenient place.

Show participants an example of group activity instructions in the manual.

*Note to trainer: For example, you could ask them to turn to the "**Task Sheet: Low-dose COC Counseling Role Play**" in the **Participant Manual, Session 10: Low-dose Combined Oral Contraceptives**..*

Tell participants:

- The **Participant Manual** also includes a few short articles that you can read in the evenings or whenever it is convenient for you. They will be pointed out to you during the various sessions.
- In addition to the Participant Manual, you have been given a copy of the World Health Organization's **Medical Eligibility Criteria for Contraceptive Use**, Third edition (Geneva: 2004). We will talk about this manual in depth in a little while.
- You should each have a set of **Cue Cards**. These cards have the key information a health provider needs when counseling a client. There is one card for each method plus a few other cards that contain useful information. We will use these cards during this training course and then hopefully you will continue to use them once you return to your home facilities.
- Lastly, you should all have an illustrated Flip Book titled "**Contraception: How to Prevent an Unwanted Pregnancy**" (EngenderHealth and the Scientific Center of Obstetrics, Gynecology and Perinatology of the Russian Academy of Medical Sciences, 2003). This Flip Book is a useful tool for counseling. It has pictures and some basic information to help you tell clients about the different contraceptive methods.

Ask participants:

- ***Does everyone have all of these materials?***

9. Go over relevant logistics (5 min)

Tell participants about:

- Who to contact for help with logistical and administrative issues.
- Arrangements for meals, lodging and transportation.

10. Introduce the Volunteer Team and the Steering Committee (5 min)

Tell participants:

- The **Volunteer Team** and the **Steering Committee** are ways that participants can have a voice in the training and give feedback to course organizers and trainers.
- The **Volunteer Team** is a group of 2 or 3 participants who volunteer to help the trainer with the daily management of the course. A different group volunteers each day.
- The **Steering Committee** is composed of the day's Volunteer Team plus the trainers and course organizers. The Steering Committee meets at the end of each day to hear feedback from the Volunteer Team and plan for the next day.

Tell participants this information while showing these slides:

The Volunteer Team's responsibilities are to:

- provide ice breakers and energizers (e.g. in the morning and after lunch).
- help manage the schedule and act as timekeepers during breaks.
- collect feedback from other participants about the course to share with trainers.
- attend a short Steering Committee meeting at the end of the day, at which they will give feedback about how the day went.
- present a short summary the following morning of the previous day's work and report what was discussed during the Steering Committee meeting to the entire group.

The Steering Committee's responsibilities are to:

- meet at the end of the day for about 30 minutes.
- hear feedback from the Volunteer Team on the day's work, from their own experience and from ideas shared by other participants.
- discuss what went well, what could be improved, and any other suggestions or issues such as logistics.
- provide the course organizers with a chance to learn about and respond to changes that can improve the course.

Show participants where the **Volunteer Team sign-up sheet** is located and **invite** them to sign up during the breaks today.

11. Establish group norms and introduce the Parking Place (5 min)

Tell participants:

- To reach the training course objectives, we should agree on how we will work together as a group.

Ask:

- ***What rules or guidelines would you like this group to follow during this training course?***

Listen to responses from as many people as possible. **Write** responses on a **flip chart** as they are said.

When no new ideas are proposed, **review** the list and **ask** the group if they would make any changes.

Note to trainer: The following are some suggested rules, but the actual list should be the one created by the participants:

- *Respect each other.*
- *Do not interrupt each other.*
- *Be on time for sessions.*
- *Do not be distracted by other tasks.*
- *Do not criticize ideas suggested by other participants.*
- *Take active part in the training – but also allow others their turn.*
- *Share your experience.*
- *Respect other peoples' points of view.*
- *Keep to the agenda.*
- *Switch off cell phones or put them on "silent" mode.*
- *No smoking in the classroom.*

Once the group norms have been agreed to, post the list in a place where it can easily be seen by everyone.

Tell participants:

- There will be a flip chart displayed at all times in the room with the heading **"Parking Place."** **Show** participants where it is.
- You can write down any questions you have about the day's sessions and post them here.
- The trainers may also post a question to the **Parking Place** if there is not time to discuss it fully during a session.
- At the end of the day or during the morning review, the trainers will "empty the **Parking Place**" by answering these questions; or in some cases we may discuss them with you individually.

12. Administer the Pre-test (20 min)

Tell participants:

- Today everyone will take a Pre-test.
- At the end of the course, you will take the same test again.

Tell participants this information while **showing** this **slide**:

The purpose of the Pre-test is:

- to help you identify topics in family planning that you want to learn more about.
- to show trainers your level of prior knowledge about family planning, and to help them identify topics that will need more time or less time.
- to help course organizers evaluate the effectiveness of the course.
- to provide a solid evidence-based approach to our work together by using the results for current and future planning.

Tell participants:

- It is all right if you do not know all the answers yet; during the training course, you will learn the answers to all the Pre-test questions.
- If you wish, you may use the **Participant Manual**, the **WHO Medical Eligibility Criteria for Contraceptive Use manual**, the **Cue Cards** and the **"Contraception: How to Prevent an Unwanted Pregnancy" Flip Book** as references during the test. However, there is a time limit for completing the test, so you should not spend too much time searching for information you do not know. You should try to answer all the questions before looking up answers you are not sure about.
- Individual tests will not be shared with anyone except the trainers and course organizers.
- Tests should be completed individually without discussion.

Give each participant a copy of **Handout 1: Pre-test**.

Tell participants:

- You should write your name at the top so that this Pre-test can be matched with your Post-test.
- Everyone will have **15 minutes** to complete the Pre-test.

After 15 minutes, **collect** all Pre-tests. **Make sure** each one has a name on it.

Note to trainer:

- **Score** the Pre-tests on the first evening, and **review** the results to see which family planning topics are well-known or unfamiliar to the participants. **Share** them with all trainers so that the timing of sessions can be adjusted if necessary.
- **Prepare** a short summary of test results to present to participants the next day. For example, you can list the average score, and the top three most commonly missed questions, on a flip chart.
- Be sure to **keep** the Pre-tests so that they can be compared with Post-tests at the end of the course.

13. Conclude the session

Tell participants:

- In the next session, we will begin setting the context for family planning by discussing the situation in the Russian Federation.

Handout 1 Pre-Test

Name: _____

INSTRUCTIONS: Each statement is either TRUE or FALSE. Make a mark in the TRUE column if you agree with the statement, or in the FALSE column if you disagree with the statement.

	TRUE	FALSE	STATEMENT
1.			Most modern contraceptive methods have a low rate of failure if used consistently and correctly and are safe for the majority of users.
2.			Internationally-recognized evidence-based eligibility criteria have been developed by the World Health Organization to help health providers be certain that couples are receiving medically-appropriate contraceptive methods.
3.			Having high quality family planning services is less important in the Russian Federation than in other countries in the world, since Russia has one of the lowest total fertility rates (TFRs) in the world.
4.			Women and couples have very different reproductive and contraceptive needs at different points in their lifecycles. With the latest advances in contraceptive technology, a single contraceptive method can meet all those changing needs, which makes family planning simpler than in the past.
5.			The goal of client-centered counseling is to help women and couples exercise their right to choose, understand and use an appropriate contraceptive method, including the right to choose no method at all.
6.			Family planning is the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so.
7.			For the optimal health of both mothers and children, the recommended birth spacing interval is 2 years.
8.			In a good counseling session, the provider carefully listens to the client's reproductive concerns and then advises which contraceptive method the client should use to meet her needs.
9.			A good counselor provides each client with detailed information about every contraceptive method available. This helps the client to make an informed choice.

	TRUE	FALSE	STATEMENT
10.			Cue cards help even the most experienced provider to quickly locate the most important information needed for counseling a client about contraceptive methods.
11.			Informing clients about the possible side effects of specific methods ahead of time tends to discourage them before they even try a method. It is better to wait and see if the client experiences any side effects.
12.			Clients need to be informed whether their contraceptive methods will help protect them from STIs/HIV.
13.			The Standard Days Method of family planning is only effective for women with regular menstrual cycles between 28-30 days long.
14.			Oil-based lubricants should never be used with condoms, as these will weaken the condoms and may cause them to tear.
15.			Emergency oral contraception must be used within 72 hours of unprotected intercourse.
16.			Repeated use of spermicides in any one day may increase a woman's risk for STIs or HIV.
17.			Since the 1980s, the hormonal doses in combined oral contraceptive pills have been greatly reduced with no reduction in effectiveness, and with fewer contraindications and fewer side effects.
18.			The various brands of low-dose oral contraceptive pills may vary slightly in the dosage of estrogen or in the type and dosage of progestin they contain. These variations are so slight that the provider should not be overly concerned about which brand of pill is available for the client to take.
19.			In a 28-day packet of combined oral contraceptive pills, the first 21 pills contain only estrogen, and the last 7 pills (which are a different color) contain only progestin.
20.			Women with blood pressure below 160/90 are eligible for low-dose combined oral contraceptive pills.
21.			It is important to routinely perform a full physical exam before providing low-dose combined oral contraceptive pills.

	TRUE	FALSE	STATEMENT
22.			With progestin-only pills, there is a higher risk of pregnancy than with the low-dose combined oral contraceptive pills if the woman forgets a pill or is late taking her pill.
23.			All of the pills in the packets of progestin-only pills contain progestin. There are no "reminder" pills.
24.			The IUD can safely be used by most HIV-positive women.
25.			The IUD is one of the most effective contraceptive methods because it requires very little action on the part of the woman once it has been inserted by a trained provider.
26.			After being treated for an STI, a woman should wait one month before having an IUD inserted. During that month, she should use a different method of contraception or abstain from intercourse.
27.			The World Health Organization recommends that sexually active women have a supply of emergency contraceptive pills on hand.
28.			The lactational amenorrhea method (LAM) of contraception is effective as long as the woman meets at least 2 of the 3 criteria for effectiveness: (1) baby is less than 6 months old; (2) baby is frequently being fed only breastmilk; (3) her menses have not resumed since delivery.
29.			In the first 6 months after delivery, all methods of contraception are safe for women and their infants while breastfeeding.
30.			The optimal time to counsel a postpartum woman about contraception is the day she is preparing for discharge from the hospital.
31.			Family planning should be integrated into all primary health care services for all clients of reproductive age.
32.			Voluntary surgical sterilization leads to a loss of sex drive in many clients.
33.			After an abortion, a woman's fertility returns after 28 days.
34.			HIV can be transmitted through contact with blood, semen, and saliva.

Note to trainer: Use this answer key to score the Pre-test and Post-test, and to explain answers to participants after the Post-test. Explanations of the answers are given in italics.

Pre-test/Post-test Answer Key

	TRUE	FALSE	STATEMENT
1.	√		Most modern contraceptive methods have a low rate of failure if used consistently and correctly and are safe for the majority of users.
2.	√		Internationally-recognized evidence-based eligibility criteria have been developed by the World Health Organization to help health providers be certain that couples are receiving medically-appropriate contraceptive methods.
3.		√	Having high quality family planning services is less important in the Russian Federation than in other countries in the world, since Russia has one of the lowest total fertility rates (TFRs) in the world. <i>(While it is true that Russia has one of the lowest TFRs, the ability to plan one's family is a human right and essential for reproductive health. The substantial role that family planning plays in ensuring safe motherhood and child survival and in meeting the challenges of HIV/AIDS has long been recognized but is at times undervalued.)</i>
4.		√	Women and couples have very different reproductive and contraceptive needs at different points in their lifecycles. Fortunately with the latest advances in contraceptive technology, a single contraceptive method can meet all those changing needs which makes family planning simpler than in the past. <i>(As reproductive and contraceptive needs change during lifecycles, the most appropriate contraceptive method may likely change. No single method available today is likely to meet all those changing needs)</i>
5.	√		The goal of client-centered counseling is to help women and couples exercise their right to choose, understand and use an appropriate contraceptive method, including the right to choose no method at all.
6.	√		Family planning is the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so.
7.		√	For the optimal health of both mothers and children, the recommended birth spacing interval is 2 years. <i>(Recent research shows that 3 to 5 year intervals reduce maternal and infant morbidity and mortality more than 2 year intervals.)</i>
8.		√	In a good counseling session, the provider carefully listens to the client's reproductive concerns and then advises which contraceptive method the client should use to meet her needs. <i>(A provider listens carefully to the client's wishes and needs, and then provides her with information about the method(s) she prefers and is eligible for. The provider helps her to make her own decision about a contraceptive method.)</i>

	TRUE	FALSE	STATEMENT
9.		√	A good counselor provides each client with detailed information about every contraceptive method available. This helps the client to make an informed choice. <i>(Clients need information to make informed choices, but no client can use all information about every contraceptive method. Too much information makes it hard to remember really important information. This is called "information overload." It is more effective to provide more detailed information about the method(s) the client is most interested in, while letting her know that there are other methods available if she should wish to change methods in the future.)</i>
10.	√		Cue cards help even the most experienced provider to quickly locate the most important information needed for counseling a client about contraceptive methods.
11.		√	Informing clients about the possible side effects of specific methods ahead of time tends to discourage them before they even try a method. It is better to wait and see if the client experiences any side effects. <i>(Clients who learn about possible side effects and how to manage them ahead of time tend to be more satisfied with their methods and to use them more successfully and for a longer period of time.)</i>
12.	√		Clients need to be informed whether their contraceptive methods will help protect them from STIs/HIV.
13.		√	The Standard Days Method of family planning is only effective for women with regular menstrual cycles between 28-30 days long. <i>(The Standard Days Method is effective for women with regular cycles between 26-32 days long.)</i>
14.	√		Oil-based lubricants should never be used with condoms, as these will weaken the condoms and may cause them to tear.
15.		√	Emergency oral contraception must be used within 72 hours of unprotected intercourse. <i>(Emergency oral contraception can be used up to 120 hours (5 days) after unprotected intercourse. The earlier it is used, the more effective it will be in preventing pregnancy.)</i>
16.	√		Repeated use of spermicides in any one day may increase a woman's risk for STIs or HIV.
17.	√		Since the 1980s, the hormonal doses in combined oral contraceptive pills have been greatly reduced with no reduction in effectiveness, and with fewer contraindications and fewer side effects.
18.	√		The various brands of oral contraceptive pills may vary slightly in the dosage of estrogen or in the type and dosage of progestin they contain. These variations are so slight that the provider should not be overly concerned about which brand of pill is available for the client to take.

	TRUE	FALSE	STATEMENT
19.		√	In a 28-day packet of combined oral contraceptive pills, the first 21 pills contain only estrogen, and the last 7 pills (which are a different color) contain only progestin. <i>(The first 21 pills contain both estrogen and progestin; the last 7 pills are "reminder" pills that contain no hormones although may contain iron.)</i>
20.		√	Women with blood pressure below 160/90 are eligible for low-dose combined oral contraceptive pills. <i>(Women with blood pressure below 140/90 are eligible.)</i>
21.		√	It is important to routinely perform a full physical exam before providing low-dose combined oral contraceptive pills. <i>(Asking the client about specific medical conditions that are listed in the WHO Medical Eligibility Criteria for Contraceptive Use manual is sufficient. Taking her blood pressure is recommended if possible. Physical exams and tests are unnecessary for the majority of women.)</i>
22.	√		With progestin-only pills, there is a higher risk of pregnancy than with the low-dose combined oral contraceptive pills if the woman forgets a pill or is late taking her pill.
23.	√		All of the pills in the packets of progestin-only pills contain progestin. There are no "reminder" pills.
24.	√		The IUD can safely be used by most HIV-positive women.
25.	√		The IUD is one of the most effective contraceptive methods because it requires very little action on the part of the woman once it has been inserted by a trained provider.
26.		√	After being treated for an STI, a woman should wait one month before having an IUD inserted. During that month, she should use a different method of contraception or abstain from intercourse. <i>(An IUD should not be inserted until 3 months after completing treatment for an STI; she should use an alternative contraceptive method during these 3 months.)</i>
27.	√		The World Health Organization recommends that sexually active women have a supply of emergency contraceptive pills on hand.
28.		√	The lactational amenorrhea method (LAM) of contraception is effective as long as the woman meets at least 2 of the 3 criteria for effectiveness: (1) baby is less than 6 months old; (2) baby is frequently being fed only breastmilk; (3) her menses have not resumed since the delivery. <i>(The woman must meet all 3 criteria for LAM to be effective.)</i>
29.		√	In the first 6 months after delivery, all methods of contraception are safe for women and their infants while breastfeeding. <i>(All contraceptive methods are safe for breastfeeding women in the first six months after delivery except low-dose combined oral contraceptive pills, which may interfere with the quantity and quality of breastmilk.)</i>

	TRUE	FALSE	STATEMENT
30.		√	The optimal time to counsel a postpartum woman about family planning is the day she is preparing for discharge from the hospital. <i>(Counseling about postpartum family planning should begin during the antenatal period and continue through the last day of her hospital stay. This gives her time to consider the information, discuss it with her partner and ask any questions she may have.)</i>
31.	√		Family planning should be integrated into all primary health care services for all clients of reproductive age.
32.		√	Voluntary surgical sterilization leads to a loss of sex drive in many clients. <i>(Voluntary surgical sterilization does not interfere with the sex drive. For many clients, sexual pleasure is increased because the worry of unintended pregnancy is eliminated.)</i>
33.		√	After an abortion, a woman's fertility returns after 28 days. <i>(Fertility can return as soon as 14 days following an abortion.)</i>
34.		√	HIV can be transmitted through contact with blood, semen, and saliva. <i>(HIV can be transmitted through contact with the blood, semen and pre-seminal fluid, vaginal secretions and breastmilk of infected persons, but NOT through contact with saliva, sweat and tears.)</i>

Note to trainer: Copy this page and post it on the wall on the first day.

Volunteer Team – Please sign up!

Day One

1.

2.

3.

Day Two

1.

2.

3.

Day Three

1.

2.

3.

2. Family Planning in the Russian Federation

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

- describe major trends in reproductive health and family planning in the Russian Federation.
- explain why family planning is important in the Russian Federation today.

Time: 20 minutes

Techniques:

- Presentation and discussion

Materials:

- Slides

Activities:

1. Present the current demographic situation in the Russian Federation (15 min)

Tell participants:

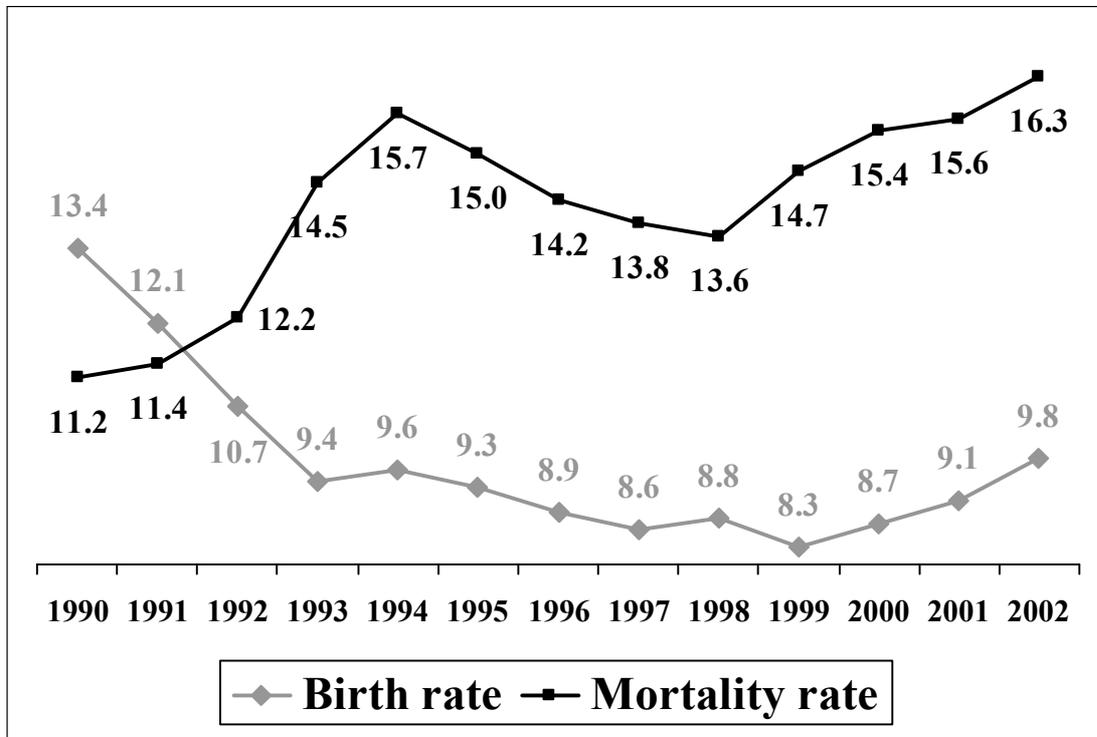
- We will begin with a brief overview of the current demographic situation in the Russian Federation. This presentation will cover some key trends affecting reproductive health today.

Tell participants this information while **showing** these **slides**.

Current demographic situation in the Russian Federation:

- It is frequently said in the Russian press and internationally that the Russian Federation is facing a demographic situation unprecedented in a developed country in peace time.
- Since the early 1990s, the birthrate has been steadily decreasing, while the overall mortality rate has been steadily increasing.
- As a result, Russia's total population has been decreasing in recent years and may continue to do so for some time.

Annual birth and death rates 1990 to 2002



- For multiple reasons, couples are choosing to have smaller families.
- The resulting decrease in the birthrate means that Russia's total fertility rate - the number of children women on average are having today - is now among the lowest in the world.

Country/Region	Total fertility rate (TFR)
Russia	1.4
Western Europe	1.6
Eastern Europe (including Russia)	1.3
Canada	1.5
United States	2.0
Brazil	2.4
REPLACEMENT LEVEL	2.1

Sources: Population Reference Bureau – 2005 World Population Data Sheet and 2005 Women of our World Data Sheet

Show the following statement on this **slide**:

What do you think?

"Having high quality family planning services is less important in the Russian Federation than in other countries in the world, since Russia's total population has been decreasing."

Ask:

- ***What do you think about this statement? Do you agree or disagree? Why?***

Listen to several responses from participants. **Summarize** their answers.

Explain the role that family planning plays in this situation while **showing** these **slides**.

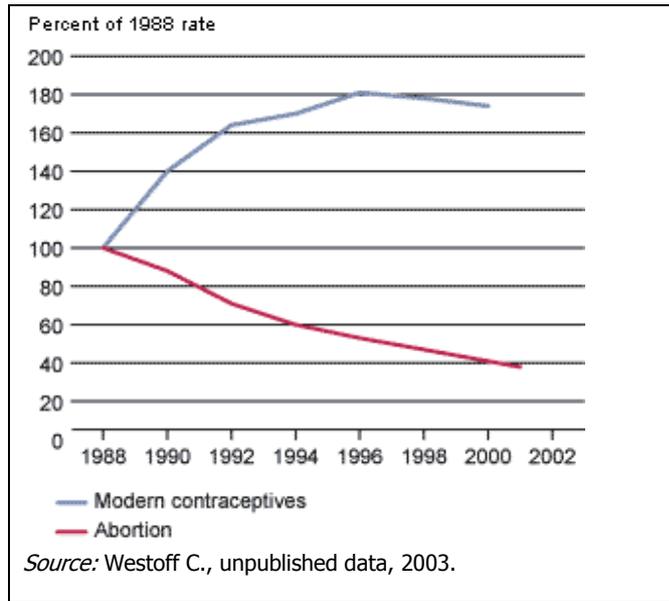
Making modern contraception less accessible is NOT the answer to this problem.

- It will not make the birth rate go up.
- It will lead to more unintended pregnancies, shorter spacing between pregnancies, and more reliance on abortion, all of which can contribute to increased infant and maternal mortality and morbidity, including infertility.

- In fact, the use of modern contraceptive methods is generally considered a much safer, healthier, cheaper way of managing one's fertility than the use of abortion.
- We can see that – in this regard – the situation in Russia is increasingly positive.

Over time:

- Use of modern contraception in Russia has steadily increased.
- Abortion rate has steadily decreased.
- Between 1988 and 2001, modern contraceptive use increased in Russia by 74%, while the abortion rate declined by 61%.



Tell participants:

- This positive trend is reinforced by the Russian Federation's commitment to the International Conference on Population and Development Programme of Action.

Then **tell** participants this information while **showing** these **slides**:

1994 International Conference on Population and Development (ICPD):

As a participant in ICPD, the Russian Federation joined an international Program of Action which:

- acknowledges that population and development are linked.
- focuses on individual rights rather than on demographic targets.
- seeks to advance gender equality and eliminate violence against women.

- seeks to ensure women's ability to control their own fertility.
- links reproductive rights to human rights.
- aims to make family planning universally available by 2015.

Tell participants:

- The adoption of the ICPD program means that the Russian Federation has officially committed itself to a progressive family planning policy.

2. Conduct a group discussion (5 min)

Ask:

- ***Do you see these trends (smaller families, fewer abortions, increased demand for modern contraception) in your own practice?***

Listen to several participants' responses.

Then **compare** responses to the national trends.

Then **tell** participants this information while **showing** this **slide**:

- Quality family planning services can help improve the population's health.
- Limiting family planning services will NOT improve Russia's demographic situation.

Tell participants:

- There is a more in-depth article in your **Participant Manual** entitled "***Family Planning: A Wise Investment,***" which you might enjoy reading in the evening or at another convenient time.

Note to trainer: This article is provided below at the end of this session.

Refer participants to **Session 2: Family Planning in the Russian Federation**, and have them find the article.

3. Conclude the session

Tell participants:

- In the next session, we will discuss some basic concepts and approaches to family planning that can help the country achieve its goals and help women and families lead healthier lives.

Note to trainer: This article is provided in the Participant Manual (Session 2) as a reference.

Family Planning: A Wise Investment

Background

All governments everywhere have as key goals protecting and improving the health and survival of their women and children. At the 1994 International Conference on Population and Development (ICPD) in Cairo, the governments of 179 countries, including the Russian Federation, agreed that population and development are inextricably linked. The conference adopted a 20-year Programme of Action that focused on individuals' needs and rights, rather than on achieving demographic targets. Advancing gender equality, eliminating violence against women and ensuring women's ability to control their own fertility were acknowledged as cornerstones of population and development policies. The ICPD was the first major international conference to define the term "reproductive rights" and affirm the link between existing human rights treaty provisions and reproductive rights.

One of the primary goals of the Programme of Action is to make family planning universally available by 2015 as part of a broadened approach to reproductive health and rights.

Certainly Russia strongly shares this commitment. The next and continuously on-going crucial step is to effectively translate these goals into concrete actions. Fortunately, there is a sizeable body of international standard evidence-based information to help the Russian Federation design solid, sensible, cost-effective programs.

Unmet need

In the early 1970s, a series of international survey programs began conducting large-scale national surveys in many countries around the world. These World Fertility Surveys (WFS),

"Reproductive rights embrace certain human rights that are already recognized in national laws, international laws and international human rights documents, and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents." ICPD 1994.

Contraceptive Prevalence Studies (CPS) and the currently on-going Demographic and Health Surveys (DHS) and Reproductive Health Surveys (RHS) have provided extensive data on fertility levels and fertility preferences in many countries.

One almost universal finding in these studies has been that a substantial proportion of women do not want more children, do not want another child in the near future or want to delay a first birth yet they are not currently practicing contraception. Women who want to prevent pregnancy but do not practice contraception are said to have an "unmet need" for contraception. The concept of "unmet need" has as corollary concepts, depending on the woman's individual situation, the "desire to limit," the "desire to space" and the "desire to delay a first birth." Additional research has shown the prime causes of "unmet need" to be: lack of knowledge; fear of side effects; concern about social, familial, or partner's disapproval; and lack of access to services.

It is universally accepted that all family planning programs should be guided by principles of voluntarism and informed choice. Voluntarism implies that people have an opportunity to choose voluntarily whether or not to use contraception and to choose what method to use from the widest range of contraceptives available. Informed choice highlights a person's ability to freely choose a contraceptive method from a range of options based on accurate and useful information and an understanding of her/his own needs.

A key component in reproductive choice is recognizing that women and couples have very different reproductive intentions and very different contraceptive needs at different points in their lifecycles, and that no single method available today is likely to meet all those changing needs. Choice is fundamental. Consequently, there is a great need for accurate information and supportive counseling at multiple life points; whether a couple wants to delay a first birth, space a subsequent birth, or limit childbearing altogether will greatly affect the ultimate choices they make.

Advances in medical technology over the last 40 or more years now make it possible for all families to plan their childbearing. By enabling couples to plan their families, family planning helps women to bear their children during the healthiest times for themselves and their families. The careful planning of births can save the lives of both mothers and their children. Family planning usually suggests the use of contraceptive methods to delay, space or prevent pregnancies but the concept in its fullest sense also includes support for couples having difficulty achieving a desired pregnancy.

Family planning methods

A wide variety of family planning contraceptive devices and approaches are now available: barrier methods such as male and female condoms, spermicides and diaphragms; hormonal contraceptives provided as pills, injections, patches, rings or

implants; intra-uterine devices (IUDs); and surgical sterilization procedures for women (tubal ligation) and men (vasectomy) as well as a range of fertility awareness/ periodic abstinence methods (including the Standard Days approach) and withdrawal (coitus interruptus).

There is no "best method." Most methods have a low rate of failure if used consistently and correctly and are safe for the majority of users. Contraceptive methods vary according to their effectiveness, convenience, cost, side effects, risks and benefits. While not all methods are appropriate for all women, there is a safe and effective contraceptive method for every family that can help protect the health of the couple and the health of their children. Given access to services and information, couples can make a voluntary and informed choice as to the contraceptive method most appropriate for their particular situation. Internationally recognized protocols are readily available to help health providers be certain that couples are receiving appropriate methods. These criteria have recently been updated and published in the World Health Organization's *Medical Eligibility Criteria for Contraceptive Use, 3^d Edition*.

The specific methods of contraception available, i.e. the "method mix," in any one country can vary considerably from country to country and depend on the accessibility, quality and relative cost of public and private sector contraceptive services, community norms, and personal preferences. Within any particular country, the specific methods of contraception available will also commonly vary by where the services are provided. Certain methods - e.g. IUDs, implants, and the permanent surgical methods - require the involvement of specially trained health personnel (but not necessarily physicians). These methods generally are provided within a health facility and, because of their duration of action, are often called the "long-term and permanent clinical methods." Other methods - e.g. barrier methods and pills - do not necessarily have to be provided within a health facility and, because a continuous supply is required, these methods are often called the "resupply methods."

Family planning in the Russian Federation

The longstanding conventional wisdom is that the Russian Federation and most of the former Soviet block countries traditionally relied on voluntary induced abortion as the primary means of birth prevention. Indeed, for decades, the abortion levels in the Russian Federation have been among the world's highest. However, over the years, the official abortion statistics have shown a steady decrease, as can be seen in Table 1 below regarding both the crude abortion rate (CAR) and the total abortion rate (TAR).

Year	Crude abortion rate (CAR) ¹	Total abortion rate (TAR) ²
1985*	137.5	3.8
1990*	116.9	3.4
1995*	77.3	2.4
2000*		1.8
2002**	45.8	
2003**	42.9	

*shows rates per 1000 women aged 15-44.

**shows rates per 1000 women aged 15-49

Periodically, questions have been raised about the validity of such official data. Of particular concern have been the possible under-reporting of early abortions done by vacuum aspiration (miniabortions or menstrual regulation) and the possible under-registration of abortions of all types performed in the commercial sector, as well as concern about a possible overall deterioration in the Russian Federation's statistical registration since the breakup of the former Soviet Union.

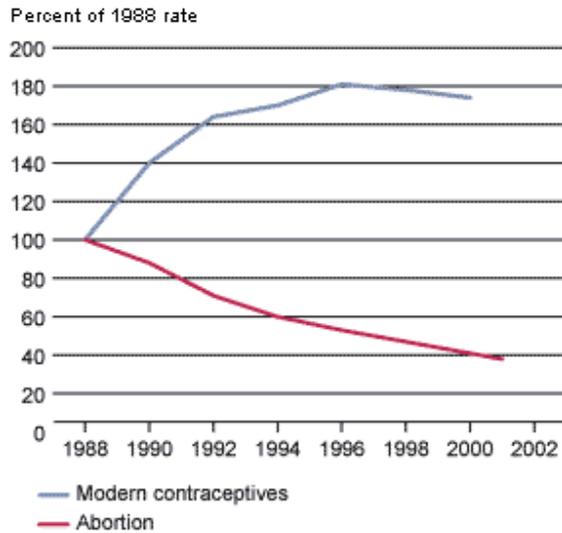
However, a recent analysis published in the *European Journal of Population* (Philipov, Andreev, Kharkova and Shkolnikov: "Induced Abortion in Russia: Recent Trends and Underreporting in Surveys," *European Journal of Population* 20: 95-117, 2004) crosschecked the official data with data from three reproductive and health surveys – including the 2000 Women and Infants' Health Project (WIN) Household Survey – and concluded that the official statistics on abortion were a true reflection of the situation they are designed to monitor and that the declining trend in abortion is a real one. It should be noted that the more recent abortion rates, while significantly lower than in previous decades, are still more than double the current rates in Western Europe, Australia, Canada and the United States.

The situation is not so clear regarding precise estimates of current contraceptive prevalence, although it does appear that modern contraceptive use has steadily increased over time. The noted demographer Charles Westoff estimates that between 1988 and 2001, modern contraceptive use increased in the Russian Federation by 74%, while the abortion rate declined by 61%.

¹ Crude abortion rate = the number of abortions per 1,000 people in a given year.

² Total abortion rate = the number of abortions per woman, if the woman was to live to the end of her child-bearing years and have abortions at each age in accordance with prevailing age-specific abortion rates.

Between 1988 and 2001, modern contraceptive use increased in Russia by 74%, while the abortion rate declined by 61%.



Source: Westoff C, unpublished data, 2003.

Generally, increases in contraceptive use over time reflect increases in the percentage of users opting for more effective, modern methods of contraception.

Although the Russian Federation has never had a full scale Demographic and Health Survey (DHS) or Reproductive Health Survey (RHS), a limited Women's Reproductive Health Survey was carried out in 1996 in Yekaterinburg City, Ivanovo City and Oblast, and Perm City, and a second Women's Reproductive Health Survey was conducted in the same sites in 1999.

The 1996 survey revealed that contraceptive prevalence was considerably higher than expected, and this was confirmed in 1999. Between 69% and 77% of couples were using some form of contraception, and roughly three of every four contraceptive users were employing a modern method, with the IUD being by far the most popular.

Despite these relatively high contraceptive prevalence rates, however, the levels of induced abortion – although considerably reduced – still remain among the highest in the world. This seeming contradiction is explained in part by the current small desired family size, which has resulted in extremely low rates of childbearing. Russia's total fertility rate (TFR)³ of 1.3 is among the lowest in the world. In addition, the number of women of reproductive age (WRA) is projected to decrease by 16% between 2000 and 2015.

The Russian surveys also showed that women almost universally hold strongly negative opinions about induced abortion and would prefer to avoid it to prevent unintended births. Very few women reported wanting to have more than two children, and some 70% of married women wanted no more children at all. From the survey findings, it is clear that substantial reductions in the reliance on abortion and improvements in maternal mortality and morbidity will depend not so much on further increases in contraceptive use (although it is noted that 23-31% of women reported using no method) as on improvements in method selection and reductions in contraceptive failure.

The effort to 1) attract new users; 2) encourage current traditional method users to consider more reliable modern methods; and 3) improve current method use to reduce contraceptive failures is hampered by Russia's narrow available method mix (the registration for injectables lapsed and the injectable form of depot medroxyprogesterone acetate has only recently been re-registered; emergency contraception appears to be used in spite of the medical care system, not because of it), by the poor quality of many commodities (spermicides, pills, IUDs), and by the lack of true access to permanent methods (lack of counseling and restrictive criteria for tubal ligations, lack of counseling and services for vasectomy).

In spite of these constraints, the Russian Federation has clearly gone a long way towards making the use of effective, safe, voluntary contraception the prevailing community norm. Further progress may depend in large part on the concept of choice being given more attention and on couples actually being offered and having access to appropriate choices.

³ Total fertility rate is the number of children who would be born per woman, if the woman was to live to the end of her child-bearing years and bear children at each age in accordance with prevailing age-specific fertility rates.

The Russian Federation in relation to other countries

The following chart shows comparative data for Russia, Europe and selected other countries.

Country	Total fertility rate (TFR)	Infant mortality rate (IMR) ⁴	Maternal mortality rate (MMR) ⁵	Contraceptive prevalence rate (CPR) ⁶ Modern Methods	CPR All Methods	% Urban	2004 per capita gross national product (GNP) (\$US)
Russian Fed	1.4	12	67	49 %	67 %	73 %	\$ 9,620
Northern Europe	1.7	5	12	76 %	82 %	82 %	\$ 30,130
Western Europe	1.6	4	12	71 %	75 %	78 %	\$ 29,410
Eastern Europe (including Russia)	1.3	11	46	42 %	64 %	68 %	\$ 7,264
Southern Europe	1.3	5	9	42 %	59 %	74 %	\$ 22,130
Canada	1.5	5	6	73 %	75 %	79 %	\$ 30,660
United States	2.0	7	17	68 %	73 %	79 %	\$ 39,710
Brazil	2.4	27	260	70 %	76 %	81 %	\$ 8,020
Costa Rica	2.0	9	43	72 %	80 %	59 %	\$ 9,530
Malaysia	3.3	10	41	30 %	55 %	62 %	\$ 9,630
Mexico	2.6	25	83	59 %	68 %	75 %	\$ 9,590

Sources: Population Reference Bureau – 2005 World Population Data Sheet and 2005 Women of our World Data Sheet

Of the more than 40 countries in all of Europe, the Russian Federation has the highest maternal mortality rate (MMR) of all, and only Moldova and Romania have higher infant mortality rates (IMR). Moldova and Romania, however, also have lower per capita gross national product rates than Russia. Albania, Belarus, Bosnia-Herzegovina, Bulgaria, Macedonia, and Ukraine have lower per capita GNPs, but also have lower IMRs. Generally there is an inverse correlation between the IMR and the GNP; as the GNP increases, the IMR decreases. As can be seen in the table, a number of countries in the world with GNPs similar to Russia's have much higher IMRs and MMRs, while others have slightly lower rates.

Women in more developed and/or more affluent countries have historically used, and continue to use, family planning to control their fertility more often than women in less

⁴ Infant mortality rate: The annual number of deaths of infants under age 1 per 1,000 live births.

⁵ Maternal mortality rate: The number of maternal deaths per 100,000 women of reproductive age (15-49).

⁶ Contraceptive prevalence rate: Percentage of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time.

developed and/or less affluent countries. Also, historically, women's educational attainment has repeatedly been found to be closely linked to the use of more effective methods of contraception. Women with some primary schooling are consistently more likely to be using contraception than women with no education, and women with more than a primary education have even higher rates of contraceptive usage.

Family planning use, especially of modern contraceptive methods, is typically higher in urban areas than in rural areas, although in some countries the differential is relatively small. These differences are partially attributable to educational differentials between urban and rural populations, partially to the higher costs of living and smaller family norms generally found in urban areas, and partially to the greater availability of family planning services and products in urban settings.

Family planning services are extremely cost-effective from a health system point of view. Preventing an unintended pregnancy is almost always less expensive than providing an abortion. And, of course, the costs of lives lost – both women and children – and the costs of disability or impairment that come from the inability to plan and space pregnancies cannot be calculated.

The substantial role that family planning plays in ensuring safe motherhood and child survival and more recently in meeting the challenges of HIV/AIDS has long been recognized but is at times undervalued. In addition to being an integral part of these health interventions, significant potential also exists for linkages between family planning and non-health interventions in the development and social sectors.

3. Basic Concepts of Family Planning

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

- explain how changes over a woman's lifespan affect her family planning needs.
- define family planning, reproductive health and sexual health.
- list at least five elements of the health care provider's role in family planning services.
- list the benefits of family planning for different populations.

Time: 55 minutes

Techniques:

- Presentation and discussion, small group work, case study

Materials:

- Slides

Activities:

1. Explain how family planning needs change over time: scenarios (15 min)

Tell participants this information while **showing** this **slide**.

Changing family planning needs:

One of the key universal findings of international surveys is that a substantial proportion of women:

- do not want more children, or
- do not want another child in the near future, or
- want to delay a first birth,
- BUT are not practicing contraception.

Tell participants:

- Women who want to prevent pregnancy but do not practice contraception are said to have an "unmet need" for contraception.
- Depending on a woman's situation this may mean the desire to limit, space or delay births.

Tell participants the main causes of "unmet need" while **showing** this **slide**:

The main causes for this unmet need are:

- lack of knowledge (or incorrect information).
- fear of side effects.
- concern about social, familial or partner's disapproval.
- lack of access to services.

Tell participants:

- To meet women's needs for family planning, we as providers need to keep the client at the center of our services.
- To help us focus on women's needs, we will now do a short exercise to put ourselves in the place of the client.

Tell participants to imagine that they are a woman seeking family planning services.

Read this description out loud:

"You are a 16-year-old high school student. You have a boyfriend and the two of you have been having unprotected sex."

Ask participants to **silently** think about these questions. **Read** them aloud:

- ***What is this woman feeling?***
- ***What are her needs?***
- ***What are her concerns?***

Then **ask** for several people to answer the questions.

Next, **read** aloud a description of a different client:

"You are a 23-year-old married woman with one young child. You eventually want to have more children, but not before finishing your university studies."

Ask participants to **silently** think about the same questions. **Ask** again for responses from several participants.

Finally, **read** aloud this description of a third client:

"You are a 35-year-old woman with a teenage daughter who doesn't want more children. You have used contraception on and off for many years, but you've had problems using some methods so you've also had more than one abortion."

Ask participants to think **silently** about the same questions. **Ask** again for responses from several participants.

Ask:

- ***How are these three women different? How are their life stages different? How are their needs different?***

Listen to responses from several participants. **Summarize** the main ideas you hear.

Tell participants this information while **showing** these **slides**:

Changing family planning needs:

- Women and couples have very different reproductive and contraceptive needs at different points in their lifecycles.
- No single method available today is likely to meet all those changing needs.
- Women need accurate information and supportive counseling at multiple life points: Whether a couple wants to delay a first birth, space a subsequent birth, or limit childbearing altogether will greatly affect the choices they make.
- Personal considerations are likely to change over time. Teenagers and 35 year-olds will use very different criteria as they evaluate their contraceptive choices.

- Health care providers need to encourage clients to rethink their contraceptive needs as life and sex and bodies change over time.
- As health care providers, we need to help clients feel comfortable with discussing their needs, and with changing a contraceptive method for whatever reason.
- Helping clients to meet their contraceptive needs and achieve their reproductive desires should be the focus of all client-centered counseling – and informed choice is fundamental to this process.

2. Define family planning and its objectives (10 min)

Ask:

- ***What is "family planning"?***

Listen to a few responses.

Show participants the definition of family planning on this **slide, pointing out** how it is similar to or different from the definitions given by participants.

Family planning:

- The basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so.

Tell participants:

- Quality health services that provide modern contraceptive methods and treat infertility help ensure this right.

Tell participants:

- The World Health Organization (WHO) has explicit definitions of reproductive health and sexual health.

Then **read aloud** these definitions while **showing** these **slides**:

Reproductive Health (RH) is defined by the World Health Organization (WHO) as a physical, mental and social state of well-being regarding all aspects of the reproductive system within all stages of human lives. RH implies:

- a satisfying and safe sexual life.
- the possibility of having children.
- the freedom of deciding when, if and how often individuals/couples want to have children.

RH includes the right of women and men:

- to be informed and to have access to safe, effective, accessible and acceptable contraceptive methods which they can choose on their own.
- to have access to adequate medical services that allow woman to go safely through pregnancy and delivery.

Sexual Health (SH) is defined by WHO as a physical, emotional, mental and social state of well-being regarding sexuality and not only the absence of illness, dysfunction or infirmity. SH implies:

- a positive approach toward sexuality and sexual relations based on mutual respect.
- the possibility of having safe and pleasant sexual experiences without coercion, discrimination or violence.

Tell participants:

- For many years, we have been told that the optimal birth spacing interval was 2 years.
- Recent research shows that 3 to 5 year intervals save more lives than intervals of 2 years or less.
- There is short article in your **Participant Manual** titled "**Birth Spacing: Research Update,**" which you might enjoy reading in the evening or at another convenient time.

Refer participants to **Session 3: Basic Concepts of Family Planning** and have them find the article.

3. Introduce the role of the health care provider in family planning services (10 min)

Ask participants to think again of the three women who were described earlier (16-year-old, 23-year-old, 35-year-old).

Ask:

- ***As a health care provider serving clients like these, what do you think is your role?***

Listen to several responses and **write** them on a **flip chart**.

Tell participants this information while **showing** these **slides, pointing out** which of these statements have already been made by participants, referring to the flip chart.

Health care providers are the key to a successful family planning program:

- They make family planning accessible to clients by providing information and counseling.
- They help a client choose an appropriate contraceptive method.
- They follow up with clients already using a contraceptive method to answer questions or help with concerns the client may have. This increases the likelihood of the client continuing to use a contraceptive method.
- They take responsibility for keeping client records updated with information on the contraceptive methods chosen, so that there is continuity between providers.

- They are the link between the client and other resources that can provide a client with a contraceptive method not available at their health facility. This is done through referral.
- They seek opportunities to provide family planning services to all clients of reproductive age who come to the health facility, by integrating family planning counseling into other health services. (antenatal care, postpartum care, well-baby services, STI/HIV services, etc.).

- They, as community leaders, are influential in promoting safe, healthy family planning practices. Health care providers can "reach out" to communities with family planning information and services by:
 - participating in community events/gatherings.
 - being a resource for information.
 - supporting the work of community workers who offer family planning counseling and information as part of their services.

- They should always seek ways to:
 - attract new users to family planning.
 - encourage traditional method users to consider more reliable modern methods.
- improve current method use to reduce contraceptive failures.

4. Conduct small group work on the benefits of family planning (5 min)

Divide the participants into 4 groups.

*Note to trainer: Mix up participants so that they do not always work with the same colleagues. See the **Introduction to the Trainer's Guide** for suggested ways to divide up participants into groups.*

Assign each group one population to consider:

Group 1: Children

Group 2: Women

Group 3: Men

Group 4: Community

Tell participants:

- You have **5 minutes** to work.
- Each group should brainstorm the benefits of family planning for its assigned population.
- Each group should list the benefits on a **flip chart**.

5. Have the groups report back (15 min)

Tell each group to **post** their **flip charts** on the wall.

Ask each group in turn to quickly present just **3 items** from their list of benefits. **Ask** groups not to repeat ideas that have already been presented.

Summarize by **referring** participants to the list of benefits in their **Participant Manuals in Session 3: Basic Concepts of Family Planning** (*shown on the next page*). **Point out** any benefits from this list that groups did not mention.

Note to trainer: You do not have to read out every item on the list since it is for participant reference.

6. Conclude the session

Tell participants:

- Now that we have established the importance of family planning, we will talk about the scientific evidence base for the family planning approaches discussed in this course.

Note to trainer: The following information is provided in the Participant Manual (Session 3) as a reference.

Benefits of Family Planning

For children, family planning results in:

- births that are planned and wanted, resulting in children who are better cared for, better fed, better educated and healthier.
- decreased infant mortality and morbidity due to premature births and "small for dates" babies.
- decreased infant mortality and morbidity when births are optimally spaced (intervals of 3 years or more).
- improvement in the quality of the family's relationships.

For women, family planning results in:

- births that are planned and wanted, resulting in children who are better cared for, better fed, better educated and healthier.
- decreased use of abortions to regulate fertility, thereby decreasing the risks of maternal morbidity and mortality due to abortion.
- decreased maternal morbidity and mortality when births are optimally spaced (intervals of 3 years or more).
- fewer problems regarding pregnancy and birth.
- decreased incidence of ectopic pregnancy, ovarian and endometrial cancer, ovarian cysts, breast nodules, heavy menstrual bleeding and secondary anemia, and dysmenorrhea, depending on the contraceptive methods used.
- prevention of sexually transmitted infections if using condoms
- improvement in the quality of the couple's and family's relationships.
- increased ability to provide for the family economically when it is at the desired size.

For men, family planning results in:

- births that are planned and wanted, resulting in children who are better cared for, better fed, better educated and healthier.
- decreased likelihood that mother and/or children will be ill or die.
- prevention of sexually transmitted infections if using condoms.
- improvement in the quality of the couple's and family's relationship.
- increased ability to provide for the family economically when it is at the desired size.

For communities, family planning results in:

- decreased infant mortality and morbidity.
- decreased child abandonment.
- decreased maternal morbidity and mortality.
- decreased reliance on abortion to control fertility.
- improved maternal and child health.
- citizens able to more fully enjoy their reproductive health rights.
- healthier families more able to achieve their personal and professional potential and contribute to their communities.
- scarce community resources (personnel, facilities, budget) being used more rationally and more productively.

4. Evidence-based Medicine

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

- define the term "evidence-based medicine."
- list the advantages and challenges of evidence-based medicine.
- state WHO's four categories of contraceptive eligibility and apply them to a specific case.

Time: 40 minutes

Techniques:

- Presentation and discussion, case study

Materials:

- *Medical Eligibility Criteria for Contraceptive Use*. Third edition (World Health Organization. Geneva: 2004), Handout "WHO Medical Eligibility Criteria for Starting Contraceptive Methods," all Cue Cards, slides.

Activities:

1. Define "evidence-based medicine" (10 min)

Tell participants:

- In this session, we will talk about ways to improve the quality of family planning services by choosing good practices.

Ask:

- ***How do you decide whether a medical practice is effective or not? What convinces you personally that a particular approach or a particular treatment is a good way to treat your clients?***

Listen to several responses.

Note to trainer: Responses might include:

- *personal clinical experience of what works well; what was taught in medical training; government regulations or prikaz; community standards of practice; guidelines from professional societies; clients' wishes and needs; the established practice in the facility; availability (or lack) of resources; reading articles in journals; searching online resources; using reference books and guidelines with reviews of modern studies.*

Tell participants:

- All of these factors have an influence on a health care provider's decisions.
- However, to give the best possible care to clients, it is also important to consider objective evidence from clinical studies and experience from health care providers worldwide.

Ask:

- ***Are you familiar with the term 'evidence-based medicine'? What does it mean?***

Listen to a few responses.

Tell participants:

- There are various definitions of "evidence-based medicine" that are currently in use.

Then **read aloud** these two definitions while **showing** these **slides, pointing out** how they are similar to or different from the definitions given by participants.

Evidence-based medicine is:

- the practice of medicine or the use of health care interventions guided by or based on supportive scientific evidence.
- also, the avoidance of those interventions shown by scientific evidence to be less efficacious or harmful.

Quality Assurance Project (QAP)

Evidence-based medicine is

- the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.

The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

The Centre for Evidence-Based Medicine

Then **tell** participants the following while **showing this slide:**

- The goal of evidence-based medicine is to improve health care quality with respect to its safety, efficacy and cost-effectiveness.
- Evidence-based practices evolve over time, as new studies and experience continuously reveal new information.

Tell participants:

- All the family planning practices presented in this training are evidence-based. This includes not only the medical recommendations for use of contraceptives, but also the recommended approach to counseling and interacting with clients.

2. Introduce the WHO *Medical Eligibility Criteria for Contraceptive Use* manual (15 min)**Tell** participants:

- To make the latest evidence and guidelines available to busy health care providers, there are resources that summarize the results of multiple studies worldwide and present the evidence in the form of easy-to-use guidelines.
- One example that we will be using extensively in this training is the Third Edition of the **WHO *Medical Eligibility Criteria for Contraceptive Use* manual**.

Ask:

- ***Has anyone heard of the WHO *Medical Eligibility Criteria for Contraceptive Use* manual? Has anyone used it before? What was your experience?***

Tell participants:

- In 1994, the World Health Organization began a process that has greatly strengthened and improved the evidence base for providing family planning counseling and services.

Tell participants the following information while **showing** these **slides**:

The WHO Process

Initially, an in-depth review of the epidemiological and clinical evidence relevant to medical eligibility criteria of well-established contraceptive methods was carried out.

- The eligibility criteria used by different agencies for various contraceptives were compared.
- Summaries of published medical and epidemiological literature relevant to medical eligibility criteria were prepared.

Secondly, a draft classification was prepared for review by a larger group of experts and agencies who made extensive comments and recommendations.

- The initial WHO Expert Working Group meetings were held in March 1994 and May 1995.
- In 1996, WHO published the first edition of its *Medical Eligibility Criteria for Contraceptive Use* manual.

Tell participants that updating and improving the **WHO Medical Eligibility Criteria for Contraceptive Use manual** has been an ongoing process that continues to this day.

Show as slides:

Successive Expert Working Groups have reviewed new evidence primarily obtained from a systematic review of the most recent scientific literature.

- The second Expert Working Group meeting in March 2000 resulted in a second edition of *Medical Eligibility Criteria for Contraceptive Use*.
- The third Expert Working Group meeting in October 2003 resulted in the third and latest edition.

Ask participants to take out their copies of the **WHO Medical Eligibility Criteria for Contraceptive Use manual**.

Point out how the book is organized:

- Each section has a separate table of contents, and the page numbering starts over for each section.
- The guide is structured to be easy for providers to use by looking up contraceptive methods and medical conditions in simple charts.
- For each contraceptive method and medical condition, the guide classifies it into one of four categories.
- The manual also includes extensive notes on the studies used to determine these recommendations for contraceptive eligibility.

Ask participants to open the **WHO Medical Eligibility Criteria for Contraceptive Use manual** to the first section titled "Medical eligibility criteria for contraceptive use" and find the page showing the "Classification of categories." (Give them the page number.)

Tell participants about the categories while **showing** this **slide**.

WHO CLASSIFICATION	Meaning
CATEGORY 1: Method may be used in any circumstances	No restriction for the use of the contraceptive method.
CATEGORY 2: Method may be generally used	The advantages of using the method generally outweigh the theoretical or proven risks.
CATEGORY 3: The use of the method is not recommended unless other more appropriate methods are not available or are not acceptable	The theoretical or proven risks usually outweigh the advantages of using the method.
CATEGORY 4: The method may not be used under any circumstances	The health risk of using the contraceptive method is considered unacceptable.

Ask participants to turn to the section titled **“Low-dose combined oral contraceptives”** in the manual and look at the **charts** (give them the page number).

Explain how the chart is organized. Tell participants:

- **Specific medical conditions** are listed in the left-hand column (e.g. age, parity, breastfeeding, postpartum, postabortion, etc.).
- **Category of risk** (numbered 1 – 4 as explained above) is given in the second column.
 - For example, look at the first condition, age. For a woman under 40 years old, the category is 1 (no restrictions). For a woman 40 years or older, the category is 2 (generally advantages outweigh risks).
- The third column gives explanatory **notes and clarifications**.
- At the end of the chart, there are pages with **additional comments** that contain much useful information.
- Lastly, each section lists all the **references** reviewed by the WHO Expert Working Groups on which their recommendations are based.

Show participants that there is a **separate chart** for each contraceptive method

For further examples, **ask** them to find the sections titled **“Intrauterine devices”** and **“Barrier methods.”**

3. Conduct a case study using the WHO *Medical Eligibility Criteria for Contraceptive Use* manual (5 min)

To help participants become comfortable using the WHO charts, **show** the following case on this **slide**:

A 30-year-old woman tells you that she smokes about 20 cigarettes per day and she wants to use low-dose combined oral contraceptives.

Ask:

- ***What is the category of eligibility for a woman in this situation? What advice would you give this client?***

Give participants a minute to individually look up the answer.

Then **ask** for a volunteer to answer the question.

Note to trainer: To find the answer, participants should look up "smoking" in the "Low-dose combined oral contraceptives" chart.

Tell participants:

- For women under age 35, the advantages of using low-dose COCs outweigh the risks regardless of smoking (Category 2).
- If the woman had been 35 or older, this amount of smoking would mean she is not eligible for low-dose COCs. (Category 4).
- We will practice using these eligibility criteria in later sessions.

4. Discuss the challenges and advantages of evidence-based medicine (5 min)

Ask:

- ***What might be the challenges of implementing evidence-based practices?***

Listen to a few responses.

Then **show** the possible responses on this **slide, pointing out** how they are similar to or different from the responses given by participants.

Challenges of implementing evidence-based practices

- Evidence may conflict with prikaz or facility policy.
- If the evidence is very different from established practice, it may be hard to convince clients and providers that it is a good idea.
- It can be difficult to access information about the latest research, especially if it was conducted in other countries and/or published in other languages.
- Some providers or facility administrators may feel threatened by new approaches.
- Needed resources may not be available.

Ask:

- ***What do you think would be the advantages of using evidence from clinical studies to help guide your decisions about client care?***

Listen to a few responses.

Then **show** the possible responses on this **slide, pointing out** how they are similar to or different from the responses given by participants.

Advantages of using evidence-based practices

- There is a solid scientific basis for developing best practices.
- Decisions can be justified by reference to a solid body of research.
- Unnecessary or harmful practices can be reduced or eliminated.
- Resources can be used more effectively and productively.
- Clients have better health outcomes.

5. Describe references for evidence-based family planning (5 min)

Tell participants:

- There are three resources to help you become more familiar with the **WHO *Medical Eligibility Criteria for Contraceptive Use* manual**.
- There is a handout entitled "**WHO Medical Eligibility Criteria for Starting Contraceptive Methods,**" which summarizes the contents of the second edition in one easy-reference table.
- There is also an article in the **Participant Manual** at the end of this session entitled "**WHO Updates Medical Eligibility Criteria for Contraceptives**" (The INFO Project, Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs, www.infoforhealth.org). It covers the major changes between the second edition and the current third edition.
- For those who have access to the internet, there is another article entitled "**Internet Resources**" that provides information on useful websites.

Refer participants to **Session 4: Evidence-based Medicine**, and have them find these **articles**.

6. Conclude the session

Tell participants:

- In the next session, we will discuss basic principles of counseling.
- Family planning counseling is an evidence-based practice that will be the main focus of this course.

Internet Resources

Available in Russian:

1. World Health Organization Medical Eligibility Criteria for Contraceptive Use, Third Edition, 2004

www.who.int/reproductive-health/publications/mec or
www.who.int/reproductive-health/family_planning/

Its sister guideline, *Selected Practice Recommendations for Contraceptive Use*, 2nd edition, is available in French and Spanish, and will soon be published in Portuguese and Russian.

This is the main reference for "Family Planning Training for Primary Health Care Providers."

2. Maternal Child Health Initiative (MCHI) website

www.jsi.ru for Russian version
www.jsi.ru/en/ for English version

The Maternal Child Health Initiative launched a website in early 2006 that includes information about the entire range of MCHI activities and events. It also includes materials and publications used by MCHI.

3. Family Health International (FHI) website

www.fhi.org

Family Health International (FHI) maintains a website with information in a range of technical areas including clinical and other research, in HIV/AIDS, sexually transmitted infections and other infectious diseases, contraceptive technology, and women's health, much of which is available in Russian.

Accessible only in English at this time but excellent and useful websites:**1. Implementing Best Practices Initiative (IBP)**

www.ibpinitiative.org

Initiated by the World Health Organization and USAID and supported by an increasing number of international and local reproductive health agencies, the goal of the IBP Initiative is to improve access and quality of reproductive healthcare through a systematic approach focused on developing and supporting strategies that introduce, adapt and apply evidence based practices in reproductive health.

2. Reproductive Health (RH) Gateway

www.rhgateway.org

Managed by the **Information and Knowledge for Optimal Health (INFO) Project at the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (JHU/CCP)**, the Reproductive Health Gateway provides quick access to relevant, accurate information about reproductive health on the World Wide Web. RH Gateway lets you search a group of websites carefully selected for accuracy, authority, and relevance - much quicker, easier, and more trustworthy than either a Web-wide search, which can yield many irrelevant or unreliable sites, or a time-consuming site-by-site search

3. Family Planning and HIV/AIDS Integration

www.fpandhiv.org

To access:

Enter the user name as: fpandhiv

Enter the password as: infoinfoinfo

Also managed by the **Information and Knowledge for Optimal Health (INFO) Project at the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (JHU/CCP)**, for the HIV/AIDS Integration Partners Working Group, the Family Planning and HIV/AIDS Integration site includes information on and links to over 300 journal articles, PowerPoint presentations, and other materials about family planning and HIV/AIDS integration - all selected as relevant to integration by a subject matter expert.

4. "The Pop Reporter": Customized Edition

Sign up for this free service at <http://prds.infoforhealth.org/signup.php>

Yet another INFO Project service, "The Pop Reporter" is the INFO Project's weekly, free e-zine for the world's reproductive health care professionals and is now available in a customized edition. This state-of-the-art feature allows subscribers to customize their subscriptions, tailoring issues to topics, delivery preferences, and regions of the world.

Subscribers may choose from among 17 categories of the most important concerns of the world's reproductive health community today:

- Family Planning/Reproductive Health Research and News
- Family Planning/Reproductive Health Law and Policy
- HIV/AIDS Research and News
- Maternal and Child Health Research and News
- Men's Health Research and News
- Population Research and News
- Women's Health Research and News
- Youth Health Research and News

Issues may be delivered in one of the following four formats:

- .pdf file attachment
- .html file attachment
- plain text e-mail
- e-mail notification with a web link to your customized issue

In a recent survey, Pop Reporter subscribers said "The Pop Reporter" was a most important electronic information source for:

- remaining informed.
- learning news of important new developments.
- Keeping abreast of current research.

Also only available in English at this point but useful tools and updates:

1. IUD Checklist Enables Providers to Help Clients Make Informed Contraceptive Choices

<http://www.fhi.org/en/RH/Pubs/servdelivery/checklists/iud/index.htm> (PDF format, Adobe Reader required)

Research findings over the past 20 years have established that many women - including women who have not given birth and those who want to space births - can safely use the intrauterine device (IUD). Most recently, the World Health Organization (WHO) removed many restrictions against IUD use by women living with HIV infection and women at risk of HIV or other STIs.

Many healthcare providers, however, are unaware of changes in IUD eligibility and continue to recommend this highly effective, reversible form of contraception to only a small percentage of eligible women. Family Health International (FHI), with support from the U.S. Agency for International Development, has developed a simple checklist to help providers determine quickly and with confidence whether a client may use an IUD. Based on WHO's Medical Eligibility Criteria for Contraceptive Use, the checklist consists of a series of questions designed to identify any medical conditions or behaviors that would either prevent safe IUD use or require further screening.

2. WHO statement on carcinogenicity of combined hormonal contraceptives and combined menopausal treatment.

http://www.who.int/reproductive-health/family_planning/cocs_hrt.html

In June 2005, the International Agency for Research on Cancer (IARC) convened a meeting of experts to review the scientific evidence on the carcinogenic risks to humans posed by combined estrogen-progestogen oral contraceptives (COCs) and combined estrogen-progestogen hormonal menopausal therapy. The outcome of this meeting will be an IARC Monograph, to be published in 2006.

This Statement, produced by the Department of Reproductive Health and Research, contextualizes the IARC statement in terms of the overall risks and benefits of contraceptive use and hormonal menopausal therapy. The statement reaffirms WHO's position on the safety of contraceptive use, namely that for most women using COCs, the health benefits clearly exceed the health risks.

3. WHO Guide to Essential Practice on STIs and RTIs

http://www.who.int/reproductive-health/publications/rtis_gep/index.htm

This publication by the World Health Organization's Department of Reproductive Health and Research (RHR) is intended to assist health care managers and practitioners in resource-limited reproductive health care settings around the world to meet the needs of individuals who may be at risk of reproductive tract infections (RTIs). It is assumed that readers are familiar with certain clinical knowledge, such as drugs and their dosages, although they may not have experience with management of sexually transmitted infections (STIs) and RTIs.

The publication reflects the involvement of a large number of international experts who reviewed and debated aspects of the document to ensure that recommendations are based on the best available evidence as well as on what are considered favorable public health outcomes. Additionally, in order to validate the usefulness of the recommendations for reproductive health care settings around the world, the manual was thoroughly reviewed by practitioners and program managers in a number of countries, prior to publication. Finally, this Guide has been pre-field tested in five countries: Brazil, China, Kenya, Jamaica and Latvia.

There are two companion documents to this Guide:

Sexually transmitted and other reproductive tract infections: a pocket guide for essential practice: This publication contains a summary of essential information for ease of reference to management flowcharts, treatment tables, counseling points, and other information in a convenient-to-carry format. The pocket guide can serve as a working tool for use by providers in their everyday interactions with their clients.

Guidelines for the management of sexually transmitted infections: This publication presents the revised recommendations, both for a syndromic approach to the management of patients with STI symptoms and for the treatment of specific STIs, based on evidence and epidemiological surveillance data from around the world. It also provides information on the notification and management of sexual partners and on STIs in children and adolescents.

5. Principles of Counseling

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

- state the advantages of good family planning counseling.
- list the characteristics of good communication.
- demonstrate the communication skill of asking open-ended questions.
- list six basic principles of counseling.

Time: 1 hour 15 minutes

Techniques:

- Demonstration role play, game, presentation and discussion

Materials:

- Closed-question game cards, slides

Preparation:

- Plan and rehearse the demonstration role play.
- Make closed-question game cards (*provided at the end of this session*).

Activities:

1. Discuss the importance of counseling (5 min)

Tell participants:

- One clear evidence-based finding is that good counseling is a critical element of successful family planning services.
- In this session, we will discuss definitions and steps for good communication and counseling. These skills lay the groundwork for later sessions in which we will practice family planning counseling.

Ask:

- ***What are the advantages of giving good counseling to family planning clients?***

Listen to several responses.

Then **summarize** their answers.

Tell participants this information, while **showing** these **slides, pointing out** any ideas that were not mentioned by participants.

Advantages of Counseling

- Through counseling, providers help clients make and carry out their own decisions about family planning.
- Good counseling makes clients feel more satisfied.
- Good counseling helps clients use family planning longer and more successfully.
- More consistent and correct use of a chosen method results in fewer unintended pregnancies.

- Clients will develop a more critical attitude toward the rumors and other information they hear about family planning.
- Good counseling does not have to take a lot of time, especially if the information is tailored to the client's needs.
- Good counseling requires training and an attitude of caring and respect for clients.

2. Conduct demonstration role play on "poor communication" (5 min)**Tell** participants:

- The trainers will now conduct a role play of a situation in which a woman comes to a health care provider for a family planning consultation.
- Watch carefully for how the provider and the woman communicate. Focus on communication, not on the specific medical details.

Trainers **perform** a short (5 min) **role play** demonstrating **poor communication skills** in a family planning counseling situation.

Note to trainer: The trainers should practice this role play and the next one in advance to make sure they convey the right ideas.

Trainer guidelines for "poor communication" role play:

Situation: A 25-year-old single woman wants to change from using traditional methods to a more modern, reliable form of contraception.

Points to demonstrate: The provider exhibits poor communication skills by:

- i. asking mostly closed questions and making assumptions about the woman's needs.*
- ii. telling the woman what method to use, and not explaining it fully.*
- iii. interrupting the woman when she is talking, not really listening to what she says, misunderstanding her.*
- iv. using negative body language: The provider does not meet the client's eyes; crosses the arms in front of the body and holds self stiffly; often turns away from the client while she is talking to look at files or do something else.*

3. Discuss demonstration role play on "poor communication" (5 min)

Ask:

- ***What did you think about this counseling scene?***
- ***How would you feel if you were this client?***
- ***What could be improved in the communication in this scene? Be specific.***

Listen to responses from many participants.

If participants do not mention provider's body language, tone of voice, and the type of questions she/he asked, **ask** them about these aspects of the role play.

4. Conduct demonstration role play on "good communication" (5 min)

Then trainers **perform a role play** on the same situation, but this time demonstrating **good communication skills**.

Note to trainer: This role play does not need to go through a full counseling session with all the steps of "GATHER." The purpose is to demonstrate good communication with a client.

Trainer guidelines for "good communication" role play:

Situation: The same as above.

Points to demonstrate: The provider exhibits good communication skills by:

- v. introducing him/herself*
- vi. asking open-ended and probing questions.*
- vii. checking understanding by asking follow-up questions.*
- viii. nodding and encouraging the woman when she speaks.*
- ix. letting the woman choose the method, not telling her what to use.*
- x. using positive body language: The provider maintains eye contact; sits down with the woman and gives her full attention; leans toward her and faces her; appears at ease.*

5. Discuss demonstration role play on "good communication" (10 min)

Ask:

- ***What was different this time?***
- ***How do you think the client felt?***
- ***What were the characteristics of the communication you saw demonstrated here?***
- ***In your experience counseling clients, what makes communication work well?***

Listen to responses from many participants.

Then **summarize** the responses.

Then **show** the possible responses on these **slides, pointing out** how they are similar to or different from the responses given by participants.

Tips for good communication

- Use a mix of closed, open-ended and probing questions as appropriate.
- Ask follow-up questions and rephrase what the client says to make sure you have understood.
- Use language and terminology that is familiar to the client.

- Use a friendly, welcoming tone of voice.
- Maintain eye contact.
- Face the client and lean toward her.

Tell participants:

- We will discuss closed, open-ended and probing questions later in this session.
- Nonverbal communication and body language is very important. Nonverbal actions on the part of the client as well as the provider often give stronger messages than words. The provider should be aware of his/her nonverbal communication, and be watchful for the same in clients.
- Using good questioning techniques, being an active listener, and observing nonverbal behavior are essential to effective counseling.

6. Introduce Client-Provider Interaction Checklist (5 min)

Tell participants to turn to the **Client-Provider Interaction Checklist** in their **Participant Manuals** in **Session 5: Principles of Counseling**.

Note to trainer: The Checklist is also provided at the end of this session.

Tell participants:

- This checklist is a tool to help providers improve their communication and counseling skills, not just in family planning but in any interaction with clients.
- The checklist covers many of the same communication tips that we discussed in this session.
- You can use this checklist during the training in role plays.
- You can also use it back at your health facilities to:
 - check your own performance.
 - observe and give feedback to peers.
 - conduct supervision.

7. Practice communication skills: Open-ended questions (10 min)**Tell** participants:

- We will now practice a communication skill that you can use with clients in a counseling session: asking open-ended questions.
- The way questions are asked determines not only the amount of information elicited, but also the quality of the relationship the provider develops with the client.
- Conveying sincere interest and a desire to help the client starts the relationship off on a solid footing.

Show the following two questions on this **slide**:

1. "Do you know how to use condoms?"
2. "What has been your experience with using condoms?"

Ask:

- *Which of these questions will be more helpful in a counseling situation? Why?*

Listen to a few responses.

Tell participants:

- In most cases, the second question is more effective.
 - The first question will lead to a yes or no answer, and you will not learn anything more about the client's experience, skill with condom use, or attitudes unless you ask further questions. This is sometimes called a "closed" question.
 - The second question allows the client to discuss concerns, past experiences, and questions about condoms. This is called an "open-ended" question.

Tell participants this information while **showing** this **slide**:

- **Closed questions** generally result in only brief answers ("yes," "no," a number, name, date, contraceptive method, etc.)
- **Open-ended questions** result in longer answers and usually provide more information than closed questions.

Ask:

- *When could a provider use closed questions?*

Listen to a few responses.

Tell participants:

- A provider might use closed questions to find out more information, especially as a follow-up question or to quickly find out basic facts about the situation.
- For example, "Are you currently using a contraceptive method?"; "What contraceptive method are you currently using?"

Ask:

- *When might a provider use open-ended questions?*

Listen to a few responses.

Tell participants:

- A provider might use open questions to find out more about a client's experiences, attitudes and practices.
 - Examples: "How well does your current method work for you?"; "What have been the challenges using that method?"
- The provider can ask an open-ended question as a follow-up, to encourage the client to offer more information.
 - Examples: "What do you mean by that?"; "Can you tell me more about that?"; "How did you feel about that?"

8. Practice open-ended questions: Game (10 min)

Tell participants:

- We will now play a short game to practice asking open-ended questions.

Distribute 5 to 10 cards with closed questions written on them to different participants.

Note to trainer: Cards are provided at the end of this session.

Ask one of the participants with a card to **read** out the question.

Then **ask** for a different participant to **re-word** the question so that it is open-ended.

Repeat until all the cards have been discussed.

Note to trainer: Below are sample answers.

Closed question cards:

Possible answers: *Participants should re-state the question on this card something like this:*

<p>Do you know what birth control pills are?</p>	<p><i>"What do you know about birth control pills?"</i></p>
<p>Does your husband like the contraceptive method you are using?</p>	<p><i>"What is your husband's attitude toward your contraceptive method?"</i></p>
<p>Did you choose the IUD because you wanted a secure method?</p>	<p><i>"Why did you choose the IUD?"</i></p>
<p>Is this method easy to use for you?</p>	<p><i>"What has it been like to use this method? What were the difficulties of using this method?"</i></p>
<p>You want to continue with low-dose pills, right?</p>	<p><i>"How are low-dose pills working out for you?"</i></p>

Tell participants:

- Closed, open-ended and probing questions all have their place in a counseling session, and a good counselor will use a mix of them.

9. Demonstrate "rephrasing" (10 min)

Tell participants:

- Another useful communication skill is **rephrasing**.
- When rephrasing, the counselor listens to the client, then restates what the client has said to check that the counselor has understood her correctly.

Demonstrate rephrasing with a volunteer participant.

Ask for a volunteer to **role play** briefly with you.

Tell participants:

- The volunteer will play the role of a woman who is worried that her partner will refuse to use condoms.
- I will play the role of the counselor and demonstrate the rephrasing technique.

Conduct the short **role play**.

Note to trainer: Listen to what the "client" says. Then restate the client's concerns in your own words, and ask her if you have understood her correctly. For example, the conversation might go like this:

Client: "I'm worried that my boyfriend is cheating on me. I want to use protection, and I don't want to get pregnant right now."

Counselor: "So, you are looking for a method to protect yourself from pregnancy and STIs/HIV, is that correct?"

Client: "Yes, I'm worried about getting a disease, and we definitely don't want a child right now, but I just don't think he will agree to use condoms."

Counselor: "If I hear you correctly, you think your boyfriend may not be willing to use a condom? I can help you think about ways to discuss it with him."

Stop the role play after rephrasing one or two statements. **Thank** the volunteer.

Tell participants:

- Although rephrasing can feel awkward at first, and it takes more time, it has the advantages of:
 - helping the provider to concentrate on what the client is saying.
 - letting the provider check whether or not he/she has understood the client correctly.
 - showing the client that she has been heard and understood.

10. Discuss principles of good counseling (10 min)

Show participants this **slide**:

Principles of good counseling:

- 1) Treat each client well.
- 2) Interact.
- 3) Tailor information to the client.
- 4) Avoid too much information.
- 5) Respect the client's right to choose.
- 6) Help the client understand and remember.

Explain the **slide** as follows:

- (1) **TREAT EACH CLIENT WELL.** The provider is polite, shows respect, and creates a feeling of trust. The provider shows the client that she or he can speak openly. The provider assures the client that their discussion will be confidential.
- (2) **INTERACT.** The provider actively listens, learns about the client, and responds to the client. The provider can help best by understanding the client's needs, concerns and situation. The provider encourages clients to talk and ask questions. The provider answers questions patiently and fully.
- (3) **TAILOR INFORMATION TO THE CLIENT.** Listening to the client, the provider learns what information each client needs. Also the stage of a person's life suggests what information may be most important. The provider gives information accurately and in language the client understands.
- (4) **AVOID TOO MUCH INFORMATION.** Clients need information to make informed choices. But no client can use all the information we have about every contraceptive method. Too much information makes it hard to remember the most important information. This is called "information overload."

(5) **RESPECT THE CLIENT'S RIGHT TO CHOOSE.** Clients are more likely to continue using the method if they choose it. Also respect the client's informed choice if she decides not to use a contraceptive method after understanding the benefits of planning pregnancies.

(6) **HELP THE CLIENT UNDERSTAND AND REMEMBER.** From time to time during counseling, the provider checks that the client understands what has been explained or discussed. When written materials are available, provide them to remind the client.

Tell participants:

- These principles apply to any counseling session, not just family planning.

Ask if there are any questions about these principles of good counseling.

11. Conclude the session

Tell participants:

- In the next session, we will focus on how to apply these generic counseling techniques specifically for family planning.

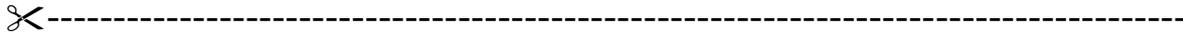
Note to trainer: The following resource is provided in the Participant Manual (Session 5).

Client-Provider Interaction Checklist

This checklist can assist providers to assess how well they are meeting the needs of clients at the health facility. Providers can use this tool for self-assessment or peer assessment. Using this checklist frequently will help the provider to become more aware of areas that need improvement, and will also increase a sense of accomplishment and satisfaction when noting areas of strength and improvement. In order to rate highly in some areas, the provider will need to motivate other staff at the facility to become involved in improving situations that affect how well clients' needs are being met. Feedback from clients and the community will also help providers know how well they are doing.

CATEGORIES	ASSESSMENT INDICATORS	ASSESSMENT RATINGS		
		NEVER	SOME-TIMES	ALWAYS
CREATING A WELCOMING ENVIRONMENT	Makes client areas pleasant and inviting			
	Checks client areas for cleanliness			
	Seats clients as comfortably as possible			
	Assists clients to locate areas in the clinic easily			
	Greets clients warmly; makes them feel welcome			
	Introduces self to clients			
	Addresses clients respectfully			
	Acts approachable by smiling and using "relaxed" body language			
REDUCING AND IMPROVING WAITING TIME	Tries to find ways to improve the smooth flow of clients			
	Makes sure there are information, education and communication (IEC) materials available in the waiting areas (example: posters, pamphlets)			
	Explains unusual delays to clients			
	In busy situations, tells clients expected waiting time			
	Arrives before clients			
COUNSELING AND COMMUNICATION SKILLS	Informs/ assures clients of confidentiality			
	Provides privacy for counseling, exams and treatments			
	Asks client why he/she has come and how he/she can be helped			
	Encourages the client to talk by using open ended questions			
	Does not monopolize communications with the client			
	Encourages the client to ask questions			
	Reflects client's feelings			
	Listens attentively; gives client his/her full attention			
Uses eye contact while listening				

COUNSELING AND COMMUNICATION SKILLS	Indicates attention by nodding and other nonverbal behavior			
	Paraphrases and re-states what the client has said, to be sure he/she (provider) understood			
	Uses language and words that the client can understand			
	Provides information the client needs to make a decision			
	Uses visual aids (cue cards, models, flip charts) in giving information			
	Asks the client to repeat an important point of information or return a demonstration in order to be sure the client understood			
	Helps the client to make the decision			
	Accepts the client's decision even if it is different from what the provider would prefer			
	Praises the client for positive behavior (even small steps)			
	Observes the client's nonverbal behavior			
	Informs clients on how to prevent STIs and HIV, including voluntary counseling and testing			
	Notes other needs the client may have (other than the main purpose of the visit) and takes the opportunity to assist him/her to meet those needs as well.			
	Assists the client to obtain services elsewhere, if not available at this health facility			
	Gives instructions on how to use a contraceptive method or other treatments, as well as how to manage possible problems associated with them.			
	Encourages client to return to the facility if he/she has concerns			
	Gives a date to return to the clinic if appropriate			
	Gives IEC pamphlets or other written materials to the client to take home.			
	Encourages client to share IEC materials with others			
OBTAINING CLIENT FEEDBACK	Seeks feedback from the client to make sure he/she felt his/her needs were met during the visit			
	Encourages client to use the suggestion box so that the health facility can continue to improve			
	Shares feedback received from clients at staff meetings			
WORKING WITH OTHER STAFF	Works with other staff to try and take actions to respond to clients' suggestions and concerns			
	Is a role model of good client-provider interactions			
	Praises other staff members who model good client-provider interactions or are making a special effort in their interactions with clients (checklist areas)			



Closed question cards

Note to trainer: Copy this page and cut it up into cards, with one question per card. You can make up more cards with closed questions if desired.

Do you know what birth control pills are?
Does your husband like the contraceptive method you are using?
Did you choose the IUD because you wanted a secure method?
Is this method easy to use for you?
You want to continue with low-dose pills, right?

6. Informed Choice: The GATHER Method of Counseling

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

- list and explain the steps in the GATHER model of counseling as it relates to family planning.
- list the key information that a health provider should give a client about contraceptive methods.

Time: 1 hour 20 minutes

Techniques:

- Presentation and discussion, case study

Materials:

- GATHER, POP and Low-dose COC Cue Cards, Illustrated Flip Book: "Contraception: How to Prevent an Unwanted Pregnancy" (EngenderHealth and the Scientific Center of Obstetrics, Gynecology and Perinatology of the Russian Academy of Medical Sciences, 2003), flip chart with GATHER steps written on it, slides

Preparation:

- Write the six steps in the GATHER method on a flip chart and post it on the wall where everyone can see it for the rest of the training.

Activities:

1. Introduce the GATHER method (5 min)

Ask:

- ***Have you heard of the GATHER method of counseling? What does it mean?***

Listen to a few responses.

Then **tell** participants:

- GATHER is one of the most widely used approaches to counseling.
- Each of the letters in GATHER helps to remind the service provider of a key step in the counseling process.

Tell participants the steps in the GATHER method while **showing** this **slide**:

GATHER method for family planning counseling:

- G – Greet the client.
- A – Ask the client about herself.
- T – Tell the client about choices.
- H – Help the client make an informed choice.
- E – Explain how to use the chosen method.
- R – Return visits should be welcomed.

Tell participants:

- Additionally, you also have a **GATHER Method for Counseling Cue Card** that lists each step in detail. It is an easy-to-use reference when working with clients so you can check to see if you've covered everything you wanted to cover.

Ask participants to find the **GATHER Cue Card** and **hold it up**.

Ask a volunteer to state the six steps in the GATHER method.

Tell participants:

- You will be learning the GATHER method for counseling clients about family planning.
- The GATHER method is an approach that can be used in any counseling situation.
- The steps are always the same, regardless of which contraceptive methods are discussed.

2. Introduce the "Greet the client" step (5 min)

Tell participants about the first step in GATHER while **showing** this **slide**:

Greet the client:

- Welcome the client.
- Introduce yourself to the client.
- Make her feel comfortable.
- Use the client's name.
- Be respectful.
- Find a private place to talk, if possible.

Ask:

- ***What are some ways you can make the client "feel comfortable"?***

Listen to a few responses.

State any of the following responses that were not mentioned:

- Find a place to sit with the client.
- Give her your full attention.
- Be patient.
- Be friendly.
- Smile.

Ask:

- ***Why is it important to "find a private place to talk" when counseling the client?***

Listen to a few responses.

State any of the following ideas if they were not mentioned:

- Clients are more comfortable talking in privacy, especially about very personal issues like family planning.
- The client feels that the information will be confidential.
- There are fewer distractions for both the client and provider.

3. Introduce the "Ask the client" step (5 min)

Tell participants about the second step in GATHER while **showing** this **slide**:

Ask the client:

- Ask how you can be of help.
- Encourage the client to talk about her family planning wishes and/or concerns.
- Ask the client whether or not she is currently using a contraceptive method. Is she happy with this method? If not, why not.
- If the client is new to family planning or wishes to switch methods, ask if she has a particular contraceptive method in mind.

Ask:

- ***What is the purpose of the "Ask" step?***

Listen to a few responses.

Then **say** that the purpose of this step is to:

- Learn what the client's wishes or concerns are about family planning.
- Learn whether she is currently using or has ever used a contraceptive method.
- Learn whether she is or was happy with that method; if not, why she was not happy with it.
- Learn whether the client has a contraceptive method in mind that she would like to use (Remember that most clients already have a method in mind).
- Learn how you can help the client (to choose a new contraceptive method or resolve concerns about her current or former method).

4. Introduce the "Tell the client about choices" step (5 min)

Tell participants about the third step in GATHER while **showing** this **slide**:

Tell the client about choices

- Focus on the method the client has in mind.
- If the client does not have a method in mind, briefly mention the available methods.
- Provide pamphlet(s) on contraceptive method(s) if available.
- Be respectful of the client's choice, including a decision not to use a method at this time.

Tell participants:

- During the counseling session, you can ask: "Have you decided on a contraceptive method that you would like to use?"

Ask:

- ***If the client does have a particular contraceptive method in mind that she is thinking of using, should you try to provide it to her? Why or why not?***

Listen to several responses.

Then **tell** participants:

- As long as the woman is medically eligible, you should try to provide her with the chosen method.
- This is because a client who is provided with the method she had in mind is much more likely to be happy with it and to continue using it.
- If the client does not know what method she prefers, you should briefly mention the various contraceptive methods using the illustrated Flip Book "**Contraception: How to Prevent an Unwanted Pregnancy**" and provide information about the methods she seems most interested in.
- When pamphlets or brochures about contraceptive methods are available, give them to the client.

5. Introduce the "Help the client make an informed choice" step (25 min)

Tell participants to look at the **GATHER Cue Card**.

Ask a volunteer to read the next step on the **Cue Card**, "HELP."

Tell participants the fourth step in GATHER while **showing** this **slide**:

Help the client make an informed choice:

- Consider medical eligibility for the method the client has expressed interest in.
- If the client is not eligible for her preferred method, briefly explain why and introduce other suitable methods.
- Encourage the client to express opinions and ask questions.
- In the end, make sure the client has made a clear and informed decision.

Ask:

- ***How can you determine whether a client is medically eligible for a particular contraceptive method?***

Listen to a few responses.

Then **tell** participants this information while **showing** these **slides**:

How to determine medical eligibility:

- The WHO *Medical Eligibility Criteria* manual contains information on medical eligibility for individual methods in considerable detail.
- The method-specific Cue Cards contain the most common contraindications listed in the WHO *Medical Eligibility Criteria* manual.

- In addition, you should ask the client if she has a history of any of the medical contraindications listed for the specific method she has chosen.
- Please note that tests or exams are not normally needed to determine eligibility.

Show the following case on a **slide** and read it aloud.

What do you think?

Client is 38 yr. old and smokes at least a pack of cigarettes daily. She wants to use low-dose COCs. Is she eligible?

Tell participants to look individually at the **Low-dose Combined Oral Contraceptives Cue Card** to find out if the client is eligible.

Ask for a volunteer to answer the question.

Then **tell** participants the correct answer:

- No, this client is NOT eligible for low-dose COCs since she is over 35 and smokes heavily.

Ask:

- ***Since this woman cannot have her first choice of method, what should we tell this client now?***

Listen to a few responses.

Then **tell** participants:

- You should explain to the client that since she smokes and is 38 years old, it is risky for her to take low-dose COC pills which contain estrogen.
- Next, you should offer her other methods and explain those methods briefly.

Ask:

- ***What other methods is she eligible for?***

Listen to a few responses.

Then **tell** participants:

- From what we know of her medical history, she is eligible for all other methods, as smoking is only a contraindication for low-dose COCs.
- Depending on the method she next selects, you may need to ask more screening questions about her medical history.
- Since the client had first expressed interest in taking pills, **progestin-only pills** could be a good suggestion for an alternative method.

Ask a participant to briefly explain POPs as if speaking to a client, using the **POP Cue Card** and/or the **Flip Book "Contraception: How to Prevent an Unwanted Pregnancy."**

Note to trainer: The participant's brief explanation should be something like this.

"There is another kind of contraceptive pill you can take that is safe for you. Pills that contain a natural hormone called progestin but no estrogen are also taken every day. You could have some irregular bleeding in the early months, and often the menses stops after a woman has been using this method for a while. This is normal, and many women find this to be an advantage. Progestin-only pills are a very effective method for preventing unintended pregnancies."

Tell participants:

- When explaining the choice of methods to a client:
 - You should be brief: If you go into great detail on each method, the client may be overloaded with information and possibly more confused. A brief explanation also is less time consuming for you. After a method is selected, you can give the woman more detailed information about that method.
 - You should use everyday language rather than medical terminology that the client may not understand.
 - If pamphlets on different methods are available, this is a very good way to send the client home with information that she can consider as her own time schedule permits and which she can discuss with her partner, if she wishes.

Tell participants to read the last bullet under "Help the client make an informed choice" on the **GATHER Cue Card: "In the end, make sure the client has made a clear and informed decision."**

Ask:

- ***How can you make sure the client has made an informed choice?***

Listen to several responses.

Then **tell** participants this information while **showing** these **slides, pointing out** how they compare to what participants have already said.

Informed choice means that:

- The client has been given the appropriate clear and accurate information she needs to make a choice, without information overload.
- The client has a selection of available contraceptive methods she can choose from to meet her own needs and situation.

- The client has had an opportunity to ask questions.
- The client makes her own decision.
- If the chosen method is not available at your health facility, you should refer the client to a known facility where the chosen method is available (e.g. IUD, sterilization).

Ask:

- ***What are some of the things a woman can and should consider when she selects a method?***

Encourage all participants to answer. As participants give answers, **write** them on a **flip chart**.

When no more answers are given, **show** the following list on **slides**, pointing out any that were not mentioned by participants:

Factors influencing the choice of a method:

Client's personal reproductive intentions:

- Delay first pregnancy?
- Space subsequent pregnancy?
- Prevent any future pregnancy?

Client's personal sexual behavior:

- Frequency
- Number of partners
- Risk of exposure to STIs/HIV

Characteristics of the methods being considered:

- Effectiveness as typically used
- Safety
- Side effects
- Convenience and ease of use

- Protection provided against STIs/HIV
- Relationship to act of sexual intercourse
- Duration of action (e.g. condoms: one act of intercourse; copper IUD: 10 years)
- Time required for fertility to return

- What user has to do to acquire and successfully use method (take a pill daily; go to trained provider; insert before sex, etc.).
- Non-contraceptive benefits.
- Confidentiality (Is it easy to hide from others? Will the partner know it is being used?).

Characteristics of the services available:

- Availability of quality supplies.
- Availability of trained providers.
- Cost and cost-effectiveness (initial cost, on-going costs).

Tell participants:

- All of these factors are valid for the woman to consider.
- As health care providers, it is very helpful to your clients if you do your best to keep up to date about the availability and accessibility of contraceptive methods in geographic areas.

Tell participants this information while **showing** this **slide**:

Information to know about method availability and accessibility:

- Where to get supplies locally.
- Whether they are reliably available.
- Relative costs of different types/brands.
- Where and how to get services not available at your facility.
- Availability of free supplies, if any (for low-income or HIV-positive clients, for adolescents, for specific high-risk groups, etc.).

6. Introduce the "Explain how to use the chosen method" step (20 min)

Tell participants:

- We will now talk about the next GATHER step: "**Explain how to use the chosen method.**"
- At this point in the counseling session, you should focus on the method or methods the client is most interested in learning about.
- To the greatest extent possible, you always need to respect the client's choice.
- If the client decides not to select a method at this time, she should be encouraged to return if she has further questions or wants a contraceptive method in the future.

Ask:

- ***What information should we tell clients about the chosen method?***

Listen to several responses.

Tell participants about the fifth step in GATHER while **showing** these **slides, pointing out** the items the participants have already named.

Explain how to use the chosen method:

- Explain the effectiveness of the method.
- Explain the advantages and disadvantages of the method.
- Inform and reassure about common (non-serious) side effects.
- Inform about possible complications (if any).
- Explain how to use the method.

- Inform whether the method provides protection against STIs/HIV.
- Make sure the client understands. Give the client the opportunity to ask questions.
- Explain when to return.

Tell participants this information while **showing** these **slides:**

- Remember that disadvantages for some are advantages for others.
- Clients who learn about side effects ahead of time tend to be more satisfied with their method and use it longer.

- Clients need to know which side effects may be bothersome but are not signs of danger or a serious condition.
- Clients need to know what symptoms if any are reasons to return to the clinic. Clients need to understand that these complications are rare.
- Clients need to understand the difference between common side effects and serious warning signs of complications, and what to do if they occur.

Tell participants this information while **showing** these **slides**:

When explaining how to use the method:

- Explain in a clear, practical way how to use the method.
- Instructions should cover what clients should do if they have problems with the method.
- If a procedure is required (IUD insertion, Deo-Provera injection, tubal ligation, etc.), explain what will happen during the procedure.

- Clients need to be informed whether their method will help protect them from STI/HIV.
- Clients at higher risk for exposure to STI/HIV should know to use condoms, even if they are using another contraceptive method.
- You can ask the woman to repeat the main instructions, or ask her open-ended questions, to check if she has understood. Don't just ask, "Do you understand?"

7. Introduce the "Return visits should be welcomed" step (5 min)

Tell participants about the sixth and final step in GATHER while **showing** this **slide**:

Return visits should be welcomed.

- Discuss when the client will return.
- Encourage the client to return if having problems or concerns .
- Return for more supplies.
- Encourage her to return if she wishes to change her contraceptive method.

Tell participants:

- There are many good reasons to return to the clinic.
- Some methods require return visits for more supplies or a procedure. If appropriate, clients should be told where they can get supplies.
- Clients having an IUD inserted or having a sterilization procedure usually require only one return visit.
- Clients should not be asked to make unnecessary visits.
- The provider should encourage the client to return any time she has concerns, has symptoms of a possible complication, needs information or advice, or wants to change to another method.
- Make it clear that changing methods is normal and welcome.

Ask the group to look at the **Low-dose COC Cue Card**.

Ask:

- ***Does this Cue Card provide all the information we have just discussed that you would explain to a client?***

Listen to a few responses.

Tell participants:

- The Cue Cards are designed for quick reference to help providers follow the GATHER steps. All the main information should be there.
- The GATHER method is a simple guideline to help structure a counseling session.
- It reminds providers that the counseling session should be led by the client's choices as much as possible.
- We will practice using the GATHER method in role plays each day.

8. Introduce client rights (10 min)**Tell** participants:

- The GATHER approach is intended to help health care providers protect and ensure the rights of their clients to good family planning services.

Ask:

- ***What do you think are the rights of a family planning client?***

Listen to several responses.

Then **show** the following **slide, pointing out** rights on the list that were already mentioned by participants.

Client rights regarding the delivery of family planning services:

Clients have a right to:

- information
- access
- choice
- safety
- privacy
- confidentiality
- dignity
- comfort
- continuity
- opinion

Tell participants:

- Every client, regardless of gender, age, race, ethnic community, religion, social, material, professional, or economic status, sexual identity and orientation, etc. has these rights.

Ask:

- ***How does the GATHER approach to counseling help us as providers to respect these client rights?***

Listen to a few responses.

Tell participants this information while **showing** this **slide**:

The GATHER method:

- keeps us focused on the client's needs and choices rather than telling the client what to do.
- reminds us to provide information about several options.
- reminds us of the key information that should be provided in full about the method the client chooses so that she can use it safely, consistently and correctly.

Ask:

- ***Do you think your facility succeeds in observing these rights?***
- ***What could be done in your health facility to promote these rights?***

Listen to a few responses.

Then **show** the possible responses on this **slide, pointing out** how they are similar to or different from the responses given by participants.

Ways to promote client family planning rights in the health facility:

- Post a list of clients' rights in the facility so that clients are aware of what they can expect.
- Establish and implement policies to ensure that all clients are welcome regardless of gender, age, ethnic group, sexuality, etc.
- Make sure providers are trained in good counseling and communication techniques.
- Create private areas for counseling.
- Keep good client records to allow continuity between providers.

9. Conclude the session**Tell participants:**

- The next several sessions will focus on helping you to gain technical knowledge and understanding of the various contraceptive methods, so that you can provide correct, up-to-date information and helpful counseling to your clients.
- Reference materials - such as the **Participant Manual**, the **WHO Medical Eligibility Criteria for Contraceptive Use**, the **Cue Cards** and the **illustrated Flip Book: "Contraception: How to Prevent an Unwanted Pregnancy"** - will make counseling easier.

7. Methods of Contraception: Overview

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

- list the types of contraceptive methods available in the Russian Federation, in order of their effectiveness.

Time: 40 minutes

Techniques: Brainstorming, presentation and discussion

Materials:

- Flip chart with "Less effective" written at the top and "More effective" written at the bottom, small pieces of paper or cards (about 25), tape or presstick, How To Tell If A Woman Is Not Pregnant Cue Card, slides.

Preparation:

- Write flip chart with "Less effective" written at the top and "More effective" written at the bottom (*see below*).

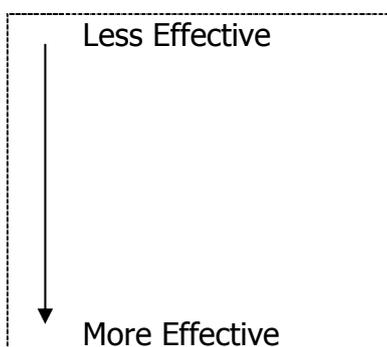
Activities:

1. Review the effectiveness of contraceptive methods (10 minutes)

Tell participants:

- In this session, we will discuss the contraceptive methods available in the Russian Federation, and how effective they are.

Show a flip chart with "Less Effective" written at the top and "More Effective" written at the bottom.



Ask:

- ***What are the less effective contraceptive methods you know, based on "typical use" - the way couples actually use the methods in practice?***

As participants name each method, **write** it down in big letters with marker on a small piece of paper/card. Then **tape** the card to the flip chart near the top.

Then **ask**:

- ***What are the most effective contraceptive methods you know, based on typical use?***

Write these methods on cards and **tape** them to the flip chart closer to the bottom.

Ask:

- ***Do you want to add any other methods to our list?***
- ***Do we need to move any of these methods up or down on the chart?***

Move the cards around on the flip chart as directed by participants, to show how effective different methods are, relative to each other.

Note to trainer: For this exercise, participants can name any method, not just those available in Russia or in their region.

2. Review the definition of effectiveness (5 min)

Tell participants:

- The **effectiveness** of a contraceptive method is measured by how well it prevents unintended pregnancies.

Tell participants the following definitions while **showing** this **slide**:

Definition of "effectiveness":

- Effectiveness with **perfect use** (theoretical effectiveness) describes the results if the method is always used consistently and correctly.
- Effectiveness with **typical use** or common use takes into account the way couples actually use the method in the real world.

3. Review the effectiveness of specific methods (20 min)

Tell participants to look at the table “**Effectiveness of Contraceptive Methods: Typical Use and Perfect Use From Least Effective to Most Effective**” in their **Participant Manual** in **Session 7: Methods of Contraception: Overview**.

Tell participants:

- The table shows contraceptive methods and their effectiveness.
- This table is based on data from the **WHO Medical Eligibility Criteria for Contraceptive Use manual** (except where indicated).

Note to trainer: This table is provided in the Participant Manual.

Effectiveness of Contraceptive Methods: Typical Use and Perfect Use From Least Effective to Most Effective

Method	Effectiveness: % of women who do NOT have an unintended pregnancy within the first year of use	
	Typical Use	Perfect Use
No method	15	15
Spermicides	71	82
Withdrawal	73	96
Periodic abstinence: calendar method, ovulation method, sympto-thermal method, post-ovulation method	75	91
Standard Days Method	88	95
Cervical cap		
Parous women	68	74
Nulliparous women	84	91
Sponge		
Parous women	68	80
Nulliparous women	84	91
Diaphragm (with spermicide)	84	94
Condom (female)	79	95
Condom (male)	85	98
Low-dose combined oral contraceptive pills and progestin-only pills	92	99.7
Combined hormonal patch	92	99.7
Combined hormonal ring	92	99.7
DMPA (Depo-Provera)	97	99.7
Combined injectable	97	99.95
IUD: Copper containing	99.2	99.4
Levonorgestral containing	99.9	99.9
Levonorgestral implants (Norplant)	99.95	99.95
Female sterilization	99.5	99.5
Male sterilization	99.85	99.9
Emergency contraceptive pills	56 to 93%, depending on regimen and how soon treatment is started ⁷	
Lactational amenorrhea method (LAM)	98%	99.5%

Source: *Medical Eligibility Criteria for Contraceptive Use*. Third edition. World Health Organization. Geneva: 2004. Emergency contraceptive pill data source: International Consortium for Emergency Contraception. "Fact Sheet: Levonorgestrel for Emergency Contraception." March 2005.

⁷ International Consortium for Emergency Contraception. Fact Sheet: Levonorgestrel for Emergency Contraception. March 2005.

Tell participants this information while **showing** this **slide**:

Using **no method** and leaving it up to chance (or relying on **abortion**) is the least effective way to prevent unintended pregnancies.

Ask:

- ***What is our goal as family planning providers when counseling clients who do not use any method but want to prevent pregnancy?***

Listen to a few responses.

Then **tell** participants this information while **showing** this **slide**:

For clients using no method or relying on abortion:

- Our goal is to **counsel them** regarding available methods.

Tell participants:

- Many couples use withdrawal or natural methods based on avoiding unprotected sex during the fertile period to prevent unintended pregnancies.

Ask:

- ***What is our goal as family planning providers when counseling clients who use these traditional methods?***

Listen to a few responses.

Then **tell** participants this information while **showing** this **slide**:

For clients using traditional methods:

- For clients who **ARE satisfied** with the traditional methods they currently use:
 - our goal is to help them use their methods more consistently and correctly for maximum effectiveness.
- For clients who are **NOT satisfied** with the traditional methods they currently use:
 - our goal is to help them learn about and try **more reliable modern methods**.

Tell participants:

- Later we will have a session where we talk about the Standard Days Method, which uses evidence-based results to improve on the old calendar method.
- The reversible modern methods range from condoms to pills to injections to IUDs.

Ask:

- ***What is our goal as family planning providers when counseling clients who use modern methods?***

Listen to a few responses.

Then **tell** participants this information while **showing** this **slide**:

For clients using modern methods:

- For clients who **ARE satisfied** with the modern methods they currently use:
 - our goal is to help them use their methods more consistently and correctly for maximum effectiveness (especially true with user-dependent methods)
- For clients who are **NOT satisfied** with the modern methods they currently use:
 - our goal is to help them choose another method if they so desire.

Tell participants:

- When clients are absolutely certain they do not want more children, they may want to choose a permanent, non-reversible method such as tubal ligation for women, or vasectomy for men.

Ask:

- ***What is our goal as family planning providers when counseling clients seeking a permanent method?***

Listen to a few responses.

Then **tell** participants this information while **showing** this **slide**:

For clients wanting a permanent method:

- Our goal is to help assure that **clients have all the information and counseling needed** to make this decision and to be certain clients understand what permanent and non-reversible means.

Go back to the flip chart with the list of methods brainstormed by participants.

Compare this list with the WHO table. Be sure to **point out** any misinformation on the participants' flip chart.

4. Discuss how to determine if a woman is pregnant (5 min)

Ask participants to take out the **Cue Card** titled "**How to Tell If A Woman Is Not Pregnant.**"

Tell participants:

- In the next sessions, we will discuss each of these contraceptive methods in more detail.
- For many of these contraceptive methods, when counseling a client about starting a method, we want to be reasonably sure she is not pregnant.
- This **Cue Card** gives you a convenient, practical list of questions to help you determine if a woman is likely to be pregnant or not.

5. Conclude the session

Tell participants:

- We will discuss each method available in the Russian Federation in order of effectiveness (from least to most effective) in the next several sessions.

Daily Reflection

Take 5 minutes to conduct a short **reflection** and **evaluation** exercise.

- Suggested activities are provided in the **Introduction to the Trainer's Guide**.
- **Review** the results of the daily evaluation in the evening, and use them to help you plan for the next day.

This is also a good time to **answer** any questions sitting in the **Parking Place**.

Remind the **Volunteer Team** to stay for the **Steering Committee Meeting**.

Morning Review of Daily Activities

Invite the **Volunteer Team** to start the day. They should be prepared to:

- **Review** the previous day's activities. This can be in the form of a quiz, game or fun activity for the group; or they can briefly talk about the main things they learned yesterday.
- **Report** on the main things that were discussed during the **Steering Committee Meeting** the night before. For example, if participants gave feedback about something needing improvement, the **Volunteer Team** can report how the concern was resolved.
- **Warm up** the group with a short energizer.

The Volunteer Team has a total of **15 minutes** to complete these activities.

Trainers present a short summary of the **Pre-test results**.

- For example, you could present the average score, and the top three most commonly missed questions, on a flip chart.

Trainers and participants **make announcements** as needed.

8. Natural Family Planning Methods

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

- state when a woman is likely to be fertile
- explain the key information about the Standard Days Method that should be covered in a counseling session with a client, including effectiveness, how to use the method, advantages and disadvantages, side effects and protection against STIs/HIV.
- list conditions that could make the Standard Days Method a poor choice for some clients.

Time: 55 minutes

Techniques:

- Presentation and discussion, gallery walk

Materials:

- Post-its or small pieces of paper (about 30), tape, flip charts with statements about natural family planning written on them, Standard Days Method Cue Card, slides.

Preparation:

Write and post 2 flip charts with statements on them (*See "Explore attitudes toward natural family planning methods: Gallery walk" below*).

Activities:

1. Introduce natural family planning (10 min)

Ask:

- ***When can a woman get pregnant?***

Listen to a few responses.

Then **show** the information on this **slide**:

When can a woman get pregnant?

- A woman's fertile period is around the time when she ovulates (releases an egg from her ovary).
- The fertile period starts a few days before ovulation and lasts a few hours after ovulation.

Tell participants this information while **showing** these **slides**:

Natural family planning methods:

- These methods are also called traditional methods or fertility awareness-based methods.
- Based on the woman's typical menstrual cycle and/or changes in her cervical secretions or basal body temperature, it is possible to estimate the days when the woman is likely to be fertile.

- During this fertile period, the couple abstain from intercourse or use condoms if they wish to prevent unintended pregnancies.
- Knowing the woman's likely fertile period can also help a couple conceive a wanted pregnancy.

2. Explore attitudes toward natural family planning methods: "Gallery walk" (25 min)

Note to trainer: Before the session, write each of the statements given below on a separate flip chart. Post the two flip charts on two different walls of the training room.

Ask a participant to read out the statements written on **flip charts** and posted on the wall:

Flip chart #1:

"Natural family planning methods are as effective as modern methods."

Flip chart #2:

"Health care providers should encourage their clients to choose a different method rather than a natural family planning method."

Give each participant a small **piece of paper**.

Ask participants to count off from 1 to 2. **Instruct** the "1"s to refer to the first flip chart, and the "2s" to refer to the second flip chart. Participants should remain seated where they are.

Show slide with these instructions:

Natural family planning exercise:

1. Read the statement about natural family planning methods on your assigned flip chart. Write down what you think about the statement. Do you agree? Disagree? Why or why not?
2. When you have finished, tape your piece of paper to the wall where the statement is posted.

Tell participants:

- You have 5 minutes to finish this activity.
- If you have extra time, you can write a response to the other statement too.

Note to trainer:

- *When participants post their responses on the wall, encourage them to spread them around so that the papers are not all clustered together. This way it is easier for the group to read the cards.*
- *If participants do not completely agree or disagree with a statement, tell them they can write down an explanation of their opinion.*

When everyone has written a response and posted it, **tell** participants to walk around the room and **read** the "gallery" of responses posted by the other participants on both flip charts. (5 minutes)

Ask everyone to be seated again. **Ask** a volunteer to summarize the responses to the **first statement**: "Natural family planning methods are much less effective than modern methods."

Ask:

- ***What were the most common answers? What did people agree or disagree about?***

Listen to responses.

Then **ask** a different volunteer to summarize responses for the **second statement**: "Health care providers should encourage their clients to choose a different method rather than natural family planning."

Ask:

- ***What were the most common answers? What did people agree or disagree about?***

Listen to responses.

Then **ask** a different volunteer to summarize responses for the **second statement**: "Health care providers should encourage their clients to choose a different method rather than a natural family planning method."

Ask:

- ***What were the most common answers? Did people agree or disagree?***

Listen to responses.

Summarize the main points that come out of the discussion:

- **List** the main attitudes you heard expressed by participants about natural family planning methods.
- **State** the main areas of agreement and disagreement among participants.
- **Explain** that disagreements do not need to be resolved right now – the purpose of the exercise was to be aware of our attitudes.

3. Introduce the Standard Days Method (15 min)

Tell participants:

- In this session, we will focus on the **Standard Days Method**.
- Among the natural methods, it has the strongest evidence base and has been demonstrated to be one of the most effective.

Tell participants this information while **showing** these **slides**:

Standard Days Method:

- A scientific analysis was conducted of thousands of women's menstrual cycles and fertility.
- The results identified days 8-19 of the menstrual cycle as the fertile period for a woman with a 26-32 day menstrual cycle.
- ***The Standard Days Method is only effective for women with regular menstrual cycles between 26-32 days long.***

Calculating the fertile period for the Standard Days Method:

- The first day of the menses (onset of bleeding) is **day 1** of the woman's cycle.
- The number of days from the onset of her menses until the onset of the next menses is the length of her cycle.
- For women with regular cycles between 26-32 days long, the fertile period is counted from **day 8** after the onset of bleeding **through day 19**.

Read the following example:

- ***If a woman with a 30-day cycle starts her menses on 10 July, what are the dates of her next fertile period according to the Standard Days Method?***

Ask for a volunteer to answer the question.

Note to trainer: The correct answer is: 17 July through 28 July. During these dates, the woman should use a barrier method like condoms or spermicides, or abstain from intercourse.

Tell participants this information while **showing** these **slides**:

Effectiveness of the Standard Days Method

- In typical use, natural family planning methods in general have an effectiveness of 75%.
- In typical use, the Standard Days Method in particular has been shown to have an effectiveness of 88%.
- The effectiveness of the Standard Days Method is similar to the effectiveness of most other user-dependent methods.⁸

Ask:

- ***What do you think are the advantages and disadvantages of the Standard Days Method?***

Listen to responses from as many people as possible. **Write** the advantages on **one flip chart** and the **disadvantages** on a second **flip chart** as they are said.

Then **show** the possible responses on these **slides, pointing out** how they are similar to or different from the responses given by participants.

Advantages of the Standard Days Method:

SDM:

- has no medical contraindications and no side effects.
- can be used by women at any age, as long as they have regular menstrual cycles of 26-32 days.
- is immediately reversible.
- is cost free and can be used under almost any circumstances, since no supplies are needed.

⁸ M. Monroy. "Lessons Learned in Provision of the Standard Days Method," Proceedings from a course held in Tegucigalpa, Honduras, July 2003. Quoted in "Standard Days Method: A Simple, Effective Natural Method." Global Health Technical Brief.

- helps the woman become more familiar with the natural rhythms of her own body.
- does not require help or supervision from health providers, after a woman has initially learned about SDM.
- involves both partners in assuming responsibility for family planning.
- is accepted by some religious groups that refuse other contraceptive methods.
- allows a couple to identify the fertile period when they do want to become pregnant.

Disadvantages of the Standard Days Method

- SDM is not effective for:
 - women with menstrual cycles outside the 26-32 days range. (*Approximately 20% of women fall outside this range.*)
 - women with irregular cycles.
 - breastfeeding women who have not yet resumed regular menses.
- Temporary abstinence or condom use might be unacceptable or difficult for some couples.

- SDM provides no protection against STIs/HIV during "safe days."
- SDM requires male participation and cooperation.
- For couples who are not properly counseled on how to use SDM or who cannot/will not avoid unprotected sex during the fertile period, **failure rates can be high.**

- The woman must keep track of the dates of her menstrual cycle while using SDM. Before starting SDM, she will need to track the dates of her cycle over several months to determine the usual length of her cycle.
- SDM might become less reliable if the woman's menstrual cycle changes for any reason (fever, vaginal infections, breastfeeding, stress, excessive exercise, aging).

4. Describe counseling for the Standard Days Method (5 min)

Tell participants:

- Some health care providers have a perception that natural family planning is ineffective, difficult and time-consuming to teach. (*Refer to such attitudes if they came up in the "Gallery walk" exercise.*)
- In some cases, these attitudes may be based on experience with clients using less reliable methods than the Standard Days Method, or clients who needed further information about the best ways to practice natural methods.

Tell participants this information while **showing** these **slides**:

Counseling for the Standard Days Method:

- The Standard Days Method is similar in effectiveness to modern user-dependent methods.
- Most clients can learn to use the Standard Days Method in a single counseling session of 20-30 minutes.⁹
- The Standard Days Method is also a comfortable context for introducing counseling on condom use.

- It is a common assumption that the Standard Days Method requires periodic abstinence, when in fact the majority of couples use condoms during the fertile period.
- If the client has been using a natural family planning method successfully (no unintended pregnancies) and is satisfied with it, you should support this choice.
- If the client has had unintended pregnancies or is unsatisfied with the method for whatever reason, then you should tell her about modern methods and help her choose one if she so desires.

5. Conclude the session**Tell** participants:

- The **lactational amenorrhea method (LAM)** can also be considered a natural method, to be used during the first 6 months of exclusive breastfeeding. We will talk more about this method in **Session 16: Postpartum Contraception and LAM**.
- There is a more in-depth article in your **Participant Manual** entitled "***Standard Days Method: A Simple, Effective Natural Method***," which you might enjoy reading in the evening or at another convenient time.

Refer participants to **Session 8: Natural Family Planning Methods** and have them find the article.

Tell participants:

- In the next session, we will talk about barrier methods of contraception.

⁹ M. Monroy, 2003.

9. Barrier Methods of Contraception

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

- explain the key information about the male condom that should be covered in a counseling session with a client, including effectiveness, how to use the method, advantages and disadvantages, side effects and protection against STIs/HIV.
- demonstrate the correct use of a condom as they would with a client.
- explain the key information about vaginal spermicides that should be covered in a counseling session with a client, including effectiveness, how to use the method, advantages and disadvantages, side effects and protection against STIs/HIV.
- list conditions that could make the condoms or spermicides a poor choice for some clients.

Time: 1 hour

Techniques:

- Presentation and discussion, demonstration

Materials:

- Male condoms (at least one per person), vaginal spermicides (one or two samples of various different kinds), male models for condom demonstration (one for every two or three participants), paper napkins, Male Condoms and Vaginal Spermicides Cue Cards, slides

Activities:

1. Introduce barrier methods and the condom (5 min)

Tell participants:

- Contraceptives that prevent the passage of bodily fluids from one person to another are called barrier methods.
- Examples of barrier methods include male and female condoms, cervical caps, diaphragms, sponges, and vaginal spermicides which may be in the form of foaming tablets, suppositories, foams, gels or creams.
- In this session, we will focus on the **male condom and vaginal spermicides**, since these are the barrier methods most commonly used and available in the Russian Federation.

Pass around samples of different brands/types of condoms for participants to look at during the session.

Ask participants to take out their **Male Condoms Cue Card**.

Tell participants this information while **showing** these **slides**:

Method of action:

- The male condom is a thin sheath made from latex (an especially durable and thin kind of rubber), vinyl or natural products, which is put on the erect penis immediately before intercourse.
- The condom prevents the sperm, as well as seminal fluid and any infectious organisms, from entering the vagina during sexual intercourse.
- The condom also keeps vaginal secretions and any infectious organisms from entering the penis during intercourse.

Effectiveness of the male condom:

- With consistent and correct use, condoms are 98% effective.
- Since many couples do not use condoms correctly or do not use them every time they have intercourse, the effectiveness with typical use is closer to 85%.
- Almost every time condoms fail, it is due to human error rather than a faulty condom.

Protection against STIs/HIV:

- The condom is the **only** method of contraception that protects against STIs that are transmitted by bodily fluids and HIV **as well as** pregnancy (dual protection).
- Condoms offer some protection against herpes, genital warts and other STIs that can cause sores on the skin, but because the infectious areas may not be covered by the condom, condoms are not completely effective protection against these STIs.

Side effects:

- None (except for rare allergy to latex, in which case another type of condom can be used.)

2. Discuss the advantages and disadvantages of condoms (10 min)**Ask:**

- *What are the advantages of condoms as a contraceptive method?*

Listen to several responses.

Tell **participants** this information while showing these **slides**:

Advantages:

- Condoms are very effective if used correctly during each act of intercourse.
- No prescription or medical examination is required.
- Condoms essentially have no side effects or contraindications.

- Condoms offer dual protection: against unintended pregnancy AND against STIs/HIV.
- Condoms offer protection against conditions related to STIs – pelvic inflammatory disorders, infertility, cervical cancer.
- It is recommended that anyone at risk for STIs/HIV use a condom with each act of intercourse even if another method is being used for contraception (dual method use).

- Condom use encourages men to be responsible for contraception.
- Condoms can be used postabortion and postpartum whether the woman is breastfeeding or not, and can be used during pregnancy to protect against STIs/HIV.
- Fertility returns immediately once condom use is stopped.

- Condoms help prevent premature ejaculation.
- Condoms are a good method for clients who only occasionally have sex.
- Condoms are a good "back-up" method (if the woman is using low-dose COCs or POPs and has missed several pills).
- Condoms are a good "interim" method when a woman has chosen a method that cannot be started immediately or that requires a procedure that cannot be done immediately.
- Condoms are easy to keep on hand in case sex happens unexpectedly

Ask:

- ***What are the disadvantages of condoms as a contraceptive method?***

Listen to several responses.

Tell **participants** this information while showing these **slides**:

Disadvantages:

- Old or damaged condoms can rupture during intercourse. If this happens, the woman has the option of using emergency contraception as soon as possible within the next 120 hours (5 days).
- Some couples complain of the decreased intensity of sexual sensations.
- Rarely, condom use provokes an allergy (to lubricant or latex).
- The man or the woman must keep a supply available. A new condom is needed for each act of intercourse. Over time, condom use can be costly.

- Couples must remember to stop and put the condom on before penetration occurs.
- The active participation of the man is necessary.
- Some people are embarrassed to purchase condoms and discuss their use with their partners.
- Condoms can be weakened if stored in heat, exposed to sun or used with oil-based lubricants (water-based lubricants are fine).

3. Discuss counseling clients on condom use (5 min)

Ask:

- ***What do your clients think about condoms? How comfortable are clients with talking about and using condoms?***

Listen to several responses.

Then **tell** participants:

- Some clients may be embarrassed by talking about condoms. You may also feel embarrassed. With practice, you can become confident in teaching your clients how to use condoms correctly. If you feel comfortable, the client will feel more comfortable too.
- When counseling clients on contraceptive methods, it is important to explain whether or not each method provides protection against STIs/HIV.

Remind participants:

- Condoms are the only contraceptive method that offers dual protection.
- If the client is at risk for STIs/HIV, the client should be counseled on condom use in addition to their family planning method.

Ask:

- ***Since condoms protect against both STIs/HIV and pregnancy, why would a couple using condoms choose an additional family planning method?***

Listen to a few responses.

Then **tell** participants the following points if they were not already mentioned:

- A woman has more effective protection against unintended pregnancy if she can control her family planning method, rather than depending on the man to use it
- When condoms are not used consistently and correctly, the woman is exposed to the risk of pregnancy and STIs/HIV, so she may want a more effective additional method.

Tell participants

- It is very important that the client (male or female) be taught how to use the condom correctly.
- Women as well as men should know the steps for how to use a male condom correctly.
- In the next activity, you will all practice doing this.

4. Conduct a condom demonstration (10 min)

Ask participants to follow the steps listed on the **Male Condoms Cue Card** as you **demonstrate** how to use a condom correctly, using a **male model**. Be sure that everyone can see and hear you.

As you perform each step, **explain**:

Steps in using a condom correctly:

1. Check the expiration date on the condom package. Do not use an expired condom. Do not use one that is brittle/dry, very sticky or has changed color.
2. Tear the packet open. Do not use anything sharp like scissors or a knife. Be careful of long fingernails and jewelry.
3. Hold the condom so that the rolled rim is facing away from the penis.
4. Pull the foreskin back if the penis is uncircumcised.
5. Place the condom on the tip of the erect penis. Leave 1 cm of space at the tip to collect the sperm (pinch out the air).
6. Unroll the condom all the way to the base of the penis. It should unroll easily. If not, it is probably backwards. Smooth out any air bubbles as air bubbles can cause a condom to break. If you want to use some extra lubrication, put it on the outside of the condom.
7. The man should pull his penis out of the vagina before completely losing his erection. He should hold the rim of the condom to the base of the penis so that it will not slip off.
8. Carefully take off the condom without spilling the semen on the vaginal opening. Try to keep the semen contained inside the condom.
9. Tie a knot in the end of the condom and dispose of it carefully. Do not leave it where children will find it and play with it. Do not flush it in the toilet since it will block plumbing.
10. Wash your hands after handling the used condom.

After finishing the demonstration, **ask** if there are any questions.

Tell participants the following guidelines while **showing** these **slides**:

Guidelines for using condoms:

- Use a condom with every sex act (vaginal, oral, anal) for protection against STIs/HIV and unintended pregnancy.
- Condoms should be kept in a cool and dry place, protected from the sun's rays. Heat, light and humidity may damage the condom.
- Do not use a condom more than once. Use it once and then dispose of it properly.

- Use only water-based lubricants. Do not use oil-based lubricants (like cooking oil, Vaseline, lotions, etc). These will weaken the condom and may cause it to tear. Many condoms come with a lubricant already on the condom. Vaginal secretions also act as a natural lubricant. Spermicides are also a good lubricant.

- If the condom tears during use:
 - If ejaculation has not occurred, the man should pull out and put on a new condom.
 - If ejaculation has occurred, wash the vagina and penis with soap and water.
 - Consider using emergency contraception as soon as possible in the next 120 hours (5 days).

5. Conduct participant practice demonstrations (15 min)

Divide the participants into pairs.

Distribute condoms and a **male model** to each pair. Also make **paper napkins** available if condoms are lubricated.

Tell participants:

- Take turns demonstrating the correct use of a condom to your partner, as if counseling a client. Explain each step to your partner as you perform it.
- Use the **Male Condoms Cue Card** as a guide.
- You will have **10 minutes**.

Note to trainer: It is essential that all the participants, without exception, take part in the work. Do not forget that some of the participants may not have dealt with condoms before and may be uncomfortable.

While pairs are practicing, **circulate** among them to **offer** encouragement, **correct** mistakes and **provide** feedback.

When pairs are finished practicing, **bring** the whole group back together.

If you saw the pairs making some mistakes or skipping some steps in the condom demonstration, **tell** the whole group to be careful to avoid these mistakes and explain how to do it correctly.

Tell participants:

- Clients are more likely to use condoms consistently and correctly if the provider demonstrates how to use them with a model, and then asks the client to demonstrate back to the provider.
- We will now talk about another common barrier method: vaginal spermicides.

6. Introduce vaginal spermicides (10 min)

Ask participants to take out their **Vaginal Spermicides Cue Card**.

Pass around sample **spermicides** for participants to look at.

Tell participants to refer to the **Cue Card** while **showing** these **slides**:

Method of action:

- Spermicides work by killing the sperm or making the sperm unable to move toward the egg.
- The woman may feel a warm sensation when the foaming type of spermicide is working.

When to start use:

Spermicides can be started:

- at any time during a woman's monthly cycle.
- as soon as the woman resumes sexual relations after childbirth, abortion or miscarriage.

Effectiveness of vaginal spermicides:

- With consistent and correct use, spermicides have an effectiveness of 82%.
- In typical use, spermicides have an effectiveness of 71%.

Protection against STIs/HIV:

- Although spermicides MAY provide some protection against some STIs, this has not been proven.
- Condoms provide more effective protection against STIs.

Contraindications to vaginal spermicide use:

- Spermicides are NOT recommended (for family planning or for prevention of STIs/HIV) for women at high risk of HIV infection or for women with HIV or AIDS who might use spermicides several times a day.
- Using spermicides several times a day can damage the vaginal mucosa, making the woman more susceptible to acquiring HIV infection or transmitting it to her partner.

Ask:

- *What are the advantages of vaginal spermicides?*

Listen to several responses.

Then **show** the following **slides** and point out any ideas that were not yet mentioned.

Advantages of vaginal spermicides:

Spermicides:

- are a woman-controlled method that almost every woman can use.
- may offer some protection against some STIs (but see qualifiers above).
- offer contraception at the moment when needed.
- are moderately effective if used consistently and correctly.
- have no hormonal side effects.
- have no effect on breastmilk.
- can be stopped at any time.

- are easy to use with little practice.
- can be inserted as much as one hour before sex to avoid interrupting sex.
- offer contraception to couples who only occasionally have sex.
- are easy to keep on hand in case sex happens unexpectedly .

- may increase vaginal lubrication.
- can be used immediately postpartum once sexual relations are resumed, whether woman is breastfeeding or not.
- can be used without visiting a health provider.
- are immediately reversible; fertility returns once use is stopped.

Ask:

- ***What are some disadvantages of vaginal spermicides?***

Listen to several responses.

Then **show** the following **slides** and point out any ideas that were not mentioned yet.

Disadvantages of vaginal spermicides:

Spermicides:

- may cause irritation to the woman or her partner, especially if used several times a day. This irritation may increase risk for STIs/HIV.
- may cause a local allergic reaction (rarely) for the woman or her partner.
- require having the method available and taking the correct action before intercourse (e.g., melting types must be inserted in the vagina at least 10 minutes before the man ejaculates and no more than 1 hour before).
- require the woman or her partner to put fingers or inserter into her vagina

- interrupt sex act if not inserted beforehand.
- may be messy.
- may be hard to conceal from partner.
- may melt in hot weather.

7. Discuss counseling on vaginal spermicides (5 min)

Tell participants:

- As with all contraceptive methods, a woman who chooses to use spermicides benefits from good counseling on how to use the method correctly, the potential advantages and disadvantages, the importance of also using a condom if at risk for STIs/HIV, where to obtain spermicides, and when to return to the provider (if she has questions, concerns, or wishes to use a different contraceptive method).

Tell participants this information while **showing** this **slide**:

Providers should give clients these instructions for how to use vaginal spermicides:

- The woman should carefully read the directions on the package for how to insert that specific spermicide.
- She inserts the spermicide in her vagina before each act of intercourse.
 - Generally less than 1 hour before intercourse, but more than 10 minutes before intercourse.
- She inserts more spermicide if intercourse is repeated.
- She should not douche for at least 6 hours after intercourse.

- Spermicides should be stored in a cool dry place.

8. Conclude the session

Tell participants:

- In the next two sessions, we will discuss hormonal methods of contraception.

10. Low-dose Combined Oral Contraceptives

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

- explain the key information about low-dose combined oral contraceptives that should be covered in a counseling session with a client, including effectiveness, how to use the method, advantages and disadvantages, side effects and protection against STIs/HIV.
- list conditions that make low-dose contraceptives a poor choice for some clients.
- discuss common myths and rumors about oral contraceptives and explain why they are incorrect.

Time: 1 hour 10 minutes

Techniques:

- Presentation and discussion, role play, brainstorm, quiz game

Materials:

- Low-dose combined oral contraceptive samples of various brands, GATHER and Low-dose COC Cue Cards, slides, small cards or post-its with +/- signs, basket or bag
- *Optional: Small prize to be shared by team winning the quiz competition (see "Discuss possible side effects and warning signs" below).*

Preparation:

- Make small cards or post-its, 1 card per participant, marking half the cards with a "+" sign and half with a "-" sign. Mix them up and put in a basket or bag.

Activities:

1. Introduce low-dose combined oral contraceptives (20 min)

Ask participants to take out their **Low-dose Combined Oral Contraceptives Cue Card**.

Tell participants:

- This session will focus on low-dose combined oral contraceptives (COCs).
- Most of the information presented in this session can also be found on the **Cue Card**.

Tell participants the following definition while **showing** this **slide**:

Definition of low-dose combined oral contraceptives:

- "Low-dose": Modern COCs contain very low doses of hormones, making them safe for most women.
- "Combined": Each pill contains a combination of two hormones similar to the natural hormones in a woman's body: estrogen and progestin.
- "Oral": Low-dose COCs are taken as pills by mouth.

Ask:

- *What has been your experience with clients who choose COCs?*
- *Why do they choose them?*
- *If a client does not want to use COCs, what reasons does she usually give?*

Listen to several responses.

Summarize the main points you heard.

Tell participants this information while **showing** this **slide**:

Changes in COCs:

Many of the conditions which limited use of COCs years ago are no longer applicable.

- In the early years of hormonal contraception (1960-1970s), the daily hormone doses were much higher (e.g. each pill contained as much estrogen as 7 modern "low-dose" pills and as much progestin as 21 low-dose pills).
- Since the 1980's, hormonal doses have been greatly reduced with no reduction in effectiveness.
- Low-dose COCs have many fewer contraindications and fewer side effects.

Types of low-dose COCs:

- **Mono**-phasic: All the hormonal pills contain the same dose of estrogen and progestin. The majority of low-dose COCs on the market are mono-phasic.
- **Tri**-phasic: The doses in the hormonal pills vary in the cycle to more closely match the menstrual cycle.
- Brands may vary slightly or look different, but they are equally effective and can be used interchangeably.

Tell participants:

- Providers and clients do not need to be concerned about the slight variations in the dosage of estrogen, or in the type and dosage of progestin.
- You should reassure your clients not to worry if they find that the name or packet looks slightly different. Each brand or type of low-dose COC should be equally effective if the pills are taken consistently and correctly.

Tell participants this information while **showing** this **slide**:

How to use low-dose COCs:

- The woman swallows a pill each day.
- Low-dose COCs are most effective if the woman takes each pill at the same time each day.

Pass out sample **packets** of low-dose COCs for participants to look at.

Tell participants:

- All the pills in the **21-day** packet contain hormones that prevent pregnancy.
- The **28-day** packet contains 21 pills with the hormones that prevent pregnancy and 7 "reminder" pills of a different color which do not contain hormones.
 - The 28-day packets were designed to help women to remember to take their pills. By taking a pill every day – even though some pills are "inactive" – the woman develops the habit of taking a daily pill.

Tell participants this information while **showing** this **slide**:

Method of action:

Low-dose COCs prevent pregnancy by:

- stopping ovulation (release of eggs from the ovaries).
- thickening cervical mucus (making it difficult for sperm to pass through).

Low-dose COCs do NOT disrupt an existing pregnancy.

Ask participants to find this information on the **Low-dose Combined Oral Contraceptives Cue Card**.

Tell participants this information while **showing** these **slides**:

When to start low-dose COCs:

- A woman can be provided with low-dose COCs at any time, but must be told when to start taking the pills.

A woman can start low-dose COCs:

- On any of the first 5 days after menses (bleeding) begins. The first day is the easiest to remember.
- After day 5 of the menstrual cycle if she is reasonably certain that she is not pregnant. If she starts low-dose COCs more than 5 days after menses began, she should also use condoms or abstain from intercourse for the next 7 days.

- After stopping breastfeeding, or 6 months postpartum if still breastfeeding, whichever comes first.
- 3-6 weeks postpartum, if not breastfeeding (she does not have to wait for menses to resume).
- Immediately after stopping another method (no need to wait for menses to resume.)
- Within the first 7 days after miscarriage or abortion.
- At any time she is reasonably certain that she is not pregnant.

Effectiveness of low-dose COCs:

- With consistent and correct use, low-dose COCs have an effectiveness of more than 99%.
- In order for low-dose COCs to be highly effective, the woman must take one pill every day at about the same time.
- For this reason, in typical use, low-dose COCs have an effectiveness of 92%.

Protection against STIs/HIV:

- Low-dose COCs do NOT provide any protection against STIs or HIV.
- Clients at risk for STIs/HIV should be counseled to use a condom with each act of intercourse even if another method is being used for contraception (dual method use).
- If indicated, show clients how to use condoms correctly as well as how to use their chosen method.

Return visits:

- A scheduled return visit is not necessary.
- If supplies are available at your facility, your client can return for more pills at her convenience, any time before her supply runs out.
- Encourage your client to return to the clinic if she has any problems with her method or if she wants to change contraceptive methods.

During a return visit it is important to:

- ask if the client has any questions or concerns.
- ask the client about her experience with low-dose COCs, whether she is satisfied, and whether she has any problems.
- ask if there has been any change in her health status. Listen especially for changes that might indicate a medical condition that would make you recheck her medical eligibility for low-dose COCs.

- check blood pressure once a year if possible.
- help her choose another method if she is NOT satisfied with low-dose COCs.
- make sure she has a supply of low-dose COCs if available.

2. Practice counseling a client on how to use low-dose COCs: Role play (30 min)

Divide participants into small **groups** (about 5 people each).

Note to trainer: Remember to mix up the participants into different groups so that they do not always work with the same colleagues or people sitting near them.

Ask participants to look in the **Participant Manual** in **Session 10** to find the "**Task Sheet: Low-dose COC Counseling Role Play.**"

Tell participants:

- With your group, follow the instructions for this activity given on the Task Sheet.
- You will have **20 minutes** to work.

Note to trainer: This task sheet is provided in the Participant Manual.

Task Sheet: Low-dose COC Counseling Role Play

(1) Read the following information silently. Discuss with your group or the trainers if you have any questions.

The most common mistakes for users of low-dose COCs are: starting new packets late, missing pills, or running out of a supply of pills. To help your client use low-dose COCs correctly, it is important to explain the following information to her.

- Give her a low-dose COC packet (21-day and/or 28-day) to look at and handle. This will help her understand better and become comfortable using it.
- Tell the woman when to begin taking the pills.
- Tell her to take one pill at the same time each day.
- Suggest that she take the pill daily along with something else she does routinely – such as eating breakfast or dinner, brushing her teeth or preparing for bed.
- Show her how to take the pill out of the packet, and let her practice if there is a spare packet.

28-day packet:

- Show her which are the hormone pills and which are “reminder pills” in the 28-day packet.
- Tell her that when she finishes a 28-day packet, she should start taking pills from the next packet on the very next day at the same time.

21-day packet:

- Point out that a 21-day packet does not have any reminder pills.
- Tell her that when she finishes a 21-day packet, she should wait 7 days (not take any pills) and then start taking pills from the next packet.
- Show her how to follow the arrows or directions on the packet so that she takes the pills in the proper sequence.
- Tell her that she can expect to have her period during the days that she is taking the “reminder” pills (28-day packet) or during the 7 days that she takes no pills (21-day packet). Her menses will probably be lighter than usual (maybe only spotting), shorter than usual, and probably much more comfortable – especially if she previously had very uncomfortable cramps. This is one of the benefits for many women of taking low-dose COCs.
- Tell the woman what to do if she **misses pills**:

- *If she misses taking 1 pill:* She should take it as soon as she remembers, even if it means taking two pills on one day or at the same time.
 - *If she misses taking two or more pills:* She should take a pill as soon as she remembers. Then she should continue taking the rest of her pills at the usual time as before. She should abstain from intercourse or use condoms until she has taken one hormone pill every day for seven days in a row.
 - *If she misses often:* Counsel her to consider changing methods.
- Finish by asking if the woman has any questions.
 - Ask her to repeat the instructions for daily use so that you can check that she understands.

(2) Now choose two people from your group to role play the following situation.

- One person is a health care provider.
- The other person is a client.
- The "provider" should use the guidelines given above and the Low-dose COC Cue Card to counsel this woman.

The client is a young woman aged 20 who has been taking low-dose COC for about one year. When she was initially started on the pills, she received very few instructions on how to take the pills and does not understand what to do when she misses a pill occasionally. So far she feels she has been "lucky" that she hasn't become pregnant, but she worries a lot after she misses a pill. She is unmarried and likes having a variety of boyfriends. She wonders whether she should change to another method although she really likes the pill.

Role play for about 5 minutes.

(3) After the role play, give feedback to the "provider."

- Did the "provider" explain the information clearly and correctly to the "client"?
- Did the "provider" ask the "client" questions about her situation?
- Did the "provider" use good communication and counseling skills?

While the groups are performing the role play, **circulate** among them to see how they are doing. If there are enough trainers, one should sit with each group.

If participants stated incorrect information during the role play, and their group members do not correct them afterward, be sure to **explain** the correct information.

Note to trainer: Besides counseling on how to take the pills correctly, the provider in the role play should also discuss condom use with her to reduce her risk of STIs/HIV; using a condom in addition to the pill in her case would provide her with the added protection needed if and when she misses a pill. Although there is not time to conduct a condom demonstration here, the role play provider should be aware that this would be done in the "real situation."

When the groups finish the activity, **bring** everyone back together.

Ask:

- **What questions do you have about counseling a woman on using low-dose COCs?**
- **What counseling skills do you want to strengthen?**

Listen to responses and **answer** questions.

If you saw participants making mistakes in their role plays, **tell** everyone the correct approaches to make sure they understand.

3. Discuss the advantages and disadvantages of low-dose COCs (5 min)

Pass around a basket or bag with small cards or post-its in it (one for every participant). Half of the cards should have a "+" sign on them, and half should have a "-" sign. **Tell** participants to **draw one card each**.

Tell participants

- Think about the advantages and disadvantages of low-dose COCs.
- If you drew a + card, think about (or write down) advantages.
- If you drew a – card, think about (or write down) disadvantages.

Give participants a few minutes to **think individually**.

Then **go around** the room and **ask** participants with a "+" card to name one **advantage** each. They should not name something that has already been said.

Then **show** the possible responses on these **slides, pointing out** how they are similar to or different from the responses given by participants.

Advantages:

Low-dose COCs:

- are very effective when used consistently and correctly.
- regulate the menstrual cycle; menses are lighter, shorter, and less uncomfortable.
- do not interfere with sexual activity.
- can be used for as long a time period as desired; no need for a "rest period."
- can be used at any age from adolescence to menopause.

- are reversible; fertility returns soon after discontinuing use.
- can be used for emergency contraception after unprotected sex or problems with other methods.
- help protect against iron deficiency anemia, endometrial cancer, ovarian cancer, ovarian cysts, pelvic inflammatory disease, benign breast disease.

Next, go around the room and **ask** participants with a **"-" card** to name one **disadvantage** each. They should not name something that has already been said.

Then **show** the possible responses on these **slides, pointing out** how they are similar to or different from the responses given by participants.

Disadvantages:

Low-dose COCs:

- may cause minor side effects; these usually disappear within 3 months.
- are user-dependent; it may be difficult for some women to remember to take a pill every day (especially with 21-day packets).
- very rarely can cause stroke, blood clots in legs, heart attack; at highest risk are women who are over 35 AND who smoke.
- do not protect against STIs/HIV; it is recommended that anyone at risk for STIs/HIV use a condom with each act of intercourse even if another method is being used for contraception (dual method use).

4. Explore common myths and rumors about low-dose COCs (5 min)

Ask:

- ***What myths and rumors do your clients hear about low-dose COCs?***
What myths and rumors do you hear?

Listen to several responses.

Then **tell** participants this information while **showing** these **slides**:

Common myths and rumors about low-dose COCs:

"Low-dose COCs cause weight gain."

- You can tell clients: It is true some women experience slight weight gain. However, others do not. It can be controlled through diet and exercise. Weight gain was a more common problem with the old high-dose COCs.

"COCs make it harder for a woman to have children later if she wants them."

- You can tell clients: A woman's fertility is not affected by taking low-dose COCs. She will have a fertile period generally within 3-6 months after she stops taking the pills.

"COCs interfere with the natural rhythms of your body."

- You can tell clients: Low-dose COCs use hormones found naturally in the female body (a combination of estrogen and progestin) based on the body's natural 28-day cycle.

"COCs cause the woman to become more hairy or to grow a mustache."

- You can tell clients: The hormones in low-dose COCs do not cause any change in hair growth.

"Women need to take a "rest" from COCs once a year."

- You can tell clients: A woman can take low-dose COCs for as long as she wants, without taking a rest. The hormones used are very low-dose.

5. Discuss possible side effects and warning signs of serious complications (5 min)**Tell participants:**

- Having unexpected side effects is one of the leading reasons why women stop using low-dose COCs.
- Side effects do not occur with all women.
- Women who know about possible side effects before they occur are more likely to continue using their chosen method than women who first learn about them when they experience them.
- When counseling a client, you should:
 - inform her about the possible side effects for the chosen method.
 - reassure her that these are not signs of a serious condition.
 - tell her they usually go away within the first 3 months.
 - encourage her to return to the clinic if she has any questions or concerns.

Tell participants:

- We will now have a short competition about the possible side effects and rare but serious complications of low-dose COCs.

Divide the participants into two teams.

Tell participants:

- I will read aloud questions about side effects and complications related to low-dose COCs. If someone on your team answers the question correctly, your team receives a point. If not, the other team gets a chance to earn the point by answering correctly.

Read the following questions one by one, **alternating** between the **two teams**. **Keep score** as they answer the questions.

Note to trainer: If neither team can answer a question correctly, be sure to tell them the correct answer (provided in italics below).

1) True or false? Light spotting between menses is a normal side effect of low-dose COCs.

Answer: True.

2) True or false? Very bad, persistent headaches are a normal side effect of low-dose COCs.

Answer: False. This is a warning sign that something more serious could be wrong. The client should see a health care provider.

3) Name two ways that a woman can reduce the side effect of tender breasts.

Answer: Reducing caffeine intake; wearing a supportive bra.

4) Name two ways that a woman can reduce the side effect of nausea.

Answer: Taking the pill at bedtime; taking the pill with food.

5) Which of the following is a NON-SERIOUS SIDE EFFECT of low-dose COCs? Yellow skin, fluid retention, severe abdominal pain.

Answer: Fluid retention. The other two are warning signs, and the woman should see a health care provider.

6) True or false? Brief loss of vision or seeing flashing lights is a warning sign of serious complications.

Answer: True. The client should see a health care provider.

7) Name one warning sign of serious complications that we have not mentioned yet.

Possible answers: Difficulty speaking, or difficulty moving arm or leg.

8) List two ways to avoid the normal side effect of slight weight gain.

Possible answers: Exercise, reduce fat in the diet, avoid extra salt, drink 6 to 8 glasses of water daily.

After all questions are answered, **add up the scores** and **declare** a winner.

Note to trainer: You may want to give a small prize to the winning team.

Tell participants:

- There is a table of side effects and ways to manage them on your **Low-dose COC Cue Card** for your reference during counseling.
- The **Cue Card** also lists warning signs of serious complications.

6. Discuss the WHO Medical Eligibility Criteria for Contraceptive Use for low-dose COCs (5 min)

Ask participants to open the **WHO Medical Eligibility Criteria for Contraceptive Use manual** to the section entitled "**Low-dose combined oral contraceptives.**"

Ask:

- **What conditions make a woman ineligible for low-dose COC? Refer to the WHO Medical Eligibility Criteria for Contraceptive Use manual and the Low-dose COC Cue Card.**

Listen to several responses.

Then **show** the possible responses on these **slides, pointing out** how they are similar or different to the responses given by participants.

Medical eligibility criteria for low-dose COCs:

Women are **not eligible for low-dose COCs** under the following conditions:

- Women with suspected pregnancy.
- Women who are breastfeeding an infant under 6 months (Low-dose COCs may affect the quantity and quality of the milk).
- Women <21 days postpartum even if not breastfeeding.
- Women who are older than 35 AND smoke.

- Women with multiple risk factors for cardiovascular disease.
- Women with high blood pressure (above 140/90).
- Women who have had deep venous thrombosis or pulmonary embolism.
- Women with heart, liver or gallbladder disease.

- Women older than 35 with migraine headaches.
- Women younger than 35 with migraine headaches who experience aura with their migraines.
- Women who have breast cancer or had it in the past.
 - There is no strong evidence suggesting low-dose COCs increase the risk of breast cancer. However, the issue is still being studied.

- Women with diabetes complicated by nephropathy, retinopathy, neuropathy or other vascular disease.
- Women with diabetes of >20 years duration.
- Women taking rifampicin or certain anticonvulsants.

Tell participants:

- Recently new delivery systems have been developed for providing combinations of estrogen and a progestin similar to those used in low-dose COC pills in the form of injections, patches and rings. The ring form is available now in Russia.
- There is a section in the **WHO Medical Eligibility Criteria for Contraceptive Use manual** titled "Combined injectable contraceptives, patch and ring" that you can look at in detail this evening or whenever it is convenient for you.
- The statements of the WHO Working Group regarding the combined vaginal ring are an excellent example of evidence-based medicine in action.

Tell participants this information while **showing** these **slides**:**WHO Working Group statements on the combined contraceptive vaginal ring:**

- Relatively limited information is available on the safety of the combined contraceptive ring among healthy women, and even less information is available for women with specific medical conditions.
-
- Pending further evidence, the WHO Working Group concluded that the evidence available for COCs applies to the ring, and that therefore the ring should have the same categories as COCs.
 - The assigned categories should be considered a preliminary best judgment, which will be re-evaluated as new data become available.

7. Conclude the session**Tell** participants:

- In the next session, we will discuss another hormonal method of contraception with a different hormonal composition: progestin-only contraceptives.

11. Progestin-only Contraceptives

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

- describe the types of progestin-only contraceptives.
- explain the key information about progestin-only contraceptives that should be covered in a counseling session with a client, including effectiveness, how to use the method, advantages and disadvantages, side effects and protection against STIs/HIV
- compare progestin-only pills with low-dose combined oral contraceptive pills.
- list conditions that make progestin-only contraceptives a poor choice for some clients.

Time: 1 hour

Techniques:

- Presentation and discussion, small group work, role play

Materials:

- Samples of progestin-only contraceptive products; POP, Progestin-only Injectables and Low-dose COC Cue Cards; WHO *Medical Eligibility Criteria for Contraceptive Use* manual; slides

Activities:

1. Introduce progestin-only contraception (5 min)

Tell participants

- We will now talk about another group of hormonal contraceptives: those that contain only progestin and no estrogen.

Tell participants this information while **showing** these **slides**:

What are progestin-only contraceptives?

- They contain only one hormone, progesterone or progestagen derivate, in very small quantities.
- These contraceptives may be used by women who are breastfeeding, as they do not influence the quality or quantity of breastmilk.
- They are available as pills or as injectables.

Depot Medroxyprogesterone Acetate:

- The injectable form of progestin-only contraception has not always been available in the Russian Federation.
- Reportedly, it has recently been re-registered and may become available.
- Depot Medroxyprogesterone Acetate (DMPA) is given every three months as an injection.

Tell participants:

- In this session, we will focus on the progestin-only pills – POPs or mini-pills – and how they are similar to and different from the low-dose COCs.
- You can use the **Progestin-only Injectables Cue Card** for counseling clients, when DMPA becomes available for them.
- Injectables are also shown in the illustrated Flip Book **“Contraception: How to Prevent an Unwanted Pregnancy.”**
- There is a short article in your **Participant Manual** entitled **“Injectable Contraceptives”** that you might enjoy reading in the evening or at another convenient time.

Refer participants to **Session 11: Progestin-only Contraceptives** and have them find the article.

2. Facilitate small group work: Comparing POPs with low-dose COCs (10 min)

Divide participants into 4 small groups, mixing them up to work with new people.

Ask participants to open the **WHO Medical Eligibility Criteria for Contraceptive Use manual** to the section titled **“Progestin-only Contraceptives.”**

Ask:

- ***What differences do you find between the recommendations for progestin-only contraceptives versus low-dose combined oral contraceptives?***

Tell participants:

- Refer to the **WHO Medical Eligibility Criteria for Contraceptive Use manual** as well as the **POP and Low-dose COC Cue Cards**.
- Make a note of any **differences** you find between the two types
- You have **10 minutes** to work.

3. Have small groups report back (15 min)

When the groups have finished working, **bring** the whole **group** back together.

Ask the first group:

- ***What are the differences between POPs and low-dose COCs in their method of action?***

Note to trainer: The group should say the following:

- POPs and low-dose COCs work the same way. This should not be surprising since they are both hormonal methods.

Ask the second group:

- ***What is the difference between the effectiveness of POPs and low-dose COCs?***

Note to trainer: The group should say the following:

- The effectiveness of POPs and low-dose COCs is the same. However:
 - POPs have a higher risk of pregnancy IF the woman misses a pill or takes it late. Even 3 hours is considered late.
 - Breastfeeding women who use POPs after 6 weeks postpartum also have the extra protection against pregnancy that breastfeeding provides.

Ask the third group:

- ***What are the differences between the advantages of POPs and low-dose COCs?***

Note to trainer: The group should say the following:

- POPs can be used by women with some medical conditions that would disqualify them from using low-dose COCs, e.g. diabetes, heart disease, migraines, BP only has to be under 160/100.
- If any of these medical conditions become worse after the client starts POPs, the pills should be stopped.
- POPs can be used by smokers
- POPs can be used by breastfeeding mothers starting 6 weeks postpartum (earlier than low-dose COCs).
- POPs cause less problems with weight gain than low-dose COCs
- POPs have no estrogenic side effects.

Ask the fourth group:

- ***What are the differences between the disadvantages and possible side effects of POPs versus low-dose COCs?***

Note to trainer: The group should say the following:

- Menstrual irregularities, especially more frequent bleeding and spotting, are more common with POPs.
- POPs have none of the estrogenic side effects of low-dose COCs: nausea, headache
- Other side effects are the same as with low-dose COCs.

4. Discuss how to use progestin-only pills (20 min)

Pass around some samples of POPs.

Ask:

- ***What is the difference between the POP packet and the low-dose COC packet?***

Listen to a few responses.

Then tell participants this information while **showing** these **slides**:

Progestin-only pills:

- The packet has either 28 pills or 35 pills.
- Regardless of number, all the pills in the POP packet are active and contain hormones.
- The client should take 1 pill each day at the same time.
- When she finishes the packet, she begins a new packet the very next day at the same time without missing a single day.

Tell participants:

- As with low-dose COCs, there are several brands of progestin-only pills available in the Russian Federation.
- Despite the fact that they may vary SLIGHTLY in the dose or type of progestin they contain, they all work the same way and are similar in terms of effectiveness.
- Neither you nor the client should be overly concerned about these slight variations in brands. It is important to reassure the clients who might be given packets that look different.
- Regardless of how the packet or pills look, she takes them the same way.
- A woman can be provided with POPs at any time, but must be told when to start taking the pills.

Then **tell** participants this information while **showing** these **slides**:

When to start progestin-only pills:

A woman can start POPs:

- on any of the first 5 days after menses (bleeding) begins. The first day is the easiest to remember.
- after day 5 of the menstrual cycle if she is reasonably certain she is not pregnant. If she starts POPs more than 5 days after menses began, she should use condoms or abstain from intercourse for the next 2 days.

- 6 weeks postpartum, if breastfeeding.
- immediately postpartum or within 21 days if not breastfeeding.
- immediately when switching from another contraceptive method.
- within the first 7 days after miscarriage or abortion.
- any time she is reasonably certain that she is not pregnant.

Ask:

- ***Which of these guidelines for starting POPs are different from low-dose COCs?***

Listen to a few responses.

Tell participants:

- The guidelines are different for breastfeeding women: They can start POPs earlier, at 6 weeks postpartum.
- If starting POPs more than 5 days after menses begin, it is only necessary to use condoms or abstain from intercourse for the next 2 days.

Tell participants the following while showing these **slides**.**What the client should do if she misses pills:**

If the client is not breastfeeding and misses one or more pills for more than 3 hrs:

- She should take one pill as soon as she remembers and take the next pill at the usual time (this may mean taking 2 pills at the same time).
- She should continue taking the rest of the pills at the usual time.
- She should use condoms or abstain from intercourse for the next 2 days.
- If the client misses pills frequently, she should consider choosing another method.

If the client is breastfeeding and misses one or more pills for more than 3 hrs:

- She should take one pill as soon as she remembers and take the next pill at the usual time (this may mean taking 2 pills at the same time).
- She should continue taking the rest of the pills at the usual time.
- Since breastfeeding provides extra contraceptive protection, she does not need to use condoms or abstain from intercourse for the next two days.
- If the client misses pills frequently, she should consider choosing another method.

Protection against STIs/HIV:

- POPs do NOT provide any protection against STIs or HIV.
- Clients at risk for STIs/HIV should be counseled to use a condom with each act of intercourse even if another method is being used for contraception (dual method use).
- If indicated, show clients how to use condoms correctly as well as how to use their chosen method.

During a return visit it is important to:

- ask if the client has any questions or concerns.
- ask the client about her experience with POPs, whether she is satisfied, and whether she has any problems.
- ask if there has been any change in her health status (listen especially for changes that might indicate a medical condition that would make you recheck her medical eligibility for POPs).

- check blood pressure once a year if possible.
- help her choose another method if she is NOT satisfied with POPs.
- tell breastfeeding women they may wish to consider low-dose COCs or another method after 6 months.
- make sure she has a supply of POPs if available.

5. Facilitate a short role play (10 min)

Ask two participants to briefly role play the following situation. Tell the role players they can read the scenario in the **Participant Manual** in **Session 11: Progestin-only Contraceptives**.

Tell the role players to **STOP** after the "provider" has found out about the "client's" conditions.

Note to trainer: This scenario is found in the Participant Manual.

Role Play Scenario

A 28-year-old woman would like to take oral contraceptive pills, since she used to take them when she was younger and found them very convenient – and she "trusted them." She and her partner have been using spermicides, but they find them messy. They have a 2-year-old and want another child in the future, but not for several more years.

After showing her some sample packets of pills, it was determined that she used to take low-dose COCs. Since the birth of her child, she has developed a "blood pressure problem" and goes for regular visits to her doctor for monitoring. Today her blood pressure is 145/94.

1. Is this woman eligible for low-dose COCs?
2. How would you counsel her?

After the role play stops, **ask** participants:

- ***Is this client eligible for low-dose COCs?***

Listen to a few responses.

Note to trainer: The correct answer is:

- ***No: Her blood pressure is higher than 140/90.***

Ask:

- ***How would you counsel her?***

Listen to several responses.

Then **ask** the role players to **continue the role play** for another 5 minutes, with the "provider" counseling the "client."

Note to trainer: In the role play, the "provider" should:

- *Explain the reason the woman is not eligible for low-dose COCs.*
- *Offer other methods such as POPs and explain how they work (give the usual summary of information as discussed previously.)*
- *If the woman chooses POPs, clarify any confusion she might have about the difference between low-dose COCs and POPs (e.g. number of pills in packet).*

End the role play and **thank** the role players.

Tell participants:

- Usually if a client indicates a preference to take pills as her contraceptive method, the provider would begin by determining her eligibility for low-dose COCs.
- Progestin-only pills are usually only considered and discussed in counseling as an option for breastfeeding women or women who have medical conditions that make them ineligible for low-dose COCs.

6. Conclude the session

Tell participants:

- In the next session, we will discuss a different method: the intrauterine device (IUD).

Injectable Contraceptives

From the Reproductive Health Outlook (RHO) website: <http://www.rho.org>

RHO provides up-to-date summaries of research findings, program experience, and clinical guidelines related to key reproductive health topics, as well as analyses of policy and program implications. An important objective of RHO is to help users link with quality online resources and collaborate with colleagues around the world. RHO is published by PATH.

Overview

Injectable contraceptives contain synthetic hormones that are administered by deep intramuscular injection. Injectables are a safe and effective method of reversible contraception for most women (IFFP 1999). Two types of injectable contraceptives are available: progestin-only injectable contraceptives and combined injectable contraceptives that contain both a progestin and an estrogen hormone. Available progestin-only injectables include DMPA (depot medroxyprogesterone acetate) and NET-EN (norethindrone enanthate). Available combined injectables are Cyclofem™ (also called Lunelle) and Mesigyna ®.

Characteristics of injectable contraceptives

Effectiveness	Progestin-only injectables: 0.1% to 0.6% failure rate during first year of use. Combined injectables: 0.2% to 0.4% failure rate during first year of use.
Age limitations	No general restrictions on use based on age for combined injectables; progestin-only injectables not recommended for girls younger than 16 because of theoretical concern about the effect on bone density.
Parity limitations	No restrictions on use.
Mode of action	Primarily by thickening cervical mucus, thereby preventing sperm penetration, and by inhibiting ovulation.
Effect on STI risk	Not protective.

Drug interaction	Use of certain antiseizure medications (barbiturates, carbamazepine, phenytoin, primadone) and antibiotics (Rifampin and Griseofulvin) may reduce the contraceptive effect of injectables .
Duration of use	Most women can use injectables safely throughout their reproductive years (if the woman is satisfied with the method and has no problems with it).
Return to fertility	After a delay of about three to six months for progestin-only injectables; within three months for combined injectables.

Key issues

DMPA and Cancer

Although injectable contraceptives were developed shortly after COCs, political controversy has limited their availability until recently. DMPA (known widely under the brand name Depo-Provera) has been the most widely studied injectable contraceptive. Recent research by the World Health Organization has allayed much of the fear about DMPA and cancer. According to a nine-year WHO study, DMPA did not increase women's overall risk of breast cancer, invasive cervical cancer, liver cancer, or ovarian cancer, and it decreased the risk of endometrial cancer. Women may face a slightly increased risk of breast cancer in the first five years after they start DMPA, perhaps due to accelerated growth of existing tumors (PATH/Outlook 1992; Lande 1995). These studies and the 1992 approval of DMPA in the United States has helped pave the way for increased use of both progestin-only and combined injectable contraceptives (PATH/Outlook 1992).

DMPA and Bone Mass

Studies on the effects of DMPA on bone mineral density have been controversial. However, one recent study on the effect of DMPA on bone mineral density seems to offer reassurance regarding long-term use of the drug. Results of a longitudinal cohort study of 59 Chinese women have led its researchers to conclude DMPA can be used on a long-term basis without fear of linear bone loss leading to early osteoporosis. Over a three-year period, the annual rate of bone loss at three sites (lumbar spine, neck of the femur, and the Ward's triangle) was significantly less than projected values, and the duration of DMPA use was not significantly related with the rate of bone loss (Tang 2000). An interesting review of hormonal contraceptives and bone mass is presented in

the IPPF Medical Bulletin (Meirik 2000). In this article, Dr. Olav Meirik concludes that the long-term effects of hormonal contraceptives on bone mass are dependent on age and the life cycle. For women in the middle years of their reproductive lives, bone-mass changes resulting from hormonal contraceptives are small and transient. In adolescents, however, DMPA in particular does seem to slow the accumulation of bone mass. It is not yet known whether this is a transient effect.

While the effects of DMPA and levonorgestrel implants on the bone mass of women in perimenopause have not been well studied, two recent studies shed some light on these issues. A study on the effect of DMPA on bone mass in women aged 30–45 years did not find that DMPA accelerated bone loss during this stage of life. For those DMPA users who did experience high bone loss early in the study, some—but not all—successfully used estradiol or calcium to reduce bone loss (Merki-Feld 2003). The second study evaluated early menopausal bone loss among women who had used DMPA through menopause compared to a control group who reached natural menopause and did not undergo hormone replacement. The DMPA group showed little change in bone mineral density during the three-year study compared to the control group, which showed rapid loss of bone density. The authors conclude that women who use DMPA through menopause have less severe rates of bone loss from lumbar spine and femoral neck, possibly because they have already lost the estrogen-sensitive component of bone (Cundy 2002).

DMPA and STI Risk

Worldwide nearly 150 million women use hormonal contraception. Use of progestin-only injectables, primarily DMPA, is high in some areas of the world where HIV prevalence is high. The relationship between hormonal contraception and acquisition, transmission, and progression of STIs—including HIV—continues to be an important area of research (FHI 2003; FHI 2001). Research results are conflicting for a variety of reasons, but it is clear that hormonal contraceptives do not protect against STIs or HIV. Providers should counsel women who use injectable contraceptives to use a condom during each act of intercourse to protect against STI or HIV infection.

Recently announced results of a study in the United States found that women who used DMPA appear to have a three-fold increase in risk of acquiring Chlamydia and Gonorrhea infection when compared to women not using hormonal contraception (MAQ 2004). While the study results should be taken seriously, the study sponsors do not call for changes in provision or use of DMPA. It is important to note that there is no increased risk of infection for women who are in monogamous relationships with uninfected partners. Reproductive Health Technologies Project has issued a brief discussing the findings from this study (RHTP 2004).

Safe Injection Practices

Where available, auto-disable (AD) syringes and sharps disposal containers can improve injection safety for family planning clients, health workers, and communities by reducing reuse of needles and preventing needle stick injuries (PATH/USAID 2001).

12. Intrauterine Devices

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

- explain the key information about intrauterine devices that should be covered in a counseling session with a client, including effectiveness, how to use the method, advantages and disadvantages, side effects and protection against STIs/HIV.
- list conditions that make intrauterine devices a poor choice for some clients.
- discuss common myths and rumors about IUDs and explain why they are incorrect.

Time: 1 hour 10 minutes

Techniques:

- Presentation and discussion, small group work

Materials:

- IUD samples, WHO *Medical Eligibility Criteria for Contraceptive Use* manual, IUD and "How to tell if a woman is not pregnant" Cue Cards, Illustrated Flip Book: "Contraception: How to Prevent an Unwanted Pregnancy," slides

Activities:

1. Introduce intrauterine devices (5 min)

Tell participants:

- This session will focus on the intrauterine device.
- Compared to the methods discussed so far, the IUD is not user-dependent and protects against unintended pregnancy for a much longer term.
- IUDs are the most popular form of reversible contraception in the world: 15% of all married women of reproductive age use an IUD.

Distribute sample IUDs among the participants for them to look at.

Ask:

- ***Do women at your health facility often choose IUDs? Why or why not?***
- ***Which IUD models do women in your region use most frequently and why?***

Summarize the main points you have heard about participants' experience with IUD clients.

2. Conduct small group work: Basic information about IUDs (15 min)

Ask participants to take out their **IUD Cue Card**.

Divide the participants into 6 small groups, mixing them up to work with new people.

Show the list of questions for groups on the following **slide**.

Group work topics from IUD Cue Card:

Group 1:

- Brief explanation
- How it works
- Effectiveness

Group 2:

- Advantages

Group 3:

- Disadvantages

Group 4:

- Possible side effects
- Eligibility

Group 5:

- When to insert
- How to use

Group 6:

- Additional points
- Return visits

Tell participants:

- With your group, follow the instructions for this activity in the **Participant Manual, Session 12: Intrauterine Devices**.
- You will have **15 minutes** to work.

Note to trainer: This task sheet is found in the Participant Manual (Session 12).

IUD Task Sheet

- With your group, read about your assigned topic(s) on the **IUD Cue Card**.
- Be prepared to present the information about your topic(s) to the rest of the participants. You can use a creative method if you prefer (such as a role play, quiz, discussion).
- You will have 5 minutes to present the information.

3. Groups present IUD basic information (40 min)

When groups have finished, **bring** everyone back together.

Ask each group in turn to present their assigned topics.

For each group:

- **Listen** to make sure the participant explained the information clearly and accurately, and make corrections if needed.
- **Ask** if there are any questions about the information just presented.

*Note to trainer: The information that each group should present on each topic is shown below for your reference. This information is taken from the **IUD Cue Card**.*

For some of the topics shown below, there are also additional slides for the trainer to present immediately after the group's presentation.

Invite Group 1 to present.

Group 1:

*Note to trainer: The group should present the following information from the **IUD Cue Card**:*

Brief explanation:

- *The IUD is a small flexible device made of metal and/or plastic that is inserted by a trained provider into the uterine cavity through the vagina and cervix.*
- *The IUD has two short strings that hang through the opening of the cervix into the vagina. These allow the woman to know the IUD is in place by touching the strings.*
- *The IUD is a very convenient long-term method of contraception, and can be left in place for up to 10 years (depending on the type chosen) before replacing.*
- *It can be removed at any time by a trained provider.*

How it works:

- *Most IUDs either contain copper or release hormones, and prevent the egg and sperm from meeting.*

Effectiveness:

- *Typical and perfect use have almost the same effectiveness (99%) since the method depends very little on action by the user.*

After the group has finished, **tell** participants this additional information while **showing** these **slides**.

Types of IUDs:

- The most widely used IUDs are copper-bearing IUDs.
- Inert (unmedicated) and progestin-releasing IUDs (levonorgestrel or progesterone) are also available.

IUDs commonly available in the Russian Federation and their duration of action:

- Copper-containing IUDs:
 - Copper T-380 A - protects for up to 10 years.
 - Multiload - protects for up to 5 years.
- Hormone-releasing IUDs:
 - Levonorgestrel (Mirena) - protects for up to 5 years.
 - Progesterone (Progestasert)– protects for only 12-18 months.

Show participants the illustration of the uterus in the **Flip Book "Contraception: How to Prevent an Unwanted Pregnancy"** to show where the IUD is inserted.

Invite Group 2 to present.

Group 2:

*Note to trainer: The group should present the following information from the **IUD Cue Card**:*

Advantages:

- *Highly effective long-term prevention of pregnancy.*
- *Copper-bearing IUDs have no hormonal effects; safe for most women including those with medical conditions that made them not eligible for hormonal methods (low-dose COCs, POCs).*
- *Does not require much routine action from the woman; once it is inserted, she only needs to occasionally check that she can feel the strings.*
- *Can be inserted immediately postpartum or postabortion if no evidence of infection.*
- *Can be removed at any time and fertility returns at once.*
- *Can be used through the peri-menopause period to menopause (1 year after last menses).*
- *Can be a good alternative for women who are not ready for a permanent method, but want a long-acting method.*
- *Can be a good alternative for women who do not want more children and would like a permanent method, but who do not meet Russia's criteria for surgical sterilization.*
- *Can be very cost-efficient: No supplies needed for up to 10 years depending on the type of IUD chosen.*
- *Does not interfere with sexual activity.*
- *Copper-bearing IUDs can also be used for emergency contraception.*

Invite Group 3 to present.

Group 3:

*Note to trainer: The group should present the following information from the **IUD Cue Card**:*

Disadvantages of the IUD:

- *Does not protect against STIs/HIV.*
- *Not a good method for women with recent STIs (within past 3 months) or who are at risk for STIs (she or her partner(s) have multiple sex partners and/or history of frequent STIs) because the presence of an STI during insertion can lead to pelvic inflammatory disease.*
- *Pelvic exam and procedure needed to insert and remove IUD; provider needs special training.*
- *Some discomfort and bleeding may occur after insertion (usually stop within 48 hours).*
- *IUD may be expelled without the woman knowing (more common during first menses after insertion and/or if inserted immediately postpartum).*
- *Woman should insert fingers into vagina occasionally to check for strings; some women may not want to do this.*
- *The IUD may perforate the wall of the uterus during the insertion procedure; perforation is rare when the insertion is done by a trained provider.*

Invite Group 4 to present.

Group 4:

*Note to trainer: The group should present the following information from the **IUD Cue Card**:*

Possible side effects:

- *Temporary spotting and cramps during the first few days following insertion (can be managed with ibuprofen or aspirin).*
- *Changes in menses: Longer and heavier bleeding, bleeding or spotting between menses, more cramping during menses.*
Reassure the woman that these side effects are normal and usually stop within 3 months. Not everyone has them.

Eligibility (Who should NOT use an IUD):

- *Women who might be pregnant.*
- *Women who have had vaginal bleeding that is unusual for them within the past 3 months; this condition should be evaluated before inserting an IUD.*
- *Women with a current STI or history of an STI within the past 3 months. If an STI is known or suspected, she should be treated, and an IUD should not be inserted until 3 months after successful treatment.*
- *Women who are at high risk for STIs (she or her partner(s) have multiple sex partners and/or history of frequent STIs).*
- *Women with cancer of the female organs (cervical, endometrial, ovarian).*

After the group has presented, **tell** participants this additional information:

- There is often a lot of confusion about whether women who are under 20 or who have not yet had a child can use an IUD.

Then **tell** participants this information while **showing** this **slide**.

Eligibility for IUDs:

- IUDs are **not** restricted for women who are nulliparous or are under 20 years of age.
- These women have a slightly higher risk of expulsion; however, they can still use the method successfully.

Invite Group 5 to present.

Group 5:

*Note to trainer: The group should present the following information from the **IUD Cue Card**:*

When to insert:

- *At any time during the menstrual cycle if reasonably certain that the woman is not pregnant.*
- *Immediately after stopping another contraceptive method.*
- *Any time within the first 48 hours postpartum (if the woman has been counseled and has given consent before delivery); within 10 minutes of delivery of the placenta is best.*
- *If not inserted within the first 48 hours postpartum, insertion should not be done until 4 weeks postpartum.*
- *Immediately postabortion if no sign of infection.*

How to use:

- *The woman should check at least once a month to make sure she can feel the strings.*
- *If she cannot feel the strings, she should use condoms or abstain from intercourse until she can return to the clinic.*
- *Ibuprofen or aspirin will help relieve discomfort (if any) after insertion or during menses.*
- *ALSO use condoms if at risk for STIs/HIV.*

After the group has presented, **tell** participants this additional information:

- Remember that an IUD should only be inserted when it is reasonably certain that the client is not pregnant.
- The **Cue Card titled "How To Tell If A Woman Is Not Pregnant"** is a reference you can use when counseling women on IUDs or other contraceptive methods.

Invite Group 6 to present.

Group 6:

*Note to trainer: The group should present the following information from the **IUD Cue Card**:*

Additional points:

- *IUDs can only be inserted and removed by trained providers.*
- *Refer clients wanting an IUD to a known facility that provides IUDs, if not available at your facility.*
- *The woman should be given a **written record** of the type of IUD inserted, date of insertion and when the IUD should be removed.*
- ***Whenever a client needs to wait to start any chosen method**, she should be advised to either abstain from intercourse or use condoms in the interim and should be counseled on consistent and correct use of condoms.*
- *The copper-bearing IUD can also be used as emergency contraception if inserted within 5 days (120 hours) of unprotected sex; this is an especially effective treatment for women who want to then continue using the IUD as a regular contraceptive method. See **Emergency Contraception Cue Card** for details.*

Return visits:

- *The client should return after her first menses or by 6 weeks after the IUD insertion. The provider should conduct a pelvic exam to check that the IUD is in place and that there is no sign of infection.*
- *Following this initial return visit, the client need not return unless she has concerns or problems or wishes to have the IUD removed.*

After the group has presented, **tell** participants this additional information:

- If a woman chooses to use a copper-bearing IUD for emergency contraception:
 - It should be inserted by a trained provider within 5 days (120 hours) of the unprotected intercourse.
 - For women in need of emergency contraception who also want to later use an IUD as their regular method, the insertion of an IUD immediately can be an effective and logical choice.
 - Emergency contraception by IUD insertion is even more effective than the use of pills.
- We will discuss emergency contraception in more detail in a later session.

Conclude the group presentations and **thank** the presenters.

4. Discuss IUD insertion and removal (5 min)

Remind participants:

- The IUD can only be inserted and removed by a provider who has special training in these procedures.

Ask:

- ***How many of you are trained in IUD insertion and removal?***

Listen to several responses. Then **tell** participants:

- Since not everyone is trained in IUD insertion and removal, it is sometimes necessary to refer clients.
- If you are trained in IUD insertion, you may receive referrals from your colleagues who are not trained.

Tell participants this information while **showing** these **slides**:

IUD insertion:

The provider doing the actual insertion should:

- determine when to do the actual insertion.
- teach the client to check for the presence of the string.
- give her a written record of the date of insertion and when the device should be removed.
- advise of possible problems and need for follow-up.

5. Discuss myths about IUDs (5 min)

Tell participants:

- Some clients do not choose the IUD because they have heard incorrect myths and rumors about this method.

Ask:

- ***What are myths and rumors that you or your clients hear about IUDs?***

Listen to several examples.

Then **tell** participants this information while **showing** these **slides**, pointing out the myths participants have already mentioned.

Common myths and rumors about IUDs:

"IUDs cause infertility."

- You can tell clients: The contraceptive effect of the IUD is immediately reversible once the device is removed. It does not affect fertility.

"The IUD grows into the woman's uterus."

- You can tell clients: The IUD is made of a safe material that will not irritate the uterus or attach to its walls even when an IUD is in the uterus for 10 years.

"The IUD will bother the partner during sex."

- You can tell clients: The IUD is inserted inside the uterus, where neither partner can feel it during intercourse. Rarely, the partner can feel the IUD's string, which extends into the vagina, in which case the string can easily be shortened by a trained provider.

"IUDs increase the risk of cancer."

- You can tell clients: There is no scientific evidence that suggests this.

6. Conclude the session

Tell participants:

- Now that we have discussed several different contraceptive methods, we will put this information into practice through counseling role plays in the next session.

13. Counseling Practice Day Two: Role Plays

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

- demonstrate GATHER method counseling skills in role-play situations for different clients.
- give and receive feedback with peers on counseling skills.

Time: 1 hour 40 minutes

Techniques:

- Role play and feedback

Materials:

- All Cue Cards, Illustrated Flip Book: "Contraception: How to Prevent an Unwanted Pregnancy," client role description cards with cases for role plays, WHO *Medical Eligibility Criteria for Contraceptive Use* Manual, sample products (condom, spermicide, low-dose COC and POP packets, IUD)

Preparation:

- Make client role description cards (*provided at the end of this session*).

Activities:

1. Demonstrate good counseling through a role play (15 min)

Tell participants:

- In this session, you will put into practice what you have learned so far by conducting role plays of family planning counseling situations.
- These role plays will ask you to draw on what you have learned about several different contraceptive methods, as well as your counseling skills.

To remind participants of the counseling skills discussed in earlier sessions, **ask:**

- ***What are the six steps in the GATHER method of counseling?***

Note to trainer: The correct answer is:

G – Greet the Client

A – Ask the client about her/himself

T – Tell the client about choices

H – Help the client make an informed choice

E – Explain how to use the chosen method

R – Return visits should be welcomed

Ask:

- ***What are some of the principles of counseling we discussed earlier?***

Listen to a few responses.

If the following principles are not mentioned, **add** them:

- Treat each client well.
- Interact.
- Tailor information to the client.
- Avoid too much information.
- Respect the client's right to choose.
- Help the client understand and remember.

Ask participants to make sure they have at hand the following materials:

- **Illustrated Flip Book "Contraception: How to Prevent an Unwanted Pregnancy"**
- **Cue Cards** for all methods discussed so far:
 - **Standard Days Method**
 - **Male Condoms**
 - **Vaginal Spermicides**
 - **Low-dose Combined Oral Contraceptives**
 - **Progestin-only Pills**
 - **Progestin-only Injectables**
 - **Intrauterine Device**
- **GATHER Method of Counseling Cue Card**
- **Client-Provider Interaction Checklist** in their **Participant Manual**, found in **Session 5: Principles of Counseling**.

Tell participants:

- To provide a model of good counseling, the trainers will first demonstrate a counseling session.
- During the role play, pay attention to how the trainers use the GATHER method and counseling skills. You can refer to the **GATHER Cue Card** and the **Client-Provider Interaction Checklist** to check the trainers' performance.

Conduct the demonstration for the following scenario (5-10 min).

A 21-year-old woman comes to the clinic. She is very excited as she has just graduated from University and plans to be married in 3 months. She is anxious to learn about family planning. She and her fiancé don't want to have a child for several years and have discussed contraception and think that they might like to use either the pill or an IUD.

After completing the role play demonstration, **ask:**

- ***What did you notice in this role play?***
- ***How did the "provider" use the GATHER method?***
- ***What verbal and nonverbal communication techniques did he/she demonstrate?***

Listen to several responses to each question.

Summarize the main points you heard from participants.

Tell participants:

- Now it is your turn to practice these same counseling skills.

2. Introduce the small group role play activity (5 min)

Divide the participants into groups of 3, mixing them up to work with new people.

Ask participants to look in the **Participant Manual** to find the "**Task Sheet for Counseling Practice Role Plays**" in **Session 13: Counseling Practice Day Two**.

Note to trainer: This task sheet is found in the Participant Manual.

Task Sheet: Counseling Practice Role Plays

- Choose one person to play the "client" role.
- Choose another to play the health care "provider" role.
- The third person will be an observer.
- The "provider" should use the Cue Cards and Flip Book.
- There are sample contraceptive products available at the front of the room for the "providers" to use if desired.
- You will have **15 minutes to act out the role play.**
- Afterward, **discuss** the role play for **5 minutes.**
 - The "provider" reflects on his/her own performance.
 - Then the "client" gives the "provider" feedback.
 - Then the observer gives the "provider" feedback.
- Feedback should focus on whether the "provider":
 - used good communication and counseling skills.
 - followed the GATHER steps of counseling.
 - explained the key information about the method using the Cue Card.
 - applied the WHO Medical Eligibility Criteria given on the Cue Card.

3. Have groups conduct role play: Round 1 (20 min)

Distribute the **Round 1 Client Role Description** to the "client" in each group.

Tell the "client":

- Do not share the information with the others in the group – let the "provider" find out by asking questions.

Note to trainer: Client role description cards are provided at the end of this session.

Round 1: Client Role Description

You are a 37-year-old married woman with 3 children. You are not using a contraceptive method and have had several abortions. You are interested in discussing family planning, because you don't think you want more children, but you don't have any method in mind.

Tell the groups to start the role play.

Circulate and observe how the groups are performing.

After 15 minutes, **remind** the groups that they should finish the role play and begin the feedback discussion.

4. Have groups conduct role play: Round 2 (20 min)

Ask participants to change roles within their same group.

Distribute the **Round 2 Client Role Description**.

Round 2: Client Role Description

You are a 20-year-old woman who is planning to marry in 3 months. You came to the clinic for vaccinations required for university. You have been taking low-dose COCs for 1 year, but you don't like taking a pill every day. In fact, you occasionally forget because you are so busy with school and wedding plans. You are relieved that your most recent menses came last week, and you want to change methods before you forget your pills again. You are attending University and don't want to get pregnant for at least two or three years.

Tell the groups to start the role play.

Circulate and observe how the groups are performing.

After 15 minutes, **remind** the groups that they should finish the role play and begin the feedback discussion.

5. Have groups conduct role play: Round 3 (20 min)

Ask participants to change roles within their same group. All three group members should now have had a chance to play the "provider."

Distribute the **Round 3 Client Role Description**.

Round 3: Client Role Description

You are a 22-year-old single woman who became sexually active in the last year. You date various men and occasionally have sex with casual partners. You came to the clinic because you noticed a burning sensation when you urinate. You do not want to become pregnant. Some of your friends have told you they take "the pill."

Tell the groups to start the role play.

Circulate and observe how the groups are performing.

After 15 minutes, **remind** the groups that they should finish the role play and begin the feedback discussion.

6. Discuss the role plays in plenary (20 min)

Reconvene the participants.

Ask:

- ***What did you learn in these role plays?***
- ***What was easiest? What was difficult?***
- ***Do you have any questions about the cases?***

Listen to several responses.

Summarize the main points you heard and **answer** questions.

Invite one group to choose one of their 3 role plays to perform in front of everyone. They have **10 minutes** to perform their role play.

When the role play is finished, **ask** the "provider":

- ***How would you rate your performance? What were the strengths and weaknesses?***

Ask the "client":

- ***How did you feel in this role? What suggestions do you have for the "provider"?***

Ask the rest of the participants:

- ***What else did you observe about this role play?***

Listen to several responses.

Summarize the main points you heard.

Thank the role players.

Note to trainer: If participants need guidance to help them give structured, specific feedback, you can ask them some of the following guiding questions.

- *Did the provider greet the client and make her feel comfortable?*
- *Did the provider ask the client about her family planning needs and interests?*
- *Did the provider ask if the client had a particular contraceptive method in mind?*
- *Did the provider focus on the method the client had in mind?*
- *Did the provider determine her medical eligibility for the method?*
- *Did the provider explain the advantages and disadvantages of the method?*
- *Did the provider explain how to use the chosen method?*
- *Did the provider make sure the client understood?*
- *Did the provider give the client the opportunity to ask questions?*
- *Did the provider inform the client of possible side effects?*
- *Did the provider inform the client about whether her method would offer protection against STIs/HIV?*
- *Was this client possibly at risk for exposure to STIs/HIV? Why? Did the provider discuss this risk and discuss using condoms in addition to her family planning method?*
- *Did the provider discuss when to return to the clinic?*
- *Was the provider actively listening? How could you tell?*

7. Conclude the session

Tell participants:

- We will continue building on these counseling skills in the coming sessions.
- In the next session, we will move on to discussing permanent methods.



Counseling Practice Role Plays: Day Two

Client Role Descriptions

Note to trainer: Make 5 or 6 copies of this page and cut it into pieces with one "role" per piece. Distribute the appropriate role description to the "client" in each group at the start of each round.

Round 1: Client Role Description

You are a 37-year-old married woman with 3 children. You are not using a contraceptive method and have had several abortions. You are interested in discussing family planning, because you don't think you want more children, but you don't have any method in mind.

Round 2: Client Role Description

You are a 20-year-old woman who is planning to marry in 3 months. You came to the clinic for vaccinations required for university. You have been taking low-dose COCs for 1 year, but you don't like taking a pill every day. In fact, you occasionally forget because you are so busy with school and wedding plans. You are relieved that your most recent menses came last week, and you want to change methods before you forget your pills again. You are attending University and don't want to get pregnant for at least two or three years.

Round 3: Client Role Description

You are a 22-year-old single woman who became sexually active in the last year. You date various men and occasionally have sex with casual partners. You came to the clinic because you noticed a burning sensation when you urinate. You do not want to become pregnant. Some of your friends have told you they take "the pill."

Daily Reflection

Take 5 minutes to conduct a short **reflection** and **evaluation** exercise.

- Suggested activities are provided in the **Introduction to the Trainer's Guide**.
- **Review** the results of the daily evaluation in the evening, and use them to help you plan for the next day.

This is also a good time to **answer** any questions sitting in the **Parking Place**.

Remind the **Volunteer Team** to stay for the **Steering Committee Meeting**.

Morning Review of Daily Activities

Invite the **Volunteer Team** to start the day. They should be prepared to:

- **Review** the previous day's activities. This can be in the form of a quiz, game or fun activity for the group; or they can briefly talk about the main things they learned yesterday.
- **Report** on the main things that were discussed during the **Steering Committee Meeting** the night before. For example, if participants gave feedback about something needing improvement, the **Volunteer Team** can report how the concern was resolved.
- **Warm up** the group with a short energizer.

The Volunteer Team has a total of **15 minutes** to complete these activities.

Trainers and participants **make announcements** as needed.

14. Voluntary Surgical Contraception

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

- explain the key information about voluntary surgical contraception that should be covered in a counseling session with a client, including effectiveness, how to use the method, advantages and disadvantages, side effects and protection against STIs/HIV.
- list conditions that make permanent methods a poor choice for some clients.
- discuss common myths and rumors about voluntary surgical contraception and explain why they are incorrect.
- define informed consent.

Time: 1 hour

Techniques:

- Presentation and discussion, individual questionnaire

Materials:

- Permanent Methods Cue Card, slides

Activities:

1. Introduce the permanent methods: vasectomy and tubal ligation contraception (5 min)

Tell participants:

- So far, every contraceptive method we have discussed has been totally reversible, and clients can just stop using the method if they want to get pregnant.
- In this session, we will talk about permanent methods of contraception – tubal ligation for women and vasectomy for men.

Ask:

- ***Do you often counsel clients on voluntary surgical contraception? Do you hear of men and women who are certain they want no more children and wish they didn't have to be continually concerned about an unintended pregnancy?***

Listen to a few responses.

Tell participants this information while **showing** this **slide**:

Voluntary surgical contraception:

- Types:
 - female: tubal ligation
 - male: vasectomy
- Generally the vasectomy procedure is shorter, easier and cheaper and has a lower risk of complications than the tubal ligation procedure.
- Both procedures are safe and highly effective.

2. Explore myths and rumors about voluntary surgical contraception (20 min)

Tell participants:

- Although permanent methods are safe, effective, and very popular around the world, there are many myths and rumors among both clients and providers.

Ask participants to turn to **Session 14** in their **Participant Manuals** to find the **“Voluntary Surgical Contraception: Fact or Fiction?”** questionnaire

Tell participants:

- Fill out this questionnaire individually.
- Mark each statement true or false.
- You have **5 minutes** to complete it.

When participants have finished, **ask** a volunteer to read the first statement, and to explain why it is true or false.

If other participants disagree, **ask** them to explain **why**.

Go through all the statements in the questionnaire in this way.

Note to trainer: The trainer's Answer Key with the correct answers is given below. Make sure participants know the correct answer and why the statement is true or false.

Note to trainer: This quiz is found in the Participant Manual. The answers are shown in italics below.

Voluntary Surgical Contraception: Fact or Fiction?

For each statement below, write down whether it is true or false.

Trainer's Answer Key: Answers are given at the right, with explanations in italics.

- | | True or
False? |
|---|---------------------------|
| <p>1. Tubal ligation is a painful and complicated procedure.
 <i>Tubal ligation is a simple surgical procedure when done by a trained provider. Vasectomy is even simpler. Neither surgery is painful or complex. After surgery the woman may feel minor discomfort for a few days.</i></p> | <i>FALSE</i> |
| <p>2. After surgical tubal ligation, the woman becomes frigid (loses interest in sex).
 <i>Tubal ligation does not change the woman's ability to become aroused and does not affect the woman's ability to have sex or to enjoy it. On the contrary, often the woman feels more liberated as she stops worrying about the possibility of an unintended pregnancy.</i></p> | <i>FALSE</i> |
| <p>3. It is usually possible to reverse a tubal ligation or a vasectomy.
 <i>It is expected that the effect of these procedures will be permanent, with the exception of rare cases of failure. No one should choose a permanent method with the expectation that it could be reversed at a later date. Sometimes reconstructive surgery is attempted, but such surgeries are frequently unsuccessful and quite expensive. Often they are not even possible.</i></p> | <i>TRUE</i> |
| <p>4. Menstruation will continue after tubal ligation.
 <i>The menses after tubal ligation will be the same as before the procedure until the onset of menopause. It is not true that menstruation will stop or that early menopause will occur.</i></p> | <i>TRUE</i> |
| <p>5. Vasectomy is the same as castration.
 <i>Vasectomy is not castration. During castration the testicles are removed. During a vasectomy, only the small tubes that carry sperm – the vas deferens – are cut. The testicles will not look or feel different after a vasectomy. Nor does vasectomy lead to any changes which may be observed after castration, such as voice changes, etc.</i></p> | <i>FALSE</i> |

<p>6. VSC causes a loss of sexual sensation. <i>Sterilization has no effect on the sexual sensations of the man or the woman. The couple may enjoy sex more because they can relax and not worry about unintended pregnancy.</i></p>	<i>FALSE</i>
<p>7. VSC does not affect the man's or woman's weight, nor cause hormonal changes to the secondary sexual characteristics (voice, hair). <i>None of the permanent methods cause weight loss or weight gain or changes in the secondary sexual characteristics.</i></p>	<i>TRUE</i>
<p>8. Permanent methods are the most commonly used methods of contraception in the world.</p> <ul style="list-style-type: none"> • <i>Tubal ligation is the most popular method of contraception in the world. Vasectomy is less popular, but in some countries - like the Netherlands, New Zealand and the United Kingdom – vasectomy is more commonly used than tubal ligation by couples choosing a permanent method.</i> 	<i>TRUE</i>

Ask:

- ***What other myths and rumors about voluntary surgical contraception have you heard from clients or other providers?***
- ***What effect do these myths and rumors have on clients' contraceptive choices?***

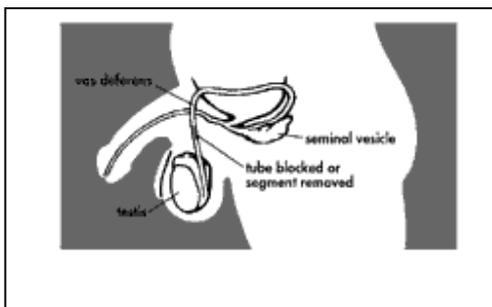
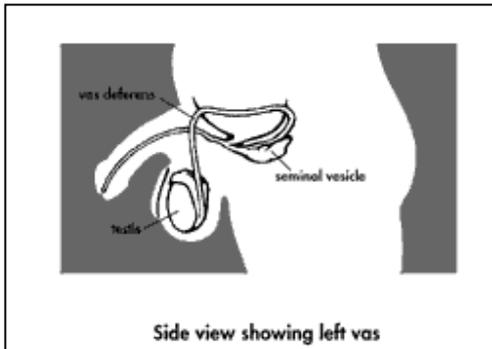
Listen to a few responses.

Tell participants:

- Myths and rumors like these may keep clients from accessing the full range of contraceptive choices.

3. Present the surgical procedures: vasectomy and tubal ligation (15 min)

Ask participants to look at the **drawing of the male anatomy** found in the **Participant Manual** in **Session 14**. **Show** it on a **slide**:



Source: "Vasectomy: Questions & Answers." EngenderHealth website, <http://www.engenderhealth.org/wh/fp/cvas2.html>, March 20, 2006.

Ask participants to look at the drawings. **Point out** that:

- The man's testicles – where sperm are produced - are located inside the scrotum.
- Small tubes called the vas deferens carry the sperm from the testicles to the opening in the penis called the urethra.

Tell participants this information while **showing** these **slides**.

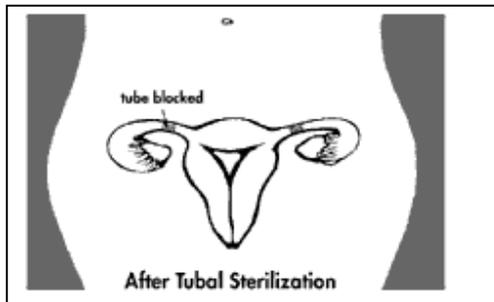
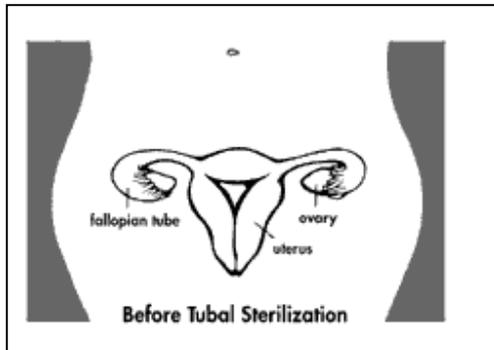
Vasectomy

- Vasectomy is a short, minor surgical procedure performed by a trained provider under local anesthesia.
- A small incision is made in the scrotum. Both tubes that carry sperm are ligated and a small section of tube removed.
- "No-scalpel" vasectomy can be performed through a small puncture in the scrotum without using a scalpel.

Vasectomy

- With the tubes blocked or cut, the man's sperm cannot meet the woman's egg.
- The man still has erections and ejaculates semen, but the semen cannot make a woman pregnant because there is no sperm in it.
- Vasectomy does not affect the man's ability to have sex or to enjoy it.

Ask participants to find the **drawing of the female anatomy** in **Session 14** of the **Participant Manual**, and **show** on these **slides**.



Source: "Female Sterilization: Questions & Answers." EngenderHealth website, <http://www.engenderhealth.org/wh/fp/cfem2.html>, March 20, 2006.

Ask participants to look at the drawings. **Point out** that:

- The woman's ovaries – where eggs are produced - are located in the abdomen.
- Tubes called Fallopian tubes transport the eggs – usually one per month - from the ovaries to the uterus.

Tell participants this information while **showing** these **slides**.

Tubal ligation:

- Tubal ligation is a simple surgical procedure performed by a trained provider under general or local anesthesia.
- A small incision is made in the woman's abdomen and either directly or via laparoscope the fallopian tubes are either blocked or cut.
- With the fallopian tubes blocked or cut, the woman's egg cannot meet the man's sperm.

- The woman still menstruates as before the procedure.
- Tubal ligation does not affect the woman's ability to have sex or to enjoy it.
- Tubal ligations can be done at various times using different procedures.
- In Russia today, most tubal ligations are done under general anesthesia using a laparoscope.

Effectiveness of voluntary surgical contraception:

- Both vasectomy and tubal ligation are more than 99% effective.
- Like the IUD, there is no difference between typical and perfect use because these methods are not user-dependent.

Protection against STIs/HIV:

- None.
- It is recommended that anyone at risk for STIs/HIV use a condom with each act of intercourse even if another method is being used for contraception (dual method use).
- If indicated, show clients how to use condoms correctly as well as how to use their chosen method.

4. Discuss the advantages and disadvantages of voluntary surgical contraception (10 min)

Ask:

- *What are the advantages of voluntary surgical contraception?*

Listen to all responses. **List** them on a **flip chart** as they are mentioned.

Then **show** the possible responses on these **slides, pointing out** those advantages that were not given by participants.

Advantages of voluntary surgical contraception:

- > 99% effectiveness.
- Permanent.
- No medical follow-up required once the procedure has been done.
- Does not interfere with sexual activity.
- Can lead to increased sexual satisfaction, because there is no need to worry about unintended pregnancies

- No long-term side effects or health risks.
- No costs beyond the initial procedure, no supplies to buy.
- Tubal ligation reduces risk of ovarian cancer and PID.

Ask:

- ***What are the disadvantages of voluntary surgical contraception?***

Listen to all responses. **List** them on a **flip chart** as they are mentioned.

Then **show** the possible responses on these **slides, pointing out** those disadvantages that were not given by participants.

Disadvantages of voluntary surgical contraception:

- Permanent; if client does not fully understand this, the client may later regret this decision. With proper counseling, this outcome is very unlikely.
- Possibility of minor complications after the procedure (pain, swelling, bleeding, or infection).

- Use of anesthetics, especially general anesthesia, carries some risk.
- Requires trained medical providers who may not be accessible in some areas.
- Provides no protection against STIs/HIV.

Tell participants:

- One disadvantage of voluntary surgical contraception in the Russian Federation is that these services are not widely available and there are medical barriers to accessing them.
- Vasectomy performed for contraceptive purposes is extremely rare.
- Women wanting a tubal ligation have to meet age and/or parity restrictions – currently she must be at least 35 years of age or have at least two children.
- For women wanting a permanent method but who do not meet the criteria for tubal ligation, IUDs - especially those with a 10 year duration of action - might be a long-acting, highly effective alternative method.

5. Discuss counseling for voluntary surgical contraception (5 min)**Ask:**

- ***What particular issues should be discussed with clients when counseling them about permanent methods?***

Listen to a few responses.

Then **show** the possible responses on these **slides, pointing out** any of the following points that are not raised by participants.

Counseling for voluntary surgical contraception:

- As with all family planning counseling, it is important to help the client make an informed choice.
- When a client is considering a permanent method, he/she needs to understand that this method is truly permanent.

- The client who has decided to have a tubal ligation should be referred to a trained specialist for further counseling and determination of eligibility before having the procedure.
- The client who is undecided should be given information about the procedure and invited to return if she has questions.
- In the meantime, all clients should be encouraged to continue with their current methods or offered help in choosing another method if desired.

6. Discuss informed consent (5 min)**Tell** participants:

- Clients choosing a permanent method should give "informed consent" to having the procedure performed.

Ask:

- ***What is "informed consent"?***

Listen to a few responses.

Tell participants the following definition while **showing** these **slides**:

"Informed consent" means that:

- the client has made a decision to have the procedure (she "consents"), without pressure from anyone else.
- she understands she will not be able to have any more children.
- she understands she has the right to choose this method or to refuse this method and instead use reversible methods or no method at all.

- she has been fully "informed" about the procedure and what it entails.
- she understands it is a surgical procedure with certain low risks and with certain benefits.
- she understands the procedure should be considered irreversible. (Although in some cases it can be reversed, usually this is not possible.)
- she may refuse to have the procedure performed at any time, and this refusal will not have any impact on her right to receive other services.

Tell participants:

- Because VSC is intended to be permanent, most countries require the informed consent process to be finalized in writing.

Ask participants to turn to **Session 14: Voluntary Surgical Contraception** in the **Participant Manual** to find a copy of the **Informed Consent Form** used in Russia, which they can read in detail during the evening or whenever it is convenient for them.

7. Conclude the session

Tell participants:

- This ends the portion of the training dealing with contraceptive methods. The next several sessions will cover family planning for clients in specific situations.

15. Emergency Contraception

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

- explain why emergency contraception is needed.
- explain the key information about emergency contraception that should be covered in a counseling session with a client, including effectiveness, how to use the method, advantages and disadvantages, side effects and protection against STIs/HIV.
- explain when and how a client should start a contraceptive method after using emergency contraception.

Time: 55 minutes

Techniques:

- Presentation and discussion, role play

Materials:

- **Emergency Contraception Cue Card**, slides

Activities:

1. Introduce emergency contraception (10 min)

Tell participants:

- Emergency contraception is a series of actions that can be taken soon after unprotected sex to help prevent unintended pregnancies.

Ask:

- *How often do you have clients seeking emergency contraception?*

Listen to a few responses.

Ask:

- *What are some situations in which a woman might need emergency contraception?*

Listen to several responses.

Add any of the following possible responses that were not mentioned:

- If she had intercourse and was not using any method of contraception.
- If she used contraception but it failed or she used it incorrectly.
 - condom breakage, slippage, or incorrect use.
 - missing pills or taking them late and not using a barrier method.
 - failed coitus interruptus/ withdrawal (e.g., ejaculation in vagina or on external genitalia).
 - failure of a spermicide tablet to melt before intercourse.
 - miscalculation of the Standard Days Method or having unprotected sex during her fertile period.
 - IUD expulsion.
- If she was sexually assaulted and was not protected by an effective contraceptive method.

Tell participants this information while **showing** these **slides**.

Emergency contraception is needed because:

- no contraceptive method is 100% effective.
- few people use their user-dependent methods perfectly every time they have intercourse.
- sometimes couples use no contraception, yet do not want to be pregnant.
- sexual assaults unfortunately occur.

WHO recommends that:

- women be encouraged to have a supply of emergency contraceptive pills on hand.

Recent evidence shows that:

- a woman is more likely to take emergency contraceptive pills after unprotected sex if she has a supply on hand.
- having emergency contraceptive pills on hand does not affect a woman's contraceptive use, does not increase her frequency of unprotected sex, and does not increase her frequency of emergency contraceptive use.

2. Present basic information about emergency contraception(20 min)

Tell participants: this information while showing these **slides**.

Types of emergency contraception:

- Progestin-only pills containing levonorgestral.
- In many countries, including Russia, levonorgestral pills are marketed as ECPs (brand name Postinor).
- Combined oral contraceptive pills.
- Intrauterine devices.

How to use pills for emergency contraception:

For use as an emergency contraceptive, pills should be taken:

- as soon as possible after unprotected sex for maximum effectiveness.
- within a maximum of 120 hours after the unprotected sex. The longer a woman waits to take them, the less likely they are to prevent pregnancy.

WHO-recommended dosage options for emergency contraceptive pills:

- A SINGLE dose of 1.5 mg of levonorgestral. The WHO Working Group considers this the best option.

OR

- TWO doses of 0.75 mg of levonorgestral; a first dose of 0.75 mg levonorgestral followed by a second dose of 0.75 levonorgestral 12 HOURS later.

OR

- TWO doses of combined estrogen-levonorgestral COCs: the "Yuzpe regimen" of a first dose of 100 microg of ethinyl estradiol plus 0.5 mg of levonorgestral followed by a second dose of the same 12 HOURS later.

Tell participants:

- You may be familiar with previous WHO guidance on emergency contraception that said emergency contraceptive pills (ECPs) could be used for up to 72 hours.
- The latest guidance from the WHO Working Group is that ECPs may be used for up to 120 hours but, as before, the sooner the better.
- The Expert Working Group recommends the single dose option because women are more likely to take a single dose than multiple doses.
- The Expert Working Group also recommends the levonorgestral-only regimen because it causes less nausea and vomiting, which are common side effects.

Tell participants this information while **showing** these **slides**:

How pills work when used for emergency contraception:

- Pills used for emergency contraception stop ovulation.
- They do NOT disrupt an existing pregnancy.
- Prior to using emergency contraceptive pills, no routine screening, examination or laboratory test is necessary.

Effectiveness of emergency contraceptive pills (ECPs):

- Pills used for emergency contraception prevent between 56% and 93% of pregnancies that would otherwise have occurred.
- The earlier the pills are taken, the greater their effectiveness.¹⁰
- Levonorgestral regimens are slightly more effective than the Yuzpe regimen.
- Using pills for emergency contraception is not as effective as consistent and correct use of modern contraceptive methods.

Tell participants:

- There is a more in-depth article in your **Participant Manual** in **Session 15**, entitled **“Regimen Update”** (International Consortium for Emergency Contraception, Policy Statement, July 2003), which you might enjoy reading in the evening or at another convenient time.

Client should be told:

- She should eat something soon after taking the ECPs to reduce nausea.
- If she vomits within 2 hours after taking the pills, she needs to take another dose.
- In most women, menses following treatment will occur within 1 week before or after the expected time.
- If her menstrual period does not come within 1 week after the expected time, she should return for evaluation of a possible pregnancy.

WHO medical eligibility criteria:

- There are no known medical conditions that preclude the use of ECPs.
- ECPs are not indicated in women with confirmed pregnancies because they will have no effect.
- However, ECPs may be given without pregnancy testing or when pregnancy status is unclear, as there is no evidence suggesting harm to the woman, the course of her pregnancy, or to the fetus if ECPs are used during pregnancy.

¹⁰ International Consortium for Emergency Contraception. Fact Sheet: Levonorgestrel for Emergency Contraception. March 2005.

- Breastfeeding women may use ECPs if needed. There is no evidence that ECPs will harm a breastfeeding woman or her infant, although some authorities recommend feeding immediately before taking the pills and then expressing and discarding the breastmilk for 6 hours afterwards.

Tell participants:

- As we saw during the session on IUDs, an IUD can also be used as emergency contraception.
- To function as emergency contraception, the IUD should be inserted by a trained provider within 5 days (120 hours) of the unprotected intercourse.
- For women in need of emergency contraception who also want to use an IUD as their regular method, the insertion of an IUD immediately can be an effective and logical choice.
- Emergency contraception by IUD insertion is even more effective than the use of pills.

3. Introduce guidelines for initiating or restarting contraceptive use after using pills for emergency contraceptive (5 min)

Ask participants to look in **Session 15: Emergency Contraception** in the **Participant Manual** to find the **"Guidelines for initiating or restarting contraceptive use after using pills for emergency contraception."**

Ask participants to use the **Guidelines** to answer the following questions. **Call on** different individuals to answer each of the questions. **Make sure** participants understand the correct answer.

- ***If a woman was using COCs at the time she took the ECPs, does she need to start a new pack?***

Answer: No: She can resume the pack she was previously using.

- ***How soon after taking ECPs can a woman start taking POPs?***

Answer: She can start immediately.

- **When can a woman start using an IUD after she has taken emergency contraceptive pills?**

Answer: After the start of the next normal menstrual period. But remember that if the client intends to use an IUD as a long-term method and meets IUD screening criteria, the insertion of an IUD within 5 days (120 hours) of the unprotected intercourse may be a good alternative to using pills as an emergency contraceptive.

Note to trainer: These guidelines are found in the Participant Manual (Session 15).

Guidelines for initiating or restarting contraceptive use after using pills for emergency contraception

Male or female condom	Can be used immediately.	
Diaphragm	Can be used immediately.	
Spermicides	Can be used immediately.	
Low-dose COCs or POPs	A) Begin using the method the day after taking the emergency contraceptive pills. Use condoms or abstain from intercourse for the next seven days after starting or restarting the method. This option is preferable because it reduces the risk of pregnancy.	
	<i>If newly starting the method, begin with a new packet of pills.</i>	<i>If previously using the method, resume using the packet of pills previously in use.</i>
	OR B) Wait until the beginning of the next menstrual cycle and then start the method according to the standard instructions. Meanwhile use condoms or abstain from intercourse.	
IUD	Have IUD inserted after the start of the next normal menstrual period. Use condoms or abstain from intercourse until the IUD is inserted. NOTE: If the client intends to use an IUD as a long-term method and meets IUD screening criteria, the insertion of an IUD within 5 days (120 hours) of the unprotected intercourse may be a good alternative to using pills as an emergency contraceptive.	
SDM	Start after the first normal menstrual period. Meanwhile use condoms or abstain from intercourse.	

4. Counseling a woman on emergency contraception use: Role play (20 min)

Tell participants this information while **showing** these **slides**:

When counseling a woman on the use of ECPs:

- ask the woman questions to determine likelihood of pregnancy. If clearly pregnant, do not give pills.
- explain the effectiveness of emergency contraception.
- explain to her how to take the pills (how many at what time).

- advise her to eat food with the pills to reduce nausea.
- explain possible normal side effects and warning signs.
- counsel her on family planning options and help her to choose a new method or better use her current method if desired.
- counsel her on STI/HIV prevention as appropriate.

Ask participants to form pairs.

Show the following scenario on this **slide**.

A 28-year-old single woman comes to the clinic the day after her boyfriend's condom broke during intercourse. She is crying and worried that she might become pregnant.

Role play how you would counsel this woman.

Tell participants:

- We will now briefly perform a role play, to practice counseling on emergency contraception.
- You will work in pairs to act out the scenario shown on this slide.
- One person should be the "provider," the other person the "client."
- You will have 10 minutes.

While participants role play, **circulate and observe**.

Bring everyone **back together** after 10 minutes.

Ask:

- ***What are the main things that the provider should discuss with this woman?***

Listen to several responses.

Add any of the following points if they were not already said.

- Ask the woman questions to determine likelihood of pregnancy.
- Explain the effectiveness of emergency contraception.
- Explain to her how to take the pills (how many at what time).
- Advise her to eat food with the pills to reduce nausea.
- Explain possible normal side effects and warning signs.
- Counsel her on STI/HIV prevention.
- Tell the woman about correct condom use, since the broken condom might have been due to human error (fingernails, expired packet, oil based lubricant, using two condoms, etc).
- Give the woman the opportunity to consider and discuss a woman-controlled family planning method in addition to the condom, if desired.
- If the client intends to use an IUD as a long-term method and meets IUD screening criteria, the insertion of an IUD within 5 days (120 hours) of the unprotected intercourse may be a good alternative to using pills as an emergency contraceptive.

5. Conclude the session

Tell participants:

- In the next session, we will discuss the specific situation of family planning in the postpartum period, with a focus on the lactational amenorrhea method.

Note to trainer: This article is provided in the Participant Manual (Session 15) as a reference.

From:
World Health Organization Updates Guidance on How To Use Contraceptives

The INFO Project • Johns Hopkins Bloomberg School of Public Health • Center for Communication Programs
April 2005 • Issue No. 4
<http://www.infoforhealth.org/infoforeports/spr/spr5.shtml>

Emergency Contraception Advice Expanded

Emergency contraceptive pills (ECPs) should be taken as soon as possible after unprotected sex for maximum effectiveness. WHO now advises that they can be taken up to a maximum of 120 hours after unprotected sex, however, rather than the previously recommended maximum of 72 hours. The Expert Working Group also recommends a new regimen for ECPs—a single dose of 1.5 mg of levonorgestrel. In addition, the expert group reiterates earlier advice that a woman can have an advance supply of ECPs.

Take ECPs as soon as possible. The new WHO guidance supports previous advice to take ECPs as soon as possible after having unprotected sex—ideally within 72 hours. Recent research shows ECPs also can be effective if taken up to 120 hours after unprotected sex (15, 42, 46, 63). Still, the longer a woman waits to take them, the less likely they are to prevent pregnancy (15, 42, 46, 63).

Three dosage options. WHO recommends three options for ECP dosage:

1. 1.5 mg of levonorgestrel in a single dose;
2. Two doses of levonorgestrel (one dose of 0.75 mg of levonorgestrel, followed by a second dose of 0.75 mg of levonorgestrel 12 hours later); or
3. Two doses of combined estrogen-levonorgestrel ECPs—the “Yuzpe regimen”³ of one dose of 100 µg of ethinyl estradiol plus 0.5 mg of levonorgestrel, followed by the same dose 12 hours later.

The first regimen is the best choice, the Expert Working Group advises. A single dose is the best option because people generally are more likely to take a single dose than multiple doses. In addition, the levonorgestrel-only regimen causes less nausea and vomiting than the combined formulation (see below).

The preferred regimen might not be available everywhere, however. The other two regimens are acceptable alternatives, the Expert Working Group concluded. In some places the regimens are prepared and labeled specifically for use as ECPs. They also can be prepared from a variety of OCs that contain levonorgestrel.

Levonorgestrel-only ECPs cause less nausea and vomiting. WHO recommends that women use levonorgestrel-only ECPs because they cause less nausea and vomiting than combined estrogen-levonorgestrel ECPs (26, 58). Nausea and vomiting are common side effects associated with ECP use (45, 58).

WHO does not recommend routine use of antiemetics (medication that helps prevent nausea and vomiting) before taking ECPs. Predicting which women will experience side effects usually is difficult, and many women taking ECPs do not experience nausea and vomiting. Antiemetics are effective for some women, however (43, 45). Thus the Expert Working Group advises that clinicians offer antiemetics on a case-by-case basis according to their medical judgment. Clinicians should take into account that antiemetics themselves may cause other side effects, such as drowsiness and dizziness.

Advance supply encouraged. The 2004 Expert Working Group supported previous recommendations that allow a woman to receive an advance supply of ECPs. The group based its recommendation on recent evidence that:

- A woman is more likely to take ECPs after unprotected sex if she has a supply on hand (7, 14, 21, 27, 38, 44, 48); and

- Having ECPs on hand does not affect a woman's contraceptive use, does not increase her frequency of unprotected sex, and does not increase her frequency of ECP use (7, 14, 21, 27, 44, 48).

Brochures about ECPs in many languages are available at www.path.org/resources/ec_client-mtrls.htm.

³The Yuzpe regimen is named after Canadian professor A. Albert Yuzpe, who published the first studies demonstrating the safety and effectiveness of using combined OCs as ECPs (67, 68).

16. Postpartum Contraception and the Lactational Amenorrhea Method

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

- explain why it is important to integrate family planning counseling into antenatal and postpartum care.
- use the WHO *Medical Eligibility Criteria for Contraceptive Use* manual as well as Postpartum Contraception and Lactational Amenorrhea Method Cue Cards to determine which contraceptive methods are appropriate for postpartum women.
- state the three conditions that must be met for a woman to effectively use the lactational amenorrhea method for contraception.

Time: 1 hour

Techniques:

- Presentation and discussion, pair work, case study

Materials:

- Postpartum Contraception and LAM Cue Cards, slides, 5 cards with LAM cases

Preparation:

- Make cards for LAM cases (*provided at the end of this session*).

Activities:

1. Discuss women's family planning needs during pregnancy and the postpartum period (10 min)

Ask:

- ***At what point do you usually discuss family planning with a pregnant woman? When do you think is the best time to begin discussing it?***

Listen to a few responses.

Then **tell** participants this information while showing these **slides**:

Counseling on family planning should:

- begin during the antenatal period.
- be integrated into the antenatal care provided for pregnant women.
- be integrated into the immediate postpartum care provided in maternities before discharge.

Antenatal counseling on family planning:

- It is important because it allows time for women/couples to consider their family planning options and preferences, and discuss them with each other and providers.
- Whenever possible, materials on family planning should be given to antenatal clients to read at home and discuss with their partners.
- Ideally, pregnant clients should have a reasonably firm plan in mind regarding postpartum contraception before they go to the maternity for delivery.
- It helps women to understand that spacing births provides for the optimal health and development of each child and allows the mother to fully recover from childbirth.

Remind participants:

- As we discussed earlier, recent research shows that birth intervals of three to five years are better for both the mother and the children than intervals of only two years.
- There is a short article in your **Participant Manual, Session 3**, titled "**Birth Spacing: 2004 Evidence Supports 3+ Years**" with more in-depth information.

Tell participants this information while **showing** these **slides**:

Counseling on family planning should also:

- be integrated into the immediate postpartum care provided in maternities.
- be provided early enough in the mother's postpartum stay (not at the last moment before discharge) to allow the woman time to discuss her family planning needs with providers and obtain any additional information she needs to make an informed choice.
- be integrated into any postpartum visits the woman makes to the facility for herself, any breastfeeding support or well-baby visits made for the baby, as well as any home visits.

Research in Russia¹¹ has shown that:

- less than 50% of women are provided with counseling on family planning following their first delivery, yet:
- more than 90% of women say they do not plan to have another child.
- more than two thirds say that if they did become pregnant again, they would have an abortion.
- among those who do plan to have more children, most plan to postpone it for at least 2 years.

¹¹ Research conducted by Obstetrics, Gynecology and Perinatology Center.

Tell participants:

- This data shows the critical importance of taking every opportunity to fill unmet family planning needs during antenatal care, postpartum care, breastfeeding support, and well-baby care.

Referring back to participants' earlier statements about when they provide family planning counseling, **ask**:

- ***How could your health care facility better integrate family planning into antenatal and postpartum care?***

Listen to several responses.

Summarize the main points you hear.

Tell participants:

- All of you will have a chance to think more about how to better integrate family planning with other services during the final session on "Increasing Access to Family Planning Services," during which time you will formulate an Action Plan.

2. Discuss contraceptive options in the postpartum period (5 min)

Ask:

- ***What are the family planning choices available to a woman after delivery?***

Listen to all responses.

Tell participants:

- For most healthy postpartum women, most contraceptive methods are safe and effective choices.
- What most influences the contraceptive choices for postpartum women is whether or not the woman is breastfeeding.
- Since most new mothers in Russia breastfeed, we will first discuss the options for a breastfeeding woman.

3. Introduce the lactational amenorrhea method (5 min)

Tell participants:

- As you likely know, breastfeeding itself provides some protection against unintended pregnancy.
- Breastfeeding exclusively can provide very good protection.

Tell participants this information while **showing** these **slides**.

Lactational amenorrhea method (LAM)

- LAM is a natural, temporary contraceptive method based on exclusive breastfeeding during the first 6 months postpartum.

- LAM has been proven to be the healthiest choice for both the mother and the child, not only for its contraceptive benefits but also for the well-being of the child.
- Women should be encouraged to exclusively breastfeed their babies for the first 6 months, and, if possible, to continue breastfeeding during the first 2 years.

Method of action

- LAM stops ovulation (release of eggs from ovaries) because breastfeeding changes the rate of release of natural hormones.

The 3 Conditions for LAM to be effective as a contraceptive:

1. The mother must be breastfeeding frequently and exclusively
 - Breastfeeding at least every 3-4 hours during the day and at least once during the night.
 - The baby gets ALL of its food and liquid requirements from breastmilk.

AND

2. The woman's menses have not returned.

AND

3. The baby is less than 6 months old.

4. Conduct small group work on LAM eligibility case studies (5 min)

Ask participants to form **5 small groups**, mixing up to work with new people.

Distribute cards with short LAM eligibility cases written on them, one per group.

Note to trainer: Cards with cases are provided below at the end of this session.

Tell participants:

- Read your case with your group.
- Decide whether or not LAM is effective as a contraceptive method for this woman under these conditions.

Give groups **two or three minutes** to discuss.

Note to trainer: Listen to participants' responses to this exercise to determine whether or not they are familiar with the conditions for LAM effectiveness.

5. Ask groups to report back (10 min)

After the groups have finished, **ask** the first group:

- **Read your case aloud.**
- **Are the conditions for the lactational amenorrhea method being met?**
- **Will LAM be effective as a contraceptive for this woman under these conditions?**
- **Why or why not?**

Go through all the cases in the same way.

Note to trainer: Cases and answers are as follows.

Case 1: Lara is breastfeeding once or twice a day, but she has had difficulty with painful, cracked nipples, so she is also giving her 2-month-old infant formula at other times. Lara's menses have not returned yet.

Answer: NOT effective. Lara is not exclusively breastfeeding (every 3-4 hours in the day and at least once during the night).

Case 2: Ana's baby is 7 months old. She is still breastfeeding him during the day and night. Her menses have not returned yet.

Answer: NOT effective. LAM is only effective for the first 6 months after birth).

Case 3: Olga is breastfeeding her 4-month-old baby every 3 or 4 hours during the day. She also feeds him at least once overnight. The baby does not eat any formula or other food. Olga's menses have not started again yet.

Answer: YES, effective. She has met all the conditions.

Case 4: Tanya is breastfeeding her 5-month-old baby several times day and night, with no other foods or liquids. Her menses started again this month.

Answer: NOT effective . She is exclusively breastfeeding (every 3-4 hours in the day and at least once during the night), but her menses have started.

Case 5: Natasha is breastfeeding her 4-month-old baby every 3 hours during the day. She is too exhausted for nighttime feedings, so her husband is giving the baby a bottle of formula during the night. Natasha's menses have not returned yet.

Answer: NOT eligible. She is not exclusively breastfeeding because she is not doing so during the night.

6. Present information about using LAM for contraception (15 min)

To **summarize** the case study activity, **ask**:

- ***To sum up, can someone tell us again what 3 conditions must be met for LAM to be effective?***

Listen to a few responses.

Then **show** the LAM requirements again on the same **slide** previously shown.

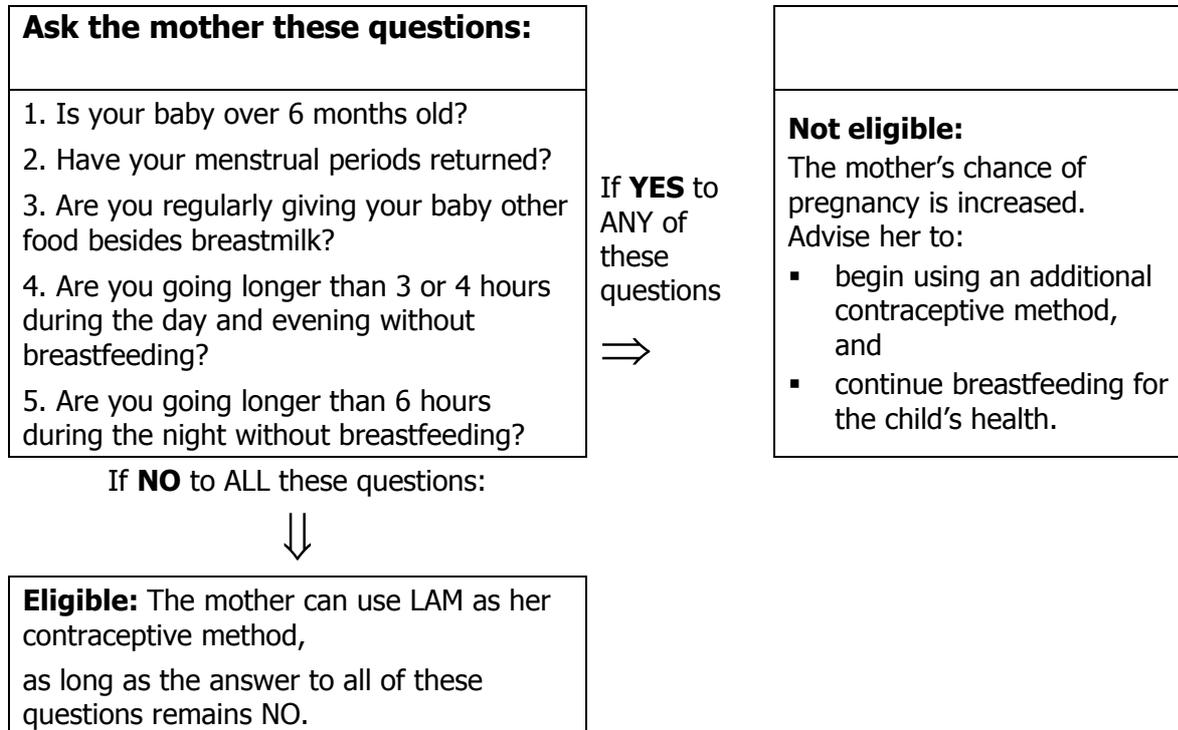
The 3 Conditions for LAM to be effective as a contraceptive:

4. The mother must be breastfeeding frequently and exclusively
 - Breastfeeding at least every 3-4 hours during the day and at least once during the night
 - The baby gets ALL of its food and liquid requirements from breastmilk
- AND**
5. The woman's menses have not returned
- AND**
6. The baby is less than 6 months old.

Tell participants:

- You can ask a woman the following questions to determine whether or not she is meeting the necessary conditions for LAM as a contraceptive method.
- These questions are found on the **Lactational Amenorrhea Method Cue Card**.

Show this slide and explain:



Tell participants this information while **showing** these **slides**:

- Other conditions that could make a woman ineligible for LAM are:**

 - taking medication that her doctor says could pass to the baby through her breastmilk and be harmful.
 - being HIV-positive or having AIDS.
- Effectiveness:**

 - LAM is >99% effective when used consistently and correctly.
 - "Consistently and correctly" means all three conditions previously discussed must be met.
 - If any of the three conditions are not met, the woman should use another method that is compatible with breastfeeding.

When to start LAM:

- LAM should be started as soon as possible after the baby is born, ideally within the first hour after delivery.
- Even if a woman does not plan to use LAM as a family planning method, she should still be encouraged to breastfeed as early and as much as she can (unless there is a contraindication to breastfeeding).
- Some women may choose to use an additional method that is compatible with breastfeeding for added protection and reassurance.

7. Facilitate pair work on advantages and disadvantages of LAM (10 min)

Ask participants to turn to the person sitting next to them and work in pairs.

Instruct half the pairs to discuss this question:

- ***What are the advantages of LAM?***

Instruct the other half to discuss this question:

- ***What are the disadvantages of LAM?***

Give the pairs **three or four minutes** to discuss. **Tell** them they do not have to write down their answers.

Then **ask** for volunteers to list the advantages. **Write** down their answers on a flip chart.

Then **show** the possible responses on this **slide, pointing out** any that were not mentioned.

Advantages of LAM:

- Effectively prevents pregnancy as long as the 3 conditions are met.
- Provides the healthiest food for the baby.
- Protects the baby from diarrhea and other infectious diseases.
- Costs nothing.
- Promotes a strong relationship between mother and baby.
- Has no hormonal side effects.

Next, **ask** volunteers to name disadvantages. **Write** down their answers on a flip chart.

Then **show** the possible responses on this **slide, pointing out** any that were not mentioned.

Disadvantages of LAM:

- Most women need help in learning how to breastfeed if they are to be successful.
- Exclusive breastfeeding may be inconvenient or difficult for some women, especially working mothers.
- The method provides no protection against STIs/HIV. Women at risk for STIs/HIV should be advised to use condoms and counseled on how to use them correctly.
- If the mother is HIV-positive or has AIDS, there is the risk of mother-to-child transmission via her breastmilk.

Tell participants the following information about **contraindications for LAM:**

- If the mother is HIV-positive or has AIDS, given the risk of mother-to-child transmission via breastmilk, the official policy in the Russian Federation is that HIV-positive mothers should not breastfeed.
- This means that LAM is not a viable contraceptive method for HIV-positive women, and they should select a different method.

8. Discuss postpartum contraceptive options other than LAM (5 min)**Tell** participants:

- For women who do not breastfeed or do not meet the conditions for LAM, fertility may resume as early as 3 weeks postpartum.

Ask participants to **look** at the Eligibility Guidelines on the **Postpartum Contraception Cue Card** (*shown below*).

Briefly **review** these eligibility guidelines.

Method	If the woman breastfeeds	If the woman does not breastfeed
Lactational amenorrhea method	Can be used for the first 6 months postpartum if the mother exclusively breastfeeds and her menses have not resumed. See the LAM Cue Card for information on counseling.	Not applicable.
Low-dose combined oral contraceptives	Can be started either immediately after termination of breastfeeding or 6 months postpartum – whichever comes first.	Can be started 3 weeks postpartum.
Progestin-only pills	Can be started 6 weeks postpartum	Can be started 3 weeks postpartum
Condoms	Can be used as soon as sexual relations are resumed	
Vaginal spermicides	Can be used as soon as sexual relations are resumed	
IUD	Can be inserted during first 48 hours postpartum or after 4 weeks postpartum. Within 10 minutes of delivery of the placenta is best.	
Voluntary surgical contraception (tubal ligation)	Can be performed immediately postpartum if the woman has been counseled, it is clear she understands that tubal ligation is permanent, and she has given proper informed consent before going into labor.	

Tell participants:

- As with any client, the guidelines for specific medical conditions on the **Cue Cards** and in the **WHO Medical Eligibility Criteria for Contraceptive Use manual** should be followed when counseling a woman postpartum.

9. Conclude the session

Tell participants:

- In the next session, we will discuss the specific situation of family planning counseling for postabortion clients.



LAM Case Study Cards

Note to trainer: For the LAM case study exercise, make 1 copy of this page and cut it into 5 cards with one case per card.

Case 1: Lara is breastfeeding once or twice a day, but she has had difficulty with painful, cracked nipples, so she is also giving her 2-month-old infant formula at other times. Lara's menses have not returned yet.

Case 2: Ana's baby is 7 months old. She is still breastfeeding him during the day and night. Her menses have not returned yet.

Case 3: Olga is breastfeeding her 4-month-old baby every 3 or 4 hours during the day. She also feeds him at least once overnight. The baby does not eat any formula or other food. Olga's menses have not started again yet.

Case 4: Tanya is breastfeeding her 5-month-old baby several times day and night, with no other foods or liquids. Her menses started again this month.

Case 5: Natasha is breastfeeding her 4-month-old baby every 3 hours during the day. She is too exhausted for nighttime feedings, so her husband is giving the baby a bottle of formula during the night. Natasha's menses have not returned yet.

17. Postabortion Contraception

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

- state some of the needs and emotions a woman may have after an abortion.
- list key points for counseling a postabortion family planning client.
- use the WHO *Medical Eligibility Criteria for Contraceptive Use* manual to determine which contraceptive methods are appropriate for postabortion women.
- use the Postabortion Contraception Cue Card to identify how and when a woman can start a contraceptive method after an abortion.

Time: 30 minutes

Techniques:

- Presentation and discussion, small group work

Materials:

- Postabortion Contraception and GATHER Method of Counseling Cue Cards, slides

Activities:

1. Explore women's feelings after an abortion (5 min)

Ask:

- ***In your experience what are some of the reasons that a woman has an unintended pregnancy?***

Listen to several responses.

Then **show** the possible reasons on these **slides, pointing out** any that were not mentioned.

Possible reasons for unintended pregnancy:

- The woman may not have received information about contraceptive options before.
- She may know about contraception, but services are not easily available or accessible.
- She may know about contraception, but postponed using it, hoping that she would not become pregnant.
- She may believe that using contraception is more dangerous for her health than having an abortion, so she chose not to use contraceptives.

- She may have been using a contraceptive method that was not very effective.
- She may be using an effective modern method, but not consistently and correctly, or the method may have failed through no fault of her own.
- She could have been forced to have intercourse at a time when she would not otherwise have a need for contraception.

Ask:

- ***What feelings and emotions may a woman have after having an abortion?***

Listen to several responses.

Add any of the following that were not stated:

- depression
- guilt
- unwillingness to communicate
- resentment toward the partner
- relief

Tell participants:

- The best way to understand the client's feelings is to imagine yourself in the client's place.
- You should show empathy and provide psychological support to any client, including a woman who has undergone an abortion.
 - "Empathy" means the ability to put oneself in the place of another person.
- By showing empathy and giving careful attention to the clients' emotions, you can facilitate communication and create an atmosphere of trust and understanding.

2. Facilitate small group work: Postabortion counseling (5 min)

Tell participants:

- Remember that in addition to being empathetic, you should use the GATHER method of counseling with all clients, including those who have just had an abortion.

Ask participants to take out their **GATHER Method of Counseling Cue Cards**, to recall the six steps.

Divide participant into **6 groups**, mixing them up to work with new people.

Assign one step of "GATHER" to each group.

Tell the groups to discuss this question for **5 minutes**:

- ***Thinking about the step in GATHER assigned to your group, what should a provider take into consideration when counseling a woman on family planning after an abortion?***

3. Report back on postabortion counseling (15 min)

Ask the **first group** to list special considerations for a postabortion client during the **GREET** step.

Then **show** the possible responses on this **slide, pointing out** any responses not given by the participants:

"Greet"

- Approach the client when she is calm, introducing yourself and using the client's name.
- If the woman is accompanied by someone, ask her whether she wants that person to be present during counseling or not.
- Do your best to provide privacy and ensure confidentiality.
- Be understanding about her physical and mental state. Put the client at ease and show her that you are not judging her about her decision to have an abortion.

Ask the **second group** to list special considerations for a postabortion client during the **ASK** step.

Then **show** the possible responses on this **slide, pointing out** any responses not given by the participants:

"Ask"

- Find out whether the client was using a contraceptive method when she became pregnant.
- Encourage her to talk about her family planning wishes and/or concerns.
- If she was using a method:
 - Was she happy with her method? Did she have a problem using it? Even with consistent and correct use, there still can be a low percentage of failures.
 - Does she want to continue her method? Change methods?
- If she was not using contraception:
 - Has she considered starting a method? Does she have a particular method in mind?

Ask the third group to list special considerations for a postabortion client during the **TELL** step.

Then **show** the possible responses on this **slide, pointing out** any responses not given by the participants:

"Tell"

- If the client wants to change methods or start a method, and has a method in mind, focus on that method.
- If the client wants to change methods or start a method and does not have a method in mind, briefly mention available methods.
- Provide pamphlet(s) on family planning method(s) if available.
- Be respectful of the client's choice, including a decision to not use a method at this time.

Ask the fourth group to list special considerations for a postabortion client during the **HELP** step.

Then **show** the possible responses on this **slide, pointing out** any responses not given by the participants:

"Help"

- If the client wants to change methods or start a method, consider medical eligibility for the method the client has expressed interest in.
- If the client is not eligible for her preferred method, briefly explain why and introduce other suitable methods.
- Encourage the client to express opinions and ask questions.
- In the end, make sure the client has made a clear and informed decision.

Ask the fifth group to list special considerations for a postabortion client during the **EXPLAIN** step.

Then **show** the possible responses on these **slides, pointing out** any responses not given by the participants:

"Explain"

- If the client is changing methods or starting a method, explain how to use the method.
- If the client is continuing a method, focus on those aspects of use that may have contributed to the unintended pregnancy.
- Explain the effectiveness of the method.
- Explain the advantages and disadvantages of the method.
- Inform and reassure the client about common (non-serious) side effects.

- Inform about possible complications (if any).
- Inform whether the method provides protection against STIs/HIV.
- Explain that it is recommended that anyone at risk for STIs/HIV use a condom with each act of intercourse even if another method is being used for contraception (dual method use).
- Make sure the client understands; give the client the opportunity to ask questions.

Tell participants:

- It is assumed that, in addition to the family planning counseling being discussed, the client will also be told about possible side effects and complications related to the abortion procedure, and that she will be given proper instructions regarding personal hygiene.

Ask the **sixth group** to list special considerations for a postabortion client during the **RETURN** step.

Then **show** the possible responses on this **slide, pointing out** any responses not given by the participants:

"Return"

- Encourage the client to return any time she has concerns, has symptoms of a possible complication, needs information or advice, or wants to change to another method.
- Make it clear that changing methods is normal and welcome.
- Make sure she knows where/how to get more commodities as needed.

Conclude by telling participants:

- Providers should follow all steps in the GATHER method for a postabortion client just as with any family planning counseling session.

4. Discuss postabortion contraceptive methods (5 min)

Ask participants to take out their **Postabortion Contraception Cue Cards**.

Ask them the following questions one by one. **Instruct** participants to find the answers on the **Cue Card**. **Call on** volunteers to give the answers.

Note to trainer: Answers are given below.

- **How soon after an abortion can a woman become pregnant again?**
Answer: On average 14 days.

- **If a woman wants to use a hormonal method postabortion, when should she start using it?**

Answer: Within the first 5 days after the abortion.

- **How soon after an abortion can an IUD be inserted?**

Answer: If there are no complications, immediately. If there are complications such as infection, the IUD can be inserted after the infection has been fully treated and if there are no other contraindications.

Ask:

- ***Are there any other questions about contraceptive methods after abortion?***

Answer questions.

5. Conclude the session

Tell participants:

- You will have a chance to role play counseling a postabortion client in a later session.
- The next session will cover the specific situation of family planning for adolescents.

18. Adolescent Contraception

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

- list characteristics of adolescents that put them at risk for unplanned pregnancy and STIs/HIV.
- list issues to consider when counseling adolescents for family planning
- list ways to make family planning services more adolescent-friendly.

Time: 30 minutes

Techniques:

- Presentation and discussion, attitudes exercise

Materials:

- Slides, flip chart with list of contraceptive methods

Preparation:

- Make and post a flip chart with contraceptive methods listed on it (*see "Discuss appropriate contraceptive methods for adolescents" below*).

Activities:

1. Discuss special characteristics of adolescents (10 min)

Ask participants to remember themselves and their friends as teenagers.

Ask:

- ***What are some typical characteristics that you associate with adolescents that might put them at risk for unintended pregnancy or STIs/HIV?***

Listen to several responses.

Then **show** the possible responses on these **slides, pointing out** ideas not already mentioned by participants.

Adolescent characteristics that may put them at risk:

Adolescents may:

- act impulsively and emotionally.
- act without considering the consequences of their actions.
- be easily influenced by peers.
- want to be grown-up and to act like adults.

- be curious about sex and interested in experimenting.
- lack the confidence and experience to negotiate with potential sex partners.
- lack money to pay for contraceptives.
- worry about getting caught, and therefore may need to hide their sexual activity and their contraceptives from parents/adults.

Tell participants:

- Every young person is an individual. He/she will not necessarily have all or any of these characteristics. Adults can exhibit these characteristics too.

Ask:

- ***What are some special considerations to keep in mind when counseling adolescents on family planning?***

Listen to all responses.

Then **show** the possible responses on these **slides, pointing out** ideas not listed by participants.

Special considerations when counseling adolescents:

It is important to:

- ensure privacy and confidentiality.
- demonstrate an empathetic, nonjudgmental attitude.
- make sure the client understands the method, how to use it, its side effects, whether it protects against STIs/HIV.
- offer affordable choices.

- tell the client about emergency contraception - for some adolescents, it may be appropriate to encourage them to have a supply of emergency contraceptive pills on hand.
- counsel on how to protect against STIs/HIV.
- counsel on strategies for negotiating with potential partners about sex, using contraception, and being protected against STIs/HIV.

Tell participants:

- These counseling issues should be kept in mind with clients of any age, but they may be especially important when counseling adolescents.

2. Discuss appropriate contraceptive methods for adolescents (15 min)

Post a **flip chart** with the following contraceptive methods written on it.

- Standard Days Method
- Vaginal spermicides
- Condoms
- Low-dose COCs
- POPs
- Injectables
- IUDs
- Voluntary Surgical Contraception
- Emergency Contraception

Tell participants:

- I am going to ask you a series of questions about adolescents' use of different contraceptive methods. The purpose of the exercise is to find out what you think about the appropriateness of these methods for young people.
- If your answer is "yes," stand up.
- If your answer is "no," stay seated.

Ask:

- ***Is the Standard Days Method an appropriate method for adolescents?***

Count how many participants stand up and **write** the number down on the flip chart next to "Standard Days Method."

Ask one of the participants who is standing to explain why he/she thinks the method is appropriate for adolescents.

Ask one of the participants who stayed seated to explain why he/she thinks the method is not appropriate for adolescents.

Repeat the same question and process for **each method** listed on the flip chart.

When all methods have been discussed, **review** the flip chart with the tally of "yes" answers, and **summarize** the answers given by participants: which methods were considered appropriate by many, which ones were not, and which ones participants disagree on.

Tell participants this information while **showing** these **slides**:

According to the WHO medical eligibility criteria:

- no method is restricted based on age.
- no method is restricted based on parity.

- In the past, there was conflicting data regarding IUD use and later infertility in nullipars; recent well-conducted studies suggest no increased risk.
- For voluntary surgical contraception, young age is one of the strongest predictors of regret. Caution is therefore advised.
- A key principle in counseling is that clients should choose their methods. In principle, every method should be available to adolescent clients, as long as the usual medical criteria for that method are met

- The choice of a method should be based on the client's individual situation and preferences, not on age and parity alone.
 - For example, some adolescents are very responsible and can count days in their cycles or take pills every day while some adults cannot.

3. Discuss making family planning services "adolescent-friendly" (5 min)

Ask:

- ***What are ways we could make family planning services more accessible and attractive to adolescents?***

Listen to suggestions.

Then **show** the possible responses on this **slide, pointing out** how they are similar to or different from the responses given by participants.

Ways to make services adolescent-friendly:

- Treat adolescents (and all clients) with a friendly, nonjudgmental attitude.
- Ensure confidentiality and privacy.
- Present information in a lively, interactive way that engages young clients.
- Involve adolescents in planning for services to find out what they want and need.
- Train adolescents as peer counselors.

- Develop and provide adolescent-specific materials.
- Set aside a private entrance and/or room for adolescents at the health facility, so that they do not worry about being seen by adult family members.
- Offer services at hours that are accessible to adolescents.
- Create an adolescent center offering multiple activities and services that will attract young people.
- Raise awareness in the community about adolescent health needs.

4. Conclude the session

Tell participants:

- You will have a chance to practice counseling adolescents in the next session.

19. Counseling Practice Day Three: Role Plays

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

- demonstrate GATHER method counseling skills in role play situations for different clients.
- give and receive feedback with peers on counseling skills.

Time: 1 hour 25 minutes

Techniques:

- Role play and feedback

Materials:

- All Cue Cards, cards with cases for role plays, WHO *Medical Eligibility Criteria for Contraceptive Use* manual, illustrated Flip Book "Contraception: How to Prevent an Unwanted Pregnancy," samples of all contraceptive products.

Preparation:

- Make cards with cases for role plays (*provided at the end of this session*).

Activities:

1. Explain role play activity (5 min)

Tell participants:

- You will now practice family planning counseling again through role plays.
- This session will work the same way as the role plays on the previous day.
- We have now covered all available contraceptive methods and also three specific groups of potential clients: postpartum, postabortion and adolescents.

Ask participants to make sure they have at hand the following materials:

- **Illustrated Flip Book "Contraception: How to Prevent an Unwanted Pregnancy"**
- **Cue Cards** for all methods
- **GATHER Method of Counseling Cue Card**
- **Client-Provider Interaction Checklist** in their **Participant Manual**, found in **Session 5: Principles of Counseling**.

Divide the participants into groups of 3.

Note to trainer: They should be in different groups than in the previous day's role play exercise.

Ask participants to look in the **Participant Manual** in **Session 19** and **review together** the instructions given in the **"Task Sheet: Counseling Practice Role Plays."**

Note to trainer: This task sheet is found in the Participant Manual (Session 19).

Task Sheet: Counseling Practice Role Plays

- Choose one person to play the "client" role
- Choose another to play the health care "provider" role.
- The third person will be an observer.
- The "provider" should use the Cue Cards and Flip Book.
- There are sample contraceptive products available at the front of the room for the "providers" to use if desired.
- You will have **15 minutes** to **act out the role play**

- Afterward, **discuss** the role play for **5 minutes**:
 - The "provider" reflects on his/her own performance.
 - Then the "client" gives the "provider" feedback.
 - Then the observer gives the "provider" feedback.
- Feedback should focus on whether the "provider":
 - used good communication and counseling skills.
 - followed the GATHER steps of counseling.
 - explained the key information about the method using the Cue Card.
 - applied the WHO Medical Eligibility Criteria given on the Cue Card.

2. Ask groups to conduct role play: Round 1 (20 min)

Distribute the **Round 1 Client Role Description** to the "client" in each group.

Tell the "client":

- Do not share the information with the others in the group. Let the "provider" find out by asking questions.

Note to trainer: Client role description cards are provided at the end of this session.

Round 1: Client Role Description

You are a 20-year-old with a four-month-old baby. You are breastfeeding. You were sure that breastfeeding would prevent pregnancy, but you unexpectedly got pregnant and have just had an abortion.

Tell the groups to start the role play.

Circulate and observe how the groups are performing.

After 15 minutes, **remind** the groups that they should finish the role play and begin the feedback discussion.

3. Ask groups to conduct role play: Round 2 (20 min)

Ask participants to change roles within their group.

Distribute the **Round 2 Client Role Description**.

Round 2: Client Role Description

You are a 15-year-old young woman. You are sexually active but don't have a regular partner. During your last menstrual cycle, you used two packs of Postinor. You have heard your friends talking about infections that can be passed during sex, and you are worried about becoming pregnant, so you came to the health clinic, even though you were very nervous about coming in.

Tell the groups to start the role play.

Circulate and observe how the groups are performing.

After 15 minutes, **remind** the groups that they should finish the role play and begin the feedback discussion.

4. Ask groups to conduct role play: Round 3 (20 min)

Ask participants to change roles within their group. All three group members should now have had a chance to play the "provider."

Distribute the **Round 3 Client Role Description**.

Round 3: Client Role Description

You are a 36-year-old woman who is six months pregnant, and you have come in for an antenatal visit. You have 2 other children and don't want more children. You have had varicose veins ever since you had your second child. You have been wondering about how you can prevent more pregnancies. But in the past when you have gone to a antenatal visit, the health care provider has never talked about family planning. You decide to wait and see whether the provider will bring it up this time.

Tell the groups to start the role play.

Circulate and observe how the groups are performing.

After 15 minutes, **remind** the groups that they should finish the role play and begin the feedback discussion.

5. Conduct new role play in plenary (20 min)

Reconvene the participants.

Ask:

- ***What did you learn in these role plays?***
- ***What was easiest? What was difficult?***
- ***Do you have any questions about the cases?***

Listen to several responses.

Summarize the main points you heard.

Invite two people to perform in front of everyone. **Give** the "client" a new role (*below*):

Plenary: Client Role Description

You have just had an abortion. You are single, 25 years old, and you were using condoms as your main method of contraception when you got pregnant. You have a regular boyfriend, but you are not planning to marry yet. You have thought about using an IUD, but you've heard that they can damage your fertility, and you want to have children some day.

Give them **10 minutes** to perform the role play.

When the role play is finished, **ask** the "provider":

- ***How would you rate your performance? What were the strengths and weaknesses?***

Ask the "client":

- ***How did you feel in this role? What suggestions do you have for the "provider"?***

Ask the rest of the participants:

- ***What else did you observe about this role play?***

Listen to several responses.

Summarize the main points you heard.

Thank the role players.

Note to trainer: If participants need guidance to help them give structured, specific feedback, you can ask them the following optional guiding questions.

- *Did the provider greet the client and make her feel comfortable?*
- *Did the provider ask the client about her family planning needs and interests?*
- *Did the provider ask if the client had a particular contraceptive method in mind?*
- *Did the provider focus on the method the client had in mind?*
- *Did the provider determine her medical eligibility for the method?*
- *Did the provider explain the advantages and disadvantages of the method?*
- *Did the provider explain how to use the chosen method?*
- *Did the provider make sure the client understood?*
- *Did the provider give the client the opportunity to ask questions?*
- *Did the provider inform the client of possible side effects?*
- *Did the provider inform the client about whether her method would offer protection against STIs/HIV?*
- *Was this client possibly at risk for exposure to STIs/HIV? Why? Did the provider discuss this risk and discuss using condoms in addition to her family planning method?*
- *Did the provider discuss when to return to the clinic?*
- *Was the provider actively listening? How could you tell?*

6. Conclude the session

Tell participants:

- In the next session, we will discuss contraceptive issues related to STIs and HIV/AIDS.



Counseling Practice Role Play Day Three Client Role Descriptions

Note to trainer: Make 5 or 6 copies of this page and cut it into pieces with one "role" per piece. Distribute the appropriate role description to the "client" in each group at the start of each Round.

Round 1: Client Role Description

You are a 20-year-old with a four-month-old baby. You are breastfeeding. You were sure that breastfeeding would prevent pregnancy, but you unexpectedly got pregnant and have just had an abortion.

Round 2: Client Role Description

You are a 15-year-old young woman. You are sexually active but don't have a regular partner. During your last menstrual cycle, you used two packs of Postinor. You have heard your friends talking about infections that can be passed during sex, and you are worried about becoming pregnant, so you came to the health clinic, even though you were very nervous about coming in.

Round 3: Client Role Description

You are a 36-year-old woman who is six months pregnant, and you have come in for an antenatal visit. You have 2 other children and don't want more children. You have had varicose veins ever since you had your second child. You have been wondering about how you can prevent more pregnancies. But in the past when you have gone to a antenatal visit, the health care provider has never talked about family planning. You decide to wait and see whether the provider will bring it up this time.

Plenary: Client Role Description

You have just had an abortion. You are single, 25 years old, and you were using condoms as your main method of contraception when you got pregnant. You have a regular boyfriend, but you are not planning to marry yet. You have thought about using an IUD, but you've heard that they can damage your fertility, and you want to have children some day.

20. STIs, HIV/AIDS and Family Planning (Part I)

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

- list ways that HIV is and is not transmitted.
- explain methods for preventing STI/HIV transmission.
- state which contraceptive methods protect against STIs/HIV.
- state questions to ask clients to screen for STI/HIV risk.
- list contraceptive methods appropriate for women who are HIV-positive, and those that are not.
- explain reasons for linking STI/HIV prevention with family planning services.

Time: 1 hour 30 minutes

****NOTE TO TRAINER:** This session is scheduled to start on Day Three, then finish on the morning of Day Four. It is suggested to conduct one hour of the session on Day Three and break after the Transmission Risk Exercise, then continue the last half hour of the session on Day Four.*

Techniques:

- Small group work, presentation and discussion

Materials:

- Transmission risk cards and flip charts with categories (3 sets), Screening for Risk of Sexually Transmitted Infections and HIV Cue Card, *Clinical-Organizational Guidelines on Prevention of HIV Mother-to-Child Transmission* (Maternal and Child Health Initiative. Moscow, 2005), slides

Preparation:

- Make transmission risk cards and flip charts (*see "Conduct HIV transmission risk exercise" below*).

Activities:

1. Introduce STIs and HIV (15 min)

Tell participants that we will now discuss STIs and HIV.

Ask:

- ***What are some STIs you have seen in your practice?***

Listen to all responses.

Then add any of the following STIs that were not mentioned:

- bacterial vaginosis
- chlamydia
- cytomegalovirus (CMV)
- genital warts
- gonorrhea
- hepatitis
- herpes
- human immunodeficiency virus (HIV)
- human papilloma virus (HPV)
- pelvic inflammatory disease (PID)
- pubic lice
- scabies
- syphilis
- trichomoniasis
- urinary tract infections (UTIs)

Tell participants this information while **showing** these **slides**:

Sexually transmitted infections:

- You can't tell by looking at a person whether or not she/he has an STI. Many STIs are asymptomatic, especially in women.
- The greater the number of sexual partners, the greater the risk of infection.
- Being faithful to one partner does not necessarily exclude the risk of infection if the partner is unfaithful, or if the partner had unprotected sex in the past with infected partners.
- Condoms protect against HIV and some - but not all - STIs

Ask participants:

- ***Why don't condoms protect against all STIs?***

Listen to all responses.

Then **show** the information on this **slide**:

Condoms and STI/HIV prevention:

- Some STIs are transmitted by bodily fluids (semen, pre-seminal fluid, vaginal fluid, blood) and condoms provide substantial protection against these STIs.
- Some STIs are also transmitted by skin-to-skin contact with open sores, lesions or discharge. Condoms may not provide protection against these STIs since they can be transmitted via contact with skin not covered by the condom.

Ask participants:

- ***Which STIs do condoms generally protect against?***

Listen to all responses.

Then **add** any of the following STIs that were not mentioned:

- bacterial vaginosis
- chlamydia
- gonorrhea
- human immunodeficiency virus (HIV)
- pelvic inflammatory disease (PID)
- syphilis
- trichomoniasis
- urinary tract infections (UTIs)

Ask participants:

- ***Which STIs do condoms often fail to protect against?***

Listen to all responses.

Then **add** any of the following STIs that were not mentioned:

- cytomegalovirus (CMV)
- genital warts
- hepatitis
- herpes
- human papilloma virus (HPV)
- pelvic inflammatory disease (PID)
- pubic lice
- scabies
- syphilis

What clients need to know:

- It is important to explain to the client what kind of protection the condom gives and how to make its use more attractive.
- It is important to teach clients ways to refuse sex, and to negotiate safer sex, with a partner.

Tell participants:

- We will talk about some tools for couples communication later in the training.

Ask:

- ***What factors put women at risk of STIs and HIV?***

Listen to several responses.

Tell participants:

- A woman is more vulnerable to transmission of infection from a male than a male is at risk from a female for biological, social and economic reasons.

Tell participants this information while **showing** these **slides**:

Biological factors putting women at risk for STIs/HIV:

- The exposed surface area in the female genital tract is greater than in the male genital tract.
- The concentrations of HIV in semen are greater than in vaginal fluids.
- More semen is exchanged during sexual intercourse than vaginal fluids.
- Rape or "rough" sex may lead to abrasions in the woman's genital tract that facilitate entry of the virus.

Social/cultural/economic factors putting women at risk for STIs/HIV:

- Gender inequalities make women more vulnerable. They are usually expected to be monogamous, while men who have multiple partners may be tolerated or even encouraged.
- Some women lack the power to avoid STI/HIV risk because of the threat of physical violence, fear of abandonment or loss of economic support by the partner.

- Cultural norms often deny women information about sexual health, or if they have the information it may be considered inappropriate for them to reveal this knowledge. This makes communication between partners difficult and even risky.

- In some communities, men make most decisions about when, where, and how to have sex, leaving women with little decision-making power.
- Social pressure to have children may also lead women to prioritize getting pregnant over protecting themselves against disease.
- Commercial sex workers are at extremely high risk of infection, particularly when they do not have the ability to negotiate with clients who refuse to wear a condom or when they are in settings where commercial sex work is illegal.

Ask:

- ***What factors put men at risk of STIs and HIV?***

Listen to several responses.

Tell participants this information while **showing** these **slides**:

Social/cultural factors putting men at risk of STIs/HIV:

- A variety of social factors can put men at risk for getting or transmitting infections.
- Cultural norms of "masculinity" often expect men to be experienced and knowledgeable about sex, which may place them at risk because they are less likely to seek information about risk reduction.
- Attitudes about masculinity may encourage men to demonstrate sexual prowess by having multiple partners and by consuming alcohol or other substances that contribute to risk-taking behavior.
- Many cultures stigmatize men who have sex with men, which results in a lack of prevention, care and health information.

2. Discuss HIV/AIDS in Russia (5 min)

Tell participants:

- We will now look at HIV specifically.
- HIV/AIDS is an increasing problem in the Russian Federation.

Ask:

- ***Do you see clients with HIV in your practice yet?***

Listen to all responses.

Tell participants this information while **showing** these **slides**:

HIV/AIDS in the Russian Federation:

- The HIV epidemic is growing more rapidly in the RF than anywhere else in the world.
- Of all the European countries, Russia has the largest number of people living with HIV and accounts for >70% of cases in the Eastern Europe and Central Asia region.

- The number of actual cases may be three times the number officially reported.
- Prevalence may be as high as 1%.
- 99% of all registered cases in Russia were identified in the last five years.
- The majority of cases are among young people 15-29 years of age, when in Europe, overall, the majority of cases are among people >30 years of age.
- Generally two men are infected for every woman.

- Although cases are concentrated in the most developed and populated regions of Russia, cases have been reported in almost every region.
- The main risk factor for HIV in the RF has been injectable drug use; increasingly it is heterosexual contact.

- In 2005, >40% of new cases were in young women infected through heterosexual contact, showing that the epidemic is increasingly spreading to the general population.
- >2000 children are known to have been infected due to mother-to-child transmission. Between 1995 and 2005, HIV prevalence among pregnant women increased by >600%.

3. Conduct HIV transmission risk exercise (15 min)

Source: Exercise adapted from *Protecting the future: HIV prevention, care and support among displaced and war-affected populations*. Holmes, W.; International Rescue Committee (IRC) / Reproductive Health Response in Conflict Consortium (RHRC Consortium), 2003.

Tell participants:

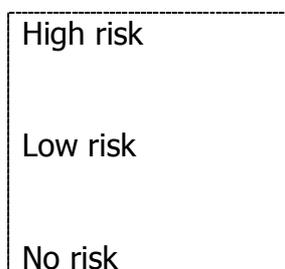
- All of your clients need to know how HIV is transmitted, which situations or behaviors are high risk and which are low risk, and how they can protect themselves.
- This exercise will help you learn about HIV risk factors so that you can explain them to clients.

Divide the participants into 3 groups, mixing them up to work with new people.

Give each group one set of the **risk cards** and some **tape**.

Note to trainer: Risk cards are provided at the end of this session.

Also **give** each group a **flip chart** labeled "No risk," "Low risk," and "High risk" as shown below.



Tell groups:

- With your group, read each of the cards describing a situation.
- Decide whether the person in the situation is at high risk, low risk, or no risk of acquiring HIV.
 - "No risk" means there has never been any evidence of HIV transmission in the situation described.
 - "Low risk" means that this situation does not represent a common means of transmission, but it has been known to happen, or it could theoretically happen.
 - "High risk" means that this situation represents a well-documented means of HIV transmission.
 - For the purpose of this exercise, the categories of risk are not precisely or numerically defined. The point of the activity is to understand which situations carry some risk.
- Stick the card onto the flip chart in the appropriate category with tape.
- You have 15 minutes to work.

4. Discuss transmission risk (30 min)

After the groups finish, **ask** them to bring their flip charts to the front of the room. **Place** the flip charts next to each other so they can be compared.

Discuss each of the situations on the cards, one by one.

For each card:

- **Point out** differences in how the groups categorized the risk.
- **Ask** participants why they categorized the behavior in this way.
- **Give** participants the correct answer based on available evidence.

Note to trainer: Below are suggested answers for each of the risk cards.

Card 1: A man has a serious accident and receives a blood transfusion in a hospital with a functioning blood bank.

Risk level: Low risk. *Increasingly, blood is universally screened for HIV antibodies prior to transfusion. Proper screening is generally available throughout the Russian Federation.*

Card 2: A couple goes on a lovely picnic and each returns with multiple mosquito bites.

Risk level: No risk. *HIV cannot be transmitted by insect bites.*

Card 3: A man goes to a barbershop where one razor is used for multiple patrons.

Risk level: Low risk. Theoretically, if a razor is used on an infected patron and blood gets on the razor, blood from the razor could transmit HIV to another patron via a small nick or cut. For this reason, it is recommended that instruments like razors be used once on one client only and then discarded, or else thoroughly cleaned and disinfected after each use.

Card 4: A child plays with an infected child at school.

Risk level: Low risk. There is a very, very low risk that an infected child could transmit HIV to another child via a very severe bite or simultaneous injury in which infected blood touched the broken skin of an uninfected child. However, there is **no risk** from normal interactions among children such as sharing toys, hugging, touching, sneezing, or sharing food and utensils. HIV-positive children can safely attend school and play with other children.

Card 5: A woman has unprotected sex with an infected partner.

Risk level: High risk. If a partner is known to be infected, or the partner's HIV status is uncertain or unknown, using condoms consistently and correctly is recommended.

Card 6: A man has sex with many partners, always using a condom consistently and correctly.

Risk level: Low risk. If any of the man's partners are HIV-positive, condoms provide good protection from HIV transmission when used consistently and correctly.

Card 7: A health care provider examines an infected person complaining of a cough and a high fever.

Risk level: No risk. HIV is only transmitted through blood, semen, vaginal fluids and breastmilk. HIV is not transmitted by saliva, tears, sweat, feces or urine. Conducting a non-invasive medical examination carries no risk.

Card 8: After administering an injection to an infected person, a health care provider accidentally sticks himself with the needle.

Risk level: Low risk. A needle-stick injury or mucous membrane exposure, such as being splashed in the face with infected blood, does carry a risk of HIV transmission. However, based on studies of actual needle-stick incidents, scientists estimate that the risk of infection is less than 1 percent. The risk of health care workers being exposed to HIV on the job is very low, especially if they carefully follow universal precautions, including injection safety. All health care facilities should have clear guidelines for the disposal of "sharps" (needles, syringes, scalpel blades, lancets, disposable medical instruments, broken glass and similar devices or materials with the potential to cut or puncture an individual as they are sent through the waste stream). To reduce the possibility of an accidental needle stick, needles should not be cut, bent or recapped.

Card 9: A family member touches an infected person's clothes and bed linens.

Risk level: No risk. HIV is only transmitted through blood, semen, vaginal fluids and breastmilk. HIV is not transmitted by saliva, tears, sweat, feces or urine. Transmission can only occur when a sufficient amount of HIV enters the bloodstream, through cuts or mucous membranes. These bodily fluids either contain no HIV or it exists in a quantity too small to result in transmission. Also, HIV does not survive well in the environment, making the possibility of environmental transmission remote.

Card 10: A friend talks with, holds hands with or hugs an infected person.

Risk level: No risk. HIV is only transmitted through blood, semen, vaginal fluids and breastmilk.

Card 11: An infected woman gets pregnant and gives birth. Risk to the baby?

Risk level: High risk. An HIV-positive woman can transmit HIV to her baby during pregnancy, labor and delivery and through breastfeeding. If she takes no preventive drugs and breastfeeds, then the chance of her baby becoming infected is around 20-45%. Precautions that can be taken to reduce the risk of transmission include antiretroviral therapy for the mother during pregnancy, labor and delivery; antiviral therapy for the newborn; and not breastfeeding when adequate breastmilk substitutes are available.

Card 12: An injectable drug user shares needles and syringes with an infected person.

Risk level: High risk. Sharing needles can transmit infected blood from one person to another.

Summarize by **asking**:

- ***What are the ways HIV is transmitted?***

Listen to a few responses.

Then **tell** participants this information while **showing** these **slides**:

HIV is transmitted through these bodily fluids:

- blood.
- vaginal secretions.
- semen and pre-seminal fluid.
- breastmilk.

Modes of transmission are:

- sexual contact with an infected person (vaginal, anal, and oral sex).
- sharing needles and/or syringes with someone who is infected, or receiving a needle-stick injury.
- receiving transfusions of infected blood or blood clotting factors.
- from infected mother to baby before or during delivery, or through breastfeeding.
- having contact with infected bodily fluids through breaks in the skin or mucous membranes.

Tell participants:

- There is a helpful **Fact Sheet** titled **HIV and Its Transmission** put out by the United States Centers for Disease Control and Prevention in your **Participant Manual**, which you might enjoy reading in the evening or at another convenient time.

Note to trainer: The Fact Sheet is provided at the end of this session.

Refer participants to **Session 20: STIs, HIV/AIDS and Family Planning** and have them find the article.

**** Stop the session here and tell participants you will complete it the next morning.**

Daily Reflection

Take 5 minutes to conduct a short **reflection** and **evaluation** exercise.

- Suggested activities are provided in the **Introduction to the Trainer's Guide**.
- **Review** the results of the daily evaluation in the evening, and use them to help you plan for the next day.

This is also a good time to **answer** any questions sitting in the **Parking Place**.

Remind the **Volunteer Team** to stay for the **Steering Committee Meeting**.

Morning Review of Daily Activities

Invite the **Volunteer Team** to start the day. They should be prepared to:

- **Review** the previous day's activities. This can be in the form of a quiz, game or fun activity for the group; or they can briefly talk about the main things they learned yesterday.
- **Report** on the main things that were discussed during the **Steering Committee Meeting** the night before. For example, if participants gave feedback about something needing improvement, the **Volunteer Team** can report how the concern was resolved.
- **Warm up** the group with a short energizer.

The Volunteer Team has a total of **15 minutes** to complete these activities.

Trainers and participants **make announcements** as needed.

20. STIs, HIV/AIDS and Family Planning (Part II)

Note to trainer: Continue Session 20 on the morning of Day 4.

Begin by **asking** a participant to **recap** briefly the key points covered the previous day in the session on **STIs, HIV/AIDS and Family Planning**.

5. Discuss HIV prevention (10 min)

Tell participants:

- Now that we have discussed how HIV is transmitted, we will briefly discuss prevention measures in various circumstances:
 - b. during pregnancy in an HIV-positive woman.
 - c. in health care settings.
 - d. during injectable drug use.
 - e. during sexual contact.

Ask:

- ***How often do you see or hear of cases of mother-to-child transmission of HIV?***

Listen to all responses.

Ask:

- ***What are some ways that the risk of mother-to-child transmission of HIV could be reduced?***

Listen to several responses.

Then **tell** participants this information while **showing** these **slides**.

To prevent mother-to-child transmission:

- HIV-positive women have the same right as all women to determine the number, timing and spacing of their children.
- Providing access to a full range of modern contraceptives is the best way to help HIV-positive women prevent unintended pregnancies.

- For HIV-positive women who do become pregnant, transmission risk can be reduced to as low as 2% by:
 - providing antiretroviral treatment to the mother during pregnancy and delivery, and to the baby after birth.
 - taking precautions during delivery (e.g. planned Caesarian section; restricting invasive procedures during pregnancy and delivery).
 - advising the mother not to breastfeed.

- By law, prevention of mother-to-child transmission services, including antiretroviral treatments, are available free of charge in the Russian Federation.
- Services are provided jointly by maternal and child health services and AIDS Centers.
- Because safe alternatives to breastmilk are available in Russia, the official policy is that HIV-positive mothers should not breastfeed, to avoid transmission through breastmilk.

Tell participants:

- PMTCT has been a key focus of the MCHI Project.
- MCHI has developed ***Clinical-Organizational Guidelines on Prevention of HIV Mother-to-Child Transmission.***
- You have received a copy for your reference.

Tell participants:

- As health care providers, we all worry about being exposed to HIV as we do our work.
- In actuality, the risk is very low.

Tell participants this information while **showing** this **slide**.

To prevent transmission in health care settings:

- follow universal precautions for infection control.
- if accidentally exposed, follow post-exposure prophylaxis recommendations using antiretroviral drugs.

Tell participants:

- The HIV epidemic started in different ways in different countries:
 - among men who have sex with other men.
 - among couples having heterosexual sex.
 - among injectable drug users.
- In Russia, as we saw earlier, the epidemic started among injectable drug users and is now entering the general population.
- As health providers, we need to constantly keep in mind that any of our clients could be at risk and need to know how to protect themselves.

Tell participants this information while **showing** these **slides**:**To prevent transmission during injectable drug use:**

- stop using injectable drugs.
- do not share needles and/or syringes.
- sterilize drug injection equipment.

To prevent transmission during sexual contact:

- practice abstinence.
- have sexual contact with only one, mutually faithful partner.
- use condoms consistently and correctly with every sexual contact.

6. Discuss contraceptive methods and STI/HIV prevention (10 min)**Ask:**

- ***Of all the contraceptive methods we have discussed, which protect against STIs/HIV?***

Listen to a few responses.

Tell participants:

- The only method that provides dual protection against pregnancy and STIs/HIV is the condom.
- All clients should be counseled about whether or not their contraceptive methods protect against STIs/HIV.
- Clients at risk for STIs/HIV should be advised to use condoms and counseled on how to use them consistently and correctly.

Ask:

- ***How do you assess whether or not a client is at risk for STIs/HIV?***

Listen to a few responses.

Then **tell** participants:

- You have a **Cue Card** on **Screening for Risk of Sexually Transmitted Infections and HIV**.
- This Cue Card lists questions a provider can ask a client to assess risk of exposure to STIs/HIV.

Go over the **Cue Card** briefly and ask if there are any questions.

7. Discuss the value of integrated services (5 min)

Ask:

- ***What are some reasons to link family planning and STI/HIV services?***

Listen to a few responses.

Then **tell** participants this information while **showing** these **slides, pointing out** ideas already mentioned by participants.

Value of integrated services:¹²

- Family planning and STI/HIV prevention services share the common goal of healthy sexuality, yet the opportunity for promoting these two services together is often lost.
 - Family planning services create an opportunity for counseling sexually active people about the whole range of sexual risks.
 - Counseling and testing services for STIs and HIV are also an opportunity to counsel clients on family planning options.

- There is a high degree of overlap between the populations at risk for unintended pregnancy and STIs/HIV.
- Providing multiple health services through one visit/provider/site can:
 - attract and benefit clients.
 - allow more opportunities for follow-up.
 - reduce the stigma attached to STI and HIV/AIDS services.

¹² Source: *Preventing HIV/AIDS through Family Planning and Contraception for Women and Couples with HIV* (Family Health International, August 2005.)

8. Discuss contraceptive options for persons living with HIV or AIDS (10 min)**Ask:**

- ***Which contraceptive methods are appropriate for persons living with HIV or AIDS?***
- ***Are there any special considerations that should be kept in mind?***

Listen to all responses.

Tell participants this information while **showing** these **slides**, **pointing out** responses already stated by participants.

Contraception for persons living with HIV or AIDS:

Persons living with HIV or AIDS:

- should be able to exercise their reproductive rights without stigma or discrimination.
- have the same right to confidentiality and the same needs for information and services in order to make informed choices as people not living with HIV or AIDS.

Benefits of contraception for persons living with HIV or AIDS:

- All the benefits that family planning gives to any client also apply to people living with HIV or AIDS.
- For women with AIDS who are taking antiretroviral drugs:
 - contraception reduces the likelihood of a complicated pregnancy (antiretroviral drugs can worsen some pregnancy complications).
 - contraception allows access to range of ARV drugs that are not compatible with pregnancy.

Specific method limitations for persons living with HIV or AIDS:

- Almost all contraceptive methods can be used successfully by clients living with HIV or AIDS.
- The following methods have some restrictions (WHO categories 3 or 4):
 - Vaginal spermicides.
 - LAM.
 - Initiation of IUD use in women with AIDS (but continuing use of an existing IUD is generally acceptable).

Ask participants to look in the **Participant Manual in Session 20** and find the table titled "**Contraceptive Options for Persons Living With HIV or AIDS.**"

Note to trainer: The table is provided at the end of this session.

Ask participants to look over the table for a few minutes.

Ask if there are any questions.

Tell participants:

- Because of their HIV status, persons living with HIV or AIDS should also be advised to use condoms and counseled on how to use them correctly.

9. Conclude the session

Tell participants:

- In the next session, we will discuss specific strategies for helping couples to communicate about condom use, STI/HIV prevention and family planning.

Note to trainer: This table is found in the Participant Manual (Session 20).

Contraceptive Options for Persons Living With HIV or AIDS

Method	Condition		
	<i>WHO Medical Eligibility Category is given in parentheses</i>		
	HIV-Infected	AIDS	Taking ARVs
Natural methods	No restriction for use (1)	No restriction for use (1)	No restriction for use (1)
Condoms	No restriction for use (1)	No restriction for use (1)	No restriction for use (1)
Spermicides	Not recommended	Not recommended	Not recommended
Low-dose COCs	No restriction for use (1)	No restriction for use (1)	Benefits generally outweigh risks (2); theoretical risk of interactions with ARVs but no evidence from clinical studies. When there is a choice, use ARVs that do not interact with hormonal methods.
Progestin-only contraceptives (pills, injectables)	No restriction for use (1)	No restriction for use (1)	Benefits generally outweigh risks (2); theoretical risk of interactions with ARVs but no evidence from clinical studies. When there is a choice, use ARVs that do not interact with hormonal methods.
IUDs	Benefits generally outweigh risks (2); use does not increase HIV transmission.	Initiating: Risks generally outweigh benefits (3) Continuing: Benefits generally outweigh risks (2)	Benefits generally outweigh risks, if clinically well (2)
Voluntary surgical contraception	No medical reason to deny.	Delay surgery if client currently suffering from an acute AIDS-related illness.	No medical reason to deny.
Emergency contraception (pills)	No restriction for use (1)	No restriction for use (1)	No data on extent and outcomes of interaction
LAM	Not recommended if safe milk alternative is available	Not recommended	Not recommended

Note to trainer: This article is provided as a reference in the Participant Manual (Session 20).

Fact Sheet: HIV and Its Transmission

Centers for Disease Control, USA (www.cdc.gov, Dec. 12, 2005)

How HIV is Transmitted

HIV is spread by sexual contact with an infected person, by sharing needles and/or syringes (primarily for drug injection) with someone who is infected, or, less commonly (and now very rarely in countries where blood is screened for HIV antibodies), through transfusions of infected blood or blood clotting factors. Babies born to HIV-infected women may become infected before or during birth or through breastfeeding after birth.

In the health care setting, workers have been infected with HIV after being stuck with needles containing HIV-infected blood or, less frequently, after infected blood gets into a worker's open cut or a mucous membrane (for example, the eyes or inside of the nose). There has been only one instance of patients being infected by a health care worker in the United States; this involved HIV transmission from one infected dentist to six patients. Investigations have been completed involving more than 22,000 patients of 63 HIV-infected physicians, surgeons, and dentists, and no other cases of this type of transmission have been identified in the United States.

Some people fear that HIV might be transmitted in other ways; however, no scientific evidence to support any of these fears has been found. If HIV were being transmitted through other routes (such as through air, water, or insects), the pattern of reported AIDS cases would be much different from what has been observed. For example, if mosquitoes could transmit HIV infection, many more young children and preadolescents would have been diagnosed with AIDS.

The following paragraphs specifically address some of the common misperceptions about HIV transmission.

HIV in the Environment

Scientists and medical authorities agree that HIV does not survive well in the environment, making the possibility of environmental transmission remote. HIV is found in varying concentrations or amounts in blood, semen, vaginal fluid, breastmilk, saliva, and tears. (See page 3, *Saliva, Tears, and Sweat*.) To obtain data on the survival of HIV, laboratory studies have required the use of artificially high concentrations of laboratory-grown virus. Although these unnatural concentrations of HIV can be kept alive for days or even weeks under precisely controlled and limited laboratory

conditions, CDC studies have shown that drying of even these high concentrations of HIV reduces the amount of infectious virus by 90 to 99 percent within several hours. Since the HIV concentrations used in laboratory studies are much higher than those actually found in blood or other specimens, drying of HIV-infected human blood or other body fluids reduces the theoretical risk of environmental transmission to that which has been observed--essentially zero. Incorrect interpretation of conclusions drawn from laboratory studies have unnecessarily alarmed some people. Results from laboratory studies should not be used to assess specific personal risk of infection because (1) the amount of virus studied is not found in human specimens or elsewhere in nature, and (2) no one has been identified as infected with HIV due to contact with an environmental surface. Additionally, HIV is unable to reproduce outside its living host (unlike many bacteria or fungi, which may do so under suitable conditions), except under laboratory conditions, therefore, it does not spread or maintain infectiousness outside its host.

Households

Although HIV has been transmitted between family members in a household setting, this type of transmission is very rare. These transmissions are believed to have resulted from contact between skin or mucous membranes and infected blood. To prevent even such rare occurrences, precautions should be taken in all settings "including the home" to prevent exposures to the blood of persons who are HIV infected, at risk for HIV infection, or whose infection and risk status are unknown. For example,

- Gloves should be worn during contact with blood or other body fluids that could possibly contain visible blood, such as urine, feces, or vomit.
- Cuts, sores, or breaks on both the care giver's and patient's exposed skin should be covered with bandages.
- Hands and other parts of the body should be washed immediately after contact with blood or other body fluids, and surfaces soiled with blood should be disinfected appropriately.
- Practices that increase the likelihood of blood contact, such as sharing of razors and toothbrushes, should be avoided.
- Needles and other sharp instruments should be used only when medically necessary and handled according to recommendations for health-care settings. (Do not put caps back on needles by hand or remove needles from syringes. Dispose of needles in puncture-proof containers.)

Businesses and Other Settings

There is no known risk of HIV transmission to co-workers, clients, or consumers from contact in industries such as food-service establishments. Food-service workers known to be infected with HIV need not be restricted from work unless they have other

infections or illnesses (such as diarrhea or hepatitis A) for which any food-service worker, regardless of HIV infection status, should be restricted. CDC recommends that all food-service workers follow recommended standards and practices of good personal hygiene and food sanitation.

There is no evidence of transmission from a personal-service worker (such as hairdressers, barbers, cosmetologists, and massage therapists) to a client or vice versa. Instruments that are intended to penetrate the skin (such as tattooing and acupuncture needles, ear piercing devices) should be used once and disposed of or thoroughly cleaned and sterilized. Instruments not intended to penetrate the skin but which may become contaminated with blood (for example, razors) should be used for only one client and disposed of or thoroughly cleaned and disinfected after each use. Personal-service workers can use the same cleaning procedures that are recommended for health care institutions.

CDC knows of no instances of HIV transmission through tattooing or body piercing, although hepatitis B virus has been transmitted during some of these practices. One case of HIV transmission from acupuncture has been documented. The medical complications for body piercing appear to be greater than for tattoos. Healing of piercings generally will take weeks, and sometimes even months, and the pierced tissue could conceivably be abraded (torn or cut) or inflamed even after healing. Therefore, a theoretical HIV transmission risk does exist if the unhealed or abraded tissues come into contact with an infected person's blood or other infectious body fluid. Additionally, HIV could be transmitted if instruments contaminated with blood are not sterilized or disinfected between clients.

Kissing

Casual contact through closed-mouth or "social" kissing is not a risk for transmission of HIV. Because of the potential for contact with blood during "French" or open-mouth kissing, CDC recommends against engaging in this activity with a person known to be infected. However, the risk of acquiring HIV during open-mouth kissing is believed to be very low. CDC has investigated only one case of HIV infection that may be attributed to contact with blood during open-mouth kissing.

Biting

In 1997, CDC published findings from a state health department investigation of an incident that suggested blood-to-blood transmission of HIV by a human bite. There have been other reports in the medical literature in which HIV appeared to have been transmitted by a bite. Severe trauma with extensive tissue tearing and damage and presence of blood were reported in each of these instances. Biting is not a common

way of transmitting HIV. In fact, there are numerous reports of bites that did *not* result in HIV infection.

Saliva, Tears, and Sweat

HIV has been found in saliva and tears in very low quantities from some AIDS patients. It is important to understand that finding a small amount of HIV in a body fluid does not necessarily mean that HIV can be *transmitted* by that body fluid. HIV has *not* been recovered from the sweat of HIV-infected persons. Contact with saliva, tears, or sweat has never been shown to result in transmission of HIV.

Insects

From the onset of the HIV epidemic, there has been concern about transmission of the virus by biting and bloodsucking insects. However, studies conducted by researchers at CDC and elsewhere have shown no evidence of HIV transmission through insects--even in areas where there are many cases of AIDS and large populations of insects such as mosquitoes. Lack of such outbreaks, despite intense efforts to detect them, supports the conclusion that HIV is not transmitted by insects.

The results of experiments and observations of insect biting behavior indicate that when an insect bites a person, it does not inject its own or a previously bitten person's or animal's blood into the next person bitten. Rather, it injects saliva, which acts as a lubricant or anticoagulant so the insect can feed efficiently. Such diseases as yellow fever and malaria are transmitted through the saliva of specific species of mosquitoes. However, HIV lives for only a short time inside an insect and, unlike organisms that are transmitted via insect bites, HIV does not reproduce (and does not survive) in insects. Thus, even if the virus enters a mosquito or another sucking or biting insect, the insect does not become infected and cannot transmit HIV to the next human it feeds on or bites. HIV is not found in insect feces.

There is also no reason to fear that a biting or bloodsucking insect, such as a mosquito, could transmit HIV from one person to another through HIV-infected blood left on its mouth parts. Two factors serve to explain why this is so--first, infected people do not have constant, high levels of HIV in their bloodstreams and, second, insect mouth parts do not retain large amounts of blood on their surfaces. Further, scientists who study insects have determined that biting insects normally do not travel from one person to the next immediately after ingesting blood. Rather, they fly to a resting place to digest this blood meal.

Effectiveness of Condoms

The proper and consistent use of latex or polyurethane (a type of plastic) condoms when engaging in sexual intercourse--vaginal, anal, or oral--can greatly reduce a person's risk of acquiring or transmitting sexually transmitted diseases, including HIV infection.

There are many different types and brands of condoms available--however, only latex or polyurethane condoms provide a highly effective mechanical barrier to HIV. In laboratories, viruses occasionally have been shown to pass through natural membrane ("skin" or lambskin) condoms, which may contain natural pores and are therefore not recommended for disease prevention (they are documented to be effective for contraception). Women may wish to consider using the female condom when a male condom cannot be used.

For condoms to provide maximum protection, they must be used *consistently* (every time) and *correctly*. Several studies of correct and consistent condom use clearly show that latex condom breakage rates in the USA are less than 2 percent. Even when condoms do break, one study showed that more than half of such breaks occurred prior to ejaculation.

When condoms are used reliably, they have been shown to prevent pregnancy up to 98 percent of the time among couples using them as their only method of contraception. Similarly, numerous studies among sexually active people have demonstrated that a properly used latex condom provides a high degree of protection against a variety of sexually transmitted diseases, including HIV infection.



Cards for HIV transmission risk exercise

Note to trainer: Make six copies of this page and cut it up with one situation per card. Give one set to each small group for the exercise.

A man has a serious accident and receives a blood transfusion in a hospital with a functioning blood bank.
A couple goes on a lovely picnic, and each returns with multiple mosquito bites.
A man goes to a barbershop where one razor is used for multiple patrons.
A child plays with an infected child at school.
A woman has unprotected sex with an infected partner.
A man has sex with many partners, always using a condom consistently and correctly.
A health care provider examines an infected person complaining of a cough and a high fever.
After administering an injection to an infected person, a health care provider accidentally sticks himself with the needle.
A family member touches an infected person's clothes and bed linens.
A friend talks with, holds hands with or hugs an infected person.
An infected woman gets pregnant and gives birth. Risk to the baby?
An injectable drug user shares needles and syringes with an infected person.

21. Couples Communication

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

- list reasons that couples may find it difficult to communicate about the need for protection against STIs/HIV and condom use.
- describe Couples Campaign resources, if available.
- practice using resources for role playing with clients on negotiating condom use with a partner.

Time: 30 minutes

Techniques:

- Exercise, presentation and discussion

Materials:

- Cards for condom negotiation exercise, basket or envelope, Couples Campaign sample materials, slides

Preparation:

- Make cards for condom negotiation exercise (*provided at the end of this session*).

Activities:

1. Introduce couples communication (5 min)

Tell participants:

- Throughout this training course, we have talked about the importance of telling clients whether their contraceptive methods provide protection against STIs and HIV.
- As we have discussed in previous sessions, consistent and correct use of condoms will significantly reduce the risk of getting or transmitting an STI or HIV.

Tell participants this information while showing this **slide**:

Regardless of level of risk, **all** persons who are sexually active should be provided with information about:

- how STIs and HIV are transmitted.
- whether or not their contraceptive method provides protection against STIs/HIV.

Ask:

- ***Why is it important to provide this information to ALL sexually active clients regardless of their risk?***

Listen to a few responses.

The **tell** participants the following points if they were not already mentioned:

- Clients' life circumstances can change.
- Clients who may not have seemed to be at risk during previous visits might find themselves at risk at a later time and should have the information needed to protect themselves. This is a responsibility of all providers.

2. Introduce the Couples Campaign (5 min)

Tell participants:

- Recently a "Couple's Campaign" was launched in Russia.
- One of the most important messages in the Couple's Campaign is that both members of the couple have a responsibility (and a right) to share in the decision-making about achieving their reproductive goals and having a healthy reproductive life.

Pass around some samples of pamphlets and materials developed by the Couples Campaign, if available.

Tell participants this information while **showing** this **slide**:

Both partners should participate in:

- deciding if and when to become sexually active.
- determining the number, timing and spacing of children.
- deciding whether or not to use a contraceptive method.
- choosing the appropriate contraceptive method.
- sharing the pregnancy and birth experience.
- protecting themselves, their partner(s) and possibly their infants from STIs and HIV.

Tell participants:

- In order to achieve these goals the couple must be able to communicate with each other about all these important issues.

3. Discuss counseling clients on communicating about condoms (5 min)

Tell participants:

- Because men, not women, control the use of male condoms, condom negotiation strategies should be an integral part of the family planning counseling session.
- Negotiating safer sex can be a difficult process for partners.

Ask:

- ***Why do you think talking about condom use with a partner could be difficult for a client?***

Listen to several responses.

Then **show** the possible responses on this **slide, pointing out** how they are similar or different to the responses given by participants.

- Women in particular, due to gender inequalities and lack of power within sexual relationships, may find it difficult, if not impossible, to negotiate safer sex with their partners.
- Partners may think a request for safer sex is related to unfaithfulness. A partner may react negatively, even violently.

Tell participants:

- Women need to be assured that condom negotiation is about respect and responsibility – for herself and for her partner.

Ask:

- ***What might be some ways for clients to make condom negotiation easier and more successful?***

Listen to several responses.

Then **show** the possible responses on these **slides, pointing out** how they are similar or different to the responses given by participants.

Possible condom negotiation strategies:

- Think about ways to speak about the topic with the partner in a non-threatening manner.
- Find a time for the discussion before the passion of the moment, not right before or during a sexual encounter.
- Practice arguments for condom use and responses to partner's excuses for not using condoms.
- Practice being assertive.

- Use indirect communication, such as sharing information or literature from a clinic or the media, leaving condoms in strategic places, or talking about how other people use condoms.
- Encourage the partner to visit a health provider, jointly or alone.
- Demonstrate that requests for safer sex are inspired by caring rather than an accusation of unfaithfulness.
- Have a supply of condoms on hand and know how to use them – do not rely on the partner to have them.
- Purchase the condoms together as a couple.

4. Practice condom negotiation scenarios for client counseling (15 min)

Note to trainer: Cards for this activity are provided at the end of this session.

Tell participants:

- One effective way to help clients talk with their partners about condoms is to practice or role play how the conversation would go, and what responses they could make to their partner's objections to condoms.

Tell participants:

- I will pass around a basket filled with cards, and invite a volunteer to draw one card.
- On each card, there is an objection that a man might make if his partner asked him to use condoms.
- The volunteer will read aloud the statement on the card.
- Then I will invite other participants to think of responses a woman could give to this objection.

Ask the first participant to draw one card from the basket and read the statement out loud.

Then **invite** other participants to share responses the woman could give to this statement.

Continue passing the basket around the room until all the cards have been read and discussed.

Note to trainer: The statements are listed below, with suggested responses.

"Sex with condoms doesn't feel as good."

Suggested response:

"Sex with a condom may feel different, but it doesn't have to be unpleasant. I know if we use condoms I'll feel a lot safer and more relaxed, and that will make sex more enjoyable for both of us."

"Don't you trust me?"

Suggested response:

"We may both feel we're disease free and trust each other, but people can have an infection and not know it. We may not be able to trust our past partners. I trust that using a condom will protect us both."

"My HIV test was negative."

Suggested response:

"HIV is not the only infection I'm worried about. There are several STIs that may not have any visible symptoms. A condom will help protect us both from getting an STI."

"I love you. If you really loved me, you wouldn't ask me to use a condom."

Suggested response:

"Love isn't the issue. Getting a sexually transmitted infection is the issue. I think that if you loved me you would be more concerned about protecting us both from infection."

"I don't have any kind of disease. Don't you trust me?"

Suggested response:

"Of course I trust you, but anyone can have an STI and not even know it. This is just a way to take care of us both."

"You're on the pill."

Suggested response:

"But that doesn't protect us from STIs, so I still want to be safe, for both of us."

"I didn't bring any condoms."

Suggested response:

"I have some right here."

"I don't know how to use condoms."

Suggested response:

"I can show you. Do you want me to put it on for you?"

"Let's do it without a condom just this one time."

Suggested response:

"It only takes one time to get pregnant or to get an STI. I just can't have sex unless I know I am safe."

"No one else makes me use condoms."

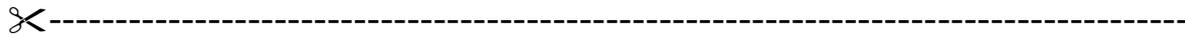
Suggested response:

"This is for both of us, and I won't have sex without protection. Let me show you how good it can be even with a condom."

5. Conclude the session

Tell participants:

- There are more sample statements and responses for couples communication in the **Participant Manual** in **Session 21: Couples Communication**. You can use these resources with clients to help them prepare for condom negotiation.
- In the next session, you will have the chance to reflect on how to put into action what you have learned in this course.



Cards for Condom Negotiation Exercise

Note to trainer: Make one copy of this page and cut it up into cards with one statement on each.

"Sex with condoms doesn't feel as good."
"Don't you trust me?"
"My HIV test was negative."
"I love you. If you really loved me, you wouldn't ask me to use a condom."
"I don't have any kind of disease. Don't you trust me?"
"You're on the pill."
"I didn't bring any condoms."
"I don't know how to use condoms."
"Let's do it without a condom just this one time."
"No one else makes me use condoms."

22. Increasing Access to Family Planning Services: Action Plans

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

- make a plan for applying what they have learned about family planning counseling and services in their workplace.
- identify possible challenges to introducing the new family planning approaches they have learned, and strategies for addressing those challenges.

Time: 1 hour 40 minutes (*including tea break to be taken during group work*)

Techniques:

- Small group work, discussion

Materials:

- Handout 2: Action Plan Worksheet

Activities:

1. Introduce the Action Plan Worksheet (5 min)

Tell participants:

- In this session, you will have the chance to work with colleagues from your health facility to make concrete action plans.
- You will plan for how to put into action the ideas and skills you have learned in this training.

Distribute Handout 2: Action Plan Worksheet.

Tell participants:

- You will work with your colleagues attending from the same health facility.
 - If you are attending this Course alone, you can choose to join another group from the same region, or work individually.
- The Action Plan questions are based on key concepts we have learned in this training. The Worksheet asks the group to make concrete plans for how you can address these concepts in your work.
- The Plan should be realistic so that you can really implement it when you go back to your facilities.
- Each facility group should complete ONE Worksheet.
- The trainers will take a copy of your Action Plan to help with follow-up, and you will also keep a copy.
- The trainers will periodically visit your health facility to help you implement your plan, as follow-up to this training.

2. Discuss integrating family planning into other services (10 min)

Before beginning the group work, **discuss** the topics covered on the Worksheet one by one in plenary.

Read aloud from the **Worksheet**:

- **Concept #1: Integrating family planning into other services: Providers should take advantage of every opportunity to offer and provide family planning counseling to any client of reproductive age who comes to the health facility, regardless of the service they come for.**

Ask:

- ***When clients come to your facility for antenatal care, well-baby care, STI/HIV treatment or other health services, do they receive family planning services as well? If yes, how is that accomplished?***

Listen to several responses.

Summarize the main points you have heard.

Remind participants:

- Some of the services that can be entry points for family planning counseling are: antenatal care, postpartum or postabortion before discharge, breastfeeding support, well-baby care, STI/HIV/AIDS care.

Tell participants:

- Part of integrating family planning into other services at your health facility may include **building the skills of other providers**.

Ask:

- ***How many of you feel that you could explain and share the information you learned in this training to some of your peers? Please raise your hand.***
- ***What support would help you to do this?***

Tell participants:

- The **WHO Medical Eligibility Criteria for Contraceptive Use manual**, the **Cue Cards**, the **Flip Book "Contraception: How to Prevent an Unwanted Pregnancy"** and the background articles in your **Participant Manual** can make it easier to share key information with other providers. For example, you can arrange to observe a colleague who is counseling and use the GATHER Cue Card to give her feedback on her performance.
- Another tool for peer support is the **Client-Provider Interaction Checklist** (in the **Participant Manual, Session 5**). You can use this instrument to check your own performance, or providers can observe one another and use the checklist to give feedback. It can also be used for supervision or for promoting discussion of ways to improve service among health facility staff. This checklist covers many of the generic counseling skills we have discussed, as well as issues about the facility environment.

3. Discuss barriers to access (5 min)

Read aloud the next concept on the worksheet:

- **Concept #2: Family planning providers should try to remove barriers that keep clients from accessing the full range of family planning services and methods.**

Ask:

- ***What are some of the barriers to family planning access in your experience?***

Listen to several responses.

Note to trainer: Some possible barriers might include:

- *Providers not trained in family planning counseling.*
- *Family planning counseling and services only offered in specific family planning clinics or rooms.*
- *Limited availability of some methods.*
- *Cost of some methods.*
- *Unnecessary exams and tests are required.*
- *Outdated or overly strict medical eligibility criteria are in place.*
- *Some providers have negative attitudes toward family planning or toward certain groups of clients such as youth or unmarried women or persons living with HIV or AIDS.*
- *Lack of printed materials for clients about contraceptive methods.*

Tell participants:

- During the group work, you can talk about these barriers with your colleagues and discuss strategies to overcome them.

4. Discuss outreach in the community (10 min)

Read aloud the next concept on the Worksheet:

- **Concept #3: Health care providers should take every opportunity to provide people in the community with accurate information about health, including family planning.**

Tell participants:

- As highly respected members of the community, health care providers have an opportunity and a responsibility to provide good information about family planning. This is especially important in light of the many sources of misinformation and rumor.

Ask:

- ***What are some ways you could reach out into the community with family planning information to make services more attractive and accessible?***

Listen to all responses and **write** them on a **flip chart** so that the groups can reference them during their planning.

If the following are not mentioned, **add** them to the list:

- Make presentations at community events.
- Hold public events at the health facility site.
- Contact the media (print, TV, radio).
- Distribute public awareness materials like posters (e.g. Couples Campaign materials).
- Develop relationships with community leaders (business leaders, religious leaders, government representatives, people representing underserved or marginalized groups, etc.).

5. Conduct small group work on Action Plans (50 min)

Ask participants to form their work groups to complete the **Action Plan Worksheets**.

Tell participants they should take a short **tea break** during their group work.

Circulate, observe and **answer** questions as needed.

6. Discuss action plans in plenary (20 min)

When the groups are finished, **bring** everyone back together.

Ask one group to share actions they have planned for the "integration of services."

Then **ask** other participants to comment and share ideas.

Ask a different group to share actions they have planned for "addressing barriers to access."

Then **ask** other participants to comment and share ideas.

Ask a third group to share actions they have planned for "community outreach."

Then **ask** other participants to comment and share ideas.

Collect the **Action Plan Worksheets**, making sure that each group submits one and that the name of their facility is written on it.

Note to trainer: During the break, have copies made of the worksheets so that the trainers can keep one and the originals can go back to the participants. Do not forget to give the originals back.

7. Conclude the session

Conclude by telling the participants the following **key points**:

- As family planning providers who have attended this training, you have an opportunity to be “change agents” in your facilities, advocating for improvements and motivating your colleagues.
- Even though sometimes it feels as if we have little control, in reality there are many positive actions we can take in our own settings to bring better family planning services to our communities.

Handout 2

Increasing Access to Family Planning Action Plan Worksheet

HEALTH FACILITY _____

OBLAST/REGION _____

PARTICIPANTS' NAMES: _____

The purpose of this activity is to brainstorm ways that your health facility can improve by increasing the access clients have to family planning counseling and modern contraceptive methods. It is important to develop a plan of action that is realistic so that you can implement it when you return to your facility.

INSTRUCTIONS:

For each section, first read the concept and then discuss the question(s) which follow with your colleagues; fill in your planned action(s) in the space provided.

1. Providers should take advantage of every opportunity to offer and provide family planning counseling to any client of reproductive age who comes to the health facility.

1.1 How can family planning information and counseling be better **integrated** into the services currently being offered at your health facility?

1.2 What **specific** actions will you take to improve the integration?

2. Family planning providers should try to remove barriers that keep clients from accessing the full range of family planning services and methods.

2.1 What are the **3 most significant barriers** that you think exist at your facility that may limit clients' access to family planning?

2.2 What are some **specific** actions that you can initiate at your health facility to reduce the most significant barriers you identified above?

2.3 How will you know if your interventions have been successful or not?

3. Health care providers should take every opportunity to provide people in the community with accurate information about health, including family planning.

- 3.1 What are 3 ways that members of your group can be **pro-active and "reach out"** to the community with accurate information about family planning?

23. Post-test and Evaluation

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

- assess and reflect on their own learning by taking a Post-test.
- review their expectations for the training and whether they were met.
- evaluate the training.

Time: 35 minutes

Techniques:

- Individual assessment

Materials:

- Handout 3: Post-test, Handout 4: Training Course Evaluation

Activities:

1. Administer the Post-test (15 min)

Tell participants:

- You will now take the same test that you completed on the first day.
- This test helps both you and the trainers assess how well the training course has met its objectives and if specific topics were given sufficient attention.
- You can use any of the course materials to look up answers if you wish, but there is a time limit of **15 minutes**.

Distribute Handout 3: Post-test and give participants **15 minutes** to work individually.

Note to trainer: The Post-test is provided at the end of this session.

2. Go over answers to the Post-test (10 min)

After 15 minutes, **collect** all tests. **Make sure** participants have written their names on the tests.

Go over the answers to the test one by one. If participants have any questions, **explain** the answers.

Note to trainer: See Session 1: Introduction/Course Opening for the Answer Key. After the training, you can analyze the change in scores. Your analysis may help you plan your next training.

3. Review participant expectations (5 min)

Ask:

- *Looking at the expectations for this training that we wrote on a flip chart on the first day, do you think these expectations have been met?*

Listen to a few responses. If any expectations were not met, **suggest** ways that participants could meet them through other resources or trainings.

If there are any questions left in the **Parking Place**, take time to answer them if possible.

4. Conduct final evaluation of the training course (5 min)

Tell participants:

- It will be very helpful to the trainers and the course organizers if you would give us honest feedback on your experiences during this training course.
- It should take no more than **5 minutes** to complete this short evaluation form.

Distribute Handout 4: Training Course Evaluation.

Participants have **5 minutes** to complete it.

Collect all questionnaires.

Handout 3 Post-Test

Name: _____

INSTRUCTIONS: Each statement is either TRUE or FALSE. Make a mark in the TRUE column if you agree with the statement, or in the FALSE column if you disagree with the statement.

	TRUE	FALSE	STATEMENT
1.			Most modern contraceptive methods have a low rate of failure if used consistently and correctly and are safe for the majority of users.
2.			Internationally-recognized evidence-based eligibility criteria have been developed by the World Health Organization to help health providers be certain that couples are receiving medically-appropriate contraceptive methods.
3.			Having high quality family planning services is less important in the Russian Federation than in other countries in the world, since Russia has one of the lowest total fertility rates (TFRs) in the world.
4.			Women and couples have very different reproductive and contraceptive needs at different points in their lifecycles. With the latest advances in contraceptive technology, a single contraceptive method can meet all those changing needs, which makes family planning simpler than in the past.
5.			The goal of client-centered counseling is to help women and couples exercise their right to choose, understand and use an appropriate contraceptive method, including the right to choose no method at all.
6.			Family planning is the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so.
7.			For the optimal health of both mothers and children, the recommended birth spacing interval is 2 years.
8.			In a good counseling session, the provider carefully listens to the client's reproductive concerns and then advises which contraceptive method the client should use to meet her needs.
9.			A good counselor provides each client with detailed information about every contraceptive method available. This helps the client to make an informed choice.

	TRUE	FALSE	STATEMENT
10.			Cue cards help even the most experienced provider to quickly locate the most important information needed for counseling a client about contraceptive methods.
11.			Informing clients about the possible side effects of specific methods ahead of time tends to discourage them before they even try a method. It is better to wait and see if the client experiences any side effects.
12.			Clients need to be informed whether their contraceptive methods will help protect them from STIs/HIV.
13.			The Standard Days Method of family planning is only effective for women with regular menstrual cycles between 28-30 days long.
14.			Oil-based lubricants should never be used with condoms, as these will weaken the condoms and may cause them to tear.
15.			Emergency oral contraception must be used within 72 hours of unprotected intercourse.
16.			Repeated use of spermicides in any one day may increase a woman's risk for STIs or HIV.
17.			Since the 1980s, the hormonal doses in combined oral contraceptive pills have been greatly reduced with no reduction in effectiveness, and with fewer contraindications and fewer side effects.
18.			The various brands of low-dose oral contraceptive pills may vary slightly in the dosage of estrogen or in the type and dosage of progestin they contain. These variations are so slight that the provider should not be overly concerned about which brand of pill is available for the client to take.
19.			In a 28-day packet of combined oral contraceptive pills, the first 21 pills contain only estrogen, and the last 7 pills (which are a different color) contain only progestin.
20.			Women with blood pressure below 160/90 are eligible for low-dose combined oral contraceptive pills.
21.			It is important to routinely perform a full physical exam before providing low-dose combined oral contraceptive pills.

	TRUE	FALSE	STATEMENT
22.			With progestin-only pills, there is a higher risk of pregnancy than with the low-dose combined oral contraceptive pills if the woman forgets a pill or is late taking her pill.
23.			All of the pills in the packets of progestin-only pills contain progestin. There are no "reminder" pills.
24.			The IUD can safely be used by most HIV-positive women.
25.			The IUD is one of the most effective contraceptive methods because it requires very little action on the part of the woman once it has been inserted by a trained provider.
26.			After being treated for an STI, a woman should wait one month before having an IUD inserted. During that month, she should use a different method of contraception or abstain from intercourse.
27.			The World Health Organization recommends that sexually active women have a supply of emergency contraceptive pills on hand.
28.			The lactational amenorrhea method (LAM) of contraception is effective as long as the woman meets at least 2 of the 3 criteria for effectiveness: (1) baby is less than 6 months old; (2) baby is frequently being fed only breastmilk; (3) her menses have not resumed since delivery.
29.			In the first 6 months after delivery, all methods of contraception are safe for women and their infants while breastfeeding.
30.			The optimal time to counsel a postpartum woman about contraception is the day she is preparing for discharge from the hospital.
31.			Family planning should be integrated into all primary health care services for all clients of reproductive age.
32.			Voluntary surgical sterilization leads to a loss of sex drive in many clients.
33.			After an abortion, a woman's fertility returns after 28 days.
34.			HIV can be transmitted through contact with blood, semen, and saliva.

Handout 4 Family Planning Training for Primary Health Care Providers Course Evaluation

Name: _____

Course date: _____

Region/ Town: _____

Facility: _____

For the following statements, please circle the number that best represents your opinion.

- 5 = I fully agree
- 4 = I partially agree
- 3 = I do not agree or disagree
- 2 = I partially disagree
- 1 = I disagree

General impressions:

- | | |
|---|-----------|
| 1. The Course objectives have been achieved. | 5 4 3 2 1 |
| 2. The Pre-test and Post-test correctly evaluated what I learned. | 5 4 3 2 1 |
| 3. This course will be useful to me in my professional activity. | 5 4 3 2 1 |

Information:

- | | |
|---|-----------|
| 4. I learned new information during this course. | 5 4 3 2 1 |
| Now I will be able to: | 5 4 3 2 1 |
| 5. Explain the benefits of family planning. | |
| 6. Describe the mechanism of action, effectiveness, advantages and disadvantages of specific contraceptive methods. | 5 4 3 2 1 |
| 7. Offer counseling to family planning clients. | 5 4 3 2 1 |
| 8. Adapt the counseling process to the client's needs. | 5 4 3 2 1 |
| 9. Counteract rumors and misinformation regarding contraception. | 5 4 3 2 1 |

Training methodology

- 10. Presentations made by the trainer(s) were clear and organized. 5 4 3 2 1
- 11. I learned and practiced new skills. 5 4 3 2 1
- 12. The trainers asked questions to find out what I knew about a topic during the sessions. 5 4 3 2 1
- 13. The trainers encouraged everyone to participate in activities. 5 4 3 2 1
- 14. Instructions given by the trainers for the exercises were clear. 5 4 3 2 1
- 15. Trainers promptly answered my questions. 5 4 3 2 1

Organization and logistics

- 16. The place where the course was conducted was satisfactory. 5 4 3 2 1
- 17. All necessary materials were provided. 5 4 3 2 1
- 18. Coffee and lunch breaks were well organized. 5 4 3 2 1
- 19. The time period was adequate for the activities. 5 4 3 2 1

Please write your answers to these questions in the space below.

20. What was the most useful part of the course? Why?

21. What was the least useful part of the course? Why?

22. Which topics were new for you?

23. What suggestions do you have for the improvement of this course?

24. Other comments:

We thank you and wish you good luck!

24. Closing

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

- receive certificates.
- conclude the training on a positive note.

Time: 30 minutes

Techniques:

- Certificate ceremony or other activity

Materials:

- Certificates
- *Optional: Materials for the closing activity, such as a ball of yarn, or pieces of paper and markers (see below).*

Activities:

1. Conduct a closing activity (10 min)

The farewell of the trainers and the group should take place in a positive, optimistic manner. **Choose** a short activity like the following:

- **Weave a Network:** Ask participants to stand in a circle. One of the trainers holds a ball of yarn. She/he says one word or phrase of good wishes for the participants. Then the trainer holds onto the end of the yarn and throws the ball to someone across the circle. Each participant takes a turn saying a good wish and throwing the ball of yarn to someone else, while still holding on to the yarn. When everyone has had a turn, the group will have created a web connecting everyone.

OR

- **Make Handprints:** Each person (trainers and participants) puts one hand on a sheet of paper and draws its outline with a marker, writes his/her name in a corner of the page and passes it to the colleague on the right. Then everyone writes a short good wish or positive message inside the hand outline of their neighbor. Next, pass the sheets to the right again. Keep passing the sheets and writing messages until the sheets return to their owners.

2. Distribute Certificates (20 min)

Optional: If special guests are attending, they can be invited to say a few words.

Thank participants for their hard work.