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CHILD SPACING MODULE

STUDENT TEXT

1980
Rural Health Development Project
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ACKNOWLEDGEMENTS

Nurse Clinician training materials are Lesotho adaptations based upon the MEDEX prototype curriculum for training mid-level health workers.

The prototype MEDEX materials were developed by the Health Manpower Development Staff of the John A. Burns School of Medicine, University of Hawaii. The original prototypes were based on training experience in over a dozen third-world countries. These were revised on the basis of HMDS experience in Micronesia, Thailand, Pakistan, and Guyana before being made available to Lesotho under a U.S.A.I.D. funded contract.

Major adaptation in Lesotho began at the National Nurse Clinician Training Programme Curriculum Adaptation Workshop held at Mazenod in January 1980. The nearly fifty participants represented all major health and health related activities in Lesotho, both Government and private. These participants and others working as individuals and then as review committees have adapted the Nurse Clinician training materials to meet the conditions and needs of Lesotho.

The Government of Lesotho and particularly the staff of the Nurse Clinician training Programme are grateful to HMDS for supplying the prototype materials and to all those individuals who have helped in the Lesotho adaptation process.

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REFERENCES USED IN THE
DEVELOPMENT OF THE
CLINICAL FAMILY PLANNING MODULE

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INTRODUCTION

This module is limited to family planning as it is handled within the clinical situation. An accompanying module, "Community Family Planning," deals with family planning and population control on a community basis.

Clinical family planning deals with individuals and couples who wish to plan their families; to decide when they want a child and how many children they would like to have. Couples who plan their families are concerned with being responsible parents of their children. This module will give the nurse clinician the tools that will enable her to help couples plan their families and become the responsible parents they wish to be.

STUDENT GUIDE

REPRODUCTIVE SYSTEM MALE AND FEMALE

I. Entry Level Knowledge:

This is a review session.

II. Objectives:

Using the information and experiences provided by the tutor and the Module Text, you will be able to:

1. Identify on a diagram the correct location of each of the organs in the male and female reproductive system.
2. Describe the physiologic process of normal conception (fertilization).
3. Review the complete physical exam of male and female.

III. Upon completion of this module, you will be tested on your attainment of the above objectives. Acceptable performance, 80%.

IV. Activities you will be participating in to accomplish the unit objectives:

1. Read the module text and answer the review questions.
2. Write at least one of your own questions about the reproductive system to share with the group during discussion.
3. View and discuss slides of the male and female reproductive systems.
4. Participate in discussion of reproduction and physical exam procedures, male and female.
5. Individual students present description of function and structure of the male and female reproductive system, reproduction and pregnancy.

THE REPRODUCTIVE SYSTEM

Function

In order for humans to continue to inhabit the earth they must have the ability to produce babies which will grow and replace those persons who have died. Both males and females are important in the reproductive process because a baby cannot develop from a cell (ovum) produced inside the female unless the ovum first comes into contact with a cell called a sperm from the male. Therefore, the human body has special structures in both males and females to allow reproduction to occur.

Male Structure and Function

The scrotum is an external sac which contains and protects the testes. The testes are two oval structures which produce sperm.

A sperm cell is a special cell consisting of a compact head and a tail which enables the sperm to swim to the ovum once it is inside the female body. Each sperm contains half the information of what the baby will be like (i.e. physical appearance, sex, etc.), while the other half of the information is contained in the ovum produced by the female. For this reason, it is necessary that the sperm and the ovum join together before a baby can begin to develop. (Figure FP 1)

After a male reaches about the age of fifteen, millions of sperm cells are continually produced in special tubules in the testes. After the sperm are produced they are stored in these tubules, and remain almost totally inactive.



Figure FP 1 - Sperms are the male sex cells. This is a sperm highly magnified.

When a male becomes sexually excited, the nerve impulses in the reproductive organs cause the arteries in those organs to dilate (become larger).

As a result, a large quantity of blood enters the tissue of the penis and causes it to become enlarged and hard. During intercourse (the sex act) the male's penis is inserted into the female vagina and the sperm is released by passing through a long tube called the vas deferens, and on through the seminal vesicles, the prostate gland and out through the penis itself through the urethra. The urethra is specially designed so that no urine can pass out at the same time that the sperm is being released from the body. (Figure FP 2) This process of sperm being suddenly expelled is called ejaculation. It moves the sperm from the testes where they are produced out the tip of the penis and into the vagina.

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In addition to the sperm, mucus from the seminal vesicles and milky fluid from the prostate gland are released during ejaculation. All these fluids plus the sperm are called semen.

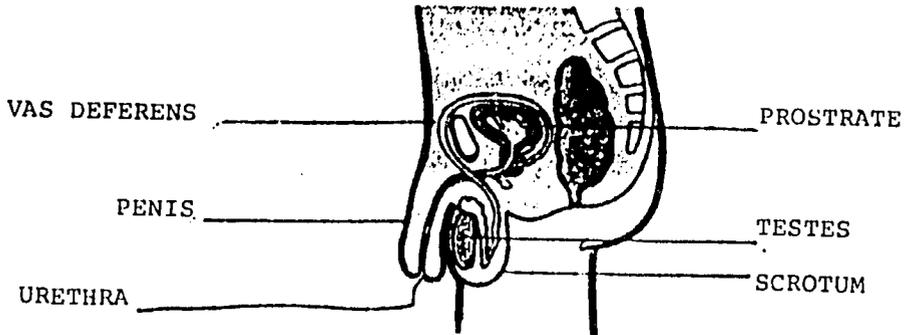


Figure FP 2 - Sperm is produced in the testes and stored in the epididymis. Reproductive fluid or semen passes along the vas deferens. Secretions from the seminal vesicles and the prostate gland are added to it. It finally leaves the body through the urethra.

Female Structure and Function.

A female has her reproductive structures contained within her body. Ovaries produce egg cells called ova and the uterus supports the baby as it grows inside the female body. (Figures FP 3, 4)

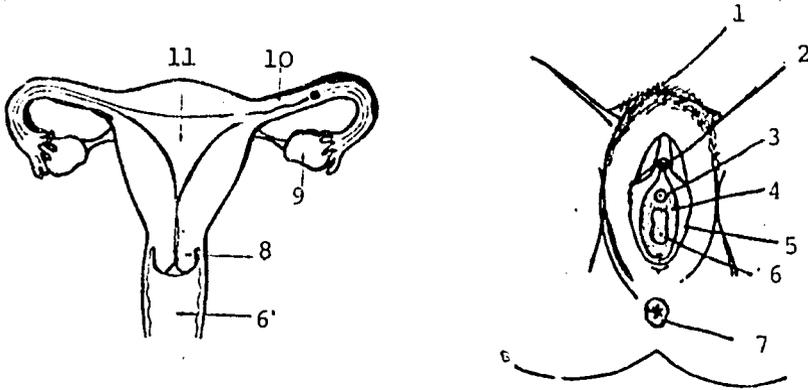
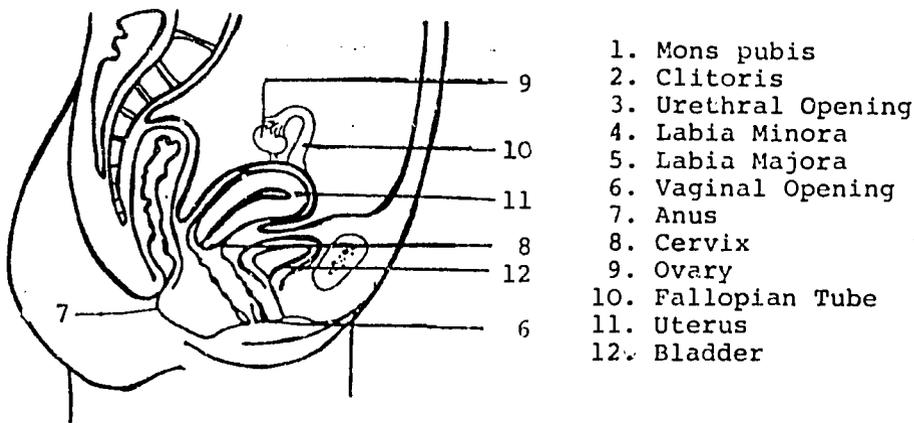


Figure FP 3 - On the left are the major internal anatomical structures of the female reproductive system. On the right are the external anatomical landmarks associated with the female reproductive system.



1. Mons pubis
2. Clitoris
3. Urethral Opening
4. Labia Minora
5. Labia Majora
6. Vaginal Opening
7. Anus
8. Cervix
9. Ovary
10. Fallopian Tube
11. Uterus
12. Bladder

Figure FP 4 - The position of the uterus is shown here between the bladder and the rectum. Its position is slightly turned forward and forms almost a right angle with the vagina.

An ovum, which is not large enough to be seen by the eye, is produced and released from an organ called an ovary, about once a month. A female has two ovaries which alternate in releasing an ovum each month. (Figure FP 5) The ovum then travels down a small tube called the fallopian tube. Sperm, which through intercourse have been released into the vagina in the female body, swim up to the fallopian tube to join with the egg. (Figure FP 6) If an ovum and a sperm are in the tube at the same time, they may join together, and the ovum is then said to be fertilized. The fertilized ovum will then travel within the female body to the uterus, where the ovum develops into a fetus and then into a baby. (Figure FP 7)

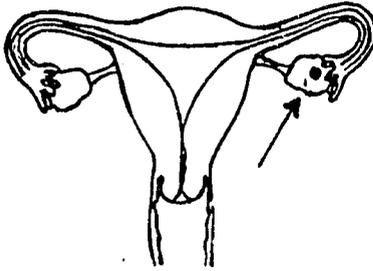


Figure FP 5 -

The ovum released by the follicle is directed into the fallopian tube by its fringed ends.

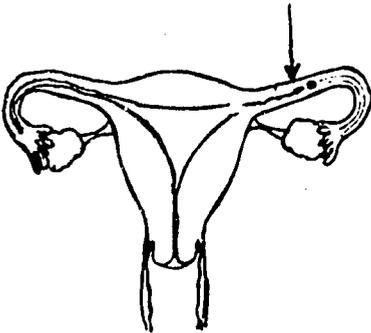


Figure FP 6 - The sperm and ovum join in the tube and fertilization takes place.

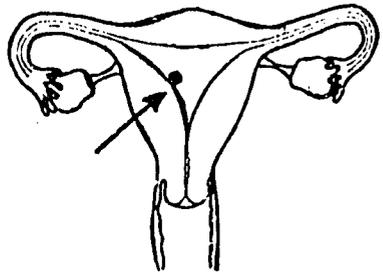


Figure FP 7 - The fertilized ovum has reached the uterus and embeds itself into the wall of the uterus.

If there are no sperm in the fallopian tube, or if there are sperm but the ovum does not join with any, the ovum continues down and out of the vagina. Ovulation is the term used for the release of the ovum. A woman is most fertile (able to become pregnant) at the time of ovulation. This is because an ovum dies after two days if it is not fertilized. Sperm from a male can live inside a female for three days. This means that an ovum can be fertilized by a sperm which entered the tubes two to three days before or two to three days after ovulation.

Menstruation

Each month the uterus builds up its lining to receive the fertilized ovum. If the ovum is not fertilized, it is not received by the uterus. Therefore, the ovum and the lining of the uterus are shed causing bleeding from the vagina for three to five days. This bleeding is called *menstruation*.

Menstruation usually starts 14 days after ovulation. This monthly cycle of events is called the menstrual cycle. The menstrual cycle varies in length. In the average woman it is 28 days but varies from about 25 to 31 days in different women.

A woman conceives (becomes pregnant) during her reproductive years. These are the years between puberty (12-15 years) and menopause (40-50 years). It is during these years that a woman has a monthly period or *menstruation*.

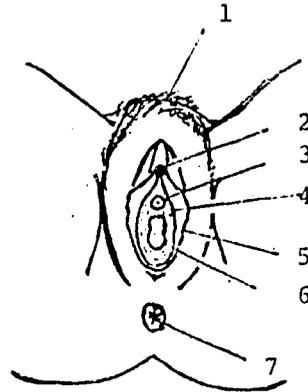
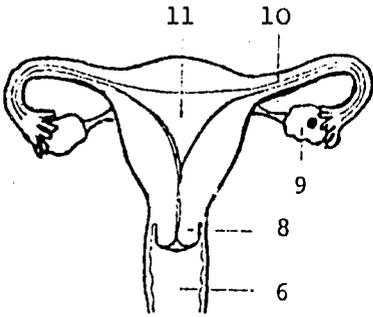
The nurse clinician should remember how long the sperm and ovum can live. Also, she should remember that the length of the menstrual cycle varies in different women so that ovulation is not always 14 days after menstruation. This will help the nurse clinician give advice on family planning.

Pregnancy

Once an ovum is fertilized, it travels to the uterus and attaches itself to the inside wall (endometrium) of the uterus.

It normally takes about nine months for the ovum to grow into a fully-developed baby within the female. At the end of these nine months, the baby is born.

8. Identify each of the female organ parts by placing the number from the drawing next to the correct name.



- _____ mons pubis .
- _____ uterus
- _____ urethral opening
- _____ vagina
- _____ ovaries (2)
- _____ fallopian tubes (2)
- _____ cervix
- _____ labia major
- _____ anus
- _____ labia minora

9. Describe the function of the following reproductive organs.

a. uterus -

b. fallopian tube -

c. ovary -

d. vagina -

STUDENT GUIDE
CHILD SPACING TECHNIQUES

I. Entry Level Knowledge and Skills

Before starting this unit, you should be able to:

1. Explain the process of fertilization.
2. Identify and describe the reproductive structures.
3. Describe the usual methods and considerations related to drug administration (Formulary Module).

II. Using the information and experiences provided by the instructor and the unit text, you will be able to:

1. Explain abstinence, withdrawal, lactation and mucous ovulation methods.
2. Given the average length of a menstrual cycle and the day of onset of menstruation, determine the most likely time for ovulation.
3. Explain the use of condoms.
4. Perform a pelvic examination.
5. Describe the mechanism of contraception provided by oral and injectable contraceptives, identify women who can safely use them and give instructions for their use.
6. Identify common side effects of contraceptive methods and explain their management.

III. Evaluation

Upon completion of this module, you will be rated on your attainment of the above objectives:

1. Knowledge: Written test based on content of the module. Acceptable performance, 80%.
2. Skills: Your ability to perform pelvic examinations, administer injections, oral contraceptives and patient education.

IV. Activities

In order to accomplish the objectives of this module, you will participate in the following activities:

1. Read module text and answer review questions.
2. Participate in small group discussions.
3. Participate in role play exercises.
4. Observe procedures in the clinical setting and demonstrate your knowledge and skill in these procedures.

CHILD SPACING TECHNIQUES

There are several different procedures that may be used by couples in order to delay pregnancy. These are called child spacing techniques and are used when couples do not want to have a child immediately but plan to have another child some time in the future.

For the health of the mother and the new infant, it is best to allow at least two years and even better three years between children. This allows the mother's body to adequately prepare for the fetus and allows the earlier child to grow and develop adequately before the mother is pregnant again.

ORDINARY METHODS

Abstinence

One of the oldest methods of child spacing is abstinence. This means that the couple refrains from intercourse. Some cultures expect the mother and father to live apart for a year after the birth of a child. Other couples plan to live apart because of work or study. If a man and woman do not have intercourse, obviously the woman will not get pregnant.

Indications: In those cultures which normally expect husbands and wives to live apart post delivery.

Contraindications: Husbands and wives living together.

Withdrawal

Another old and still common method of child spacing is withdrawal. The method is the withdrawal of the penis from the vagina before the sperm cells and fluid are released. This method is dependent on the man knowing the right time for withdrawal. Even if the timing is correct, there is a risk of pregnancy because some sperm may be present in the moisture at the tip of the penis before actual ejaculation occurs.

Indications: For those couples that choose this method and can successfully perform it.

Contraindications:

- a. There is some risk of pregnancy even if performed well, so this should not be the method of choice if another pregnancy is life-threatening to the woman.
- b. Some couples may not be able or willing to perform this technique.

Lactation

It is known that when comparing large groups of lactating women to those non-lactating, that the group lactating will have fewer pregnancies. However, the incidence of pregnancy is too high for a couple to depend on.

Indications: Only indicated as a general community method

Contraindications: This method is undependable for specific couples wanting to delay pregnancy.

Mucous ovulation

This method is based on the avoidance of sexual intercourse during the fertile period of a woman's cycle. The fertile period are those days just before and after ovulation. Ovulation occurs 14 days before the onset of menstruation.

Immediately after menstruation, begin making the mucous observation daily. While learning, it is good if the mucous observation is made several times during the day since the mucous flow is not constant.

During the time between menstruation and appearance of mucous, the nurse clinician should advise against intercourse on successive days. The reason being that the residue from intercourse one evening may still be present the next day and obscure the mucous observation.

Technique: Insert 2 fingers into the vagina and then observe the discharge. Preovulation mucous at first is cloudy and breaks as soon as any attempt is made to stretch it. It appears as the mucous you blow from your nose the last stages of a cold.

As ovulation approaches, the mucous increases and at the same time becomes stretchy and clear in appearance (like raw egg white). It may stretch 2-10 cms and become slippery and sticky. This type of mucous indicates the greatest time of fertility. It may last one to several days. The mucous also causes a feeling of wetness on the labia.

Around the day of ovulation, the mucous begins to change. It loses its qualities of being clear or cloudy raw egg white, stretchy, slippery and wet. It becomes non-stretchy, tacky, thicker, more opaque and then usually disappears (dry day or dry period).

Once pre-ovulation mucous appears, intercourse and genital contact should cease until the fourth dry day.

If fertile (ovulation) mucous should appear during the cycle, treat as first mucous, refrain from intercourse and genital contact until the fourth dry day.

The nurse clinician should remind women that the mucous sign is frequently observed just by noticing the lubricative feeling of vaginal wetness. Secondly, the quality or consistency of the mucous is much more important than the quantity.

Indications: For those couples who are prevented from using other methods for religious reasons.

Contraindications: Some couples object to the strict limiting of intercourse required by this method. The method can be confused by abnormal mucous discharge.

Review Questions (Ordinary Methods)

1. Abstinence means:

- the avoidance of sexual intercourse.
- withdrawal.
- cessation of the lactating period.

True or False

- 2. Lactation is a dependable method of child spacing.
 - 3. The withdrawal method is dependent on the man.
 - 4. When a man and woman do not have intercourse, the woman will not get pregnant.
5. Describe the technique for the mucous ovulation method.

CHEMICAL AND MECHANICAL METHODS

Condoms

A condom is a thin rubber sheath that is used to cover the penis. (Figure FP 9) This sheath retains the fluid containing the sperm and prevents it from spilling into the vagina.

A new condom is required for every use. They usually come in small clean packages in the rolled positions. When used, the rolled condom is placed over the tip of the penis and unrolled up the erect penis. It may be necessary to hold it in place on the penis when removing it from the vagina to prevent semen from spilling into the vagina.

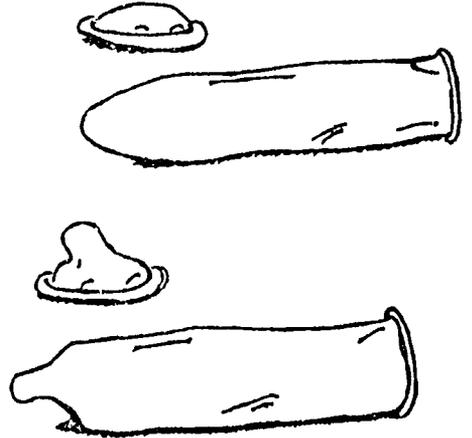


Figure FP 9 - Condoms, plain and teat-ended, rolled and unrolled.

The condom has the advantage of preventing the passage of common venereal diseases such as gonorrhoea and syphilis.

Indications: Whenever a couple decides to use this technique.

Contraindications: None

Diaphragms

Diaphragms are thin slightly cup-shaped discs of rubber covering a flexible circular coiled spring. They are designed to cover the cervix after insertion in the vagina. With the addition of contraceptive jelly which kills sperm, they are an effective method of contraception.

Diaphragms come in different sizes so must be fitted to each woman.

Women using diaphragms should be seen yearly to check its fit and the condition of the rubber. After a pregnancy and delivery, the required size of diaphragm often changes so should be refitted.

Indications: For a woman who is willing to follow the procedure, this is an effective method with few side effects.

Contraindications: The diaphragm is difficult and messy to use in village homes that have limited privacy and no running water.

Review Questions (Condoms, diaphragms)

1. The condom prevents fertilization because it:

- Kills the sperm
- Prevents ovulation.
- Prevents the production of sperm.
- Blocks the sperm from reaching the ovum.

True or False

2. Diaphragms are an effective contraceptive method when used with spermicidal jelly.
3. Before providing a woman with a diaphragm, a pelvic exam is required.

DIAGNOSTIC SKILL
PELVIC EXAMINATION

Supplies

1. A good light source (flashlight or lamp)
2. A sterile speculum
3. A pair of surgical gloves
4. Lubricant jelly
5. An examining table or bed

Purpose of the Procedure

The purpose of the procedure is to examine a woman's reproductive organs.

Steps in the Procedure

Preparation:

First, describe to the woman the examination you will perform and explain the reasons for the exam. Then, ask the woman to pass urine so that her bladder will be empty. Then have the woman remove her clothes from the lower part of her body. The woman should lie on an examining table with her legs apart and knees bent (lithotomy position), (Figure FP 8).

The nurse clinician washes her hands and puts on clean gloves.

The nurse clinician warms the speculum so that the cold metal will not make the patient uncomfortable.

As you do each step of the exam, tell the woman what you are going to do before you do it. Ask her to tell you if any part of the procedure is painful to her.



Figure FP 8 - Here you see the correct lithotomy position.

Part 1 - External Examination:

Using the left hand, spread the labia apart and observe the genitalia. Look for any abnormal signs, discharge, blood, lacerations, or swellings.

Part 11 - Speculum Examination:

Insert Speculum

Keeping the labia separated with the left hand, take the speculum in the right hand and gently insert it into the vagina. Move it into a position which will allow it to be opened easily. Arrange the light so that you can see inside the vagina. If the cervix is not visible, adjust the speculum by closing it and changing its position until it becomes visible.

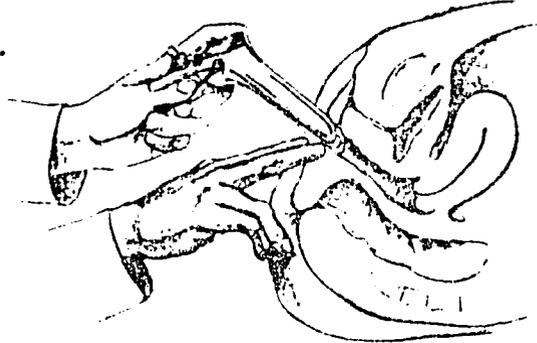


Figure FP 9 - Insertion of vaginal speculum.

Observe the cervix.

In a woman who has never had a child, the cervix will be 1.5 to 2.5 cm. diameter, pink, smooth and firm.

The centre opening will be round and small.

In a woman who has had babies, the cervix and the centre opening will be larger and irregularly shaped and possibly darker in colour.

Look for any abnormalities of the cervix, discharge, colour, irregularities, bleeding, IUD strings, erosion.

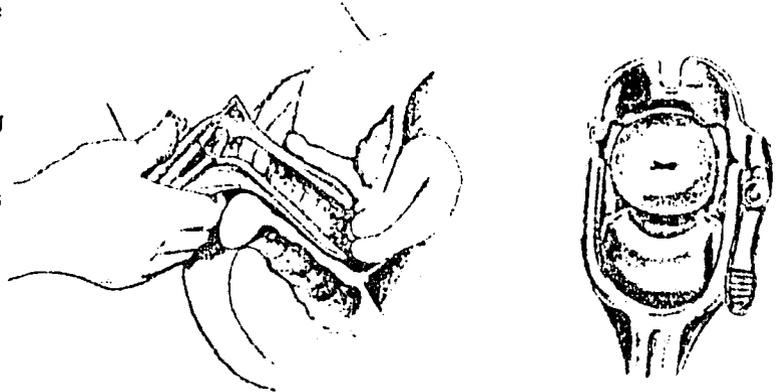


Figure FP 10 - Vaginal speculum cervix inspection.

Observe the vaginal walls.

The vaginal walls should be pink and firm with ridges. They should have a moist appearance. Look for any abnormalities on the vaginal walls - colour, discharge, tears.

Remove speculum.

Mentally, remember all of the normal and abnormal findings and then gently close the speculum and remove.

Part III - Bimanual Examination:

The examiner puts the speculum aside and puts some lubricant jelly on the index and middle finger of the right hand. These fingers are gently inserted into the vagina until the cervix is located. (It normally feels like the end of a nose.)

In the centre of the cervix, there is a dimple. If the cervix is closed, the examining finger will not enter this dimple. If it is open, the fingertip will go inside the uterus. The examiner should not allow the finger to actually enter the uterus. The two inserted fingers are placed under the cervix to keep it in place.

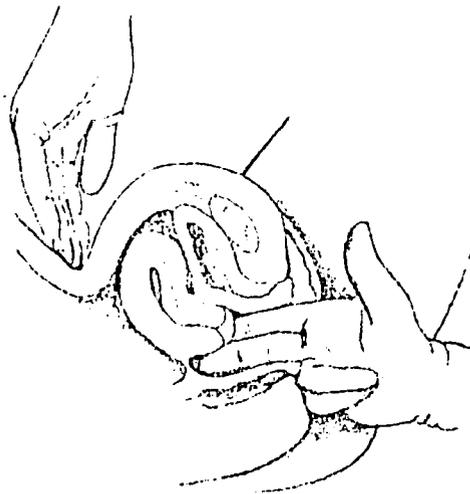


Figure FP 11 - Bimanual examination.

The left hand is placed on the lower abdomen and presses downward. This procedure locates the uterus between the two hands (bimanual). A normal uterus feels about the size of a lemon. After noting the size, gently and slowly wiggle the uterus. Normally, the uterus should move easily without causing pain. Move the left hand on the abdomen to either side of abdomen and together move the inside fingers to either side of the cervix. This allows you to feel the sides of the pelvis that contain the Fallopian tubes and ovaries (adnexal areas). Normally, the tubes cannot be felt and the area has no masses or tenderness. The ovaries are difficult to palpate. They are normally almond-shaped and freely movable.

Abnormalities that might be noted during the bimanual exam are tenderness on uterine movement, adnexal tenderness, enlargement of the uterus, a mass in the adnexal areas.

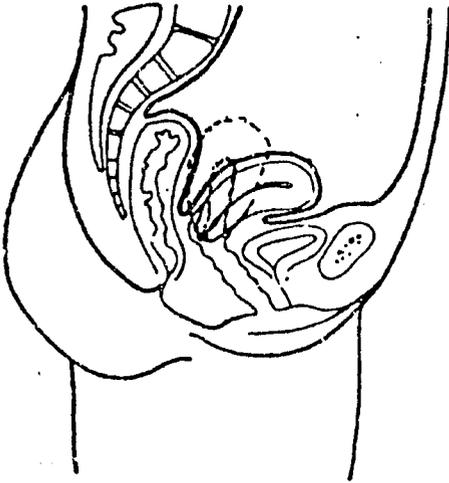


Figure FP 12a - Retroversion of the uterus - a tilting of the entire uterus towards the back.

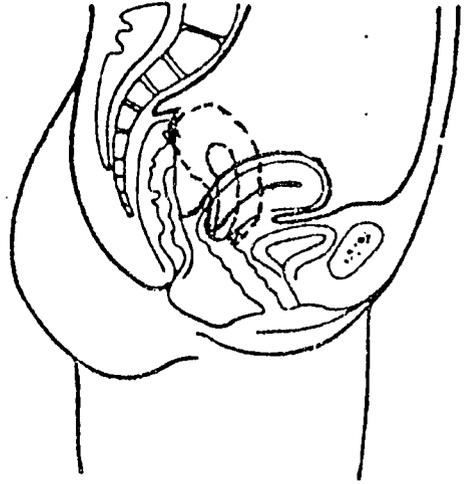


Figure FP 12b - Retroflexion of the uterus - a bending of the body of the uterus towards the back. The cervix remains in the normal position.

After these findings are mentally recorded, remove your hands from the position. Ask the woman to re-dress.

Part 1V - Recording

Remove your gloves, wash your hands and immediately record your findings. After recording your findings, explain them to the woman.

PELVIC EXAM CHECKLIST

- a. Record "N" if Normal
- b. Describe if abnormal

External Genitalia:

Clitoris _____

Labia _____

Urethral opening _____

Rectum _____

Discharge _____ Bleeding _____

Speculum:

Cervix - colour _____ discharge _____

open or closed _____ bleeding _____

irregularities _____

Vaginal walls - colour _____ tears _____

discharge _____

Bimanual:

Uterine size _____

Uterine position _____

Tenderness of Uterine Movement _____

Adnexal masses _____

Adnexal tenderness _____

ORAL CONTRACEPTIVES (THE PILL)

The pill contains female hormones which stop ovulation. Therefore, since ova are not being released, pregnancy will not occur. This is a very reliable method of contraception but only if the woman remembers to take a pill every day.

Since there are some rare but serious side effects that occur while taking the pill, a thorough history and physical should be done before starting a woman on the pill.

History

A thorough history should be taken on each woman which includes a checklist including important symptoms that are contraindications to taking the pill. The hormone in the pill has been known to increase the chance of certain women getting these illnesses. Although the chances are slight, it is best not to begin this contraceptive if the symptoms are present.

1. Any past or present history of thrombophlebitis (clotting or inflammation of the leg veins).
2. Breast lumps or breast cancer.
3. High blood pressure
4. Serious headaches (middle or top of the head, constant and severe)
5. Liver disease
6. Severe heart disease
7. Cancer of the cervix or uterus or vaginal bleeding
8. Breastfeeding. The pill will decrease the milk supply that is so important to the young child.

Physical Exam

The physical should be thorough and should especially look for any signs of:

1. Thrombophlebitis
2. Heart disease
3. High blood pressure
4. Cancer of the breast, cervix or uterus.

If any of these conditions are found, she should be managed as indicated, and oral contraceptives should not be used. If she is breastfeeding an infant, another method should be used until she is no longer breastfeeding because oral contraceptives will decrease her milk supply.

If there are no contraindications to the use of the pill, the following instructions for its use should be given to the woman.

Instructions for the Use of the Pill

The pill now comes in plastic bubble packs. Instructions for their use must be discussed with all women deciding on this method.

There are 28 pills in each packet; 21 are white and 7 brown. (Figure FP 12)

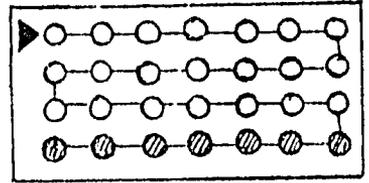


Figure FP 12 - Pill Packet.

A pill must be taken daily without fail. The first white pill should be taken on the fifth day after menses begins. Thereafter, a pill is taken daily following the line and using all the white pills before starting on the brown ones.

While taking the brown pills, her menses will begin. The daily pill is continued until the package is completed. Remind her that the pill must be taken every day to be effective. If she forgets a pill for a day, she should take the forgotten pill as soon as she remembers it as well as the regular pill for that day.

Two days before the completion of the first package, she should visit the clinic for additional packets and a follow-up visit.

She should also be told that she may experience some slight headaches, nausea, vomiting, weight gain or slight bleeding. These are mild side effects that gradually disappear after some time.

If she has any sudden severe headaches, visual disturbances, severe chest pain or pain and swelling in the leg, she should come directly to the health centre or clinic for management.

Follow-up

During the first visit after taking the pill for a month, the nurse clinician should determine whether the woman is taking the pills correctly by asking her to explain how she is taking the pills.

If she has stopped taking the pills, find out why and discuss the reason.

If she has any side effects, manage as indicated. Always look for those symptoms and signs that indicate contraindications to the pill. If found, discontinue the method. If no side effects occur, give her two packets for continuation and ask her to return in two months.

On the second and following follow-up visits, she may be given three packets at a time, if there are no contra-indications.

Annually, she should have a thorough history and physical including a pelvic examination looking especially for the list of abnormalities at the beginning of this section.

Indications: For women who want a sure method of protection and have no contraindications to its use.

Contraindications: History of thrombophlebitis, breast lumps or cancer, high blood pressure, severe headaches, heart disease, cancer of the reproductive organs or blood, and breastfeeding.

Review Questions (Oral Contraceptives)

1. The pill is the most reliable form of contraception if used correctly, but there are some rare serious side effects. Check those that may be associated with the pill.

Thrombophlebitis and blood clots
 Gangrene
 Pneumonia
 Hypertension
 Sterility

2. Put a check in front of these instructions which should be given to a woman beginning the pill.

Take the pill every day.
 Take the pill every other day.
 If you miss one day, don't worry, it won't matter.
 You may expect some nausea when first starting on the pill, but it will gradually disappear.

3. Follow-up visits for women on the pill should include:

History check for headaches, leg pain and bleeding.
 A chest X-ray.
 An annual history and physical.
 A review of how to take the pills.

4. The pill prevents conception by:

Preventing the sperm from entering the uterus.
 Stopping ovulation.
 Preventing the fertilized ovum from growing in the uterus.

INJECTABLES (DMPA)

DMPA (depo medroxy progesterone acetate) is a hormone which prevents ovulation. It is administered as an intramuscular injection every three months.

Before choosing this method, it is important to do a complete history and physical. If there is a history of irregular vaginal bleeding or spotting, the method should not be used. If a pregnancy is present, it should not be used. If the woman has never been pregnant, it should not be chosen because if the woman cannot get pregnant later, she may blame the injection.

During the physical the nurse clinician should look for breast lumps, and signs of cervical or uterine cancer. If these are present, she should be referred to a doctor and not be given the injection. (See Problems of Women Module.)

Method of Giving the Injection

DMPA comes in 3 cc vials containing 50 mgs./cc.

The accepted dose is 150 mgs or 3 cc given intramuscularly every 3 months or 12 weeks. The suspension must be shaken before drawing into the syringe. A 21-gauge needle should be used. The site of injection can be either the hip or the arm.

Side Effects

Significant side effects relate to changes in menstruation.

Below is the management schedule for heavy bleeding while on Depo-Provera:

| WEEKS AFTER DEPO-PROVERA INJECTION | TREATMENT |
|---|--|
| Bleeding during: The first 4 weeks after 1st. injection <i>or</i> The first 4 weeks after 2nd. injection | Give Lyndiol 1 tablet daily X 22 days (1 packet), or ethinyl oestradiol 0.05 mg. 1 tablet daily X 22 days but warn the patient of <i>withdrawal bleed</i> 2-3 days after the last pill, and that she must report if this is prolonged. |
| Bleeding during: 4-12 weeks after 1st.injection <i>or</i> 4-12 weeks after 2nd.injection | Repeat the Depo-Provera. Bleeding should stop within 7 days. Give the patient a new appointment 3 months after the extra injection for her next routine injection. |
| If bleeding occurs: Any time after 3rd.injection | Treat with Lyndiol 1 tablet daily X 22 days (1 packet), or ethinyl oestradiol 0.05 mg.daily X 22. Warn of withdrawal bleed. |

IF BLEEDING PERSISTS AFTER THESE MEASURES
REFER TO PHYSICIAN.

If the woman wants another pregnancy, the injection should be discontinued and fertility will return in 6 to 12 months in most women.

Indications: The method is indicated for use in women who have nearly completed their families and would prefer this method to a sterilization procedure.

Contraindications: It should not be used in women with breast lumps, suspicion of uterine or cervical cancer and women who have never been pregnant. If DMPA is given to women who are breastfeeding, the ethynl estradiol should not be used because it will suppress milk production.

Review Questions (Injectibles)

1. Injectable DMPA prevents pregnancies by:

- diverting the sperm.
- preventing ovulation.
- placing a foreign body inside the uterus.

2. The injection of DMPA should be given: (choose one)

- every month
- every 2 months
- every 3 months
- every 4 months

3. The injectable DMPA should not be used for: (choose one)

- women who have never had children
- women who have completed their families
- women with suspicion of breast cancer
- women with suspicion of cancer of the uterus.

5. If bleeding occurs 6-12 weeks after first or second injection:

- women should have a pelvic examination.
- another injection, but keep her appointment for her next injection.
- should have another injection plus change her appointment for next injection for over three months.
- should be put on the pill.

STUDENT GUIDE

INTRAUTERINE DEVICES

I. Entry Level Knowledge and Skills

Before starting this unit, you should be able to:

1. Explain the anatomy of the male and female reproductive organs.
2. Perform a pelvic examination.

II. Objectives:

Using the information and experiences provided by the instructor and the unit text, you will be able to:

1. Describe the Lippes Loop and explain its function.
2. Identify contraindications for recommending loop insertion as a means of contraception.
3. Explain and perform the procedures for insertion and removal of a Lippes Loop.

III. Evaluation

Upon completion of this module, you will be assessed on the following:

1. Knowledge: Written test based on content of this unit. Acceptable performance, 80%.
2. Skills: Your ability to safely insert and remove a Lippes loop.

IV. Activities

In order to meet the objectives, you will be participating in the following activities:

1. Read unit text and answer review questions.
2. View and discuss slide presentation.
3. Participate in role play exercises.
4. Observe in the clinical setting and demonstrate your understanding and skill with relation to insertion and removal of Lippes loop.

INTRAUTERINE DEVICES (IUD)

IUD's are plastic or metal devices that are placed within the uterine cavity. Their presence within the uterus prevents the implantation of the fertilized ovum.

There are many different kinds of IUD's, but this section will discuss the most common type available, the Lippes Loop (See Figure FP 14). When the loop is in the uterus, it looks like this: (See Figure FP 15).

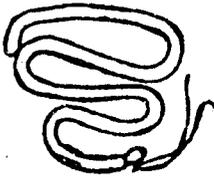


Figure FP 14 -
Lippes Loop.

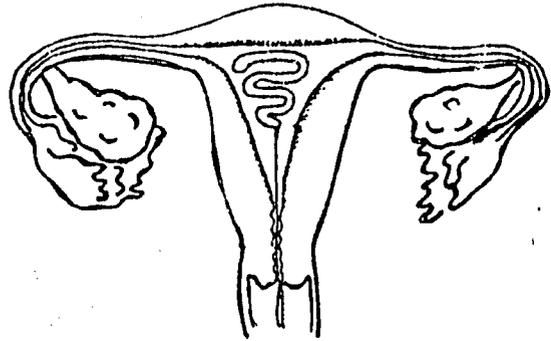


Figure FP 15 - Lippes loop lying
correctly in the uterus, with
threads passing through cervix.

It is an effective contraceptive that requires a specific skill to insert. (See Management Skill - IUD Insertion.)

When a woman wants to have another child or wants to change to another contraceptive, it can easily be removed. (See Management Skill - IUD Removal.)

2 Indications: A good method for women who want reliable protection without having to remember to do something before intercourse.

Contraindications:

- a. Vaginal infection, cervical lesions.
- b. Pregnancy
- c. Heavy bleeding
- d. Some women cannot retain the loop - repeated expulsions.
- e. The risk of ectopic pregnancies is increased.
- f. The risk of salpingitis increases.

MANAGEMENT SKILL

IUD INSERTION

Supplies

1. A good light source (flashlight or lamp)
2. A sterile speculum
3. A pair of sterile surgical gloves
4. An examining table or bed
5. Antiseptic sponges
6. Lippes loops, B, C, D sizes
7. Introducers
8. Sponge holding forceps
9. Uterine sound
10. Tenaculum
11. Two kidney dishes or other metal pans
12. Long, curved scissors
13. Bowl of 1:2500 aqueous solution iodine.

Purpose of the Procedure

The purpose of this procedure is to insert a Lippes loop into the uterine cavity.

Steps in the Procedure

1. Pelvic Exam

The first step in the procedure of Lippes loop insertion is to do a pelvic examination on the woman. During this examination, one should look for any contraindication to a loop insertion.

Contraindications will include:

- a. Signs of pregnancy: An IUD should not be inserted into a pregnant uterus. An abortion will occur with possible severe bleeding and infection. Since the uterus is soft during pregnancy, there is an increased risk of perforation which may result in peritonitis.
- b. Cervical erosion or mass.
- c. Vaginal infections.

During the pelvic examination, one should also observe the position, size, and mobility of the uterus because this will aid in determining the direction of the IUD insertion. See Pelvic Exam, p.20.

After being assured that there are no contraindications to loop insertion, one proceeds to the actual loop insertion. The safest and easiest time to do a loop insertion is on the last day of the woman's menses. But in cases where the risk of pregnancy before the next menstrual period is increased by social factors, such as arrival of the husband after a long absence, the woman should not be sent home but should have the IUD inserted.

2. Prepare Instruments

All instruments should be germ-free. The metal instrument and introducers used should be boiled for 20 minutes in a sterilizer or a pan. The plastic loops cannot be boiled. They should be soaked in a 1:2500 solution of aqueous iodine for 20 minutes before using.

3. Discuss with Woman

Before doing the procedure, it should be thoroughly discussed and explained to the woman. Ask the woman to urinate. During the procedure, she should be continually informed of the steps being taken.

4. Prepare loop. The nurse clinician then puts on a pair of sterile gloves and threads the loop into the introducer and places it on a sterile cloth.

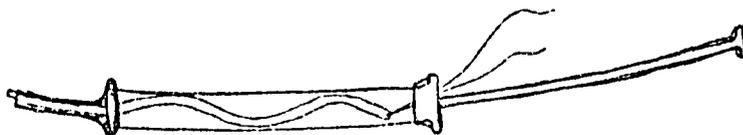


Figure FP 16 - Introducer ready for use.

5. Positioning the Speculum

While the woman is in position as for the pelvic exam, the nurse clinician again wipes the external genitalia from top down with an antiseptic sponge. Then, while keeping the labia separated with the left hand, take the speculum in the right hand and gently insert it into the vagina. Move it into a position which will allow it to be opened easily. Arrange the light so that you can see into the vagina. If the cervix is not visible, adjust the speculum by closing it and change its position until the cervix is visible. Then, gently insert the speculum a little deeper into the vagina until the cervix is well outlined by the speculum blades.

Tighten the screw on the right side of the speculum so that it remains open by itself.

6. Sound the Uterus

Take an antiseptic sponge with the sponge forceps and clean the cervix. Then take the tenaculum and attach it to the anterior lip of the cervix. Ask the woman to take a deep breath and let it out slowly so as to reduce the cramp feeling produced by the tenaculum. The tenaculum is held in the left hand and allows control of the position of the cervix.

Taking the sound in the right hand, gently insert it into the cervix in the general direction of the main body of the uterus remembering that a slight pull on the tenaculum will straighten the natural curve of the uterine body. Gently probe the uterus until the sound reaches some slight resistance. Then remove it after noting the depth to which the uterus sounded. This procedure allows the nurse clinician to measure the depth of the uterine cavity and determine the angle of the uterus. (See positions of uterus, p. 23.)

7. Loop Insertion

While holding the tenaculum in the left hand for control, take the threaded introducer in the right hand and insert it into the cervix to the level of the block guard. (Figure FP 17)

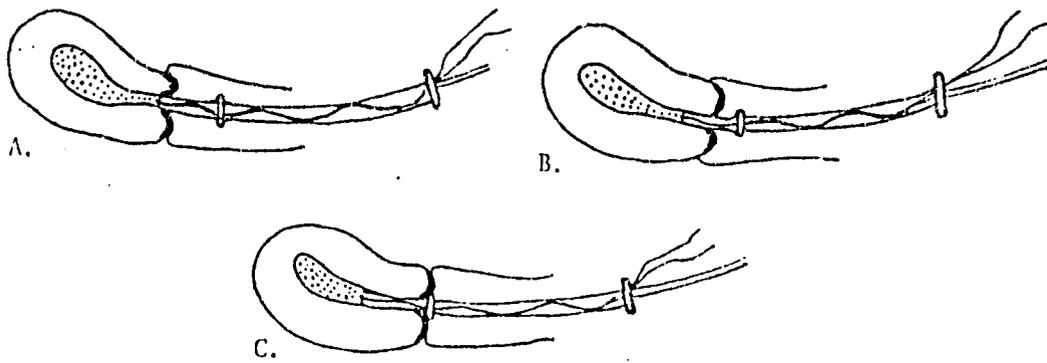


Figure FP 17 - A.) Insertion started; B.) Insertion proceeding; C.) Introducer passing through inner cervical opening.

Using firm, slow pressure on the plunger, allow the loop to unfold within the uterus (Figure FP 18)

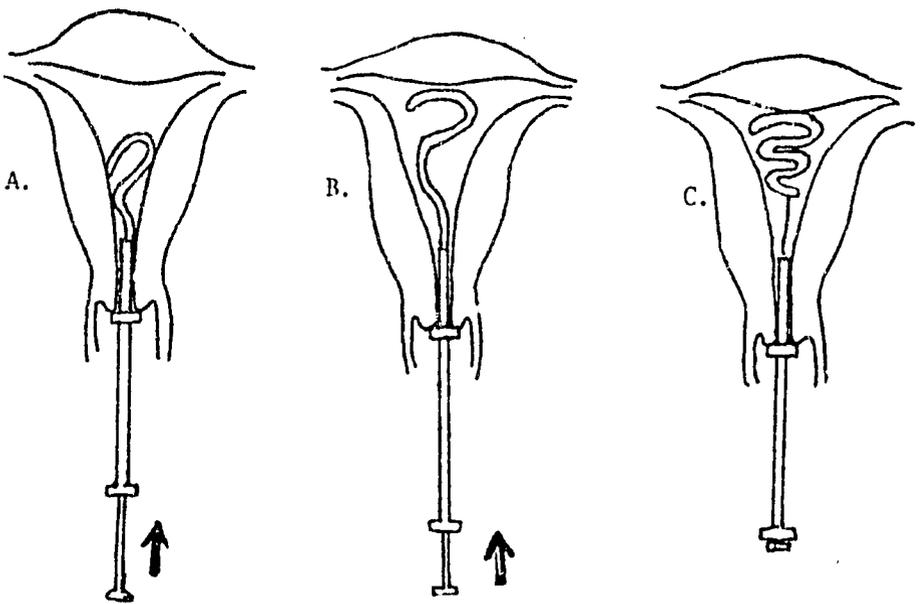


Figure FP 18 - A) Starting to insert the loop into the uterine cavity; B) Insertion of loop half way through; C) Loop in proper position in uterine cavity.

The plunger is then completely withdrawn followed by the introducer. If the loop strings are very long and extend outside the vagina, they should be trimmed, but they should remain visible outside the cervix.

8. Remove Tenaculum and Speculum

After the loop is inserted, the tenaculum is taken off the cervix and the speculum gently closed and removed.

9. Check Threads

The woman should then be asked to feel the threads present in the vagina. She should check them after every menses, especially the first three months to be sure that the IUD is still in place.

10. Follow-Up Instructions

Before she leaves the clinic, she should be told to expect some slight bleeding after the insertion, but if moderate to heavy bleeding or signs of vaginal discharge occur, she should return to the clinic

If there are no problems, she should return to the clinic in four weeks to determine the presence of the IUD and after that visit an annual check up is recommended.

In case the loop is expelled, she should return to the clinic where it can be reinserted or refer for Copper T insertion.

MANAGEMENT SKILL

REMOVAL OF IUD

Supplies

1. Good light source (flashlight or lamp)
2. A sterile speculum
3. An examining table or bed
4. Antiseptic sponges
5. An artery forceps

Purpose of the Procedure

The purpose of the procedure is to remove a Lippes loop intrauterine device.

Steps in the Procedure

1. Discuss the procedure thoroughly with the woman and continually explain what is being done throughout the procedure.
2. The woman is placed in the position for a pelvic examination. The external genitalia is wiped with an antiseptic swab and the speculum gently inserted as in the IUD insertion.
3. After exposure of the cervix and the IUD strings, an artery forceps is used to grasp the threads. A gentle steady pull will cause the loop to come out.
4. If the threads have disappeared, she should be referred to a doctor in the hospital, if they do not appear during next period.
5. If another contraceptive is desired, be certain to replace the same day the removal is performed.

Review Questions

1. The IUD is an effective contraceptive because it:
 - _____ Prevents the sperm from entering the uterus.
 - _____ Prevents the sperm from entering the vagina.
 - _____ Prevents the implantation of the fertilized ovum.
 - _____ Prevents intercourse.
2. Contraindications to the insertion of a loop include:
 - _____ pregnancy
 - _____ upper respiratory tract infection
 - _____ cervical lesion
 - _____ vaginitis
 - _____ breast cancer
3. Name the three parts of the pelvic exam.
 - a.
 - b.
 - c.

True and False

- _____ 4. The Lippes loop is made of flexible plastic
- _____ 5. Everything entering the uterine cavity should be germ free.
- _____ 6. The loop can be sterilized by placing it in 1:2500 solution of iodine for 3 minutes.
7. Indications for loop removal include:
 - _____ Severe bleeding
 - _____ Pus in the vagina
 - _____ Nausea
 - _____ Headaches

STUDENT GUIDE

VASECTOMY, TUBAL LIGATION, ABORTION, STERILITY

I. Entry Level Knowledge and Skills

Before starting this unit, you should be able to:

1. Explain the anatomy of the male and female reproductive organs.
2. Perform a pelvic examination.

II. Objectives:

Using the information and experiences provided by the instructor and the unit text, you will be able to:

1. Describe the procedures for vasectomy and tubal ligation and explain anatomical and physiological effects.
2. Describe methods commonly used for abortions and their complications.
3. Explain the common causes of sterility.

III. Evaluation

Upon completion of this module, you will be assessed on the following:

1. Knowledge: Written test based on content of this unit. Acceptable performance, 80%.

IV. Activities

In order to meet the objectives, you will be participating in the following activities:

1. Read unit text and answer review questions.
2. View and discuss slide presentation.
3. Participate in role play exercises.

PERMANENT METHODS OF PREVENTING PREGNANCY

Permanent methods of preventing pregnancy are suitable for couples who have had all the children they want. Permanent means that it is not possible to reverse the procedure. There are, in fact, some operations to reverse the procedure but they are so unreliable that no one should depend on them.

Permanent methods of preventing pregnancy can be performed on the man or the woman. When it is done on a man, it is called a vasectomy and when on a woman it is called a tubal ligation. These procedures do not affect sexual function, but merely prevent the sperm or egg from reaching the outside.

Vasectomy

A vasectomy is a minor procedure performed on a man. It can be performed in 10 to 15 minutes by a doctor. The man can go home immediately after the operation and it does not cause any disabilities.

Common concerns and problems men may have about a vasectomy should be discussed.

- a. A vasectomy does not mean castration. No harm comes to the testicles.
- b. Sexual function does not change. Erections and ejaculations are not affected.
- c. It does not cause backache or weakness.

Indications: Indicated in men who do not want to have any more children.

Contraindications: None for healthy men.

Tubal Ligation

A tubal ligation is the permanent surgical method used on women to prevent further pregnancies. The operation is done by a doctor. It usually involves staying in the hospital for one to three days. It does not cause any disability to the woman.

Indications: Indicated for women who do not want to have any more children.

Contraindications: Any serious illness that makes an abdominal operation dangerous.

Review Questions (Permanent Methods)True or False

- 1. Vasectomies are performed on men.
 - 2. Tubal ligations are performed on men.
 - 3. A vasectomy impairs sexual function.
 - 4. Permanent methods should only be done on couples who definitely do not want children.
5. A vasectomy prevents conception by:
- stopping the sperm from reaching the outside.
 - preventing ejaculation.
 - destroying the testes.
6. A tubal ligation prevents conception by:
- preventing the ovum from reaching the uterus.
 - stopping ovulation.
 - removing the ovaries.

STERILITY

Sterility (infertility) is the condition of not being able to have a child.

The cause of sterility can be found in either the man or the woman. In a man, the cause is usually due to insufficient sperm production. This may be secondary to undescended testes, mumps, orchitis, or a hormonal dysfunction. In the woman, the cause may be related to imperfect ovum production or an abnormality in the tubes or uterus. Other general causes such as obesity, undernutrition, tuberculosis, and pelvic inflammatory disease also may affect fertility.

A general history related to the sexual functions and frequency of intercourse of the couple may reveal some reasons for infertility, such as insufficient sexual exposure or inadequate technique. Intercourse must be vaginal to result in pregnancy and must occur at the time of ovulation.

In general, infertility is a difficult condition to successfully treat, but there are certain couples that can be helped.

Management

After checking on the adequacy of sexual exposure and technique, the couple should be referred to a hospital for a sperm count and general examination of both the woman and the man.

Review Questions (Sterility/Infertility)

1. In this section, sterility means:
 - _____ being free from germs.
 - _____ not being able to conceive a child.
 - _____ the condition of being unmarried.

2. Causes of sterility may be due to:
 - _____ infection.
 - _____ insufficient sexual exposure.
 - _____ not enough sperm.
 - _____ headaches.
 - _____ closed cervix.
 - _____ social status of the couple.

3. The management of a couple with a sterility problem is:
 - _____ referral of the woman to the hospital
 - _____ referral of the man to the hospital.
 - _____ referral of both the man and the woman to the hospital.

COMMON SIDE EFFECTS OF FAMILY PLANNING METHODS.

Side effects are those developments which are an unnecessary effect of using the individual methods of birth control, the necessary effect being to prevent pregnancy.

The side effects can:

be a nuisance (minor) - harmless but sometimes annoying.
 cause metabolic changes - change essential bodily activities.
 serious - life threatening.

Some side effects that the nurse clinician may see in the health centre are listed below.

Oral Contraceptives

Nuisance (minor)

Nausea and Vomiting

This is common in women just beginning the pill. The complaint gradually decreases over time. If the vomiting is severe, the woman should be referred to the doctor so that she may adjust the dosage of the pill. Usually reassurance that the symptoms will disappear is sufficient.

Weight Gain

Some women experience weight gain and breast fullness and tenderness during the beginning period of taking the pill. Often this weight gain is due to fluid retention. If this is the cause, it will gradually decrease over time.

If the weight gain is due to an increase in food intake, decreased food intake would be recommended.

Bleeding and Spotting (Break through bleeding)

Often during the first three months of using the pill, bleeding occurs between periods. Such bleeding usually disappears by itself. Consult with physician if the bleeding is heavy or continues past three months.

Amenorrhea

Occasionally bleeding does not occur at all when the woman is taking the pill. If the woman took all her pills at approximately the same time every day, then she is not pregnant and should continue taking her pills. If she forgot a few pills, then it is possible that the woman could be pregnant, but she should continue with the pills until pregnancy can be verified. If pregnancy is proven, then the woman should discontinue the pill.

Amenorrhea in a non-pregnant woman on the pill has not been proven to be harmful. If the woman wishes to continue on the pill and is not concerned about not having a menses, then she may continue with the pill. If she wishes to continue, but wishes to have a menses, consult with a physician.

Amenorrhea after stopping the pill can occur. Infrequently, the woman does not ovulate and does not have her menses for six or more months. In most cases, the menses will spontaneously re-occur. If it bothers the woman not to have her menses, or if she wishes to become pregnant, consult with a physician.

Metabolic Effects

Many activities of the body are chemical reactions, such as digestion, excretion, thinking, walking, etc. All of the chemical reactions in the body are called metabolism, and hormones produced within the body. The pill being a hormone can affect the bodies metabolism.

Some of the effects the pill has on the body include:

Liver function - the pill causes the liver to increase its production of many enzymes and proteins including blood clotting proteins. Women taking the pill are more susceptible to blood clotting such as thrombophlebitis.

Diabetes - the pill can change the way a woman metabolizes glucose. The pill does not cause diabetes, but if the woman has diabetic tendencies, then the pill could precipitate an underlying diabetic condition. If the woman has a history or is a known diabetic, consult a physician before dispensing the pill.

Blood pressure - the pill can cause a rise in the blood pressure. The woman's blood pressure should be taken before she starts the pill, and every three months after starting the pill. If the woman has a high blood pressure before the pill, she should not be given the pill. If after starting the pill the blood pressure should rise, she should stop taking the pill.

Breast feeding - the pill reduces the quantity of breast milk that is produced and should not be given to a breast feeding woman.

Serious Effects

Thromboembolism, pulmonary embolism and stroke

Because women taking the pill can be more susceptible to blood clots, clots could form in a blood vessel (thrombus). As this thrombus is forming, it interferes with blood flow. The most common site for thrombus formation is in the leg veins. Symptoms of thrombus formation in leg veins is redness, swelling, and a positive Homan's sign. Once the thrombus forms, it can dislodge and flow through blood vessels (embolus) and lodge in smaller blood vessels cutting off the blood supply.

Thromboembolism - is a disease when an embolus from a leg vein is trapped in organs.

Pulmonary embolism - is a form of thromboembolism in which the embolus lodges in the lungs.

Symptoms of pulmonary embolus are chest pain, difficult breathing, and fast pulse. If a pulmonary embolus is suspected, refer the patient immediately.

Stroke - is caused when an embolus lodges in the brain. Symptoms of stroke are headache, vomiting, paralysis and sometimes unconsciousness. If stroke is suspected, refer the patient immediately.

Myocardial Infarction - if the embolus lodges in the heart, a myocardial infarction occurs. (See Respiratory and Heart Module). Refer the patient immediately.

The above serious complications are rare.

The five symptoms listed below may mean serious trouble.

| <u>Symptoms</u> | <u>Possible Problem</u> |
|--|---|
| A bdominal pain (severe) | Gall bladder disease, blood clot |
| C hest pain (severe) or shortness of breath | Blood clot in lungs or myocardial infarction |
| H eadaches (severe) | Stroke or hypertension or migraine headache |
| E ye problems: blurred vision, flashing lights, or blindness | Stroke or hypertension or temporary vascular problems |
| S evere leg pain (calf or thigh) | Blood clot in legs |

The chart below list the common side effects and how long after starting the pill that they usually occur.

| Worse in First 3 Months | Over time: Steady-Constant |
|---|--|
| <ol style="list-style-type: none"> 1. Nausea plus dizziness 2. Thrombophlebitis (venous) Leg veins Pulmonary emboli Pelvic vein thrombosis Femoral vein thrombosis 3. Cyclic weight gain edema 4. Breast fullness, tenderness 5. Endometrial bleeding 6. Adrenalinal cramping 7. Suppression of lactation 8. Failure to understand correct use of oral contraceptives; pregnancy | <ol style="list-style-type: none"> 1. Headaches during 3 weeks that Pills are being taken 2. Arterial thromboembolic events, blurred vision, stroke. 3. Anxiety, fatigue, depression 4. Susceptibility to amenorrhea post-Pill discontinuation 5. Decrease in libido 6. Asthenia, chronic dilation of Eustachian tubes rather than cyclic opening and closing 7. Acne |
| Worse Over Time | Worse Post-Discontinuation |
| <ol style="list-style-type: none"> 1. Headaches during week Pills are not taken 2. Weight gain 3. Monilial vaginitis 4. Periodic missed menses while on oral contraceptives. 5. Chloasma 6. Myocardial infarction 7. Spider angiomas 8. Growth of myoma 9. Predisposition to gallbladder disease 10. Hirsutism 11. Decreased menstrual flow 12. Cystic breast changes 13. Photodermatitis - sunlight sensitivity with hypopigmentation 14. One form of hair loss - alopecia 15. Hypertension 16. Focal hyperplasia of liver and hepatocellular adenomas | <ol style="list-style-type: none"> 1. Infertility, amenorrhea; hypothalamic and endometrial suppression, and miscalculation of the expected date of confinement. 2. Hair loss - alopecia 3. Depression (in some women) |

may be irreversible or produce permanent damage.
 3. To avoid this complication in many patients desiring to be pregnant, discontinue Pills 3-6 months prior to desired pregnancy. Another possible way to avoid this problem is to avoid prescribing Pills for women with a history of very irregular menses.

Intrauterine Devices

Minor side effects - the minor side effects are very common.

Bleeding

Most women have heavier than normal menstrual bleeding. Often the menses also lasts longer during the first few periods following insertion. If the heavy menses continues, the woman should be observed for anaemia or pelvic infection and the IUD should be removed.

Irregular bleeding or spotting between periods

Irregular bleeding is not harmful, it is just a nuisance. If irregular bleeding is accompanied by very severe abdominal pain, ectopic pregnancy needs to be ruled out.

Heavy Menstrual Cramps

Some women experience heavy menstrual cramps during the first few months after insertion of the IUD. Reassurance and aspirins may help to relieve most of the pain. If pain is continuous or worsens, the IUD should be removed.

IUD expulsion

It is common that the IUD is expelled spontaneously within the first year. The symptoms of IUD expulsion may include unusual vaginal discharge, cramping, lengthening of IUD string, ability to feel the hard end of the IUD at the external O.S. The partially expelled IUD should be removed.

If the IUD has totally fallen out, the string will be absent. If no pregnancy is suspected and no infection present, the IUD can be replaced at the next menses.

Loss of IUD string

If the IUD has not been expelled, then it is possible that the string was drawn up into the uterus. Sometimes exploration of the canal with a pair of narrow sterile forceps, locates the string immediately. If the string is not felt in the canal, pregnancy must be excluded before further evaluation can be done. Refer the patient to a physician to evaluate whether the IUD is in place.

Serious Complications

Pelvic infections

If lower abdominal pain, severe cramps, back pain, fever and a general feeling of ill-health should occur, pelvic infections should be considered. The IUD should be removed and antibiotics started. (See Problems of Women Module.)

Perforation of the Uterus

Sometimes at the time of insertion the IUD perforates the uterus or is implanted into the uterine wall and perforates at a later date and goes into the abdominal cavity. An IUD which has perforated the uterus can injure the intestines or other abdominal organs, or can cause infection. The only way to remove an IUD which has perforated is by surgery. A woman may not know her IUD has perforated until she misses the string, becomes pregnant, or develops an infection. If perforation is suspected, refer immediately to a physician.

Pregnancy

Pregnancy may occur even with the IUD in place. 50% of women who become pregnant with the IUD in place will abort. 95% of women who abort while the IUD is in place will show signs of infection.

If pregnancy occurs while the IUD is in place, it should be removed. Removal of the IUD may also cause a spontaneous abortion.

Ectopic pregnancy occurs in 5% of all women who have IUDs. The symptoms of ectopic pregnancy should always be observed for they include absence of menses, then spotting and severe abdominal pain (see also Problems of Women Module).

When a woman has an IUD, observe for the symptoms below:



early IUD danger signals

- ✓ Period late, no period
- ✓ Abdominal pain
- ✓ Increased temperature, fever, chills
- ✓ Nasty discharge, foul discharge
- ✓ Spotting, bleeding, heavy periods, clots

Injectables

Minor Nausea can occur, but usually disappears within a few days of receiving the injection.

Fluid Retention can occur, it will decrease over time.

Breast Tenderness can occur, related to fluid retention.

Amenorrhoea occurs in most women; see module text for discussion.

Bleeding see Page 29 of this text.

Metabolic

Change in glucose tolerance can occur, diabetic patients should be monitored closely.

Serious

Thromboembolic disorders can occur (thrombophlebitis, pulmonary embolism, cerebro vascular disorders)

The symptoms listed below may mean trouble (same as with the pill).

| <u>Symptoms</u> | <u>Possible Problem</u> |
|--|---|
| A bdominal pain (severe) | Gall bladder disease, blood clot |
| C hest pain (severe) or shortness of breath | Blood clot in lungs or myocardial infarction |
| H eadaches (severe) | Stroke or hypertension or migraine headache |
| E ye problems: Blurred vision, flashing lights, or blindness | Stroke or hypertension or temporary vascular problems |
| S evere leg pain (calf or thigh) | Blood clot in legs |

STUDENT GUIDE

FAMILY PLANNING COUNSELING

I. Entry Level Knowledge and Skill:

Before starting this unit you should be able to:

1. Explain the use and action of contraceptive methods.
2. Describe anatomy and physiology of reproductive system.

II. Objectives:

Using the information and experiences provided by the instructor and the module text, you will be able to:

1. Interview couples (or individuals) to determine interest in family planning.
2. Apply communication skills during interview.
3. Recommend appropriate family planning practice.

III. Evaluation:

MODULE PHASE:

1. Knowledge: Written test based upon module content. Acceptable performance, 80%.
2. Skill: See rating sheet for acceptable performance level
Conduct interview and provide family planning information.

ROTATION/PRECEPTOR PHASE:

IV. Activities you will be participating in to accomplish the objectives:

1. Read module text and answer the review questions.
2. Participate in communication role plays with emphasis on awareness of cultural sensitivity and use of appropriate local terminology when discussing family planning methods.

FAMILY PLANNING COUNSELING

Family planning is a process that allows couples to plan the number of children they want and when they want them. Family planning extended to larger communities or countries allows countries to plan their population growth. These broader aspects of family planning are covered in the module entitled (Community Family Planning).

This module is concerned with family planning for the couple, man and wife, when visiting a clinic. Family planning may be handled in:

- a. special clinics organised at specified times;
- b. maternal child health clinics;
- c. general clinics.

When the patient is seen during a special family planning clinic, the nurse clinician will know that he or she is interested in talking about family planning. When the patient is seen in a general clinic, or an MCH clinic, in most cases, the nurse clinician will have to suggest the subject. Certainly, all women in a MCH clinic should be asked if they are interested in discussing planning their family. This may be just the encouragement they need to ask some questions regarding family planning or a reminder to go home and discuss it with her husband.

Communication Skills

There are some basic communication skills that should be developed by all nurse clinicians to increase their ability to meaningfully talk and listen to people. These are especially important in the area of family planning counseling. These skills include the ability to:

- a. be culturally sensitive,
- b. use acceptable local words,
- c. express ideas clearly,
- d. listen responsively,
- e. draw out questions and stimulate interest, and
- f. lead the couple to making a decision.

a. Cultural Sensitivity.

In the area of human reproduction there are certain cultural sensitivities that are unique to each community. These sensitivities will vary according to whether a man is talking to a man; a man is talking to a woman; a man is talking to a couple (a woman to a man, a woman to a woman or a woman to a couple). The nurse clinician should become knowledgeable of these sensitivities within the social groups visiting his clinic.

b. Local Terminology

In order to do appropriate counseling, it is important to know the local language and to be able to speak to both members of the couple in their own language. Also, the vocabulary chosen should be clear and adjusted to the patient's understanding and cultural sensitivities. For example, in English, common words used for urine may be: urine, water, pee, piss, wee wee, etc. Some of these words will mean nothing at all to some patients and may be very offensive to others. Proper selection of vocabulary is important for clear communication.

c. Clear Expression of Ideas

It is important that the nurse clinician be able to clearly explain necessary concepts related to reproduction and give instructions regarding the use of contraceptives. These should be freely and clearly discussed without showing any embarrassment or shyness. Be direct and specific in your expression within the cultural guidelines of the community.

d. Responsive Listening.

The nurse clinician should be a good listener - that means fully sharing one's attention with the patient. This will mean putting down your pen and paper and really concentrating on what she is saying and feeling. This will help the nurse clinician respond to the person on the human level and really hear her concern.

e. Encourage questions

Not only is it important to allow the couple to ask questions and fully answer the questions, they should be stimulated to ask further questions. A hearty exchange of questions and answers will lead to a better understanding of these new ideas and methods.

f. Lead to Decision-Making

The discussion with the couple should lead them to make a decision to take some action regarding family planning. This may lead to choosing a contraceptive, to not using a contraceptive, or simply to return home to discuss it with a spouse. But finally, the nurse clinician should lead the discussion to result in an action-assisted decision.

Review Questions (Family Planning Counseling)

1. What is the best definition of family planning?
 A process to stop having children.
 A process to space children
 A process to increase population growth.
 A process to decide when and how many children a couple wants.
2. What clinics should be used for family planning activities?
 Special family planning clinics.
 Prenatal-postnatal clinics.
 General clinics.
 Child clinics.

True or False

3. Nurse clinician should not discuss family planning with women.
 4. Nurse clinician should only use technical words when discussing family planning.
 5. Nurse clinician should explain family planning methods clearly
 6. Patients should be encouraged to ask questions.
7. List 6 important elements to remember when communicating in the clinic.
- 1)
 - 2)
 - 3)
 - 4)
 - 5)
 - 6)

Counseling in a Family Planning Clinic

When a couple or individual visits a family planning clinic, they usually come with some specific questions or problems relating to family planning. Therefore, the first natural approach is to encourage the person to tell you what brings them to the Family Planning Clinic. Based on this problem or question, the nurse clinician responds.

The response must tie together clinical and technical knowledge with good communication skills and allows for a free give-and-take discussion, resulting in a sharing of the nurse clinician's technical knowledge and the couple's preference.

Examples:

1. If the couple expresses the wish to stop having children permanently, the nurse clinician must assure herself that this is really what the couple is saying. Then, discuss the various options available to the couple (vasectomy and tubectomy), and the referral that is necessary. The couple should be encouraged to discuss what they have heard about these operations, their fears, concerns and problems. Finally, the couple and nurse clinician should make some action-oriented decision.
2. If a woman with known treated breast cancer comes to the clinic to postpone pregnancy for two years, the nurse clinician must help her select an appropriate contraceptive. The hormonal methods (pill and injectibles) are contraindicated so she must select among the IUD and condom. The effectiveness of each should be discussed with the woman. She should be encouraged to ask questions until she is fully aware of the methods and their proper use.
3. If a newly married couple wants to wait three years before having a child, the nurse clinician should discard permanent methods and the injectibles from consideration. The loop can be considered. The methods appropriate for this couple are the pill and condom. If for religious reasons the couple cannot choose "devices" then they should be instructed in the use of the mucous ovulation method.
4. If the couple has a problem of sterility, the nurse clinician must check whether the couple is actually living together and having intercourse regularly. Then a brief reasssuring discussion regarding causation of sterility should lead to both the man and woman going to the hospital for an examination.

Family Planning Counseling in MCH Clinics

Every woman attending a maternal child health clinic either as the mother of a sick child or for her own care should be given the opportunity for discussing family planning. This may be easily handled by asking her when she is planning to have her next pregnancy. This naturally leads to further discussion about spacing and family planning

Examples:

1. An eight-month pregnant woman comes for a prenatal check and the nurse clinician asks when she is planning to have her next baby. She may say that she doesn't know. The nurse clinician may then advise that she wait at least two years before having her next baby to give this new up-coming child a good chance to grow. Then a discussion of the use of the loop or condom may follow. (Pills are not recommended for lactating women.)
2. A mother comes into the clinic with a 2-year old child for an immunization. The nurse clinician asks when she is planning to have her next baby. She says she thinks she is two months pregnant now, so the nurse clinician examines her and finds that she is pregnant. She completes the prenatal exam and then discusses family planning methods for the future. She then reveals that she would like to stop having more children. The nurse clinician advises her to come in next time with her husband to discuss a permanent method.
3. A mother comes in with undernourished twins of 3-years each and a history of losing a 6-month old child last month because of diarrhoea dehydration. She also has a 5-year old son and an 8-year old daughter. After taking care of the twins, the nurse clinician asks when she is planning to have another child and she comments "God only knows." The nurse clinician then explains methods of family planning that couples can use. She seems interested but unconvinced so she asks her to return with the twins and her husband the next time.

Family Planning Counseling in General Clinics

Family planning in general clinics is a little more difficult than in MCH clinics because the patients are often unprepared for the subject. However, this can be handled by integrating the topic into the general patient health education topics given in the clinics.

Appropriate illustrations related to the importance of family planning to the economic health status of families can be used. A discussion of inheritance and the break up of family land and fields through succeeding generations is important to the rural farmer.

A general family planning discussion in the OPD allows for easy introduction of the subject in the clinic. "What methods are you using for spacing your family?" should be a part of any history.

Special Counseling Problems in Family Planning

Down's Syndrome (Mongolism) - The conditions of mental retardation associated with a typical moon face, mongoloid eyes, and low set ears with congenital heart disease is more commonly born to women over 36 years. This condition may also occur in children born to younger women and then may be hereditary, that is another birth to that couple has a higher chance of having Down's Syndrome.

Family Planning should be discussed with all older women because of the increased risk of having an abnormal child and all couples who have had a Down's child because they may have another.

Other Hereditary Conditions - Certain diseases seem to run in families. If a couple is concerned about a particular disease that may be hereditary, it is best to refer that couple to a doctor for a thorough discussion of the possible genetic relationship of that particular condition.

High Risk Pregnancies - Women who have had high risk pregnancies in the past need special family planning counseling. This is best done by the doctor who handles her high risk pregnancy, but some women will be seen by the nurse clinician.

Women with a history of heart disease, diabetes or active tuberculosis should avoid another pregnancy. It would be best for their health if they would accept a method of family planning.

Review Questions (Family Planning Counseling)

True or False

- _____ 1. Family planning counseling should only be done in a family planning clinic.
 - _____ 2. A woman with a 6-month old breastfeeding infant should not be given the pill as a contraceptive.
 - _____ 3. A woman with more than five living children should be ordered to have a tubectomy.
 - _____ 4. MCH clinics are good situations for the discussion of family planning.
 - _____ 5. A newly married couple desiring to wait three years before pregnancy should have a vasectomy.
6. Describe some appropriate ways to introduce family planning in a general clinic.

MODULE PHASE

SKILL EVALUATION

Before you are advanced to the rotation phase of training, a staff member will evaluate your mastery of the physical examination procedures and discriminations which have been identified in the modules.

You will have the opportunity to be rated on your performance of these skills at any time during the module phase that you feel prepared.

To help you prepare, the module contains a list of the skills to be evaluated. You are advised to do the following:

1. Work at perfecting your techniques of examination by practicing with another student.
2. During the clinical practice time provided, each week, practice the skills applicable to the subject being taught.
3. Have a fellow student observe and evaluate your performance.
4. When you feel you are ready, ask a trainer to observe and rate your performance.
5. If your performance is unacceptable, the trainer will give you specific comments on how to improve.
6. Practice again until you are ready for evaluation, and arrange to be rated.
7. If after two attempts you are unable to perform a skill at an acceptable level, arrange for a meeting with members of the training staff, who will help you obtain the experiences necessary for improving your performance.