USAID
FROM THE AMERICAN PEOPLE

Maternal and Child Health Initiative

Family Planning Training for Primary Health Care Providers

Participant Manual

April 2006

Acknowledgements

The Maternal and Child Health Initiative (MCHI) would like to thank the following people for their contributions to the development of this curriculum for a short training course in family planning:

Marina Gennadievna Nikolaeva, Chief Contraceptologist, Barnaul City
Anna Valentinovna Samarina, MCHI Expert on Family Planning and Reproductive Health, Obstetrician-Gynecologist, Ott Institute of Obstetrics and Gynecology, St. Petersburg
Irina Sergeevna Savelieva, MCHI Expert on Family Planning and Reproductive Health, Head of International Programs Department, Research Center for Obstetrics, Gynecology and Perinatology of the Russian Academy of Medical Sciences, Moscow
Irina Olegovna Taenkova, Executive Director, Khabarovsk Regional Family Planning Association, Khabarovsk
Elena Stemkovskaya, Training Coordinator, MCHI
Laurie Cappa, John Snow, Inc.
Mary Lee Mantz, John Snow, Inc.
Katherine Shields, World Education, Inc.

The curriculum was pilot-tested in a Training of Trainers in 2006 led by the four Russian Master Trainers listed above, with a group of key personnel from Tumen, Vologda, Irkutsk, Vladivostok, Komi, Orenburg and Moscow oblasts.

This curriculum is based in part on the *Integrated Family Planning 3-Day Training: Trainer's Guide and Curriculum*, developed under the John Snow, Inc. (JSI)/Albania Family Planning Activity (USAID contract number GHS-I-00-03-00026-00) in 2005; and the *Family Planning Curriculum for Training Primary Health Care Professionals* developed by JSI Research & Training (JSI R&T)/Romanian Family Health Initiative (USAID Cooperative Agreement #186-A-00-01-00103-00) in 2003 in partnership with the Society for Education on Contraception and Sexuality (SECS).

The support and assistance of the MCHI staff, leaded by MCHI Chief of Party - Natalia Vartapetova is much-appreciated.

Financial support for this publication was provided by USAID, contract number HRN-1-00-98-00032-00, delivery order 813. The views expressed in this document do not necessarily reflect those of USAID. The Maternal Child Health Initiative is implemented by John Snow, Inc.

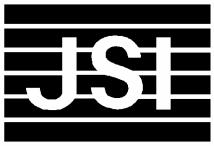


Table of Contents

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) 10:50-11:10 **2. Family Planning in the Russian Federation** (20 m)	9:00-9:15 **Review of Daily Activities** 9:15-10:10 **8. Natural Family Planning Methods** (55 m) 10:10-11:10 **9. Barrier Methods of Contraception** (1 hr)	9:00-9:15 **Review of Daily Activities** 9:15-10:15 **14. Voluntary Surgical Contraception** (1 hr) 10:15-11:10 **15. Emergency Contraception** (55 m)	9:00-9:15 **Review of Daily Activities** 9:15-9:45 **20. STIs, HIV/AIDS and Family Planning: Part II** (30 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) 12:20-13:00 **4. Evidence-based Medicine** (40 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) 12:25-12:55 **17. Postabortion Contraception** (30 m)	11:55-12:30 **23. Post-test and Evaluation** (35 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) 14:35-15:45 **12. Intrauterine Devices** (1 hr 10 m)	13:55-14:25 **18. Adolescent Contraception** (30 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) 16:50-17:30 **7. Methods of Contraception: Overview** (40 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)	
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

1. Introduction/Course Opening

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).

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.

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.

Training Methodology

- 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.

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.

Volunteer Team and Steering Committee

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:

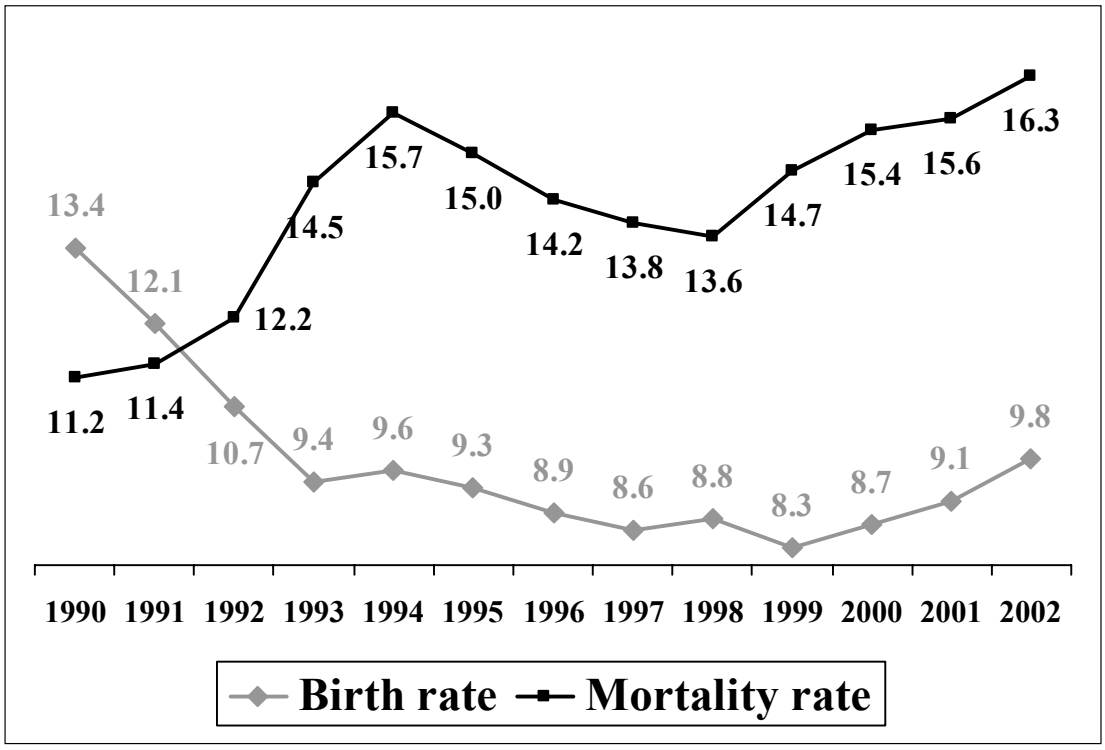
- meet at the end of the day for about 30 minutes.
- hear feedback from the Volunteer Team on the day's work, from their own experience and from ideas shared by other participants.
- discuss what went well, what could be improved, and any other suggestions or issues such as logistics.
- provide the course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

2. Family Planning in the Russian Federation

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

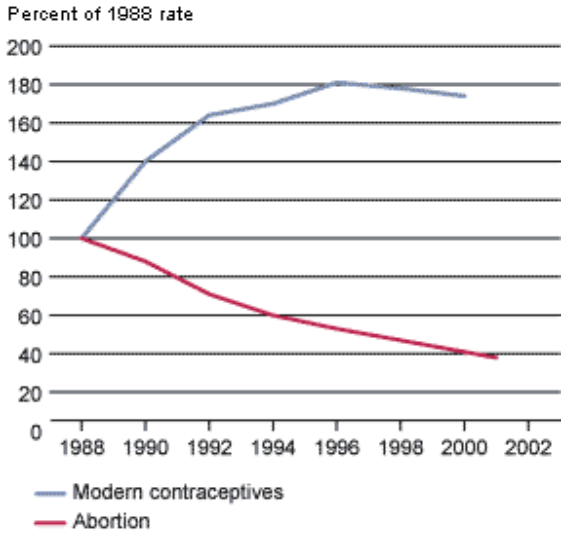
Sources: Population Reference Bureau – 2005 World Population Data Sheet and 2005 Women of our World Data Sheet

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%.



Source: Westoff C., unpublished data, 2003.

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.

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.

> *"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.*

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), 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, 3rd 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.

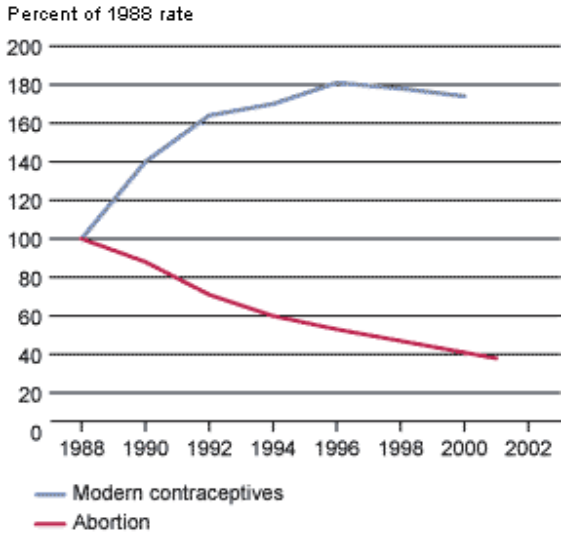
However, a recent analysis published in the European Journal of Population (Philipov, Andreev, Kharkova and Shkolnikov: "Induced Abortion in Russia: Recent Trends and Underreporting in Surveys," *European Journal of Population* 20: 95-117, 2004) crosschecked the official data with data from three reproductive 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.

[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.

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 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

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.

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.

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.

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.

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.

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.

Birth spacing: New research

- 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.
- See article at the end of this session titled **"Birth Spacing: Research Update"** for details.

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.

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 dysmenorrheal, 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

Definitions

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 clients.

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

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.

WHO *Medical Eligibility Criteria for Contraceptive Use* manual

This WHO manual makes the latest evidence and guidelines about contraceptives available to busy health care providers by summarizing the results of multiple studies worldwide, and presenting the evidence in the form of easy-to-use guidelines.

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.

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.

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.

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.

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.

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

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.

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.

Types of Questions

Closed questions generally result in only brief answers ("yes," "no," a number, name, date, contraceptive method, etc.)

- 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?"

Open-ended questions result in longer answers and usually provide more information than closed questions.

- 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?"

Principles of Good Counseling

(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.

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 ENVIRON-MENT	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 COMMUNIC-ATION 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 COMMUNIC-ATION 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)			

6. Informed Choice: The GATHER Method of Counseling

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.

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 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.

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.

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.

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.

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).

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).

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.).

<u>Explain</u> 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.
- 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.

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, Depo-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?"

<u>Return</u> 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.

Client Rights Regarding the Delivery of Family Planning Services

Clients have a right to:

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

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.

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.
- Creating private areas for counseling.
- Keep good client records to allow continuity between providers.

7. Methods of Contraception: Overview

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.

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

	Effectiveness: % of women who do NOT have an unintended pregnancy within the first year of use	
Method	**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.

Health Care Provider's Goals in Family Planning Counseling

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

For clients using no method or relying on abortion:

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

For clients using traditional methods:

- 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**.
- 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 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.

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.

8. Natural Family Planning Methods

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.

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.

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.

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**.

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]

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.
- 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.

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

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).

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.

[9] M. Monroy, 2003.

9. Barrier Methods of Contraception

Barrier methods:

- Contraceptives that prevent the passage of bodily fluids from one person to another.
- Examples: 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.
- **Male condoms** and **vaginal spermicides** are the barrier methods most commonly used and available in the Russian Federation.

Male Condom

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.)

Advantages of condoms:

- 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

Disadvantages of condoms:

- 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).

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).

Vaginal Spermicides

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.

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.

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.

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.

10. Low-dose Combined Oral Contraceptives

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.

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.

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.

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.

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.

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?

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.

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).

Side effects of low-dose COCs:

- 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.

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.

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 (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 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.

Combined Contraceptive Vaginal Ring

- 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.

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.

11. Progestin-only Contraceptives

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.

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

Types of POPs:

- As with low-dose COCs, there are several brands of progestin-only pills available in the Russian Federation.
- Despite the fact that they may very 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 not 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.

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.

What the client should do if she misses progestin-only 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 that they may wish to consider low-dose COCs or another method after 6 months.
- make sure she has a supply of POPs if available.

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?

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

The IUD is not user-dependent and protects against unintended pregnancy for a long term.

IUDs are the most popular form of reversible contraception in the world: 15% of all married women of reproductive age use an IUD.

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.

Basic Information about the IUD

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.

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.

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.

Advantages:

- Highly effective long-term contraceptive method that most women can use successfully.
- Copper-bearing IUDs have no hormonal effects and are safe for many women with medical conditions that make them ineligible for hormonal methods (low-dose COCs, POPs).
- Does not require much routine action by the woman – once IUD is inserted, she only needs to occasionally check that she can feel the strings.
- Can be inserted immediately postpartum or abortion if no evidence of infection.
- Can be removed at any time, and fertility returns at once.
- Can be used through 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-term 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 current criteria for surgical sterilization.
- Can be very cost-efficient: No supplies needed after initial purchase of the IUD for up to 10 years (depending on the type chosen).
- Does not interfere with sexual activity.
- Copper-bearing IUDs can also be used for emergency contraception.

Disadvantages:

- **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.

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).

Note on eligibility:

- 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.

When to insert:

- At any time during the menstrual cycle if reasonably certain that the woman is not pregnant. *(See **Cue Card: "How To Tell If A 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.**

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. Emergency contraception by IUD insertion is even more effective than the use of pills. (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.

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.

13. Counseling Practice Day Two: Role Plays

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.

14. Voluntary Surgical Contraception

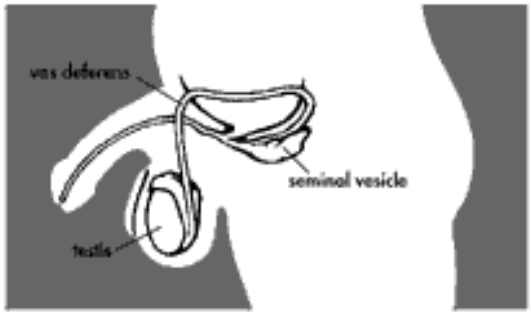
Voluntary surgical contraception:

- 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.

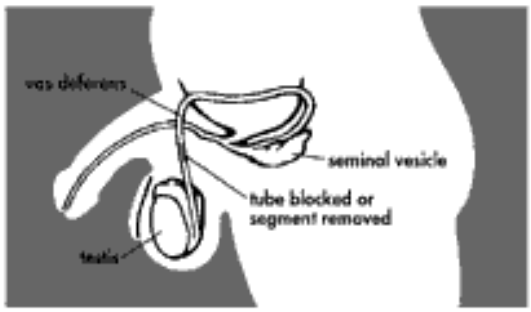
Voluntary Surgical Contraception: Fact or Fiction?

For each statement below, write down whether it is true or false.

	True or False?
1. Tubal ligation is a painful and complicated procedure.	
2. After surgical tubal ligation, the woman becomes frigid (loses interest in sex).	
3. It is usually possible to reverse a tubal ligation or a vasectomy.	
4. Menstruation will continue after tubal ligation.	
5. Vasectomy is the same as castration.	
6. Voluntary surgical contraception causes a loss of sexual sensation.	
7. Voluntary surgical contraception does not affect the man's or woman's weight, nor cause hormonal changes to the secondary sexual characteristics (voice, hair).	
8. Permanent methods are the most commonly used methods of contraception in the world.	



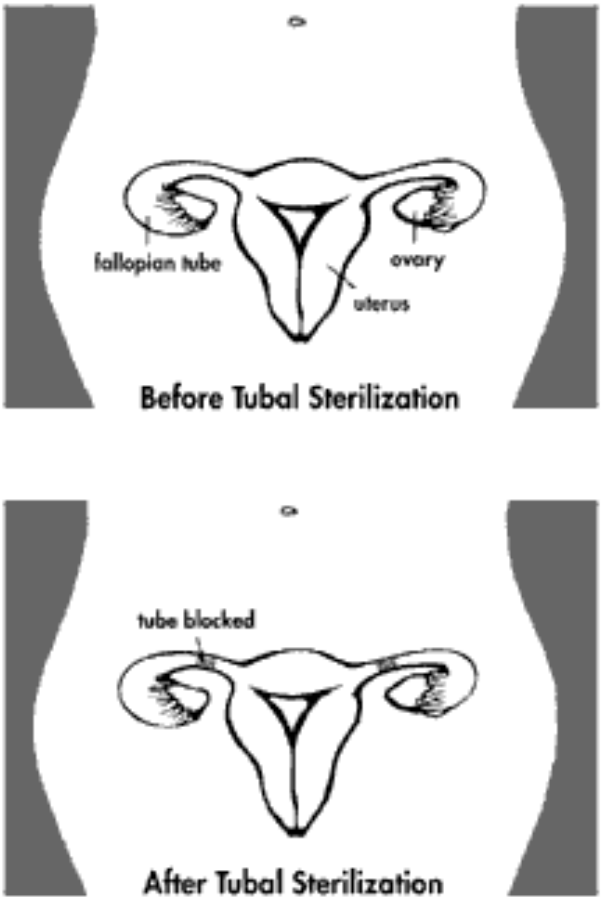
Side view showing left vas



Source: "Vasectomy: Questions & Answers." EngenderHealth website, http://www.engenderhealth.org/wh/fp/cvas2.html, March 20, 2006.

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.
- 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.



Source: "Female Sterilization: Questions & Answers." EngenderHealth website, http://www.engenderhealth.org/wh/fp/cfem2.html, March 20, 2006.

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.

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.

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.

Voluntary surgical contraception in the Russian Federation:

- 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.

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.

"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.

15. Emergency Contraception

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.

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.

New WHO guidance:

- The previous WHO guidance on emergency contraception stated that 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.

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 regimes 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.

[10] International Consortium for Emergency Contraception. Fact Sheet: Levonorgestrel for Emergency Contraception. March 2005.

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.
- 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.

Using a copper-bearing IUD for emergency contraception:

- A copper-bearing 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 that the use of pills.

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.	
	If newly starting the method, begin with a new packet of pills.	*If previously using the method,* resume using the packet of pills previously in use.
	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.	

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.

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. www.infoforhealth.org/inforeports/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**.

[3]The 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

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 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.

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 Russia[11] 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.

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.

Ask the mother these questions:

1. Is your baby over 6 months old? 2. Have your menstrual periods returned? 3. Are you regularly giving your baby other food besides breastmilk? 4. Are you going longer than 3 or 4 hours during the day and evening without breastfeeding? 5. Are you going longer than 6 hours during the night without breastfeeding?	If **YES** to ANY of these questions ⇒	**NOT eligible:** The mother's chance of pregnancy is increased. Advise her to: ▪ begin using an additional contraceptive method, and ▪ continue breastfeeding for the child's health.

If **NO** to ALL these questions:

⇓

ELIGIBLE: The mother can use LAM as her contraceptive method,

as long as the answer to all of these questions remains NO.

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.

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.

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.
    - 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.

Contraceptive Eligibility Postpartum

For women who do not breastfeed or do not meet the conditions for LAM, fertility may resume as early as 3 weeks postpartum.

This chart shows eligibility and when each of the following methods can be started postpartum.

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.	

17. Postabortion Contraception

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.

Using the GATHER Method of Counseling with Postabortion Clients

"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"

- 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?

"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.

"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.

"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.

"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.

Providers should follow all steps in the GATHER method for a postabortion client just as with any family planning counseling session.

18. Adolescent Contraception

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.

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.

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 nullips; 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.

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.

19. Counseling Practice Day Three: Role Plays

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.

20. STIs, HIV/AIDS and Family Planning (Part I)

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 doesn't 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

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.
    - Examples: bacterial vaginosis, chlamydia, gonorrhea, human immunodeficiency virus (HIV), pelvic inflammatory disease (PID), syphilis, trichomoniasis, urinary tract infections (UTIs).

- 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.
    - Examples: 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.

Biological factors putting <u>women</u> 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 <u>women</u> 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.

Social/cultural factors putting <u>men</u> 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.

HIV/AIDS in the Russian Federation

HIV/AIDS Trends in the RF:

- 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%.

HIV Transmission Risk

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.

20. STIs, HIV/AIDS and Family Planning (Part II)

HIV Prevention

To prevent <u>mother-to-child</u> 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.

To prevent transmission in <u>health care settings</u>:

- follow universal precautions for infection control.
- if accidentally exposed, follow post-exposure prophylaxis recommendations using antiretroviral drugs.

To prevent transmission during <u>injectable drug use</u>:

- stop using injectable drugs.
- do not share needles and/or syringes.
- sterilize drug injection equipment.

To prevent transmission during <u>sexual contact</u>:

- practice abstinence.
- have sexual contact with only one, mutually faithful partner.
- use condoms consistently and correctly with every sexual contact.
    - 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.

Integrating STI and HIV/AIDS Services with Family Planning Services

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 population at risk for unintended pregnancy and those at risk for 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.

Contraception for persons living with HIV or AIDS

Persons living with HIV or AIDS:

- have the right 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.

[12] Source: *Preventing HIV/AIDS through Family Planning* and *Contraception for Women and Couples with HIV* (Family Health International, August 2005.)

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).

Contraceptive Options for Persons Living With HIV or AIDS

Method	**Condition** *WHO Medical Eligibility Category is given in parentheses*		
	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

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 clients being infected by a health care worker in the United States; this involved HIV transmission from one infected dentist to six clients. Investigations have been completed involving more than 22,000 clients 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 client'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 clients. 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.

21. Couples Communication

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.

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.

Importance of helping couples to communicate about safer sex:

- 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.
- 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.

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.

Couples Communication: Statements and Responses for Talking about Condoms

The following are some statements or objections that a partner might make when asked to use condoms, with suggested responses.

"Sex with condoms doesn't feel as good."

> *"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?"

> *"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."

> *"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."

> *"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?"

> *"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."

> *"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."

> *"I have some right here."*

"I don't know how to use condoms."

"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."

"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."

"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."

"We can use withdrawal. I will pull out in time."

"A woman can still get an STI from pre-ejaculation fluid. And condoms are a much less risky way to avoid getting pregnant than withdrawal."

"Condoms don't work."

"Condoms rarely break if we use them properly. They are very good protection against many STIs and HIV if we use them every time. That's much better projection than no condom!"

"Why do we need to use condoms? We're married."

"Many married couples use condoms. They can be a very effective family planning method."