

Romanian Family Health Initiative

A Comprehensive Reproductive Health Curriculum

Family Planning Training Curriculum for Primary Health Care Professionals



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SECS

2003 Romanian Family Health Initiative

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How to use this manual

This manual is designed for training health professionals (family doctors and nurses) from the primary health care level in the provision of Family Planning services.

The concept of the manual is designed for an interactive working style, with active involvement of the trainees in the learning process.

This manual offer to trainers the model to be followed during the training workshop, in order to facilitate the training activities, so that the trainees will acquire the necessary knowledge, abilities and skills –through own experience- for providing quality, client-focused family planning services.

At the end of the workshop, trainees will be able to provide general and specific counseling for contraception; to initiate, monitor and evaluate the use of contraceptives by their clients and to correctly manage the contraceptives supplies, applying the Logistic Management System, in order to ensure free-of-charge contraceptives to certain categories of individuals.

The manual contains 19 sessions:

1. Introduction/Workshop opening
2. Reproductive Health and Family Planning
3. Reproduction and fertility
4. Contraception – Overview
5. Natural methods of Family Planning
6. Combined Oral Contraceptives
7. Progestagen-Only Contraceptives
8. Intrauterine Devices
9. Barrier methods
10. Voluntary Surgical Contraception
11. Emergency Contraception
12. Contraception in particular situations
13. Contraception –summarization
14. Individual values and health behaviors
15. Counseling
16. Simulations of Family Planning counseling sessions
17. Logistic system for contraceptives management
18. Post abortion Contraception
19. Closing

Each session contains:

- **Description of the session** – contains necessary technical information for conducting the activities of each session
- **Flipcharts/Overheads** – contain necessary information for conducting a specific activity; depending on technical conditions of the room in which the workshop will take place, trainer can choose either to project the overheads, if a projector is available, or to prepare the flipcharts in advance, before the beginning of the activities
- **Trainer's Documents/Materials** – contain standard information necessary to trainer for conducting the activities
- **Participant's Material/Handouts** – will be distributed during the workshop, linked to different activities

At the beginning of each session are mentioned: specific objectives of the session, time, training techniques, and necessary materials. The trainers will check, prior to the beginning of the workshop and before each session that all necessary materials are in place.

Notes to the Trainer

The trainer during any workshop must always consider the following aspects:

DO-s:

- Do prepare in advance, prior to the beginning of the workshop/ session/ activity
- Do maintain eye contact
- Do involve participants in the activities
- Do use audio-visual aids
- Do speak loud and clear
- Do encourage questions
- Do recap at the end of each session
- Do encourage participation
- Do write clearly and visibly
- Do summarize
- Do watch the time
- Do keep it simple
- Do give feed-back
- Do position visuals so everyone can see them
- Do avoid distracting and distraction in the workshop room
- Do be aware of the participants' non-verbal language
- Do keep the group focused on the task they have to complete
- Do check to see if instructions are understood by the participants
- Do permanently evaluate as you go
- Do be patient

DON'T-s:

- Don't talk to the flipchart
- Don't block visibility
- Don't stand in one place, move around in the room
- Don't ignore the participants' comments and feedbacks (verbal and non-verbal)
- Don't read from the curricula/ manual
- Don't raise your voice

Bibliography and resources

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Legrain, G., Delvoe P. – La Planification Familiale, 1994

Ministry of Health and Family –National Strategy for Reproductive and Sexual Health, 2003

RFHI/ SECS – Counseling Curriculum, 2002

Solter, Cathy, Comprehensive Reproductive Health and Family Planning Training Curriculum, Pathfinder International, 1997

Other sources:

IPPF – www.ippf.org

Johns Hopkins University School of Public Health, Center for Communication Programs – www.jhuccp.org

JHPIEGO Corporation – www.jhpiego.org

JSI R&T Institute - www.jsi.com

Pathfinder International - www.pathfind.org

Population Reference Bureau – IMPACT

WHO/ Reproductive Health Publications – www.who.int/reproductive-health/publications

FAMILY PLANNING TRAINING WORKSHOP AGENDA

TIME	DAY I	DAY II	DAY III	DAY IV	DAY V
9.00-11.00	Session 1: Introduction/ Opening	"Where we are?" Session 6: Combined Oral Contraceptives	"Where we are?" Session 9: Barrier Methods	"Where we are?" Session 14: Values and Health Behaviors	"Where we are?" Session 17: Logistic System for Contraceptives
11.00-11.15	Coffee break	Coffee break	Coffee break	Coffee break	Coffee break
	Session 2: Reproductive Health and Family Planning Session 3: Reproduction and Fertility	Session 6 – following	Session 10: Voluntary Surgical Contraception Session 11: Emergency Contraception	Session 15: Counseling	Session 17: following
13.00-14.00	Lunch break	Lunch break	Lunch break	Lunch break	Lunch break
14.00-15.15	Session 4: Contraception - Generics	Session 7: Progestagen- only Contraceptives	Session 12: Contraception in Specific Situations	Session 16: FP Counseling (simulations)	Session 18: Post-abortion Contraception
15.15-15.30	Coffee break	Coffee break	Coffee break	Coffee break	Coffee break
15.30-16.45	Session 5: Natural Family Planning methods	Session 8: IUD	Session 13: Contraception – Sum-up	Session 16: FP Counseling (simulations) - following	Session 20: Post-Test Participants' evaluation
16.45-17.00	Summarizing the day	Summarizing the day	Summarizing the day	Summarizing the day	Summarizing the workshop

Session 1: Introduction/Workshop Opening

Objectives

By the end of the session participants will:

- Refer to the trainers and to the other participants by their names
- Reconsider their expectancies in relationship with the objectives of the workshop
- Name at least 4 norms that they will respect during the workshop
- Describe the schedule of the workshop
- Evaluate their knowledge in Family Planning

Time: 100 minutes

Techniques: Presentations, listing, individual work

Materials:

Flipcharts/Overheads (FC/OH)

- 1.1 Optional: Introduction guide
- 1.2 General objectives of the workshop

Trainer's Documents (TD)

- 1.1 Presentation exercises
- 1.2 Presentation of the National Program No. 3
- 1.3 Group norms
- 1.4 Answers-key for the pre/post-test

Participants' Materials/Handouts (HO)

- 1.1 The Strategy of the Ministry of Health and Family for Reproductive and Sexual Health in Romania
- 1.2 Romanian Family Health initiative
- 1.3 JSI presentation
- 1.4 UNFPA presentation
- 1.5 SECS presentation
- 1.6 General objectives of the workshop
- 1.7 Workshop agenda
- 1.8 Initial evaluation test

Other materials

- Folders containing A4 paper sheets
- Name tags
- Flipchart paper sheets/ A0 paper sheets
- Markers
- A4 paper sheets
- Pens
- Flipchart

Activities:

1. Introduction (30 min)

- Greet participants as they arrive and welcome them. Hand each one of them a folder and a pen. Thank them for participating in the program.

- At the time mentioned for the beginning of the workshop, start the opening session. If not all the participants were arrived, ask those present how much minutes they would like to delay the workshop opening with. Do not begin with more than 15 minutes later from the scheduled time because you will encounter difficulties in recuperating the lost time. However, the trainers must be in front of the audience starting with the hour programmed for the opening. While waiting for those not present, entertain “social” conversations with those present in the room. During the waiting time you should **not** continue any arrangements or talk to your training colleague, thus ignoring those that have been punctual and that are present in the room.
- State the fact that a participative workshop will begin, and it is very important that everyone can see, hear and participate without any artificial barriers. Mention the fact that during the workshop, they do not have to take notes, as all important information is printed and will be distributed to all participants, during each session.
- Introduce yourself. State your name, surname, position, professional experience, steady job position.
- Ask the co-trainer to introduce him/ herself.
- If a representative of the District Public Health Authority or a representative of another institution involved in the program is present, ask him/ her to introduce him/ herself and to say a few words to participants.
- Ask participants to introduce themselves or choose an activity from the trainers’ document 1.1: “**Introductory exercises**”. Check the time!
- Make a short presentation of the National Program No. 3, based on the trainers’ document 1.2: “**NP3 Presentation**”. Remind participants that they do not have to take notes because they will receive printed material at the end of the session.
- Mention the organizers of the workshop and the donors that financially support the costs.
- If a representative of the District Public Health Authority is present, ask him/ her whether wants to add something else about the program.

2. **Participants’ expectations** (10 min)

- Ask the trainees about their expectations regarding this workshop and write down on the flipchart all their answers (what they expect/ want to find out during this workshop).

3. **Workshop Objectives** (20 min)

- Post on the flipchart: “**General Objectives of the Workshop**”
- Ask a participant to read the first objective. Ask what this objective means. After you have gathered few opinions, highlight the fact that this objective means that at the end of the workshop, all trainees will have the necessary information about the contraceptive methods available in Romania.

- Ask another participant to read the second objective. Ask what this objective means. After you have gathered few opinions, highlight the fact that this objective means that at the end of the workshop, all trainees will be able to apply in their day-by-day medical practice the theoretical information received during the training.
- Ask another participant to read the third objective. Ask what this objective means. After you have gathered few opinions, highlight the fact that in family planning services, the most important thing is the way in which the service provider can help the clients to make a decision regarding the use of a contraceptive method, to choose the method and to learn how to use it correctly. Within the workshop, each trainee will learn and practice the skills necessary to help clients.
- Ask another participant to read the fourth objective. Ask what this objective means. After you have gathered few opinions, highlight the fact that reaching this objective is highly important for ensuring the access of the population to free-of-charge contraceptives through NP No.3; in order to ensure the continuity of access to contraceptives, a correct management of supplies is needed. Also, the registration of data is very important, as well as the quantification of the services provided to population, for the continuity of the program.
- After you checked that the objectives have been clearly understood, go back to the list with the participants' expectations and compare it with the stated objectives. Emphasize the expectations which are in accordance with the workshop's objectives. State the fact that, for those expectations which are not in accordance with the workshop's objectives, they could be solved through participation to other workshops, or by others means; try to indicate alternative solutions, using the participants' ideas also.
- At the end of the exercise, the list with participants' expectations will be displayed in a visible place and during the workshop, the expressed elements, which are solved, will be marked as they find their solutions, preferably at the end of each day.

4. Group norms (10 min)

- Explain that, in order to attain the workshop's objectives, another important factor is the way in which the participants will work together as a group.
- Ask participants to propose rules, norms and write them down on the flipchart. Discuss each of the proposed rules, asking for arguments to sustain them.
- If difficulties occur in formulating the norms/ rules , suggest them through direct questions, or refer to the consequences of disrespecting these rules ("what happens when everybody is talking and no one is listening?").
- In the end, review the list and make sure that there is a consensus for assuming the norms.

5. Workshop agenda presentation (5 min)

- The co-trainer distributes to participants the handout 1.7 "**Workshop Agenda**".
- Make a brief presentation of the subjects which will be discuss during the workshop.

6. Pre-test (25 min)

- Give each participant a copy of the pre-test. The test will be completed individually; if participants ask any question, answer it. Emphasize that it is all right not to know all the answers; during the workshop the participants will receive answers to all questions contained in the pre-test.
- Mention the time allowed for this activity (20 min)
- While the participants are completing the test, the trainers are walking through them.
- Collect the pre-tests.
- Give participants the handout 1.1 "The Strategy of Ministry of Health and Family for Reproductive and Sexual Health in Romania", 1.2 "Romanian Family Health Initiative presentation", 1.3 "JSI presentation", 1.4 "UNFPA presentation", 1.5 "SECS presentation", 1.6 "General objectives of the workshop".

Note to trainers: Remember: the test have to be corrected after the first day of the workshop, in order to identify those subjects which need special attention!

PARTICIPANTS INTRODUCTION GUIDE

- **What is your name?**
- **What do you like to be called?**
- **Where do you work?**
- **What other courses/ workshops have you participated in?**
- **What kind of music do you like?**
- **What are your favorite flowers?**

GENERAL OBJECTIVES OF THE WORKSHOP

We propose participants to:

- Achieve information about the contraceptive methods available in Romania
- Achieve abilities to initiate, monitor and evaluate use of contraceptive methods by clients
- Achieve the necessary skills for family planning counseling
- Learn how to keep evidences and write reports about FP activities, including for the efficient management of free-of-charge contraceptives.

INTRODUCTION EXERCISES FOR PARTICIPANTS

Choose an exercise depending on the number of participants and on the time available, starting from the beginning of the session.

Exercise 1

Guide the participants' introductions through a series of questions which you post on the flipchart/ projector. Pick from the following questions, a maximum of 4, without omitting the underlined ones.

- What is your name?
- How would you like to be called?
- Where do you work?
- What other courses/ workshops have you participated in?
- How do you like to spend your leisure time?
- What kind of music do you like?
- What are your favorite flowers?

As each participant states the name he/she would like to be called, the co-trainer writes down this name on a name tag and will hand it to each participant "as an award", after the person has finished introducing himself/ herself.

Exercise 2

Draw or ask a participant to draw the map of the district on the flipchart. Invite each participant to come to the map, to indicate through a dot, the location where he/ she works and to write down the name he/she wants to be called during the workshop. At the end of the exercise, we will have a "map of the group".

As each participant states the name he/she would like to be called, the co-trainer writes down this name on a name tag and will hand it to each participant "as an award", after the person has finished introducing himself/ herself.

NB: The goal of this activity is to warm up the atmosphere and to help participants to know each other.

Presentation of the National Program No. 3 for Child and Family Health

The workshop is part of the new implementation of the MoHF strategy for reproductive and sexual health, especially the extension of the family planning services at the level of primary health care.

In order to decrease the rate of abortion, child abandon, maternal mortality and morbidity, MoHF has made constant efforts starting with 1990 in order to ensure access of population to family planning services. Within the initial stage, a family planning network has been developed at country level. Starting with the year 2000, MoHF has initiated a broad consulting process -that has ended at the beginning of this year- for elaboration of a national strategy for reproductive and sexual health.

The goal of this strategy is to improve the reproductive and sexual health state in Romania and to ensure the Romanian citizens the possibility to exercise their rights in the field of reproduction and sexuality, all life long.

Of the multitude of the identified problems, the following items have been established as priorities for the 2002 – 2006 period:

1. Family Planning (reproductive options)
2. Abortion and services for pregnancy interruption in safety conditions.
3. Safe motherhood – prenatal care, safe delivery, mother and infant care at birth, postnatal care and breastfeeding.
4. Prevention and management of sexually transmitted infections and HIV/ AIDS infection.
5. Reproductive and sexual health of adolescents and young people.
6. Sexual health of elder people.
7. Early detection and management of genital and breast cancer.
8. Prevention and management of infertility.
9. Prevention and management of all types of violence against women and children, especially of sexual abuse.
10. Prevention of trafficking women and children.

(The strategy is presented in the Handout 1.1)

Starting with the year 2000, MoHF also has elaborated a model for increasing the access of population to family planning services and contraceptives through integrating this type of services at the primary health care level, based on pilot-projects implemented starting with the year 1997; this model was elaborated in partnership with international agencies active in the field and with Romanian non-governmental organizations, in 5 districts (Alba, Cluj, Constanta, Iasi, and Tulcea). The extension has been applied in the first phase in other 13 districts and then it has moved on at the national level, all over the country, starting with this year. This model ensure the training for the service providers, as well as the distribution of free-of-charge contraceptives by the doctors and nurses trained, and the promotion campaigns for the services and contraceptives available in the rural communities. All these activities belong to the National Program No. 3 – The Program for Child and Family Health. The implementation of this program is based on the partnership between MoHF and UNFPA, USAID through the John Snow Research and Training Institute and SECS, as well as on the complementary funds ensured by MoHF, JSI and UNFPA.

(The presentation of the projects and of the agencies mentioned is included in the Handouts 1.2, 1.3, 1.4 and 1.5)

Group Norms (examples)

- 1. Participate in all sessions!**
- 2. One person at a time is speaking!**
- 3. Do not interrupt those that are speaking!**
- 4. Be concise!**
- 5. Respect the points of view and ideas that are different from yours!**
- 6. Punctuality is respected by everybody!**
- 7. Smoke in spaces destined for this!**
- 8. Turn off the cell phones or put "on silent"!**

Pre-Test Answers Key

Note to the trainer: *The correct answers are bolded.*

Questions 9-20 do not have pre-formulated answers. Any of the mentioned answers will be graded as correct.

1. The family planning objectives are:

- a. **facilitating individuals to decide if and when to have children**
- b. **prevention of unwanted pregnancies, of abortion and child abandonment**
- c. safe use of contraceptives
- d. **prevention/ early detection/ treatment of diseases which influence reproduction, including the sexually transmitted infections**
- e. **maintaining/ improving the quality of sexual life**

2. The benefits of the family planning services mean:

- a. **reduced number of abortions**
- b. **women with a better health state**
- c. **desired pregnancies and well care of children**
- d. **decrease in number of persons infected with sexually transmitted infections**
- e. **more time granted for curative medical assistance**
- f. **less social problems**

3. Ovulation takes place:

- a. at mid-time of menstrual cycle
- b. **14 days before the next period**
- c. days 12-14 after the first day of the period

4. The fertility phase lasts:

- a. one week, at the mid-time between two periods
- b. **4 days before ovulation + 4 days following ovulation**
- c. the ovulation day + the next 2 days

5. Emergency contraception can be used after unprotected sexual intercourse within maximum:

- a. 1 day
- b. **3 days**
- c. 4 days
- d. **5 days**

6. Switching one contraceptive method to a combined oral contraceptive can be done:

- a. **immediately, without waiting the next period**
- b. after the interruption of the previously used method, the woman will wait for her next period and she will start taking the pills from the first day
- c. after a 3 months break necessary for full recovery of the organism

d. anytime, if the woman is certain that she is not pregnant

7. The factors which determine and influence the forming and the evolutions of the behavior are:

- | | |
|---------------------|-------------------------|
| a. school | e. mass-media |
| b. family | f. role-models |
| c. entourage | g. experiences |
| d. tradition | h. social status |

8. FP counseling means:

- a. helping a person/ couple choose whether they want children or not**
- b. helping a person/ couple choose a contraceptive method**
- c. facilitating the safe use of the contraceptives**
- d. helping a person identify his/ her problems within the reproductive health sphere**
- e. helping a person/ couple assume their responsibility about maintaining their health**

9. The period phases are:

- The pre-ovulatory or follicular or proliferate phase
 - The ovulation or intermediate phase
 - The post-ovulatory or secretor phase or the follicle-luteal phase
- 1 point will be awarded for each statement*

10. Enumerate the contraceptive methods that you know:

Subdermal implants (Norplant)
 Vasectomy
 Injectable combined contraceptives
 Progestagen injectable contraceptives
 Tubal ligation (Feminine sterilization)
 Copper IUD
 Progestagen-only Pills (used during breastfeeding)
 Lactational amenorrhea method
 Combined oral contraceptives
 Progestagen only oral contraceptives (used by non-breastfeeding woman)
 Male condoms
 Coitus interruptus
 Diaphragm combined with spermicid
 Methods based on awareness of fertile period
 Female condoms
 Spermicidal jelly
 Caps, sponges

1 point will be awarded for each mentioned method

11. Which are the classes/ categories established by W.H.O. for contraceptive classification? What do they mean?

CLASS 1: method which can be used in any circumstance	A state in which there are no restrictions for using the contraceptive method.
CLASS 2: method which can be generally used	A state in which, generally, the benefits of using the methods exceed the theoretical or proven risks.
CLASS 3: use of the method is not recommended unless other methods are inaccessible or unacceptable	A state in which the theoretical or proven risks usually exceed the benefits of using the method.
CLASS 4: method should not be used, under any circumstance	A state in which the risks of using the contraceptive method are unacceptable.

12. What natural family planning methods do you know?

The lactation amenorrhea method

Methods based on the recognition of the fertile phase/ awareness of fertile period:

- The calendar method
- The cervical mucus method
- The body basic temperature method
- The sympto-thermal method

1 point will be awarded for each mentioned method

13. Enumerate 5 advantages of the contraceptive pills:

- Increased efficiency if used correctly
- Do not interfere with sexual intercourse
- Benific influence on the menstrual blood loss
- Are immediately reversible
- Can be used by many categories of women, at any age
- Prevent the iron deficiency anemia
- Prevent some genital disorders: ectopic pregnancy, endometrial cancer, ovarian cancer, ovarian cysts, pelvic inflammatory disease
- Prevent benign breast affections
- Can be used as emergency contraception

Any statement will be awarded 1 point.

14. Mention at least two types of side effects possible for:

- a. Barrier methods – latex allergy, diminishing of tactile sensations (condom); irritations, local allergic reactions (spermicidal jelly); urinary tract infections (diaphragm)
- b. Oral combined contraceptives – nausea, intermenstrual bleeding/spotting, headache, breast tenderness, weight gain
- c. Progestagen-only Contraceptives –menstrual changes, amenorrhea, headache, acne, weight gain, breast tenderness
- d. Intra-uterine device – abdominal pains, increased menstrual flow, secondary anemia, (rarely) uterine perforations

1 point will be awarded for each statement

15. Mention two failure causes (occurrence of unwanted pregnancy) in the use of the following methods:

- a. Natural Family Planning methods– difficulties in identifying the fertile phase, disrespecting abstinence during the maximum fertility phase, modifications of the health state which interfere with the NFP methods (fever, leucorrhea); diversification of the alimentation (LAM)
- b. Barrier methods – breaking/ sliding of the condom, using the condom along with oil or vaseline lubricants, incorrect application, perforation of diaphragm (by washing it with alkaline soap), vaginal wash within less than 6 hours from sexual intercourse
- c. Combined oral contraceptive (COC) – incorrect administration, vomiting, diarrhea, concomitant use with other medicine
- d. Progestagen Only Pills – incorrect administration, vomiting, diarrhea, concomitant use with other medicine
- e. The intra-uterine device (IUD) – IUD expulsion, IUD migration

16. Which are the methods which protect against unwanted pregnancy, as well as against STIs?

Condom

17. Mention the permanent contraception methods.

VSC – tubal ligation and vasectomy

One point will be granted for each answer

18. How could be a pregnancy excluded with a reasonable degree of certainty?

The woman:

- Hasn't engaged in sexual contact from her last normal period
- Has correctly and consequently used an efficient contraceptive method
- Is within the first 7 days after starting of a normal period
- Is within the first 4 weeks after delivery (in the case of women which are not breastfeeding)
- Is within the first 7 days after an abortion (upon request or spontaneous)
- Is breastfeeding integrally a baby under the age of 6 months and has amenorrhea

19. What information is necessary to a person for correct and safe use of a contraceptive method?

- How to use the chosen method
- Possible side-effects
- Alarm signs and what to do if these occur

20. Enumerate the 10 rights of the FP clients

- | | |
|---------------------------|------------------------|
| I. Information | VI. Opinion |
| II. Access | VII. Continuity |
| III. Dignity | VIII. Choice |
| IV. Comfort | IX. Privacy |
| V. Confidentiality | X. Safety |

The following questions have only one correct answer:

21. One of the following statements does not constitute the FP counseling objective. Which one is it?

- Helps the client decide whether he/ she wants a family planning method and offers him/ her the necessary information in order to help him/her to choose one;
- Helps the client apply his/ her decision of using family planning
- The provider, based on his/ her professional competency, recommends the most adequate method to the client**

22. If a client request changing the family planning method, you must:

- Change her method, because she knows best what she wants;
- Ask her why she wants to change the method and try to discover the reason, in order to make sure that she has taken a well-informed decision;**
- Try to find a medical reason in order to change the method and if this is not found, try to convince her to continue with the method she is already using.

23. The most important aspect of counseling is:

- Offering brochures about FP methods, so that the client will be able to discuss them with his/ her partner
- Identifying the client's needs and concerns regarding the use of contraception and the answer to these;**
- Obtaining the written consent of the client regarding the use of contraception;
- Describing all side-effects of the FP methods.

24. The following statements, except for one, are important elements of the information necessary for a client in order for her to take an "informed decision". Which of the following is not important?

- Major advantages and disadvantages of the contraceptive methods that present interest to the client
- Short description of all the available contraceptive methods
- Personal experience of the provider regarding the available methods**
- Possible side-effects
- Relative efficiency of the methods.

The Strategy of the Ministry of Health and Family for Reproductive and Sexual Health

Introduction

Starting with the year 1990, Romania has entered a new era of the policies destined to ensure the reproductive and sexual health. The decreased level of information and population's education in the field of contraceptive methods, the absence of training in the field of family planning within the Romanian Medical School, the lack of family planning have all determined Romania's population to resort to abortion in order to be able to maintain the desired size of their family or, in the most unfortunate cases, they have determined some citizens to resort to child abandonment. These elements, as well as the high level of maternal mortality and morbidity have determined the Ministry of Health to consider the field of family planning as a constant priority. In 1991, the Ministry has started negotiations as to obtain a loan from the World Bank, loan used to create a national family planning clinics network, represented in most of the urban regions of the country and the populations' access to modern contraceptives has been assured. The doctors and the registered nurses employed within these clinics have gone through a special training process as to assure quality services, focused on the specific needs of the client. The civil society, by creating associations and foundations specialized in this field and by developing partnerships with the Romanian Governmental institutions, as well as with international organizations, has successfully supported the Ministry of Health efforts.

Romania is the beneficiary of two population studies in the field of reproductive health: the first – in 1993, the second – in 1999. These studies demonstrate the result of the efforts made within this field, respectively the doubling of the use of modern contraceptives prevalence, within a period of 5 years and the decrease in the abortion rate. But, in the meantime, these studies focus the attention on the important differences in comparison with other European countries, as far as these two indicators are concerned.

In order to respond to the important public health problems in the field of reproductive and sexual health, in the terms of a limited access to resources, the Ministry of Health and Family has started in the year 2000, the elaboration of a strategy in this field. The elaboration process for this strategy has been based on a wide consulting with all professional categories involved in this field, as well as with the beneficiaries. This process has involved representatives of the medical services within the primary and secondary assistance, gynecologists, family doctors, registered nurses, representatives of the medical school and of different governmental institutions, political decision factors and representatives of the civil society, along with local and international experts. Within these debates, the most important problems of this field have been defined, as well as interventions destined for solving or improving them. The process has been finalized through the elaboration of a document which has been presented to the public at the beginning of this year, within which the Ministry of Health and Family has presented the long-term vision regarding the policies and the reproductive and sexual health in Romania, for the 2002 – 2006 period.

Applying this strategy has been achieved through the Health Program No. 3 – The Program for the Health of the Child and of the Family.

Due to the specifics and intra-discipline feature of this field, particular strategies are being developed for some components of the reproductive health. These strategies view:

- prevention and monitoring of the transmission of the Human Immunodeficiency Virus (HIV) and of the Acquired Immune Deficiency Syndrome (AIDS)

- prevention and monitoring of the sexually transmitted diseases;
- prevention and monitoring of the genital cancers;
- prevention of domestic violence, sexual abuse and illicit trade of alive human beings.

Romania's efforts are in accordance with the efforts made at worldwide level in this field. The World Health Organization considers reproductive health as one of the most relevant sectors for the improvement of the population's general health, stressed within the resolution of the 1995 World Assembly of the World Health Organization, as well as within the WHO/ EURO "Health for everyone".

Principles

The basic principles which have stood at the root of the elaboration of the strategy are those that have been adopted and reconfirmed within a number of international conferences and reunions, mentioned in all international documents important within this field: The World Declaration on World Health (adopted in May 1998, at the 51st Assembly of the World Health Organization – "Health 21"); The International Conference for Population and Development Report (Cairo, 5-13 September 1994); Global Evaluation of the Implementation of the International Conference for Population and Development Action Program presented within the General Assembly of the United Nations (July 1st 1999).

These principles are:

- Health is a fundamental human right. Anyone has the right to the highest standard of physical and mental health. As any member state of WHO, Romania will have to take the adequate measures in order to ensure universal access to health services, which include not only family planning, but also sexual health.
- The state has the responsibility of assuring this right; it also has to ensure respecting different religious, ethnical, cultural values, in conformity with the internationally acknowledged universal human rights.
- The legislative and the regulatory frame, as well as the regulations necessary for ensuring access to RSH services must all respect the standards and recommendations of the international organizations and institutions, in the context of Romania's desideratum of integration within the European Union. The whole legislative set will consider the WHO, EU guides.
- "Prevention" will represent a priority and the balance of the "curative" within the Romanian sanitary system, in conformity with the principles of promoting health, signed by Romania within the Ottawa Chart (1986);
- Women and men's, as well as social solidarity and justice chances of equality will be assured;
- The clinic standards and protocols will be developed solely based on the scientific proof and will assure an access as broad as possible, as well as viability in time for the population.
- The basic medical services availability insurance, as they are stipulated in the Alma-Ata Declaration.
- The integration of the RSH services within the primary health assistance, in order to make them as accessible to population as possible.
- The active participation of the beneficiaries, communities and non-Governmental organizations in the development of health services;
- Ensuring the coherence of the policies in the field of health care

Goal

The goal of the strategy is to improve the reproductive and sexual health state in Romania and to ensure the Romanian citizens with the possibility for them to exercise, lifetime, their rights in the field of reproduction and sexuality.

Priorities

Of the multitude of the problems identified during the counseling process, based on consensus, the following have been established as priorities for the 2002-2006 time period:

- I. Family planning (reproductive options)
- II. Abortion and services for safety pregnancy termination
- III. Safe-motherhood – prenatal care, safe delivery, care at birth and care for the infant, postnatal care and breastfeeding
- IV. Prevention and management of sexually transmitted diseases (STD) and of the HIV/AIDS infection
- V. Reproductive and sexual health in teenagers and young people
- VI. Sexual health in older people
- VII. Early detection and management of genital and breast cancer
- VIII. Prevention and management of infertility
- IX. Prevention and management of all types of violence against women and children, especially of sexual abuse
- X. Prevention of trafficking women and children

Objectives

For each of the identified priority fields, general and specific objectives have been established.

I. FAMILY PLANNING (REPRODUCTIVE OPTIONS)

General objectives

1. Ensuring the reproductive rights, including the informed option.
2. Growth of accessibility to the family planning (FP) services.
3. Growth of the addressability towards FP services.
4. Granting equal chances both to women and men.

Specific Objectives

- Until 2004, the regulations which are in favor of the access and addressability towards family planning services within the primary health network will be adopted and implemented at national level.
- Until 2004, the persons within the disadvantaged categories will be offered the possibility of receiving a cost-free quality contraceptive.
- Until 2004, the rest of the population which is in need will be offered a contraceptive that should not exceed 2% out of the minimum economy income.
- Until 2004, the information management system in the field of family planning will be functional and integrated within the national medical statistic system.
- Until 2004, at least two national campaigns in favor of communication for behavior change in the field of reproductive and sexual health will be held.
- Until 2006, the prevalence of the use of modern contraception will reach a minimum rate of 40%.
- Until 2006, minimum 40% of the units within the primary health assistance will offer quality family planning services.
- Until 2006, the specialized medical staff will be trained in the field of offering surgical contraception services destined for both partners.

II. ABORTION AND SERVICES FOR SAFETY PREGNANCY TERMINATION

General Objectives

1. Maintenance of the access to abortion in safety conditions services.
2. Increase of the quality of care within the pregnancy interruption services.
3. Diminution of the incidences of unsure abortion and of the morbidity and mortality associated with this.
4. The increase of the level of information regarding the behavior in the case of an unwanted pregnancy and the abortion risks.

Specific Objectives

- Until 2004, the legislative measures and the regulations necessary in order to assure quality standards for the services of pregnancy interruption in safety conditions, including for post-abortion contraception, will be adopted and applied at national level.
- Until 2006, all units which offer pregnancy interruption services, will also offer quality services, including post-abortion counseling services.
- Until 2004, the information management system concerning abortion will be adopted and will become functional within all units belonging to the public and private system.
- Until 2004, at least one national campaign in favor of communication for behavior change regarding the conduct in the case of an unwanted pregnancy, as well as regarding abortion risks, will be held annually.
- Until 2006, the number of abortions upon request will decrease with a minimum of 20%.

- Until 2006, the number of unsafe abortions will decrease with a minimum of 15%.
- Until 2006, the maternal mortality through abortion rate will decrease with a minimum of 15%.
- Until 2006, the complications regarding abortion will drop by 15%.

- Until 2006, the number of abortions upon request will decrease with a minimum of 20%.

III. SAFE MOTHERHOOD

General Objectives

1. The decrease in the mortality and morbidity rate.
2. The increase of the level of information regarding risk-free maternity among population.

Specific Objectives

- Until 2004, all pregnant women will have cost-free access to quality pre-, intra- and post-natal services.
- Until 2004, the system of quality and efficiency of the prenatal consultation insurance will be implemented at national level.
- Until 2006, the rate of maternal mortality will be reduced with 10%.
- Until 2006, the maternal morbidity rate specific through iron deficiency anemia will be reduced with minimum 20%.
- Until 2006, at least one national communication campaign for behavior change regarding pregnancy, birth, breastfeeding will be held annually.

IV. PREVENTION AND MANAGEMENT OF SEXUALLY TRANSMITTED DISEASES (STD), INCLUDING HIV AND AIDS INFECTION

General Objectives

1. Assuring the legislative frame necessary for preventing the discrimination of persons suffering from HIV or AIDS.
2. Decrease of the incidence of the sexually transmitted diseases (STD), including of HIV/ AIDS.
3. The decrease of the incidence of infection with HIV/ AIDS of the mother and fetus.
4. The increase of the information and education of population in the field of STD prevention, especially of the groups of population presenting an increased risk rate.

Specific Objectives

- Until 2004, all pregnant women which will accept, will be offered the possibility to be voluntarily and free of charge tested for HIV.
- Until 2004, at least one national communication campaign in favor of behavior change regarding infection with sexually transmitted diseases will be also achieved in the field of HIV/AIDS.
- Until 2006, the real incidence of infection through syphilis will decrease with 10% among the fertile aged population.
- Until 2006, the real incidence of STD will decrease with 10% among the fertile aged population.

- Until 2006, 50% of the primary medical assistance will offer precocious discovery and management in adequate STD cases.
- Until 2006, all women diagnosed with an STD will benefit from specialized, integrated, quality treatment.
- Until 2006, the vertical transmission of syphilis will be eliminated.
- Until 2006, the rate of HIV infection vertical transmission will decrease with 80%, through efficient management of HIV positive pregnant women and mothers.

V. REPRODUCTIVE AND SEXUAL HEALTH IN TEENAGERS AND YOUNG PEOPLE

General Objectives

1. Improvement of the legislative and regulatory frame necessary for adequate RSH services for teenagers and young people.
2. The decrease of the morbidity rate in teenagers and young people.
3. The insurance of access to adequate reproductive and sexual health services.
4. The decrease of the rates of unwanted pregnancies in teenagers and young women.
5. The decrease of sexually transmitted diseases among teenagers and young people.
6. The increase of information, education, and of teenagers' and young people's acquired skills in the field of reproductive and sexual health, regarding the embracement of a healthy behavior.

Specific Objectives

- Until 2004, at least one national communication campaign for behavior change regarding prevention of unwanted pregnancies and infection with sexually transmitted diseases among teenagers and young people will be held annually.
- Until 2006, education in the field of reproductive and sexual health addressed to teenagers and young people will be offered in schools.
- Until 2006, all facilities which are offering reproductive health services will also offer services adequate for the needs of young people.
- Until 2006, the rate of unwanted pregnancies among teenagers and young women will be reduced with 20%.
- Until 2006, the rate of infections with sexually transmitted diseases will decrease with 10%.

VI. SEXUAL HEALTH OF THE ELDERLY

General Objectives

1. The improvement of the sexual health state of older women.
2. The increase in the rate of informing and educating the population in the field of sexual health for older women.

Specific Objectives

- Until 2006, at least one national communication campaign for behavior change in the field of an efficient menopause management will be held annually.
- Until 2006, specialized services addressed to older women will exist in every county capital city.

VII. EARLY DETECTION AND MANAGEMENT OF GENITAL AND BREAST CANCER*General Objectives*

1. The improvement of the precocious discovery of uterine cervical cancer.
2. The improvement of the precocious discovery of breast cancer.
3. The increase of informing and educating the population in the field of genital-mammary cancer

Specific Objectives

- Until 2006, a national program for the precocious discovery of uterine cervix neoplasm will be organized.
- Until 2006, a national program for the precocious discovery of breast neoplasm will be organized.
- Until 2004, one national communication campaign for behavior change regarding the prevention of mammary and uterine cervical cancer will be held.
- Until 2006, 25% of the primary medical assistance services and 100% of the specialized services will perform precocious discovery of and/ or screening for uterine cervical cancer.
- Until 2006, all primary assistance health services will perform annually the breast examination in conformity with the standards.
- Until 2006, half (50%) of the women at risk will beneficiate from the mammography examination in order to be diagnosed.
- Until 2006, all women with mammary or uterine cervical cancer will beneficiate from specialized, integrated, quality treatment.
- Until 2006, 45% of the cases of uterine cervical neoplasm will be discovered in stages 0 and I.

VIII. INFERTILITY PREVENTION AND MANAGEMENT*General Objectives*

1. Increase in the access to specialized infertility management services.
2. Increase in informing and educating the population regarding infertility prevention and management.

Specific Objectives

- Until 2006, specialized services for the efficient management of infertility will exist within every level III gynecology unit.
- Until 2006, one national communication campaign for behavior change (CBC) regarding STD and infertility prevention and management will be held annually.

IX. VIOLENCE AND SEXUAL ABUSE PREVENTION AND MANAGEMENT*General Objectives*

1. Ensuring the legislative frame necessary for the prevention of domestic and sexual violence in Romania.
2. Diminishment of domestic and sexual violence against women and children.
3. The growth in informing and educating the population with regard to the domestic and sexual violence.

Specific Objectives

- Until 2004, the legislative measures necessary for preventing domestic and sexual health will be adopted and applied.
- Until 2004, one national communication campaign for the change of behavior regarding the domestic and sexual violence phenomenon, as well as its prevention will be held annually.
- Until 2006, a national level data base containing the victims of domestic and sexual violence which have been assisted within the medical assistance services will exist.
- Until 2006, specialized services addressed to the victims of domestic and sexual violence will exist within each county capital city.
- Until 2004, a national ONG network which offer specific services through collaborating with public institutions will exist.

X. PREVENTION OF TRAFFICKING WOMEN AND CHILDREN*General Objectives*

1. Ensuring the legislative frame for illicit trade of women and children prevention.
2. Diminishment of the illicit trade of women and children.
3. Increase in informing and educating the population in the field of illicit trade of women and children.

Specific Objectives

- Until 2004, an adequate legislative frame against illicit trade of women and children will be adopted.
- Until 2004, a national communication campaign for behavior change (CBC) regarding the negative health implications of the illicit trade of women and children phenomenon, as well as its prevention will be held.
- Until 2006, specialized services which will offer adequate medical services to the victims of illicit trade of women and children will exist.

Responsibilities

In the context of developing the strategy, all institutions, organizations and groups which play an important part in ensuring a successful solution to all identified problems have been submitted to inventory.

The Governmental Sector

The Romanian Government is the primary responsible for implementing the National RHS Strategy. The public institutions which play an essential part in performing and assuring the success of the present strategy are: The Ministry of Health and Family and its territorial structures (Regional Public Health Authorities), Ministry of Education and Research and its territorial structures (Regional School Inspectorates), The Ministry of Public Administration (local authorities gradually undertaking more and more of the social components), the structures in The Ministry of Labor and Social Protection, in The National Authority for Child Rights Protection and Adoptions, The Ministry of Internal Affairs, The Ministry of Justice.

Through the decentralization process, the local authorities will play a more and more important part in establishing the local priorities, their solving through assigning the necessary resources.

The Non-Governmental Sector

The non-Governmental Organizations (the NGOs) represent a sector which is assigned with an important part in applying this strategy due to achieving a good and direct working experience with the population. They have the possibility of answering rapidly and efficient to the needs of the population they are addressing, of offering services to groups that are vulnerable, marginalized or have behaviors at risk. NGOs will represent the partner of the governmental structures which have the possibility of expanding the models and experiences of the NGOs at national level.

Collaboration within the Health Sector

In Romania, the primary health assistance is widely represented, which makes it the strongest link regarding the growth of the access of population to RH/ FP services. The family doctor represents the most important element of this new model of ensuring RH/ FP services. The reorientation of the financial resources within the sanitary system towards the primary assistance is an important condition for applying this strategy.

Collaboration between Sectors

Education represents the most important communication area for sustaining reproductive and sexual health. Through these collaborations, preventive programs elaborated especially for young people and which can determine adopting healthy behaviors can be applied. Education in this field will consider the young people's psycho-somatic development stages, as well the cultural ethnical and gender differences.

Apart from the educative sector, other social sectors, such as social services, child rights protection, police, internal affairs, the judicial system, etc., will be drawn into partnerships.

The local public administration will be playing a more and more important part in mobilizing the local communities and identifying the local complementary resources.

International Collaboration

The technical and financial collaborations with the international governmental and non-governmental agents and institutions are essential. Thus, an important part is played by:

United Nations Funds for Population Activities (UNFPA) which has signed an agreement with the Ministry of Health and Family for the 2000 – 2003 period, called "Support for the Reproductive and Sexual Health Program in Romania". This program has the goal of increasing the RSH state of women, men and young people in Romania. Having two major components – the increase of the use and of the quality of the RSH services and the young people's embracement of a responsible sexual behavior, the activities of this program are focused on the training of the providers working within the primary medical assistance, the achievement of educational programs for family life, of CBC campaigns, assistance for improvement of public health promotion network, accomplishment of pilot-programs.

The United Nations Children Fund (UNICEF) which has signed with the Romanian Government an agreement for the development of a 5 year collaboration program, starting with the year 2000, which has the goal of extending and improving the social protection program and of the basic services for children and women, based on the international documents in which Romania is signatory. The principal activity domains of this program are: promotion of breastfeeding; improvement of prenatal assistance and prevention of vertical transmission of HIV/ AIDS; prevention of HIV/ AIDS and promotion of a healthy lifestyle. UNICEF collaborates closely with UNAIDS in this field.

World Health Organization (WHO) which supplies technical assistance for the elaboration and application of programs, and in certain cases, supplies financial support especially when such activities offer results and conclusions which can also be applied internationally. Additionally, WHO is an adequate forum for exchange of ideas between countries and programs with scientific echo.

United States Agency for International Development (USAID). Starting with 2001, for the following 5 years, John Snow Research and Training Institute Inc. (JSI R&T) takes up along with MoHF and USAID, the roles of primary technical coordinator and implementer of the "Romanian Family Health Initiative" (RFHI), program financed by the USA Government through USAID.

Swiss Government's Agency for Cooperation and Development (SDC) which supports WHO in improving neo-natal assistance through rehabilitation of maternities; it supports the achievement of programs in favor for eliminating discrimination of persons infected with HIV, as well as projects for maternal abandonment prevention.

Canadian International Development Agency (CIDA) which supports Romania through the projects carried out by UNICEF in two main fields: HIV/AIDS prevention and monitoring the compliance with The Child's Rights Charter.

The Norwegian Government which supports the delivery of a project on favor of assistance for women and children victims of domestic violence, through specialized counseling and temporary shelter.

The Canadian Government which offers Romania support by the contribution brought especially through UNICEF in the field of prevention of HIV and AIDS transmission programs.

The European Commission which invests considerably in the Romanian sanitary reform process, through assistance provided to the governmental structures. In the context of the support offered to the government, the EU funds are oriented in two priority fields: the efficiency of the Romanian epidemiological surveillance and control over transmitted diseases system's improvement (where HIV and AIDS represent one of the main intervention areas); surveillance of and control over non-transmitted diseases, where precocious discovery of and control over mammary neoplasm are highly situated.

The World Bank which supports a program within the Romanian sanitary sector, with components which include subjects regarding RSH. Thus, the achievement of a National Public Health Strategy, the training of the staff within the health promotion network, the strengthening of the capacity of providing services at the level of primary medical assistance, the planning and utilization of human and financial resources rationalization are foreseen.

Romanian Family Health Initiative

The training workshops for the FP service providers within the primary health care level belong to the strategy of The Ministry of Health and Family for increase of the population's access to family planning services. In order to accomplish this strategy, MoHF will attend in the applying of Romanian Family Health Initiative.

Through the Partnership Convention signed in November 2001, JSI Research and Training Institute becomes the technical coordinator and the main implementer, alongside with the Ministry of Health and Family and USAID, of the "Romania Family Health Initiative", program financed by the USA Government through USAID.

The objectives of this Initiative are those of increasing the access and the utilization for the reproductive health services and the integration of these services at community level. Thus, JSI R&T will collaborate with The Ministry of Health and Family, as well as with a series of Romanian non-governmental organizations for improving access and increasing utilization of quality, client-focused reproductive health services; implementation of the policies and rules which are to promote the initiatives within reproductive health; ensuring adequate placement of resources to services within primary and preventive health care and for increasing the degree of population's knowledge about services and active participation of the community in solving problems regarding reproductive health.

The most important ways which the Initiative will adopt to achieve these objectives are:

1. Supporting the primary health care in integrating the reproductive health services (family planning, pre- and post-natal care, early detection of cervical and breast cancer, of sexually transmitted infections, including HIV/ AIDS and of the domestic violence cases);
2. Developing an efficient structure for providing reproductive health services;
3. Promoting the use of reproductive health services

Along the 5 years of the Initiative, JSI R&T will collaborate with The Ministry of Health and Family as to the significant and lasting improvement of the access to quality reproductive health services in Romania. Some of the most important results expected at the end of this project are:

- Maternal mortality, infant mortality, number of abortions, sexually transmitted infections and HIV/ AIDS incidence diminished; degree of population's knowledge regarding family planning services, screening for detection of breast and cervical cancer, prevention of sexually transmitted infections, including HIV/ AIDS, increased;
- Number of medical units which provide basic reproductive health services increased;
- Use of modern contraceptives among Romania's population increased;
- Beneficiaries from early detection of breast and cervical cancer services increased.
- Available services destined for victims of domestic violence improved.

General Presentation of JSI Activities

John Snow, Incorporated is an American consulting company in the field of public health management, with headquarters in Boston and with more than 60 international offices. The company has adopted this name in honor of Dr. John Snow, the founder of modern epidemiology and whose work represents a continuous source of inspiration for the JSI team.

The mission carried by John Snow, Incorporated (JSI) and by The JSI Research and Training Institute (JSI R&T), the affiliated non-governmental organization, is to improve the quality and the accessibility of medical services throughout the world. The goal of the company's activity is to develop and implement efficient systems of management and to increase the organizational efficiency and effectiveness.

Starting with 1978, JSI has answered to urgent public health issues in 84 countries of the world and in the United States, carrying out over 300 projects and managing contracts estimated at 324 million US Dollars, through identifying and applying innovative solutions, as well as through ensuring technical support for the development of governmental and non-governmental institutions and organizations.

Within its activity, JSI permanently collaborates with local institutions, from community organizations to Ministries, as well as with international organizations and forums. The international and multi-disciplinary JSI staff includes over 400 specialists and has proven its managerial capacity within a vast series of multinational projects and local programs by responding to each country's specific necessities. Our competency areas include:

- Elaboration and management of health programs,
- Clinical and managerial training of the medical and paramedical staff,
- Strategic planning of the public health programs,
- Organizing informational systems regarding health,
- Technical support for financial analysis, research, evaluation and logistic management of medical systems,
- Elaboration and implementation of models for continuous improvement of quality services in health area.

Among our clients, there are: United States Agency for International Development, The World Bank, United Nations Children Funds, United Nations Funds for Population Activities, United Nations High Commissary for Refugees, World Health Organization, "Save the Children" Organization.

Among the significant contributions brought by JSI at international level the following are mentioned:

- Development of medical systems for children care, especially the diarrheic disease control, oral re-hydration therapy, immunization for children and pregnant women, control of respiratory infections and correction of malnutrition;
- Implementing and developing quality reproductive health services, as well as maximizing access of population to family planning services;
- Development of extensive programs in the field of maternal-infant health, which covers pre- and post-natal care, improvement of the pregnant woman's nutrition state, family planning, breastfeeding of the infant, treatment and prevention of HIV/AIDS and other sexually transmitted infections;

- Pioneer activity in supporting the development of the private health sector at the level of primary health care (family doctors medical offices and family planning centers) in numerous countries worldwide.
- Creating and implementing coherent logistic systems, in the absence of which no public health program can be efficient.

General Presentation of the United Nations Funds for Population Activities (UNFPA)

The United Nations Funds for Population Activities formed in 1969 and is presently the greatest source for multilateral financing in the world in the field of population.

From its forming and until now, UNFPA has provided the countries in course of development over 6 billion dollars in the support for the improvement of the reproductive health situation and of the efforts in the field of development.

The UNFPA mandate in Romania represents the support offered to the Ministry of Health and Family in developing and implementing national policies in the field of reproductive health as to:

- a) decrease the maternal mortality and morbidity rate,
- b) reduce the incidence of sexually transmitted infection,
- c) improve the knowledge and attitude of the population, especially of the young people, regarding reproductive health and
- d) diminish the domestic violence.

Presently, the UNFPA assistance focuses **on the following types of activities:**

- supporting the mechanisms of coordination and collaboration at central and local level regarding the implementation of national policies and programs in the field of reproductive health;
- organizing family planning services, training the medical staff working in specialized family planning cabinets and clinics and in the family doctors' medical offices, as well as implementing an information management system regarding the endowment with family planning services and the supply of contraceptives;
- developing the National Strategy for Prevention and Control of Sexually Transmitted Diseases, including the organizations of specialized services;
- acquiring contraceptives at low prices to be distributed to the disadvantaged population through the national family planning network or through the family doctors' medical offices;
- organizing campaigns for informing the wide public regarding the family planning services, the contraceptive methods and the prevention of sexually transmitted infections;
- carrying out sexual education programs in high-schools and elementary schools, in urban, as well as in rural environment;
- developing the National Strategy for Fighting, Monitoring and Controlling Domestic Violence and organizing the activity of centers which offer assistance to persons abused within their families.

SOCIETY FOR EDUCATION ON CONTRACEPTION AND SEXUALITY (SECS)

SECS Mission

- Society for Education on Contraception and Sexuality (SECS) is a Romanian non-governmental, apolitical organization which contributes to the improvement of the individual's health state through education and provision of comprehensive, integrated, quality reproductive health services. SECS is a full rights member of the International Family Planning Associations Federation (IPPF). The association militates for promoting and respecting the free access of all persons, based on own informed decision, to education for health and to services within the field of reproductive health.

SECS General Objectives

- To provide information, education and services in the RSH/ FP field, respecting the right to informed decision of each client;
- To provide quality and accessible reproductive health services, through own network of family planning offices.
- To promote the respecting of sexual and reproductive rights.
- To collaborate with governmental, non-governmental and international institutions which are active in the reproductive and sexual health/ family planning (RSH/ FP) fields.
- To promote excellence within all its activities, through respecting the standards elaborated by SECS.
- To support the communities in identifying and solving public health issues.
- To promote the benefits of responsible behavior of young people and to militate for their integration in the society.
- To promote partnerships between different governmental/ non-governmental institutions and donors in the benefit of the Romanian population.

The Goal of the Services Offered by SECS

In the last years SECS has collaborated with The Ministry of Health and Family for the development of the National Strategy in the field of reproductive health. SECS has made sustained efforts, offering technical assistance in the field for governmental resources coordination and for adapting the health reform to the necessity of a wider access to health services, based on a system which focuses on the client. SECS has representatives within all the consultative groups initiated by MoHF: group for development of RSH/ FP strategy, group for policy elaboration and advocacy, group for continuous training of the medical professionals, finance group, MIS group, IEC group.

SECS has contributed to the development of the local strategies within 18 districts (Alba, Botosani, Cluj, Constanta, Calarasi, Dolj, Hunedoara, Iasi, Ilfov, Ialomita, Mures, Maramures, Salaj, Suceava, Teleorman, Tulcea, Vaslui, Vilcea) with financing from the United States Agency for International Development (USAID), through The JSI Research and Training Institute (JSI R&T) and from The United Nations Funds for Population Activities (UNFPA). Starting with 2003, SECS has initiated the same process within the other 23 regions, as well as within the capital city Bucharest.

SECS has elaborated and implemented a logistic system meant to ensure the efficient management of the National Program No.3 for Child and Family Health.

SECS has involved in the field of human resources development, especially of FP service providers, with a major stress on the training of the providers within the rural environment; training materials have been elaborated by SECS and authorized by MoHF.

SECS provides the following types of services:

1. Technical assistance for the governmental institutions in elaborating strategies in the field of RSH/ FP, in the management of programs and promotion of reproductive health services;
2. Technical assistance granted to DPHAs as to improve the management of the National Program for Child and Family Health at local level – specifically, management of the distribution of free-of-charge contraceptives;
3. Elaboration and implementation of a logistic system for the management of the free-of-charge contraceptives distribution program (within the FP clinics and the family doctors' medical offices) and the training of service providers regarding the use of this;
4. Ensuring the administration of the distribution in 18 regions, of free-of-charge contraceptives obtained from donations;
5. Elaborating training handbooks and protocols in the field of reproductive health;
6. Training of providers for basic FP services, contraception, counseling for FP;
7. Training of promoters for promoting FP benefits;
8. Counseling for non-governmental organizations in project elaboration, fund raising, project management, financial management, team building.
9. Translation and publishing of reference materials in the RSH/ FP field and information, education and communication materials (IEC).
10. Providing services through the network of SECS model clinics (counseling, a wide range of contraceptives, emergency contraceptives, IUD insertions and extractions, pregnancy tests, gynecological services, STIs prevention, diagnosis and treatment services, Babes-Papanicolau tests, endocrinology consultations, menopause care, premarital counseling, pre- and post-natal counseling, pre- and post-abortion counseling, distribution of contraceptives)
11. IEC campaigns.

Human Resources and Their Structure

SECS is a volunteer organization with a network of 30 branches in 30 districts and over 1200 active volunteers. SECS Administrative Headquarter is located in Bucharest. The structure of the SECS branches is territorial; one branch in each region. SECS is a decentralized organization, structured on three levels: local/district branches, Regional Offices and Central Headquarter. Field activities are coordinated and supervised at local level by the regional offices in Cluj, Iasi, Constanta, Timisoara, Craiova, Covasna, as well as by the central headquarter.

SECS provides reproductive health services through its own network of 11 offices, financially self-sustained, in Bucharest, Cluj, Constanta, Turnu Severin, Tulcea, Calarasi, Iasi, Sibiu, Timisoara, Alba-Iulia, Tg. Mures and Constanta. The SECS offices provide complex obstetrics-gynecology, psychological counseling, endocrinology, STIs services.

GENERAL OBJECTIVES OF THE WORKSHOP

We intend to:

- Achieve knowledge on the contraceptive methods available in Romania
- Be able to initiate, monitor and evaluate the use of contraceptive methods by our clients
- Develop the necessary skills for family planning counseling
- Know how to complete the documentation and write reports about the FP activities, including for efficient management of free-of-charge contraceptives

FAMILY PLANNING TRAINING WORKSHOP AGENDA

TIME	DAY I	DAY II	DAY III	DAY IV	DAY V
9.00-11.00	Session 1: Introduction/ Opening	"Where we are?" Session 6: Combined Oral Contraceptives	"Where we are?" Session 9: Barrier Methods	"Where we are?" Session 14: Values and Health Behaviors	"Where we are?" Session 17: Logistic System for Contraceptives
11.00-11.15	Coffee break	Coffee break	Coffee break	Coffee break	Coffee break
	Session 2: Reproductive Health and Family Planning Session 3: Reproduction and Fertility	Session 6 – following	Session 10: Voluntary Surgical Contraception Session 11: Emergency Contraception	Session 15: Counseling	Session 17: following
13.00-14.00	Lunch break	Lunch break	Lunch break	Lunch break	Lunch break
14.00-15.15	Session 4: Contraception - Generics	Session 7: Progestagen- only Contraceptives	Session 12: Contraception in Specific Situations	Session 16: FP Counseling (simulations)	Session 18: Postabortion Contraception
15.15-15.30	Coffee break	Coffee break	Coffee break	Coffee break	Coffee break
15.30-16.45	Session 5: Natural Family Planning methods	Session 8: IUD	Session 13: Contraception – Sum-up	Session 16: FP Counseling (simulations) - following	Session 20: Post-Test Participants' evaluation
16.45-17.00	Summarizing the day	Summarizing the day	Summarizing the day	Summarizing the day	Summarizing the workshop

Initial Evaluation Test

Name, Surname:

Date:

Please circle the letters that correspond to the answers which you consider correct (there can be more than one correct answer):

1. The family planning objectives are:

- a. facilitating individuals to decide if and when to have children
- b. prevention of unwanted pregnancies, of abortion and child abandonment
- c. safe use of contraceptives
- d. prevention/ early detection/ treatment of diseases which influence reproduction, including the sexually transmitted infections
- e. maintaining/ improving the quality of sexual life

2. The benefits of the family planning services mean:

- a. reduced number of abortions
- b. women with a better health state
- c. desired pregnancies and well care of children
- d. decrease in number of persons infected with sexually transmitted infections
- e. more time granted for curative medical assistance
- f. less social problems

3. Ovulation takes place:

- a. at mid-time of menstrual cycle
- b. 14 days before the next period
- c. days 12-14 after the first day of the period

4. The fertility phase lasts:

- a. one week, at the mid-time between two periods
- b. 5 days before ovulation + 2 days following ovulation
- c. the ovulation day + the next 2 days

5. Emergency contraception can be used after unprotected sexual intercourse within maximum:

- a. 1 day
- b. 3 days
- c. 4 days
- d. 5 days

6. Switching one contraceptive method to a combined oral contraceptive can be done:

- a. immediately, without waiting the next period

- b. after the interruption of the previously used method, the woman will wait for her next period and she will start taking the pills from the first day
- c. after a 3 months break necessary for full recovery of the organism
- d. anytime, if the woman is certain that she is not pregnant

7. The factors which determine and influence the forming and the evolutions of the behavior are:

- a. school
- b. family
- c. peers
- d. tradition
- e. mass-media
- f. role-models
- g. experiences
- h. social status

8. FP counseling means:

- a. helping a person/ couple choose whether they want children or not
- b. helping a person/ couple choose a contraceptive method
- c. facilitating the safe use of the contraceptives
- d. helping a person identify his/ her problems within the reproductive health sphere
- e. helping a person/ couple assume their responsibility about maintaining their health

For the following questions, please give as many answers as you can, according to the knowledge you have previously acquired:

9. The period phases are:

-
-
-

10. Enumerate the contraceptive methods that you know:

11. Which are the classes/ categories established by W.H.O. for contraceptive classification? What do they mean?

12. What natural family planning methods do you know?

13. Enumerate 5 advantages of the contraceptive pills:

-
-
-
-
-

14. Mention at least two types of side effects possible for:

- a. Barrier methods
- b. Oral combined contraceptives
- c. Progestagen-only contraceptives
- d. Intra-uterine device

15. Mention two failure causes (occurrence of unwanted pregnancy) in the use of the following methods:

- a. Natural Family Planning methods
- b. Barrier methods
- c. Combined oral contraceptive (COC)
- d. Progestagen Only Pills
- e. The intra-uterine device (IUD)

16. What are the methods that protect against unwanted pregnancy, as well as against STIs?

17. Mention the permanent contraception methods.

18. How could be a pregnancy excluded with a reasonable certain degree?

19. What information is necessary to a person for correct and safe use of a contraceptive method?

20. Enumerate the 10 rights of the FP clients

For the following questions, circle the letter corresponding with the most suitable answer. (There is only one correct answer)

21. One of the following statements does not constitute the FP counseling objective. Which one is it?

- a. Helps the client decide whether he/ she wants a family planning method and offers him/ her the necessary information in order to help him/her to choose one;
- b. Helps the client apply his/ her decision of using family planning
- c. The provider, based on his/ her professional competency, recommends the most adequate method to the client

22. If a client request changing the family planning method, you must:

- a. Change her method, because she knows best what she wants;
- b. Ask her why she wants to change the method and try to discover the reason, in order to make sure that she has taken a well-informed decision;
- c. Try to find a medical reason in order to change the method and if this is not found, try to convince her to continue with the method she is already using.

23. The most important aspect of counseling is:

- a. Offering brochures about FP methods, so that the client will be able to discuss them with his/ her partner
- b. Identifying the client's needs and concerns regarding the use of contraception and the answer to these;
- c. Obtaining the written consent of the client regarding the use of contraception;
- d. Describing all side effects of the FP methods.

24. The following statements, except for one, are important elements of the information necessary for a client in order for her to take an "informed decision". Which of the following is not important?

- a. Major advantages and disadvantages of the contraceptive methods that present interest to the client
- b. Short description of all the available contraceptive methods
- c. Personal experience of the provider regarding the available methods
- d. Possible side-effects
- e. Relative efficiency of the methods.

Thank you!

Session 2: Reproductive Health and Family Planning

Objectives:

By the end of the session, the trainees:

- will define the concepts of Reproductive Health and Family Planning
- will describe the objectives of Family Planning and services
- will describe the benefits of Family Planning (for individuals, health professionals, community)

Time: 60 min

Techniques: Presentations, discussions, listing, brainstorming

Materials:

Flipcharts/Overheads

2.1 Family Planning, Reproductive Health and Sexual Health Definitions

2.2 FP/ RH Objectives

2.3 FP/ RH Services

2.4 Optional - Evolution of Contraceptives Use in Romania

2.5 Optional - Distribution of Contraceptive Methods Use (Method Mix)

2.6 Optional - Evolution of Abortion Rate in Romania

2.7 Optional - Comparison between Abortion Rate and Prevalence of Contraceptives Use in Romania

2.8 Optional - Evolution of Maternal Mortality

2.9 Optional - Evolution of Demographic Indicators in Romania and Europe

Material for the trainer

2.1 Evolution of Demographic Indicators in Romania

Material for the trainees

2.1 Family Planning – General Aspects

2.2 Evolution of the Demographic Indicators in Romania

Activities:

1. Family Planning and Reproductive Health (45 min)

- Ask participants to state difficult situations, problems they are confronting with in their professional activity, related with reproductive health (including mother and child's health status). Ask: What kind of issues are you confronting with? Do you have any children that are not well cared? Why? (*Make sure that you have the issue of families with many children on this list*).
- List all the issues mentioned by the group on the flipchart. Post the obtained list in a visible place (you will return to this list at the end of the session).
- Make a short presentation of the evolution of demographic data, morbidity and mortality indicators in Romania.
- Post on the flipchart ***RH/ FP Definition***.

- Ask one of the participants to read the FP definition.
- Ask then one of the participants to read the RH definition.
- Ask then one of the participants to read the Sexual Health definition.
- Post on the flipchart "**FP Objectives**". Ask one of the participants to read the first objective. Ask what the significance of the objective is. After receiving a few answers, mention the fact that FP services want to motivate individuals and the couples to start thinking about the size of the family they could take care for.
- Ask another volunteer to read the following objective. Request opinions on this objective. Mention the fact that FP services are destined to help the individuals/ couples prevent unwanted pregnancies, abortion and child abandonment.
- Ask another volunteer to read the Objective No. 3. Request opinions regarding this objective. Mention the fact that in order for a contraceptive method to be used correctly, it is important that the certain method be chosen by the user and nobody else (such as the provider).
- Ask another participant to read the Objective No. 4. Request opinions regarding this objective. Make sure that the statement has been understood.
- Ask another participant to read the Objective No. 5. Request opinions regarding this objective. Clarify if needed.
- Ask another participant to read the Objective No. 6. Request opinions regarding this objective. Clarify if needed.
- Ask another participant to read the Objective No. 7. Request opinions regarding this objective. Clarify if needed.
- Return to the list of issues/problems identified at the beginning of the activity and ask participants: How do you believe you may help in solving these problems through the light of the FP objectives? Which are the services you might provide in your office in order to solve these issues?
- Ask participants: How could FP objectives be attained? Do you believe that such objectives can be attained within the family doctor's office current practice?
- Mention the fact that the list of FP services also includes services other than those stated. Post the list of FP services.
- In conclusion, mention the fact that the main majority of these services can be offered by family doctors.

2. Benefits of FP/ RH Services (15 min)

- Conduct a brainstorming regarding the benefits of FP services for women, men, children, medical professionals and community. *(Explain to participants that their statements shouldn't have more than 3 words and must be as spontaneous as possible. Also, mention the fact that none of the statements are commented. When you find that the flux of ideas*

is dropping, start processing: if there are any statements which seem unclear, request additional clarifications from the person that has had the idea. None of the stated ideas will be excluded). After this stage – together with the participants– group the stated benefits according to the categories of beneficiaries. If consequently to the exercise the benefits are not produced for all categories of beneficiaries, help the group by asking questions. Emphasize the benefits for health professionals (family doctors and registered nurses).

- Compare the list of benefits with that of issues identified by the participants at the beginning of the activity.

At the end of the session, distribute the handouts: 2.1 "***Family Planning – General Aspects***" and 2.2 "***Evolution of the Demographic Indicators in Romania***".

DEFINITIONS

Family Planning (FP) defines the individual's or couple's capacity to anticipate and have the desired number of children, at chosen time and at the intervals between births which they establish by themselves. This can be accomplished through using contraceptive methods and through treatment of involuntary infertility.

Reproductive Health (RH) is defined by W.H.O. as a physical, mental and social state of well being regarding all aspects of the reproductive system, within all stages of human lives. As a consequence, RH implies a satisfying and safe sexual life, the possibility of procreation, as well as the liberty of deciding when, if and how often individuals/ couples want to procreate; RH includes the women and men's rights to be informed and to have access to safe, efficient, accessible and acceptable family planning methods which they can choose on their own, as well as the right to have access to adequate medical services which allow woman to go safely through the pregnancy and delivery.

Sexual Health represents a physical, emotional, mental and social state of well being regarding sexuality, not only the absence of illness, dysfunction or infirmity. Sexual health implies a positive approach of sexuality and sexual relations based on mutual respect, as well as the possibility of having safe and pleasant sexual experiences, without coercion, discrimination and violence. (W.H.O.)

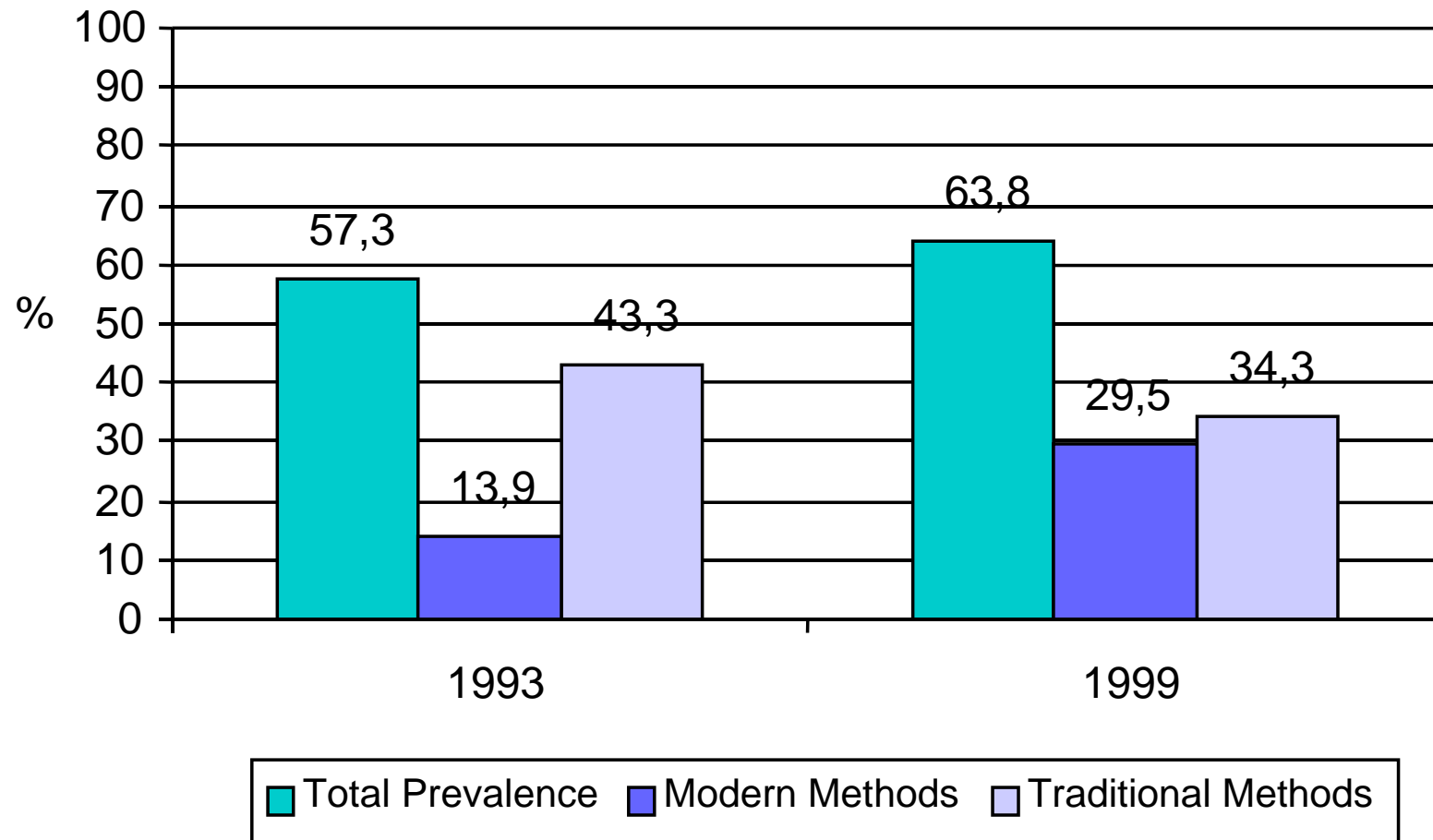
FAMILY PLANNING SERVICES OBJECTIVES

1. facilitating individual/couple to decide whether and when to have children
2. prevention of unwanted pregnancies, abortion and child abandonment
3. identifying individual's personal needs to able him/her to make an informed choice of a contraceptive method
4. ensuring correct use of the chosen contraceptive
5. prevention of sexually transmitted infections (STIs)
6. prevention and early detection of cervical and breast cancer
7. maintaining/ improving the quality of couple's life

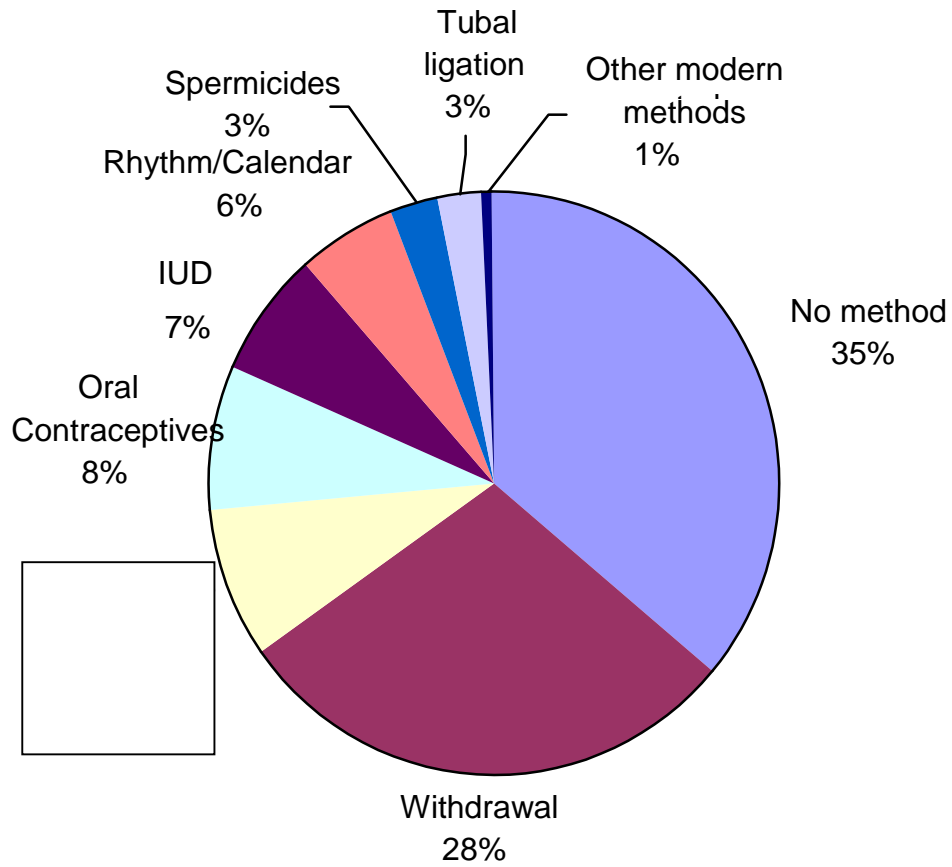
FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES

- providing information regarding family planning and contraception methods
- providing contraceptive supplies
- counseling for using family planning methods
- evaluation of the health status in order to use safely a contraceptive method
- monitoring of use of contraceptive methods
- diagnosis, counseling and management of side-effects of the contraceptives methods
- diagnosis pregnancy
- pre- and post-abortion counseling
- premarital counseling
- prevention of cervical and breast cancer
- prevention of sexually transmitted infections
- counseling for sexually transmitted infections
- diagnosis (and treatment) of infertility
- diagnosis of genetic diseases
- counseling for couples with genetic problems
- psycho-sexual counseling
- counseling in the case of domestic violence and sexual abuse
- education for sexual and reproductive health

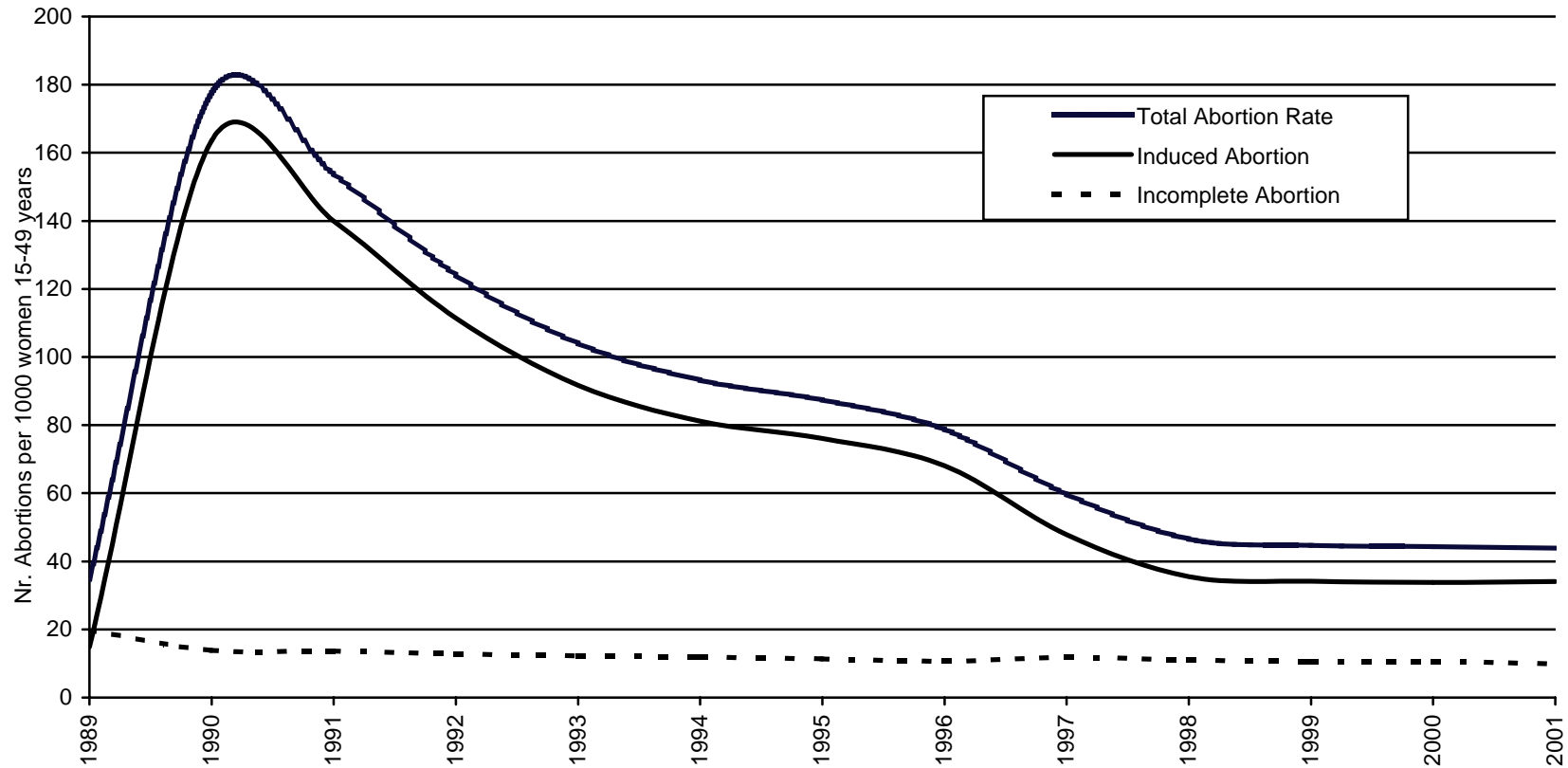
Prevalence of Contraceptives Use



Distribution of Contraceptives Use

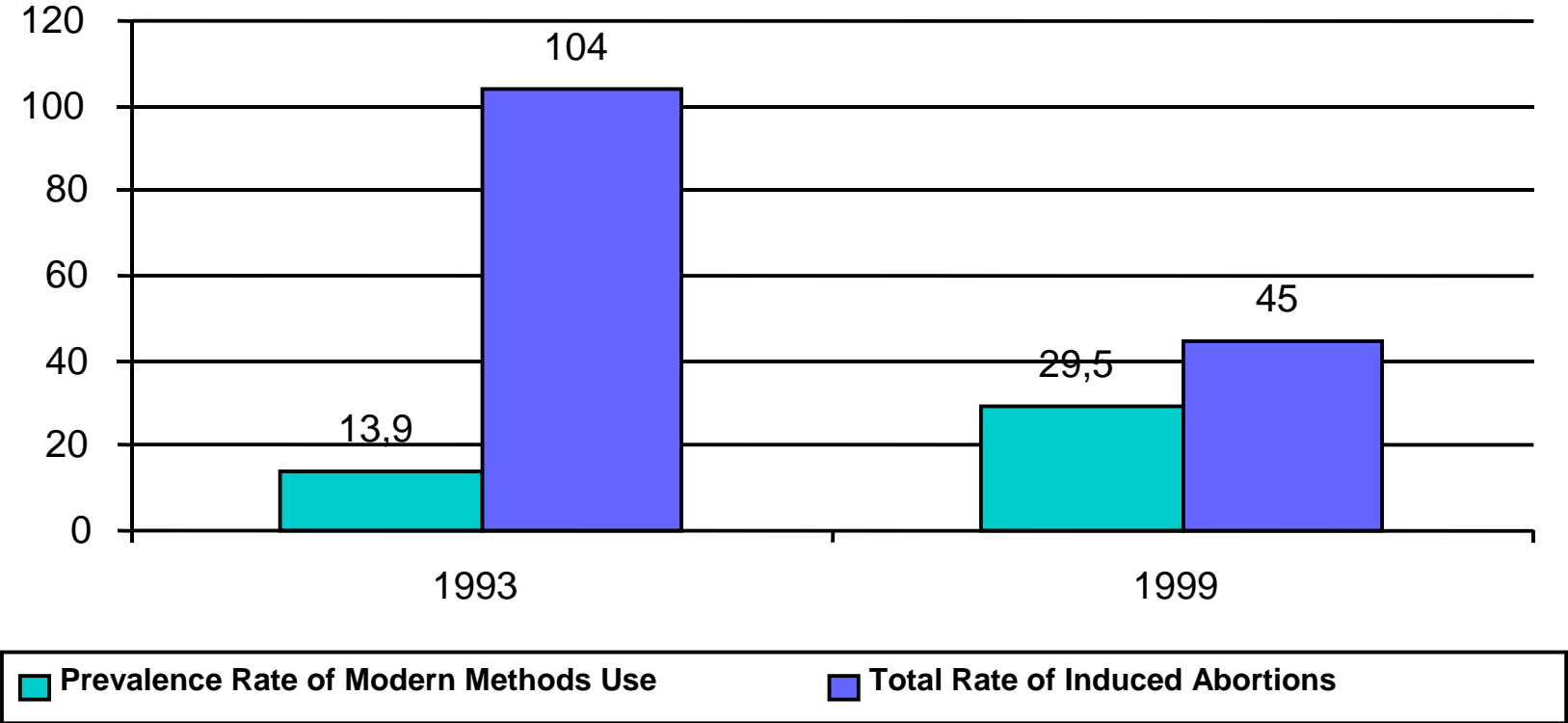


Evolution of Abortion Rate between 1989 – 2001

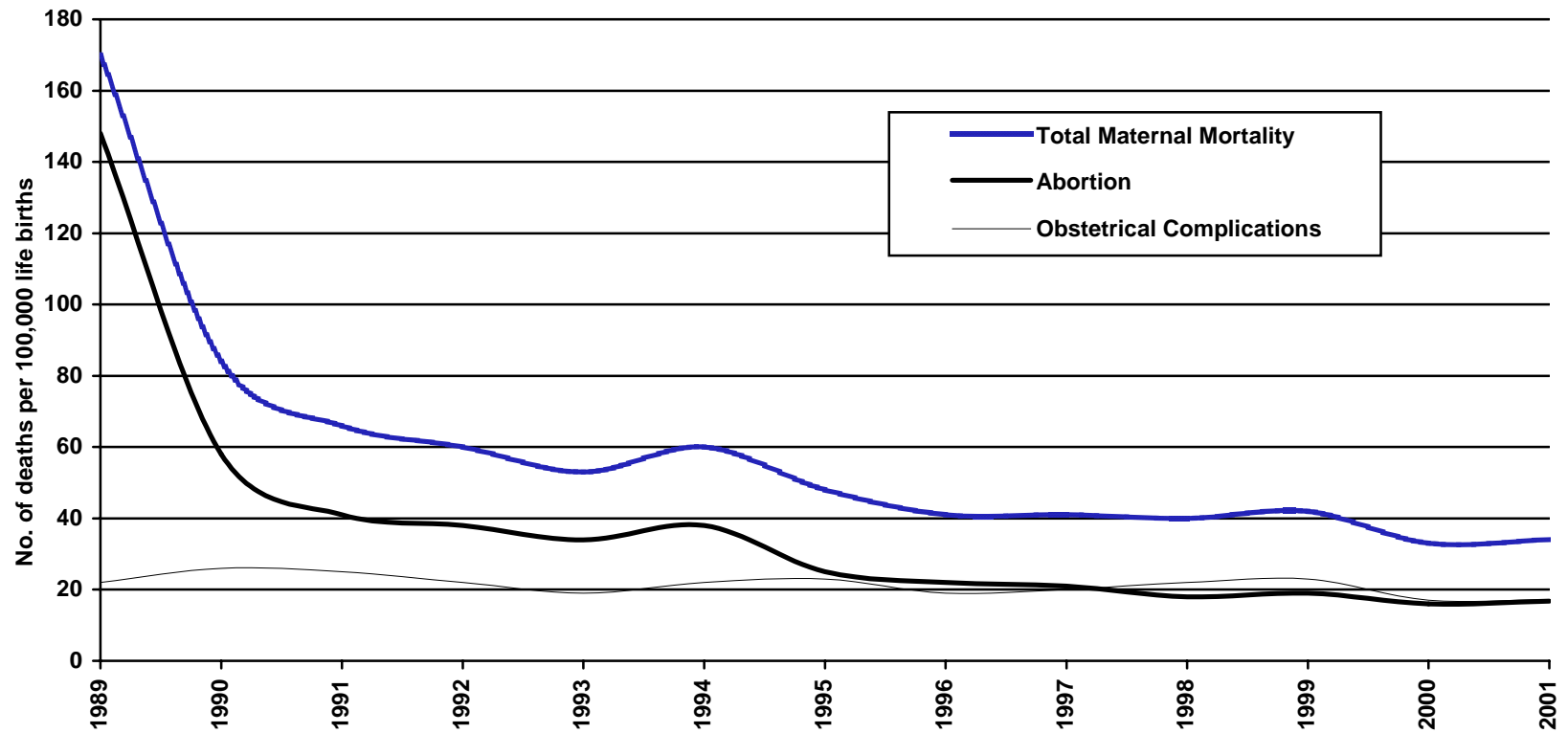


(Source: CCSSDM / MOHF)

Evolution of Abortion Rate and of Contraceptive Prevalence



Evolution of Maternal Mortality between 1989 and 2001



(Source: CCSSDM/MOHF and SSRR, 1999)

Demographic Data selected for Europe, European Regions and for Romania

<u>Country/ Region</u>	Birth Rate (annual number of births/ 1000 inhabitants)	Mortality Rate (number of annual deaths/ 1000 inhabitants)	Infantile Mortality Rate (infantile deaths/1000 live births)	Maternal Mortality Rate (maternal deaths/ 1000 live births)	The rate of modern contraceptives used by married women, 15-49 years of age (%)	The attitude of mothers towards the infant, % of unwanted children
Europe	10	11	8	28	52	N/A
Northern Europe	11	10	5	N/A	67	N/A
Western Europe	11	9	5	N/A	73	N/A
Southern Europe	10	9	6	N/A	47	N/A
Eastern Europe	9	14	13	N/A	42	N/A
Romania	10	12	18,4	60	30	46,5

N/A= Non-available Data

(Source: Population Reference Bureau, 2002 data)

The Evolution of the Demographic Indicators in Romania and Europe

Demographic Data selected for Europe, European Regions and for Romania
(Source: Population Reference Bureau, 2002 data)

Country/ Region	Birth Rate (annual number of births/ 1000 inhabitants)	Mortality Rate (number of annual deaths/ 1000 inhabitants)	Infantile Mortality Rate (infantile deaths/1000 live births)	Maternal Mortality Rate (maternal deaths/ 1000 live births)	The rate of modern contraceptives used by married women, 15-49 years of age (%)	The attitude of mothers towards the infant, % of unwanted children
Europe	10	11	8	28	52	Na
Northern Europe	11	10	5	Na	67	Na
Western Europe	11	9	5	Na	73	Na
Southern Europe	10	9	6	Na	47	Na
Eastern Europe	9	14	13	Na	42	Na
Romania	10	12	18,4	60	30	46,5

Na= Unavailable Data

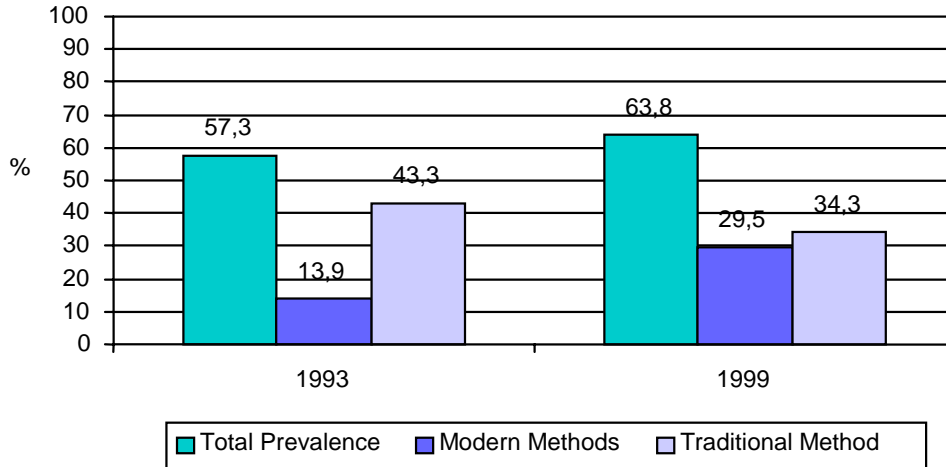
Study on the reproductive Health in Romania (1999)

According to the data contained in the study, completed on a sample representative for the reproductive aged population in Romania, formed by women with ages between 14-44 and men with age from 15 to 49:

- almost all the population (99%) has heard about at least one modern contraceptive method;
- approximately 92% of the population has heard about the IUD; 55% of these know how it is used;
- 23,3% of women and 22,8% of men in Romania use modern contraceptive methods;

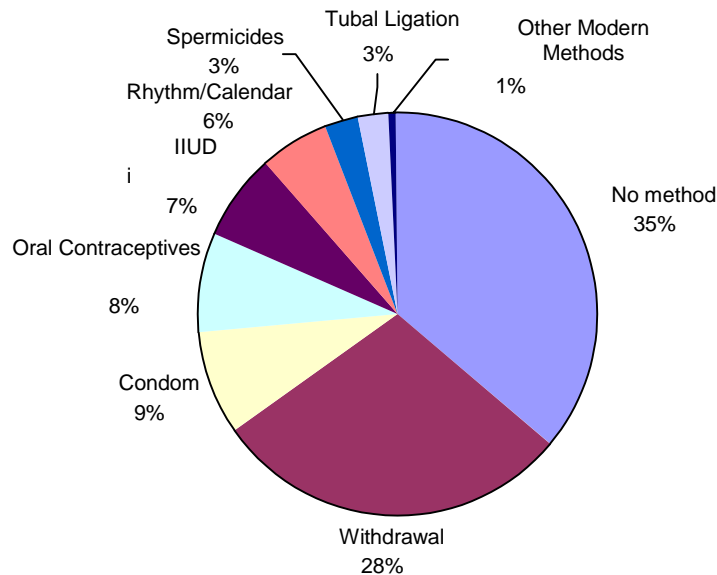
- 58% of the women and 52% of the men that are either married or cohabiting together without being legally married do not want any more children.
- 72% of the women and 61% of the men would like to receive more information regarding the contraceptive methods.

The evolution of the rate of the contraception's prevalence in women of reproductive ages (15 and 44 years), married or in consensual relationship with men in Romania is depicted in Figure 1.



Graph 1. Evolution of prevalence rates of contraception in women of reproductive ages (15-44 years), married or in consensual relationship with men
Source: SSRR¹, 1999

The structure of the contraceptive methods used is shown in Graph 2



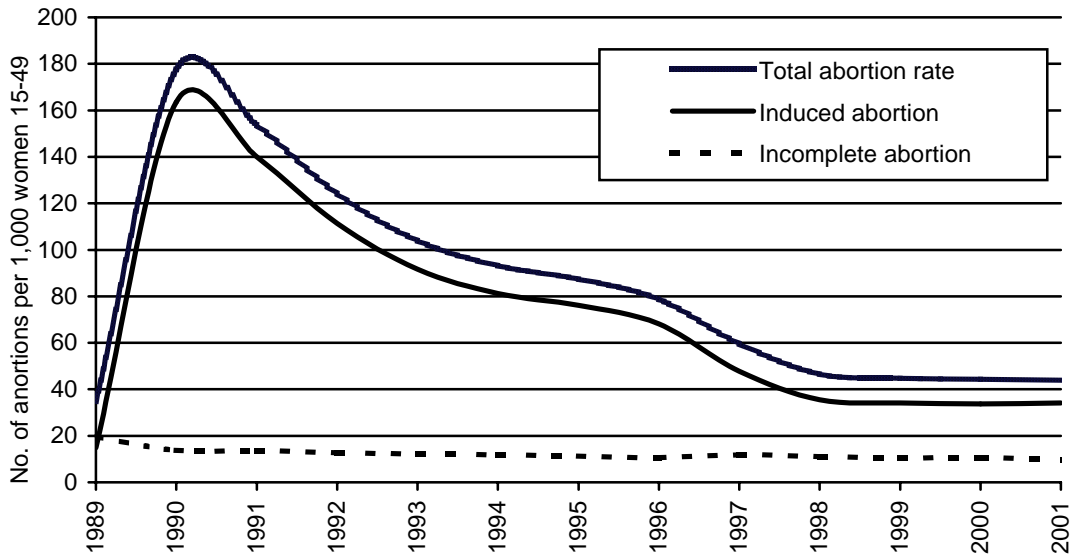
Graph 2. Distribution of Contraceptive Methods Use (Method Mix)
Source: SSRR, 1999

¹Serbanescu F. and collaborators, 2001, *Study Regarding the Reproductive Health in Romania, 1999: Final Report*, Bucharest and Atlanta: The Romanian Public Health Association and Sanitary Management, "Carol Davila" Medical and

Pharmaceutical University, Bucharest, The National Statistic Commission and the Control and Prevention of Diseases Center, Atlanta GA, USA.

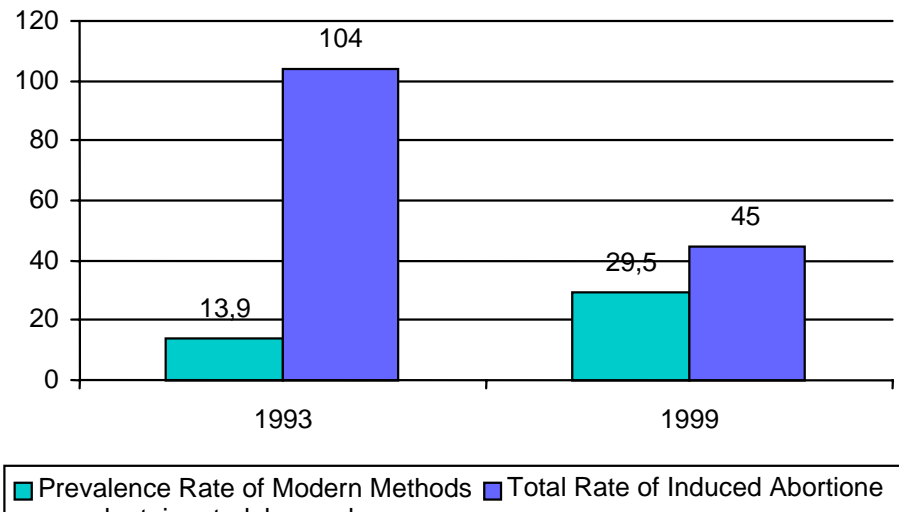
Abortion and Services for Pregnancy Termination in Safety Conditions

The abortion evolution in the last ten years is decreasing, from 2.34 abortions per born alive infant in 1993, to 1.16 abortions per born alive infant in 2001. The largest number of abortions has been recorded within the 20-34 age groups. The evolution recorded in the past 10 years of the incidence of abortions (15-49 age groups) is shown in Figure 3.



Graph 3. Abortion Rate evolution between 1989 – 2001 (Source: CCSSDM/ MOHF)

Graph 4 emphasizes the marked drop of the induced abortion rate (at less than half) in parallel with the clear rise of the use of modern contraceptives (over double).



Graph 4. Reduction of Induced Abortion Rate in parallel with the Rise of Use of Modern Contraceptives (Source: CCSSDM/ MOHF and SSRR, 1999)

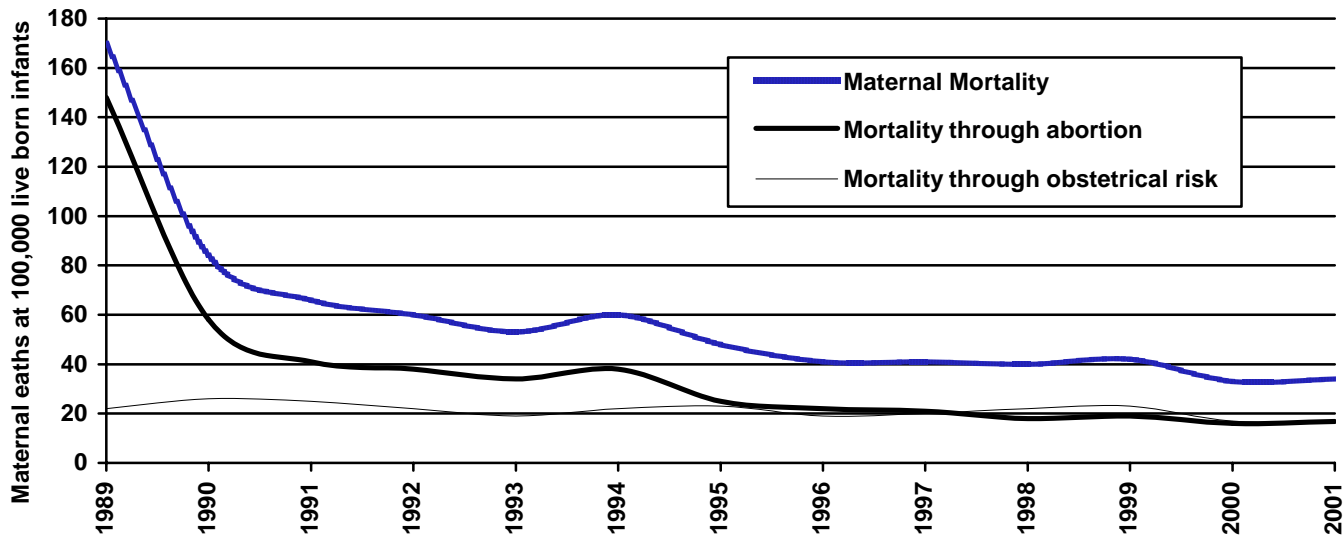
Safe Motherhood – pre-natal care, safe delivery, post-natal care and breastfeeding

- approximately 20% of the pregnant women which have given birth in 2001 have not been registered during their pregnancy;
- approximately 60% of the registered pregnant women have benefited from the first visit to the doctor in the first trimester of pregnancy;
- the average number of the pre-natal visits in registered pregnant women included is 5
- in the 2001 year maternal mortality registered in Romania was 34 deaths/100,000 live born, out of which:

16.8 deaths/100,000 live born due to abortions

17.2 deaths/100,000 live born due to obstetrical causes

After 1990, a significant drop in the maternal mortality rate can be noticed, through the drastic reduction (of approximately 8 times less) of the maternal mortality through abortion, due to legalization of abortion upon request and due to contraception (Figure 5).

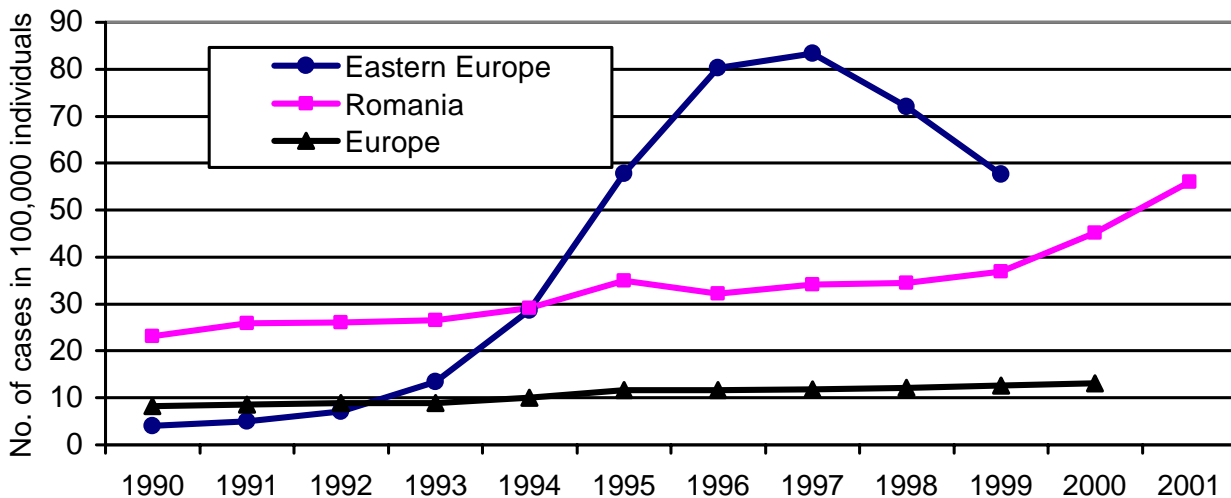


Graph 5. Evolution of Maternal Mortality between 1989 and 2001 (Source: CCSSDM/ MOHF)

Prevention and Management of Sexually Transmitted Infections (STIs), Including HIV Infection / AIDS

- in 2001, the incidence rate of Syphilis has been of 56.0 cases in 100,000 individuals, out of which 97% have been recent cases (53.9 in 100,000 individuals).
- the incidence of Syphilis has registered a continuous increase between 1990-2001; in 2000 and 2001 years, the incidence rate of Syphilis increase, both total, as well as recent Syphilis, being with at least 20% greater compared with the previous year;
- the incidence of Syphilis cases is greater in urban areas rather than in rural areas, in men and in young ages (20-24 years and 25-29 years), followed by 15-19 years old teenagers;

- on September 30th 2002, the total number of cumulated HIV/ AIDS cases registered was 13,279, out of which 9,928 people infected with HIV/ AIDS were still alive, approximately 75% of these being children;
- in 2001, the rate of deaths by HIV/ AIDS has been of 2.2/100,000 inhabitants, with an HIV/ AIDS incidence of 1.64/100,000 inhabitants;
- the principal way of transmission of HIV infection/ AIDS was heterosexual way (57%), while the clearly determined transmission through sharing syringes in the case of injectable drugs had the smallest balance (0.1%), even though a growth in the balance of this way of transmission of the infection is anticipated in the future;
- the number of children diagnosed with AIDS is dropping:
between 1991 – 1998, approximately 400 – 500 new cases per year have been registered;
in 1999, 255 new cases have been registered, in 2000, other 290 cases;
in 2001, 166 new cases have been diagnosed in children under 14 years (125 HIV infections and 36 AIDS cases), out of a total of 267 new HIV/ AIDS cases;
- in children, the main way of transmission is nosocomial way (51.6); transmission from mother to child was incriminated in 5% of the cases; and for 26.7% of the cases the way of transmission was not determined or unknown;
- 90% of the persons interviewed by SSRR are aware of the protective effect of condom use;
- 75% of the women and 69% of the men do not consider themselves to be at risk of infection with HIV;
- approximately 10% of the people with ages between 15-49 use condoms.



Graph 6. Evolution of Incidence of Syphilis (all forms) during 1990 – 2001 in Romania comparative with the average for Europe and Eastern Europe (Source: CCSSDM/ MOHF)

Reproductive and Sexual Health in Teenagers and Young People

- most teenagers know about the risk of sexual transmitted infections (source: SSRR, 1999);

- in 1991, the average age at the first intercourse was 19.5 years, decreasing in comparison with 1993, when the average age was 20.5;
- half of the young people use a contraceptive methods; 23% use a modern method and 27% use a traditional contraceptive method;
- 40% of the young women and 25% of the young men have correct knowledge of the menstrual cycle;
- 34% of the women and 86% of the men under 24 year sexual active, report having two or more sexual partners;
- proportion of women starting their sexual life before 20 is 56%, while 80% of the men start their sexual life before this age.

Sexual Health of the Elderly

The dysfunctions caused by menopause can have long-term effects (e.g. women which are at menopause are at risk for osteoporosis). The unpleasant effects of the menopause can be avoided by adequate hormone replacement therapies.

Early Detection and Management of Genital and Breast Cancer

- breast and cervical cancer constitute the first two causes of mortality through cancer in Romanian women, both registering a tendency of growing in the last years;
- in 2001, approximately 17% of the deaths occurred in women through cancer have been caused by breast cancer (the raw mortality rate – 26.2/100,000 women), and 1,763 of the deaths have been caused by cervical cancer (15.4/100,000 women);
- in 1999, 4,373 new breast cancer cases have been registered among women (22% of the new cancers in women) and 3,001 new cervical cancer cases (14%);
- most women are diagnosed in late stages, when the healing chances are reduced, the education of the population playing an essential role in amending this situation:
- in 1999, under 10% of the new cases have been diagnosed in early stages (stages 0 or I), while 45% of the cases were in stages III-IV at the moment of diagnosis, in the conditions in which in Romania the quality of registering the cancers is still showing a deficit (e.g. for 23.7% of the new breast cancer cases data regarding the stages of the disease at the moment of the registration cannot be provided);
- in 1999, 4% of the cervical cancer cases were "in situ" (early stages), approximately 33% of the cases were within stages III and IV at the moment of diagnosis (for 23% of the new cases, data regarding the stage at the moment of discovery are not available.);
- the main problems are the increased incidence and mortality through cervical cancer (in 2000, the standardized mortality rate through cervical cancer was the highest in Europe), and the diagnosis in advances stages for both of the mentioned types of cancer.

Infertility Prevention and Management

The 1999 Reproductive Health Study has also investigated aspects linked to the perception of infertility in women aged from 15 to 44. Results indicate the fact that 4.4% of the women between 15-19 years, 2.4% of the 20-24 aged women, 6.5% of the women with ages between 25-29, 12% of the 30-34 years old women, 21.3% of the women with ages between 35-39 and

35.8% of the 40-44 aged women considered themselves being infertile or sub-fertile (because they could not obtain a pregnancy in the past 2 years, even though they wanted to become pregnant and did not use contraception). Even though national statistics based on medical diagnosis of infertile women are not available, experts in this field estimate that approximately 10% of the reproductive age couples are affected in different degrees.

FAMILY PLANNING – General Aspects

DEFINITIONS

Family Planning defines the individual's or the couple's capacity to anticipate and to have the desired number of children, at the time they want and at the optimal births spacing intervals establish by themselves. This can be accomplished by using contraceptive methods and treatment of involuntary infertility.

Reproductive Health (RH) is defined by WHO as a physical, mental and social state of well being regarding all aspects of the reproductive system, in all human life stages. As a consequence, RH implies a satisfying and safe sexual life, possibility of reproduction, as well as the liberty of deciding when, if and how often individuals/ couples want to procreate; RH includes the women and men's rights to be informed and to have access to safe, efficient, accessible and acceptable family planning methods which they can choose on their own, as well as the right to having access to adequate medical services which allow woman to go safely through the pregnancy and delivery stages.

Sexual Health represents the physical, emotional, mental and social state of well being regarding sexuality, and not only the absence of an illness, dysfunction or infirmity. Sexual health implies a positive approach of sexuality and sexual relations based on mutual respect, as well as the possibility of having safe and pleasant sexual experiences, without coercion, discrimination and violence. (WHO)

FAMILY PLANNING SERVICES OBJECTIVES

Family Planning services have the following objectives:

- facilitating the individual/couple decide whether and when to have children
- prevention of unwanted pregnancies, abortion and child abandonment
- identifying the individual's personal needs for making an informed choice of a contraceptive method
- ensuring the correct and safely use of the chosen contraceptive
- prevention of sexually transmitted infections (STIs)
- prevention and early detection of cervical and breast cancer
- maintaining/ improving the quality of the couple's life

FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES

The following services are included within the family planning:

- providing information regarding family planning and contraception methods
- providing contraceptive supplies
- counseling for family planning methods
- evaluation of the health status for the use of a contraceptive method
- monitoring use of contraceptive methods
- diagnosis, counseling and management of side-effects of contraceptives
- diagnosis pregnancy
- pre- and post-abortion counseling
- premarital counseling

- prevention of cervical and breast cancers
- prevention of sexually transmitted infections
- counseling for sexually transmitted infections
- diagnosis (and treatment) of sterility
- diagnosis of genetic disorders
- counseling for couples with genetic problems
- psycho-sexual counseling
- counseling for the cases of domestic violence and sexual abuse
- education for sexual and reproductive health

FAMILY PLANNING BENEFITS

For children:

- Wanted children are better cared, better fed, better educated, healthier
- Decrease of morbidity rate due to premature births, "small for date" babies and decrease of the infantile mortality rate with minimum 20% if the interval between births is of minimum 2 years
- Decrease in the rate of morbidity through respiratory infections and acute diarrheic diseases rate due to malnutrition
- Breastfeeding protects children from diarrhea and other infectious diseases

For women:

- Decrease in the number of abortions upon request and empirical abortions, thus in the maternal morbidity and mortality rates as well
- Drop of the maternal morbidity and mortality rate through optimal births spacing interval
- Reduction of problems regarding pregnancy and birth
- Prevention of diseases: ectopic pregnancy, ovarian and endometrial cancer, ovarian cysts, breast nodules, heavy menstrual bleeding and secondary anemia, dysmenorrhea
- Prevention of Sexually Transmitted Infections
- Improvement in the quality of the couple's life

For men:

- Prevention of Sexually Transmitted Infections
- Improvement of the couple relationship
- Increased work efficiency

For families:

- Harmonious couple life
- Raised educational/ professional opportunities
- Choosing the adequate moment for having wanted children, which will be better cared
- Reduction of expenses for medicines, medical services in the case of abortion and complications of unwanted pregnancies

For communities:

- Prevention of child abandonment in maternities and hospitals –allow using of money for other community/ budget goals

- Decrease in the number of unwanted children and thus the decrease in the need for institutionalization
- Maintaining a good health status allows people to use their professional potential
- Redistribution of funds which are not used for avoidable health issues, to other community needs.

For health professionals/medical staff:

- Better health status of women and children through optimal births spacing interval
- Better health status of women and men through prevention of sexually transmitted infections, cancer
- Wanted children are better cared, thus lower medical assistance needed
- Offering preventive services will save time, through reduction of morbidity and improvement of the assisted population's health status.

The Evolution of the Demographic Indicators in Romania and Europe

Demographic Data selected for Europe, European Regions and for Romania
(Source: Population Reference Bureau, 2002 data)

Country/ Region	Birth Rate (annual number of births/ 1000 inhabitants)	Mortality Rate (number of annual deaths/ 1000 inhabitants)	Infantile Mortality Rate (infantile deaths/1000 live births)	Maternal Mortality Rate (maternal deaths/ 1000 live births)	The rate of modern contraceptives used by married women, 15-49 years of age (%)	The attitude of mothers towards the infant, % of unwanted children
Europe	10	11	8	28	52	Na
Northern Europe	11	10	5	Na	67	Na
Western Europe	11	9	5	Na	73	Na
Southern Europe	10	9	6	Na	47	Na
Eastern Europe	9	14	13	Na	42	Na
Romania	10	12	18,4	60	30	46,5

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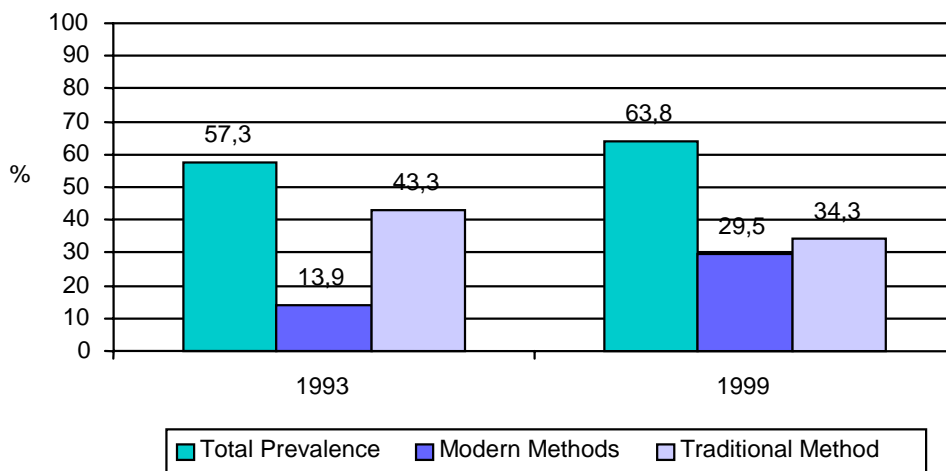
Study on the reproductive Health in Romania (1999)

According to the data contained in the study, completed on a sample representative for the reproductive aged population in Romania, formed by women with ages between 14-44 and men with age from 15 to 49:

- almost all the population (99%) has heard about at least one modern contraceptive method;
- approximately 92% of the population has heard about the IUD; 55% of these know how it is used;
- 23,3% of women and 22,8% of men in Romania use modern contraceptive methods;
- 58% of the women and 52% of the men that are either married or cohabiting together without being legally married do not want any more children.

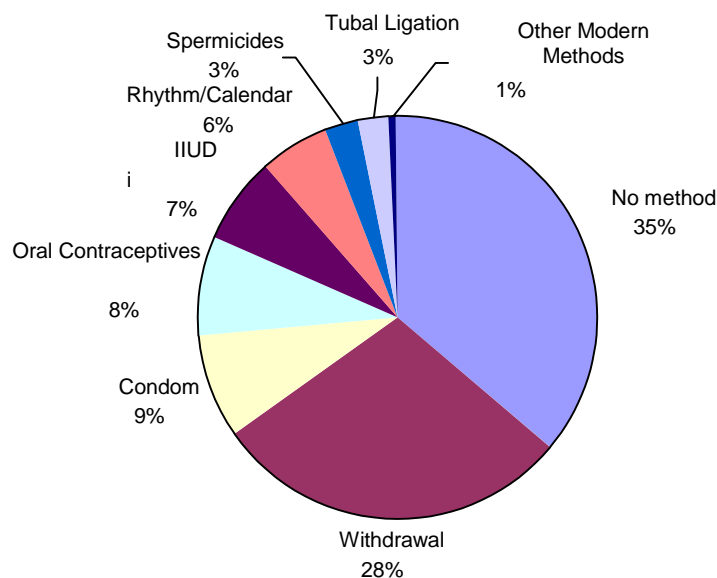
- 72% of the women and 61% of the men would like to receive more information regarding the contraceptive methods.

The evolution of the rate of the contraception's prevalence in women of reproductive ages (15 and 44 years), married or in consensual relationship with men in Romania is depicted in Figure 1.



Graph 1. Evolution of prevalence rates of contraception in women of reproductive ages (15-44 years), married or in consensual relationship with men
Source: SSRR¹, 1999

The structure of the contraceptive methods used is shown in Graph 2



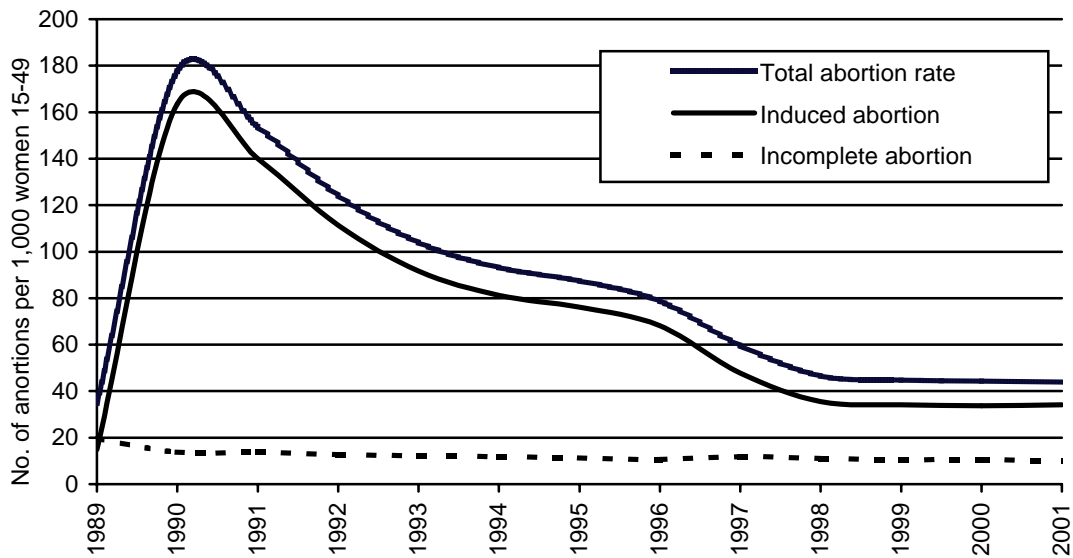
Graph 2. Distribution of Contraceptive Methods Use (Method Mix)
Source: SSRR, 1999

¹Serbanescu F. and collaborators, 2001, *Study Regarding the Reproductive Health in Romania, 1999: Final Report*, Bucharest and Atlanta: The Romanian Public Health Association and Sanitary Management, "Carol Davila" Medical and Pharmaceutical University, Bucharest, The National Statistic Commission and the Control and Prevention of Diseases Center, Atlanta GA, USA.

Abortion and Services for Pregnancy Termination in Safety Conditions

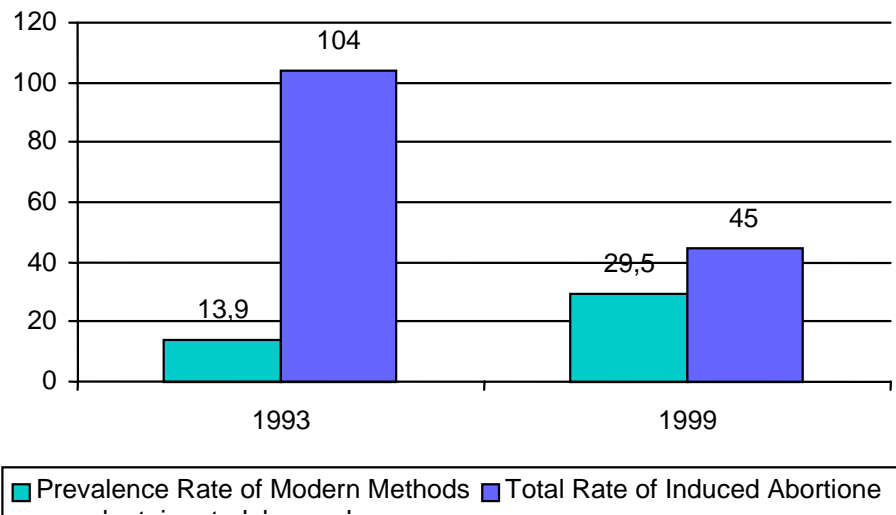
The abortion evolution in the last ten years is decreasing, from 2.34 abortions per born alive infant in 1993, to 1.16 abortions per born alive infant in 2001. The largest number of abortions

has been recorded within the 20-34 age groups. The evolution recorded in the past 10 years of the incidence of abortions (15-49 age groups) is shown in Figure 3.



Graph 3. Abortion Rate evolution between 1989 – 2001 (Source: CCSSDM/ MOHF)

Graph 4 emphasizes the marked drop of the induced abortion rate (at less than half) in parallel with the clear rise of the use of modern contraceptives (over double).



Graph 4. Reduction of Induced Abortion Rate in parallel with the Rise of Use of Modern Contraceptives (Source: CCSSDM/ MOHF and SSRR, 1999)

Safe Motherhood – pre-natal care, safe delivery, post-natal care and breastfeeding

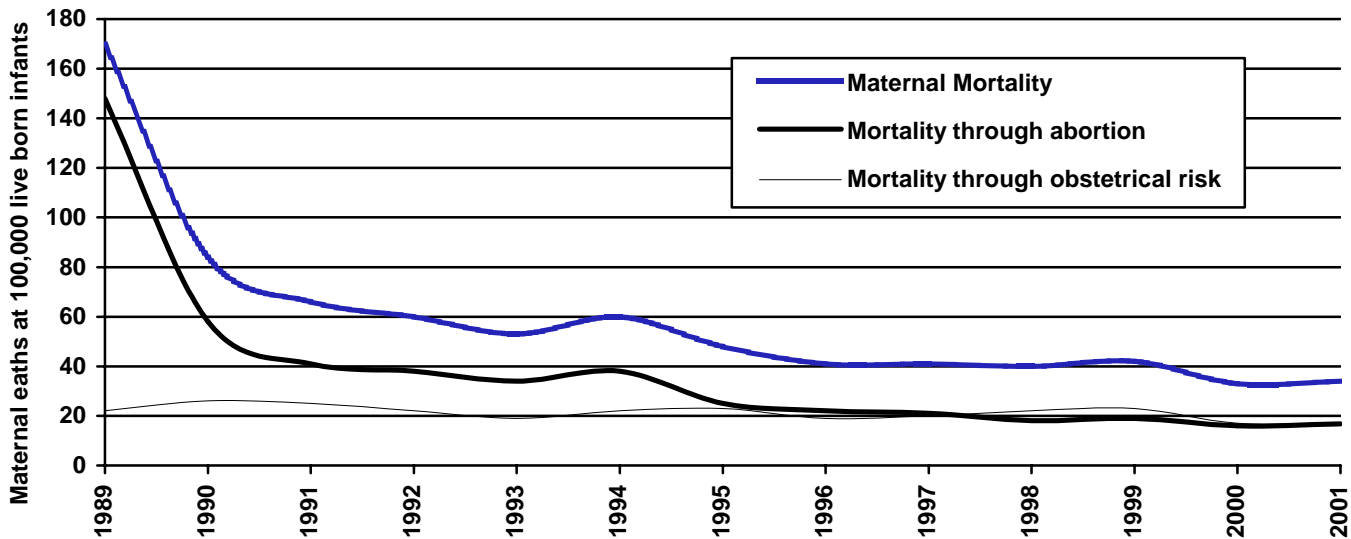
- approximately 20% of the pregnant women which have given birth in 2001 have not been registered during their pregnancy;

- approximately 60% of the registered pregnant women have benefited from the first visit to the doctor in the first trimester of pregnancy;
- the average number of the pre-natal visits in registered pregnant women included is 5
- in the 2001 year maternal mortality registered in Romania was 34 deaths/100,000 live born, out of which:

16.8 deaths/100,000 live born due to abortions

17.2 deaths/100,000 live born due to obstetrical causes

After 1990, a significant drop in the maternal mortality rate can be noticed, through the drastic reduction (of approximately 8 times less) of the maternal mortality through abortion, due to legalization of abortion upon request and due to contraception (Figure 5).



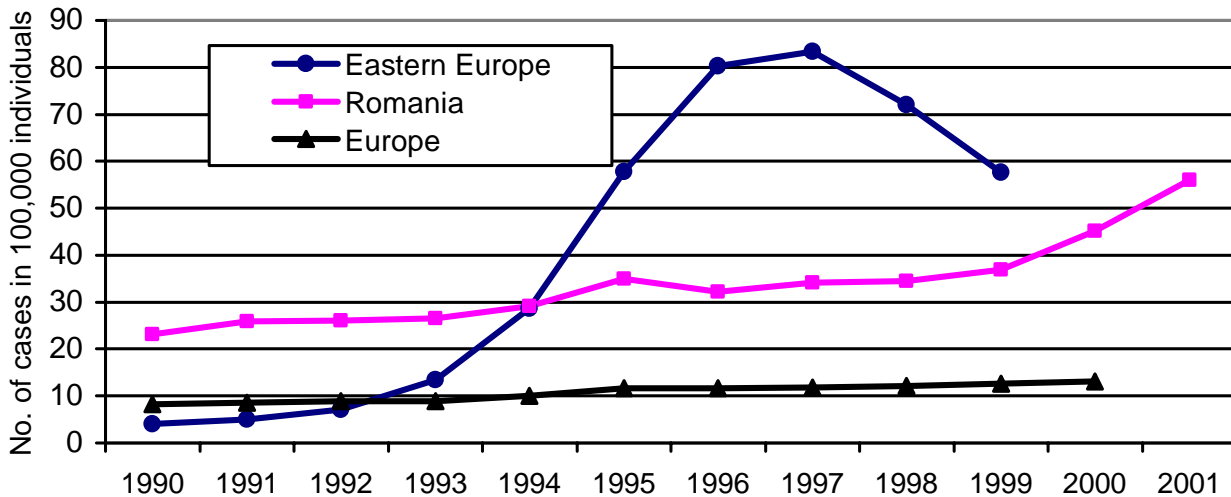
Graph 5. Evolution of Maternal Mortality between 1989 and 2001 (Source: CCSSDM/ MOHF)

Prevention and Management of Sexually Transmitted Infections (STIs), Including HIV Infection / AIDS

- in 2001, the incidence rate of Syphilis has been of 56.0 cases in 100,000 individuals, out of which 97% have been recent cases (53.9 in 100,000 individuals).
- the incidence of Syphilis has registered a continuous increase between 1990-2001; in 2000 and 2001 years, the incidence rate of Syphilis increase, both total, as well as recent Syphilis, being with at least 20% greater compared with the previous year;
- the incidence of Syphilis cases is greater in urban areas rather than in rural areas, in men and in young ages (20-24 years and 25-29 years), followed by 15-19 years old teenagers;
- on September 30th 2002, the total number of cumulated HIV/ AIDS cases registered was 13,279, out of which 9,928 people infected with HIV/ AIDS were still alive, approximately 75% of these being children;
- in 2001, the rate of deaths by HIV/ AIDS has been of 2.2/100,000 inhabitants, with an HIV/ AIDS incidence of 1.64/100,000 inhabitants;
- the principal way of transmission of HIV infection/ AIDS was heterosexual way (57%), while the clearly determined transmission through sharing syringes in the

case of injectable drugs had the smallest balance (0.1%), even though a growth in the balance of this way of transmission of the infection is anticipated in the future;

- the number of children diagnosed with AIDS is dropping: between 1991 – 1998, approximately 400 – 500 new cases per year have been registered; in 1999, 255 new cases have been registered, in 2000, other 290 cases; in 2001, 166 new cases have been diagnosed in children under 14 years (125 HIV infections and 36 AIDS cases), out of a total of 267 new HIV/ AIDS cases;
 - in children, the main way of transmission is nosocomial way (51.6); transmission from mother to child was incriminated in 5% of the cases; and for 26.7% of the cases the way of transmission was not determined or unknown;
 - 90% of the persons interviewed by SSRR are aware of the protective effect of condom use;
 - 75% of the women and 69% of the men do not consider themselves to be at risk of infection with HIV;
 - approximately 10% of the people with ages between 15-49 use condoms.



Graph 6. Evolution of Incidence of Syphilis (all forms) during 1990 – 2001 in Romania comparative with the average for Europe and Eastern Europe (Source: CCSSDM/ MOHF)

Reproductive and Sexual Health in Teenagers and Young People

- most teenagers know about the risk of sexual transmitted infections (source: SSRR, 1999);
- in 1991, the average age at the first intercourse was 19.5 years, decreasing in comparison with 1993, when the average age was 20.5;
- half of the young people use a contraceptive methods; 23% use a modern method and 27% use a traditional contraceptive method;
- 40% of the young women and 25% of the young men have correct knowledge of the menstrual cycle;
- 34% of the women and 86% of the men under 24 year sexual active, report having two or more sexual partners;

- proportion of women starting their sexual life before 20 is 56%, while 80% of the men start their sexual life before this age.

Sexual Health of the Elderly

The dysfunctions caused by menopause can have long-term effects (e.g. women which are at menopause are at risk for osteoporosis). The unpleasant effects of the menopause can be avoided by adequate hormone replacement therapies.

Early Detection and Management of Genital and Breast Cancer

- breast and cervical cancer constitute the first two causes of mortality through cancer in Romanian women, both registering a tendency of growing in the last years;
- in 2001, approximately 17% of the deaths occurred in women through cancer have been caused by breast cancer (the raw mortality rate – 26.2/100,000 women), and 1,763 of the deaths have been caused by cervical cancer (15.4/100,000 women);
- in 1999, 4,373 new breast cancer cases have been registered among women (22% of the new cancers in women) and 3,001 new cervical cancer cases (14%);
- most women are diagnosed in late stages, when the healing chances are reduced, the education of the population playing an essential role in amending this situation:
- in 1999, under 10% of the new cases have been diagnosed in early stages (stages 0 or I), while 45% of the cases were in stages III-IV at the moment of diagnosis, in the conditions in which in Romania the quality of registering the cancers is still showing a deficit (e.g. for 23.7% of the new breast cancer cases data regarding the stages of the disease at the moment of the registration cannot be provided);
- in 1999, 4% of the cervical cancer cases were “in situ” (early stages), approximately 33% of the cases were within stages III and IV at the moment of diagnosis (for 23% of the new cases, data regarding the stage at the moment of discovery are not available.);
- the main problems are the increased incidence and mortality through cervical cancer (in 2000, the standardized mortality rate through cervical cancer was the highest in Europe), and the diagnosis in advances stages for both of the mentioned types of cancer.

Infertility Prevention and Management

The 1999 Reproductive Health Study has also investigated aspects linked to the perception of infertility in women aged from 15 to 44. Results indicate the fact that 4.4% of the women between 15-19 years, 2.4% of the 20-24 aged women, 6.5% of the women with ages between 25-29, 12% of the 30-34 years old women, 21.3% of the women with ages between 35-39 and 35.8% of the 40-44 aged women considered themselves being infertile or sub-fertile (because they could not obtain a pregnancy in the past 2 years, even though they wanted to become pregnant and did not use contraception). Even though national statistics based on medical diagnosis of infertile women are not available, experts in this field estimate that approximately 10% of the reproductive age couples are affected in different degrees.

Session 3: Reproduction and Fertility

Objectives:

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

- Describe the menstrual cycle and the physiological modifications in its different stages.
- Describe the mechanism of pregnancy apparition.

Time: 50 min

Techniques: Exercises, presentation

Materials:

Flipcharts/Overheads

- 3.1 Menstrual cycle chart
- 3.2 FSH and LH
- 3.3 Ovarian hormones
- 3.4 Withdrawal bleedings

Trainer's documents

- 3.1 Cards containing elements of the menstrual cycle
- 3.2 Menstrual cycle – presentation

Handouts

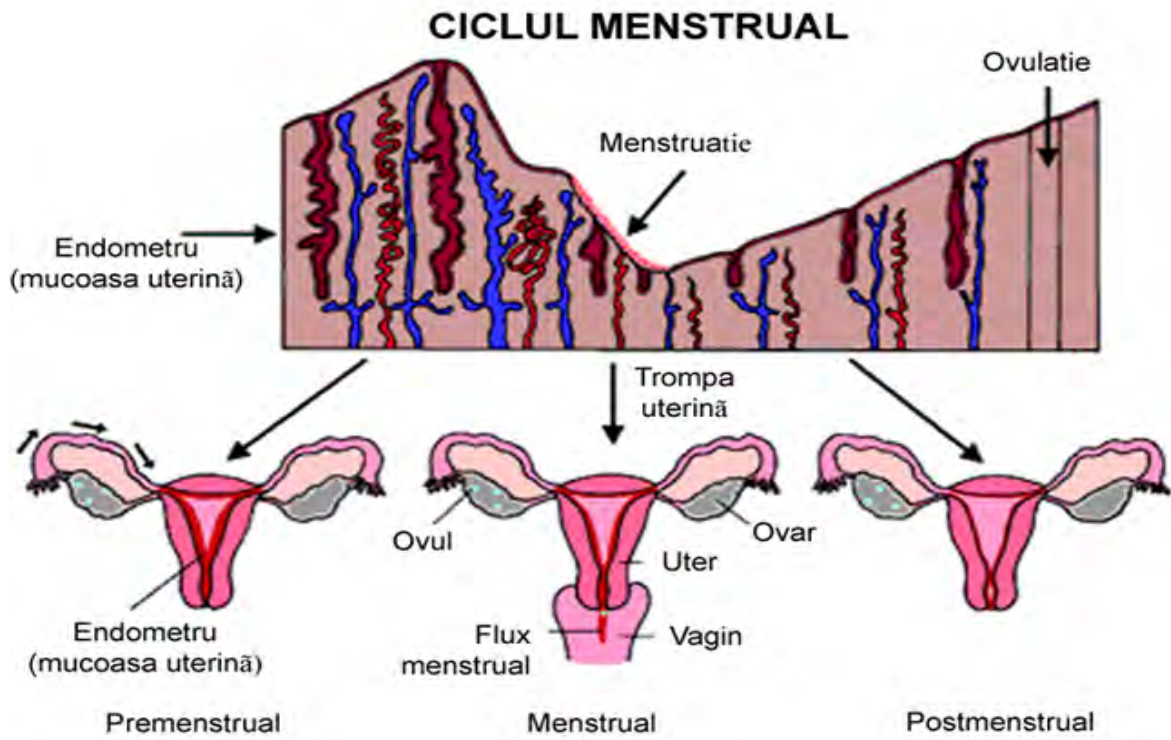
- 3.1 Menstrual cycle – presentation
- 3.2 Effects of the female sexual hormones
- 3.3 Menstrual cycle chart
- 3.4 Withdrawal bleeding

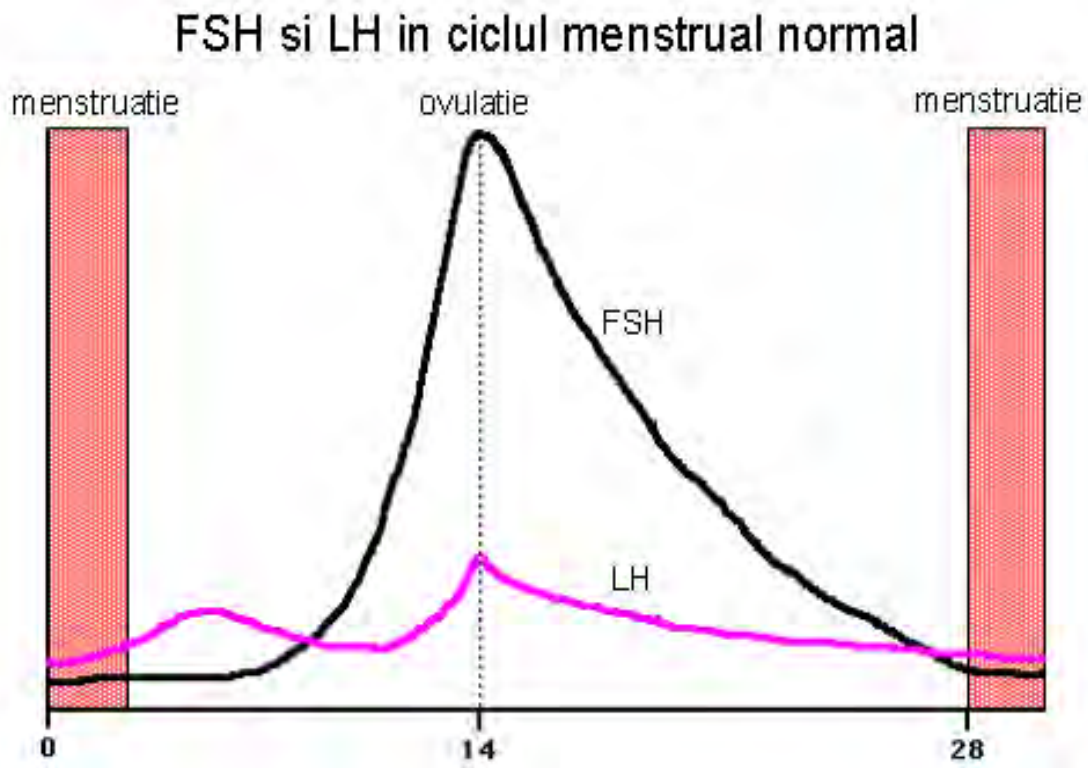
Activities: Reproduction and Fertility (50 min)

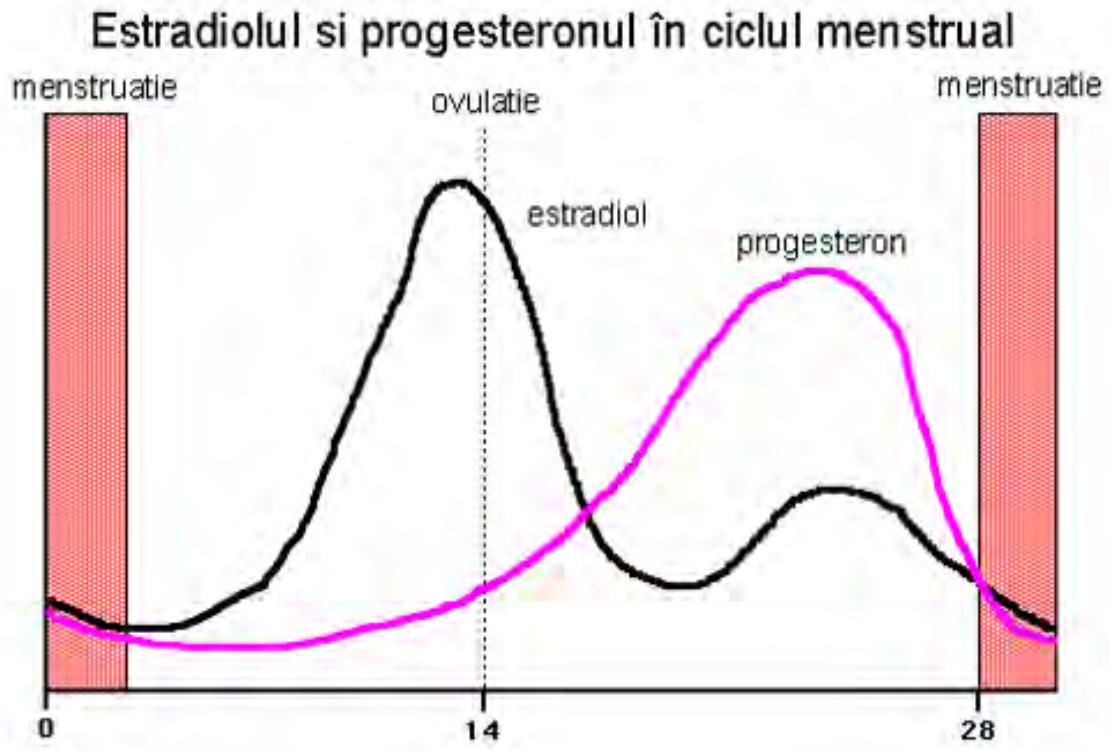
- Divide participants into groups of 3 or 4. Give each group a set of cards with elements of the menstrual cycle.
- Explain to the groups the fact that the exercise consists of ordering the cards on a flipchart paper sheet as to form the menstrual cycle moments. State the fact that they have 10 minutes to complete this.
- Meanwhile the groups are working, the two trainers move along from one group to the other, in order to make sure that the participants have understood the exercise.
- After 10 minutes, ask the groups to nominate a person to present their results. After the presentation, the paper sheet is returned the group. The whole presentation of the groups should not last more than 10 minutes.
- Post the following flipcharts/project overheads individually: 3.1 "**Menstrual cycle chart**", 3.2 "**FSH and LH**", 3.3 "**Ovarian hormones**", 3.4 "**Withdrawal bleedings**" and explain the mechanism of action of the female sexual hormones.
- Present the mechanism of pregnancy apparition. Explain the way in which different contraceptive methods action, preventing apparition of pregnancy.(15 min)

- Ask participants to return to the initial groups and to make corrections on their papers, as necessary.
- The two trainers move along from one group to the other in order to make sure that all necessary corrections have been made. (15 min)
- At the end of the session, distribute the handouts: 3.1 ***“Menstrual cycle”*** and 3.2 ***“Effects of female sexual hormones”***.

Menstrual Cycle Chart

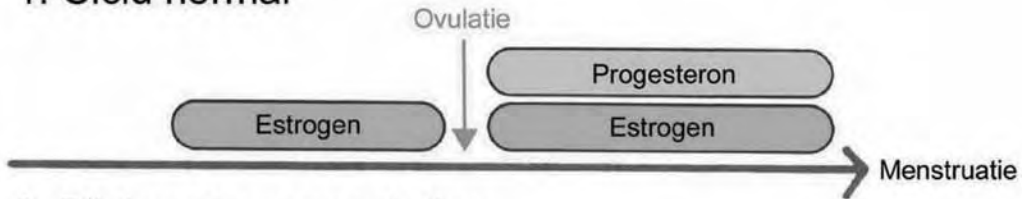




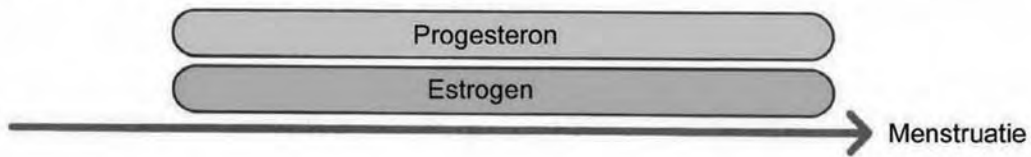


Hemoragie de privatie

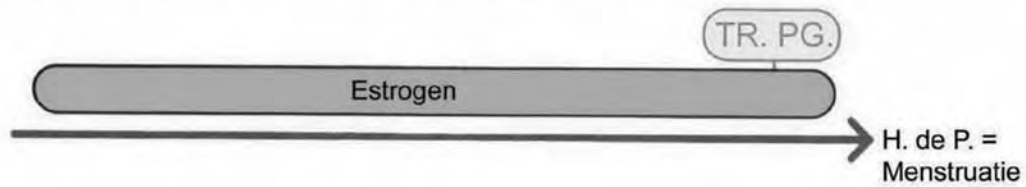
1. Ciclu normal



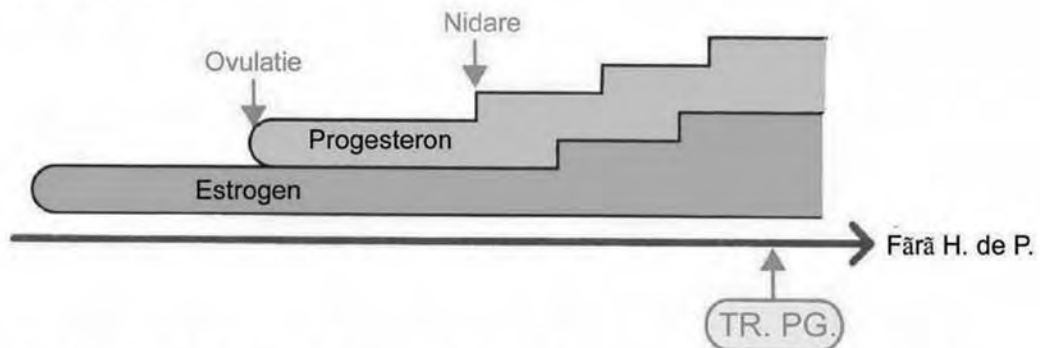
2. Pilule esto-progestative



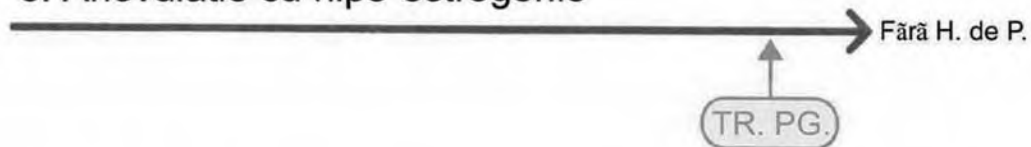
3. Anovulatie + secreție prelungită de estrogeni



4. Sarcină



5. Anovulatie cu hipo-estrogenie



TR. PG.: Tratament progestativ
 H. de P.: Hemoragie de privatie

Menstrual Cycle Presentation Exercise

The groups of participants receive a set of cards previously prepared, which they stick on an A0 sheet of paper as to form the sequence of the menstrual cycle phases; give Day 1, Day 14 and Day 28 of the menstrual cycle as guiding points.

(It is preferable to have small work groups, to avoid the risk that only one or two persons to work, the rest of the group not being active; it is ideal the work to be done in groups formed of few people)

Remember: For each workshop you must prepare a sufficient number of sets of cards!

DAY 1

DAY 14

DAY 28

THICK MUCUS

T= 36.6

ABSENT MUCUS

T= 37.1

FILANT MUCUS

REDUCED FSH

INCREASED FSH

ESTROGEN ↑

PROGESTERONE ↑

ESTROGEN ↓

PROGESTERONE ↓

OVULATION

SECRETORY PHASE

LH PEAK

PROLIFERATIVE PHASE

MENSTRUAL CYCLE

Menstrual cycle implies organs situated at 3 levels:

- I. **Hypothalamus-Hypophysis Axis** – release the hypophysis hormones:
 - FSH which stimulates the growth and the development of ovarian follicles (first half of the menstrual cycle)
 - LH released at the middle of menstrual cycle (LH peak), causes ovulation and maintains the corpus luteum in the second half of the menstrual cycle
 - Prolactine ensures the development of breasts during pregnancy, causes and maintains lactation, inhibits ovulation during breastfeeding

- II. **Ovaries** – sensitive to the action of pituitary hormones, produce sexual hormones (At birth, girls have approximately 400,000 ovarian follicles in the 2 ovaries, out of which approximately 250-300 will reach maturity during the ovarian activity period.)
 - In the first part of the menstrual cycle an ovarian follicle is developed which contains an ovule and secretes a greater and greater quantity of estradiol (folliculine)
 - At the middle of the menstrual cycle, under the effect of LH, the follicle expulses the ovule (ovulation), then it transforms into corpus luteum
 - In the second part of the menstrual cycle, corpus luteum secretes estradiol and progesterone; it has a 14 days life period

- III. **Receptors:** genital tract, breasts
 - Uterus
 1. The uterine body and the endometrium
 - In the first half of the menstrual cycle the endometrium proliferates under the action of the estradiol
 - In the second part of the menstrual cycle
 - the corpus luteum is still secreting estradiol, but the endometrium suffer transformations under the action of progesterone
 - secretion of the endometrial glands appears (secretory endometrium)
 - endometrium becomes adequate for implantation (impregnation with progesterone reaches its maximum between days 20 and 24 of the menstrual cycle; this is the moment when the fertilized ovule reaches the uterine cavity)
 2. The uterine cervix
 - In the first half of the menstrual cycle, under the action of estradiol, the cervical mucus becomes more and more abundant, more transparent, more filant and more adequate for the penetration of the spermatozoa
 - In the second part of the menstrual cycle, under the effect of the progesterone, the cervical mucus thickens and becomes unfitting for the progression of the spermatozoa (and micro-organisms – natural protection mechanism for a possible product of conception)
 - Breasts
 - Develop during puberty and during pregnancy and lactation
 - Towards the 7th day of the menstrual cycle, a proliferate activity of the ducts begins (Estradiol develops the galactopherous ducts)
 - In the second part of the menstrual cycle a proliferate activity of the glandular acini appears, under the action of progesterone
 - At the end of the menstrual cycle an edema of the stroma appears which will regress once with the menstruation.

Menstrual cycle develops on an approximately 28 days period, divided into 3 periods:

- I. Pre-ovulation phase** or the follicular or proliferative phase, with a variable duration
- II. Ovulation phase** or the intermediary phase (1 day)
- III. Post-ovulatory phase** or the follicular-luteal or secretory phase, with a relatively constant duration of 14 days, the same duration as the corpus luteum.

Mechanism of Menstruation:

If the fertilization and the implantation of the egg have not been produced, the corpus luteum will atrophy within 14 days.

Estradiol and progesterone are no longer secreted; the endometrium is no longer stimulated and detaches itself.

The significance of the apparition of menstruation:

1. The integrity of the hypothalamus-pituitary-ovarian-uterine axis
2. Absence of pregnancy (e.g. the an-ovulate cycles, the uterine synechie)

The significance of amenorrhea:

1. Pregnancy
2. Disturbances of the hypothalamus-pituitary-ovarian-uterine axis (e.g. the an-ovulate cycles, the uterine synechie).

Essential Conditions for Apparition of Pregnancy:

1. Sufficient number of **Spermatozoids** (between 400 and 100 million within a normal ejaculation) and good biologic quality (mobile, without histological alteration)
2. **The Cervical Mucus** – modified so that it facilitates the penetration of the spermatozoa
3. Ovulation = release of a mature **ovule**, ready for fecundation
4. Permeable **Fallopian Tubes**, with normal peristalsis
5. Receptive **endometrium**, ready to receive the egg and to allow implantation

If one condition is not fulfilled out of the ones listed above, the pregnancy cannot appear.

MENSTRUAL CYCLE

Menstrual cycle implies organs situated at 3 levels:

IV. Hypothalamus-Hypophysis Axis – release the hypophysis hormones:

- FSH which stimulates the growth and the development of ovarian follicles (first half of the menstrual cycle)
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- V. Ovulation phase** or the intermediary phase (1 day)
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7. **The Cervical Mucus** – modified so that it facilitates the penetration of the spermatozoa
8. Ovulation = release of a mature **ovule**, ready for fecundation
9. Permeable **Fallopian Tubes**, with normal peristalsis
10. Receptive **endometrium**, ready to receive the egg and to allow implantation

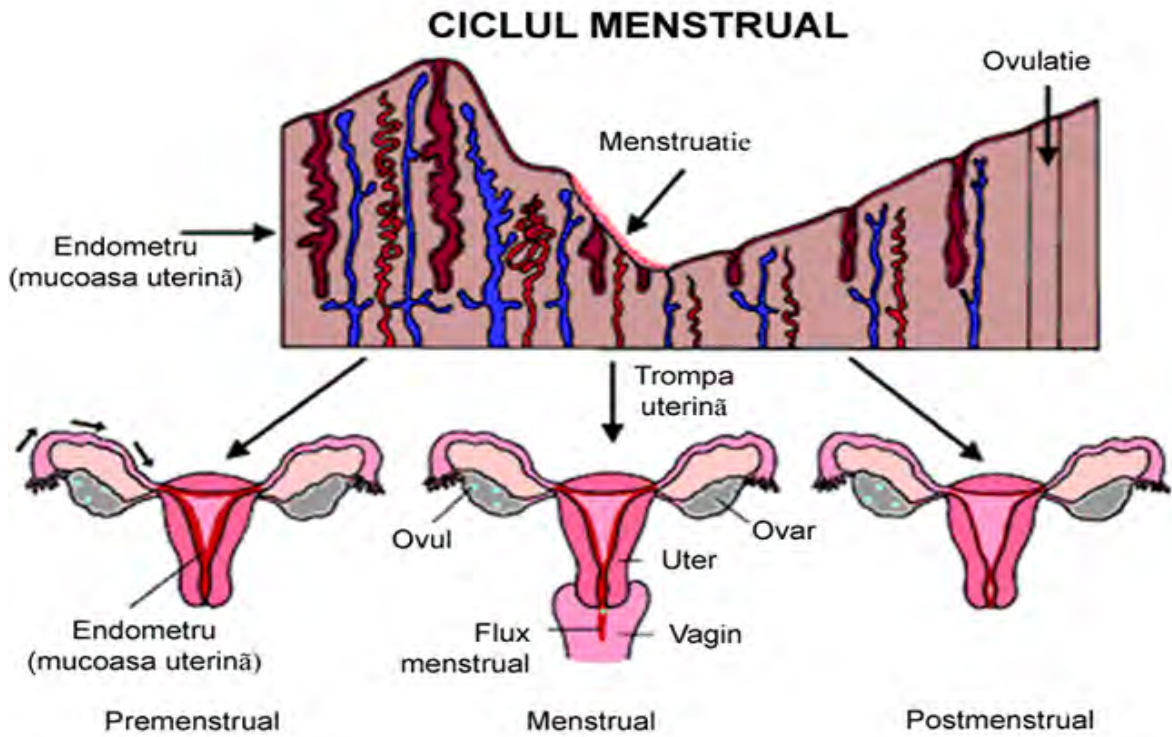
If one condition is not fulfilled out of the ones listed above, the pregnancy cannot appear.

ESTROGEN EFFECTS

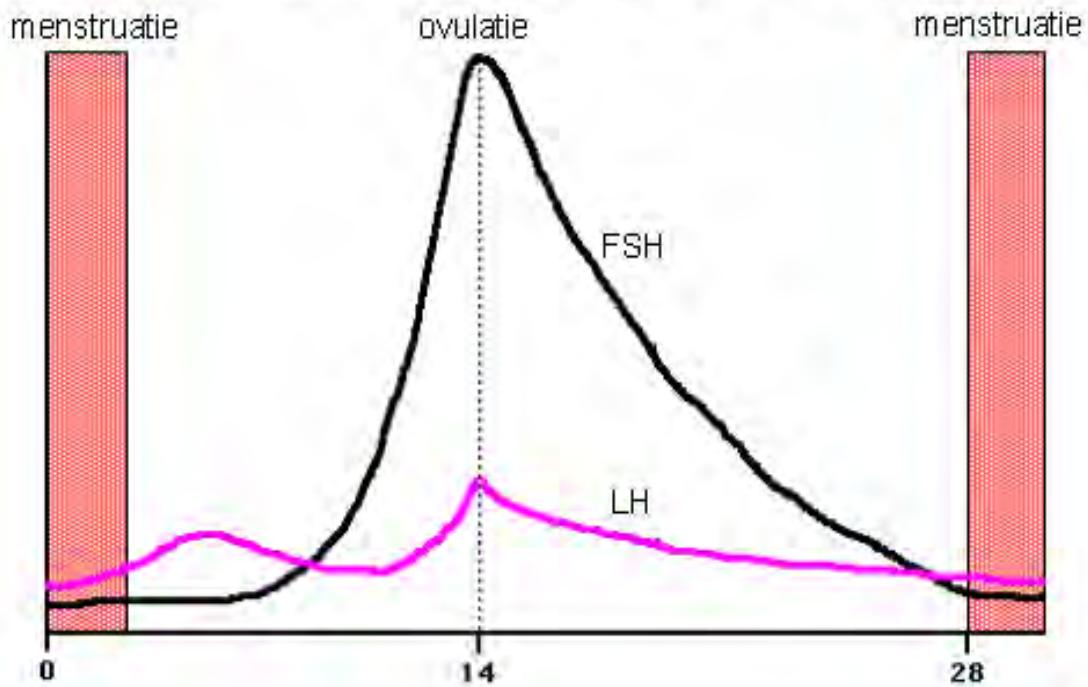
- Development of the secondary female characters
- Control of the menstrual cycle
- Regeneration and proliferation of the endometrium in the first half of the menstrual cycle
- Relaxation of the external ostium of the uterine cervix and stimulation for the production of a filamentous cervical mucus, which facilitates the penetration of the spermatozoa
- Hypertrophy and growth in the muscular motility of the genital system
- Approach of the uterine tubes fringes to the ovarian follicle, facilitating the reception of the ovule
- Possible influence on the libido through direct action on the hypothalamus
- Effects on the breast (breast tension due to proliferation of the lactiferous ducts)
- Alteration in the metabolism of electrolytes, proteins and lipids
- Weight gain due to hydro-saline retention

PROGESTERONE EFFECTS

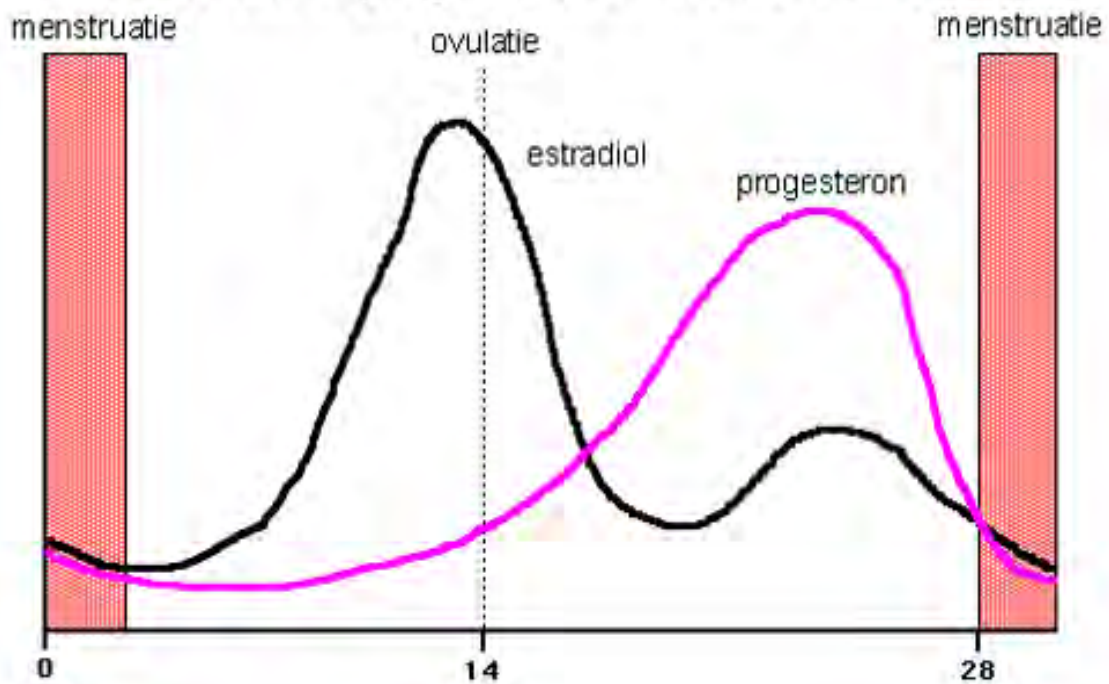
- Transformation of the endometrium during the secretory phase and preparation for implantation
- Production of a thick, viscous cervical mucus which inhibits the penetration of the spermatozoa and of the microorganisms
- Modification of different estrogen-induced responses, which favors implantation and maintaining the pregnancy
- Rise of the body base temperature (from ovulation until around the onset of the next menstruation)
- Effects on the breasts (development of the glandular acini cells)
- Alteration of the carbohydrates metabolism (decrease in tolerance towards corporal weight gain through the growth of the fat tissue) – individual, reversible receptivity



FSH si LH in ciclul menstrual normal

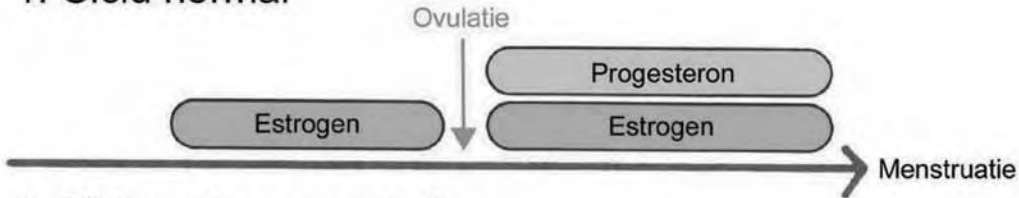


Estradiolul si progesteronul în ciclul menstrual

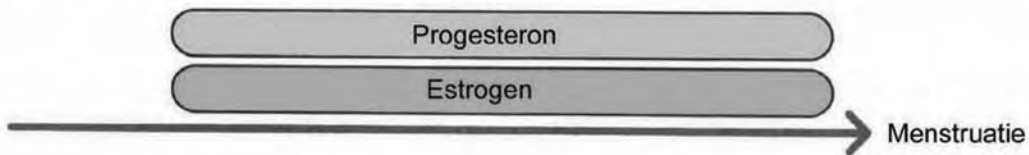


Hemoragie de privatie

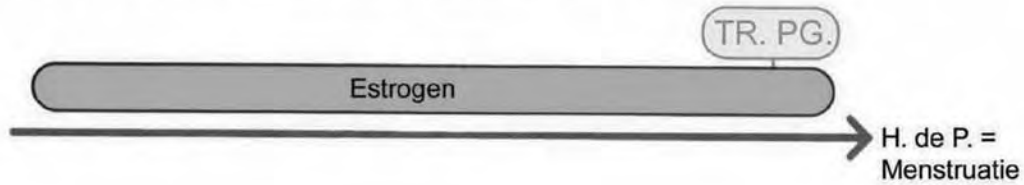
1. Ciclu normal



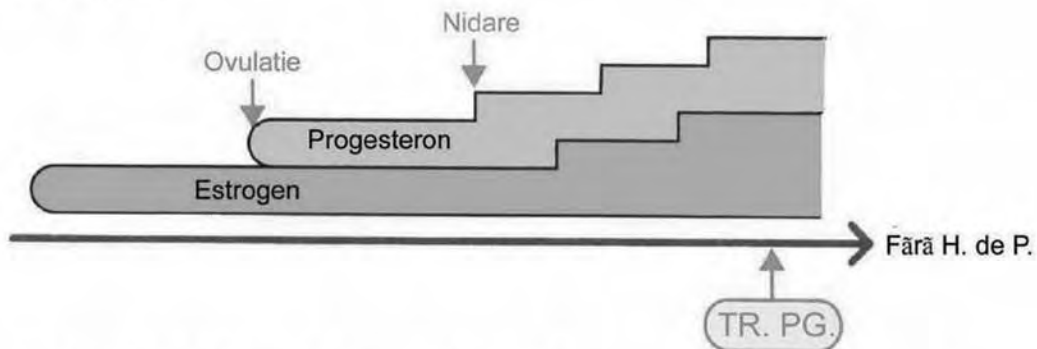
2. Pilule estro-progestative



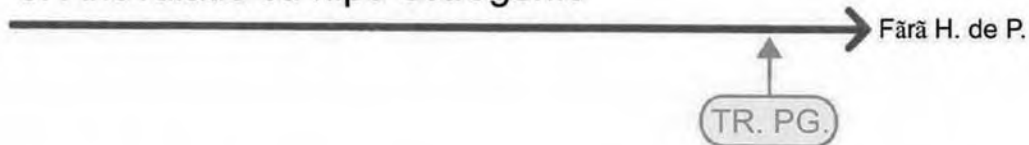
3. Anovulatie + secreție prelungită de estrogeni



4. Sarcină



5. Anovulatie cu hipo-estrogenie



TR. PG.: Tratament progestativ
 H. de P.: Hemoragie de privatie

Session 4: Contraception – Overview

Objectives:

At the end of this session, participants:

- Will list the features of the ideal contraceptive
- Will list the available contraceptive methods
- Will order the contraceptive methods according to their efficiency
- Will recognize the WHO classification criteria

Time: 40 minutes

Techniques: Brainstorming, listing, presentations

Materials:

Flipcharts/Overheads

- 4.1 Efficiency of the contraceptive methods
- 4.2 Eligibility criteria for contraceptive methods

Trainer's documents

- Contraceptives presentation kit

Handouts

- 4.1 Efficiency of the contraceptive methods
- 4.2 Family Planning methods
- 4.3 Categories of classification for contraceptive methods established by WHO
- 4.4 "Medical Eligibility Criteria for Contraceptives Use" WHO Guide

Activities:

1. The Ideal Contraceptive (10 min)

- Initiate a brainstorming concerning the ideal contraceptive. Explain participants that their statements should not contain more than 3 words and must be as spontaneous as possible. Also, mention the fact that none of the statements will be commented. Note the answers on the flipchart. When the idea flow is decreasing, start processing the exercise: if there are any statements that seem unclear, request additional clarifications from the person which has had the idea. *(None of the stated ideas will be excluded).*
- Place the obtained list on the wall in a visible place *(Attention! This list must be permanently kept on the wall, so that each contraceptive method will be compared with the ideal contraceptive).*

2. Contraceptives: Generics (15 min)

- Make a list of contraceptive methods, by the help of participants. Make sure that all methods are listed. Place the list on the wall.

- Write a few contraceptives classification criteria (traditional/modern, efficiency, mechanism of action).
- Ask participants to go through the list of the mentioned methods and to classify them according to the first listed criteria, then do same thing for the second and third criteria.
- As a conclusion, state the fact that contraceptive methods can be classified according to several different criteria.
- Mention the FP methods which will be discussed during the workshop.
- Specify which of these methods are available in Romania and which are the contraceptive methods that participants will distribute.
- Explain the difference between the efficiency of the method in common use and the theoretical efficiency. (Efficiency = the percentage in which a contraceptive method ensures prevention of pregnancy; Pearl index = the pregnancy prevention percentage/ 100 users at continuous and correct use / 12 months).
- Post on the flipchart: "Efficiency of the Contraceptive Methods".

3. Medical Eligibility Criteria for Contraceptives Use (15 min)

- The co-trainer distributes to participants copies of WHO Guide: "**Medical Eligibility Criteria for Contraceptives Use**"
- Allow few minutes to participants to go through the material.
- Tell participants that this guide is structured in such a manner that it is easy to use: in the first part each contraceptive method is presented compared with different physiological and pathological states, so that, in the final part, within the summarization, all physiological and pathological states will be individually listed compared with each contraceptive method. The charts which can be found at each type of contraceptive method are easy to go over, as they provide important clues for the use of the method by the client in harmless conditions.
- Tell participants that they will find at page 8 of the WHO Guide, the material: **Categories of Classification**. Post on the flipchart: **Categories of Classification**. Present each category.
- Ask a volunteer to read the definition of First Category. Ask what this definition means. Specify the fact that in this situation, there are no risks associated with the use of the contraceptive method.
- Ask a volunteer to read the definition of The Second Category. Ask what this definition means. Specify the fact that in this situation, the risks associated with pregnancy (the carriage and delivery, as well as the termination of pregnancy) exceed, in importance, the risks associated with the use of the method. Second Class means that the method may be used, but it needs a more careful surveillance of the client's health status.
- Ask a volunteer to read the definition of The Third Category. Ask what this definition means. Specify the fact that in this situation, the risks associated with the use of the method exceed the benefits, they are greater than the risks associated with a pregnancy. The patient has a state for that a pregnancy already represents a major risk for her health. The chosen method

can be used by the client only in the conditions in which other methods are inaccessible or unacceptable and she needs a very close surveillance.

- Ask a volunteer to read the definition of The Fourth Category. Ask what this definition means. Specify that in this situation, the risks associated with the use of the method are unacceptable, thus the method is not to be used under any circumstances.
- Emphasize that a woman, according to her health status, can be framed in different categories for different methods.
- Explain that the use of the guide will be broadly discussed for each contraceptive method.

EFFICIENCY OF CONTRACEPTIVE METHODS

Group of efficiency	Contraceptive method
Always very efficient	<p>Norplant Implants</p> <p>Vasectomy</p> <p>Combined Injectables</p> <p>Progestagen Injectables</p> <p>Tubal Legation</p> <p>Copper IUD</p> <p>Progestagen-Only Pills (used by breastfeeding women)</p>
<p>Efficient in common use</p> <p>Very efficient in correct and consequent use</p>	<p>Lactation amenorrhea method</p> <p>Combined Oral Contraceptives</p> <p>Progestagen-Only Pills (used by non-breastfeeding women)</p>
<p>Relatively efficient in common use</p> <p>Efficient in correct and consequent use</p>	<p>Male condoms</p> <p>Coitus interruptus</p> <p>Diaphragm with Spermicide</p> <p>Methods based on awareness of the fertile period</p> <p>Spermicidal jelly</p> <p>Cervical caps</p>
Low efficiency	Absence of use of any contraceptive method

W.H.O. CATEGORIES OF CLASSIFICATION FOR CONTRACEPTIVE METHODS

W.H.O. CLASSIFICATION	DEFINITION
FIRST CLASS: method may be used in any circumstances	A state in which there is no restriction for the use of the contraceptive method
SECOND CLASS: method may be generally used	A state in which, generally, the benefits of using the method exceed the theoretical or proven risks.
THIRD CLASS: the use of the method is not recommended unless other methods are inaccessible or unacceptable	A state in which the theoretical or proven risks usually exceed the benefits provided by the use of the method.
FOURTH CLASS: the method may not be used under any circumstances	A state in which the risks of using the contraceptive method are unacceptable.

EFFICIENCY OF CONTRACEPTIVE METHODS

Group of efficiency	Contraceptive method
<p>Always very efficient</p>	<p>Norplant Implants</p> <p>Vasectomy</p> <p>Combined Injectables</p> <p>Progestagen Injectables</p> <p>Tubal Legation</p> <p>Copper IUD</p> <p>Progestagen-Only Pills (used by breastfeeding women)</p>
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<p>Relatively efficient in common use</p> <p>Efficient in correct and consequent use</p>	<p>Male condoms</p> <p>Coitus interruptus</p> <p>Diaphragm with Spermicide</p> <p>Methods based on awareness of the fertile period</p> <p>Spermicidal jelly</p> <p>Cervical caps</p>
<p>Low efficiency</p>	<p>Absence of use of any contraceptive method</p>

FAMILY PLANNING METHODS

NATURAL FAMILY PLANNING METHODS

- Lactation amenorrhea method
- Methods based on awareness of the fertile period
 - Method based on calendar
 - Method of cervical mucus
 - Method of body basal temperature
 - Sympto-thermal method

LOCAL (BARRIER) METHODS

- Condom
- Diaphragm with spermicide
- Spermicides
- Cervical cap

HORMONAL METHODS

- Combined hormonal contraceptives (estro-progestative):
 1. Combined Oral Contraceptives
 - a) Mono-phased Combined Oral Contraceptives (COC):
 - macro-dosed: over 50 mcg EE
 - normal-dosed: 35-50 mcg EE
 - mini-dosed: less than 35 mcg EE
 - b) Multi-phased Combined Oral Contraceptives:
 - Three-phased COC
 2. Combined injectable contraceptives
- Progestagen only contraceptives
 1. Progestagen Only pills PNP/ POP
 2. Injectable progestative contraceptives
 3. Hormonal implant

INTRA-UTERINE DEVICE (IUD)

- Copper IUD
- Progestative IUD

VOLUNTARY SURGICAL CONTRACEPTION

- Male / Vasectomy
- Female / Tubal Ligation

EMERGENCY CONTRACEPTION

W.H.O. CATEGORIES OF CLASSIFICATION FOR CONTRACEPTIVE METHODS

W.H.O. CLASSIFICATION	DEFINITION
FIRST CLASS: method may be used in any circumstances	A state in which there is no restriction for the use of the contraceptive method
SECOND CLASS: method may be generally used	A state in which, generally, the benefits of using the method exceed the theoretical or proven risks.
THIRD CLASS: the use of the method is not recommended unless other methods are inaccessible or unacceptable	A state in which the theoretical or proven risks usually exceed the benefits provided by the use of the method.
FOURTH CLASS: the method may not be used under any circumstances	A state in which the risks of using the contraceptive method are unacceptable.

Session 5: Natural Family Planning Methods

Objectives

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

- Describe the natural family planning methods
- List the advantages and disadvantages of the natural FP methods
- Identify the difficulties and the causes of failure in using NFP

Time: 60 minutes

Techniques: Presentation, discussions, listing

Materials:

Trainer's documents

5.1 Presentation of natural FP methods

Handouts

5.1 Presentation of Natural Family Planning Methods based on Periodical Abstinence

5.2 NFP: Advantages and Disadvantages

Activities:

1. Natural Family Planning (30 min)

- Present each natural method based on periodical abstinence (15 minutes). Emphasize the importance of:
 - 1) recognition of signs which are to be followed
 - 2) following correctly the signs of fertile period
 - 3) respecting the fertile period
- Invite participants to address questions; ask the group if any one of them knows the answer; if the answer is wrong, request other opinions. If there are more answers, precise the correct answer.
- Present the lactation amenorrhea method and the three conditions necessary in order for this method to be efficient (10 minutes).
- Ask participants what is the efficiency of this method.

2. NFP Advantages and Disadvantages (15 min)

- Divide participants into 4 groups; two groups will list the advantages of using natural methods; the other two groups will list the disadvantages.
- Explain participants the task they are assigned and mention that they have 5 minutes in order to complete it.

- During the exercise, the two trainers pass in order to make sure that they have correctly understood the task they have been assigned.
- At the end of the given time, the trainer asks one of the groups that have worked on advantages to state one advantage. Then he asks the other group that has also worked on advantages to state another advantage. This will continue alternately from one group to another (out of the two that have worked on advantages), until all the advantages identified by the two groups will be obtained. Each statement is written by the trainer on the flipchart sheet which is divided into two columns (advantages/ disadvantages). The groups which have worked on advantages are asked if they have anything else to add. If needed, provide additional information.
- The same will be done when listing disadvantages.
- Compare these methods with the ideal contraceptive.

3. Difficulties, Failure Causes in Using NFP (10 min)

- Ask participants to name the failure causes in using NFP. Write the answers on a flipchart sheet.

Expected Answers:

- The incapacity of following the signs which accompany the different stages of the menstrual cycle (lack of awareness)
 - Reduced abilities of self-exploration
 - Lack of communication in the couple
 - Lack of collaboration from the part of the male partner
- Mention the fact that you will keep the elaborated list in order to go over it within the counseling session, when together with participants, you will identify the modalities of preventing these difficulties and failure causes.
(Keep the list for the second half of the workshop, the counseling session.)
 - The co-trainer distribute the handouts: 5.1 ***“Presentation of the Natural Family Planning Methods based on Periodical Abstinence”*** and 5.2 ***“NFP: Advantages and Disadvantages”***.

PRESENTATION OF THE NATURAL FAMILY PLANNING METHODS BASED ON PERIODICAL ABSTINENCE

The fertile phase is that interval of the menstrual cycle in which the woman can become pregnant. Identifying the fertile period (the moment in which the fertile phase of the menstrual cycle begins and the moment in which it ends) can be done in various ways:

- **Calculation based on the calendar of the menstrual periods (Method based on Calendar)**

Woman needs to keep an evidence of her menstrual cycles over a period of minimum 6 months. The first day of the menstrual cycle is the day in which the menstrual bleeding occurs (Day 1). Then the days are numbered consequently (Day 2, Day 3, etc.) until the last day before the next menstruation. A menstrual cycle means the interval of time between the first day of menstruation (Day 1 of the menstrual cycle) and the first day of the next cycle; it can vary from 25 to 35 days. Out of the shortest menstrual cycle subtract 18; the number obtained is the day in which the fertile period begins.

Out of the longest menstrual cycle subtract 11; the number obtained is the day in which the fertile period ends.

Example: a woman has menstrual cycles with duration of 26-31 days

$26-18=8$. Starting with Day 8 of any menstrual cycle, intercourse must be avoided; thus, she can have sexual contacts until and including the 7th day.

$31-11=20$. She can have intercourses after the 20th day of the menstrual cycle (abstinence period: between days 8 – 20 of the menstrual cycle).

- **Vaginal Secretion/ Cervical Mucus (Method based on Cervical Mucus/Billings Method)**

The woman checks daily the presence, the aspects, as well as the quantity of the cervical secretions.

A few days after the menstruation, the secretion is reduced/ non-existent. Afterwards, the secretion becomes more and more abundant, the woman has the sensation of humidity and she can observe the mucus on her fingers, toilet paper or underwear. At a certain point, the secretion is abundant, elastic, fluid, and transparent (like a white of egg). In the few days that follow this moment, the secretion becomes sticky, thick, viscous, it loses elasticity and transparency and its quantity is reduced.

During the days following menstruation, before the apparition of secretions, the couple can have intercourse; it is best have sexual contact every two days in order not to fail to differentiate sperm from cervical mucus. Abstinence is recommended starting with the moment in which secretions appear. The maximum secretion moment corresponds with ovulation. Abstinence must be practiced for another 4 days after this maximum secretion moment, until the secretion changes and is reduced/ disappears, after which the couple can have intercourse without any restrictions, until the apparition of the following menstruation.

- **Auto-Palpation of the Cervix**

Woman must palpate her uterine cervix. Outside the fertile period, the cervix is hard (consistency as that of the nasal cartilage), firm, with the external orifice/ostium closed. During the fertile

period, the cervix is softer (consistency as that of the chin), humid, covered with secretions, with the external orifice half-open.

(The method is rarely used as a unique sign).

- **Body Basal Temperature (BTT Method)**

Woman takes her temperature daily in basic conditions (in basal conditions, in the morning, after repose, before getting out of bed), always in the same way (orally, rectally or vaginally). When ovulating, the temperature raises by 0.2 – 0.5 Celsius degrees and it maintains that way until around the next menstruation. Sexual contacts are allowed after 3 days from the rise of the basal temperature and until the next menstruation.

Couples can either use one of these methods or they can combine more of the pursued elements in order to determine the fertile period more correctly as well as reduce the abstinence period (sympto-thermal method or the multiple indicators method).

During the fertile period, couples can completely avoid vaginal sex (periodical abstinence) or they can use contraceptive methods: barrier (condom, spermicided), coitus interruptus ("withdrawal").

Efficiency

Efficiency varies much more than in the cases of other contraceptive methods due to the fact that it depends greatly on the accuracy of the use, as well as on the abilities of identifying different signs.

In the case of common use, the efficiency is reduced – up to 20 pregnancies in 100 women within the first year of using the method.

If the methods are used correctly and consequently the efficiency rows, thus:

- if the cervical secretion is followed – 3 pregnancies/ 100 women within the first year of using the method
- if the basal temperature is measured – 1 pregnancy/ 100 women
- if the calendar method is used – 9 pregnancies/ 100 women
- if the sympto-thermal method is used – 2 pregnancies/ 100 women

PRESENTATION OF THE LACTATIONAL AMENORRHEA METHOD (LAM)

The method consists of using breastfeeding as a temporary contraceptive method. It offers natural protection against pregnancy and it encourages couples to begin using another contraceptive method at the right time.

Woman is naturally protected against pregnancy when:

1. She breastfeeds an infant frequently, during the daytime, as well as at night (ideally 8-10 times/24 hours, out of which at least once at night), ensuring the infant's alimentation in a proportion of 85%-100%. The interval between two breast feedings should not exceed 4

hours during the day and 6 hours during the night. The breastfeeding technique is correct (both breast are emptied with each breastfeeding).

2. The infant is less than 6 months old.
3. The menstruations have not reinstalled yet.

The LAM **efficiency** is very high if all the enumerated conditions are respected: 0.5 pregnancies/ 100 women within the first 6 months after birth.

In common use, the efficiency is of 2 pregnancies/ 100 women within the first 6 months after birth.

If one or more of the enumerated conditions are not fulfilled, the woman should use another efficient contraceptive method, which should not interfere with breastfeeding and she should continue breastfeeding the infant even after his alimentation is diversified, if possible until the age of 2 years (WHO recommendation).

THE BENEFITS OF BREASTFEEDING

For child:

- Breastfeeding is the best manner of feeding the infant.
- It protects the child against diarrheic diseases.
- It assures protection against certain infectious diseases, which can be extremely severe for an infant/ small child (through passing immunity from the mother)
- It helps create a stronger affective relationship between mother and child.

For mother:

- It protects the woman from the apparition of a new pregnancy
- It offers protection against the development of breast cancer
- Positive feelings, special affective relationship between mother and child during breastfeeding.

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- It helps create a stronger affective relationship between mother and child.

For mother:

- It protects the woman from the apparition of a new pregnancy
- It offers protection against the development of breast cancer
- Positive feelings, special affective relationship between mother and child during breastfeeding.

NATURAL FAMILY PLANNING: ADVANTAGES

- It does not influence the health status, it does not constitute a risk for health
- It can be used by anyone, its use does not imply boundaries
- There are no side-effects
- It is cost-free
- It is immediately reversible
- It facilitates acknowledgement of own body
- After it has been learned, the method no longer needs help from the medical staff or from other trained personnel
- Once it is correctly understood, the method can be used for avoiding, as well as for obtaining a pregnancy, depending on the couple's interest
- It involves both partners in assuming pregnancy related responsibilities
- The method is accepted by some religious groups which refuse other contraceptive methods

NATURAL FAMILY PLANNING: DISADVANTAGES

- Within the common use, these methods are more or less efficient: up to 20 pregnancies in 100 women in the first year of use
- The method based on calendar implies keeping track of data about the menstrual cycle over a period of 6-12 months
- The methods based on recognizing the fertile period need a time period for learning the signs which indicate the fertile period
- Touching the genitals is unacceptable to some women, thus self-exploration of the genital sphere possibly being a difficult process to some persons
- Temporary abstinence might be unacceptable or difficult for some couple/ the male partner
- Natural methods could become unsure and hard to use when the woman's health status goes through changes (fever, vaginal infections, breastfeeding or others conditions that can affect the body temperature, the aspect of cervical mucus or the length of the menstrual cycle)
- In situations in which the menstrual cycles are irregular, the efficiency of temporary abstinence is unclear
- It does not protect against sexually transmitted infections.

Session 6: Combined Oral Contraceptives

Objectives:

At the end of the session, participants will be able to:

- Describe the combined oral contraceptives: classification, mechanisms of action, efficiency, reversibility, advantages – contraceptive and non-contraceptive, disadvantages, side-effects, alarm sign, management.
- Identify the causes of failure encountered in the use of the method
- Describe the medical eligibility criteria for using the method, the conditions which restrict use/ require precautions
- Complete correctly “The Annexes for Contraception”

Time: 180 minutes

Techniques: Presentation, demonstration, small groups, discussions, case study

Materials:

Flipchart/Overhead

6.1 Information on contraceptive methods

Trainer’s documents

6.1 Combined Oral Contraceptives –presentation

6.2 Side-effects of COC and their management

6.3 Case studies

6.4 Optional – Annex A

6.5 Optional – Annex B

6.6 Optional – Annex C

6.7 Optional – Instructions for Completing the Annexes

6.8 Combined Oral Contraceptives samples – sufficient number of Marvelon, Desorelle or Tri-Regol, (depending on the product which is distributed in the region), in order to allow all participants to make demonstrations

Handouts

6.1 Questions regarding the combined oral contraceptives

6.2 Side-effects and their management

6.3 Presentation of the combined oral contraceptives

6.4 COC available in Romania

6.5 Checklist

6.6 Annex A

6.7 Annex B

6.8 Annex C

6.9 Instructions for Completing the Annexes

6.10 Medical Practice Recommendations – WHO Guide (for doctors)

Activities

1. Combined Oral Hormonal Contraceptives: COC (90 min)

- Post the flipchart: ***“Information Regarding the Contraceptive Methods”***. Make a short presentation (15 min) of COC: description, types of COC, pharmaceutical forms, mechanism of action, efficiency, reversibility, administration.
- The two trainers carry out a demonstration in which they show how essential information regarding the use of COC is transmitted to the client (5 min)
- Divide participants in pairs of two.
- Hand each pair a sample of COC (*be careful to use the product which is available in the district*) and ask them to demonstrate the way in which clients are given the information they need, following the pattern demonstrated by the trainers. (One of the participants is the doctor and the other, the client)
- Tell them that they have 5 minutes in order to complete this.
- The co-trainer hands each pair of participants a checklist and the trainer asks participants, still divided in pairs, to check –using the list- if all necessary information has been offered to the clients.
- Ask if there have been many oversights compared to the list (*the exercise will take around 10 minutes to complete*)
- Afterwards, divide the participants into groups of three, which will establish: 1) the advantages/ benefits of COC, 2) the disadvantages, 3) the alarm signs. Explain to the groups what their tasks are, hand them a flipchart paper sheet in order for them to write the results of their discussions. Grant them 5 minutes for the completion of this exercise.
- Let participants know that they can use ***“Contraception – Practical Guide”*** (book which they have received prior to or in the first day of the workshop).
- Ask a representative of the first group to present the result of the discussions of his group. After the presentation, ask if the other members of the group have anything they would like to add. Then ask the rest of the participants whether they have anything to add.
- Do the same with the other 2 groups.
- If needed, step in to make corrections or to add something. (The exercise will take 40 minutes in all)
- Distribute the handout 6.1: ***“Questions regarding the combined oral contraceptives”*** and ask them to read, taking turns and to comment/ answer; the others may intervene if they have different opinions. Trainer intervene to make necessary remarks, if any, and to propose solutions, if these haven't already been identified by the participants. (10 min)
- Present the side-effects and their management. State the fact that you will also go over these again during the counseling session.

- Emphasize that when a woman presents alarm signs, she will be refer to a specialized medical service (to FP, Ob-Gyn etc. office) for evaluation and contraceptive option re-discussing. (10 min)

2. Causes of failure in the use of COC (20 min)

- Ask participants which are the situations in which a COC user can become pregnant. List the answers on the flipchart. Ask how these situations can be avoided or what is to be done when they cannot be avoided.
- Thus, review the correct way of administration of COC (including when the use of COC can be started, what is to be done if the pills are omitted or the woman is vomiting, has diarrhea, is following treatment with other medicine).
- Compare the discussed aspects with the list of the ideal contraceptive's features and infer that this method too does not constitute an ideal contraceptive.
- Distribute to participants the handout 6.10: "**Medical practice recommendations – WHO Guide**". Emphasize that this is a very valuable material, which has been translated and printed in Romania very recently and that it summarizes the experience of specialists worldwide. The book is the result of the WHO experts team and it is based on several studies carried out at global level.

3. Medical Eligibility Criteria for COC (40 min)

- Distribute the handouts 6.6 "Annex A", 6.7 "Annex B", 6.8 "Annex C" and 6.9 "Instructions for Completing the Annexes". Explain participants that you will learn together about the way in which the annexes are to be completed. Stress the fact that these annexes will be attached to the patients' medical files, which already exist in their offices.
- Afterwards, quickly review the contraception annexes. Ask participants to take a look at Annex A – Personal medical history and risk factors. Ask participants what kind of information is filled in this first annex. Listen to a few answers (*possible answers: personal history, information regarding risk factors and contraceptive methods used before*).
- Tell participants that on the counter page they will find the Instructions for completing the annexes; aided by these, they will find it easier to remind the most important elements which they will have to follow to their clients and they will be able to correctly fill out these annexes.
- Move to Annex B – Medical Consultations. Ask participants what kind of information is to be filled in here. The expected answers are the key-titles on the page. Explain that this annex is to be filled in each time when a medical examination is needed for using a certain contraceptive method.
- Then, present Annex C – Follow-up Visits. Ask participants what kind of information should be filled in here. *Expected answers: information regarding the user, the contraceptive used by the client, general data regarding the health status, etc. (e.g. Blood Pressure, Weight, date of the last menstrual period)*. Emphasize that this annex will be filled in each time when the client receives contraception, including the first visit. Stress the fact that it is highly important that all the client's visits to the office are mentioned in order to have a whole view on the ulterior evolution and that the client has to sign, each time, for the free-of-charge contraceptives s/he receives. The patient's signature will certify the free-of-charge contraceptive provision and permits offload; and

it turns these annexes into medical-legal documents. Information contained in this annex is also useful for possible medical studies and for supervision visits, at different time intervals, which will follow the distribution protocols, the rate of continuity with the contraceptive method rate or the renunciation rate. *(these presentations should last approximately 10 min)*

- Afterwards divide the trainees into groups of 2-3 and hand each group a case study which they are to solve. Tell them that they have 10 minutes for solving the cases and completing the Annexes for Contraception, aided by the instructions which they have received. State the fact that they will use the **WHO Guide - Medical Eligibility Criteria for COC**.
- Invite one volunteer from each group to present the case and solution. (5 min)
- Ask: what investigations are necessary for the safety use of COC? What does the service provider have to follow when the woman comes in for check-up? List the answers received from participants on the flipchart. Clarify each proposition aided by the manuals **Contraception - Practical Guide** and by **Medical Practice Recommendation-WHO Guide**. (10 min)
- As a conclusion to this activity, tell participants that -by using the received materials- they will find it easier to monitor the COC use by their clients in safety conditions and to identify the situations in which a client should be refer to Family Planning offices or other specialists.

INFORMATION REGARDING CONTRACEPTIVES

- Description/ presentation of the method
- Mechanisms of action
- Efficiency
- Reversibility
- Utilization
- Interactions with other medicines
- Advantages and disadvantages
- Side-effects
- Alarm signs/ complications
- Limits in use of the method
- Frequency of follow-up visits
- STI prevention

Combined Oral Contraceptives (presentation)

COC, also known as contraceptive pills or birth control pills or oral contraceptives, contain two hormones similar to the female sexual hormones: estrogen and progesterone. The hormones contained by the pill are chemically synthesized.

The hormone doses contained by the products which are presently used are very low, that is why the pills are called micro-dosed. Many of the conditions which were limiting the COC use are no longer applicable in the COC used nowadays. In the 1960-1970s, at the beginning of hormonal contraception, the daily doses were much bigger (each pill contained the estrogen dose equivalent to that contained by 7 modern pills and the progestagen dose was equivalent to that of a 21-pills actual package and they were called macro-dosed pills). In the '80s the so called normal-dosed pills were used, with similar content as the incipient pregnancy period (the first trimester). In time, the tendency of the producers of such products was to reduce the hormone doses down to the limit at which the side-effects are canceled, without having to also reduce the benefits.

Presentation forms

The COC can have:

- 21 pills, which contain hormones (active pills)
- 28 pills, out of which the first 21 contain hormones (active pills) and the rest 7 pills which don't contain hormones (inactive pills or placebo pills, for getting for continuation, "ED = everyday" pills); these usually have another color or another size than the active pills, in order to be easily recognizable.

The hormone doses can be constant during the whole period of administration or they can be varied. Thus, there are:

- mono-phased pills, which contain equal quantities of hormones in each of the 21 active pills
- multi-phased pills (actually, only the three-phased pills are being used), in which the estrogen and progestative dose varies over the 21 pills.

Mechanism of Action

- COC blocks ovulation (the release of ovules from the ovaries)
- Determines the thickening of the cervical mucus, impeding the penetration of the spermatozoa
- Reduces the motility of the Fallopian tubes

Efficiency

If they are used correctly and continuously, COC are very efficient: 0.1 pregnancies in 100 women within the first year of usage. Studies show that in common use, efficiency is more reduced 6-8 pregnancies in 100 women within the first year of usage; it is obvious that the efficiency directly depends on a correct usage and on the woman's compliance.

Reversibility

The method is rapidly reversible, practically the woman can become pregnant immediately after giving up the method (or even during incorrect administration, this being a certain proof of immediate reversibility!)

Administration

In order for the method to have a maximum of efficiency, the pills must be taken daily, approximately at the same hour, for 21 days, with a 7 day break. In the case of 28 pills per package form, there is no break.

The beginning of administration can be done:

- During the menstrual bleeding (moment in which the probability that the woman becomes pregnant is very low)
 - it is best to start taking the pill in the first day of the menstrual cycle
 - within the first 5 days from the installation of the menstruation, if the woman has a regular menstrual cycle; in this case she does not need additional protection;
 - administration of the pills can start after the fifth day of the menstrual cycle, but in this case it is strongly recommended that an additional protection method be used or that sexual contacts be avoided within the first 7 days after starting to use the pills;
- In any moment of the menstrual cycle, if we can be sure that the woman is not pregnant (hasn't had any sexual contacts since her last menstruation or has correctly used an efficient family planning method); if more than 5 days from the beginning of the menstrual cycle have passed, the woman will start the pills and must avoid intercourse or use an additional protection method within the first 7 days after starting to use the pills.
- After birth:
 - COC can be started within 3-6 weeks after birth, in the absence of the menstruation, if the woman is not breastfeeding (during the breastfeeding period estrogen pills are not recommended due to the fact that it can reduce the quantity and the quality of the maternal milk);
 - COC administration can be started by women which are not breastfeeding on the occasion of any menstruation, with the previous mentioned precautions;
 - After 6 months from birth, if the woman continues to breastfeed, she hasn't had menstruation and she has correctly used LAM.
- After abortion:
 - within the first 7 days after a complications-free abortion upon request or a 1st semester or 2nd semester spontaneous abortion;
 - after 7 days from abortion, in any moment before the menstruation reappears if the woman is sure that she is not pregnant; in this situation she will avoid sexual contacts or she will use an additional protection method within the first 7 days after starting to use COC;
- Immediately after the woman has interrupted using another contraceptive method (it isn't necessary to wait for her next menstruation in order to start using COC)

If the pills are omitted:

- ◆ If **only one active pill** is omitted, the woman will take the omitted pill immediately after she reminds and she will continue taking the pills from the package at the usual hour (she can therefore take 2 pills in the same day or at the same hour). She does not need additional protection.
- ◆ If she forgets to take **2-4 pills out of the first 7 active pills** in the package or if she **starts a new package two or more days later**, the woman will take a pill as soon as she reminds and she will continue taking the pills in the package at the same hour; additionally in the next 7 days (until the contraceptive protection is regained) she will not engage in sexual contact or she will use an additional protection method (condom or spermicides).
- ◆ If she forgets to take 2-4 pills out of the 8-21 pills and the package still contains more than 7 pills, she will take the rest of the pills as usual; if the package contains less than 7 pills, the woman will finish the active pills and she will begin a new package, without taking the usual 7 day break. She does not need additional protection.

If the woman has digestive disorders:

- ❖ Vomiting after less than 2 hours from administering the pill – she will take another pill, identical to the one vomited, from a back-up package
- ❖ Diarrhea or vomiting for more than 24 hours – she will continue taking the pills and will use an additional protection method or will avoid sexual contact until she will succeed to take 7 active pills, after the diarrhea or vomiting have ceased (she will not take the seven days break if the package finishes meanwhile)

If the woman needs a treatment which reduces the efficiency of the pills:

- She will either reconsider the contraceptive method, if the treatment is long-term
- She will either continue taking the pills, but she will use an additional protection method (the same as in the case of omitted pills).

Management of COC Side Effects

Common side-effects at the beginning of COC administration:

Nausea/ Vomiting	Recommend the administration of pills during meals or in the evening, before going to bed
Inter-menstrual bleeding/ spotting	<p>If the woman has started taking COC recently, recommend that she continue administering the pills;</p> <p>Verify whether the pills are being taken at the same time each day;</p> <p>Explain that these phenomena naturally disappear after the first 3 months.</p> <p>Verify the correctness of the administration and ask her if she has had diarrhea, if she has vomited or if she has taken medicine (Rifampin, Griseofulvin, seizure medication)</p> <p>Verify the existence of gynecological disorders or conditions.</p>
Slight headache	<p>Measure the arterial pressure</p> <p>Treat with analgesics and re-evaluate after one month.</p> <p>Verify whether the headache has installed after she has started taking COC.</p>
Breast tenderness	<p>Explain to the woman that this happens often at the beginning when taking COC (verify whether the woman is used to sleeping faced down; these women are usually the ones who complain).</p> <p>Verify to see if she is pregnant.</p> <p>Examine the breasts for nodules and galactorrhea.</p>
Slight body weight gain	<p>Weigh the woman.</p> <p>Ask if she has changed her lifestyle, if she has been eating more than before she started taking COC.</p> <p>Explain that due to the COC, the alimentary appetite can increase.</p> <p>Explain that during the first months, even if they do not eat more than before, most women may notice a slight weight gain, of a around 1-2 kg, but that the weight will return to its initial value, if the woman will eat the same as before</p>
Amenorrhea	<p>Ask if she has had any bleeding (she could present a reduced menstrual bleeding, which she may not consider menstruation).</p> <p>Check whether the woman has correctly taken COC (omitting them might increase the risk of becoming pregnant; taking the pills without taking the break might lead to amenorrhea).</p> <p>Verify whether the woman is pregnant.</p>

Alarm Signs:

Severe or modified headache after starting to take COC	If it is intense or persistent or it has modified since starting to use COC, stop the COC and check the health status (ophthalmologic exam, neurological examination, etc.)
Temporary loss of vision, loss of vision on a limited portion of the visual range	They might indicate cerebral circulation disorders or HBP (high blood pressure). Stop COC immediately and investigate.
Severe pain at abdominal, thoraces or inferior members level	They might indicate thrombosis. Immediately stop COC and investigate.
Jaundice, discolored stools, hyper-chrome urines	They might indicate incipient viral acute hepatitis (situation which forces stopping the COC) or affections of the gallbladder (which forces choosing another contraceptive method) or the existence of a hepatic tumor. Stop COC.

Case Studies

29 years old woman, having a child, requests a modern and very sure contraceptive method, other than the pill, because she has taken contraceptive pills and however became pregnant and she has also noticed that she had gained weight (3-4 kg). How will you approach the case?

36 years old woman, non-smoker, having Diabetes type II, not insulin-dependent discovered after a series of urinary infections, out of which one with nephritis, wants a very sure contraceptive method, due to the fact that the gynecologist which has performed her last abortion/curettage has warned her about the possible complications. What is to be done?

32 years old woman, with two children with ages of 5 and 2, request a contraceptive which would eventually also adjust her menstrual cycle as it is irregular, especially after her last delivery. You discover a systolic murmur in the mitral focus. Possible approaches/alternatives?

Teenager who has recently started her sexual life would like to take birth control pills because all her friends do, but she is afraid that she might gain weight, due to the fact that she might suffer – just like her mother – from “gland”. How would you approach this case?

41 years old woman, non-smoker, suffering for several years of fibrocystic mammary disease, has been having for a few months medium intensity meno-metrorrhagia, for which the gynecologist has recommended “light” pills (micro-dosed), with the purpose of controlling the menstrual cycle and uterine fibroma which he has diagnosed. She asks for your advice. What alternatives would you offer to her?

36 years old woman requests pills, following the advice of a friend which has been taking pills for many years (actually she has just finished her first package borrowed from her friend and she has felt very good). She doesn't have a particular pathological background; she smokes a few cigarettes daily (“when she drinks her coffee”). After the gynecological examination, you discover a lesion at the uterine cervix level, and the cytological exam is graded II, with a strong inflammatory reaction and rare metaplasia cells. What would you do in this case?

QUESTIONS REGARDING COMBINED ORAL CONTRACEPTIVES

1. Client who uses COC phones in order to receive information on what she has to do if she will undergo a surgical intervention in 20 days. What is she told?
2. A client complains that she has had 3-4 diarrheic stools in the last 3 days. What is to be done?
3. A COC user has been recommended long term treatment with Phenobarbital. What is to be done?
4. A patient who takes COC has forgotten to take one pill for more than 24 hours, she has used additional protection (condom) but this has broken during the third day. What should she do?
5. What happens if a client who takes COC has forgotten to take one active pill for more than 24 hours in the last week (before the 7 day break)?
6. The client takes COC, she is at her first package and at the middle of it she has abundant bleedings. What is to be done?
7. Client, who has taken COC for one year, interrupts them and complains having absence of menstruation. What do we tell her?
8. Patient who is taking COC knows that she will have a 2 month period of abstinence. Does she interrupt COC?
9. Patient who starts COC with the third day of her menstrual cycle needs additional protection or not?
10. Does a patient who takes COC and has forgotten to take the active pill for 2 days need additional protection or not?
11. The patient who uses COC has been having 2-3 diarrheic stools a day. The doctor has recommended treatment with tetracycline. Does she need additional protection?
12. The client has been to a party and during the evening, after she took the pill with a 5 hours delay, she vomits it 2 hours after taking it. She repeats the dose; she vomits again and thus, she delays taking the pill with 12 hours from the usual hour. What do we tell her?
13. Client, who has been using COC for a year, has a urinary infection and is recommended treatment with Septrin (Biseptol), Chlorzoxazone, Tylenol. What should she do?
14. Client, who has been using COC for one year, starts to have light inter-menstrual bleedings. What is to be done?
15. A woman has been using COC for 5 months, she leaves for vacation, she forgets the pills at home and she pauses taking COC for 1 week. During this time, she has one bleeding. What happens? What is to be done?
16. COC user complains noticing a decrease in her sexual appetite. What is to be told her?
17. COC user complains having eyesight disturbances and headaches. What attitudes are recommended?

18. COC user has gained 6 kg in weight. What is she told? What is to be done?
19. A patient who takes COC complains having edemas in her inferior limbs, especially on her right foot which is also painful. What is she told?
20. A patient complains having discolored stools and hyper-chromic urines. What is to be done?
21. The patient wishes to take COC, but has had acute B hepatitis 2 years ago and has remained HBs-Ag carrier. The doctor who has treated her told her that everything is alright, she can remain a carrier without being ill, but she still fears. What is she told?
22. 37 years old woman who uses COC complains having violent abdominal pain. What are the adequate attitudes?
23. COC user states that her menstrual bleeding is very reduced. She fears being pregnant. What is she told?
24. Client who has taken COC from the office phones in to tell that even if, at the office she has been told to begin to take pills from the first day of her period, her gynecologist has told her to start them from the fifth day. Which of the attitudes is correct?
25. COC user asks why she has been given a certain type of pills if she hasn't had her hormonal dosage done. What is she told?
26. A woman who uses COC asks whether it is good to pause taking the pills from time to time. What is she told?
27. COC user asks whether she will be able to have children once she stops taking the pills. What is she told?
28. A woman who has been taking COC for 5 years asks whether the risk of giving birth to children with malformations exists. What do we tell her?

Management of COC Side Effects

Common side-effects at the beginning of COC administration:

Nausea/ Vomiting	Recommend the administration of pills during meals or in the evening, before going to bed
Inter-menstrual bleeding/ spotting	<p>If the woman has started taking COC recently, recommend that she continue administering the pills;</p> <p>Verify whether the pills are being taken at the same time each day;</p> <p>Explain that these phenomena naturally disappear after the first 3 months.</p> <p>Verify the correctness of the administration and ask her if she has had diarrhea, if she has vomited or if she has taken medicine (Rifampin, Griseofulvin, seizure medication)</p> <p>Verify the existence of gynecological disorders or conditions.</p>
Slight headache	<p>Measure the arterial pressure</p> <p>Treat with analgesics and re-evaluate after one month.</p> <p>Verify whether the headache has installed after she has started taking COC.</p>
Breast tenderness	<p>Explain to the woman that this happens often at the beginning when taking COC (verify whether the woman is used to sleeping faced down; these women are usually the ones who complain).</p> <p>Verify to see if she is pregnant.</p> <p>Examine the breasts for nodules and galactorrhea.</p>
Slight body weight gain	<p>Weigh the woman.</p> <p>Ask if she has changed her lifestyle, if she has been eating more than before she started taking COC.</p> <p>Explain that due to the COC, the alimentary appetite can increase.</p> <p>Explain that during the first months, even if they do not eat more than before, most women may notice a slight weight gain, of a around 1-2 kg, but that the weight will return to its initial value, if the woman will eat the same as before</p>
Amenorrhea	<p>Ask if she has had any bleeding (she could present a reduced menstrual bleeding, which she may not consider menstruation).</p> <p>Check whether the woman has correctly taken COC (omitting them might increase the risk of becoming pregnant; taking the pills without taking the break might lead to amenorrhea).</p> <p>Verify whether the woman is pregnant.</p>

Alarm Signs:

Severe or modified headache after starting to take COC	If it is intense or persistent or it has modified since starting to use COC, stop the COC and check the health status (ophthalmologic exam, neurological examination, etc.)
Temporary loss of vision, loss of vision on a limited portion of the visual range	They might indicate cerebral circulation disorders or HBP (high blood pressure). Stop COC immediately and investigate.
Severe pain at abdominal, thoraces or inferior members level	They might indicate thrombosis. Immediately stop COC and investigate.
Jaundice, discolored stools, hyper-chrome urines	They might indicate incipient viral acute hepatitis (situation which forces stopping the COC) or affections of the gallbladder (which forces choosing another contraceptive method) or the existence of a hepatic tumor. Stop COC.

Combined Oral Contraceptives (presentation)

COC, also known as contraceptive pills or birth control pills or oral contraceptives, contain two hormones similar to the female sexual hormones: estrogen and progesterone. The hormones contained by the pill are chemically synthesized.

The hormone doses contained by the products which are presently used are very low, that is why the pills are called micro-dosed. Many of the conditions which were limiting the COC use are no longer applicable in the COC used nowadays. In the 1960-1970s, at the beginning of hormonal contraception, the daily doses were much bigger (each pill contained the estrogen dose equivalent to that contained by 7 modern pills and the progestagen dose was equivalent to that of a 21-pills actual package and they were called macro-dosed pills). In the '80s the so called normal-dosed pills were used, with similar content as the incipient pregnancy period (the first trimester). In time, the tendency of the producers of such products was to reduce the hormone doses down to the limit at which the side-effects are canceled, without having to also reduce the benefits.

Presentation forms

The COC can have:

- 21 pills, which contain hormones (active pills)
- 28 pills, out of which the first 21 contain hormones (active pills) and the rest 7 pills which don't contain hormones (inactive pills or placebo pills, for getting for continuation, "ED = everyday" pills); these usually have another color or another size than the active pills, in order to be easily recognizable.

The hormone doses can be constant during the whole period of administration or they can be varied. Thus, there are:

- mono-phased pills, which contain equal quantities of hormones in each of the 21 active pills
- multi-phased pills (actually, only the three-phased pills are being used), in which the estrogen and progestative dose varies over the 21 pills.

Mechanism of Action

- COC blocks ovulation (the release of ovules from the ovaries)
- Determines the thickening of the cervical mucus, impeding the penetration of the spermatozoa
- Reduces the motility of the Fallopian tubes

Efficiency

If they are used correctly and continuously, COC are very efficient: 0.1 pregnancies in 100 women within the first year of usage. Studies show that in common use, efficiency is more reduced 6-8 pregnancies in 100 women within the first year of usage; it is obvious that the efficiency directly depends on a correct usage and on the woman's compliance.

Reversibility

The method is rapidly reversible, practically the woman can become pregnant immediately after giving up the method (or even during incorrect administration, this being a certain proof of immediate reversibility!)

Administration

In order for the method to have a maximum of efficiency, the pills must be taken daily, approximately at the same hour, for 21 days, with a 7 day break. In the case of 28 pills per package form, there is no break.

The beginning of administration can be done:

- During the menstrual bleeding (moment in which the probability that the woman becomes pregnant is very low)
 - it is best to start taking the pill in the first day of the menstrual cycle
 - within the first 5 days from the installation of the menstruation, if the woman has a regular menstrual cycle; in this case she does not need additional protection;
 - administration of the pills can start after the fifth day of the menstrual cycle, but in this case it is strongly recommended that an additional protection method be used or that sexual contacts be avoided within the first 7 days after starting to use the pills;
- In any moment of the menstrual cycle, if we can be sure that the woman is not pregnant (hasn't had any sexual contacts since her last menstruation or has correctly used an efficient family planning method); if more than 5 days from the beginning of the menstrual cycle have passed, the woman will start the pills and must avoid intercourse or use an additional protection method within the first 7 days after starting to use the pills.
- After birth:
 - COC can be started within 3-6 weeks after birth, in the absence of the menstruation, if the woman is not breastfeeding (during the breastfeeding period estrogen pills are not recommended due to the fact that it can reduce the quantity and the quality of the maternal milk);
 - COC administration can be started by women which are not breastfeeding on the occasion of any menstruation, with the previous mentioned precautions;
 - After 6 months from birth, if the woman continues to breastfeed, she hasn't had menstruation and she has correctly used LAM.
- After abortion:
 - within the first 7 days after a complications-free abortion upon request or a 1st semester or 2nd semester spontaneous abortion;
 - after 7 days from abortion, in any moment before the menstruation reappears if the woman is sure that she is not pregnant; in this situation she will avoid sexual contacts or she will use an additional protection method within the first 7 days after starting to use COC;
- Immediately after the woman has interrupted using another contraceptive method (it isn't necessary to wait for her next menstruation in order to start using COC)

If the pills are omitted:

- ◆ If **only one active pill** is omitted, the woman will take the omitted pill immediately after she reminds and she will continue taking the pills from the package at the usual hour (she can therefore take 2 pills in the same day or at the same hour). She does not need additional protection.
- ◆ If she forgets to take **2-4 pills out of the first 7 active pills** in the package or if she **starts a new package two or more days later**, the woman will take a pill as soon as she reminds and she will continue taking the pills in the package at the same hour; additionally in the next 7 days (until the contraceptive protection is regained) she will not engage in sexual contact or she will use an additional protection method (condom or spermicides).
- ◆ If she forgets to take 2-4 pills out of the 8-21 pills and the package still contains more than 7 pills, she will take the rest of the pills as usual; if the package contains less than 7 pills, the woman will finish the active pills and she will begin a new package, without taking the usual 7 day break. She does not need additional protection.

If the woman has digestive disorders:

- ❖ Vomiting after less than 2 hours from administering the pill – she will take another pill, identical to the one vomited, from a back-up package
- ❖ Diarrhea or vomiting for more than 24 hours – she will continue taking the pills and will use an additional protection method or will avoid sexual contact until she will succeed to take 7 active pills, after the diarrhea or vomiting have ceased (she will not take the seven days break if the package finishes meanwhile)

If the woman needs a treatment which reduces the efficiency of the pills:

- She will either reconsider the contraceptive method, if the treatment is long-term
- She will either continue taking the pills, but she will use an additional protection method (the same as in the case of omitted pills).

Types of COC Available in Romania

Mono-phased micro-dosed COC:

Microgynon/ Rigevidon/ Minidril – 21 pills
EE 0.03 mg + levonorgestrel (LNG) 0.150 mg

Marvelon/ Desorelle
EE 0.03 mg + desogestrel 0.075 mg

Femoden
EE 0.03 mg + gestoden 0.075 mg

Cilest
EE 0.035 mg + norgestimate

Mono-phased ultra-micro-dosed COC:

Mercilon/ Novynette
EE 0.02 mg + desogestrel 0.150 mg

Logest
EE 0.02 mg + gestoden 0.075 mg

Three-phased COC:

Triquilar/ Tri-regol
6 pills containing EE 0.03 mg + LNG 0.05 mg
5 pills containing EE 0.04 mg + LNG 0.075 mg
10 pills containing EE 0.03 mg + LNG 0.125 mg

Laurina
EE + etonogestrel (active metabolite of the desogestrel)

CHECKLIST

- Description/ Presentation of method
- Mechanisms of action
- Efficiency
- Reversibility
- Administration
- Interactions with others medicine drugs
- Side-effects

Session 7: Progestagen Only Contraceptives

Objectives:

By the end of the session, the participants:

- Will describe the hormonal contraceptives containing only progesterone derivatives: types of contraceptives, mechanism of action, efficiency, reversibility, advantages, disadvantages, side-effects, alarm signs, management.
- Will describe the failure causes of the method.
- Will be familiar with W.H.O. Guide –Eligibility Criteria for progestagen-only contraceptives
- Will completely “The Annexes” for contraception

Time: 105 min.

Techniques: Presentation, simulation, working groups, demonstration

Materials:

Flipchart

6.1 Information regarding the contraceptive methods

Trainer’s documents

7.1 Progestagen-Only Contraceptives Presentation

7.2 Progestagen-Only Contraceptives– Side-effects

7.3 Case Studies

7.4 Samples of progestatives only contraceptive products: Exluton, Depo-Provera, Megestron (sufficient quantities of Exluton and Depo-Provera in order ensure demonstrative materials for all participants)

Handouts

7.1 Progestagen-Only Contraceptives Presentation

7.2 Progestagen-Only Contraceptives– Side-effects

7.3 Checklist

7.4 Annexes for Contraception

Activities:

1. Progestagen Only Pills (75 min)

- Post on the flipchart: **Information Regarding the Contraceptive Methods** and make a brief presentation of the Progestagen-Only Pills (POP): mechanism of action, efficiency, side-effects, reversibility, administration, follow-up visits. (15 min)
- The two trainers make a demonstration in which they show the essential information regarding the POP usage which must be transmitted to clients. (5 min)
- Group the participants into pairs.
- Hand each pair of participants a sample of Exluton (*be careful to use the product available in that district*) and ask them to demonstrate the transmission of the information regarding this method to the clients, following the model demonstrated by the trainers (one of them is the doctor and the other, the client).
- Tell them they have 5 minutes available for this.

- The co-trainer hands each pair a checklist and the trainer asks participants to check within their partner they have worked with, using the list, whether all information necessary to clients has been offered.
- Ask whether there have been many lapses compared to the list (*the exercise takes around 10 min to complete*)
- Repeat the same exercise for the injectable contraceptive.
- The two trainers make a demonstration in which they show the essential information regarding the use of injectables. (5 min)
- Group the participants into pairs.
- Hand each pair a sample of Depo-Provera and ask them to demonstrate the transmission of information regarding this method to the clients, following the pattern demonstrated by the trainers.
- Tell them they have 5 minutes available for this.
- The co-trainer hands each pair a checklist and the trainer asks participants to check within the pair they have worked in, using the list, whether all information necessary to clients has been offered.
- Ask whether there have been many lapses compared to the list (*This whole exercise, the simulation carried out by the trainers, the demonstration done by participants and the checking with the list, takes around 15 min.*)
- Then, divide participants into 4 groups which will establish: 1) Advantages of POP; 2) Disadvantages of POP; 3) Advantages of the Injectable Contraceptives; 4) Disadvantages of the Injectable Contraceptives.
- Explain to the groups what their tasks are, hand each of them a flipchart paper sheet in order for them to write down the results of their discussions.
- Let them know that they have 5 minutes in order to complete this exercise.
- Ask a representative of the first group to present the result of their discussions. After the presentation, ask whether the other members of the group would like to add anything.
- Do the same with each of the other 3 groups.
- If needed, clarify or offer additional information. (*The exercise takes 20 minutes in all.*)

2. Side-effects. Failure Causes (10 min)

- Ask participants to remember and list the side-effects that you, the trainers, have mentioned throughout the presentation of the methods.
- After you obtain the most important side effects of POP and injectables, ask what usually happens when a side-effect appears. You will probably obtain the answer that the woman will interrupt using the method.
- Ask participants to think about the extent to which side-effects can lead to giving up the method. Facilitate a discussion whose goal is to identify solutions for management of side-effects.

- Ask participants what are the causes which can lead to the method's failure and go over the correct administration of the method.
- Compare the discussed methods with the list which record the features of the ideal contraceptive and conclude that neither this method constitutes an ideal contraceptive.

3. Eligibility Criteria for Progestagen Only Contraceptives (30 min)

- Divide participants into 4 groups.
- Give each group a case study and indicate the fact that they have 10 minutes to check in which W.H.O. category the client belongs as to the progestagen methods, by using the W.H.O. Guide - *Eligibility Criteria*. Ask them to fill in the Annexes for contraception for these cases.
- Walk around the trainees during the exercise and help them in order to successfully complete the exercise.
- After the 10 minutes have expired, ask one of the groups to present their case and their solution, through nominating a representative.
- After he/ she have carried out the presentation, ask his/ her team colleagues whether they would like to add anything.
- Afterwards, ask participants if there any questions or misunderstandings.
- Do the same with the other 3 groups.
- Summarize by stating the fact that these methods have very few limits in usage; they represent a very useful alternative to some women which present risks towards estrogen administration (temporary or permanent) due to the fact that they are easy to use, especially in the case of injectable contraceptives.
- Ask which the alarm signs are in the case of using these methods. The occurrence of the alarm signs requests referring the woman to a specialized service for consultation.

PROGESTAGEN ONLY CONTRACEPTIVES – PRESENTATION

Progestagen Only Pills (POP, Mono-hormonal pills or mini-pills)

They contain only one hormone, progesterone or progestagen derivate, in very small quantities. In Romania, the product Exluton is on the market; it contains a synthetic progestagen derivate called lynestrenol, with 28 pills per packet.

These are the best contraceptives for women who are breastfeeding.

Mechanism of Action

- It thickens the cervical mucus, making it difficult for sperm to pass through
- It blocks ovulation in almost half of the menstrual cycles.

Efficiency

Within common use they are very efficient in women who are breastfeeding: 1 pregnancy in 100 women within the first year of use.

Efficiency is very high when the method is correctly and continuously used, even outside the breastfeeding period: 0.5/ 100 women within the first year of use.

Reversibility

Immediate.

Administration

One pill taken daily, at the same time, without breaks. ATTENTION! Each packet contains 28 pills; after finishing one packet, immediately start a new one, without break.

How to start using POP

- After delivery:
 - if the woman is breastfeeding –she can begin in the 6th week after delivery (if the woman is not fully breastfeeding or if the menstruations have come back or if the child is over 6 months a FP method is necessary)
 - If the woman is not breastfeeding, she can start in any moment of the first 4 weeks after delivery, without having to wait for her menstrual periods to return, or after the first 4 weeks if she is reasonably certain that she is not pregnant.
- After abortion:
 - Immediately or in the first 7 days after an abortion or miscarriage (1st or 2nd trimester)
 - In any other moment later then 7 days, if the woman is reasonably certain that she is not pregnant.
- If the woman is menstruating:
 - In the first 5 days of the menstrual cycle (it is best to start in the first day); it is not necessary for her to use an additional method

- In any moment of the menstrual cycle, if she is reasonably certain that she is not pregnant; she needs to use an additional method (condoms or spermicides) in the first 2 days after starting to use the pills
- Immediately when stopping the correct use of another efficient contraceptive method.

Once this method is begun to be used, the pills will be taken continuously, without taking breaks between cycles of pills.

What to do when:

- The pills are missed
 - If the woman is not breastfeeding, delaying in taking a pill with a few hours (over 3 hours) might increase the risk of becoming pregnant (the risk raises significantly if more than 2 pills are omitted); she should take one pill as soon as she remembers and then keep taking the pills every day and an additional protection method will be used for the following 2 days;
 - If the woman is breastfeeding and is using progestagen only pills as additional protection, she continues to be protected even if she missed one pill;
- If digestive disorders occur (vomiting within less than 1 hour after taking the pill, diarrhea which persist for a few days) do the same as in the case of COC.
- If the woman has to undergo treatment with Rifampin, Griseofulvin or seizure medication do the same as in the case of COC

Side-effects

Common side-effects:

- changes in the regularity of the menstrual cycles (irregular menstruations, amenorrhea)
- inter-menstrual bleeding or spotting
- headaches (rarely)
- breast tenderness (more rarely than in the case of COC)

Menstrual changes, breast tenderness are less annoying to women who are breastfeeding, and thus they are easier to accept. In the case of women who are not breastfeeding and which have regular cycles, these minor side-effects might be perceived as unpleasant.

Injectable Contraceptives with Progestagene

Depot-medroxyprogesterone acetate (DMPA) is used most frequently – brand name: Depo-Provera, Megestron.

There are injectable contraceptives which contain another progestagen derivative called norethisterone enanthate (NET-EN) – brands' names: Norysterat, Doryxas.

Presently, in Romania, as well as in most of the countries of Europe and in the U.S.A., the product DMPA is being used.

Action Mechanism

- It stops ovulation
- Thickens the cervical mucus

Efficiency

Very effective: 0.3 pregnancies per 100 women in the first year of use, if are correctly administered.

Reversibility

The return of fertility can be slightly delayed (with approximately 4 months later than in the case of using other methods).

Administration

One injection every 3 months (2 months in the case of products containing NET-EN)

Important:

- bottles are to be stored with the cap upwards, in order to avoid precipitation on the interior of the cap;
- shake the vial vigorously and fill syringe with proper dose;
- verify whether the whole content has been aspired;
- avoid the loss of the content when releasing the air out of the syringe;
- the injection will be administered deep into a muscular area (in the gluteal muscle or in deltoid muscle);
- do not massage the injection site!

In order to avoid unpleasant aspects linked to the technique of injecting Depo-Provera, there are special syringes (auto-disposable syringes), with the aid of which administration mistakes, which can lead to the failure of the method, are avoided.

If the administration of the injection cannot be done at the scheduled time (3 months interval), the injection can be done 2 weeks earlier or 2 weeks later.

If the woman has delayed the administration of the injection with more than 2 weeks, it is necessary to avoid intercourse or to use another method until she will be able to come back to the office.

How to begin the use of injectable contraceptive:

- After birth
 - if the woman is breastfeeding –she can begin in the 6th week after delivery (if a woman is not fully breastfeeding or if her menstrual bleeding return or if the child is over 6 months, she need a contraceptive method)

- If the woman is not breastfeeding, she can start in any moment of the first 4 weeks, without having to wait for her menstrual bleeding to return, or after the first 4 weeks if she is certain that she is not pregnant.
- After abortion
 - Immediately or in the first 7 days after a miscarriage or abortion
 - Later, in any other moment, if the woman is certain that she is not pregnant.
- If the woman is menstruating
 - In the first 5 days of the menstrual cycle (it is best to start in the first day); it is not necessary for her to use an additional method
 - In any moment of the menstrual cycle, if she is certain that she is not pregnant; she needs to use an additional method (condoms or spermicides) in the first 2 days after starting to use the pills
- Immediately after correct use of another efficient contraceptive method.

Side-effects

- Changes in the menstrual cycle: inter-menstrual bleedings, spotting, amenorrhea
- Weight gain
- Acne
- Headache
- Breast tenderness.

MANAGEMENT OF SIDE EFFECTS OF THE PROGESTAGEN CONTRACEPTIVES

SIDE EFFECT	ATTITUDE
Amenorrhea	If client uses POP, check if she takes it correctly (this rarely occurs in the case of POP) If client is using an injectable contraceptive, explain that this effect is relatively frequent (up to 40% of the users in the first year if use) Check for pregnancy. Perform/recommend a gynecological exam. If the woman is older than 45-50, stop the method and wait 9 months in order to see if her menstruations reappear; meanwhile, recommend a non-hormonal method.
Light Bleeding/ Spotting Prolonged/ Medium bleeding	Explain in a friendly way to the client that it is normal and she doesn't have to worry. If bleeding prolonged or becomes moderate (> normal menstruation) recommend a gynecological exam in order to exclude other causes (e.g.: genital disorders, cervicitis, cervical polypus, uterine fibroma). Check for pregnancy.
Prolonged/ Heavy bleeding	Recommend gynecological exam. Verify if woman has anemia (Hb/ Ht) and give treatment with iron preparations.
Lower abdominal pain	Take client history, perform physical exam (pulse, blood pressure, temperature), and exclude an ectopic pregnancy (in the case of POP), pelvic inflammatory disease, ovarian cysts – recommend gynecological exam.
Weight Gain	Check food ingestion and physical effort. Weight gain > 2 kg. – revise the diet. Change the method if the situation is not acceptable for her.
Acne	Recommend cleansing of the face twice a day and avoiding greasy creams. If the situation is intolerable, help client to choose another method.
Breast tenderness	Check for pregnancy. Examine breasts for nodules or galacthorea (in non-breastfeeding woman) If the physical exam detects a possible cancer formation, refer the client to an adequate service for diagnosis. If not, reassure the client that it is only a regular and harmless side effect.
Excessive hair growth/ Hirsutism	The pre-existent states, such as hypertrichose, might become more serious. Assure the woman that these changes are not excessive and they might improve in time.
Depression/ Decrease of libido	They might be caused by the use of progestatives. Aid client to choose another method if she wants to.
Nausea. Vomiting	Check for pregnancy. If the client is not pregnant, explain that it is not a serious problem and that it disappears in time.

CASE STUDIES

1. One of your patients has been diagnosed with pulmonary tuberculosis for which she has received treatment with Rifampin and HIN. Until now she has used Exluton. She asks you if her contraceptive method will be influenced by the treatment.
2. A 38 years old patient wishes to take "pills", but she has heard that these are harmful for smokers. She usually smokes around 20 cigarettes a day. What do you tell her?
3. You make a postnatal home visit to a woman who delivered 4 weeks ago and she is breastfeeding. Everything is alright with she and her baby; she has enough milk for the infant. She asks you: "What can I do from now on in order to avoid to become pregnant?"
4. 18 year old woman wants a very "sure" and easy to administrate contraceptive method. Alternatives?

One of your patients, a 26 years old woman, known to have prolapsed mitral valve, just has had an abortion. She wants a modern contraceptive method (until now they used withdrawal and she does not want to go through another abortion). What do you tell her?

Progestagen -Only Contraceptives (Presentation)

Progestagen Only Pills (POP, Mono-hormonal pills or mini-pills)

They contain only one hormone, progesterone or progestagen derivate, in very small quantities. In Romania, the product Exluton is on the market; it contains a synthetic progestagen derivate called lynestrenol, with 28 pills per packet.

These are the best contraceptives for women who are breastfeeding.

Mechanism of Action

- It thickens the cervical mucus, making it difficult for sperm to pass through
- It blocks ovulation in almost half of the menstrual cycles.

Efficiency

Within common use they are very efficient in women who are breastfeeding: 1 pregnancy in 100 women within the first year of use.

Efficiency is very high when the method is correctly and continuously used, even outside the breastfeeding period: 0.5/ 100 women within the first year of use.

Reversibility

Immediate.

Administration

One pill taken daily, at the same time, without breaks. ATTENTION! Each packet contains 28 pills; after finishing one packet, immediately start a new one, without break.

How to start using POP

- After delivery:
 - if the woman is breastfeeding –she can begin in the 6th week after delivery (if the woman is not fully breastfeeding or if the menstruations have come back or if the child is over 6 months a FP method is necessary)
 - If the woman is not breastfeeding, she can start in any moment of the first 4 weeks after delivery, without having to wait for her menstrual periods to return, or after the first 4 weeks if she is reasonably certain that she is not pregnant.
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 - In any moment of the menstrual cycle, if she is reasonably certain that she is not pregnant; she needs to use an additional method (condoms or spermicides) in the first 2 days after starting to use the pills
- Immediately when stopping the correct use of another efficient contraceptive method.

Once this method is begun to be used, the pills will be taken continuously, without taking breaks between cycles of pills.

What to do when:

- The pills are missed
 - If the woman is not breastfeeding, delaying in taking a pill with a few hours (over 3 hours) might increase the risk of becoming pregnant (the risk raises significantly if more than 2 pills are omitted); she should take one pill as soon as she remembers and then keep taking the pills every day and an additional protection method will be used for the following 2 days;
 - If the woman is breastfeeding and is using progestagen only pills as additional protection, she continues to be protected even if she missed one pill;
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- If the woman has to undergo treatment with Rifampicine, Griseofulvine or seizure medication do the same as in the case of COC

Side-effects

Common side-effects:

- changes in the regularity of the menstrual cycles (irregular menstruations, amenorrhea)
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Efficiency

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Administration

One injection every 3 months (2 months in the case of products containing NET-EN)

Important:

- bottles are to be stored with the cap upwards, in order to avoid precipitation on the interior of the cap;
- shake the vial gently and fill syringe with proper dose;
- verify whether the whole content has been aspired;
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- After birth
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- Immediately after correct use of another efficient contraceptive method.

Side-effects

- Changes in the menstrual cycle: inter-menstrual bleedings, spotting, amenorrhea
- Weight gain
- Acne
- Headache
- Breast tenderness.

Management of Side Effects

SIDE EFFECT	ATTITUDE
Amenorrhea	<p>If client uses POP, check if she takes it correctly (this rarely occurs in the case of POP)</p> <p>If client is using an injectable contraceptive, explain that this effect is relatively frequent (up to 40% of the users in the first year if use)</p> <p>Check for pregnancy.</p> <p>Perform/recommend a gynecological exam.</p> <p>If the woman is older than 45-50, stop the method and wait 9 months in order to see if her menstruations reappear; meanwhile, recommend a non-hormonal method.</p>
Light Bleeding/ Spotting Prolonged/ Medium bleeding	<p>Explain in a friendly way to the client that it is normal and she doesn't have to worry.</p> <p>If bleeding prolonged or becomes moderate (> normal menstruation) recommend a gynecological exam in order to exclude other causes (e.g.: genital disorders, cervicitis, cervical polypus, uterine fibroma).</p> <p>Check for pregnancy.</p>
Prolonged/ Heavy bleeding	<p>Recommend gynecological exam.</p> <p>Verify if woman has anemia (Hb/ Ht) and give treatment with iron preparations.</p>
Lower abdominal pain	<p>Take client history, perform physical exam (pulse, blood pressure, temperature), and exclude an ectopic pregnancy (in the case of POP), pelvic inflammatory disease, ovarian cysts – recommend gynecological exam.</p>
Weight Gain	<p>Check food ingestion and physical effort.</p> <p>Weight gain > 2 kg. – revise the diet.</p> <p>Change the method if the situation is not acceptable for her.</p>
Acne	<p>Recommend cleansing of the face twice a day and avoiding greasy creams. If the situation is intolerable, help client to choose another method.</p>
Breast tenderness	<p>Check for pregnancy.</p> <p>Examine breasts for nodules or galacthorea (in non-breastfeeding woman)</p> <p>If the physical exam detects a possible cancer formation, refer the client to an adequate service for diagnosis.</p> <p>If not, reassure the client that it is only a regular and harmless side effect.</p>
Excessive hair growth/ Hirsutism	<p>The pre-existent states, such as hypertrichose, might become more serious.</p> <p>Assure the woman that these changes are not excessive and they might improve in time.</p>
Depression/ Decrease of libido	<p>They might be caused by the use of progestatives. Aid client to choose another method if she wants to.</p>
Nausea. Vomiting	<p>Check for pregnancy.</p> <p>If the client is not pregnant, explain that it is not a serious problem and that it disappears in time.</p>

Checklist

- Description/ Presentation of method
- Mechanisms of action
- Efficiency
- Reversibility
- Administration
- Drugs interactions
- Side-effects

Session 8: Intrauterine Device

Objectives:

At the end of the session, participants:

- Will describe IUD: types of IUD, mechanism of action, efficiency, advantages, disadvantages, side-effects, alarm signs, reversibility
- Will be familiar with eligibility criteria for IUD, in conformity with the WHO recommendations
- Will list the medical units in the region where the IUD insertion can be performed for their clients

Time: 45 min

Techniques: Presentation, working groups, case studies

Materials:

Trainer's documents

- 8.1 Description of the Method
- 8.2 IUD Case Studies
- 8.3 IUD Side Effects
- 8.4 IUD Samples

Handouts

- 8.1 Description of the Method
- 8.2 IUD Side Effects
- 8.3 List of medical units where IUD insertion can be performed within PN3 *(to be elaborated by the local trainers together with the DPHA representatives during the preparation for the workshop, one day before training)*

Activities:

1. Intrauterine Device – IUD (30 min)

- In the beginning, pass the IUD to the first participant on your left in order for him/ her to examine it and to express his/ her opinions about it. Exercise will continue until all participants will express their opinions on it.
- Make a short presentation of the information regarding IUD necessary for the family doctor (15 min) (mechanism of action, possible side-effects and their management, efficiency, reversibility, conditions for IUD insertion, self-control (strings checking) , follow-up visits)
- Ask the group what are the IUD advantages and disadvantages.
- Write down the statements on the flipchart. Make clarifications if needed (10 min).
- Compare this method with the ideal contraceptive.

2. IUD Eligibility Criteria (15 min)

- Ask: “Who can use this method?” and invite participants to give the answers.
- Divide participants into groups of three and distribute to each group a **Case Study**. Ask them to find solutions for the proposed cases. Tell them to use the “**WHO Eligibility Criteria**” for their work.
- One representative of each group will present the case and the identified solutions.
- Clarify the practical aspects regarding the use of IUD (*if needed, use WHO Guide “**Medical Practice Recommendations**”*).
- *Distribute the handouts “**IUD Description**” and “**List of medical units/ clinics**” towards which they can orient clients for IUD insertion.*

Intra Uterine Device – Presentation

Types of IUD available in Romania

- Copper IUD: T Cu-380 A
- Progestagen (levonogestrel) IUD: Mirena

Mechanism of Action

- IUD works by preventing sperm and egg from meeting.
- It makes it hard for sperm to move through the feminine genital tract and it reduces the ability of sperm to fertilize the ovule (secondary mechanism).
- It prevents egg from implanting in wall of uterus (secondary mechanism).
- It stops ovulation (Progestagen IUD – main mechanism).

Efficiency

Very high – 0.8 pregnancies per 100 women in the first year of use (up to 0.6/ 100 in correct use); higher efficiency for Mirena.

Reversibility

Immediately after the IUD removal from the uterine cavity.

Side Effects

Common side effects:

- Changes in the menstrual cycles
- Spotting or inter-menstrual bleeding
- Cramps or pain during periods

Other, uncommon side-effects:

- Heavy menstrual bleeding or inter-menstrual bleedings, with risk of secondary anemia – very rare in the case of Copper IUD use, inexistent in the case of Mirena use
- Severe cramps and pain beyond the first 3-5 days after insertion
- Perforations of the walls of the uterus – very rare if IUD properly inserted.

Conditions for IUD Insertion

- ❖ Excluding pregnancy (see special chapter in Medical Practice Recommendations)
- ❖ Healthy reproductive tract (vaginal examination – with valves/speculum and bimanual examination – are mandatory before IUD insertion)
- ❖ Excluding a reproductive tract infection / STI by taking a correct and accurate medical history (mandatory=Class A) or by laboratory tests (these are not compulsory=Class B)

- ❖ Excluding sexual behaviors associated with a high risk for STIs/HIV.

IUD can be inserted:

- Anytime during the menstrual cycle, if it is reasonably sure that the woman is not pregnant (she hasn't had intercourse since her last normal period or she has correctly and consistently used an efficient contraceptive method)
- Immediately after an abortion upon request, if there are no signs of infection
- Immediately after birth (10 minutes – 48 hours) by trained personnel
- 4 weeks after birth in the case of T Cu-380A IUD
- 6 weeks after birth in the case of Progestagen IUD (Mirena)

Control

- After each period the woman will do self-control, through introducing 1-2 fingers in her vagina as far as she can until she feels the strings.
- Client will come back for a routine check-up 3-6 weeks after IUD insertion
- Client will come back for check-up anytime if:
 - she can no longer feel the strings or she can feel something hard at the level of the cervix (the IUD stem)
 - she missed her period or she has had a modified menstrual bleeding (regarding flow, timing of the period) or accompanied by signs of pregnancy
 - she thinks may have been exposed to STI or she has HIV
 - she has heavy or prolonged menstrual bleedings
 - she has severe pain in the lower abdomen, especially if it is associated with fever, intermenstrual bleedings
 - she or her partner are unsatisfied with the method
 - she wants the IUD removal for any reason
 - she wants another contraceptive method
 - the period of use has expired (10 years for T Cu 380 A, 5 years for Mirena).

CASE STUDIES

- 32 years old woman, with 2 children, 4 abortions, out of which the last, recently performed, has lead to an infection, requests for IUD.
- Woman, 21, multiple partners, requests IUD (she has used a combined oral contraceptive, but the method has failed, due to incorrect administration and has undergone an abortion).
- 25 years old woman has gone through a Cesarean section within an interval shorter than 12 months.
- 31 years old woman, with a cervical lesion treated 6 years ago (by electro-cauterization), requests IUD.
- 28 years old woman, with 2 children and an ectopic pregnancy (left salpingectomy), requests IUD.
- 34 years old woman, IUD carrier for 2 years, complains with prolonged menstrual bleedings and pains in lower abdomen for two months.

IUD Side Effects

SIDE EFFECT	SUGGESTIONS
Amenorrhea	Ask the woman: <ul style="list-style-type: none"> - when she had her last period - when she has last felt the strings - whether she has pregnancy symptoms Check for pregnancy. Perform/ refer for a gynecological exam.
Irregular bleeding	Refer for a gynecological exam in order to exclude other causes (e.g.: genital tract disorders, cervical infection, cervical polypus, uterine fibroma). Exclude pregnancy (intra-uterine or ectopic).
Prolonged/ Heavy bleeding	Refer for gynecological examination. Check for anemia (Hb/ Ht) and, if yes, recommend iron therapy. If the client has an IUD inserted for more than 3 months, recommend extraction and offer counseling for another contraceptive method (or Progestagen IUD).
Pain in lower abdomen	Take client history, perform physical exam (pulse, BP, temperature) and recommend gynecological examination in order to exclude a possible ectopic pregnancy, pelvic inflammatory disease, ovarian cysts.
Pelvic infection	Refer for gynecological exam and supervise the treatment.
STI high-risk/ STIs symptoms	Take client history. Refer for laboratory tests and treatment. If the woman presents a high STI risk, emphasize the risks of continuing IUD use. Also, recommend the use of condoms and help her choose the method.
Strings missing	Ask client: <ul style="list-style-type: none"> - if she knows whether the IUD has been expelled - when she had her last period - when she has last felt the strings - if she has used an additional method starting with the moment when she noticed the strings missing Exclude pregnancy Refer for gynecological exam
The strings are felt by her partner	Check whether the IUD is in its place or not (it is not partially expelled) Options: <ul style="list-style-type: none"> - Cutting the strings shorter until they reach the external ostium of the cervix (the woman will be informed about this and it will be written in her chart) - IUD removal

Intra Uterine Device – Presentation

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Mechanism of Action

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- It stops ovulation (Progestagen IUD – main mechanism).

Efficiency

Very high – 0.8 pregnancies per 100 women in the first year of use (even 0.6/ 100 in correct use); higher efficiency for Mirena.

Reversibility

Immediately after the IUD removal from the uterine cavity.

Side Effects

Common side effects:

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Other, uncommon side-effects:

- Heavy menstrual bleeding or inter-menstrual bleedings, with risk of secondary anemia – very rare in the case of Copper IUD use, inexistent in the case of Mirena use
- Severe cramps and pain beyond the first 3-5 days after insertion
- Perforations of the walls of the uterus – very rare if IUD properly inserted.

Conditions for IUD Insertion

- ❖ Excluding pregnancy (see special chapter in Medical Practice Recommendations)
- ❖ Healthy reproductive tract (vaginal examination – with valves/speculum and bimanual examination – are mandatory before IUD insertion)
- ❖ Excluding a reproductive tract infection / STI by taking a correct and accurate medical history (mandatory=Class A) or by laboratory tests (these are not compulsory=Class B)

- ❖ Excluding STIs high-risk sexual behaviors.

IUD can be inserted:

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- Immediately after an abortion upon request, if there are no signs of infection
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- Client will come back for check-up anytime if:
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Prolonged/ Heavy bleeding	Refer for gynecological examination. Check for anemia (Hb/ Ht) and, if yes, recommend iron therapy. If the client has an IUD inserted for more than 3 months, recommend extraction and offer counseling for another contraceptive method (or Progestagen IUD).
Pain in lower abdomen	Take client history, perform physical exam (pulse, BP, temperature) and recommend gynecological examination in order to exclude a possible ectopic pregnancy, pelvic inflammatory disease, ovarian cysts.
Pelvic infection	Refer for gynecological exam and supervise the treatment.
STI high-risk/ STIs symptoms	Take client history. Refer for laboratory tests and treatment. If the woman presents a high STI risk, emphasize the risks of continuing IUD use. Also, recommend the use of condoms and help her choose the method.
Strings missing	Ask client: <ul style="list-style-type: none"> - if she knows whether the IUD has been expelled - when she had her last period - when she has last felt the strings - if she has used an additional method starting with the moment when she noticed the strings missing Exclude pregnancy Refer for gynecological exam
The strings are felt by her partner	Check whether the IUD is in its place or not (it is not partially expelled) Options: <ul style="list-style-type: none"> - Cutting the strings shorter until they reach the external ostium of the cervix (the woman will be informed about this and it will be written in her chart) - IUD removal

List of medical units recommended for IUD Insertion

(this list must be elaborated by the trainers, with the aid of the DPHA representatives)

Session 9: Barrier Methods

Objectives:

At the end of the session, participants will be able to:

- Describe barrier methods (presentation, utilization, etc.)
- Demonstrate the correct use of the condom
- Identify barriers in using the condom and will propose solutions for overcoming these

Time: 90 minutes

Techniques: Exercises, demonstration, dyads, brainstorming, discussions

Materials:

Flipchart/Overhead

6.1 Information regarding contraceptive methods

Trainer's documents

9.1 Steps in condom use – cards

9.2 Presentation of the barrier methods

9.3 Samples: condoms, diaphragm, spermicides (different types)

Handouts

9.1 Correct steps in condom use

9.2 Presentation of the barrier methods

9.3 Condoms (sufficient number for all participants)

Activities:

1. The Condom (60 min)

- Give a condom to the first participant on your right side and ask about his/her feelings, reactions towards this “object”; after the first person has expressed his/ her point of view, he/ she will pass it on to the neighbor on his right and so on until all participants will have had the occasion of stating their opinions regarding the condom (10 min).

Pay attention to the trainees' non-verbal messages during this exercise; it helps you to identify their attitudes towards the condom).

- Hand each participant a note/ card containing a “step” in the condom use (*use the Trainer's document 9.1 **Steps in condom use – cards**; be sure that you have copies before each training that you are conducting!*).
- Ask participants to get up from their chairs and to find the right place, in a logical time frame, forming a circle. (10 min)

If the number of trainees does not correspond to the number of cards, you might ask them to work in small groups, each group receiving a set of cards; within each group, the cards will be placed in order according to the correct steps in condom use. At the end of the

exercise, each group will present its result and will compare it with the results of the other groups.

- At the end of the exercise, ask for a volunteer and demonstrate the use of the condom, following the participants' indications. (5 min).
- Demonstrate the correct way of using the condom, if needed. Then divide the participants into pair groups and ask them to "demonstrate" the correct way of using the condom. (10 min) (*Make sure that all participants are working! Do not forget that some of them may directly experience the condom use for the first time in their life*).
- Distribute the handout 9.1 **Steps in condom use**.
- List with the aid of participants the advantages and disadvantages of the condom. Write down each statement on a flipchart paper divided into two columns: one for advantages and the other for disadvantages. Review the elements proposed by the participants, offer additional information, corrections if necessary; try to bring arguments in order to eliminate incorrect information, misconceptions, "myths" regarding the condom. (15 min) (Example: *A frequent disadvantage brought in discussion is a reduction in tactile sensations; ask participants to palpate their nose tip with one of their fingers and then with another finger covered with a condom; ask: can you feel your nose through the condom? Emphasize that a slight reduction in tactile sensations can extend the duration of the sexual intercourse, most of the couples considering this as an advantage.*)
- Stress the importance of the double protection, against unwanted pregnancy, as well as against STIs and emphasize that condom is the only method which ensures double protection.
- Compare the condom with the ideal contraceptive.

2. Condom Use (15 min)

- Ask participants to name difficulties in approaching the discussion regarding the condom with their clients; list the answers on the flipchart; then ask the group to offer solutions for identified problems. If the group doesn't give the answers, offer them yourself. (*It is possible to receive from participants the arguments stated by trainer during the presentation of the disadvantages, which indicates the fact that they have correctly understood the message and -maybe- some of them changed their attitude towards the condom*)
- Ask participants to check, with the aid of **WHO Guide - Medical Eligibility Criteria** whether there are limits in the use of condom (5 min).
- State the fact that in the case of distributing condoms to clients, it isn't necessary to complete an "Annex A and B for Contraception"; Only an Annex C will be filled in, which the client will sign for receiving condoms and will be attached to the client's medical file existent at the Family Doctors' cabinet (number of condoms is 12 pieces/ month or 36 pieces/ visit, in order to standardize the follow-up/supplying visit at 3 months).
- Summarize by asking: Who should use the condom and when? Listen to the answers and offer additional information if necessary.

Make sure that the following types of messages were mentioned:

- Each sexual contact needs protection against STD

- Any type of sexual contact needs protection (including oral and anal sex)
- Women, as well as men, should know how to use the condom and they should have it on them.
- There are no contra-indications for the condom use

3. Other barrier methods (15 min)

- Make a short presentation of the other local methods (spermicides, diaphragm, female condom/femidom), following the general model for presentation of the contraceptive methods. State the correct way for utilization of each method.
- Tell trainees that, even if they will not distribute these barrier methods in their cabinets, it is important for them to know the correct way of use and to inform the clients who want, for example, to purchase them from the drugstore.
- Distribute the handout 9.2 *Presentation of the barrier methods*.

Steps in Condom Use

Eliminate the air from the tip of the condom	Sexual intercourse	Open the package
The penis becomes erect	Man ejaculates	Carefully remove the condom
Throw the condom in the garbage can	Withdraw the penis before it becomes flaccid	Place the unrolled condom on the tip of the penis
Bend the penis and carefully remove the condom	Check the expiry date	Maintain the condom at the base of the penis
Both partners are sexually aroused	Tie a knot at the end of the condom	Unroll the condom all the way to the base of the penis

N.B. Before each workshop, make sure that you have enough copies of this material! (it is possible that you will complete this exercise with few small groups of participants).

Presentation of the Barrier Methods

THE CONDOM

The condom is a protection method against unwanted pregnancy and against STIs.

It is destined to cover the penis when in erection.

Most of the times, it is made out of very thin latex. Some condoms are covered with a lubricant or with spermicidal substances.

In some countries, there are also female condoms ("femidom"), which cover the walls of the vagina.

Efficiency is very high when used correctly, every time: 3 pregnancies per 100 women in the first year of use.

Relatively efficient as commonly used– 14 pregnancies per 100 women in the first year of use.

Advantages

- Condoms are the best way of preventing STIs and HIV/ AIDS.
- Helps prevent the pathological states caused by STIs – pelvic inflammatory disease, chronic pain, infertility, cervical cancer.
- They may be used during pregnancy for STIs prevention
- They do not have side-effects; they are harmless
- They may be used by women while breastfeeding
- Helps prevent ectopic pregnancy
- Does not need daily administration
- They may be purchased from various places
- Their use can be interrupted in any moment, with immediate reversibility
- Helps prevent premature ejaculation
- Involves the man in contraception decisions

Disadvantages

- Very rare they can determine allergies (due to lubricants or latex)
- They may decrease the sensations during the sexual intercourse
- They interfere with the sexual intercourse
- There is the risk that the condom might break or slide during sexual intercourse
- The man's cooperation is needed
- To some people, purchasing the condoms, discussing with the partner regarding the use of condoms may be embarrassing.

Use Instructions

When buying condoms check the manufacture date and the expiry date on the package.

The condom will be placed only on the erect penis!

In order to use the condom correctly:

- Open the package
- Carefully remove the condom
- Hold the condom with the rolled side up
- Eliminate air from the tip of the condom

- Pull the foreskin back
- Put the unrolled on the tip of the penis
- Completely unroll the condom all the way to the base of the penis
- Sexual intercourse
- Man ejaculates
- After ejaculation, hold the rim of the condom to the base of the penis so it will not slip off
- Withdraw the penis before it becomes flaccid
- Bend the penis and carefully remove the condom
- Tie a knot at the end of the condom
- Throw the condom in the garbage can (avoid throwing the condom in the toilet, where the condom floats); do not throw it in places that can easily be reached by children, which can play with it, exposing themselves to infection risks.

If the condom breaks, a spermicide may be immediately applied in the vagina; washing the vagina and the penis with water and soap will reduce the risks of STI occurrence. In order to prevent pregnancy, the woman may request emergency contraception.

Condoms should be kept in cool and dark places, protected from sunlight. Heat, light and humidity damage condoms.

If the package is damaged, do not use the condom.

VAGINAL BARRIER METHODS

There are woman-controlled methods, so that woman may use them whenever she needs them; they are to be placed in the vagina before engaging in sexual intercourse.

There are more types of local/ vaginal methods:

- Spermicides – tablets, ovules, foaming tablets, films, gel, cream
- Diaphragm – a soft rubber cupola which covers the uterine cervix and which is used together with a spermicidal gel or cream; it is rarely used in Romania
- The cervical cap – a cupola smaller than a diaphragm; isn't used in Romania

Mechanism of Action

Spermicides destroy sperms or it affects their motility, so that these can no longer move toward ovule to fecundate it.

The diaphragm and the cupola constitute a mechanical barrier, which impedes the penetration of the spermatozoa into the uterus.

Efficiency

Efficiency depends on the correct and constant use, as well as on the type of spermicide.

In common use, spermicides are somewhat efficient – 20 pregnancies per 100 women in the first year of use.

In correct and constant use, efficiency is higher – 6 pregnancies per 100 women in the first year of use.

Reversibility

Immediate.

Side Effects

Spermicide

- Irritations in women, as well as in men (especially if used more than once a day)
- Local allergic reactions (rarely)

Diaphragm

- May increase the frequency of the occurrence of urinary infections in women who use it

Use Instructions

The use of these methods may start whenever the woman wants.

Spermicides are introduced deep into the vagina, close to the uterine cervix, with the aid of the fingers or an applicator (in the case of cream, foam and gel). Can be inserted as much as mostly 1 hour before the sex to avoid interruption. If tablets, ovules or films are used, it is necessary to wait minimum 10 minutes after these are introduced, in order for them to dissolve in the interior of the vagina.

If more than one sexual contact, a new dose of spermicide is needed before each sexual intercourse.

Vaginal douches are not allowed at least 6 hours after the (last) sexual intercourse.

The diaphragm is inserted into the vagina, following a technique which is shown to the woman in the FP consultation.

Before inserting the diaphragm, place a quantity of spermicidal cream or jelly in the cup of the diaphragm and around the rim.

The opposite sites of the rim are pressed and diaphragm is introduced deep into the vagina, so that the posterior side will be inserted in the back of the uterine cervix, in the posterior fornix of the vagina; anterior, the diaphragm is positioned in the back of the symphysis pubis. The correct position of the diaphragm will be checked through palpation.

After sexual intercourse, the diaphragm will be kept in the vagina at least 6 hours, but no longer than 24 hours (risk of Toxic Shock Syndrome).

The removing of the diaphragm will be done gently, with one finger put under the rim, which pulls it down and out.

The diaphragm will be washed with water and non-alkaline soap after each use. It is reusable over a period of maximum 2 years.

The Correct Steps in Condom Use

1. Check the expiry date
2. Both partners are sexually aroused
3. The penis becomes erect
4. Open the package
5. Carefully remove the condom
6. Eliminate the air contained in the tip of the condom
7. Place the unrolled condom on the tip of the penis
8. Completely unroll the condom all the way to the base of the penis
9. Sexual intercourse
10. Man ejaculates
11. Maintain the condom at the base of the penis
12. Withdraw the penis before it becomes flaccid
13. Bend the penis and carefully remove the condom
14. Tie a knot at the end of the condom
15. Throw the condom in the garbage can

Presentation of the Barrier Methods

THE CONDOM

The condom is a protection method against unwanted pregnancy and against STIs.

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Most of the times, it is made out of very thin latex. Some condoms are covered with a lubricant or with spermicidal substances.

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Efficiency is very high when used correctly, every time: 3 pregnancies per 100 women in the first year of use.

Relatively efficient as commonly used– 14 pregnancies per 100 women in the first year of use.

Advantages

- Condoms are the best way of preventing STIs and HIV/ AIDS.
- Helps prevent the pathological states caused by STIs – pelvic inflammatory disease, chronic pain, infertility, cervical cancer.
- They may be used during pregnancy for STIs prevention
- They do not have side-effects; they are harmless
- They may be used by women while breastfeeding
- Helps prevent ectopic pregnancy
- Does not need daily administration
- They may be purchased from various places
- Their use can be interrupted in any moment, with immediate reversibility
- Helps prevent premature ejaculation
- Involves the man in contraception decisions

Disadvantages

- Very rare they can determine allergies (due to lubricants or latex)
- They may decrease the sensations during the sexual intercourse
- They interfere with the sexual intercourse
- There is the risk that the condom might break or slide during sexual intercourse
- The man's cooperation is needed
- To some people, purchasing the condoms, discussing with the partner regarding the use of condoms may be embarrassing.

Use Instructions

When buying condoms check the manufacture date and the expiry date on the package.

The condom will be placed only on the erect penis!

In order to use the condom correctly:

- Open the package
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- Hold the condom with the rolled side up
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If the condom breaks, a spermicide may be immediately applied in the vagina; washing the vagina and the penis with water and soap will reduce the risks of STI occurrence. In order to prevent pregnancy, the woman may request emergency contraception.

Condoms should be kept in cool and dark places, protected from sunlight. Heat, light and humidity damage condoms.

If the package is damaged, do not use the condom.

VAGINAL BARRIER METHODS

There are woman-controlled methods, so that woman may use them whenever she needs them; they are to be placed in the vagina before engaging in sexual intercourse.

There are more types of local/ vaginal methods:

- Spermicides – tablets, ovules, foaming tablets, films, gel, cream
- Diaphragm – a soft rubber cupola which covers the uterine cervix and which is used together with a spermicidal gel or cream; it is rarely used in Romania
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Mechanism of Action

Spermicides destroy sperms or it affects their motility, so that these can no longer move toward ovule to fecundate it.

The diaphragm and the cupola constitute a mechanical barrier, which impedes the penetration of the spermatozoa into the uterus.

Efficiency

Efficiency depends on the correct and constant use, as well as on the type of spermicide.

In common use, spermicides are somewhat efficient – 20 pregnancies per 100 women in the first year of use.

In correct and constant use, efficiency is higher – 6 pregnancies per 100 women in the first year of use.

Reversibility

Immediate.

Side Effects

Spermicide

- Irritations in women, as well as in men (especially if used more than once a day)
- Local allergic reactions (rarely)

Diaphragm

- May increase the frequency of the occurrence of urinary infections in women who use it

Use Instructions

The use of these methods may start whenever the woman wants.

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If more than one sexual contact, a new dose of spermicide is needed before each sexual intercourse.

Vaginal douches are not allowed at least 6 hours after the (last) sexual intercourse.

The diaphragm is inserted into the vagina, following a technique which is shown to the woman in the FP consultation.

Before inserting the diaphragm, place a quantity of spermicidal cream or jelly in the cup of the diaphragm and around the rim.

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After sexual intercourse, the diaphragm will be kept in the vagina at least 6 hours, but no longer than 24 hours (risk of Toxic Shock Syndrome).

The removing of the diaphragm will be done gently, with one finger put under the rim, which pulls it down and out.

The diaphragm will be washed with water and non-alkaline soap after each use. It is reusable over a period of maximum 2 years.

Session 10: Voluntary Surgical Contraception

Objectives:

At the end of the session, trainees:

- Will describe the voluntary surgical sterilization: mechanism of action, efficiency, reversibility, advantages, disadvantages, side-effects, possible complications and their approaching
- Will be familiar with WHO recommendations for VSC.
- Will list the places where the method can be obtained.

Time: 30 minutes

Techniques: Presentation, discussion, brainstorming, listing, chart work

Materials:

Trainer's document

10.1 Method Presentation

Handouts

10.1 Statements regarding the female and male surgical sterilization

10.2 Method Presentation

10.3 List with the medical units which can provide VSC services (this list must be elaborated by the trainers, with the aid of the DPHA representatives)

Activities

1. Female Surgical Contraception and Vasectomy (20 min)

- Make a short presentation of the methods, mechanism of action, advantages and disadvantages of the method. (10 min)
- Emphasize that this is a permanent, irreversible method of contraception.
- Offer information regarding the medical units, places where the VSC can be performed.
- Distribute the handout 10.1 ***Statements regarding the female and male surgical contraception***; divide participants in groups of 2; the participants read the statements and write down next to each whether they believe them to be true or false. The group discussion will take approximately 5 minutes. Afterwards, ask each trainee to read one statement, as well as the identified answer. Should there be any incorrect answers, request the opinion of the other participants and make the necessary corrections.

2. WHO Criteria for VSC (10 min)

- Invite participants to follow the chapter regarding VSC within **The WHO Guide**; go through the charts, clarify aspects linked to limits in the use of VSC, the reasons which impose prudence or postponing the decision of using the method.
- Distribute the handouts to participants.

Voluntary Surgical Contraception – Presentation

This method provides permanent contraception for persons who not want more children. It is a safe, simple and harmless surgical procedure, with no side-effects.

Female Surgical Contraception or Tubal Ligation

The method consists in blocking or sectioning of the uterine tubes, so that the ovules released by the ovaries can no longer come meet the sperm.

The method is very efficient (0.5 pregnancies per 100 women in the first year of use); it depends partially on the technique used.

Usually, the method is permanent, irreversible.

There are various surgical techniques. Usually the intervention can be performed under local anesthesia and light sedation. The approach is most of times done by laparoscopy, rarely through mini-laparotomy.

After surgery, the woman continues to have normal menstrual periods.

Male Surgical Contraception or Vasectomy

The method consists in blocking or sectioning of the deferent tubes/ ducts/ vessels that carry sperms from the testicles, so this intervention keeps sperm out of semen.

Efficiency is very high – 0.5 pregnancies per 100 couples in the first year of use. If the method is used correctly, the efficiency is greater. Correct use means that the man/ couple use consistently condoms or another effective contraceptive method for 3 months after the intervention or for at least 20 ejaculations, whichever comes first.

The technique is simple, rapid and it does not need hospitalization. The anesthesia is local, at the scrotum level, where the two deferent channels are approached.

After intervention, the man will have normal erections and ejaculations, the difference being that the ejaculated liquid does not contain semen (this fact can be confirmed by performing a semen analysis, which is not usually and necessary).

The VSC Advantages

- Very efficient method
- Permanent, performed only once
- It does not need medical follow-up after it has been performed, neither re-supply
- The user doesn't depend on something, he/ she doesn't need to remember anything particular (with the exception of the first 20 ejaculations in the case of vasectomy)
- It does not interfere with sex
- Increased sexual satisfaction, because no need to worry about pregnancy
- No health risks, neither long-term side-effects
- The cost-efficiency ratio is low (it costs at most once)

VSC Disadvantages

- Possible minor complications after the intervention: pain, tumefactions, bleeding at the level of incision, or infections (this should not occur at all if the rules regarding asepsis and antisepsis are strictly followed)
- Risks regarding the use of anesthetics
- Requires special trained medical staff, thus it is less accessible to population
- No protection against STIs
- The reversibility surgery is difficult, expensive and it is not available in most areas; plus, the successful reversal it cannot be guaranteed.

Statements on Female and Male Surgical Contraception

1. Tubal ligation leads to weight gain
2. Vasectomy leads to impotence
3. Tubal ligation stops menstrual periods.
4. Tubal ligation leads to headache, neurosis.
5. If wanted, the tubes or the deferent channels can be reversed.
6. If the tubes are cut, the hormones add up in the ovaries, because they no longer have where to flow out of the organism.
7. Tubal ligation leads to uterine cancer.
8. Tubal ligation can lead to high blood pressure (BP).
9. Surgical contraception is a very painful operation.
10. The man who has had a vasectomy does not ejaculate normally anymore.

Voluntary Surgical Contraception – Presentation

This method provides permanent contraception for persons who not want more children. It is a safe, simple and harmless surgical procedure, with no side-effects.

Female Surgical Contraception or Tubal Ligation

The method consists in blocking or sectioning of the uterine tubes, so that the ovules released by the ovaries can no longer come meet the sperm.

The method is very efficient (0.5 pregnancies per 100 women in the first year of use); it depends partially on the technique used.

Usually, the method is permanent, irreversible.

There are various surgical techniques. Usually the intervention can be performed under local anesthesia and light sedation. The approach is most of times done by laparoscopy, rarely through mini-laparotomy.

After surgery, the woman continues to have normal menstrual periods.

Male Surgical Contraception or Vasectomy

The method consists in blocking or sectioning of the deferent tubes/ ducts/ vessels that carry sperms from the testicles, so this intervention keeps sperm out of semen.

Efficiency is very high – 0.5 pregnancies per 100 couples in the first year of use. If the method is used correctly, the efficiency is greater. Correct use means that the man/ couple use consistently condoms or another effective contraceptive method for 3 months after the intervention or for at least 20 ejaculations, whichever comes first.

The technique is simple, rapid and it does not need hospitalization. The anesthesia is local, at the scrotum level, where the two deferent channels are approached.

After intervention, the man will have normal erections and ejaculations, the difference being that the ejaculated liquid does not contain semen (this fact can be confirmed by performing a semen analysis, which is not usually and necessary).

The VSC Advantages

- Very efficient method
- Permanent, performed only once
- It does not need medical follow-up after it has been performed, neither re-supply
- The user doesn't depend on something, he/ she doesn't need to remember anything particular (with the exception of the first 20 ejaculations in the case of vasectomy)
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- Possible minor complications after the intervention: pain, tumefactions, bleeding at the level of incision, or infections (this should not occur at all if the rules regarding asepsis and antisepsis are strictly followed)
- Risks regarding the use of anesthetics
- Requires special trained medical staff, thus it is less accessible to population
- No protection against STIs
- The reversibility surgery is difficult, expensive and it is not available in most areas; plus, the successful reversal it cannot be guaranteed.

List of Medical Units Providing VSC Services

(This list shall be developed by the trainers, aided by DPH representatives)

Session 11: Emergency Contraception

Objectives

By the end of the session, trainees:

- Will describe emergency contraception
- Will list the situations in which emergency contraception is needed

Time: 30 minutes

Techniques: Presentation, listing, discussions

Materials:

Flipchart/Overhead

11.1 Emergency Contraception

Trainer's document

11.1 Emergency Contraception –presentation

Handouts

11.1 Emergency Contraception - administration

11.2 Emergency Contraception –presentation

Activity:

Emergency Contraception

- Post on the flipchart ***Emergency Contraception***. Make a short presentation of the method (see Trainer's document). Tell participants that at the end of the session they will receive written material/handout on this method.
- Check whether the participants have understood how they can use the brand of contraceptives that they will receive for distribution to provide emergency contraception.
- State the fact that when they will provide this method to a woman, she has the right to know what kind of pills the method supposes.
- Ask participants to define the situations of unprotected sex. List the answers on the flipchart.

Expected Answers:

- The woman has had sexual intercourse without contraception
- The woman has had sex against her will
- The woman has used a contraceptive method, but it has failed: e.g. the condom broke, the diaphragm has slide out of the vagina before 6 hours, the IUD has been expelled, pills were trough out after less than 1 hour after administration.

- The woman has incorrectly used the contraceptive method: e.g. she has run out of pills or she has forgotten to take them, she has delayed administering a new dose of injectable contraceptive, she has done vaginal douche within less than 6 hours after using spermicidal jelly, etc.
 - The woman is using oral contraceptives and she has undergone treatment with a medicine which decreases the method's efficiency and she hasn't used any kind of additional protection.
- State the fact that in any of these situations emergency contraception can be used.
 - Emphasize that this type of contraception should not be used as routine ("in place of family planning methods"), but only in emergency situations (when unprotected sex has occurred and woman wants to avoid pregnancy).
 - Add the fact that frequent use of the method is not recommended due to the higher hormonal doses that it contains in comparison to regular use of oral contraceptives; add that if a woman repeatedly requests emergency contraception, she needs in fact a family planning method and she should be counseled for choosing one.
 - It is not recommended for a service provider to refuse to a client emergency contraception (even if she is not for the first time in this situation), if she is at risk of an unwanted pregnancy; unwanted pregnancy is, many times, more dangerous than using emergency contraception.
 - In the end of the session, distribute the two handouts to participants.

Emergency Contraception

1. Hormonal Contraception

Combined Oral Contraceptives

The pills should be administered up to 72 hours after unprotected sex.

Administration: 2 doses of 4 pills (low-dose COC)

- first dose: 4 pills Rigevidon/ Microgynon/ Lo-femenal, or 4 white pills out of the Tri-Regol blister/package (out of the last 10 pills)
- second dose: another 4 pills the same type as the ones used for the first dose, 12 hours later

Progestagen Oral Contraceptives

POP should be administered in the first 72 hours following unprotected sex (administration within the first 48 hours increases efficiency)

Administration:

1 tablet containing 0.75 mg levonogestrel (LNG) and after 12 hours, another tablet (commercial brand existing in Romania: Postinor II)

2. IUD

IUD should be inserted in the first 5 days after unprotected sex.

Emergency Contraception - Presentation

It is a contraceptive method which can be used after the sexual intercourse; it is also called Post-coital Contraception; contraception with pills used 10-15 years ago was called "the morning-after pill".

Mainly, it acts through blocking ovulation and/ or through other mechanisms which works in other ways (it modifies the motility of the uterine tubes; it modifies the reactivity of the endometrium). It does disrupt the evolution of an existing pregnancy.

The efficiency of the method is lower than other contraceptive methods used in a regular way. This method should not be used instead of other methods.

It seems to prevent at least $\frac{3}{4}$ of pregnancies that would otherwise have occurred (average chance of pregnancy due to one unprotected intercourse is 8%; after the use of emergency contraception this risks drops to 2%). The efficiency is higher if the method is used immediately after unprotected sex.

Situations in which the emergency contraception is recommended:

- The woman has had sexual intercourse without contraception
- The woman has had sex against her will
- The woman has used a contraceptive method, but it has failed: e.g. the condom broke, the diaphragm has slide out of the vagina before 6 hours, the IUD has been expelled, pills were trough out after less than 1 hour after administration.
- The woman has incorrectly used the contraceptive method: e.g. she has run out of pills or she has forgotten to take them, she has delayed administering a new dose of injectable contraceptive, she has done vaginal douche within less than 6 hours after using spermicidal jelly, etc.
- The woman is using oral contraceptives and she has undergone treatment with a medicine which decreases the method's efficiency and she hasn't used any kind of additional protection.

Possible **side-effects** after emergency contraception with pills:

- Nausea; you may prescribe anti-emetics, which will be taken $\frac{1}{2}$ hour before each dose and 4-6 hours after; advise the client to eat soon after taking the pills.
- Vomiting: if this occurs within 2 hours after taking the pills, the administration should be repeated
- Slight bleeding within a few days after taking the pills; explain the fact that these are not dangerous
- The next period may start earlier or later than expected; reassure the client that this is not dangerous
- Encourage client to come back to the office if more than 4 weeks pass from the emergency contraception and the period does not occur or it was modified (very reduced flow, unusual pain), because pregnancy might be possible, including ectopic pregnancy.

If the method fails and the woman becomes pregnant after she has used emergency contraception, she may decide to terminate the pregnancy or not.

Any woman can use emergency contraception if she is not already pregnant.

If the woman wishes, she may start to use a contraceptive method immediately after emergency contraception, such as condoms or spermicide, or she should avoid sex until she can start her preferred method (e.g. pills or injectable contraceptives), due to the fact that it is better to wait for next period, in order to exclude a possible pregnancy.

If IUD is used as emergency contraception, this can be kept as an ulterior contraceptive method, if the woman wishes to and if no STI risk has been identified.

Emergency contraception does not protect against STIs (in the case of IUD, this risk could even be increased).

Emergency Contraception - Presentation

It is a contraceptive method which can be used after the sexual intercourse; it is also called Post-coital Contraception; contraception with pills used 10-15 years ago was called "the morning-after pill".

Mainly, it acts through blocking ovulation and/ or through other mechanisms which works in other ways (it modifies the motility of the uterine tubes; it modifies the reactivity of the endometrium). It does disrupt the evolution of an existing pregnancy.

The efficiency of the method is lower than other contraceptive methods used in a regular way. This method should not be used instead of other methods.

It seems to prevent at least $\frac{3}{4}$ of pregnancies that would otherwise have occurred (average chance of pregnancy due to one unprotected intercourse is 8%; after the use of emergency contraception this risks drops to 2%). The efficiency is higher if the method is used immediately after unprotected sex.

Situations in which the emergency contraception is recommended:

- The woman has had sexual intercourse without contraception
- The woman has had sex against her will
- The woman has used a contraceptive method, but it has failed: e.g. the condom broke, the diaphragm has slide out of the vagina before 6 hours, the IUD has been expelled, pills were trough out after less than 1 hour after administration.
- The woman has incorrectly used the contraceptive method: e.g. she has run out of pills or she has forgotten to take them, she has delayed administering a new dose of injectable contraceptive, she has done vaginal douche within less than 6 hours after using spermicidal jelly, etc.
- The woman is using oral contraceptives and she has undergone treatment with a medicine which decreases the method's efficiency and she hasn't used any kind of additional protection.

Possible **side-effects** after emergency contraception with pills:

- Nausea; you may prescribe anti-emetics, which will be taken $\frac{1}{2}$ hour before each dose and 4-6 hours after; advise the client to eat soon after taking the pills.
- Vomiting: if this occurs within 2 hours after taking the pills, the administration should be repeated
- Slight bleeding within a few days after taking the pills; explain the fact that these are not dangerous
- The next period may start earlier or later than expected; reassure the client that this is not dangerous
- Encourage client to come back to the office if more than 4 weeks pass from the emergency contraception and the period does not occur or it was modified (very reduced flow, unusual pain), because pregnancy might be possible, including ectopic pregnancy.

If the method fails and the woman becomes pregnant after she has used emergency contraception, she may decide to terminate the pregnancy or not.

Any woman can use emergency contraception if she is not already pregnant.

If the woman wishes, she may start to use a contraceptive method immediately after emergency contraception, such as condoms or spermicide, or she should avoid sex until she can start her preferred method (e.g. pills or injectable contraceptives), due to the fact that it is better to wait for next period, in order to exclude a possible pregnancy.

If IUD is used as emergency contraception, this can be kept as an ulterior contraceptive method, if the woman wishes to and if no STI risk has been identified.

Emergency contraception does not protect against STIs (in the case of IUD, this risk could even be increased).

Emergency Contraception

I. Hormonal Contraception

Combined Oral Contraceptives

The pills should be administered up to 72 hours after unprotected sex.

Administration: 2 doses of 4 pills (low-dose COC)

- first dose: 4 pills Rigevidon/ Microgynon/ Lo-femenal, or 4 white pills out of the Tri-Regol blister/package (out of the last 10 pills)
- second dose: another 4 pills the same type as the ones used for the first dose, 12 hours later

Progestagen Oral Contraceptives

POP should be administered in the first 72 hours following unprotected sex (administration within the first 48 hours increases efficiency)

Administration:

1 tablet containing 0.75 mg levonogestrel (LNG) and after 12 hours, another tablet (commercial brand existing in Romania: Postinor II)

II. IUD

IUD should be inserted in the first 5 days after unprotected sex.

Session 12: Contraception in Specific Situations

Objectives

By the end of the session, participants:

- Will describe the contraceptive methods eligible in specific conditions such as: post-abortion, post-partum, teenagers, premenopausal/perimenopausal women.

Time: 30 minutes

Techniques: Small groups, Discussions

Materials:

Handout

12.1 Contraception – particular situations

Activity:

Contraception in Specific Situations

- Divide participants into 4 groups and give to each group a different task to complete: to establish the most suitable contraceptive methods for the following situations: 1) After abortion, 2) After birth, 3) Women in pre-menopause and 4) Teenagers, youth. Give each one of the groups an AO paper sheet and a marker in order to write down the results.
- Tell them that they have 10 minutes to complete the task.
- Tell them to think of as many possible criteria for the hierarchy of the contraceptive methods for each case (stages of the reproductive life, age, health status, desire to have children or not, number of sexual partners, behavior, lifestyle).
- By the end of the exercise, each group empowers a representative to present their results.
- After each presentation, ask participants of the other groups whether they have anything to add or if they have other opinions.
- This activity creates the frame for repeating what they have learned regarding contraception.
- Check whether there are any unclear aspects, which you will clarify before the end of the session.
- Distribute the handout 12.1 ***Contraception in Particular Situations***.
- State the fact that these contraceptive methods which health professionals consider to be the most suitable in certain situations, do not always correspond to the opinions of our clients and that we will come back, in the counseling session, on the subject of choosing the most suitable contraceptive method for a certain person, in a certain moment of his/ her life.

Contraception for Teenagers/Youth

- The providers should consider methods which will ensure very good protection against unwanted pregnancy (at this age, an unwanted pregnancy has an increased risk, and the probability of abandonment of the child is higher than in other ages).
- Even though teenagers can use any contraceptive method, most of the time, the choice of a method can be influenced by a series of social aspects and specific behaviors:
 - sporadic, occasional sex
 - need of concealing sexual activity and the use of a contraceptive method
 - increased risk for STIs (multiple partners, lack of negotiation skills with the partner)
 - administration of the method
 - side-effects (less tolerated at this age, they can lead to abandon of the method)
 - accessibility of the method
 - influence on future fertility
 - influence on the health status (relief of some specific dysfunctions: dysmenorrhea, menstrual cycle disorders, acne, etc., if possible)
- Contraceptive methods eligible for the teenagers: condom, COC, Progestagen-only contraceptives
- Methods which are non-recommended: natural FP based on awareness of the fertile period, IUD, diaphragm, spermicides, voluntary surgical contraception.

Contraception for Women in Pre-menopause

- The following must be taken into account:
 - the menstrual changes characteristic for this period
 - some health problems might be present
 - fertility is reduced naturally
 - the risk of an unwanted pregnancy is higher than in other ages.
- Eligible methods: COC (if the woman does not smoke over 15 cigarettes per day and if she hasn't have any other status which might place her in the III-IV WHO classes), Progestagen-only contraceptives, IUD, voluntary surgical contraception, diaphragm and spermicides, condoms
- Methods which are to be avoided: the natural FP methods based on awareness of the fertile period (recognizing the fertile period can be difficult in this period, when a series of changes in the features of the menstrual cycle occur)

Post-abortum Contraception

- The following are taken into account:
 - The woman's sexual behavior (how she has ended up in the situation of having an abortion, if she has used or not a contraceptive method, and if she has, did she use the method correctly?)
 - The effect of contraceptives on the genital tract
 - Possible complications of the abortion

- The following methods can be used: all types of hormonal contraceptives (that can be started in the first 7 days after the abortion or in any other moment, if the woman hasn't had sex after abortion), IUD (immediately, or after 2-3 months if complications occurred after abortion), barrier methods, voluntary surgical contraception (for persons which have the desired number of children)
- Methods which are not recommended: natural methods based on awareness of the fertile period (cervical mucus) or periodic abstinence.

Post-partum Contraception

- Consider the following:
 - the woman needs strong protection against pregnancy in order to be able to continue breastfeeding (because a new pregnancy can suppress lactation)
 - birth spacing is recommended (the time necessary for the organism to recover is of at least 2 years).
- If the woman is breastfeeding:
 - The best methods are the non-hormonal methods: the lactation amenorrhea method (the first 6 months after delivery), barrier methods, copper IUD
 - Out of the hormonal methods, the progestagen-only contraceptives can be used after 6 weeks (POP/mini-pills, injectables, Progestagen- IUD)
- If the woman is not breastfeeding:
 - She can use hormonal methods, as well as IUD or barrier methods

The woman can also take into account voluntary surgical contraception (the first 48 hours from birth or 6 weeks after), if she already has the desired number of children.

Methods which are not recommended: natural methods based on recognition of the fertile period (periodical abstinence), COC (if she is breastfeeding, for the first 6 months).

Session 13: Contraception – Sum-up

Objectives

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

- Describe the necessary elements for safely use of the contraceptive methods, including laboratory tests
- List the reasonably certain criteria to exclude pregnancy
- Describe the conditions for switching from one contraceptive method to another and how this is done

Time: 90 minutes

Techniques: Discussions, Listing, Individual work

Materials:

Flipcharts/Overheads

6.1 Information regarding the contraceptive methods

13.1 Information necessary for the use of contraceptive methods

Trainer's documents

13.1 Information necessary for the use of contraceptive methods (filled out table)

13.2 Switching one contraceptive method to another

Handouts

13.1 The importance of procedures associated with FP services (worksheet)

13.2 The importance of procedures associated with FP services (filled out table)

13.3 Criteria for exclusion of pregnancy

13.4 Switching one contraceptive method to another

Activities:

1. Safety use of contraceptive methods (45 min)

- Review with the group the basic elements which should be known by the FP service providers regarding the available contraceptive methods, as it has been discussed in the sessions about contraception. If needed, refer to flipchart 6.1 (**Information on contraceptive methods**), which you have used in the contraception sessions. (5 min)
- Post flipchart 13.1: **Information necessary for the use of contraceptive methods** (filled out table) and fill in the first column of the table the elements that you have just reviewed together with the trainees. (5 min)
- Afterwards, ask the group to identify the necessary information for those who want to use any contraceptive method (potential clients) without health risks. Fill in the second column of the table the information necessary to clients, involving participants to this task (*be sure that the table contains all the elements listed in the trainer's document 13.1: Information necessary for the use of contraceptive methods*). (5 min)

- State the fact that you will discuss in the counseling sessions about the **way** in which this information are communicated to clients.
- The co-trainer distributes the handouts 13.1: ***The Importance of procedures associated with FP services - worksheet.***
- Ask participants to think what procedures are necessary for the safety use of certain contraceptive methods. Suggest them to review what has been discussed during the sessions about the contraceptive methods and ask them to fill in the table. Give them 5 minutes for individual work.
- Discuss results. (10 min)
- Distribute the handout 13.2: ***The Importance of procedures associated with FP services – filled-in table.***
- Review the content and the protocols of the initial contraceptive visit and of follow-up visits (general physical exam, BP, weight, gynecological exam etc.). Mention the fact that an amount of contraceptives for 3-months period will be distributed at each follow-up/re-supply visit. (10 min)
- Post the list containing the qualities of the ideal contraceptive, which you have elaborated together with the participants during session 4 (Contraception – Overview), and afterwards you have used it for presentation of each contraceptive method.
- Ask the group: Which contraceptive method do you believe to be ideal? *The expected answer is: the method that each person wants to use in a certain moment, according to personal preferences.* The method preferred by each person is established by counseling for family planning.

2. Pregnancy Exclusion (15 min)

- Ask participants: Which of the contraceptive methods require exclusion of possible pregnancy before starting their use?

Expected answers: COC, POP, injectable contraceptives, IUD, female VSC

- Ask: How can an FP service provider know that a woman is not pregnant? Listen to a few answers.
- Distribute the handout 13.3: ***Criteria for exclusion of pregnancy.***
- State the fact that the only contraceptive method which is indeed dangerous for the pregnant woman is the IUD, due to the fact that its insertion can be dangerous for the fetus, as well as for the woman. When starting to use hormonal methods, it is recommended to exclude the possibility of pregnancy, but studies show that these are not harmful if the woman is pregnant.
- Emphasize that using a list of questions is usually sufficient for the exclusion of possible pregnancy. Conditioning the provision of contraceptive methods by repeated medical examinations, compulsory pregnancy tests or other laboratory tests, can discourage the woman and also waste resources.

3. Switching from one contraceptive method to another (30 min)

- Ask trainees which are the situations in which it is necessary to switch from one contraceptive method to another: 1) medical reasons, 2) the client request, due to minor, unpleasant side-effects. Make up a list, which you will afterwards go through, asking participants for solutions for identified situations.
- Present the way in which the switching from one contraceptive method to other is done; clearly refer to the types of contraceptives that the family doctors will receive.
- Resort to the printed materials which participants have received during the workshop and state the fact that these materials will be useful every time they will need a well reasoned opinion, even when discussing with colleagues, not only with patients.
- Remind that those situations, in which the woman belongs to 3 and 4 WHO-classes, require her referral to specialist.
- Distribute handout 13.4: ***Switching one contraceptive method to another.***

Information Necessary for Use of Contraceptive Methods

FP PROVIDERS	CLIENTS

Information Necessary for Use of Contraceptive Methods

FP PROVIDERS	CLIENTS
<p>Description of the method/ Presentation</p> <p>Mechanism of Action</p> <p>Efficiency</p> <p>Drugs Interactions</p> <p>Advantages and Disadvantages</p> <p>Administration</p> <p>Side Effects</p> <p>Alarm Signals/ Serious Complications</p> <p>Reversibility</p> <p>Follow-up</p> <p>Costs</p> <p>STIs Protection</p> <p>Instructions for the user</p>	<p>To choose a method:</p> <ul style="list-style-type: none"> ▪ What the method is ▪ The relative effectiveness ▪ How the method is used ▪ The advantages and disadvantages of the method (NB: an advantage for one person may be a disadvantage for another and visa versa ▪ Possible secondary effects associated with the method <p>To use the chosen method correctly and safely:</p> <ul style="list-style-type: none"> ▪ how to use the chosen method ▪ Possible side effects ▪ Warning signs and what to do in case of a warning sign.

Switching one Contraceptive Method to Another

- Switching from one Progestagen-only hormonal method to COC
 - Using COC will be started immediately if the woman has correctly used Progesteron-only contraceptives
 - If she has used an injectable the woman may start to use COC when she would have the next injection.
- Switching from a non-hormonal method (other than IUD) to COC
 - The woman can start to use COC in the first 5 days after her period started
 - The woman can start using COC even later if she is reasonably certain that she is not pregnant; it is necessary to use an additional contraceptive method in the next 7 days.
- Switching from IUD to COC
 - The woman can start taking COC in the first 5 days of the menstrual cycle. IUD can be extracted when she is menstruating.
 - The woman can start anytime, if she is certain that she is not pregnant
 - If the woman has had sexual intercourse in the actual menstrual cycle and more than 5 days have passed since her menstrual bleeding started, it is recommended that IUD extraction to be postponed to the following menstruation
 - If the woman hasn't had sex and more than 5 days have passed since her menstrual bleeding started, she may start COC administration and she will avoid sex or use additional protection in the next 7 days (or she could wait for her next menstruation for IUD extraction)
 - If the woman does not have regular cycles or she has amenorrhea, she can start taking COC same with other situations of amenorrhea.
- Switching another hormonal method to POP
 - The woman can start taking POP immediately after she has used the previous method consequently and correctly
 - If she has used an injectable contraceptive, she will start POP when she would have had the next injection.
- Switching from a non-hormonal method (other than IUD) to POP
 - The woman can start taking POP in the first 5 days of menstrual bleeding
 - She can start taking POP anytime, if she is reasonably certain that she is not pregnant. If more than 5 days have passed since her period started, she will have to avoid sex or use additional protection in the next 2 days.
- Switching from IUD to POP
 - The woman can start taking POP in the first 5 days of menstruation. IUD can be extracted in that moment
 - The woman can start taking POP anytime if she is reasonably certain that she isn't pregnant

- If the woman has had sex in the actual menstrual cycle and more than 5 days have passed since her period started, it is recommended that IUD extraction to be postponed to the following menstruation.
 - If the woman hasn't had sex and more than 5 days have passed since her menstrual bleeding started, she will avoid sexual contacts or use additional protection for the next 7 days (or she could wait for her next period for IUD extraction)
 - If the woman does not have regular menstrual cycles or she has amenorrhea, she can start POP same with other situations of amenorrhea.
- Switching from another hormonal method to injectable contraceptive
- If the previous method has been correctly and consequently used or if the woman is reasonably certain that she is not pregnant, she can immediately start injectable contraceptive.
- Switching from another method to Copper IUD
- The woman can have IUD inserted immediately if she is reasonably certain that she is not pregnant. She does not need additional protection.

The Importance of the Procedures Associated With Family Planning Services (Worksheet)

Category A = Essential and compulsory procedure or important for the safe use of the contraceptive method	Category B = Procedure is indicated from the medical point of view for safer use of the contraceptive method, but it is possible to be not adequate to all clients, in any situations.	Category C = Procedure can be adequate for prevention, but it is not directly linked to the safety of the contraceptive method	Category B = Procedure is not only useless, but also irrelevant for the safety use of the contraceptive method

Use the following table in order to identify each method:

Low-dose Combined Oral Contraceptives	COC	Vasectomy	Vas
Progestagen-Only Pills for breastfeeding women	POP	Barrier Methods	BM
DMPA/ NET-EN Injectables	DMPA	Copper IUD	IUD
Norplant Implants	NP	Lactational amenorrhea method	LAM
Female voluntary surgical contraception*	FVSC	Fertility Awareness-Based Methods	FABM

Procedure	COC	POP	DMPA	NP	FVSC*	Vas	BM**	IUD	LAM	FABM
Pelvic Examination (speculum and bi-manual exam) in women; genital organs examination in men										
BP Measurement										
Breast Examination										
Lab Tests for STI screening (asymptomatic persons)										
Cervical Cancer Screening										
Compulsory, routine lab tests (e.g. tests for cholesterol level, glicemia, hepatic function)										
Procedures adequate for infection prevention										
Specific Counseling for each family planning method***										
Counseling regarding menstrual changes, including the irregular menstrual bleedings or absence of period										

- * Classification available for general and local anesthesia
- ** Classification available for condoms, spermicides and diaphragm
- *** Specific recommendations: efficiency, common side-effects, correct use instructions, signs and symptoms which require a visit to the doctor, STIs protection (when the case).

The Importance of the Procedures Associated With the Family Planning Services (Filed out Table)

Category A = Essential and compulsory procedure or important for the safe use of the contraceptive method	Category B = Procedure is indicated from the medical point of view for safer use of the contraceptive method, but it is possible to be not adequate to all clients, in any situations.	Category C = Procedure can be adequate for prevention, but it is not directly linked to the safety of the contraceptive method	Category B = Procedure is not only useless, but also irrelevant for the safety use of the contraceptive method
-- Is not taken into account		NA = Not Applicable	

Use the following table in order to identify each method:

Low-dose Combined Oral Contraceptives	COC	Vasectomy	Vas
Progestagen-Only Pills for breastfeeding women	POP	Barrier Methods	BM
DMPA/ NET-EN Injectables	DMPA	Copper IUD	IUD
Norplant Implants	NP	Lactational amenorrhea method	LAM
Female voluntary surgical contraception*	FVSC	Fertility Awareness-Based Methods	FABM

Procedure	COC	POP	DMPA	NP	FVSC*	Vas	BM**	IUD	LAM	FABM
Pelvic Examination (speculum and bi-manual exam) in women; genital organs examination in men	C	C	C	C	A	A	C ¹	A	C	C
BP Measurement	B	C	C	C	A	C	C	C	C	C
Breast Examination	B	C	C	C	C	NA	C	C	C	C
Lab Tests for STI screening (asymptomatic persons)	C	C	C	C	C	C	C	B ²	C	C
Cervical Cancer Screening	C	C	C	C	C	NA	C	C	C	C
Compulsory, routine lab tests (e.g. tests for cholesterol level, glicemia, hepatic function)	D	D	D	D	C ³	D	D	D	--	--
Procedures adequate for infection prevention	C	C	A	A	A	A	C ⁴	A	C	C
Specific Counseling for each family planning method***	A ⁵	A ⁵	A	A	A ⁶	A ⁶	B ⁷	A ⁸	A ⁹	A ¹⁰
Counseling regarding menstrual changes, including the irregular menstrual bleedings or absence of period	A	A	A	A	--	NA	--	A	--	--

Classification available for general and local anesthesia

** Classification available for condoms, spermicides and diaphragm

*** Specific recommendations: efficiency, common side-effects, correct use instructions, signs and symptoms which require a visit to the doctor, STIs protection (when the case).

1. Category A for diaphragm
2. However, STI screening is traditionally considered Category A

3. **However, hemoglobinuria and the presence of glucose in the blood determination tests are included in Category B.**
4. **Category A for diaphragm insertion.**
5. **Including instructions for the situation a pill is not taken**
6. **Recommendations to be made: the permanency, irreversibility of the method, pre and post-intervention instructions**
7. **Counseling not always possible when directly selling condoms and spermicides. However, regarding diaphragm, this is included in Category A.**
8. **Reference points: high risk behavior; the need of condoms use in women that, under certain conditions, can present a STI high risk. Note: women who present a STI high risk shouldn't generally use IUD.**
9. **Reference points: LAM criteria, behavior during breastfeeding, when and where additional method can be obtained.**
10. **The importance of cooperation between partners.**

Reasonable Certain Criteria for Exclusion of the Possibility of Pregnancy

The provider can be reasonable that a woman is not pregnant if she does not present pregnancy symptoms or signs **and** if she meets any of the following criteria:

- She did not have sexual intercourse since her last menstrual bleeding.
- She correctly and consequently used an efficient contraceptive method.
- Her menstrual period started within the last 7 days.
- She gave birth within the last 4 weeks (the case of non-breastfeeding woman).
- She gave birth within the last 6 months (the case of fully-breastfeeding woman who has not yet had a menstrual period).
- She had an abortion or miscarriage within the last 7 days.

Switching one Contraceptive Method to Another

- Switching from one Progestagen-only hormonal method to COC
 - Using COC will be started immediately if the woman has correctly used Progesteron-only contraceptives
 - If she has used an injectable the woman may start to use COC when she would have the next injection.

- Switching from a non-hormonal method (other than IUD) to COC
 - The woman can start to use COC in the first 5 days after her period started
 - The woman can start using COC even later if she is reasonably certain that she is not pregnant; it is necessary to use an additional contraceptive method in the next 7 days.

- Switching from IUD to COC
 - The woman can start taking COC in the first 5 days of the menstrual cycle. IUD can be extracted when she is menstruating.
 - The woman can start anytime, if she is certain that she is not pregnant
 - If the woman has had sexual intercourse in the actual menstrual cycle and more than 5 days have passed since her menstrual bleeding started, it is recommended that IUD extraction to be postponed to the following menstruation
 - If the woman hasn't had sex and more than 5 days have passed since her menstrual bleeding started, she may start COC administration and she will avoid sex or use additional protection in the next 7 days (or she could wait for her next menstruation for IUD extraction)
 - If the woman does not have regular cycles or she has amenorrhea, she can start taking COC same with other situations of amenorrhea.

- Switching another hormonal method to POP
 - The woman can start taking POP immediately after she has used the previous method consequently and correctly
 - If she has used an injectable contraceptive, she will start POP when she would have had the next injection.

- Switching from a non-hormonal method (other than IUD) to POP
 - The woman can start taking POP in the first 5 days of menstrual bleeding
 - She can start taking POP anytime, if she is reasonably certain that she is not pregnant. If more than 5 days have passed since her period started, she will have to avoid sex or use additional protection in the next 2 days.

- Switching from IUD to POP
 - The woman can start taking POP in the first 5 days of menstruation. IUD can be extracted in that moment
 - The woman can start taking POP anytime if she is reasonably certain that she isn't pregnant

- If the woman has had sex in the actual menstrual cycle and more than 5 days have passed since her period started, it is recommended that IUD extraction to be postponed to the following menstruation.
 - If the woman hasn't had sex and more than 5 days have passed since her menstrual bleeding started, she will avoid sexual contacts or use additional protection for the next 7 days (or she could wait for her next period for IUD extraction)
 - If the woman does not have regular menstrual cycles or she has amenorrhea, she can start POP same with other situations of amenorrhea.
- Switching from another hormonal method to injectable contraceptive
- If the previous method has been correctly and consequently used or if the woman is reasonably certain that she is not pregnant, she can immediately start injectable contraceptive.
- Switching from another method to Copper IUD
- The woman can have IUD inserted immediately if she is reasonably certain that she is not pregnant. She does not need additional protection.

Session 14: Values and Behaviors and their Influence on Health

Objectives

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

- Accept different values of individuals
- List factors which interfere in behavioral change for preserving/ regaining health
- Describe the elements of a responsible sexual behavior

Time: 90 minutes

Techniques: Exercises, Discussions, Listing

Materials:

Trainer's Document

14.1 Statements for forced choice exercise

Handouts

14.1 The influence of personal beliefs on behavior

14.2 Factors involved in behavioral change

14.3 Responsible sexual behavior

Activities:

1. Values (40 min)

- Start the activity with a forced choice exercise.

Instructions:

- Indicate opposite sides of the room representing the 2 choices available, or positions that can be taken (FOR or AGAINST), concerning certain issues you will present.
- Read the first statement in material for the trainer 14.1 **Statements** and ask participants to go to the place (one side or the other of the room) which reflects their opinion or reaction to the statement.
- After participants have placed themselves according to their reaction to the statement, ask several volunteers (4 -6) from each side (those 'for' and those 'against') to share with the group why they took that position.
- Invite participants to change positions if they feel, after having heard the opinions of their colleagues (on both sides), that the other position better reflects their values.
- The group repeats the same steps for each statement.

Note to trainer: During this exercise, there may be heated discussion depending upon people's values and reactions. Several ideas may be drawn from the group dynamics depending upon the situation:

- If there were participants who interrupted/reacted while a colleague was expressing an opposing point of view, ask the group:
 - What happens when someone else's point of view doesn't make sense, or differs greatly from our own?
 - What happens when we begin to talk while the other person is trying to explain something?
 - How did you feel when your colleagues quit listening to you (*question for participants who were interrupted*)?
- State that often, people take opposing positions (or have different values). There are valid reasons for taking one position or another. Our values may change as we benefit from new information and experiences.
- A value is neither 'good' nor 'bad' in and of itself. What is important is not to impose them on others.
- Ask the group:
 - What have we learned from these exercises?
 - ✓ Was it easy to listen to opposing points of view, to accept that your colleagues have opposing points of view?
 - ✓ What did you want to do when they were talking?

We are not always conscious of our values until we are confronted by another person whose behavior is different or who makes a decision with which we do not agree. It is not easy to listen to opposing points of view, nor to accept that our colleagues have opposing points of view. We want to convince them of our point of view.

Our values are formed unconsciously in growing up and through experiences we have. We seldom think of them as values but rather as the truth. We feel threatened when someone questions our values and we feel obliged to defend them.

Interpersonal conflicts are often the result of opposing values.

- In which situations are you more tempted to impose your values? What provokes this? Are you always conscious of the fact that you are imposing your values?

We may be more inclined to impose our values when:

- We have personal conflicts about situations or decisions associated with that value (Example: Experience with certain clients not following instructions in the use of certain FP methods may lead us to feel that those methods are not appropriate for all clients with similar personal characteristics.)
- We accept values without serious thought. (Examples: 1) Certain contraceptive methods are automatically better than others for certain clients, even though there are no absolute contraindications to other choices. 2) Girls should automatically be more discouraged from having sexual relations than boys before marriage.)

- How do these exercises apply to the delivery of FP services? Why does the service provider need to be conscious of his values?

The service provider may be tempted to influence the client toward what he/she thinks is "good" and away from what he thinks is "bad" without realizing he/she is imposing his values.

Additional points to make:

- If participants felt uncomfortable with the expression of certain values by their colleagues during the session, they should ask themselves how clients feel when a service provider imposes his/her values or otherwise passes judgment on them. In this latter case, there is the additional element of power: the relative power of the service provider may add an additional element of intimidation which may facilitate the imposition of his/her point of view or decision; but it does not facilitate mutual respect nor responsible decision-making in the long run.
- Values have an important influence on what one is ready to accept or not accept. In ignoring or rejecting values expressed by clients, we:
 - frustrate them,
 - will never have the information we need to better help them in the resolution of their problems.
- Values may change with new experiences and information but if they are imposed:
 - they are often rejected
 - there often develops conflict between people
- The more we are conscious of our own values, the more easily we can accept that our clients have their own values and distinguish between theirs and ours. This allows us to:
 - better facilitate their decision-making based on their values, and
 - better appreciate the effect of values conflicts on our relationship with clients.
- Ask the group:
 - What may be the consequences when a service provider imposes his/her values on a client in the context of providing FP services?

The client may feel obliged to accept the service provider's decisions even if they are in conflict with her values (for example choice of method). Problems may arise in terms of use of the method, respect for follow-up visits, responsibility for contraception etc. When the choice is not the choice of the client, results are not often positive.

If the client accepts and follows the service provider's advice though she is not convinced and has not made her own choice, she may regret it and later blame the service provider for everything that happens related to this decision.

- Summarize by adding that:
 - Information and methods must be presented in a neutral and objective manner so the client may make her own decision (always respecting medical contraindications).
 - The client has the right to:
 - o make a choice different than that of the service provider
 - o change her choice at any time (always respecting medical contraindications)

2. Factors which determine and influence behaviors (15 min)

- Choose an example of behavior from every day life (a good example would be “Brushing the teeth”) and ask participants to remember how they have learned, what factors have influenced them to adopt this behavior. List the received answers on the flipchart:

Expected answers:

- *family*
 - *school*
 - *mass media*
 - *peers*
 - *models*
 - *pain (personal experience)*
 - *benefits vs. risks*
 - *product quality*
 - *accessibility*
 - *costs*
 - *social success*
- Ask: Do these factors also influence the decision of using or not a FP method?
 - Which of these factors can be used by the family doctors and the registered nurses in order to influence people’s behavior? Underline the answers contained in the list.
 - Add the fact that in the present program, the following factors have been taken into account: high-quality contraceptives chosen, costs supported by the program (the contraceptives are free-of-charge for population in rural areas), population’s access to FP services ensured by training family doctors and registered nurses.
 - Distribute the handouts 14.1 ***The Influence of Personal Beliefs on Behavior*** and 14.2 ***Factors Involved in Behavioral Change***. Ask volunteers to read and comment on the application of the various influences on the family planning behavior of clients.

3. Responsible Sexual Behavior (35 min)

- Split the sheet of flipchart paper into two columns: Responsible Sexual Behavior and Irresponsible Sexual Behavior.
- Hand to each participant notes/cards containing following statements:
 - A 36 year old woman has protected sex with an 18 year old young man
 - A 20 year old young woman, with multiple sexual partners, uses COC plus condom
 - A 20 year old woman, married, uses COC and has extra marital sex
 - A married man has extra marital sex; he doesn’t worry about contraception because his wife uses a very efficient contraceptive method (Depo-Provera)
 - A 25 years old woman, religious, has 7 children, she doesn’t use any contraceptive method
 - A 20 year old man follows correct treatment for an STD; he does not inform his partner
 - A prostitute, accepting only safe sex
 - A woman who has a history of multiple abortions requests contraception
 - A 17 year old girl, virgin, requests information regarding contraceptive methods

- A man who has undergone vasectomy, has multiple sexual partners
- Faithful homosexual couple has sex without using a condom.
- Ask participants to think in which of the 2 columns they would like to place the statement cases. Afterwards, put participants into groups of 2 (or 3) and ask them to reach a common conclusion. Then continue with groups of 4-6, of 8-12 persons. Allow 5 minutes for each stage of the exercise. (*They will work following the pyramid technique*).
- At the end write on the flipchart the conclusions of the large group.
- Ask participants whether they have encountered difficulties in agreeing upon certain statements. If you have any "Yes" answers, ask them why do they think this has happened? *The expected answers would be that each of the choices has been made also according to the personal (moral) values, not only according to the person's behavior within each of the discussed cases.*
- Add the fact that during the FP consultations, the client's values are important, not ours, due to the fact that the issue is the client's life and behavior and not ours.
- It is important to everybody to establish what "a responsible sexual behavior" consists of. Ask participants what they consider important for a person to know and to do in order to have a "responsible" sexual behavior. List the received answers on the flipchart.
- Distribute the handout 14.3 ***Responsible Sexual Behavior***.
- In the end of the session, do with participants an exercise to demonstrate how difficult a behavior change can be (especially when it is imposed). You might choose:
 - To invite participants to cross their arms over their chest, in the way they naturally do it (right over left or vice-versa), after which ask them to place their arms the opposite way.
 - Ask a participants to "borrow" you a shoe (make sure that it is the wrong size!); demonstrate how hard you find it to "put yourself into somebody else's shoes".
- Tell them to think until the next session whether it is easy or not to make a change in their lives, even an easy change, like the one they have just experimented/assisted.

Statements for Forced Choice Exercise

1. The majority of contraceptive failures are due to clients who do not follow instructions.
2. Easy availability of contraceptive methods encourages sexual activity, especially among young people.
3. Parents should not allow their daughters as much sexual freedom as they do their sons.
4. The woman should marry her first sexual partner.
5. Prostitutes deserve as much attention from us as all other patients/ clients.
6. The woman who cheats on her husband deserves no consideration.
7. A person with a STI deserves no consideration.
8. Oral sex is a sexual perversity.

The Influence of Personal Beliefs on Behavior

Factors which influence human behavior in general and which must be considered in helping certain clients make informed choices:

Cultural factors:

- Norms or customs
- Traditions
- Beliefs

Social factors: influences of other people (spouse, parents/ relatives, friends, religious leaders, traditional healers etc).

A person may judge a proposed behavior favorably but may perceive that those important to him/her do not want him/her to change (example: a woman may want to practice FP but knows her husband would not approve)

A person may have an unfavorable attitude towards the behavior but be pressured by those around him/her to perform it (example: an adolescent girl may not wish to have sex but feel pressured into it by her boyfriend)

Whether a person's own judgment can overcome the influence of those around him/her depends upon the person's strength of will and susceptibility to pressure.

Perception: subjective process in which people attempt to understand and interpret messages. It is influenced by:

- one's familiarity with, and understanding of, language and terminology used
- the clarity of visual aids used to explain the message
- the quantity of information given

Enabling factors: factors which facilitate, or inhibit, certain behavior changes (for example the time, money, skills necessary to practice FP; the accessibility & quality of FP services)

Examples of beliefs people may have that may influence their decisions to practice or not practice FP. Beliefs about:

- The causes of MCH problems
- How easy it is to practice FP; the effort involved in practicing FP
- The benefits of using FP
- The consequences of many and/or closely-spaced pregnancies
- One's personal susceptibility to health problems resulting from many and/or closely-spaced pregnancies
- "Normal" versus "risky" in terms of the number and spacing of pregnancies
- What other persons think you should do (for example one's husband, mother-in-law)
- The possibility of change (beliefs about what happens being God's will versus the individual having some control over his/her life)
- The credibility of the communication source (clients' perceptions of the competence and caring or commitment of the service provider)
- The prestige/status of practicing FP versus having many children

It is difficult to change those beliefs that:

- Are based on a person's direct experience unless you can explain the basis for their experience, and explain and demonstrate the rationale for and safety of the proposed change (ex: perforation of uterus by IUD)
- Are part of wider, and strongly held, belief systems (religion or tradition) Examples: Catholic beliefs about artificial FP; Islamic belief in polygamy; prestige or other reasons for having many children)
- Have been held since childhood or have been acquired from trusted persons.

A person's readiness to change behavior is strongly influenced by:

- Influences of other people (social factors):
 - A person may judge a proposed behavior favorably but may perceive that those important to him/her do not want him/her to change (example: a woman may want to practice FP but knows her husband would not approve)
 - A person may have an unfavorable attitude towards the behavior but be pressured by those around him/her to perform it (example: an adolescent girl may not wish to have sex but feel pressured into it by her boyfriend)
 - Whether a person's own judgment can overcome the influence of those around him/her depends upon the person's strength of will and susceptibility to pressure.
- Beliefs that:
 - He/She is susceptible (that the health problem could affect him/her rather than just 'other people')
 - The health problem is serious/could lead to serious consequences if action is not taken
 - The health problem can be prevented by the prescribed actions and that the benefits of taking action would outweigh the disadvantages

Important Factors Involved in Behavioral Changes (used by health programs)

The health programs aim behavioral changes in the benefit of health. Programs for reproductive and sexual health propose changes for different categories of beneficiaries (all these categories would need to make changes)

- Different categories of health professionals
- Non-medical staff: social workers, teachers, educators
- Individuals/couples/ families/ communities
- Local authorities (in order to involve the community)
- Mass media

PHISICAL FACTOR:

Based on recounting suffering; people are willing to make changes if their actual or potential pain/illness becomes greater than the benefits of a certain behavior, or if the pain is still in the person's memory.

RATIONAL FACTOR:

It needs clear and concise information: people change habits, styles if they understand their disadvantages, what they have to loose if they persist in certain behaviors, if they understand what they gain through changing their behavior.

PRACTICAL FACTOR:

It refers to the practical competences necessary for adopting a new behavior (e.g. how to use the condom, control of the IUD strings, following and noting the body basal temperature etc.)

EMOTIONALLY FACTOR:

Founded on the intensity of feelings; some people change behaviors if they are feeling exposed to the risks and if they emotionally accept new behaviors which allow them to avoid those risks. The emotional factor can be negative, based on fear, or positive, build on feelings like: love, hope, desire to do well to the loved-ones.

STRUCTURAL FACTOR:

Based on environmental factors, institutional, political, economic, material contexts; behaviors in the benefit of health will be enhanced by improving the access to services, existence of certain waves favorable to changes, environment and community leaders which encouraged adopting benefic attitudes for health, legislative frame directed to covering the people's needs etc.

INTERPERSONAL FACTOR

Based on the social network within which the people take action for common interests. Individuals will change their behaviors if they are not alone in these challenges, if they feel sustained, if they are encouraged and if they can associate with others in order to follow their common interests which are beneficial for everybody.

Responsible Sexual Behavior

In order to adopt a responsible behavior, a person needs:

- Basic information regarding: anatomy, physiology of reproduction, pregnancy
- To know that there are means of controlling fertility and of avoiding unwanted pregnancy
- To know where to obtain information regarding RH/ FP
- To know that abortion can lead to (very) severe complications
- To know where to obtain protection against unwanted pregnancy
- To know how to use contraceptive methods
- To know where to request help for solving problems
- To know that there are (very) severe diseases which may evaluate without any signs, and may be transmitted by sex
- To know how HIV/ AIDS is transmitted and how it is not transmitted
- To know that there are protection means against STIs/ AIDS and to also know how to use them
- To know that it is good to check own health status from time to time, even if nothing is bothering her/ him
- To know how to make a decision
- To know what responsibility means and to assume responsibilities
- To know how to apply what s/he knows in order to solve his/ her problems regarding sexuality.

Session 15: Family Planning Counseling

Objectives:

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

- Describe the communication elements
- Identify barriers in communication
- Describe the counseling process
- Acknowledge the process of decision making and solving problems
- Describe the six steps of the FP consultation
- List the rights of the FP client

Time: 3 hours

Techniques: Presentation, Simulation, Small groups, Brainstorming, Discussions, Case studies, Demonstration

Materials:

Flipcharts/Overheads

- 15.1 Process of Communication (diagram)
- 15.2 Counseling = Interpersonal Communication Process
- 15.3 Counseling (definition)
- 15.4 Decision-Making Process
- 15.5 Information necessary for Use of Contraceptive Methods
- 15.6 Qualities of FP Services
- 15.7 Counseling – GATHER model

Trainer's documents

- 15.1 Process of communication (diagram)
- 15.2 The influence of each component on the effectiveness of the communication process
- 15.3 Statements: Obstacles to Communication
- 15.4 Counseling – GATHER model
- 15.5 Client Rights Regarding the Delivery of Family Planning Services

Handouts

- 15.1 Process of communication (diagram)
- 15.2 The influence of each component on the effectiveness of the communication process
- 15.3 Counseling = Interpersonal Communication Process
- 15.4 Decision-Making Process
- 15.5 Counseling – GATHER model
- 15.6 Information necessary to clients for use of contraceptive methods
- 15.7 Principles of counseling
- 15.8 Benefits of Counseling; Consequences of the Lack of Counseling
- 15.9 Basic Family Planning Counseling Concepts
- 15.10 Client Rights Regarding the Delivery of Family Planning Services
- 15.11 Personal Considerations in Using Family Planning Methods
- 15.12 Principles for Using Clarifying Questions
- 15.13 Examples of Clarifying Questions Useful in Family Planning Consultations

Activities:

1. The communication process (15 min)

- Make a short presentation of the definition and process of communication (using flipchart/overhead 15.1: **Diagram of the Process of Communication**)

Definition: process in which a message is transmitted from a source to a recipient through a verbal or non-verbal channel.

Components of communication:

- Sender: person who speaks (or makes jests)
- Message (of the sender)
- Channel (for the message)
- Receiver (person who listens/receive/s the message)
- Feedback (from receiver to sender)
- Channel (for feedback)
- Code (language or non-verbal jests used)

- State the way in which each component influence on the effectiveness of the communication process.

- Sender (source). Qualities that make a person trusted:
 - competence (in message content & communication of information, though not necessarily by virtue of educational status)
 - ability to establish positive & constructive rapport with the individual
 - coherence between verbal & non-verbal messages
 - influence on the client (resulting from communication of respect & trust, not power)
 - natural position in the community
 - personal qualities or actions (readiness/ willingness to help)
 - similar characteristics (e.g. age, culture, experiences etc)
- Message: clarity, simplicity, relevance to needs of the receiver
 - 2 components of a message:
 - content
 - emotions/feelings (often communicated non-verbally: facial expressions, jests, tone of voice etc)
 - Feelings behind what is said are often more important than the content in interpreting the meaning of the message.
- Channel (for the message): relevance to the characteristics of the individual (participative/active versus passive)
- Receiver: interest in the subject, other preoccupations, attitude toward the sender
 - Anxiety in the receiver may provoke defensiveness & a tendency to misinterpret what is said (perceive threats which are not there). (Ex: adolescent clients; clients during STI risk assessment)
- Feedback: degree to which it is sought, respected & constructive
- Channel (for feedback): depends on the degree of client openness & verbal expression, & on service provider awareness of non-verbal channels used by the client
- Code: language (words, expressions) must be common to the sender and receiver (counselor and client/group). (ex: technical language, adolescent jargon)

- Ask the group: Why is it important for a service provider to understand these components of communication? How can it help you in counseling?

- Distribute participants' handouts 15.1 ***Process of Communication (diagram)*** and 15.2 ***The influence of each component on the effectiveness of the communication process.***

2. Obstacles to Communication (60 min)

- Make the following exercise: together with the co-trainer simulate a real situation that should illustrate the regular doctor-patient relationship.
- Ask participants to follow the simulation and to identify the obstacles to communication between the doctor and client, generated by the doctor (service provider).
- Discuss in the large group about identified obstacles and how they might be removed if the exercise should be repeated. (10 min)
- Ask participants: Usually, do you get a second chance to respond more appropriately to a client if you have responded inappropriately the first time?
(It is possible to have a "Yes" answer, so be prepared to answer: "When a person comes to discuss about her own sexuality and is not received as she/he desires, do you think he/she is willing to come back?")
- Group participants in pairs of two and ask them to tell, by turn, to their partner something about their body (not about sexuality!); each one has 5 minutes to speak, then they switch the roles (speaker and listener).
- Ask participants to answer the question: What obstacles have you identified? On behalf of whom? *(this exercise usually induces an emotional status, similar to that one felt by a patient to the doctor)*.
- Ask at the end of the exercise: Who wants to speak about how he/she felt when speaking about him/herselves? Emphasize that our patients have the same emotions when addressing to us. (20 min)
- Ask few volunteers (3 or 4) for a role play. Simulate some possible situations, with different doctor-patient relationship; the doctor (one of the trainers) adopts different attitudes towards the patients (played by the volunteers). The other participants are following attentively in order to identify the obstacles appeared during communication. You may use the Trainer's Document 15.3 ***Statements: Obstacles to Communication.***
- Ask "the patients" how did they feel? *Probably, you will get some answers that reflect negative feelings. (The role-play is an appropriate technique to identify some attitudes and to understand the situations, feelings of other persons, with different values than ours).*
- Emphasize that our patients/clients have similar feelings too. (20 min)
- Ask the following question: What usually happens in a conversation?

- You speak I listen
- I speak you listen

or

- You speak I listen – evaluate – listen – plan – prepare what I'm going to say – speak (at the first chance I get to interrupt).

We often evaluate what others say before trying to understand them; by so doing, we risk drawing false conclusions.

- Are there are other obstacles, or sources of obstacles, to communication? (Give examples, as necessary, to help participants name the different obstacles.)

- differences in values, education, class, vocabulary
- extreme appearance (of client or worker)
- client's problem is shocking
- service provider is unable to respond
- information/message communicated by the client is not what the service provider wanted to hear
- service provider is distracted by other pre-occupations
- service provider's response is not what the client needed, wanted to hear
- environment and/or atmosphere is not conducive to communication (noisy, distracting, no privacy)
- client feels uncomfortable and distracted, is self-conscious to discuss problems because of people overhearing or does not really trust the health worker
- health worker does not understand the client's problem, uses complicated language with unfamiliar terms, gives advice that is irrelevant or impossible to implement
- too much information is given: the person only remembers part of what was said, especially if she was worried or anxious
- people who do not know each other or otherwise lack confidence in each other have difficulties hearing each other

Tell that we will learn in the next sessions about and practice techniques of communication that will help us 1) avoid these obstacles, and 2) improve our communication with clients.

3. Counseling (45 min)

- Post the flipchart/project the overhead 15.2 **Counseling = Interpersonal Communication Process**. Describe each element. (10 min)

THE MESSAGE

- Verbal/oral message (language)
- Non-verbal message (body language)

COMMUNICATION SKILLS

- **Active listening**
- **Reflection/Feed-back**
- **Questions**
 - Closed
 - Open
 - Clarifying
- **Reformulation/Paraphrasing**
- **Clarification - through questions, paraphrasing**
- **Summarize**

- Post on the flipchart/project the overhead 15.3 **Counseling**. Ask a volunteer to read the definition. Ask the group:
 - How would you describe the difference between counseling and giving advice? Which do we tend to do most of in our consultations?

- ✓ Do counseling?
- ✓ Give advice?

➤ What is the purpose of counseling?

To enable the client to:

- Make informed choices
- Assume responsibility for his/her problems and choices/decisions.

➤ What does the concept 'informed choice' mean?

Informed choice: a voluntary choice/decision based on knowledge of all information relevant to the choice/decision.

- Ask participants: How do we usually make a decision? Which are the stages we go through?

Ask the following questions concerning participants' attendance at the workshop, in order to introduce the process of decision-making:

➤ How did you receive the information about this workshop?

- I was told to come
- I learned that this training would take place and I asked to attend
- I received official notification that I was to attend

➤ Did you decide to come as soon as you received the information?

Responses will vary depending upon the individual

➤ What did you do in order to prepare to attend the workshop?

- Delegated my activities to someone else
- Made sure that someone could take my place during my absence
- Made provisions for the family before leaving home

➤ What questions did you ask yourself?

- What will be the content and/or the process of training?
- Where will the training take place? Who will be the trainers? Who will the other participants be?

- Outline on flipchart 15.4 **Decision-making Process** and emphasize the steps, referring to the above questions and participant responses:
(*this activity: counseling, the informed decision shall last approximately 20 min*)

- Ask the following questions in order to bring out the importance of respecting the decision-making process in a FP consultation.

➤ What happens at the Reflection step?

- People weigh the pros and cons of the situation
- People anticipate the consequences of their decision
- People ask themselves questions
- People consider the alternatives

- What is the importance of the step Information on the step Reflection?

Information provided must:

- Be relevant to the clients' interests and needs
- Be complete, precise, and clear; and be understood by the clients

- What can/should a service provider do to facilitate the decision-making process for the client?

- Imagine the needs/interests of the client based on your experience as a service provider
- Help the client express him/herself and listen carefully
- Adapt information to the needs/interests of the client/s; encourage their questions and reactions (in order to better understand, and respond to, their concerns & needs)
- Give people time to reflect on the information before making a decision

- Do we usually respect the decision-making process?

No. Often we give information and expect clients to decide immediately what they wish to do (as expressed in 'you should . . . , ought to . . .' etc)

- What are the consequences of such rushed/forced decisions?

Either the client doesn't act at all or makes a decision without adequate thought and without conviction, not an informed decision. Often, clients do not follow through with/implement such decisions. The client does not accept responsibility for the decision and may even blame the service provider for any negative consequences of the decision.

- What should be the role of the service provider in this process of decision-making in FP?

- Give complete, precise, objective and clear information
- Ask questions to help the client to reflect on the information and choices
- Ensure follow-up to reduce the risk of problems once the decision is put into action

Role of FP counseling in ensuring an informed choice: assist the client to consider all aspects of her problem/choice in order to choose what suits her best.

- Go back to the flipchart 13.1 ***Information necessary for the use of contraceptive methods***, which was filled in session 13.
- State that for making an informed decision, the client need:
 - to be informed on all methods available
 - to know the advantages and disadvantages of each method
 - to know the relative efficiency of each method
 - to understand the side effects and possible complications
 - to know how the method is used correctly to be efficient
 - to understand the risks of not using any method, as well as the risks associated with pregnancy/ delivery vs. the risk associated with the contraceptives use
- Explain that a slightly different concept is the problem-solving process. Explain this process and the FP service provider's role in both processes:
 - Client identifies the problem (including causes and effects of the problem)
 - Client identifies possible alternatives for dealing with the problem
 - Client identifies possible consequences of each alternative (pros and cons of each alternative)
 - Client identifies the best alternative or solution (for him/her), given all the alternatives and possible consequences of each
 - Client implements his/her solution

- Add that in each stage of this process, the service provider asks questions and provides information (as necessary) to help the client reflect upon his/her situation in order to come to the best decision for him/her and to implement it.
- Distribute to participants the handout 15.4 *Decision-making process*.

4. Counseling in the context of FP consultations (60 min)

- In order to place the counseling process in the context of a FP consultation, ask participants:
 - What are the steps of a FP consultation (from the client's arrival to his/her departure)?
 - How and where does counseling fit into a FP consultation?

Steps in a consultation:

- reception
- interview
- exam
- method prescription
- follow-up

Counseling is done at all steps

- Introduce the acronym GATHER which represents the steps of counseling in a FP consultation. The elements of GATHER correspond to the steps of a consultation and specify the content of counseling at each step.
- Review with the group key elements of each step of GATHER & the goal of each step. (see document: **GATHER**)

G = Greet the client
A = Ask about client needs, medical history, etc
T = Tell client about methods
H = Help client to choose a method
E = Explain the method
R = Return visit

- Emphasize that while the GATHER approach to FP counseling provides a logical structure for counseling which helps make the consultation process both more effective and efficient, it is not a routine that applies identically to every situation. Service providers need to be ready throughout the consultation to refer back to previous steps if it appears that: something was missed or misunderstood, the client has further questions, or the client has contradicted herself etc.
- Distribute the handout 15.5 *Counseling - GATHER model*. (20 min)
- Then ask the group:
 - What must a doctor and/or nurse know about contraceptive methods in order to be able to counsel FP clients?

For all the methods available in the country, service providers must know:

- description of the method
- availability of the method (where one can obtain it)
- how the method works (contraceptive action)
- effectiveness of the method
- advantages of the method
- disadvantages of the method
- reversibility of the method
- cost of the method
- contraindications (relative and absolute)/precautions in the provision of the method
- secondary/side effects of the method and what to do in case of a secondary effect
- warning signs of the method and what to do in case of warning signs
- rumors about the method and how to respond to them
- follow-up schedule for the method
- instructions for the user of the method
- the method's effectiveness against STIs

- Do clients typically have sufficient information to make an informed choice of contraceptive method when they first seek FP services?

No. Clients come to clinics with a range of information, ideas, and preferences regarding contraceptive methods. However, the service provider can never assume that they have sufficient information upon their arrival in the clinic to be able to make an informed choice.

- Refer to the information clinicians need to know about contraceptive technology in order to counsel clients in FP. Ask:
 - What kinds of information should you give to clients in order to help them:
 - ✓ Choose a method?
 - ✓ Use the method they have chosen correctly and safely? (go back to the flipchart ***Information necessary for the use of contraceptive methods***, which was filled in session 13).
 - State the importance of providing essential information (what clients must know to use the method correctly and to avoid problems). Do not overload the client with unnecessary information. Distribute the handout 15.6 ***Information necessary to clients for safely use of contraceptive methods*** (10 min)
 - The trainers perform a demonstration in front of the group, following the steps of GATHER model for FP consultation. (10 min)
 - Distribute the handout 15.7 ***Principles of Counseling***. Ask volunteers to read the principles. Invite the group to make any comments they may have regarding the various principles.
 - Distribute the handout ***Benefits of Counseling; Consequences of the Lack of Counseling***. Ask volunteers to read it to the group. Suggest to the group that this document can help us think about the effect of the quality of counseling we do in providing family planning services. (10 min)
- 5. The Climate and the Client Rights Regarding The Delivery of Family Planning Services (40 min)**

- Post a flip chart on which are written (haphazardly) the following words: organized, professional, warm, clean, flexible, informal, helpful, polite, efficient, understanding, educational, discrete, accessible, comfortable, productive, orderly, friendly, privacy, confidentiality, empathy, welcoming, patience, competent, approachable.
- Ask the group:
 - Which of these words describe a health facility where you would like to receive FP services? Which represent behaviors or characteristics which say to you that a health clinic provides acceptable services?
- As participants name a word as being a characteristic that they would appreciate in a health facility of their choice, underline the word on the flip chart. (At the end, all words will likely be underlined.)
- Ask if there are other words, or characteristics participants would like to add to the list. Give the group 2 to 3 minutes to propose other words, then add them to the posted list.
- Explain that not all FP services have all of these qualities, and that you are going to tell a story of a client who faced a somewhat different situation when she needed FP services. Ask the group to listen carefully to her story. (10 min)
- Ask the group to analyze attentively the quality of their own services and if they wish to make these more acceptable and more effective for their clients.
- Address participants the following questions, in order to help them to think about their service provision in their medical cabinets:
 - Are there differences between the characteristics you listed of a health facility where you would like to receive FP services and the facility in which you work?
 - Do you think that the quality of the services could be influence by these differences? What are the consequences of poor quality of service?

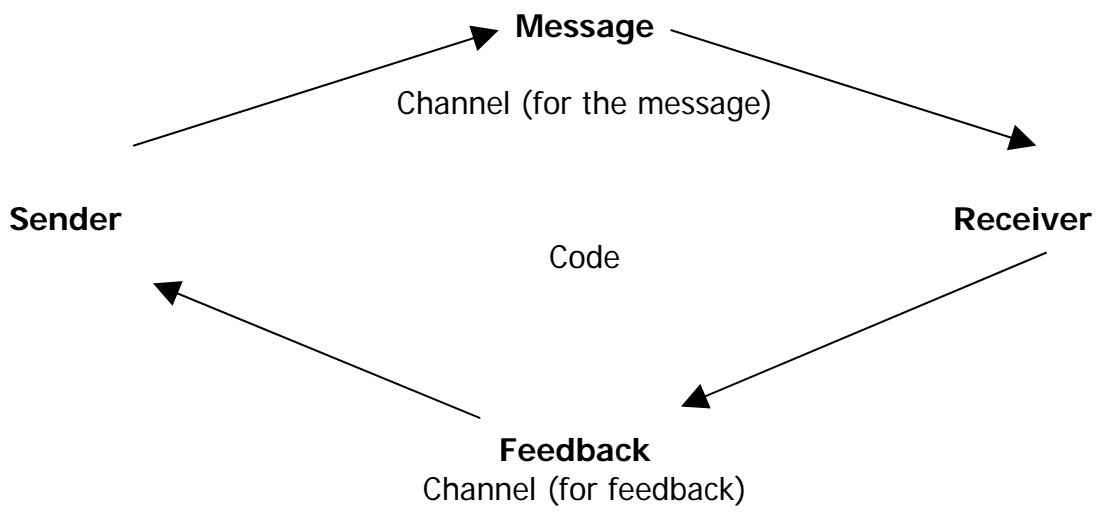
- | |
|---|
| <ul style="list-style-type: none">• Low contraceptive use, accompanied by higher abortion rates and more abandoned children• High contraceptive drop out rates• Contraceptive failures due to poor technique (for some methods) and lack of adequate and/or correct information• Unnecessary follow-up visits (due to poor technique and/or inadequate or incorrect information) |
|---|

(10 min)

- Suggest that this training will emphasize interpersonal factors and clinic atmosphere, and the extent to which improved counseling skills can contribute to the acceptability of our services.
- Using the Trainer's document 15.5 **Client Rights** prepare notes with the rights of the client.
- In groups of two/three, participants receive one note/group with 2 client rights. Mention they will have 5 minutes at disposition.
- Each group presented the meaning of each right in front of the large group.
- Invite others in the group to complete the descriptions of client rights and their application as appropriate. Explain that we will refer to these client rights as appropriate throughout the training. (15 min)

- Emphasize the special importance of confidentiality.
- Distribute the handouts: ***Basic Family Planning Counseling Concepts, Client Rights Regarding the Delivery of Family Planning Services, Personal Considerations in Using Family Planning Methods, Principles for Using Clarifying Questions, Examples of Clarifying Questions Useful in Family Planning Consultations***
- Mention that these materials will be useful to them in the next session, as well in their future activity as FP services providers.

Process of Communication



Counseling = Interpersonal Communication Process

MESSAGE

- Verbal/oral message (language)
- Non-verbal message (body language)

COMMUNICATION/COUNSELING SKILLS

- **Active listening**
- **Reflection/Feed-back**
- **Questions**
 - Closed
 - Open
 - Clarifying
- **Reformulation/Paraphrasing**
- **Clarification** - through questions, paraphrasing
- **Summarize**

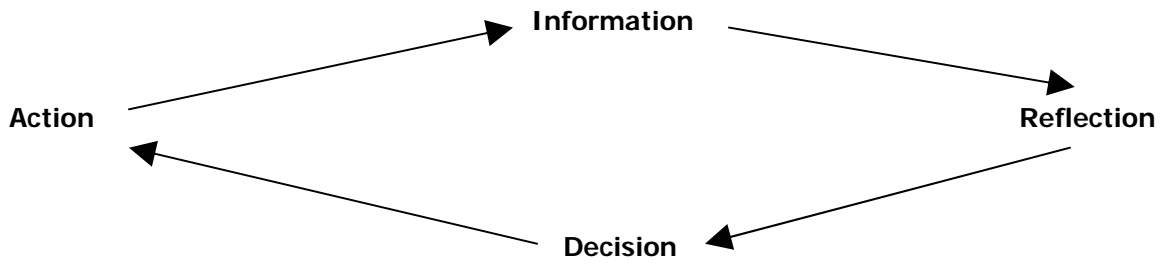
Counseling

Face to face communication, within which the counselor helps the client to better understand the problems, the situation and the feelings and to identify and apply the appropriate solution for that situation/problem.

The counselor does that through:

- **Open questions which help the client to evaluate his/her situation, to ponder his/her options, to identify and apply solutions.**
- **Providing necessary information to help the client through this process, so that the client may take his/her own decisions and put these into practice.**

Decision-Making Process



Organized

Professional

Warm

Clean

Flexible

Informal

Helpful

Polite

Efficient

Understanding

Educational

Discreet

Accessible

Comfortable

Productive

Orderly

Friendly

Privacy

Confidentiality

Empathy

Welcoming

Patience

Competence

Approachable

Counseling – GATHER Model

GREET

ASK

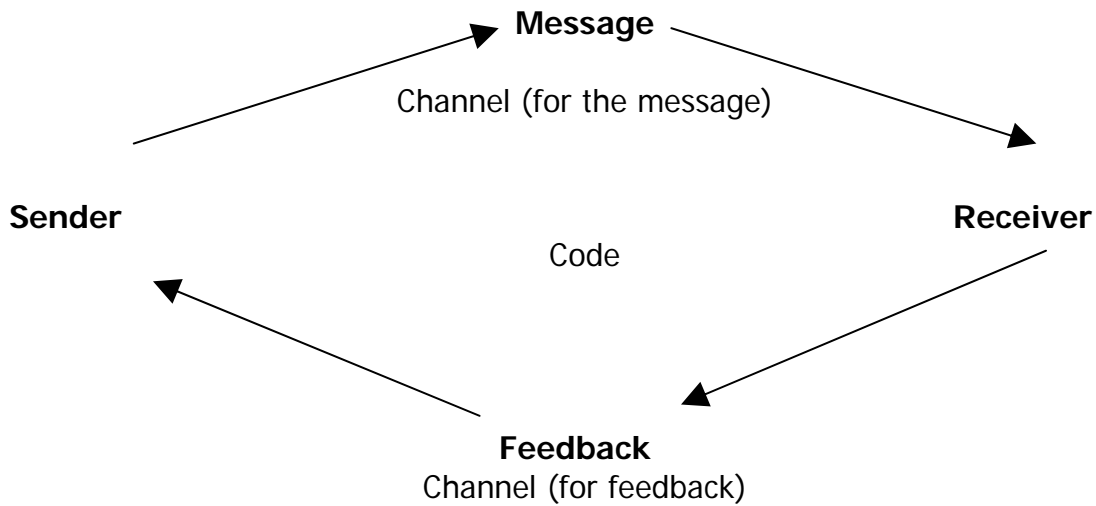
TELL

HELP

EXPLAIN

RETURN FOR FOLLOW-UP

Process of Communication



Definition of Communication: process in which a message is transmitted from a source to a recipient through a verbal or non-verbal channel.

Components of communication:

- Sender: person who speaks (or makes jests)
- Message (of the sender)
- Channel (for the message)
- Receiver (person who listens/receive/s the message)
- Feedback (from receiver to sender)
- Channel (for feedback)
- Code (language or non-verbal jests used)

The influence of each component on the effectiveness of the communication process

- Sender (source). Qualities that make a person trusted:
 - competence (in message content & communication of information, though not necessarily by virtue of educational status)
 - ability to establish positive & constructive rapport with the individual
 - coherence between verbal & non-verbal messages
 - influence on the client (resulting from communication of respect & trust, not power)
 - natural position in the community
 - personal qualities or actions (readiness/ willingness to help)
 - similar characteristics (e.g. age, culture, experiences etc)
- Message: clarity, simplicity, relevance to needs of the receiver
 - 2 components of a message:
 - content
 - emotions/feelings (often communicated non-verbally: facial expressions, jests, tone of voice etc)
 - Feelings behind what is said are often more important than the content in interpreting the meaning of the message.
- Channel (for the message): relevance to the characteristics of the individual (participative/active versus passive)
- Receiver: interest in the subject, other preoccupations, attitude toward the sender
 - Anxiety in the receiver may provoke defensiveness & a tendency to misinterpret what is said (perceive threats which are not there). (Ex: adolescent clients; clients during STI risk assessment)
- Feedback: degree to which it is sought, respected & constructive
- Channel (for feedback): depends on the degree of client openness & verbal expression, & on service provider awareness of non-verbal channels used by the client
- Code: language (words, expressions) must be common to the sender and receiver (counselor and client/group). (ex: technical language, adolescent jargon)

Statements: Obstacles to Communication

1. A woman with 8 children. She nearly died from hemorrhage during her last delivery. It is doubtful she would be able to support another pregnancy. She has come in for a consultation for her baby who is 6 months old. You ask her if she is interested in family planning. She responds: "I don't believe in family planning. Those things make you sick. I don't need it."
2. A woman 27 years old with 3 children. She has come to ask for a tubal ligation because she doesn't want any more children. When you try to discuss other family planning methods with her, she responds: "I don't want to hear about other methods. I told you that I don't want any more children. And for that reason, I want to be sterilized."
3. A single girl, 17 years old, who has been having sex for the last 2 years. She is 8 weeks pregnant. She has already had one induced abortion and she intends to abort this pregnancy as well. When you try to discuss family planning with her, she responds: "I will not need it. I'm not going to have sex any more before I get married."
4. A single girl, 16 years old. She is 10 weeks pregnant. All of a sudden, she cries out: " I don't know what to do. My parents will kill me if they find out what I have done. What would you do if you were me?"
5. A woman with 2 children (ages 2 years, and 5 months) came in for family planning services the first time 4 months ago. You prescribed the pill for her. Her husband has just found her pills and thus learned that she is on contraception. He is completely opposed to contraception and has forbid her to continue taking the pills. She tells you: "I don't want more children right now. I don't agree with the position of my husband but I cannot continue if he doesn't want it."

FP Counseling - The GATHER Model

GREET the client

- ❖ Welcome the client warmly and with respect
- ❖ Introduce yourself (if the client does not already know you)
- ❖ Offer the client a seat
- ❖ Ask what you can do for the client
- ❖ Assure the client of confidentiality
- ❖ Explain what will happen during the visit. Describe physical examinations and laboratory tests, if any

ASK/ASSESS the client's reproductive health needs

- ❖ Help the client talk about her FP needs, wants, doubts, concerns and/or questions about FP; keep in mind her reproductive stage and listen to her personal motivations, objectives and/or preferences
- ❖ Determine what decisions or actions the client needs/wants to make in this visit
- ❖ Ask about family and medical history (using a standard checklist which includes: age, marital status, number of pregnancies, number of births, number of living children, family planning use now and in the past, and basic medical information), paying particular attention to those items that relate to the client's choices or preferences.
 - Explain that you are asking for this information to help her choose the best FP method
 - Keep questions simple and brief
 - Look at the client as you speak

TELL: provide information based on the client's FP needs and knowledge

Ask the client if she is interested in a particular method.

- ❖ If the client already has a preference for a particular method that is not contraindicated by her health status, and if she is not interested in discussing other methods, proceed with information about her method of choice.
 - Evaluate the client's knowledge of her preferred method (to better know what she understands about the method and the reasons behind her preference):
 - What the method is
 - The relative effectiveness of the method
 - How the method is used
 - The advantages and disadvantages of the method (NB: an advantage for one person may be a disadvantage for another and visa versa)
 - Possible secondary effects associated with the method
 - Correct any erroneous information she may have
 - Complete her information if necessary
 - Inform the client about the possibility of changing the method if she needs to at a later time
 - Verify the client's understanding of the information
- ❖ If the client has not talked much about her reproductive intentions, and if she has not expressed a preference for a method, ask about her reproductive plans and about her knowledge of FP methods. Ask:
 - What are your reproductive plans? (Ask additional questions if necessary in order to help the client match her reproductive plans and concerns with a family planning method.) Review with the client:
 - her family situation
 - her plans about preventing, spacing and/or limiting pregnancies
 - what her partner wants (what would he like to use?)
 - her criteria regarding the choice of method

- What do you know of the different methods of FP? Do you have any preferences?
 - Mention available methods that might interest the client now or later. Ask if she would like more information about any of them.
 - Tell the client about any methods she is interested in.
 - How the method works
 - Its relative effectiveness
 - Advantages and disadvantages of the method (recognizing that what is an advantage for one person may be a disadvantage for another and visa versa)
 - Possible side effects of the method
- ❖ Explain that condoms are the only FP method that provides protection against STI/HIV.

HELP the client choose a method that responds to his/her FP needs

- ❖ Ask the client: Based on our discussion of methods (her preferred method and/or other methods), what would you like to use? Listen carefully to the client's response.
- ❖ If the client is not sure what she wants to use, review the questions already asked about her family situation, plans, partner etc, and about the her criteria regarding the choice of method.
- ❖ If the client chooses a method that is medically contraindicated, explain why and help her focus on other possibilities.
- ❖ Ask the client how she thinks she will tolerate potential side effects of the chosen method.
- ❖ Ask if there is anything that is not clear or that the client does not understand, or if there is other information she would like. Repeat and/or rephrase information as necessary
- ❖ Verify that the client has made a clear decision. Ask: "What method have you decided to use?"

EXPLAIN how to use the chosen method

- ❖ Give the method to the client.
- ❖ If the client cannot have the method the same day, propose and provide a temporary method; and tell the client how, when and where she can get her method
- ❖ Explain how to use the chosen method, possible secondary effects, warning signs and what to do in case of a warning sign. Give essential information, what the client needs to know in order to use the method and avoid problems with it (unless the client asks specific questions). Do not overwhelm the client with information
- ❖ Ask the client to repeat the instructions. Listen to make sure that she has understood them. Verify with open questions the client's understanding of what to do in case of problems.
- ❖ Tell the client when to return for a follow-up visit.
- ❖ Explain that the client can return at any time in case of questions, secondary effects or warning signs. Assure the client of your availability in the case of questions or problems.

RETURN VISIT

- ❖ Welcomes the client warmly and with respect
- ❖ Ask if the client is still using her method.
 - If yes, ask if she is satisfied with it and/or has had any problems or secondary effects from the method.
 - Reassure the client in the case of minor side effects.
 - Counsel, treat and/or refer the client in case of more serious side effects.
- ❖ Ask how the client is using the method. Verify that it is being used correctly.
- ❖ If appropriate, explore changes in the client's current health status and/or life style that might indicate need for a different method or no method at all. Help the client to change her method if she wishes to do so.
- ❖ Provide contraceptive supplies (for example, a follow-up injection or additional OCs) as appropriate.
- ❖ Makes a return appointment for the client (if appropriate).

Client Rights Regarding the Delivery of Family Planning Services

Every client, disregarding of sex, age, race, ethnic community, religion, social, material, professional, economic status, sexual identity and orientation, etc. has the right to:

Information

Access

Choice

Safety

Intimacy

Confidentiality

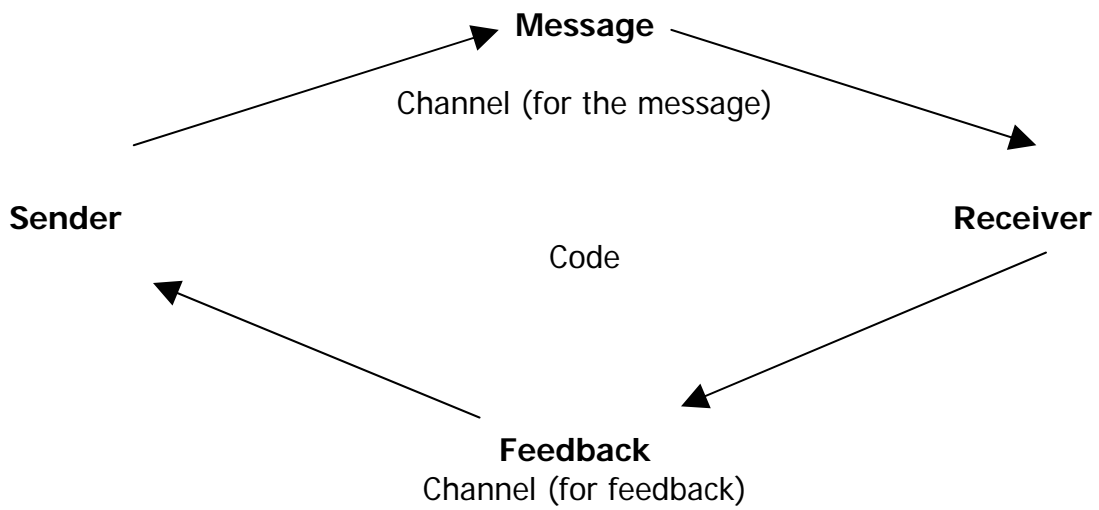
Dignity

Comfort

Continuity

Opinion

Process of Communication



The influence of each component on the effectiveness of the communication process

- Sender (source). Qualities that make a person trusted:
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- Message: clarity, simplicity, relevance to needs of the receiver
 - 2 components of a message:
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- Code: language (words, expressions) must be common to the sender and receiver (counselor and client/group). (ex: technical language, adolescent jargon)

Counseling = Interpersonal Communication Process

MESSAGE

- Verbal/oral message (language)
 - Adapted content, dosage of information
 - Tone of voice
- Non-verbal message (body language)
 - Eye contact
 - Facial expressions
 - Distance between persons
 - Body's posture, general attitude
 - Head's posture
 - Gestures

Major condition for the message to be convincing: Congruence between verbal and non-verbal language.

COMMUNICATION/COUNSELING SKILLS

- **Active listening** participatory, reflective (not just passive)

Definition:

- Exclusively non-verbal communication
- It is more than "hearing"

Qualities:

- Focused on speaker's feelings
- Determined by the level of interest
- Helps the speaker to understand his/her reactions, attitudes and talk about them
- Transmits to sender that he/she is followed and encouraged
- Contributes to creating a climate of trust and safe

Demonstrated by:

- Eye contact
- Leaning forward
- Nodding
- Brief responses which demonstrate interest & encourage the person to continue to talk: uh-huh, oh, I see, etc.
- Facial expression

- **Reflection/Feed-back** – of words and/or feelings

Communication technique which transmits/receive reactions to behaviors, sayings, acts

- **Questions**

- Closed
- Open
- Clarifying

- **Reformulation/Paraphrasing**

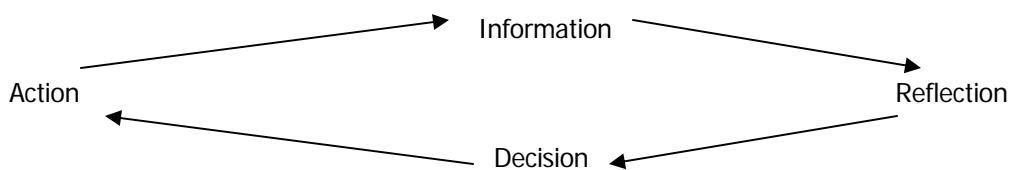
Reformulation of what the person said in own words, including perception of feelings behind the message (expressed by tone of voice, facial expression, body language), in order to verify the correct understanding of what had been said. Allows the client to approve or disapprove the aspects reflected by the provider, helping him/her to become aware of his/her own feelings.

- **Clarification** - through questions, paraphrasing

- **Summarize** - the conclusions to client's situation expressed by the provider.

Decision-Making Process

1. The decision-making process is facilitated by adequate and accurate information. In the diagram below, the service provider helps the client reflect on his/her own information (about his/her situation, problem or needs) and provides the client additional information as necessary. This information must be appropriate to the client's needs; be complete, precise, and clear; and be understood by the client.
2. The client reflects on the information about his/her situation, feelings, alternatives etc. S/he weighs the pros and cons of the situation, anticipates the consequences of his/her decision, asks him/herself questions, considers the alternatives.
3. The client makes a decision.
4. The client acts on his/her decision.



To facilitate the client's decision-making process, the service provider needs to:

1. imagine the needs of the client based on your experience with other clients
2. help the client express him/herself and listen carefully
3. adapt information to the needs/interests of clients; encourage their questions & reactions (in order to better understand, and respond to, their concerns & needs)
4. give clients time to reflect on the information before making a decision
5. ensure follow-up to reduce the risk of problems once the decision is put into action

When service providers do not respect the decision-making process, and instead give information and expect clients to decide immediately what they wish to do (as expressed by 'you should . . . , ought to . . .' etc), often clients don't act at all or they make decisions without adequate thought and without conviction; they do not make informed decisions. The client may not accept responsibility for the decision and may even blame the service provider for any negative consequences of the decision.

FP Counseling - The GATHER Model

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- ❖ Explain what will happen during the visit. Describe physical examinations and laboratory tests, if any

ASK/ASSESS the client's reproductive health needs

- ❖ Help the client talk about her FP needs, wants, doubts, concerns and/or questions about FP; keep in mind her reproductive stage and listen to her personal motivations, objectives and/or preferences
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 - Explain that you are asking for this information to help her choose the best FP method
 - Keep questions simple and brief
 - Look at the client as you speak

TELL: provide information based on the client's FP needs and knowledge

Ask the client if she is interested in a particular method.

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 - What the method is
 - The relative effectiveness of the method
 - How the method is used
 - The advantages and disadvantages of the method (NB: an advantage for one person may be a disadvantage for another and visa versa)
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- What do you know of the different methods of FP? Do you have any preferences?
 - Mention available methods that might interest the client now or later. Ask if she would like more information about any of them.
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- ❖ Explain that condoms are the only FP method that provides protection against STI/HIV.

HELP the client choose a method that responds to his/her FP needs

- ❖ Ask the client: Based on our discussion of methods (her preferred method and/or other methods), what would you like to use? Listen carefully to the client's response.
- ❖ If the client is not sure what she wants to use, review the questions already asked about her family situation, plans, partner etc, and about the her criteria regarding the choice of method.
- ❖ If the client chooses a method that is medically contraindicated, explain why and help her focus on other possibilities.
- ❖ Ask the client how she thinks she will tolerate potential side effects of the chosen method.
- ❖ Ask if there is anything that is not clear or that the client does not understand, or if there is other information she would like. Repeat and/or rephrase information as necessary
- ❖ Verify that the client has made a clear decision. Ask: "What method have you decided to use?"

EXPLAIN how to use the chosen method

- ❖ Give the method to the client.
- ❖ If the client cannot have the method the same day, propose and provide a temporary method; and tell the client how, when and where she can get her method
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- ❖ Ask the client to repeat the instructions. Listen to make sure that she has understood them. Verify with open questions the client's understanding of what to do in case of problems.
- ❖ Tell the client when to return for a follow-up visit.
- ❖ Explain that the client can return at any time in case of questions, secondary effects or warning signs. Assure the client of your availability in the case of questions or problems.

RETURN VISIT

- ❖ Welcomes the client warmly and with respect
- ❖ Ask if the client is still using her method.
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- ❖ Ask how the client is using the method. Verify that it is being used correctly.
- ❖ If appropriate, explore changes in the client's current health status and/or life style that might indicate need for a different method or no method at all. Help the client to change her method if she wishes to do so.
- ❖ Provide contraceptive supplies (for example, a follow-up injection or additional OCs) as appropriate.
- ❖ Makes a return appointment for the client (if appropriate).

Information Necessary to Clients for Use Contraceptive Methods

To choose a contraceptive method:

- What the method is
- The relative effectiveness of the method
- How the method is used
- The advantages and disadvantages of the method (NB: an advantage for one person may be a disadvantage for another and visa versa)
- Possible secondary effects associated with the method

To use the chosen method correctly and safely:

- how to use the chosen method,
- possible secondary effects,
- warning signs and what to do in case of a warning sign.

Principles of Counseling

Counseling: a process in which a person is helped to express his problems and identify possible solutions as well as consequences of his decision.

Principles:

1. Establish a relationship of trust with the client. Use a warm tone of voice, avoid criticisms & judgments. Listen carefully to what the client says & pay attention to any feelings or messages behind what is said. Respect confidentiality.
2. Ensure a logical sequence to the counseling.
3. Limit closed questions (with 'yes'/'no' answers) which do not facilitate communication.
4. Gather information about the client's needs, expectations of the consultation and concerns (through open questions). Draw out information which may help the client in making and carrying out her decision. The choice of FP method may be easy but the development of habits necessary to use the method correctly may be difficult.
5. Pay attention to problems and concerns expressed by the client; do not ignore nor negate them. Such acknowledgement contributes to a trusting relationship and allows the service provider to gain information which may be important in the choice of method and instructions to give the client.
6. Be positive in the diagnosis of problems related to the client's use of her chosen contraceptive method. For example, if the client has problems forgetting to take the pill, instead of asking "Why did you forget to take the pill?", a more positive response would be "Let's see what you did when you took the pill regularly. Since you were taking it correctly, you can do it again."
7. Recognize that certain clients who are ill at ease may unconsciously test the service provider to see if he accepts them before revealing their problems or concerns, or asking questions. If the client becomes defensive, it may mean that she feels threatened or ill at ease. This may be because the service provider has not shown respect for the client or doesn't accept her; or because the service provider is ill at ease.
8. Provide concrete, correct, objective information.
9. Support and encourage the client:
 - realize that the use of contraception may be a new experience for the client.
 - be patient & encourage questions; take the time necessary.
 - verify that you have responded to all the client's questions and concerns, & that she has understood all the necessary information.
10. Identify possible obstacles related to the choice & use of methods (via open questions about the client's marital/social situation, & her & her partners knowledge and preferences re the different FP methods). If there are obstacles to the use of FP methods which are not discussed and resolved, it may prevent effective use of the method.

Certain questions may facilitate the identification of potential obstacles:

- What does the client know about the different methods?
 - What does the client see/prefer as her choice?
 - What led the client to choose the method she chose?
 - What is, or would be, her partner's preference?
11. Use language the client can understand.
 12. Correct rumors by questioning the client to see where the rumor comes from and helping her/him to see the lack of logic her/himself.
 13. Respect the client's privacy and do not judge his or her behavior
 14. Respect the client's confidentiality: in the process of counseling and in maintenance of client records
 15. Use visual aids and contraceptive supplies to help clients better understand explanations of methods
 16. Pay close attention to the client's non-verbal communication
 17. Speak simply & minimize unnecessary explanations. Emphasize the essential
 18. Develop one idea at a time. Define terms before developing entire concepts
 19. Establish a rapport between new ideas and the client's existing knowledge and/or experience, associate the unknown with the known
 20. Repeat important &/or difficult information & concepts (using examples)
 21. Do not try to convince the client of your point of view nor give her solutions to her problems (except for clinical/medical advice)

Benefits of Counseling; Consequences of the Lack of Counseling

Benefits of counseling:

For the **client**:

- resolution of the problem
- satisfaction with the result/solution
- increased self-confidence and independence in future decision-making
- increased skill in decision-making
- better choices
- decision to adopt FP
- correct use of chosen FP method
- greater likelihood of continuing to use the chosen FP method
- better coping with minor side effects
- greater respect follow-up visits
- less influenced by rumors and myths
- fewer unwanted pregnancies

For the **clinic**:

- positive reputation of the clinic; satisfied clients promote FP and refer other clients
- more continuity in method use/higher continuation rates
- fewer unscheduled visits for time-consuming minor complaints and side effects
- builds trust and respect between client and provider

Some consequences of a lack of counseling

For the **client**:

- non-resolution of the problem (ex: poor choice of method)
- lack of satisfaction with the result/solution
- increased dependence on the service provider
- de-motivation
- no learning (in terms of decision-making)

For the FP **service**:

- rumors & misconceptions
- increased number of client dropouts
- negative reputation of the clinic
- frequent revisits: staff spends much time correcting and re-correcting problems

Basic Family Planning Counseling Concepts

Counseling: face-to-face communication in which the service provider helps a client to better understand his/her problem, situation &/or feelings so that he/she can make his/her own decision and then act on it. Counseling helps the client decide if s/he wants to practice FP and if so, to choose a contraceptive method that is personally and medically appropriate for her/him (one he/she wants, understands how to use and is able to use correctly for safe and effective contraceptive protection).

Counseling generally communicates the message: "The problem and decision are yours and I have confidence that you are capable of resolving the problem by making the decision that is best for you."

Advice: face-to-face communication in which the service provider tries to solve client's problem/find her solution/make her decision by giving his/her opinion and/or proposing the solution to the client.

Advice generally communicates the message: "You are not capable of resolving this so I will have to do it for you". It perpetuates the client's dependency on the service provider.

Informed choice: a voluntary choice or decision based on knowledge of all information relevant to the choice or decision. In order to make an informed choice, the client needs to:

- be made aware of all the methods available (at the site or by referral)
- know the (major) advantages and disadvantages of each method
- understand possible side effects of each method
- understand risks of not using any method, such as risks associated with pregnancy/childbirth versus risks associated with contraceptive use
- know how to use the chosen method safely and effectively

Role of FP counseling in ensuring an informed choice: assist the client to consider all aspects of his/her problem, or need for contraception, and his/her choice in order to choose what suits him /her best.

Client Rights Regarding the Delivery of Family Planning Services

Every client, disregarding of sex, age, race, ethnic community, religion, social, material, professional, economic status, sexual identity and orientation, etc. has the right to:

1. Information

To receive information on FP, available services, methods, etc.

2. Access

To receive quality services, irrespective of sex, age, race, religion, ethnic community, etc.

3. Choice

To decide without constraints if will use FP and what method to use

4. Safety

To use FP methods without risks for health

5. Intimacy

To receive any services in a pleasant climate

6. Confidentiality

To have the certitude that personal information will be kept secret

7. Dignity

To be treated with consideration, respect and interest

8. Comfort

To feel good, irrespective of the provided services

9. Continuity

To receive contraceptive methods, information, counseling, etc, as long as the client wants it and needs it

10. Opinion

To have the opportunity to express opinions, feelings about the provided services

Personal Considerations in Using Family Planning Methods

- 1. The client decides what personal considerations matter.**
Only the potential user of contraceptive methods can mix all the elements for her own personal choice. The clinician will not be able to predict what matters to her. Privacy? Lubrication? Light periods? What her best friend uses? Do not guess; ask.
- 2. It's a long way from the exam room to the bedroom.**
We offer methods as medicines in a clinical setting, and then our clients go home and use them in a sexual setting in the bedroom (or elsewhere). Remember to help your clients think through the sexual aspects of contraception.
- 3. Give clients permission to choose a second (or third or fourth) contraceptive.**
She may not like the first method at all and will need to know it is okay to come back and try something else. Besides, it is always good to know how to use several methods.
- 4. Encourage your client to talk about contraceptive issues with her partner.**
How can one person decide if a method of contraception will be compatible with a couple's personal and sexual styles? Help your client practice discussing contraception with his/her partner if indicated.
- 5. Personal considerations are likely to change over time.**
Teenagers and 35 year-olds will use very different criteria as they evaluate their contraceptive choices. Encourage clients to rethink their contraceptive needs as life and sex and bodies change over time.
- 6. Teach clients a wise and cautious approach to sexual activity.**
All sexually active people need to know the risk factors for STIs and HIV infection. They need to know how to avoid those risk factors.

Principles for Using Clarifying Questions

1. Do not ask open questions too early in the interview. The service provider should have listened sufficiently to the client (using passive listening, paraphrasing and closed questions) to have gained the client's trust and be able to ask relevant and useful questions.
2. The service provider must be able to have the client's confidence in order for the interview to be productive.
3. Clarifying questions should not serve as an interrogation but rather assist the client to reflect on her situation.
4. Clarifying questions should not begin with "Why . . .?" Questions that begin with "Why ?" tend to put people on the defensive and create reasons and excuses when there were none.

Examples of Clarifying Questions Useful in Family Planning Consultations

Open-ended questions (examples):

- What do you know about the pill (or other method)?
- What is your husband's opinion on the method you use?
- What type of problems are you having?
- What do you think about using condoms?
- Which family planning methods would you like to know about?
- Can you describe for me some of the signs and symptoms of STIs?
- Tell me more about _____
- Would you tell me about _____
- I'd be interested in knowing _____
- How did you feel about _____
- Would you explain _____
- I'm not certain I understand _____
- Would you explain that in more detail _____
- What do you mean by _____
- Perhaps you could clarify _____
- What was there about _____ that appealed to you?
- What prompted your decision to _____
- How did you happen to _____
- Has there been any opportunity to _____
- To what do you attribute _____

Questions to verify your understanding of the client's concerns, problems and/or questions; and to give you clues about the presence of misinformation, about attitudes and expectations, and about the nature and meaning of client concerns

- I need to ask you a question or two to help me know how best to answer your concern
- Would you tell me a little more about that?
- Can you tell me your feelings about that?

When you have provided answers to a request for information, you may verify the client's understanding by asking:

- Is that what you were asking me?
- Do you want to ask me more about this?

Questions you may use to verify if you understand the vocabulary and idioms of the client.

Example:

- Client: I know you can get pregnant from going down.
- Service provider: When you say 'going down', do you mean 'having intercourse'?

If you are not comfortable using the same vocabulary as the client, you may say/ask:

- When I respond to your questions, I'll feel more comfortable using the word _____ instead of _____. Will that mean the same thing for you?

If you do not know the answer to a question posed by a client, acknowledge that you do not know, that you are not able to be of help

- I don't know the answer to your questions (followed by)
 - Let's see if we can find the answer together
 - Perhaps I can put you in touch with someone who can help you.

Session 16: FP Consultation

Objectives:

At the end of the session, the trainees will:

- Demonstrate counseling skills in a role-play situation for different clients, in the context of providing other medical services
- Demonstrate the ability of counseling clients that present minor side effects

Time: 3 hours

Techniques: Triads, Role play, Feedback

Materials:

Flipchart/Overhead

16.1 Condition Conducive to Active Listening

Handouts

16.1 Condition Conducive to Active Listening

16.2 Role-Play Discussion Questions

16.3 Counseling Check List

Activities:

1. Integration of counseling components to the practice (2 hours)

- Invite participants to practice integrating skills of passive listening, paraphrasing and asking clarifying questions by participating in role-plays based on:
 - *Series 1:* the cases participants prepared the first day of training (for one series of role plays). There will be three of these role-plays so that each participant will have the opportunity to play the part of service provider, client and observer in these role-plays.
 - *Series 2:* role-plays that will have been written to allow application of the GATHER method of conducting a FP consultation. (for a second series of role plays). There will be three of these role-plays so that each participant will have the opportunity to play the part of service provider, client and observer in these role-plays.
- Post on the flipchart ***Condition Conducive to Active Listening*** and distribute to participants the same handout. Ask Them to consider these recommendations during the role play.
- Distribute the handout ***Role-Play Discussion Questions*** and review the questions with the group. Explain that these questions will be useful to them in observing what happened in the role-plays and in sharing feedback at the end of the role-plays.
- Distribute the handout ***Counseling Checklist*** and suggest that it will be useful to the groups during the second series of role plays in which participants will apply the steps of GATHER to the counseling they do with clients.

Series 1:

- Divide the group into groups of 3. In each group, there is a service provider, client and observer. Give a prepared role play case to the client who reads it (silently to him/herself) to prepare his/her role. (*The same role play situation should be given to all groups so that the large group discussion following each role play can focus on common issues.*)
- Give the groups 15 minutes to conduct their role-plays.
- Stop the role-plays and give the groups 5 minutes for feedback within their groups (beginning with the service provider, followed by the client & the observer). Participants use the flip chart/hand out *Role Play Discussion Questions* as a basis for giving feedback.
- Discuss in the large group what participants learned from applying active listening skills in the role play and any particularities about how best to respond to similar situations in the clinic (10 min).
- Ask participants to change roles within the groups and conduct a second, then a third, role-play, as indicated in the instructions above. Each time, give the client of each group a new role (*the same role play situation to be used by all groups*).
- Following the second and the third role-plays, discuss in the large group what participants learned from applying active listening skills in the role play and any particularities about how best to respond to similar situations in the clinic (10 min).
- Following the three role plays, lead a discussion on the experience of counseling using Active Listening skills: problems participants have experienced as well as the application of this counseling technique to the conduct of FP consultations.

[Note for the trainer: It is good for the services provider to give feedback to him/her self, in order to have the chance to reflect on how he feels he managed the situation, before finding out his/her colleagues observations; this 1) makes the person to reflect on how well he applied, exercised new-achieved abilities and 2) if she/he admits there had problems, acknowledge it, it means that is capable to face/solve them through another approach or it might ask suggestions from the group].

Series 2:

- Ask participants to come back in the large group. Invite 6 volunteer for another 3 role-plays, in each role-play will be a service provider and a client. Give a prepared role play case to the client who reads it (silently to him/herself) to prepare his/her role.
- Give the groups 15 minutes to conduct their role-plays.
- The others are following the steps demonstrated in the “Family Planning consultation”, focused on GATHER approach.
- After each exercise the two volunteer share with the group their feeling during the role-play and the eventually difficulties they met.

- Discuss in the large group what participants learned from applying active listening skills and GATHER in the role play and any observations about how best to conduct similar consultations in the clinic (10 min).
- Following the second series of role-plays, lead a discussion on the added experience of applying the GATHER method of conducting a FP consultation:
 - How well did participants apply it?
 - What problems did they encounter?
 - How useful did they find it?
- Suggest to the group that the ***Counseling check list*** plus the role play questions can be used to continue to monitor the application of one's counseling skills to the delivery of FP services.

2. Counseling for the Side Effects of the Contraceptive Methods (one hour)

- Using the flipchart ***Information necessary for the use of contraceptive methods***, revise together with the participants what are the important information for the clients, for each contraceptive method.
- Ask participants to remind the side effects of each contraceptive method.
- Post the resulting list from Session 5, containing ***difficulties and the failure causes of the natural FP methods***, identified by the group.
- Invite participants to exemplify how they would approach such situations/solve the problems.
- Continue in the same way with the other contraceptive methods. Work with the help of ***Recommendations for Medical Practice - WHO Guide***.

Conditions Conducive to Active Listening

The client must have a problem, which s/he shares with the service provider

The service provider must:

- feel accepting of the client/be available to the client
- want to help the client
- have time to help the client
- have confidence that the client can solve her problem
- feel sufficiently apart:
 - not be upset by the subject
 - be able to understand the client's emotions but not be overcome/immobilized by the situation
 - be able to allow the client to take responsibility for her problem

NB: Do not use active listening when the person only asks for specific information.

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NB: Do not use active listening when the person only asks for specific information.

Role Play Discussion Questions

Questions for counselors

1. What did you do to put the client at ease, to gain her confidence?
2. What did you do to help the client talk about her problem, to clarify information about her problem?
3. Were you able to respond to concerns of the client? If yes, how? If no, why not?
4. What additional services or assistance might this client still need?
5. Were there any blockages during your interaction with the client (problems of communication, client's reaction to you and/or something you asked or said, lack of information etc)? What did you do to resolve any problems between you and the client? What might you have done differently?

Questions for clients

1. How did you feel at the beginning of the counseling session?
2. Did the counselor put you at ease? How? If not, why not?
3. Did the counselor help you? How? If not, why not?
4. What more might the counselor have done to help you?
5. Did the counselor give you correct and appropriate information in a way that you could understand?
6. Did you sense any judgments on the part of the counselor? Give examples.

Questions for observers

1. Did the counselor:
 - introduce him/herself to the client?
 - define his/her role (what the client could expect from him/her)?
 - encourage the client to discuss her problem?
 - give advice? (give an example)
 - pass judgements or moralize?
 - demonstrate respect for the client?
 - allow the client time to think about (or reflect on) her situation?
 - verify the client's understanding of important points?
 - demonstrate confidence in his/her skills, & in the client's abilities to deal with her problem?
 - lack certain information? (give examples)
 - offer to see the client again if the client wishes?
 - respect the steps of GATHER?

2. Was the information given by the counselor correct and complete?
3. Did the session end in a positive manner?
4. Other points/observations not already covered?

Checklist for Counseling

In general, the service provider:

1. Is respectful of the client and non-judgemental.
2. Is knowledgeable of FP methods.
3. Listens to the client and gives the client his/her complete attention.
4. Uses body language to show interest in, and concern for, the client.
5. Asks open questions as appropriate.
6. Encourages the client to ask questions.
7. Uses language that the client can understand.
8. Uses visual aids appropriately to explain contraceptive methods.

Session 17: Logistic System for Contraceptives Management /MIS

General Presentation of MIS Session

Objectives:

By the end of the session, participants should be able to:

- Describe the MOH recipient categories for the Free of Charge Contraceptives and the recommended dispensing protocols.
- Describe the purpose and components of the Contraceptive Logistics System.
- Identify their individual responsibilities in the Logistics System.
- Correctly complete the FH Cabinet Monthly Report for Distribution of Free of Charge Contraceptives
- Correctly complete the FH Cabinet Quarterly Report and Order Form.
- Describe how to store contraceptives according to the storage guidelines

Methods: Discussions, practical exercises

Time: 185 minutes

Materials:

Flipcharts/Overheads

- 17.1 Definition of a Logistic System
- 17.2 Purpose of a Logistic System: The Six Rights
- 17.3 Essential Data Items
- 17.4 Parameters for the Romanian Contraceptive Logistic System
- 17.5 FH Cabinet Monthly Report for Distribution of Free-of-Charge Contraceptives
- 17.6 Partially Completed Monthly Report
- 17.7 FH Cabinet Quarterly Report and Order Form
- 17.8 Partially Completed June FH Cabinet Monthly Report

Trainer's Document

- Storage photos (enough copies so there is one for each group of 4-5 participants)

Handouts

- 17.1 Population Groups Entitled to Free-of-Charge Contraceptives – Necessary Documents
- 17.2 Recommended Contraceptive Dispensing Protocols
- 17.3 Definition and Purpose of a Logistic System
- 17.4 FH Cabinet Monthly Report for Distribution of Free-of-Charge Contraceptive
- 17.5 Guide: How to Complete the FH Cabinet Monthly Report for Distribution of Free-of-Charge Contraceptives.
- 17.6 Instructions
- 17.7 March Report
- 17.8 April Report
- 17.9 Blank Report form (to be completed for May)
- 17.10 Report Exercise Answer Sheet – May Report
- 17.11 FH Cabinet Quarterly Report and Order Form
- 17.12 Guide: How to Complete the FH Cabinet Quarterly Report and Order Form
- 17.13 Report Exercise Answer Sheet – June Report
- 17.14 Blank Monthly Report (to be completed for June)

- 17.15 1st Quarterly Report and Order Form – blue copy
- 17.16 Blank Quarterly Report and Order Form (to be completed for the 2nd quarter)
- 17.17 Report Exercise Answer Sheet – Monthly Report for June – green copy
- 17.18 Report Exercise Answer Sheet – Quarterly Report after receiving contraceptives – blue copy
- 17.19 Health Products Storage Guidelines

The session is divided in four parts.

Part I: Introduction to the MIS logistic system

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

1. Describe the MoHF recipient categories for the Free of Charge Contraceptives and the recommended dispensing protocols.
2. Describe the purpose and components of the Contraceptive Logistics System.
3. Identify their individual responsibilities in the Logistics System.

Methods: Discussions

Evaluation: Participant response

Time: 30 minutes

Materials– part I:

Flipchart/ Overheads

- 17.1 Definition of a Logistics System
- 17.2 Purpose of a Logistics System: The Six Rights
- 17.3 Essential Data Items
- 17.4 Parameters for the Romanian Contraceptive Logistics System

Handouts

- 17.1 Population Groups Entitled to Free-of-Charge Contraceptives – Necessary Documents
- 17.2 Recommended Contraceptive Dispensing Protocols
- 17.3 Definition and Purpose of a Logistics System

Activities:

1. Recipient Categories for Free-of-Charge Contraceptives (10 min)

- Explain that among the clients to whom family doctors and nurses will offer FP services, some will be entitled to receive contraceptives free of charge. Distribute the handout 17.1: ***Population Groups Entitled to Free-of-Charge Contraceptives – Necessary Documents.***
- Review with the group the categories of clients who will be eligible for free contraceptives and the documents that doctors and/or nurses must complete when providing services to this population.

- Explain that for this population entitled to Free-of-Charge Contraceptives, there is an established protocol for the dispensing of contraceptives. Refer the group to the bottom half of the above handout, entitled ***Recommended Contraceptive Dispensing Protocols***. Review this with the group.

2. Contraceptive Logistics System (20 min)

- Explain that in order for the MOH to be able to ensure an adequate supply of free contraceptives for this population of people eligible for free contraceptives, there has been established a Contraceptive Logistics System. Display the overhead 17.1 ***Definition of a Logistics System*** and briefly review the definition with the group.
- Display the overhead 17.2 ***Purpose of a Logistics System: the Six Rights***. Ask a volunteer to read the first scope.
- Ask participants what the first scope means from the perspective of contraception. Same for all scopes:
 - The **right quantities** (enough contraceptives) of
 - The **right contraceptives** (those that people are asking for)
 - At the **right place** (at the cabinet level)
 - At the **right time** (available when people ask for it, not the next day or week)
 - Under the **right condition** (clean and sanitary)
 - At the **right cost**.

(Emphasize that even if these contraceptives are free-of-charge to clients, the MOH is procuring some of them; and there are costs associated with delivering them to clients i.e. personnel, transportation and storage)

- Explain that in order for a logistics system to function and fulfil its purpose, it must have certain types of data. Display the overhead 17.3 ***Essential Data Items***.
- Review each item and ask if participants are currently collecting this information.
- Briefly discuss about each item.
- Explain that in order for the system to function, three minimal and essential data items need to be collected and available at every level. They are:
 1. **Stock on Hand**: Quantities of usable stock available at all levels of the system at a point in time. (Items that are expired or damaged are not usable and should not be counted.)
 2. **Rate of Consumption**: The average quantity of commodities dispensed to users during a particular time period.
 3. **Losses/Adjustments**: Losses are the quantity of contraceptives removed from the distribution system for any reason other than consumption by clients (e.g. losses, expiry, damage). Adjustments may include receipt or issue of supplies to/from one facility to another at the same level (e.g. a transfer or loan) or a correction for an error in counting. Losses/adjustments may therefore be a negative or positive number.

- Explain that you will be using the words *perishables/adjustments* which can be positive or negative. If it were a loss, it would therefore be negative.
- Ask the group: What is an example of a perishable or negative adjustment?
- Listen few answers. The following it shall be among the answers:
 - Changes in stock due to items that are expired, missing, or damaged
 - An IUD that is dropped during insertion and must be thrown away
 - Corrections of previous mathematical mistakes in the record keeping

3. Ordering and Reporting Contraceptive Supplies

- Post the overhead 17.4 ***Parameters for the Romanian Contraceptive Logistics System***. Discuss each of the four items as follows:

1. **The cabinets will give monthly reports to the DPHA**

The FH and FP cabinets will be responsible to prepare their monthly reports and have them received by the DPHA by the 5th of every month.

2. **The cabinets will prepare an aggregated quarterly report and order form**

On a quarterly basis, the cabinets will prepare an aggregated report, which will also be the order form. This report must be received by the DPHA along with the monthly report by the 5th of the appropriate month. The cabinets will then be responsible to return to the DPHA between the 15th and the 25th of that month to pick up their contraceptive orders. The months in which people will pick up their supplies will be January, April, July and October. The aggregated reports will cover the normal calendar quarters.

3. **FH and FP cabinets will pick up their supplies from the DPHA quarterly**

Cabinets will order all contraceptives each quarter, up to the maximum, which is set at six months of supply. (The forms will show how this calculation is made.)

4. **The cabinets will order all contraceptives (up to a 6 month maximum) quarterly**

The system is designed to be sure that no one runs out of stock. Emphasize that the supplies are to be picked up quarterly, but the maximum is six months of stock. That means that at the end of a "normal" quarter, cabinets will still have enough to last for an additional 3 months. There should always be enough supplies of contraceptives to last until the next quarter's order. One goal of setting these levels is to ensure that cabinets will not have to make multiple trips to the DPHA to get supplies during the quarter.

Emergency Orders

- Explain that if there is ever concern about running out of stock, an emergency order can be placed. It would be done in the same way as a regular order, but only for the product that is needed immediately. The form would be filled out and the words "Emergency Order" would be written across the top of the form.
- Distribute the handout 17.3 ***Definition and Purpose of a Logistics System***

Part II: Monthly Reports for the Distribution of Free-of-Charge Contraceptives

Objective: By the end of the session, participants should be able to:

- Correctly complete the FH Cabinet Monthly Report for Distribution of Free of Charge Contraceptives

Methods: Discussion, practical work

Evaluation: Accuracy of participant work.

Time: 70 minutes

Materials– part II: Flipcharts/Overheads

17.5 FH Cabinet Monthly Report for Distribution of Free-of-Charge Contraceptives

17.6 Partially Completed Monthly Report

Handouts

17.4 FH Cabinet Monthly Report for Distribution of Free-of-Charge Contraceptive

17.5 Guide: How to Complete the FH Cabinet Monthly Report for Distribution of Free-of-Charge Contraceptives.

17.6 Instructions for exercise

17.7 March Report

17.8 April Report

17.9 Blank Report form (to be completed for May)

17.10 Report Exercise Answer Sheet – May Report

Activities:

- Explain that the key to any logistics system is how well the Logistics Management Information System (LMIS) works.
- Display the overhead 17.5 ***FH Cabinet Monthly Report for Distribution of Free-of-Charge Contraceptives*** and distribute the handout 17.4 ***FH Cabinet Monthly Report for Distribution of Free-of-Charge Contraceptives***. Explain that in order to ensure that everyone is following the new system correctly, we have developed a step-by-step guide that service providers are to keep in their offices and refer to when completing the Monthly Report. Distribute the handout 17.5 ***Guide: How to Complete the FH Cabinet Monthly Report for Distribution of Free-of-Charge Contraceptives***.
- Using the overhead 17.5 ***FH Cabinet Monthly Report for Distribution of Free-of-Charge Contraceptives***, and referring to each step in the guide, fill in the following hypothetical example, asking participants to follow along by filling in their blank handout.
- Have a different participant read each new step and the notes that accompany the step. *It is very important that you give the participants dates and numbers as outlined below; if you do not use these numbers, the final calculations will not come out correctly.*
- Step 1. *Cabinet*: Ask participants to give you a name (of a doctor's cabinet).

- Step 2. *Date*: Ask participants to fill in the month of April.
- Step 3. *Year*: Ask participants to fill in 2003.
- Step 4. *Page*: Ask participants to fill in 1 (since this is the first page).
- *Emphasize that unlike other reports that participants may fill in at the end of the month, they will start filling in certain information on this one at the beginning of the month.*
- Step 5. *Name of product and movement of product during the month* (items B-I): Tell participants that for most of them, they will not have to add any other names except those that are already printed for the next couple of years.
- Step 6. *Number, Date, Client Card #*: Ask participants what kind of information should be reported here.
Expected answer:
 - **Number of units of contraceptives dispensed to client (consumption)**
 - Client card #
 - Workload (by recording the dates and numbers of FP clients coming to the cabinet).
- Tell participants to write the number 1 for the first client of the month. Explain that each month, they should start with number one.
- Step 7. *Date of first client's visit in the month of April*: Tell participants it is April 1st. Write in the date: 1 / 4.
- Step 8. *Client Card #*: Tell participants that they should use the same client card number that they use when they provide other services to their client. They should not start new numbers for reproductive health services. For those who are not already using Client Card Forms, explain that we will give them some forms later in the training that pertain to reproductive health services and the provision of contraceptives to their clients, to be added to the client cards they already have. If the client does not already have a client card and number, start one.
- For this example, write in client card number 362.
- Step 9. *Contraception received by the client*. For this example, the client received three cycles of Marvelon. Write a 3 in the appropriate column.
- Step 10. *Total Contraceptives Dispensed on Current Page*. Emphasize that if a cabinet only provides contraceptives to several clients in a month, then the personnel should put in the appropriate total here. If they have provided services to more clients than there are spaces to record client data (see above steps 7, 8, and 9) and need more pages, they will total each page separately.
- For this exercise, let's suppose that 12 cycles of Marvelon were dispensed. Write this in Row J.
- Step 11. *Stock balance at the end of the month*. Emphasize that cabinets should do a **physical inventory** first before completing the rows at the top of the form. Tell them that they now have 55 cycles of Marvelon. Ask them what kind of data this is.
Stock on Hand, one of the three essential data items.

- Step 12. *Stock balance at the beginning of the month.* Write in 30. Emphasize that this number must match the previous month's end of the month stock balance.
- Step 13. *Received during the month.* Write in 38. Explain that since this report is for the same month as the order month, you have contraceptives to report as received. For the other two months in the quarter, you would not normally have anything to report here.
- Step 14. *Dispensed during the month.* Explain that since we only needed one page for this month, this number comes from Row J below.
- Ask participants what kind of data item this is.
It reports what is dispensed to users/clients. It is used to calculate the Rate of Consumption (one of the three essential data items).
- Step 15. *Adjustments.* Explain that one cycle of Marvelon was damaged, so the cabinet will need to write in a negative one (-1). Ask what kind of data item this is.
Losses and Adjustments, one of the three essential data items.
- Tell participants that they will have to explain this perishable/adjustment in the quarterly report.
- Step 16. *Stock balance at the end of the month.* Ask participants to check the balance from the physical inventory and verify that it is correct. Explain that this is a "self-balancing" form: that is, the form works mathematically ($B+C-D+E=F$).
- Ask why they would want a self-balancing form.
Because if $B+C-D+E$ does not equal "F", you know that you made a mistake somewhere (in stock count or calculation).
- Step 17. *Dispensed to users during the last three months.* Tell participants that for March you dispensed 12 cycles of Marvelon, and for February 10 cycles. Ask them what number you would write for this example in this column.
 $12+12+10= 34$
- Step 18. *Average monthly consumption.* Have participants do the calculation ($34/3= 11.3$; round to 11). Be sure that everyone understands this calculation, especially the rounding principle (see handout 2: Guide).
- Briefly discuss what to do when you only have one or two months of dispensed data (according to the notes in handout 2: Guide).
- Step 19. *Months of stock on hand.* Have participants do the calculation (F/H or $55/11= 5.0$ months of supply on hand). Ask participants, based on the notes, if this is a sufficient supply situation.
Yes. At the end of the first month of the quarter, they should have between 4.0 and 5.5 months of supply on hand.
- Discuss making an emergency order. Note that you would order only those products where you have fallen below the emergency order point of two months supply on hand.
- Step 20. *Report prepared by...* Put in appropriate signatures.

- Step 21: Discussion – explain why the date of the 5th of the month has been chosen. All family doctors and family planning doctors we have discussed with told us that this is a convenient date.

Individual Exercise (30 min)

- Explain to the group that it has been decided to make the 5th of the month the time to receive reports as it follows the NIH rules and that FH and FP doctors in other regions indicated that this could easily be done.
- Distribute to each participant the following handouts:
 - Instructions
 - March Report
 - April Report
 - Blank Report (to be completed for May)
- Give them 20 minutes to complete the report. Ask them to work individually. **Emphasize to the participants that they should follow the guide, step by step!**
- Review the exercise with the group. Use Overhead 17.6: *Partially completed Monthly Report* to fill in the answers (the client data has already been filled in to save time, but each entry should be quickly gone over). Ask the participants to evaluate the stock situation at the end of May based on this report. Ask them what they found.
- Marvelon is a little bit low after two months, but it is still not a problem. Depo-Provera and condoms are both within the prescribed stock levels after two months.
- Remind participants that May is the second month of the second quarter.
- At the conclusion, distribute Handout 17.10 *Report Exercise Answer Sheet*. It is important that the participants keep all of the monthly reports from the exercise. (They will need them for the next exercise that comes later.)
- Say: You will note that for this exercise we have used only three products; as stated in the step by step guide, you will have to report all products, even those you have on stock, but did not dispense any for the month.
- Conclude this session by asking if participants have any questions about how to correctly complete the FH Cabinet Monthly Report.

Part III: FH Cabinet Quarterly Report and Order Form

Objective: By the end of the session, participants should be able to:

- Correctly complete the FH Cabinet Quarterly Report and Order Form.

Methods: Discussion, practical work

Evaluation: Accuracy of participant work

Time: 70 minutes

Materials:

Overheads

17.7 FH Cabinet Quarterly Report and Order Form

17.8 Partially Completed June FH Cabinet Monthly Report

Handouts

17.11 FH Cabinet Quarterly Report and Order Form

17.12 Guide: How to Complete the FH Cabinet Quarterly Report and Order Form

17.13 Instructions for exercise

17.14 Blank Monthly Report (to be completed for June)

17.15 1st Quarterly Report and Order Form – blue copy

17.16 Blank Quarterly Report and Order Form (to be completed for the 2nd quarter)

17.17 Report Exercise Answer Sheet – Monthly Report for June – green copy

17.18 Report Exercise Answer Sheet – Quarterly Report after receiving contraceptives – blue copy

Activities:

- Explain that as with the monthly report, there is a step-by-step guide for completing the quarterly report and order form. Distribute Handout 17.11 ***FH Cabinet Quarterly Report and Order Form*** and Handout 17.12 ***Guide: How to Complete the FH Cabinet Quarterly Report and Order Form***.
- Using Overhead 17.7 ***FH Cabinet Quarterly Report and Order Form***, and referring to each step in the guide, asking participants to follow along the heading of the form, based on the information received for monthly report.
- Explain that it is very important to check the existing stock through physical inventory at the end of each trimester.
- Explain that the stock at the end of last month of the quarter represents as well the final stock of the quarter. In consequence, the registrations listed under the “F” row in the monthly report of last month will be the same for the “G” row of the Quarterly Report and Order Form. In order to ease the filling in of Quarterly Report, explain participants that they may use another registration from the monthly report for the last month, precisely the data registered under the “G” row of the monthly report (distributed in the last three months) are the same that will be listed under the “C” row (distributed during the quarter) of the Quarterly Report.
- Verify if participants have questions.

Individual exercise (40 min)

- Explain that participants will now practice individually completing the quarterly report and order form for the second quarter of the year. To do so, they will have to first complete the

June Monthly Report; and they will use the reports they already have for March and April as well as the first quarter report which they will receive.

- Distribute to each participant the following handouts:
 - 17.13 - Blank **Monthly Report** to be completed for June
 - 17.14 – **1st Quarterly Report and Order Form** – the blue copy
 - 17.15 – **Blank Quarterly Form for reporting and ordering** – to be completed for the 2nd quarter filled in for the second.
- Give them 30 minutes to complete the reports. Ask them to work individually. Emphasize the importance of following the guides step by step.
- Review the exercise with the group. Use Overhead 17.8 ***Partially completed Monthly Report for June*** to fill in the answers (the client data has already been filled in to save time, but each entry should be quickly reviewed). Ask participants to evaluate the stock situation at the end of June based on this report and to share what they found.
- Conclusion is that Marvelon is low after two months, and it was not the month for ordering. Therefore, they must place an emergency order. Depo-Provera and condoms are both within the prescribed stock levels after two months.
- Be sure that participants understand that they should have concluded that they lost one Depo-Provera vial in order for Row F to balance.
- Distribute the following handouts:
 - 17.17: ***Monthly Report Exercise Answer Sheet for June*** – green copy
 - 17.18: ***Quarterly Report after receiving contraceptives*** – blue copy
- Ask if participants have any questions about completing the monthly reports or quarterly reports and order forms. Ask them: When will you first fill out the new monthly report? When will you first fill out the new quarterly report and order form? Fill out the first monthly report for the month you are in even if you did not dispense anything: 0.
- Fill out the first quarterly report when the end of the quarter happens. If they are in the end of the quarter already and will not dispense any contraceptives, they can wait until the next quarter; if they dispense any contraceptives this quarter, then they should complete it for this quarter.
- Discuss the rule for reporting in general: if a facility does not report for two months, then it will be dropped from the system and will no longer receive free contraceptives.

Part IV: Guidelines for Storing Contraceptives

Objective: By the end of the session, participants should be able to:

- Describe how to store contraceptives according to the storage guidelines

Methods: Discussion

Time: 25 minutes

Materials:

Samples: Storage photos (enough copies so there is one for each group of 4-5 participants)

Handout:

17.19 Health Products Storage Guidelines

Activities:

- Note that one of the most serious effects of poor storage is a reduction in contraceptive shelf life. Ask participants what is meant by “shelf life”.
- **The length of time a product may be stored without affecting the usability, safety, purity or potency of the item.**
- Explain that each contraceptive or drug has a specified shelf life and that similar products may have different shelf lives if they are produced by different manufacturers. While each manufacturer specifies the shelf life of the products it produces, particular countries may have policies that affect shelf lives. In general, the shelf life is printed on the product’s packing, expressed as the expiration date.
- Explain that in order to ensure the availability of quality health products, it is essential to maintain good storage practices.
- Distribute the **Storage photos** to groups of 4-5 participants. Ask them to look at the photo and to list both good and bad storage practices that they see.
- Ask each group in turn to give one bad and one good storage practice they see in the photo. Write the good practices on one flipchart and the bad practices on a second flipchart. Ask participants to explain why the storage practices are good or bad.

Expected answers:

Good practices:

- Clean
- Well organized
- Can see labels
- Expiration dates written on condom boxes

Bad practices:

- Pesticide near contraceptives
- Not following FEFO: note second box’s expiration date is 2/04, should be stacked on top of expiration date 3/05
- The box of Depo-Provera is upside down, which is not good for Depo as it can dry out on the cork.
- Ask participants: What can you do during storage that will maximize the shelf life of contraceptives and drugs?
- Distribute the handout 17.19 **Health Products Storage Guidelines** and review the guidelines with the group.

1. Clean and disinfect storeroom regularly.

Rationale: Rodents and some insects e.g. termites and roaches, eat oral contraceptives,

as well as shipping cartons and inner packaging. It is important to stop the pests from getting into the store room. If the store room becomes infested with pests, kill them. Cats and certain pesticides are effective against termites, rodents and roaches. Once the store room is clear of pests, keep it clean. A clean store room keeps pests away. Food and drinks in the store room increases the risk of pests.

2. Store health commodities in a dry, well lit and well ventilated storeroom – out of direct sunlight.

Rationale: If the store room gets hot, the heat may cause some of the contraceptive supplies to spoil (i.e. decrease shelf life). The shelf life of oral contraceptives is generally 4 to 5 years. However, this period may be reduced if temperatures inside the warehouse rise above 104 degrees Fahrenheit (40 degrees C). For condoms, shelf life depends directly on storage conditions, and shelf life is likely to be much shorter at high temperatures. Although air conditioning is ideal it is expensive. Alternatives include ceiling fans and/or forced ventilation. Direct exposure to sunlight can also reduce the shelf life of contraceptives. Use roofing and windows that shade the interior of the store room from sunlight. Store supplies in their shipping cartons. Moving supplies out of direct sunlight should be easy.

If cabinets are unheated at night in very cold regions, staff should leave the contraceptives in their containers and in closed-in places to keep the cold out.

3. Secure storeroom from water penetration.

Rationale: Water destroys both contraceptive supplies and their packaging. If packaging is damaged, this makes the product unacceptable to the client even if the contraceptive is undamaged. The obvious preventive measure is to repair the warehouse so that water cannot enter. Other measures include stacking contraceptive supplies off the floor on pallets (at least 10 cm off the floor and 30 cm away from walls) since moisture can seep through walls and floors and into the contraceptive supplies.

4. Assure fire safety equipment is available and accessible.

Rationale: Being able to stop a fire before it spreads can save thousands of dollars of contraceptives and other stored items, not to mention the storage space itself. Keeping fire extinguishers accessible is easy, even if keeping them in working order may be more difficult. Keep one near the door and others at obvious and accessible places throughout the warehouse.

5. Store latex products away from electric motors and fluorescent lights.

Rationale: Latex products, including condoms, can be damaged if they are directly exposed to the light of fluorescent lamps. These, and electric motors, create a chemical called ozone, which can rapidly deteriorate condoms. Condoms in their paper boxes and cartons should not be affected and should therefore be left in their boxes. However, by simply moving condom boxes away from these sources, potential damage can be eliminated.

6. Maintain cold storage, including a cold chain, for commodities that require it.

Rationale: Cold storage, including the cold chain, is essential for maintaining the shelf life of drugs that require it. Once these items have left cold storage, they become irrevocably damaged. Where the flow of electricity is unreliable, bottled gas or kerosene-powered refrigeration may be necessary. During immunization campaigns, cold boxes or insulated coolers may be sufficient for rapid transport.

7. Assure proper security.

Rationale: Insure that all stock movement is authorized, by locking the storeroom, limiting access to persons other than the storekeeper and his/her assistants, and ensuring that both incoming and outgoing stock matches documentation. Also inventory records should be periodically verified by a systematic physical inventory.

Ask participants: How many keys should there be to the storeroom or the desk drawer if that is all that they use?

More than one key to the storeroom should be available to ensure that the storeroom can always be accessed (because people go on vacation, are ill, or misplace keys). However, control of a second key should be maintained so that not everyone can access the storeroom. One way to do this would be to have the key in a centrally located lock box, under the control of the storekeeper's supervisor.

8. Store flammable products separately with appropriate safety precautions.

Rationale: Some medical procedures involve the use of flammable products. Bottled gas or kerosene is used to power refrigerators, alcohol is used in sterilization, and mineral spirits is used to power Bunsen burners. These are all highly flammable products that should be stored away from other products, near a fire extinguisher.

9. Stack cartons at least 10 cm (4 inches) off the floor, 30 cm (1 foot) away from the walls and other stacks, and no more than 2.5 m (8 feet) high.

Rationale: In large warehouses, pallets should be used to keep products off of floors, where they will be less susceptible to pest, water and dirt damage. Pallets should be stacked away from walls and far enough apart to allow one to walk completely around each pallet. This promotes air circulation and facilitates movement of stock, cleaning and inspection.

For family health cabinets, a locking cabinet with a set of shelves will be the most likely place contraceptives will be stored.

Proper stacking of supplies will avoid crushing cartons at the bottom of a stack. Cartons should be stacked no more than 8 feet (2.5 meters) high. This will also reduce potential injury to warehouse personnel.

Keeping contraceptives away from walls promotes circulation and prevents cartons from moisture damage, which may occur if water condenses or penetrates walls.

10. Arrange cartons so that arrows point up and so that identification labels, expiry dates and manufacturing dates are visible.

Rationale: This helps make it easier to follow FEFO, and to select the right product. In the case of Depo-Provera, it is necessary so that the liquid does not dry to the cork. If shipping cartons do not show either a date of manufacture or an expiration date, the date of receipt of supplies at the receiving warehouse should be clearly marked on the cartons and on bin cards. Write large, easy-to-read numbers with a marking crayon. Rewrite in large numbers the manufacturing or expiration dates if the original markings are small or difficult to read.

11. Store health commodities in a manner accessible for FEFO, counting, and general management.

Rationale: Insure that the supply management principle of FIRST EXPIRY – FIRST OUT (FEFO) is followed. Ask a participant to explain the difference between FEFO and First In, First Out (FIFO) policies. Contraceptive supplies that have been recently received may sometimes be older than the store's existing stock. (Either of these policies will be

better than one often seen, First In, Still Here (FISH). This procedure will most certainly lead to product expiration.)

12. Store health commodities away from insecticides, hazardous materials, old files, office supplies and equipment.

Rationale: Insecticides and other chemicals may affect the shelf life of a number of products. By keeping other supplies away from contraceptives, the contraceptives are easily accessed. Since contraceptives have a relatively short shelf life overall, they must move quickly to the end user. Storing old junk that gets in the way may slow down access to products.

13. Separate damaged or expired health commodities without delay, and dispose of them in accordance with established procedures.

Rationale: By separating these products out, FEFO is more easily implemented. By destroying damaged products right away, more space is available. Although it is easy to separate out the product, the bureaucracy in destroying any government property may be difficult.

- Discuss with the group which of the guidelines are within their ability and which require money or input from the health insurance house or the MOH. Emphasize the importance of implementing the guidelines as appropriate and feasible in order to prolong the shelf life of contraceptives and other health products.
- Remind participants that damaged or expired products should be disposed of, not kept on shelves. Items removed from shelves should be considered losses. Small amounts of damaged/expired products should not be considered a problem, since we generally keep a bit extra on hand to make sure we never have a stock-out.
- Ask participants how they would account for items that are disposed of and/or expired.
- Ask them to identify which of the discussed rules depend on them and which imply the intervention of the Health Insurance House or MOF. Discuss the subject for a few moments and end the discussion by emphasizing the fact that while some solutions may be very expensive, implying physical or structural changes or are natural-induced (heat and insects, for instance), some others solutions depend directly on them, having low or inexistent costs, and can prolong the contraceptives and other health products storage in the shelf period.

Definition of a Logistics System

The total flow of products, from the acquisition of raw materials to the delivery of finished goods to users, including the related flow of information that controls and records the movement of those products.

Purpose of a Logistic System

The **PURPOSE** of a logistics system
is to get the

RIGHT GOODS in the

RIGHT QUANTITIES in the

RIGHT CONDITION to the

RIGHT PLACES at the

RIGHT TIME for the

RIGHT COST.

ESSENTIAL DATA ITEMS

STOCK ON HAND:

The quantities of usable contraceptives available at all levels of the system at a point in time.

RATE OF CONSUMPTION:

The average quantity of contraceptives dispensed to clients during a particular time period.

LOSSES/ADJUSTMENTS:

The quantity of contraceptives removed from the distribution system for any reason other than consumption by clients (e.g. losses, expiry, damage). Adjustments may include receipt or issue of supplies to/from one facility to another at the same level (e.g., a transfer) or a correction for an error in counting. Losses/adjustments may therefore be a negative or positive number.

Key Characteristics of the Free of Charge Contraceptive Logistics System

- 1. The cabinets will give monthly reports to the DPHA**
- 2. The cabinets will prepare an aggregated quarterly report and order form**
- 3. FH and FP cabinets will pick up their supplies from the DPHA quarterly**
- 4. The cabinets will order all contraceptives (up to a 6 month maximum) quarterly**

Population Groups Entitled to Free-of-Charge Contraceptives - Necessary Documents

- (a) Pupils (pupil card);
- (b) Students (student's card);
- (c) Unemployed (unemployment certificate);
- (d) Persons receiving social assistance (social assistance certificate);
- (e) Women living in rural areas (I.D. card);
- (f) Women having requested abortions, performed in a public medical unit;
- (g) Other population categories with low income – they will fill in a statement on their own responsibility in the presence of the doctor or of the nurse stating that they do not benefit from income that would allow them to buy contraceptives.

N.B. For persons fitting a, b, c, d, e, the doctor and the nurse will write down in the client card the number of the document based on which the person received free of charge contraceptives, **without keeping the document or a copy of it**. For persons fitting the (g) category, the statement filled in on their own responsibility will be attached to the patient's card, without any need for official authorization from a notary.

Recommended Contraceptive Dispensing Protocols

- For pills, **at each visit**, 3 cycles will be prescribed;
- The injectable will be administered only in the medical unit, under strict medical surveillance;
- Maximum 12 pieces of condoms will be dispensed to one person to cover one month (an amount of condoms for 3-months period may be distributed at each visit, means 36 condoms);
- For emergency contraception Tri-Regol can be used in the following way: 2 doses of 4 white pills each, from the last 10 in the cycle. After being used, the rest of the cycle will be destroyed under the same conditions as the other drugs and medical supplies, according to acting norms and regulations. In the Monthly Report Order Form, a cycle of Tri-Regol will be reported as having been dispensed.

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How to Complete the FH Cabinet Monthly Report for Distribution of Free of Charge Contraceptives

STEPS	ACTIONS	NOTES
1.	Write the name of your cabinet	Be sure to write firmly, so that every copy can be read.
2.	Write in the correct month that this report covers	
3.	Year: Write in the year that this report covers	
4.	Write in the page number, beginning with one for the first page	Some cabinets will use more than one page to complete this monthly report with the day to day listing of what you dispensed to clients.
5.	Row A – Be sure that each product that you are reporting is listed here; write in any products not already listed	It is best to try to follow the same sequencing of the names of the products every month
6.	When your first client comes in during the month, you will go down to Nr. and put a 1; subsequent clients will receive the sequenced number: 2,3,4,...	Continue the numbering onto any additional pages needed for the month, so that at the end of the month you will know how many clients came in to receive contraceptives.
7.	Write in the date the client came into the cabinet for contraceptives	
8.	Write in the Client Card Number for the client.	This number should be the same one written on the client card. There should not be a separate number for reproductive health services.
9.	Write in the appropriate column the exact amount of the contraceptive you gave.	Condoms by piece, pills by cycles, injectables by vial. For emergency contraception, the use of TriRegol will be counted as one cycle, even though you are not using the entire cycle of pills.
10.	Complete Row J with the totals for each contraceptive dispensed when you have either filled the page or at the end of the month.	
11.	At the end of the month, do a physical inventory! And write in Row F the quantity of each product you counted.	You should count <u>all</u> of the stock in your facility. Remember not to include expired or damaged stock.
12.	Row B– Write the quantity of each product you had at your facility at the beginning of the report month (beginning balance)	This number must be the same as the number you reported in Row F on the previous month's report.
13.	Row C – Write the quantity of each product you received from the DPHA, if any, during the report month	This number should normally be the same as the number recorded in Row J on the last quarterly report (blue copy) if it was also an ordering month. If you received contraceptives from any facility other than the DPHA, that amount should be reported as a positive adjustment in Row F.
14.	Row D– Write the total quantity of each product given to <u>clients</u> during the report month.	If you have used only one page this month, then the total here will be the same as Row J at the bottom of the page. If you have used more than one page, you will total all of the numbers in Row J for each page. If you do not distribute any of a particular product, you must still report.

15.	<p>Row E – Write the total quantity of perishables and adjustments for each product for the report month. If it is a negative adjustment, put a minus sign before the number; if it is a positive adjustment, put a + sign before the number.</p> <p>Be prepared to explain all perishables and adjustments on the comments line of the quarterly report form.</p>	<p>Any discrepancy between the physical inventory and the expected Ending Balance should be reported as an adjustment.</p> <p>Any product received from any facility other than the DPHA should be reported as a positive adjustment on the report.</p> <p>If you were asked to return product to the DPHA, you would report that amount as a negative adjustment on the report.</p>
16.	<p>Row F – Now follow the formula: B+C-D+E = F and verify that the number that you have written from the physical inventory here is correct</p>	<p>In all cases, the actual physical inventory count is the most important number to report. <i>If this formula does not equal.</i></p> <ol style="list-style-type: none"> Check your math Redo your physical inventory Check that the information in each Row is correct Recalculate your adjustments if necessary to make it equal
17.	<p>Row G – Add up the totals of the amounts dispensed for this report month and the previous two months.</p>	
18.	<p>Row H – determine the average monthly consumption by dividing the total dispensed in the past three months (Row G) by three.</p>	<p>If when you divide the total three months dispensed by 3 and the answer is a fraction, you must use standard rounding principle, rounding to the nearest whole number. Ex. 3.3=3; 3.5=4; 3.7=4</p> <p>If you have a new product and only one month's dispensed data, use that month as your average, when you have two months, divide by two to get the average.</p>
19.	<p>Row I – determine how many months of stock you have at the end of the month by dividing the amount of stock on hand, Row F, by the average monthly consumption, the figure in Row H.</p>	<p>Do the calculation to one decimal point: $3.73 = 3.7$</p> <p>In general, you should have the following months of supply on hand: <u>End of first month</u> of the quarter – between 4.5 to 6 months of supply; <u>End of second month</u> of quarter – between 3.5 to 5 months; <u>End of the third month</u> of the quarter – between 2.5 to 4 months of supply.</p> <p>If you have fallen below two months of supply on hand and <u>it is not the end of the quarter</u>, you should make an <i>emergency order</i> by completing an order form and writing emergency order across the top. Order up to the 6-month max following the formula.</p>
20.	<p>The preparer should sign the report; take off the bottom copy (green) to keep at the Cabinet.</p>	<p>You will need a copy of the monthly report in order to complete the quarterly report and order form.</p> <p>If you have used more than one copy of the report to record you daily dispensed to user, be sure to keep the green copy of each report.</p>
21.	<p>The Monthly Report must be delivered to the DPHA by the 5th of the month.</p>	<p>Monthly report for May is due in the DPHA offices by June 5th. If you have used more than one copy of the report to record your daily dispensed to user, be sure to deliver all copies attached together to the DPHA.</p>

COMPLETING THE FH CABINET MONTHLY REPORT FOR DISTRIBUTION OF FREE OF CHARGE CONTRACEPTIVES

EXERCISE

Using the following data and the FH monthly reports for March and April complete your monthly report for May.

Physical Inventory at the End of May:

Marvelon Cycles - 41
Depo-Provera vials - 16
Condom pieces -140

You did not receive any contraceptives this month from the DPHA.

Your Family Planning Clients in May were the following:

Date	Client Card #	What They Received
2/5	62	3 cycles Marvelon
2/5	612	A depo injection
9/5	200	One cycle of marvelon
10/5	109	12 condoms
13/5	845	1 depo injection
14/5	433	3 cycles of marvelon
20/5	480	12 condoms
20/5	117	6 cycles of Marvelon
21/5	630	1 depo injection
22/5	544	12 condoms
28/5	902	1 depo injection
29/5	435	1 cycle of Marvelon

Known adjustments: You dropped and broke a vial of Depo-Provera.

How to Complete the FH Cabinet Quarterly Report and Order Form

STEPS	ACTIONS	NOTES
22.	Write the name of your cabinet	Be sure to write firmly, so that every copy can be read.
23.	Check the appropriate quarter that pertains to this report	The quarters are: 1 st = January to March; 2 nd = April to June; 3 rd = July to September; 4 th = October to December
24.	Year: Write in the year that this report covers	
25.	Row A – Be sure that each product that you are reporting is listed here; write in any products not already listed	It is best to try to follow the same sequencing of the names of the products every month
26.	Row B– write in the smallest unit size for any product not already listed	You will note that Row B in the quarterly report is different than Row B in the monthly report.
27.	Do a physical inventory at the end of the month! And write in Row G the quantity of each product you counted.	You should count <u>all</u> of the stock in your facility. Remember not to include expired or damaged stock.
28.	Row C – Write the quantity of each product you had at your facility at the beginning of the report quarter (beginning balance)	This number must be the same as the number you reported in Row G on the previous quarter's report. This number should also be the same as reported on the first monthly report for the quarter in Row B.
29.	Row D – Write the quantity of each product you received from the DPHA during the report quarter	This number should be the same as the number recorded in Row J on the previous quarter's report (blue copy). This number should also match the total reported in Row C for the three monthly reports in the quarter. If you received contraceptives from any facility other than the DPHA, that amount should be reported as a positive adjustment in Row F.
30.	Row E – Write the total quantity of each product given to <u>clients</u> during the report quarter.	This number should come from totalling the amount reported in Row D of the <u>three</u> monthly reports for the quarter. This report cannot be completed until the monthly report has been completed for the last month of the quarter.
31.	Row F – Write the total quantity of perishables/adjustments for each product for the report quarter. If it is a negative adjustment, put a minus sign before the number; if it is a positive adjustment, put a + sign before the number. Explain all perishables/adjustments on the comments line at the bottom of the form.	Any discrepancy between the physical inventory and the expected Ending Balance should be reported as an adjustment. Any product received from any facility other than the DPHA should be reported as a positive adjustment on the report. If you were asked to return product to the DPHA, you would report that amount as a negative adjustment on the report.
32.	Row G – Now follow the formula: C+D-E+F = G and verify that the number that you have written from the physical inventory here is correct	In all cases, the actual physical inventory count is the most important number to report. <i>If this formula does not equal.</i> e. Check your math f. Redo your physical inventory g. Check that the information in each Row is correct h. Recalculate your adjustments if necessary to make it equal

33.	Row H – Write in your order after completing the calculation: (Two times row E) minus row G	<p>If you have just started dispensing contraceptives or have a new product and only one month's dispensed data, you will have to first multiply Row E by 3, then take that number and multiply by 2 to determine your order. If you have only two month's dispensed data, divide by two, then multiply by 3, then multiply by 2 and subtract the amount in Row G to determine the order.</p> <p>A negative answer for this Row means that you are overstocked. Be sure to note it as a negative answer.</p>
34.	The doctor should sign, stamp, and date the report and take off the bottom copy (green) to keep at the Cabinet.	The green copy of the report should be kept until you receive the supplies and the blue copy with all of the approvals and the amount received recorded.
35.	The Quarterly Report along with the latest Monthly Report must be delivered to the DPHA by the 5 th of the month.	
36.	Row I – will be completed by the DPHA DFC Coordinator	<p>Normally the number written here should be exactly the same as the number you wrote in Row H. If there is a calculation problem discovered, the number will be changed to reflect the correction. (Serious corrections should be communicated to you by the DPHA before you come to get your supplies)</p> <p>If there is a negative number in Row H, then the coordinator can show a 0 in Row I as no product is required and there should be a 0 in Row J, amount received.</p> <p>Also if for some reason you think you will need more than the normal order, on a very special case basis, the Coordinator may determine a higher order.</p>
37.	Row K – This Row will be completed only when you receive your supplies from the DPHA Storeroom. Write in exactly what you received or be sure that the storeroom manager has done so.	<p>This amount received from the DPHA should match what has been approved in Row I.</p> <p>You may go to the DPHA storeroom between the 15th and the 25th of the month that you have placed the order. You will pick up orders in April, July, October, and January.</p>
38.	The DPHA storeroom manager (Issued) and the person picking up the contraceptives for the cabinet (Received) will then sign the report.	<p>You should receive the blue copy of the report with the completed Aviz.</p> <p>With the amounts written in Rows I & J and the signatures, this version of the report is the more complete and supercedes the green copy that was kept at the cabinet. Be sure to file this copy of the report.</p>

COMPLETING THE FH CABINET MONTHLY REPORT FOR DISTRIBUTION OF FREE OF CHARGE CONTRACEPTIVES

AND

FH CABINET QUARTERLY REPORT AND ORDER FORM

Using the following data and the FH monthly reports for April and May, complete your monthly report for June and then your quarterly report for the second quarter. When you are finished, give the trainers the copies of the reports that would be appropriate for the DPHA, keep the copies that you will normally keep at the cabinet.

Physical Inventory at the End of June:

Marvelon Cycles - 26
Depo-Provera vials - 11
Condom pieces -104

You did not receive any contraceptives in June from the DPHA.

Your Family Planning Clients in June were the following:

Date	Client Card #	What They Received
3/6	362	3 cycles Marvelon
3/6	609	3 cycles Marvelon
5/6	102	12 condoms
5/6	520	1 depo injection
7/6	701	12 condoms
10/6	543	3 cycles of marvelon
10/6	548	6 cycles of marvelon
12/6	90	12 condoms
14/6	360	1 depo injection
17/6	467	1 depo injection
25/6	908	1 depo injection

GUIDELINES FOR PROPER STORAGE OF HEALTH COMMODITIES

1. **Clean and disinfect storeroom regularly.**
2. **Store health commodities in a dry, well-lit, and well-ventilated storeroom. Do not store in direct sunlight.**
3. **Secure storeroom from water penetration.**
4. **Make sure that fire safety equipment is available and accessible and that employees are trained to use it.**
5. **Store latex products away from electric motors and fluorescent lights.**
6. **Maintain cold storage, including a cold chain, for commodities that require it.**
7. **Keep narcotics and other controlled substances in a locked place.**
8. **Store flammable products separately with appropriate safety precautions.**
9. **Stack cartons at least 10 centimeters (4 inches) off the floor, 30 centimeters (1 foot) away from the walls and other stacks, and no more than 2.5 meters (8 feet) high.**
10. **Arrange cartons so that arrows point up (↑) and identification labels, expiry dates, and manufacturing dates are visible.**
11. **Store health commodities in a manner that facilitates “First Expiry, First Out” (FEFO) stock management.**
12. **Store health commodities away from insecticides, hazardous materials, old files, office supplies, and equipment.**
13. **Separate damaged or expired health commodities without delay and dispose of them in accordance with established procedures.**

Definition of a Logistics System

The total flow of products, from the acquisition of raw materials to the delivery of finished goods to users, including the related flow of information that controls and records the movement of those products.

THE PURPOSE OF A LOGISTICS SYSTEM

The **PURPOSE** of a logistics system
is to get the

RIGHT GOODS in the

RIGHT QUANTITIES in the

RIGHT CONDITION to the

RIGHT PLACES at the

RIGHT TIME for the

RIGHT COST.

ESSENTIAL DATA ITEMS

STOCK ON HAND:

The quantities of usable contraceptives available at all levels of the system at a point in time.

RATE OF CONSUMPTION:

The average quantity of contraceptives dispensed to clients during a particular time period.

LOSSES/ADJUSTMENTS:

The quantity of contraceptives removed from the distribution system for any reason other than consumption by clients (e.g. losses, expiry, damage). Adjustments may include receipt or issue of supplies to/from one facility to another at the same level (e.g., a transfer) or a correction for an error in counting.

Losses/adjustments may therefore be a negative or positive number.

Key Characteristics of the Free of Charge Contraceptive Logistics System

- The cabinets will give monthly reports to the DPHA**
- The cabinets will prepare an aggregated quarterly report and order form**
- FH and FP Cabinets will pick up their supplies from the DPHA quarterly**
- Order all contraceptives up to 6 month max quarterly**

FH Cabinet Monthly Report for Distribution of Free of Charge Contraceptives

Page: _____

Cabinet: _____

Month: _____

Year: _____

A	Name of Product	COC			POP	INJ		COND	OTHERS
		Marvelon / Lo-femenal	TriRegol*		Exluton	Depo- Provera	Megestron		
B	Stock balance at the beginning of month								
C	Received during the month								
D	Dispensed during the month (add row (J) from curent page with row/s (J) from any additional page/s)								
E	Adjustments (-/+)								
F	Stock balance at the end of the month (B+C-D+E)								
G	Dispensed to users during the last 3 months								
H	Average monthly consumption (G/3)								
I	Months of stock on hand (F/H)								
Nr.	Date	Client Card #							
J	Total Contraceptives Dispensed on Curent Page								

Report prepared by: _____
(Signature)

*For emergency contraception one cycle of TriRegol will be counted

Report verified by DFC Coordinator _____
(Signature)

This Copy for the DPHA - Coordinator for Distribution of Free Contraceptives (DFC)

FH Cabinet Monthly Report for Distribution of Free of Charge Contraceptives

Page: _____

Cabinet: _____

Month: _____ Year: _____

A	Name of Product	COC			POP	INJ		COND	OTHERS
		Marvelon / Lo-femenal	TriRegol*		Exluton	Depo- Provera	Megestron		
B	Stock balance at the beginning of month								
C	Received during the month								
D	Dispensed during the month (add row (J) from curent page with row/s (J) from any additional page/s)								
E	Adjustments (-/+)								
F	Stock balance at the end of the month (B+C-D+E)								
G	Dispensed to users during the last 3 months								
H	Average monthly consumption (G/3)								
I	Months of stock on hand (F/H)								
Nr.	Date	Client Card #							
1	2/5	62	3						
2	2/5	612				1			
3	9/5	200	1						
4	10/5	109						12	
5	13/5	845				1			
6	14/5	433	3						
7	20/5	480						12	
8	20/5	117	6						
9	21/5	630				1			
10	22/5	544						12	
11	28/5	902				1			
12	29/5	435	1						
J	Total Contraceptives Dispensed on Curent Page								

Report prepared by: _____

(Signature)

Report verified by DFC Coordinator _____

(Signature)

*For emergency contraception one cycle of TriRegol will be counted

FH Cabinet Quarterly Report and Order Form for Free of Charge Contraceptives

✓ 1st quarter 2nd quarter 3rd quarter 4th quarter Year _____

NAME OF CABINET: _____

A	Name of Product	COC				POP		INJ		CON	OTHER
		Marvelon/ Lo-Femenal	Tgri Regol			Exluton		Depo-provera	Megestron	Condoms	
B	Unit	Cycle	Cycle	Cycle		Cycle		Vial	Vial	Piece	
C	Beginning Balance at the beginning of the quarter										
D	Received during the quarter										
E	Dispensed during this quarter										
F	Perishables / Adjustments (+/-)										
G	Ending Balance (C+D-E+F)										
H	Order (2*E)-G										
I	Approved Amount										
J	Amount Received										

Explain all perishables / adjustments: _____

Prepared by _____
(Signature and Stamp)

Date _____

Approved by Coordinator for Distribution
of Free of Charge Contraceptives _____
(Signature and Stamp)

Date _____

Issued by person in charge
of storeroom _____
(Signature)

Date _____

Contraceptives Received by _____
(Signature)

Date _____

This Copy for the DPHA Coordinator for Distribution of Free Contraceptives

FH Cabinet Monthly Report for Distribution of Free of Charge Contraceptives

Page: _____

Cabinet: _____

Month: _____

Year: _____

A	Name of Product	COC			POP	INJ		COND	OTHERS
		Marvelon / Lo-femenal	TriRegol*		Exluton	Depo- Provera	Megestron		
B	Stock balance at the beginning of month								
C	Received during the month								
D	Dispensed during the month (add row (J) from curent page with row/s (J) from any additional page/s)								
E	Adjustments (-/+)								
F	Stock balance at the end of the month (B+C-D+E)								
G	Dispensed to users during the last 3 months								
H	Average monthly consumption (G/3)								
I	Months of stock on hand (F/H)								
Nr.	Date	Client Card #							
1	3/6	362	3						
2	3/6	609	3						
3	5/6	102						12	
4	5/6	520				1			
5	7/6	701						12	
6	10/6	543	3						
7	10/6	548	6						
8	12/6	90						12	
9	14/6	360				1			
10	17/6	467				1			
11	25/6	908				1			
J	Total Contraceptives Dispensed on Curent Page								

Report prepared by: _____
(Signature)

Report verified by DFC Coordinator _____
(Signature)

*For emergency contraception one cycle of TriRegol will be counted



Population Groups entitled to free of charge contraceptives and necessary documents

- (a) Pupils (pupil card);
- (b) Students (student's card);
- (c) Unemployed (unemployment certificate);
- (d) Persons receiving social assistance (social assistance certificate);
- (e) Women living in rural areas (I.D. card);
- (f) Women having requested abortions, performed in a public medical unit;
- (g) Other population categories with low income – they will fill in a statement on their own responsibility in the presence of the doctor or of the nurse stating that they do not benefit from income that would allow them to buy contraceptives.

N.B. For persons fitting a, b, c, d, e, the doctor and the nurse will write down in the client card the number of the document based on which the person received free of charge contraceptives, **without keeping the document or a copy of it**. For persons fitting the (g) category, the statement filled in on their own responsibility will be attached to the patient's card, without any need for official authorization from a notary.

Recommended Contraceptive Dispensing Protocols

- For pills, **at each visit**, 3 cycles will be prescribed;
- The injectable will be administered only in the cabinet, under strict medical surveillance;
- Clients who want to have an IUD inserted as a contraceptive method, are to be referred to the nearest FP/ObGyn cabinet that has this method on stock;
- Maximum 12 pieces of condoms will be dispensed to one person to cover one month;
- For emergency contraception Tri-Regol can be used in the following way: 2 doses of 4 white pills each, from the last 10 in the cycle. After being used, the rest of the cycle will be destroyed under the same conditions as the other drugs and medical supplies, according to acting norms and regulations. In the Monthly Report Order Form, a cycle of Tri-Regol will be reported as having been dispensed.

DEFINITION OF A LOGISTICS SYSTEM

The total flow of products, from the acquisition of raw materials to the delivery of finished goods to users, including the related flow of information that controls and records the movement of those products.

The **PURPOSE** of a logistics system
is to get the

RIGHT GOODS in the

RIGHT QUANTITIES in the

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RIGHT TIME for the

RIGHT COST.

FH Cabinet Monthly Report for Distribution of Free of Charge Contraceptives

Page: _____

Cabinet: _____

Month: _____

Year: _____

A	Name of Product	COC				POP	INJ		COND	OTHERS
		Marvelon / Lo-femenal	TriRegol*			Exluton	Depo- Provera	Megestron		
B	Stock balance at the beginning of month									
C	Received during the month									
D	Dispensed during the month (add row (J) from curent page with row/s (J) from any additional page/s)									
E	Adjustments (-/+)									
F	Stock balance at the end of the month (B+C-D+E)									
G	Dispensed to users during the last 3 months									
H	Average monthly consumption (G/3)									
I	Months of stock on hand (F/H)									
Nr.	Date	Client Card #								
J	Total Contraceptives Dispensed on Curent Page									

Report prepared by: _____

(Signature)

*For emergency contraception one cycle of TriRegol will be counted

Report verified by DFC Coordinator _____

(Signature)

This Copy for the DPHA - Coordinator for Distribution of Free Contraceptives (DFC)

How to Complete the FH Cabinet Quarterly Report and Order Form

STEPS	ACTIONS	NOTES
1.	Write the name of your cabinet	Be sure to write firmly, so that every copy can be read.
2.	Check the appropriate quarter that pertains to this report	The quarters are: 1 st = January to March; 2 nd = April to June; 3 rd = July to September; 4 th = October to December
3.	Year: Write in the year that this report covers	
4.	Row A – Be sure that each product that you are reporting is listed here; write in any products not already listed	It is best to try to follow the same sequencing of the names of the products every month
5.	Row B– write in the smallest unit size for any product not already listed	You will note that Row B in the quarterly report is different than Row B in the monthly report.
6.	Do a physical inventory at the end of the month! And write in Row G the quantity of each product you counted.	You should count <u>all</u> of the stock in your facility. Remember not to include expired or damaged stock.
7.	Row C – Write the quantity of each product you had at your facility at the beginning of the report quarter (beginning balance)	This number must be the same as the number you reported in Row G on the previous quarter's report. This number should also be the same as reported on the first monthly report for the quarter in Row B.
8.	Row D – Write the quantity of each product you received from the DPHA during the report quarter	This number should be the same as the number recorded in Row J on the previous quarter's report (blue copy). This number should also match the total reported in Row C for the three monthly reports in the quarter. If you received contraceptives from any facility other than the DPHA, that amount should be reported as a positive adjustment in Row F.
9.	Row E – Write the total quantity of each product given to <u>clients</u> during the report quarter.	This number should come from totaling the amount reported in Row D of the <u>three</u> monthly reports for the quarter. This report cannot be completed until the monthly report has been completed for the last month of the quarter.
10.	Row F – Write the total quantity of perishables/adjustments for each product for the report quarter. If it is a negative adjustment, put a minus sign before the number; if it is a positive adjustment, put a + sign before the number. Explain all perishables/adjustments on the comments line at the bottom of the form.	Any discrepancy between the physical inventory and the expected Ending Balance should be reported as an adjustment. Any product received from any facility other than the DPHA should be reported as a positive adjustment on the report. If you were asked to return product to the DPHA, you would report that amount as a negative adjustment on the report.

11.	Row G – Now follow the formula: $C+D-E+F = G$ and verify that the number that you have written from the physical inventory here is correct	In all cases, the actual physical inventory count is the most important number to report. <i>If this formula does not equal.</i> a. <i>Check your math</i> b. <i>Redo your physical inventory</i> c. <i>Check that the information in each Row is correct</i> d. <i>Recalculate your adjustments if necessary to make it equal</i>
12.	Row H – Write in your order after completing the calculation: (Two times row E) minus row G	If you have just started dispensing contraceptives or have a new product and only one month's dispensed data, you will have to first multiply Row E by 3, then take that number and multiply by 2 to determine your order. If you have only two month's dispensed data, divide by two, then multiply by 3, then multiply by 2 and subtract the amount in Row G to determine the order. A negative answer for this Row means that you are overstocked. Be sure to note it as a negative answer.
13.	The doctor should sign, stamp, and date the report and take off the bottom copy (green) to keep at the Cabinet.	The green copy of the report should be kept until you receive the supplies and the blue copy with all of the approvals and the amount received recorded.
14.	The Quarterly Report along with the latest Monthly Report must be delivered to the DPHA by the 5 th of the month.	
15.	Row I – will be completed by the DPHA DFC Coordinator	Normally the number written here should be exactly the same as the number you wrote in Row H. If there is a calculation problem discovered, the number will be changed to reflect the correction. (Serious corrections should be communicated to you by the DPHA before you come to get your supplies) If there is a negative number in Row H, then the coordinator can show a 0 in Row I as no product is required and there should be a 0 in Row J, amount received. Also if for some reason you think you will need more than the normal order, on a very special case basis, the Coordinator may determine a higher order.
16.	Row K – This Row will be completed only when you receive your supplies from the DPHA Storeroom. Write in exactly what you received or be sure that the storeroom manager has done so.	This amount received from the DPHA should match what has been approved in Row I. You may go to the DPHA storeroom between the 15 th and the 25 th of the month that you have placed the order. You will pick up orders in April, July, October, and January.
17.	The DPHA storeroom manager (Issued) and the person picking up the contraceptives for the cabinet (Received) will then sign the report.	You should receive the blue copy of the report with the completed Aviz. With the amounts written in Rows I & J and the signatures, this version of the report is the more complete and supercedes the green copy that was kept at the cabinet. Be sure to file this copy of the report.

COMPLETING THE FH CABINET MONTHLY REPORT FOR DISTRIBUTION OF FREE OF CHARGE CONTRACEPTIVES EXERCISE HANDOUT 3

Using the following data and the FH monthly reports for March and April complete your monthly report for May.

Physical Inventory at the End of May:

Marvelon Cycles - 41
Depo-Provera vials - 16
Condom pieces -140

You did not receive any contraceptives this month from the DPHA.

Your Family Planning Clients in May were the following:

Date	Client Card #	What They Received
2/5	62	3 cycles Marvelon
2/5	612	A depo injection
9/5	200	One cycle of marvelon
10/5	109	12 condoms
13/5	845	1 depo injection
14/5	433	3 cycles of marvelon
20/5	480	12 condoms
20/5	117	6 cycles of Marvelon
21/5	630	1 depo injection
22/5	544	12 condoms
28/5	902	1 depo injection
29/5	435	1 cycle of Marvelon

Known adjustments: You dropped and broke a vial of Depo-Provera.

FH Cabinet Monthly Report for Distribution of Free of Charge Contraceptives

Page: 1

Cabinet: Viagra

Month: March

Year: 2002

A	Name of Product	COC			POP	INJ		COND	OTHERS
		Marvelon / Lo-femenal	TriRegol*		Exluton	Depo- Provera	Megestron		
B	Stock balance at the beginning of month	42				9		118	
C	Received during the month	0				0		0	
D	Dispensed during the month (add row (J) from curent page with row/s (J) from any additional page/s)	12				4		36	
E	Adjustments (-/+)	0				0		0	
F	Stock balance at the end of the month (B+C-D+E)	30				5		82	
G	Dispensed to users during the last 3 months	34				13		112	
H	Average monthly consumption (G/3)	11				4		37	
I	Months of stock on hand (F/H)	2.7				1.3		2.2	
Nr.	Date	Client Card #							
1	2/3	206	3						
2	2/3	906	3						
3	9/3	1002				1			
4	10/3	1020						12	
5	13/3	58				1			
6	14/3	345	3						
7	20/3	845						12	
8	20/3	900	3						
9	21/3	630				1			
10	22/3	645						12	
11	28/3	890				1			
J	Total Contraceptives Dispensed on Curent Page	12				4		36	

Report prepared by: Laurentiu Koo
(Signature)

Report verified by DFC Coordinator _____
(Signature)

*For emergency contraception one cycle of TriRegol will be counted

FH Cabinet Monthly Report for Distribution of Free of Charge Contraceptives

Page: 1

Cabinet: Viagra

Month: April

Year: 2002

A	Name of Product	COC			POP	INJ		COND	OTHERS
		Marvelon / Lo-femenal	TriRegol*		Exluton	Depo- Provera	Megestron		
B	Stock balance at the beginning of month	30				5		82	
C	Received during the month	38				21		142	
D	Dispensed during the month (add row (J) from curent page with row/s (J) from any additional page/s)	12				5		48	
E	Adjustments (-/+)	-1				0		0	
F	Stock balance at the end of the month (B+C-D+E)	55				21		176	
G	Dispensed to users during the last 3 months	34				12		116	
H	Average monthly consumption (G/3)	11				4		39	
I	Months of stock on hand (F/H)	5.0				5.3		4.5	
Nr.	Date	Client Card #							
1	1/4	362	3						
2	2/4	609	3						
3	5/4	102						12	
4	5/4	520				1			
5	8/4	701						12	
6	10/4	543	3						
7	10/4	548	3						
8	12/4	90						12	
9	15/4	360				1			
10	15/4	456						12	
11	18/4	908				1			
12	22/4	467				1			
13	22/4	502				1			
J	Total Contraceptives Dispensed on Curent Page		12			5		48	

Report prepared by: Laurentiu Koo
(Signature)

Report verified by DFC Coordinator _____
(Signature)

*For emergency contraception one cycle of TriRegol will be counted

FH Cabinet Monthly Report for Distribution of Free of Charge Contraceptives

Page: _____

Cabinet: _____

Month: _____

Year: _____

A	Name of Product	COC			POP	INJ		COND	OTHERS
		Marvelon / Lo-femenal	TriRegol*		Exluton	Depo- Provera	Megestron		
B	Stock balance at the beginning of month								
C	Received during the month								
D	Dispensed during the month (add row (J) from curent page with row/s (J) from any additional page/s)								
E	Adjustments (-/+)								
F	Stock balance at the end of the month (B+C-D+E)								
G	Dispensed to users during the last 3 months								
H	Average monthly consumption (G/3)								
I	Months of stock on hand (F/H)								
Nr.	Date	Client Card #							
J	Total Contraceptives Dispensed on Curent Page								

Report prepared by: _____
(Signature)

Report verified by DFC Coordinator _____
(Signature)

*For emergency contraception one cycle of TriRegol will be counted

FH Cabinet Monthly Report for Distribution of Free of Charge Contraceptives

Page: 1

Cabinet: Viagra

Month: May

Year: 2002

A	Name of Product	COC			POP	INJ		COND	OTHERS
		Marvelon / Lo-femenal	TriRegol*		Exluton	Depo- Provera	Megestron		
B	Stock balance at the beginning of month	55				21		176	
C	Received during the month	0				0		0	
D	Dispensed during the month (add row (J) from curent page with row/s (J) from any additional page/s)	14				4		36	
E	Adjustments (-/+)	0				-1		0	
F	Stock balance at the end of the month (B+C-D+E)	41				16		140	
G	Dispensed to users during the last 3 months	38				13		120	
H	Average monthly consumption (G/3)	13				4		40	
I	Months of stock on hand (F/H)	3.2				4.0		3.5	
Nr.	Date	Client Card #							
1	2/5	62	3						
2	2/5	612				1			
3	9/5	200	1						
4	10/5	109						12	
5	13/5	845				1			
6	14/5	433	3						
7	20/5	480						12	
8	20/5	117	6						
9	21/5	630				1			
10	22/5	544						12	
11	28/5	902				1			
12	29/5	435	1						
J	Total Contraceptives Dispensed on Curent Page		14			4		36	

Report prepared by: Laurentiu Koo
(Signature)

Report verified by DFC Coordinator _____
(Signature)

*For emergency contraception one cycle of TriRegol will be counted

FH Cabinet Quarterly Report and Order Form for Free of Charge Contraceptives

✓ 1st quarter 2nd quarter 3rd quarter 4th quarter Year _____

NAME OF CABINET: _____

A	Name of Product	COC				POP		INJ		CON	OTHER
		Marvelon/ Lo-Femenal	Tgri Regol			Exluton		Depo-provera	Megestron	Condoms	
B	Unit	Cycle	Cycle	Cycle		Cycle		Vial	Vial	Piece	
C	Beginning Balance at the beginning of the quarter										
D	Received during the quarter										
E	Dispensed during this quarter										
F	Perishables / Adjustments (+/-)										
G	Ending Balance (C+D-E+F)										
H	Order (2*E)-G										
I	Approved Amount										
J	Amount Received										

Explain all perishables / adjustments: _____

Prepared by _____
(Signature and Stamp)

Date _____

Approved by Coordinator for Distribution
of Free of Charge Contraceptives _____
(Signature and Stamp)

Date _____

Issued by person in charge
of storeroom _____
(Signature)

Date _____

Contraceptives Received by _____
(Signature)

Date _____

This Copy for the DPHA Coordinator for Distribution of Free Contraceptives

How to Complete the FH Cabinet Quarterly Report and Order Form

STEPS	ACTIONS	NOTES
1.	Write the name of your cabinet	Be sure to write firmly, so that every copy can be read.
2.	Check the appropriate quarter that pertains to this report	The quarters are: 1 st = January to March; 2 nd = April to June; 3 rd = July to September; 4 th = October to December
3.	Year: Write in the year that this report covers	
4.	Row A – Be sure that each product that you are reporting is listed here; write in any products not already listed	It is best to try to follow the same sequencing of the names of the products every month
5.	Row B– write in the smallest unit size for any product not already listed	You will note that Row B in the quarterly report is different than Row B in the monthly report.
6.	Do a physical inventory at the end of the month! And write in Row G the quantity of each product you counted.	You should count <u>all</u> of the stock in your facility. Remember not to include expired or damaged stock.
7.	Row C – Write the quantity of each product you had at your facility at the beginning of the report quarter (beginning balance)	This number must be the same as the number you reported in Row G on the previous quarter's report. This number should also be the same as reported on the first monthly report for the quarter in Row B.
8.	Row D – Write the quantity of each product you received from the DPHA during the report quarter	This number should be the same as the number recorded in Row J on the previous quarter's report (blue copy). This number should also match the total reported in Row C for the three monthly reports in the quarter. If you received contraceptives from any facility other than the DPHA, that amount should be reported as a positive adjustment in Row F.
9.	Row E – Write the total quantity of each product given to <u>clients</u> during the report quarter.	This number should come from totalling the amount reported in Row D of the <u>three</u> monthly reports for the quarter. This report cannot be completed until the monthly report has been completed for the last month of the quarter.
10.	Row F – Write the total quantity of perishables/adjustments for each product for the report quarter. If it is a negative adjustment, put a minus sign before the number; if it is a positive adjustment, put a + sign before the number. Explain all perishables/adjustments on the comments line at the bottom of the form.	Any discrepancy between the physical inventory and the expected Ending Balance should be reported as an adjustment. Any product received from any facility other than the DPHA should be reported as a positive adjustment on the report. If you were asked to return product to the DPHA, you would report that amount as a negative adjustment on the report.

11.	Row G – Now follow the formula: $C+D-E+F = G$ and verify that the number that you have written from the physical inventory here is correct	<p>In all cases, the actual physical inventory count is the most important number to report.</p> <p><i>If this formula does not equal.</i></p> <ol style="list-style-type: none"> <i>Check your math</i> <i>Redo your physical inventory</i> <i>Check that the information in each Row is correct</i> <i>Recalculate your adjustments if necessary to make it equal</i>
12.	Row H – Write in your order after completing the calculation: (Two times row E) minus row G	<p>If you have just started dispensing contraceptives or have a new product and only one month's dispensed data, you will have to first multiply Row E by 3, then take that number and multiply by 2 to determine your order. If you have only two month's dispensed data, divide by two, then multiply by 3, then multiply by 2 and subtract the amount in Row G to determine the order.</p> <p>A negative answer for this Row means that you are overstocked. Be sure to note it as a negative answer.</p>
13.	The doctor should sign, stamp, and date the report and take off the bottom copy (green) to keep at the Cabinet.	The green copy of the report should be kept until you receive the supplies and the blue copy with all of the approvals and the amount received recorded.
14.	The Quarterly Report along with the latest Monthly Report must be delivered to the DPHA by the 5 th of the month.	
15.	Row I – will be completed by the DPHA DFC Coordinator	<p>Normally the number written here should be exactly the same as the number you wrote in Row H. If there is a calculation problem discovered, the number will be changed to reflect the correction. (Serious corrections should be communicated to you by the DPHA before you come to get your supplies)</p> <p>If there is a negative number in Row H, then the coordinator can show a 0 in Row I as no product is required and there should be a 0 in Row J, amount received.</p> <p>Also if for some reason you think you will need more than the normal order, on a very special case basis, the Coordinator may determine a higher order.</p>
16.	Row K – This Row will be completed only when you receive your supplies from the DPHA Storeroom. Write in exactly what you received or be sure that the storeroom manager has done so.	<p>This amount received from the DPHA should match what has been approved in Row I.</p> <p>You may go to the DPHA storeroom between the 15th and the 25th of the month that you have placed the order. You will pick up orders in April, July, October, and January.</p>
17.	The DPHA storeroom manager (Issued) and the person picking up the contraceptives for the cabinet (Received) will then sign the report.	<p>You should receive the blue copy of the report with the completed Aviz.</p> <p>With the amounts written in Rows I & J and the signatures, this version of the report is the more complete and supercedes the green copy that was kept at the cabinet. Be sure to file this copy of the report.</p>

COMPLETING THE

FH CABINET MONTHLY REPORT FOR DISTRIBUTION OF FREE OF

CHARGE CONTRACEPTIVES

AND

FH CABINET QUARTERLY REPORT AND ORDER FORM

EXERCISE

Using the following data and the FH monthly reports for April and May, complete your monthly report for June and then your quarterly report for the second quarter. When you are finished, give the trainers the copies of the reports that would be appropriate for the DPHA, keep the copies that you will normally keep at the cabinet.

Physical Inventory at the End of June:

Marvelon Cycles - 26
 Depo-Provera vials - 11
 Condom pieces -104

You did not receive any contraceptives in June from the DPHA.

Your Family Planning Clients in June were the following:

Date	Client Card #	What They Received
3/6	362	3 cycles Marvelon
3/6	609	3 cycles Marvelon
5/6	102	12 condoms
5/6	520	1 depo injection
7/6	701	12 condoms
10/6	543	3 cycles of marvelon
10/6	548	6 cycles of marvelon
12/6	90	12 condoms
14/6	360	1 depo injection
17/6	467	1 depo injection
25/6	908	1 depo injection

FH Cabinet Quarterly Report and Order Form for Free of Charge Contraceptives

1st quarter
 2nd quarter
 3rd quarter
 4th quarter
 Year 2002

NAME OF CABINET: Viagra

A	Name of Product	COC				POP		INJ		CON	OTHER
		Marvelon/ Lo-Femenal	Tgri Regol			Exluton		Depo-provera	Megestron	Condoms	
B	Unit	Cycle	Cycle	Cycle		Cycle		Vial	Vial	Piece	
C	Beginning Balance at the beginning of the quarter	24						3		84	
D	Received during the quarter	41						15		110	
E	Dispensed during this quarter	34						13		112	
F	Adjustments (+/-)	-1						0		0	
G	Ending Balance (C+D-E+F)	30						5		82	
H	Order (2*E)-G	38						21		142	
I	Approved Amount	38						21		142	
J	Amount Received	38						21		142	

Explain all adjustments: Lost one cycle of Marvelon

Prepared by Laurentiu Koo Date 1, April 2002
(Signature and Stamp)

Approved by Coordinator for Distribution of Free of Charge Contraceptives Mihai Horga Date 6, April 2002
(Signature and Stamp)

Issued by person in charge of storeroom Vadim Tudor Date 17, April 2002
(Signature)

Contraceptives Received by Laurentiu Koo Date 17, April 2002
(Signature)

This Copy for the DPHA Coordinator for Distribution of Free Contraceptives

FH Cabinet Quarterly Report and Order Form for Free of Charge Contraceptives

✓ 1st quarter 2nd quarter 3rd quarter 4th quarter Year _____

NAME OF CABINET: _____

A	Name of Product	COC				POP		INJ		CON	OTHER
		Marvelon/ Lo-Femenal	Tgri Regol			Exluton		Depo-provera	Megestron	Condoms	
B	Unit	Cycle	Cycle	Cycle		Cycle		Vial	Vial	Piece	
C	Beginning Balance at the beginning of the quarter										
D	Received during the quarter										
E	Dispensed during this quarter										
F	Perishable / Adjustments (+/-)										
G	Ending Balance (C+D-E+F)										
H	Order (2*E)-G										
I	Approved Amount										
J	Amount Received										

Explain all perishables / adjustments: _____

Prepared by _____
(Signature and Stamp)

Date _____

Approved by Coordinator for Distribution
of Free of Charge Contraceptives _____
(Signature and Stamp)

Date _____

Issued by person in charge
of storeroom _____
(Signature)

Date _____

Contraceptives Received by _____
(Signature)

Date _____

This Copy for the DPHA Coordinator for Distribution of Free Contraceptives

FH Cabinet Monthly Report for Distribution of Free of Charge Contraceptives

Page: 1

Cabinet: Viagra

Month: June

Year: 2002

A	Name of Product	COC			POP	INJ		COND	OTHERS
		Marvelon / Lo-femenal	TriRegol*		Exluton	Depo- Provera	Megestron		
B	Stock balance at the beginning of month	41				16		140	
C	Received during the month	0				0		0	
D	Dispensed during the month (add row (J) from curent page with row/s (J) from any additional page/s)	15				4		36	
E	Adjustments (-/+)	0				-1		0	
F	Stock balance at the end of the month (B+C-D+E)	26				11		104	
G	Dispensed to users during the last 3 months	41				13		120	
H	Average monthly consumption (G/3)	14				4		40	
I	Months of stock on hand (F/H)	1.9				2.8		2.6	
Nr.	Date	Client Card #							
1	3/6	362	3						
2	3/6	609	3						
3	5/6	102						12	
4	5/6	520				1			
5	7/6	701						12	
6	10/6	543	3						
7	10/6	548	6						
8	12/6	90						12	
9	14/6	360				1			
10	17/6	467				1			
11	25/6	908				1			
J	Total Contraceptives Dispensed on Curent Page	15				4		36	

Report prepared by: Laurentiu Koo
(Signature)

Report verified by DFC Coordinator _____
(Signature)

*For emergency contraception one cycle of TriRegol will be counted

FH Cabinet Quarterly Report and Order Form for Free of Charge Contraceptives

1st quarter 2nd quarter 3rd quarter 4th quarter Year 2002

NAME OF CABINET: Viagra

A	Name of Product	COC				POP		INJ		CON	OTHER
		Marvelon/ Lo-Femenal	Tgri Regol			Exluton		Depo-provera	Megestron	Condoms	
B	Unit	Cycle	Cycle	Cycle		Cycle		Vial	Vial	Piece	
C	Beginning Balance at the beginning of the quarter	30						5		82	
D	Received during the quarter	38						21		142	
E	Dispensed during this quarter	41						13		120	
F	Adjustments (+/-)	-1						-2		0	
G	Ending Balance (C+D-E+F)	26						11		104	
H	Order (2*E)-G	56						15		136	
I	Approved Amount	56						15		136	
J	Amount Received	56						15		136	

Explain all adjustments: Dropped one vial of Depo, lost one vial of Depo

Prepared by Laurentiu Koo Date 28, June 2002
(Signature and Stamp)

Approved by Coordinator for Distribution of Free of Charge Contraceptives Mihai Horga Date 8, July 2002
(Signature and Stamp)

Issued by person in charge of storeroom Vadim Tudor Date 18, July 2002
(Signature)

Contraceptives Received by Laurentiu Koo Date 18, July 2002
(Signature)

This Copy for the DPHA Coordinator for Distribution of Free Contraceptives

GUIDELINES FOR PROPER STORAGE OF HEALTH COMMODITIES

- 1. Clean and disinfect storeroom regularly.**
- 2. Store health commodities in a dry, well-lit, and well-ventilated storeroom. Do not store in direct sunlight.**
- 3. Secure storeroom from water penetration.**
- 4. Make sure that fire safety equipment is available and accessible and that employees are trained to use it.**
- 5. Store latex products away from electric motors and fluorescent lights.**
- 6. Maintain cold storage, including a cold chain, for commodities that require it.**
- 7. Keep narcotics and other controlled substances in a locked place.**
- 8. Store flammable products separately with appropriate safety precautions.**
- 9. Stack cartons at least 10 centimeters (4 inches) off the floor, 30 centimeters (1 foot) away from the walls and other stacks, and no more than 2.5 meters (8 feet) high.**
- 10. Arrange cartons so that arrows point up (↑) and identification labels, expiry dates, and manufacturing dates are visible.**
- 11. Store health commodities in a manner that facilitates “First Expiry, First Out” (FEFO) stock management.**
- 12. Store health commodities away from insecticides, hazardous materials, old files, office supplies, and equipment.**
- 13. Separate damaged or expired health commodities without delay and dispose of them in accordance with established procedures.**

John Snow, Inc.

Session 18: Post-Abortion Counseling

Objectives:

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

- Describe the elements of the post-abortion counseling
- Promote the use of contraception for women who have gone through the experience of an abortion.

Time: 30 minutes

Techniques: Listing, Discussions

Materials

Handouts

18.1 Counseling Guide for Providers

18.2 Client Education Guide: "How to Take Care of Yourself" (what we tell women who have recently had an abortion)

Activities:

1. Post-abortion Counseling (15 min)

- Address the following questions to the group:
 - Are there any women who use abortion as a method of controlling their fertility in the region where you work?
 - How many?
 - Do you think that it is important to offer counseling to these women? Why?

Expected Answers:

- Most often, women who have had an abortion have not received information regarding possibilities of fertility control, contraception (and thus were in the situation of having an abortion)
 - They do not have information regarding their access to Family Planning/contraceptive methods
 - They have knowledge regarding contraception, but they have postponed using it, hoping that they will not become pregnant; the reason of such a behavior are various, such as the visit to the doctor in order to start using a contraceptive method,.
 - They believe that using the contraceptive methods is more dangerous for their health than having an abortion
 - They have unsuccessfully used a traditional family planning method
 - They can have negative feelings about the abortion that they have gone through and they might need support.
 - They may need to clarify their feelings regarding pregnancy and abortion. Counseling provided by health professionals can help them to think about what they will do in the future in order to prevent unwanted pregnancies and to make the decision of taking action for the prevention of another unwanted pregnancy.
- Make a list of the obtained answers. Starting with the stated situations, help participants to identify as many solutions for these problems as they can.

- Ask: What could the doctor or the nurse do in order to help women who have had an abortion?

Possible Answers:

- They could offer correct information regarding the contraceptive methods
 - They could inform population about the existence of services at the doctor's office in the county
 - They could present the FP advantages on any occasion
 - They could actively promote contraception
 - They could present the abortion risks Vs. contraception risks
- As a conclusion, state the fact that these things can be done by all those who have participated in the workshop.
 - Distribute handout 18.1 ***Counseling guide for providers.***
 - Afterwards, ask: What should know a woman who has recently had an abortion?

Expected answers:

- rules for personal and general hygiene
 - signs to be followed, alarm signs and symptoms
 - when to have sexual intercourse without any health risk
 - use of contraceptive methods (what methods can be used after abortion, when to start to use them, what side-effects might occur)
- Distribute to trainees the handout 18.2: ***Client Education Guide "How to Take Care of Yourself"*** (what do we tell women who have recently had an abortion).

2. Active Promotion of Family Planning for Women Who Use Abortion as a Means of Fertility Control

- Ask participants to think of the situations in which they might promote the use of contraception by women who control their fertility through abortions.
- Ask: How can we initiate a counseling session for a woman about whom we know that has had abortion(s), but does not request contraception?
- Help participants to identify the moments in which they come into contact with women regarding other medical problems, which might represent a good opportunity to discuss about the use of contraceptive methods; e.g. vaccination of children, release of prenuptial certificates, release of other medical documents (medical certificates), treatment for gynecological infections, etc.
- Summarize by asking the group:
 - How can we use what we have learned here in our future practice?
 - Which is the most adequate attitude towards these women? (Do we scare them? Do we scold them? Do we understand them? Do we judge them? Do we offer the alternative of contraception?).

Important: we must approach the alternative of FP use, following the women's motivation for using a contraceptive method.

Counseling Guide for Providers

- Approach the client when she is calm and has recovered after the abortion. Be understanding towards her physical and psychic state. If you force her to listening to you when she is not ready, it will be only a waste of time.
- Be flexible during counseling; some women are strong and quickly recover after abortion, others need a longer period of time.
- Don't forget that the most important thing is to offer to woman the information she needs.
- If the woman is accompanied by someone when she comes to the office, ask her if she wants the person that is accompanying her to assist in the discussion.
- Explore the woman's feelings, ask questions about her worries regarding abortion and offer her support.
- Ask what are her future plans regarding her own fertility.
- Check what type of information she needs:
 - regarding side-effects, complications of abortion
 - regarding hygiene rules, how to take care of herself
 - regarding contraception
 - regarding STIs risk.
- Evaluate whether she needs other services and orient her towards these.

“How to Take Care of Yourself”

(What we should tell women which have recently had an abortion)

- You shall avoid tiresome activities in the next 2-3 days after abortion. You may recommence usual activities only when you feel well enough to do this.
- If you have received drugs, take them correctly, as the gynecologist recommended.
- Go back for checkup at the date you have been told to after abortion. You may come back here anytime, if something is not going well.
- Follow the rules for personal and general hygiene:
 - Wash external genitals twice a day
 - Vaginal washing/ irrigations are not recommended in the first 2 weeks after abortion
 - Have shower with no-hot, no-cold water, avoid baths
- Sexual intercourse
 - Vaginal sex shall be avoided 2 weeks after abortion
- Pay attention to the following signs, alarm signs and symptoms
 - the aspect of the vaginal secretions
 - the body temperature

It is normal:

- to have moderate bleeding and slight abdominal pain, similar as those caused by menstrual bleeding, up to one week after abortion
- to feel a little tired for a few days
- to have a slightly depressive status for a few days

It isn't normal:

- to have abundant or swelling secretions
- to have heavy bleeding (twice more than menstrual bleeding)
- to experience intense abdominal pain
- to have fever, chills
- to feel that your general health status worsens abruptly
- menstrual bleeding do not occur after 2 months from abortion

- The use of contraceptive methods
 - You may begin using a contraceptive method immediately or few days after abortion, if you wish to (the methods which can be used after abortion are described in session 12: “Contraception in Particular Situations”).

Session 19: Closing of the Workshop

Time: 60 minutes

Handouts:

19.1 Final Test

19.2 Evaluation of the Workshop

Activities:

1. Post-test. Evaluation

- Ask participants to complete the test individually (20 min). Trainers are moving around the class/ room while participants are completing this activity.
- Ask then participants to complete the workshop evaluation form (anonymously).
- Each trainee shall complete also the evidence chart with personal data and the table of participants.
- Ask participants: "What have you gained through participating in this workshop? What benefits will this bring for your work? What will your patients gain? What do different community members gain?"
- Review the list of expectancies stated by the trainees in the first day of the workshop and compare it with the achievements.
- Strengthen motivations, encourage trainees to take action and to involve in the program.
- Invite trainees to think and share with the group, how they will put into practice what they have learned, what difficulties they estimate they will encounter and how they will overcome them, what positive aspects the participation in this workshop will bring to their lives (both professional and personal).

2. Closing workshop

The farewell of the trainers and the group will take place in a positive, optimistic manner. Exercises like the following can be used:

- One of the trainers holds in his/her hands a thread spool of thick thread, which he/she throws like a ball, to one of the participants, offering him/ her good wishes or a compliment. Each of the trainees throws and receives "the ball", keeping a portion of the thread, so that by the end it will look like a network created.
- Each person (trainers and participants) put his/ her hand on a sheet of paper and draws its contour, writes his/ her name in a corner of the page and "passes" it to the colleague on the right. The sheets will circulate from one person to another (always the person on the right site). Each person writes a positive message, a good wish or a quality of the person, who's "hand" is in front of him. This continues until everyone has written about all persons and the sheets returned to their owners.
- All people are standing up, forming a circle, joining hands; each one makes a good wish to the whole group.

Final Evaluation Test

Name, Surname:

Date:

Please circle the letters that correspond to the answers which you consider correct (there can be more than one correct answer):

1. The family planning objectives are:

- a. facilitating individuals to decide if and when to have children
- b. prevention of unwanted pregnancies, of abortion and child abandonment
- c. safe use of contraceptives
- d. prevention/ early detection/ treatment of diseases which influence reproduction, including the sexually transmitted infections
- e. maintaining/ improving the quality of sexual life

2. The benefits of the family planning services mean:

- a. reduced number of abortions
- b. women with a better health state
- c. desired pregnancies and well care of children
- d. decrease in number of persons infected with sexually transmitted infections
- e. more time granted for curative medical assistance
- f. less social problems

3. Ovulation takes place:

- a. at mid-time of menstrual cycle
- b. 14 days before the next period
- c. days 12-14 after the first day of the period

4. The fertility phase lasts:

- a. one week, at the mid-time between two periods
- b. 4 days before ovulation + 4 days following ovulation
- c. the ovulation day + the next 2 days

5. Emergency contraception can be used after unprotected sexual intercourse within maximum:

- a. 1 day
- b. 3 days
- c. 4 days
- d. 5 days

6. Switching one contraceptive method to a combined oral contraceptive can be done:

- a. immediately, without waiting the next period
- b. after the interruption of the previously used method, the woman will wait for her next period and she will start taking the pills from the first day

- c. after a 3 months break necessary for full recovery of the organism
- d. anytime, if the woman is certain that she is not pregnant

7. The factors which determine and influence the forming and the evolutions of the behavior are:

- a. school
- b. family
- c. entourage
- d. tradition
- e. mass-media
- f. role-models
- g. experiences
- h. social status

8. FP counseling means:

- a. helping a person/ couple choose whether they want children or not**
- b. helping a person/ couple choose a contraceptive method
- c. facilitating the safe use of the contraceptives
- d. helping a person identify his/ her problems within the reproductive health sphere
- e. helping a person/ couple assume their responsibility about maintaining their health

For the following questions, please give as many answers as you can, according to the knowledge you have previously acquired:

9. The period phases are:

-
-
-

10. Enumerate the contraceptive methods that you know:

11. Which are the classes/ categories established by W.H.O. for contraceptive classification? What do they mean?

12. What natural family planning methods do you know?

13. Enumerate 5 advantages of the contraceptive pills:

-
-
-
-

14. Mention at least two types of side effects possible for:

- a. Barrier methods –
- b. Oral combined contraceptives
- c. Progestagen-only contraceptives
- d. Intra-uterine device

15. Mention two failure causes (occurrence of unwanted pregnancy) in the use of the following methods:

- a. Natural Family Planning methods
- b. Barrier methods
- c. Combined oral contraceptive (COC)
- d. Progestagen Only Pills
- e. The intra-uterine device (IUD)

16. What are the methods which protect against unwanted pregnancy, as well as against STIs?

17. Mention the permanent contraception methods.

18. How could be a pregnancy excluded with a reasonable certain degree?

19. What information is necessary to a person for correct and safe use of a contraceptive method?

20. Enumerate the 10 rights of the FP clients

For the following questions, circle the letter corresponding with the most suitable answer. (There is only one correct answer)

21. One of the following statements does not constitute the FP counseling objective. Which one is it?

- a. Helps the client decide whether he/ she wants a family planning method and offers him/ her the necessary information in order to help him/her to choose one;
- b. Helps the client apply his/ her decision of using family planning
- c. The provider, based on his/ her professional competency, recommends the most adequate method to the client

22. If a client request changing the family planning method, you must:

- a. Change her method, because she knows best what she wants;
- b. Ask her why she wants to change the method and try to discover the reason, in order to make sure that she has taken a well-informed decision;
- c. Try to find a medical reason in order to change the method and if this is not found, try to convince her to continue with the method she is already using.

23. The most important aspect of counseling is:

- a. Offering brochures about FP methods, so that the client will be able to discuss them with his/ her partner
- b. Identifying the client's needs and concerns regarding the use of contraception and the answer to these;
- c. Obtaining the written consent of the client regarding the use of contraception;
- d. Describing all side-effects of the FP methods.

24. The following statements, except for one, are important elements of the information necessary for a client in order for her to take an "informed decision". Which of the following is not important?

- a. Major advantages and disadvantages of the contraceptive methods that present interest to the client
- b. Short description of all the available contraceptive methods
- c. Personal experience of the provider regarding the available methods
- d. Possible side-effects
- e. Relative efficiency of the methods.

Thank you!

Workshop Evaluation

Period of the workshop:

Region/ Town:

Name and surname of the trainers:

1. _____
2. _____

Please estimate if you agree with the following statements, using the answer key:

- 5 = I fully agree**
- 4 = I partially agree**
- 3 = I do not agree, but I am not against**
- 2 = I partially disagree**
- 1 = I am against**

General impression regarding the workshop:

I believe that:

- The workshop's objectives have been clearly defined 5 4 3 2 1
- The subjects have been presented in a clearly and organized way 5 4 3 2 1
- The initial test, as well as the final test has been correctly evaluated what I have learned 5 4 3 2 1
- This workshop will be useful to me in my professional activity 5 4 3 2 1

Information

I have received new information during this workshop 5 4 3 2 1

Now I will be able to:

- explain the benefits of family planning 5 4 3 2 1
- describe the action mechanism, the efficiency, the advantages and disadvantages of contraceptive methods 5 4 3 2 1
- describe the limits and obstacles in quality FP services 5 4 3 2 1
- offer counseling to FP clients 5 4 3 2 1
- adapt the counseling process to the client's needs 5 4 3 2 1
- counteract the rumors and misinformation regarding contraception 5 4 3 2 1
- correctly fill out the contraceptive annexes and the reports 5 4 3 2 1

Work Style

Presentations made by the trainer have been clear and organized	5 4 3 2 1
Discussions during the workshop helped me learn new things	5 4 3 2 1
I have learned/ practiced new practical abilities during role-playing and simulations	5 4 3 2 1
The trainers have encouraged me in asking questions	5 4 3 2 1
The trainers have encouraged me in participating in activities	5 4 3 2 1
Instructions given by the trainers regarding the exercises have been clear	5 4 3 2 1
Trainers have promptly answered my questions	5 4 3 2 1

What I liked best

- Presentations carried out by the trainers
- Team work
- Simulations
- Interaction with the trainers

The proposed exercises have been

- Useful
- Relevant
- Interesting
- Childish
- Irrelevant to the subject

Which has been the most useful part of the workshop?

Which has been the least useful part of the workshop?

Organization

The place where the workshop was conducted has been adequate	5 4 3 2 1
All necessary materials has been assured	5 4 3 2 1
Coffee and lunch breaks have been well organized	5 4 3 2 1
The time period has been adequate for the proposed activities	5 4 3 2 1

How do you believe that it is preferable for such a workshop to be organized?

- Over two weekends
- During weekdays, 5 consequent days
- I don't know

Suggestions

What suggestions do you have for the improvement of this workshop?

Other comments:

Please tick the square which corresponds to your situation:

- | | | |
|---|---|--|
| Profession | <input type="checkbox"/> M.D. | <input type="checkbox"/> registered nurse |
| Professional status | <input type="checkbox"/> freelancer | <input type="checkbox"/> employee |
| Work place | <input type="checkbox"/> urban | <input type="checkbox"/> rural |
| Address | <input type="checkbox"/> in the region where I work | <input type="checkbox"/> in another region |
| I have participated in FP/RH courses /workshops | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If yes, which have been the theme and the approximate date of the course?

I have come to this workshop:

- In order to obtain credits
- In order to complete my professional
- In order to distribute free of cost contraceptives
- Because my colleagues who have participated in workshop have recommended it to me
- Upon DPHA's request

We thank you and we wish you good luck!