CONTRACEPTIVE TECHNOLOGY UPDATE

for

SERVICE PROVIDERS in
UTTAR PRADESH

TRAINER'S NOTEBOOK

AUGUST 1995

सिफ्सा
SIFPSA

State Innovations in Family Planning
Services Agency, Lucknow

Department of Health and
Family Welfare
Government of Uttar Pradesh
CONTRACEPTIVE TECHNOLOGY UPDATE

for

SERVICE PROVIDERS in
UTTAR PRADESH

TRAINER'S NOTEBOOK

AUGUST 1995

State Innovations in Family Planning Services Agency, Lucknow
Department of Health and Family Welfare Government of Uttar Pradesh
# TABLE OF CONTENTS

OVERVIEW .................................................................................................................... 1
  Participant Learning Objectives .................................................................................. 1
  Contraceptive Technology Update (CTU) Training Package ...................................... 2
  How to Use the Training Package ............................................................................... 3
  Course Design ............................................................................................................. 4

MODEL COURSE TIMETABLE ......................................................................................... 9

PRE/POST-COURSE QUESTIONNAIRE ........................................................................ 13
  Directions to the Trainer—Using the Questionnaire .................................................. 13
  CTU Pre/Post-Course Questionnaire .......................................................................... 14
  Pre/Post-Course Questionnaires Answer Sheet .......................................................... 20
  Pre/Post-Course Questionnaires Answer Key .............................................................. 21
  CTU Pre/Post-Course Questionnaires Answers .......................................................... 22

CONTRACEPTIVE TECHNOLOGY UPDATE WORKSHOP EVALUATION .................. 28

ROLE PLAYS FOR COUNSELLING ............................................................................... 30
  What is Role Play? ...................................................................................................... 30
  Purpose ...................................................................................................................... 30
  General Instructions for Role Plays ............................................................................ 30
  Trainer Preparation for Role Play ............................................................................. 30
  Condom Role Play ...................................................................................................... 31
  Copper T 200B Role Play ........................................................................................... 33
  Combined Oral Pills Role Play ................................................................................... 33
  Vasectomy Role Play .................................................................................................. 34

CASE STUDIES .......................................................................................................... 35
  Emergency Contraception ........................................................................................... 36
  Postabortion Contraception ......................................................................................... 37

PRESENTATION GRAPHICS ......................................................................................... 38
OVERVIEW

The purpose of Contraceptive Technology Update (CTU) workshops is to update the technical knowledge and contraceptive service provision practices of medical officers working in the public sector in Uttar Pradesh. The CTUs will serve to update participants knowledge regarding contraceptive service delivery and the health benefits of family planning with a particular focus on IUCDs, combined oral contraceptives, barrier methods, counselling, lactational amenorrhoea method, voluntary sterilisation, infection prevention, postabortion services and postpartum contraception.

Course content focuses on the essential “need-to-know” information that medical officers must have to provide family planning services effectively and supervise LHV’s and ANMs who provide services. Thus, workshop content focuses on practical questions and approaches to providing family planning services in health care facilities throughout UP.

It is hoped that as a result of the CTUs,

- the competence and confidence of service providers will improve when assisting clients in making contraceptive choices,
- the quality of family planning will improve (e.g., increased client satisfaction), and
- access to quality contraceptive services will increase.

PARTICIPANT LEARNING OBJECTIVES

By the end of this CTU, the participant will be able to:

1. Identify the need for strengthening family planning service provision in Uttar Pradesh
2. Explain the indications and precautions for both spacing and permanent methods of contraception, including the Copper T 200B IUCD, combined oral contraceptives, LAM, male and female sterilisation and barrier methods.
3. Explain how the Copper T 200B IUCD prevents pregnancy and its performance characteristics
4. Load the Copper T 200B IUD inside the sterile package without using high-level disinfected or sterile gloves
5. Explain how to manage combined oral contraceptive and Centchroman users
6. Provide postpartum, postabortion and emergency contraception
7. Describe the health benefits of vasectomy and the no-scalpel vasectomy procedure
8. Use recommended infection prevention practices in the provision of family planning services
9. Demonstrate effective family planning counselling
10. List key technical and programmatic “lessons learned” about family service planning provision during the workshop and identify approaches to disseminating these lessons to others at their centres

CONTRACEPTIVE TECHNOLOGY UPDATE (CTU) TRAINING PACKAGE

The Contraceptive Technology Update (CTU) training package is intended for use by trainers conducting CTU workshops throughout UP. This package includes information on the following topics relevant to the provision of family planning and reproductive health services:

- Family Planning in Uttar Pradesh
- Counselling
- Client Assessment
- Infection Prevention (IP)
- Emergency Contraception
- Combined Oral Contraceptives (COCs)
- Condoms
- Intrauterine Contraceptive Devices (IUCDs)
- Lactational Amenorrhoea Method (LAM)
- Natural Family Planning
- Postabortion Contraception
- Postpartum Contraception
- Progestin-Only Injectables
- Voluntary Surgical Contraception (VS) (Female)
- Voluntary Surgical Contraception (VS) (Male)
- Withdrawal (Coitus Interruptus)

This CTU training package has the following components:

- The *Reproductive Health Resource Document for UP* which contains reference materials for trainers

- *CTU Trainer’s Notebook* which contains a model CTU course timetable, miniature reproductions of the transparencies with room for notetaking, a course outline which includes the materials to be used when teaching each topic, and evaluation tools (e.g., pre/end-of-course questionnaire, an end of workshop evaluation)

- *Trainer’s Kit: CTU Presentation Graphics for Family Planning Service Providers in UP* which contains transparencies on each of the topics to be discussed during the CTU

- *Family Planning Policies and Service Delivery Guidelines for UP*

- *Handbook for Family Planning Service Providers in UP*
HOW TO USE THE TRAINING PACKAGE

Trainer's Notebook
The Trainer's Notebook serves as a road map for the trainer in conducting the course. It contains the course timetable, suggestions for teaching the course, and all supplemental printed materials (pre/post-course questionnaire, case studies and evaluation instruments). It also contains miniature versions of the transparencies provided in the Trainer's Kit. The reproductions of the graphics can be used by the trainer for notetaking on key points that s/he wishes to discuss during her/his presentation. Some trainers may also wish to duplicate the copies and provide them to participants.

Course Timetable and Transparencies
Topics included in the CTU workshop timetable have been designed to be taught using the transparencies in this kit. For each method of family planning, information is provided on mechanisms of action, benefits and limitations, method-specific counselling and recommendations regarding management of side effects. The trainer is expected to update participants on each method. Trainers are encouraged to supplement these transparencies with additional information from the Handbook, Resource Document and Family Planning Policies and Service Delivery Standards. The sequence of the transparencies is not necessarily suggestive of the order of presentation. Prior to the start of the CTU, trainers should review the transparencies on the topic they are to teach. The format of the session should be based on participant needs as well as the time made available for each presentation.

Trainer's Kit
The transparencies for the CTUs have been designed to reflect the information that medical officers must have to provide family planning services effectively and supervise LHV's and ANMs who provide services. In addition to topic specific transparencies, the kit contains a transparency stating the Goals and Objectives of the CTU as well as templates for use by the working groups.

Reproductive Health Resource Document for Uttar Pradesh
This can serve as a key reference document for the trainer. Prior to teaching a topic, the trainer should review the information on the topic in the Resource Document to enable her/himself to respond appropriately to questions raised by course participants.

The following two documents are designed to provide the essential information needed to update the contraceptive knowledge and practices of medical officers. Each medical officer should be provided a copy at the workshop.

The Family Planning Policies and Service Delivery Standards for Uttar Pradesh provide the standards and policies for the provision of family planning service in UP. The Standards, which were developed by SIFPSA and the Department of Health and Family Welfare, contain explicit guidelines on each of the topics covered in the CTUs.

The Handbook for Family Planning Service Providers in Uttar Pradesh provides client management information for clients with special conditions as well as for each contraceptive method. It will assist medical officers in providing high quality family planning services.
COURSE DESIGN

The CTU covers a sequence of topics that have been identified as essential to the effective provision of family planning services in UP. In addition to the different family planning methods, attention is given to counselling, infection prevention practices, postabortion and postpartum family planning and emergency contraception.

Based on the model course timetable on page 9, are the following suggestions for how each component can be taught.

DAY ONE

Unmet Need for Family Planning
The trainer will review the unmet need for family planning based on the transparencies in the kit. Particular focus should be placed on the need for spacing methods (IUCD and combined oral contraceptives) and its relationship to the need for well trained service providers who can provide high quality services.

Goal and Objectives of the Workshop
Using the provided transparency, review the major CTU objectives which are:
- Update contraceptive knowledge and practices relative to family planning service delivery
- Strengthen infection prevention practices at PHCs
- Strengthen counselling skills
- Identify and resolve technical and programmatic issues relating to family planning service delivery at the PHC
- Design a plan for sharing “Lessons Learned” with staff at the PHC

Explain how meeting the objectives will strengthen the ability of medical officer’s to provide family planning services and supervise LHVs/ANMs which ultimately will lead to improved access, quality and demand for family planning services in UP.

Identification of Participant Needs
Trainer’s should ask participants to write on a piece of paper at least one thing that they would like to learn at the workshop about a topic listed on the timetable. Collect all the responses. Distribute the pre-test questionnaire. As the participants are answering the questionnaire, summarize on a flip-chart the participants’ needs (e.g., how to manage clients on oral contraceptives, etc.). Prior to the start of the session on oral contraception, review the listed needs with participants and indicate that each point listed will be addressed during the CTU. Also, request that the participants raise points during discussion, if necessary.

Pre-Course Questionnaire
Have each participant complete individually. Trainer should score. It is VERY IMPORTANT that trainers cover the content of the test questions during the course of the CTU.

Using Combined Oral Contraception (COC)
After review of the transparencies on COCs, ask the participants some of the important technical questions relating to the management of COC users. During the session, key misconceptions and issues regarding COCs should be addressed such as the need to “rest” from the pill after a certain number of years or a requirement that a pelvic exam is needed prior to providing pills to a client. It is also important that client management issues be addressed such as when a client can begin COC use and what she should do if she forgets to take two or more of her pills. Finally, it is important that participants understand the health benefits of COC use (e.g., users have decreased incidence of ectopic pregnancy, ovarian cancer and anaemia, etc.). During discussion, ask for suggestions on how COC use could be increased in UP (now currently at about 1% of all users).
Centchroman
Provide a brief overview of Centchroman. During the discussion, ask participants to share their experiences with this method. Discuss possible solutions to problems raised.

Update on the Effectiveness and Use of Condoms and Other Barrier Methods
Ask participants which barrier method is most commonly used in their area. Prior to showing the transparencies on proper use of a condom, ask for a volunteer to demonstrate proper placement of the condom on the “condom model.” (If the model is not available, use the end of a stick or something similar). During the discussion, ask for suggestions on how condom use might be increased in UP. The following are important points the trainer should cover during the session: Condoms are protective against STDs/HIV transmission, they should be used at every act of intercourse, they should not be used with vaseline or other petroleum based lubricants and they cannot be reused.

Improving Quality of Care Through Counselling
Review the transparencies on counselling. Provide examples to explain each principle of counselling. Emphasize how effective counselling increases client acceptance for family planning and continuation rates. In a “role play,” demonstrate effective counselling of a “new” IUCD client. A volunteer should be selected to play the client. Ask the participants to write on a piece of paper the good counselling qualities demonstrated by the counsellor. Also ask participants to suggest how the counselling might have been improved. Recapitulate the important principles of counselling and the qualities of a good counsellor.

Work Groups: Key Issues and Problems in Managing COC and Condom Users in UP and in Strengthening Counselling Practices
Form three work groups to discuss medical and programmatic issues relating to: COCs, barrier methods and strengthening counselling. A trainer should be assigned to each group as the moderator, and one of the participants should be selected to serve as the rapporteur to provide the working group report. For their assigned topic, each work group will address key issues and problems relating to strengthening the provision of services at PHCs and will provide solutions to the problems identified. The rapporteur will use the transparency “template” to make their groups report.

Suggestions for Group Works

- Provide clear instructions on what is expected from each group prior to the start of the exercise.
- Use different methods to divide the group. One approach might be to place three different brands of condoms or COCs (e.g., Nirodh, Bliss and Sawan) in a bag. Ask each participant to pick up one piece from the bag to make Nirodh, Bliss and Sawan groups. Another approach is to write the names of colors (red, blue, green, etc.) on slips of paper and place in a bag. Ask participants to pick a slip of paper from the bag. The color which they have chosen will be the group to which they are assigned.
- The group should know the exact time they are to form into the larger group to make their report.
- Discussion of local administrative problems should be avoided. (They should be discussed with the CMO during monthly meetings).
- Every participant should actively participate in the work group.
The trainer should try to elicit from the group major issues and problems relating to the methods.

After the rapporteur provides the group report, general discussion should occur eliciting input and comments from the entire group.

DAY 2

Issues in IUCD Use in UP
Ask participants to write on a piece of paper one question they have about IUCD use. Select approximately 10 questions and write them on the flip chart. After reviewing the transparencies, make sure that all of the questions have been addressed. As part of the session, the trainer should make certain that the following key points are discussed about the Copper T 200 B IUCD: "withdrawal" technique for insertion, effective life (3 years), the IUCD is effective IMMEDIATELY after insertion, what the client should do if she cannot feel the IUCD strings (return to the clinic), and can the IUCD be used if the copper tarnishes (e.g., yes it can).

Exercise: Loading the Copper T 200B IUCD in the Sterile Package
Explain why the IUCD should be loaded in the package. Form small groups of 3–4. At least one person in the group should be familiar with how to load the IUCD in the package. The trainer will demonstrate the procedure to the participants, and then will distribute a Copper T 200 B IUCD to each participant for practice in loading in the package under supervision/Coaching by the trainer. Suggest that participants, upon returning to their centers, conduct a similar activity with other medical officers and ANMs who are providing IUCD services.

The Case of Mrs. Savitri: Postabortion Contraception
Distribute case. Have participants review. Trainer will initiate discussion regarding which method of contraception is best suited for the client in the case. Trainer will then review transparencies on these topics emphasizing important messages.

Infection Prevention (IP)
Open the session by asking one or two participants about the precautions that are taken at their primary health centre to assure asepsis during IUCD insertion. Review transparencies on IP. During the session, discuss how these practices can be incorporated into service delivery at the PHCs.

The Case of Mrs. Shila: Emergency Contraception
Distribute the case for review by the participants. The trainer will initiate discussion regarding which method of contraception is best suited for client in the case. Trainer will then review transparencies on the topic, emphasizing important messages (e.g., IUCD can be used as an emergency contraceptive within 5 days of unprotected intercourse).

Work Groups: Strengthening IUCD, Postabortion/Postpartum Family Planning and Infection Prevention Practices
Form three work groups to discuss medical and programmatic issues relating to: IUCDs, postabortion/postpartum family planning and IP practices. A trainer should be assigned to each group as the moderator, and one of the participants should be selected to serve as the rapporteur to provide the working group report. For their assigned topic, each work group will address key issues and problems relating to strengthening the provision of services at PHCs and will provide solutions to the problems identified. The rapporteur will use the transparency “template” to make their groups report. (Refer to suggestions for group work (Day 1) for tips on how to conduct the group session.)
Trends and Issues in Minilaparotomy and Laparoscopy
The trainer will ask each participant to write on a piece of paper one technical question or issue regarding minilaparotomy or laparoscopy. The trainer will then write 5-6 of the issues on the flipchart. Trainer will review transparencies, making sure to address issues raised by participants. Mention that issues not addressed in the large group should be addressed in working groups. Show video on minilap at end of session. Important client management issues should be addressed (e.g., when a client should be told to return to the clinic if problems like infection, high fever, etc. occur).

Vasectomy: Health Benefits and No-scalpel Approach
At the beginning of the session, ask participants about reasons why vasectomy has declined as part of the program in UP. Review the transparencies. Show video at end of session. Make sure that participants are aware of the fact that a man must ejaculate up to 20 times after the vasectomy procedure to be sure his semen is free of sperm. Also, clarify that studies have shown that there is no relationship between vasectomy and prostate or testicular cancer or cardiovascular disease.

Injectable Contraception: The Case of Mrs. Z
At the beginning of the session, ask participants if clients ever come to their clinics seeking help for side effects of injectables. Indicate that injectables are not part of UP state program but are available in the private sector, and clients are appearing at some centers seeking guidance regarding management of the common side effects of the method. Distribute case. Ask participants how they would manage the client's problems. Review transparencies, emphasizing how to manage a common side effect like bleeding.

Lactational Amenorrhoea Method (LAM): Review and Update
Begin session by asking questions on current breastfeeding practices in UP. Based on the responses, indicate that LAM can be a highly effective means of birth spacing if certain conditions are met (e.g., woman should breastfeed her baby on demand about 6 to 10 times a day). During the transparency presentation, discuss advantages of LAM as compared to other methods during the postpartum period. When summarizing the session, ask participants about the three conditions that need to be met for LAM to be effective.

Post-Course Questionnaire
The post-course questionnaire is the same as the pre-course questionnaire. It should be given immediately before lunch on Day 3.

Work Groups: Female Sterilisation, Male Sterilisation and “Making Use of Lessons Learned”
Form three work groups to discuss: medical and programmatic issues relating to female sterilisation and male sterilisation and key “lessons learned” during the workshop which they feel should be shared with other medical officers and ANMs at their centers. A trainer should be assigned to each group as the moderator, and one of the participants should be selected to serve as the rapporteur to provide the working group report. Trainers should try to develop a list of “lessons learned” and reach agreement with the participants that they will return to their centers and disseminate the information to others based on a strategy or approach developed by the work group on lessons learned. The rapporteurs will use the transparency “templates” to make their group reports. (Refer to suggestions for group work (Day 1) for tips on how to conduct the group session).
Review of Post-Course Questionnaire
Trainer’s should review/discuss each question with the CTU participants immediately following the report of the working groups. This review is very important in that the information included in the questions are key to improving the quality of service delivery in UP. The trainer should be sure to clarify any misunderstanding the participant’s have regarding the correct answer to the question. Trainer’s should keep on file a record of the pre/post-course questionnaire scores. It is hoped that all participants score at least 85% on the post-course questionnaire. If this is not being achieved, trainers should work to make sure that all of the material in the post-test is covered by trainers.

Presentation of Certificates
DAY ONE

9:00 A.M.  Welcome

9:15 A.M.  Unmet Need for Family Planning in UP
          Goals and Objectives of the Workshop

9:45 A.M.  Identification of Participants Needs*
          •  Pre-test

10:15 A.M. Break

10:45 A.M. Using Combined Oral Contraception

11:30 A.M. Discussion:  Management of COC Users

11:45 P.M.  Centchroman
          •  Discussion

12:15 P.M.  Update on the Effectiveness and Use of Condoms and Other Barrier Methods
          •  Discussion

1:00 P.M.  Lunch

* Before starting the pre-test, participants review the workshop schedule and write on a piece of paper at least one thing that they would like to learn at the workshop about a topic listed. The trainer will list the participant' needs on a flipchart, discuss the with the participants and try to make sure that by the end of the workshop all needs are addressed.
2:00 P.M.  Improving Quality of Care Through Counselling

- Principles of Counselling
- Demonstration/role play with trainers and “volunteer” participants
- Discussion

3:00 P.M.  Break

3:15 P.M.  Work Groups: Key Issues and Problems in Managing IUCD, COC and Condom Users in UP

1. COCs
2. Barriers and Genital Tract Infections
3. Counselling

(Work groups discuss both medical and programmatic issues relating to the methods. During work group reports, issues and problems raised are discussed, and solutions identified).

4:15 P.M.  Report of Working Groups
DAY 2

9:00 A.M.  Issues in IUCD Use in UP
  • Discussion

10:00 A.M. Exercise: Loading the Copper T 200B IUCD in the Package

10:30 A.M. Break

10:45 A.M. The Case of Mrs. X: Postpartum and Postabortion Contraception
  • Discussion

11:30 A.M. Infection Prevention
  • Discussion

12:30 P.M. Lunch

1:30 P.M. The Case of Mrs. Y: Emergency Contraception
  • Discussion

2:15 P.M. Work Groups: Strengthening IUCD, Postabortion/Postpartum Family Planning and Infection Prevention Practices

1. IUCDs
2. Postabortion/Postpartum Family Planning
3. Infection Prevention

(Work groups discuss both medical and programmatic issues relating to the topics. During report of working groups, issues and problems raised are discussed, and solutions identified).

3:30 P.M. Break

3:45 P.M. Report of Working Groups
DAY 3

9:00 A.M. Trends and Issues in Minilaparotomy and Laparoscopy
   • Video: Minilaparotomy
   • Discussion

10:00 A.M. Vasectomy: Health Benefits and No-Scalpel Approach
   • Video: No-Scalpel Vasectomy
   • Discussion

10:45 A.M. Break

11:00 A.M. Injectable Contraception: The Case of Mrs. Z
   • Discussion

11:45 A.M. Lactational Amenorrhoea: Review and Update
   • Discussion

12:15 P.M. Post-test

12:45 P.M. Lunch

1:30 P.M. Work groups: Key issues and problems in providing male and female sterilization services and how to disseminate “Lessons Learned” from this workshop.

1. Female Sterilisation
2. Male Sterilisation
3. Making Use of “Lessons Learned” (How to disseminate the information gained from this workshop)

(Work groups form to discuss both medical and programmatic issues relating to male and female sterilisation as well as key “Lessons Learned” from this workshop which participants plan to share with others at their centres.

2:15 P.M. Report of Working Groups

2:45 P.M. Review of Post-test Questions

Summary and Close

Presentation of Certificates
DIRECTIONS TO THE TRAINER—USING THE QUESTIONNAIRE

This knowledge assessment questionnaire should be given to participants attending the CTU prior to the start of the workshop sessions.

The same questionnaire should be given to participants prior to lunch on Day 3. At the end of the workshop, trainers should review the correct answers to the questionnaire with course participants to assure that they are leaving the course with the correct information.

It is expected that all course participants will score at least 85% correct on the post-test. If this does not occur, trainers should review each question to make certain that the information is being covered during the workshop.
Instructions: Write the letter of the single best answer to each question in the blank next to the corresponding number on the answer sheet.

1. For a woman in good health, a contraceptive method is best selected by:
   a) the woman herself
   b) the medical officer or ANM providing services to the woman
   c) the village health worker who recommends that the woman visit the center
   d) the woman’s husband

2. The most important part of counselling is:
   a) providing brochures about contraceptive methods to the woman for review with her husband
   b) identifying the woman’s concerns about using contraceptives and answering her questions
   c) obtaining formal consent for the procedure from the client
   d) describing side effects

3. The Copper T 200B IUCD can be left in the uterus for:
   a) 3 years
   b) 4 years
   c) 7 years
   d) 10 years

4. A woman who has a past history of pelvic inflammatory disease (PID) which has been treated can use an IUCD provided she:
   a) does not have intercourse during her menstrual period
   b) is over 35 years of age
   c) is not at risk for a genital tract infection
   d) does not have a retroverted (posterior) uterus
5. The technique used for inserting the Copper T 200B IUCD is the:
   a) withdrawal technique  
   b) push and remove technique  
   c) Lippes technique  
   d) push-in technique

6. Surgical (metal) instruments used for IUCD insertion, (i.e., the vaginal speculum, uterine sound and tenaculum) can be safely used if, after thorough cleaning, they are:
   a) dried and stored in a sterile container  
   b) high-level disinfected  
   c) soaked in Savlon® or Dettol® for 30 minutes  
   d) used immediately

7. To minimize the risk of staff contracting hepatitis B or AIDS during the cleaning process, all soiled instruments and surgical gloves first should be:
   a) rinsed in water and scrubbed with a brush before disinfecting by boiling  
   b) soaked in a fresh solution of 0.5% chlorine for 10 minutes before cleaning  
   c) rinsed in water and scrubbed with a brush before sterilizing  
   d) soaked overnight in 8% formaldehyde

8. Tarnished (discolored) Copper T 200B IUCDs which are still in an undamaged, sealed package should be discarded because:
   a) the tarnish prevents the copper from being released  
   b) the IUCD is no longer sterile  
   c) the tarnish weakens the copper wire  
   d) none of the above
9. The single most important infection prevention procedure is:
   a) wearing gloves when performing a procedure
   b) autoclaving
   c) savlon rinses
   d) handwashing

10. To high-level disinfect instruments by boiling, the instruments should be boiled in a pot with a lid for:
   a) 1 hour
   b) 20 minutes
   c) 90 minutes
   d) 7 minutes

11. After insertion, the IUCD is effective:
   a) after 5 days
   b) immediately
   c) after one complete cycle
   d) after 2 weeks

12. Correctly loading the Copper T 200B IUCD in the sterile package:
   a) is unnecessary if high-level disinfected or sterile gloves are available
   b) assures that the IUCD will remain sterile until it is removed from the package
   c) is difficult to learn to do
   d) all of the above
13. If a woman with an IUCD cannot feel the strings of her IUCD when she checks them after her period, she should:
   a) not worry because sometimes the string dissolves
   b) wait until her next period and check them again before doing anything else
   c) check them every day until they reappear
   d) go immediately to the service provider because her IUCD may have fallen out and she can get pregnant

14. A new combined oral contraceptive user should:
   a) begin taking her first pack of pills whenever it is convenient
   b) begin taking her first pack of pills 5 days after the end of her menstrual cycle
   c) begin taking her first pack of pills within the first 7 days of her menstrual cycle
   d) must always begin taking her first pack of pills on the first day of her menstrual cycle

15. If a woman forgets to take two or more of her pills, she should:
   a) stop taking the pills and begin again when she has her menstrual period
   b) throw away the pills she missed and continue taking the rest of the pack
   c) take 2 pills the day she discovers that she has forgotten to take her pills, and then return to taking one pill a day
   d) none of the above

16. A woman can take combined oral contraceptives:
   a) for a one year period, followed by a rest period of two cycles during which she should be protected by condoms
   b) indefinitely, as long as she is happy with the method and there are no major side effects
   c) for 2 years, followed by up to a 6 month rest period during which she should switch to a barrier method or IUCD
   d) for a maximum of 10 years, after which she should switch to some other method
17. Prior to starting a client on combined oral contraceptives, a pelvic exam:
   a) must always be performed
   b) must be performed only if the woman is under 20 years of age
   c) is not necessary
   d) must only be performed on women who have never had children

18. Vasectomy is effective in preventing pregnancy after the man has ejaculated:
   a) one time
   b) fifty times
   c) twenty times
   d) vasectomy is immediately effective

19. Studies have shown that vasectomy increases the risk of:
   a) prostate cancer
   b) testicular atrophy
   c) cardiovascular disease
   d) none of the above

20. A woman practicing the lactational amenorrhea method (LAM):
   a) should breastfeed her baby on demand about 6 to 10 times per day
   b) should not breastfeed her baby during the night
   c) must allow 7 hours between feedings of the baby
   d) can continue practicing the method, even when her menstrual period returns

21. Combined oral contraceptive users have been shown to have a:
   a) decreased incidence of ectopic pregnancy
   b) increased incidence of ovarian cancer
   c) increased incidence of anaemia
   d) all of the above
22. When can an IUCD be used as an “emergency” contraceptive?
   a) never
   b) within 1 month of unprotected intercourse
   c) within 5 days of unprotected intercourse
   d) within 14 days of unprotected intercourse

23. A client who has received a tubal ligation should be counselled to return to the clinic or hospital for a check-up if she experiences:
   a) fever (greater than 38° C or 100.4° F)
   b) shoulder pain
   c) nausea
   d) cough and nasal congestion

24. A client who has received her first dose of DMPA one month earlier, and comes to the centre with light, intermenstrual bleeding or spotting:
   a) should immediately switch to another method of contraception
   b) should immediately receive a second injection
   c) is not a good candidate for injectable contraception
   d) should be reassured and told that this light bleeding pattern will become more regular after 6 to 12 months

25. Which ONE of the following statements is false regarding condoms?
   a) Condoms can be reused.
   b) Condoms should be used at every act of intercourse.
   c) Condoms are the only method of contraception that protect against HIV/STD.
   d) Petroleum based lubricants like Vaseline should not be used with condoms.
1. a
2. b
3. a
4. c
5. a
6. b
7. b
8. d
9. d
10. b
11. b
12. b
13. d
14. c
15. c
16. b
17. c
18. c
19. d
20. a
21. a
22. c
23. a
24. d
25. a
1. For a woman in good health, a contraceptive method is best selected by:
   A) THE WOMAN HERSELF
   b) the medical officer or ANM providing services to the woman
   c) the village health worker who recommends that the woman visit the center
   d) the woman’s husband

2. The most important part of counselling is:
   a) providing brochures about contraceptive methods to the woman for review with her husband
   B) IDENTIFYING THE WOMAN’S CONCERNS ABOUT USING CONTRACEPTIVES AND ANSWERING HER QUESTIONS
   c) obtaining formal consent for the procedure from the client
   d) describing side effects

3. The Copper T 200B IUCD can be left in the uterus for:
   A) 3 YEARS
   b) 4 years
   c) 7 years
   d) 10 years

4. A woman who has a past history of pelvic inflammatory disease (PID) which has been treated can use an IUCD provided she:
   a) does not have intercourse during her menstrual period
   b) is over 35 years of age
   C) IS NOT AT RISK FOR A GENITAL TRACT INFECTION
   d) does not have a retroverted (posterior) uterus
5. The technique used for inserting the Copper T 200B IUCD is the:

A) WITHDRAWAL TECHNIQUE
b) push and remove technique
c) Lippes technique
d) push-in technique

6. Surgical (metal) instruments used for IUCD insertion, (i.e., the vaginal speculum, uterine sound and tenaculum) can be safely used if, after thorough cleaning, they are:

a) dried and stored in a sterile container
B) HIGH-LEVEL DISINFECTED
c) soaked in Savlon® or Dettol® for 30 minutes
d) used immediately

7. To minimize the risk of staff contracting hepatitis B or AIDS during the cleaning process, all soiled instruments and surgical gloves first should be:

a) rinsed in water and scrubbed with a brush before disinfecting by boiling
B) SOAKED IN A FRESH SOLUTION OF 0.5% CHLORINE FOR 10 MINUTES BEFORE CLEANING
c) rinsed in water and scrubbed with a brush before sterilizing
d) soaked overnight in 8% formaldehyde

8. Tarnished (discolored) Copper T 200B IUCDs which are still in an undamaged, sealed package should be discarded because:

a) the tarnish prevents the copper from being released
b) the IUCD is no longer sterile
c) the tarnish weakens the copper wire
D) NONE OF THE ABOVE
9. The single most important infection prevention procedure is:
   a) wearing gloves when performing a procedure
   b) autoclaving
   c) savlon rinses
   D) HANDWASHING

10. To high-level disinfect instruments by boiling, the instruments should be boiled in a pot with a lid for:
    a) 1 hour
    B) 20 MINUTES
    c) 90 minutes
    d) 7 minutes

11. After insertion, the IUCD is effective:
    a) after 5 days
    B) IMMEDIATELY
    c) after one complete cycle
    d) after 2 weeks

12. Correctly loading the Copper T 200B IUCD in the sterile package:
    a) is unnecessary if high-level disinfected or sterile gloves are available
    B) ASSURES THAT THE IUCD WILL REMAIN STERILE UNTIL IT IS REMOVED FROM THE PACKAGE
    c) is difficult to learn to do
    d) all of the above
13. If a woman with an IUCD cannot feel the strings of her IUCD when she checks them after her period, she should:
   a) not worry because sometimes the string dissolves
   b) wait until her next period and check them again before doing anything else
   c) check them every day until they reappear
   D) GO IMMEDIATELY TO THE SERVICE PROVIDER BECAUSE HER IUCD MAY HAVE FALLEN OUT AND SHE CAN GET PREGNANT

14. A new combined oral contraceptive user should:
   a) begin taking her first pack of pills whenever it is convenient
   b) begin taking her first pack of pills 5 days after the end of her menstrual cycle
   C) BEGIN TAKING HER FIRST PACK OF PILLS WITHIN THE FIRST 7 DAYS OF HER MENSTRUAL CYCLE
   d) must always begin taking her first pack of pills on the first day of her menstrual cycle

15. If a woman forgets to take two or more of her pills, she should:
   a) stop taking the pills and begin again when she has her menstrual period
   b) throw away the pills she missed and continue taking the rest of the pack
   C) TAKE 2 PILLS THE DAY SHE DISCOVERS THAT SHE HAS FORGOTTEN TO TAKE HER PILLS, AND THEN RETURN TO TAKING ONE PILL A DAY
   d) none of the above

16. A woman can take combined oral contraceptives:
   a) for a one year period, followed by a rest period of two cycles during which she should be protected by condoms
   B) INDEFINITELY, AS LONG AS SHE IS HAPPY WITH THE METHOD AND THERE ARE NO MAJOR SIDE EFFECTS
   c) for 2 years, followed by up to a 6 month rest period during which she should switch to a barrier method or IUCD
   d) for a maximum of 10 years, after which she should switch to some other method
17. Prior to starting a client on combined oral contraceptives, a pelvic exam:
   a) must always be performed
   b) must be performed only if the woman is under 20 years of age
   C) IS NOT NECESSARY
   d) must only be performed on women who have never had children

18. Vasectomy is effective in preventing pregnancy after the man has ejaculated:
   a) one time
   b) fifty times
   C) TWENTY TIMES
   d) vasectomy is immediately effective

19. Studies have shown that vasectomy increases the risk of:
   a) prostate cancer
   b) testicular atrophy
   c) cardiovascular disease
   D) NONE OF THE ABOVE

20. A woman practicing the lactational amenorrhoea method (LAM):
   A) SHOULD BREASTFEED HER BABY ON DEMAND ABOUT 6 TO 10 TIMES PER DAY
   b) should not breastfeed her baby during the night
   c) must allow 7 hours between feedings of the baby
   d) can continue practicing the method, even when her menstrual period returns

21. Combined oral contraceptive users have been shown to have a:
   A) DECREASED INCIDENCE OF ECTOPIC PREGNANCY
   b) increased incidence of ovarian cancer
   c) increased incidence of anaemia
   d) all of the above
22. When can an IUCD be used as an "emergency" contraceptive?
   a) never
   b) within 1 month of unprotected intercourse
   C) WITHIN 5 DAYS OF UNPROTECTED INTERCOURSE
   d) within 14 days of unprotected intercourse

23. A client who has received a tubal ligation should be counselled to return to the clinic or hospital for a check-up if she experiences:
   A) FEVER (GREATER THAN 38° C OR 100.4° F)
   b) shoulder pain
   c) nausea
   d) cough and nasal congestion

24. A client who has received her first dose of DMPA one month earlier, and comes to the centre with light, intermenstrual bleeding or spotting:
   a) should immediately switch to another method of contraception
   b) should immediately receive a second injection
   c) is not a good candidate for injectable contraception
   D) SHOULD BE REASSURED AND TOLD THAT THIS LIGHT BLEEDING PATTERN WILL BECOME MORE REGULAR AFTER 6 TO 12 MONTHS

25. Which ONE of the following statements is false regarding condoms?
   A) CONDOMS CAN BE REUSED.
   b) Condoms should be used at every act of intercourse.
   c) Condoms are the only method of contraception that protect against HIV/STD.
   d) Petroleum based lubricants like Vaseline should not be used with condoms.
CONTRACEPTIVE TECHNOLOGY UPDATE WORKSHOP

EVALUATION

Participant: ________________________________

Date of Workshop ____________ Workshop Venue ____________

1. Which session did you find most helpful?

2. Which session did you find least helpful?

3. Name one or two things that you learned in the CTU which will be of use to you in your work.

4. What information was not included in this CTU that should be included in future CTUs for Medical Officers?
5. What one or two "lessons learned" do you plan to discuss with your staff, colleagues
   and LHV's/ANMs when you return to your center?

6. Overall, how would you rate this workshop?

   1 = Excellent
   2 = Good
   3 = Average
   4 = Below Average
   5 = Poor

7. Overall, I learned

   a) A great deal   b) a little   c) not too much

8. Please provide other comments about the CTU (e.g., logistics, trainers, etc.).
ROLE PLAYS FOR COUNSELLING

WHAT IS ROLE PLAY?

A role play is a method of instruction in which participants play out roles in a situation related to training objectives. Advantages of role play include:

- Role plays can create a highly motivational climate because participants are actively involved in a realistic situation.
- Participants can experience a real life situation without having to take real life risks.
- Role play gives participants an understanding of the client’s situation.

PURPOSE

- To practice counselling and communication skills
- To practice the steps in the GATHER approach
- To apply information learned about different methods of contraception

GENERAL INSTRUCTIONS FOR ROLE PLAYS

- Every participant should be involved in the role play exercise either as a player or observer
- Players should meet for 10-15 minutes during lunch to prepare: assign roles, decide what is the major message/main point the role play is to make, who is going to say what, etc.
- As much as possible, use the steps of GATHER to structure your role-play.
- Observers should pay close attention to the process and content of the role play and record your observations on the observers form for feedback
- All the participants should get a chance to practice during the course of training

Time Limits
Preparation: 15 minutes
Role play presentation: 5 minutes
Analysis and Feedback: 5 minutes

TRAINER PREPARATION FOR ROLE PLAY

- Decide what the participants should learn from the role play (the objectives)
- Devise a simple situation
- Explain what the participants should do and what the audience should observe
- Discuss the important features of the role play by asking questions of both the players and observers
- Summarize the session, what was learned and how it applies to the activity being learned
Kishor (23) and Rama (19) were married 3 months ago. Rama recently returned from her mother’s place. Kishor works as a helper in an automobile service station. Rama went to school for 7 years before marriage. Kishor and Rama do not want any child at least for the next 2 years so that Kishor can start his own business. When she went to the PHC, the ANM suggested that she use oral pills, but Rama thinks she will not be able to take pills regularly. The couple knows about condoms but some of their friends told them that condoms break very frequently and others told them that they will not enjoy sex as they would without condoms. Kishor and Rama have come to the senior LHV, Kanta, of the PHC Sarangpur to get correct information about the condom use.

Consider the following in your role play:

- What questions would the couple ask about condoms?
- How would the couple present their problem?
- What questions will Kanta ask?
- What would she tell Kishor and Rama about condoms?
Kamala is 20 years old and has finished the 9th standard. She is the mother of a 6 month old daughter and does not want to have another child for 2 to 3 years. She was told by her mother that she and her maternal grandmother did not get pregnant for 2 years following the birth of a child. Kamala has heard about the Copper T as an effective method of contraception on the T.V. She wants to get more information about the Copper T and also about what her mother told her. Her husband Kishanlal, 24 years agrees with her that they should not have another child for at least 2-3 years. Kamala meets Manorama, LHV in the PHC Sitapur and asks her for more information.

Consider the following in your presentation:

- What questions will Kamala ask Manorama about IUCD?
- What questions would she ask Manorama about not getting pregnant for 2 years after giving birth (as happened to her mother)?
- How would Manorama respond to her questions?
COMBINED ORAL PILLS ROLE PLAY

A 34 years old woman, named Shanta has 3 children (the youngest is a two year old girl) and wants a contraceptive method. She has used an IUCD for the past 4 months but it was removed because of heavy menstrual bleeding, cramps and pain. She is afraid of and absolutely refuses to consider tubectomy or another IUCD. She has heard that she is too old to take the pill and she thinks that there will be many side effects. She visits Kalyani, LHV at the PHC Ganganagar.

Consider addressing the following in your role play:

- How will Kalyani respond to Shanta’s belief that she is too old for the pill?
- What questions will she ask Shanta to ascertain if the oral pill is appropriate for her?
- Emphasize the importance of taking medical and reproductive health history using the history checklist.
- What benefits of oral pills will Kalyani discuss with Shanta?
Mr. Mohan Kumar, is a 31 year old primary school teacher. He has 2 daughters, the youngest is 1 year old. He is thinking about having a vasectomy because he does not wish to have any more children. He talked with his wife Sita about this but she is strongly opposed to the idea because she learned from an ANM that a cut is made on the testes during the operation. She is very much afraid that her husband will become impotent following the operation. On hearing this, Mohan Kumar also became concerned and confused. Both of them have come to visit the house of Chamelidevi, an ANM in their village to get correct information.

Consider the following in your role play:

- How would Mohan Kumar and his wife present their problem?
- How would Sita discuss her anxiety regarding impotency following vasectomy?
- What would Chamelidevi do and say to ease the couples’ anxiety?
- What would Chamelidevi tell this couple about vasectomy and tubectomy?
CASE STUDIES

A case study is a method of instruction using realistic scenarios that focus on a specific issue, topic or problem. Participants typically read, study and react to the case study in writing or orally during group discussion. The primary advantage of the case study is that it focuses the attention of the participant on a real situation. Participants may work separately or in small groups to solve or complete a case study.

Some advantages of using case studies include:

• It is a participatory method of training which actively involves participants and encourages them to interact with each other.

• Participants react to realistic and relevant cases that directly relate to the training course and often to their work environment.

• Reactions often provide different perspectives and different solutions to problems presented in case studies.

• Reacting to case studies helps participants develop problem-solving skills.

Case studies can be developed by the clinical trainer or the participants. Situations for case studies can be found in one or more of the following sources:

• Clinical experiences
• Medical histories/records, reference manuals, clinical journals
• Experiences of clinic staff, participants or clients

After participants have read the case study, either individually or in small groups, they should be given the opportunity to react to it. Typical reaction exercises include:

• Analysis of the problem. The participants are asked to analyze the situation presented in the case study and determine the source of the problem.

• Focused questions. These inquiries ask participants to respond to specific questions.
• Open-ended questions. These questions provide participants more flexibility in responding.
• Problem solutions. The participants are asked to offer suggestions regarding the situation being presented.

Once participants have reacted to the case study, they should be given the opportunity to share their reactions. This sharing might take the form of one or more of the following:

• Reports from individuals or small groups
• Responses to case study questions
• Role plays presented by individuals or small groups
• Recommendations from individuals or small groups

The clinical trainer should summarize the results of the case study activity prior to moving on to the next topic.
EMERGENCY CONTRACEPTION

The Case of Mrs. Shila

Mrs. Shila is 23 years old and the mother of one daughter who is 1 year. Shila and her husband are using condoms regularly to space the second child. They used to buy condoms from the chemist shop. Shila’s husband noticed one day that the condom had broken during intercourse and the couple was concerned about this. She went to the ANM working in her village but the ANM was not sure what to do and she had never managed such a situation before. She asked Shila to go to the Primary Health Centre. Shila meets Dr. Dayal at the PHC and explains the problem. Questions:

1. Do you think Dr. Dayal at the PHC could help Mrs. Shila prevent possible pregnancy due to condom breakage?

2. How would you manage this situation and help Mrs. Shila?

3. What methods of contraception would you suggest to help Shila prevent possible pregnancy?
POSTABORTION CONTRACEPTION

The Case of Mrs. Savitri

Mrs. Savitri is a 24 year old, mother of two children. Her husband Mr. Bimal is 28 years old, and works in a sugar factory in the nearby township. The couple is not using any method of contraception, however they have discussed not having any more babies. They have also discussed using a spacing method for at least for 3 years after which, Bimal would get a vasectomy. They never made a final decision.

Savitri did not get her period on the expected date and later she realized that she was pregnant. The couple did not want to have another baby. Savitri visited the village Auxiliary Nurse Midwife, Nalini. Nalini suggested that she visit the Doctor at the District Hospital. Savitri asked her some questions about which family planning methods she could use following MTP. Nalini told her about condoms, oral pills and the IUCD but was not sure which method could be used immediately following MTP, except condoms. Savitri also asked her how soon following MTP she would become pregnant again if she did not use any method. Nalini could not reply to her questions. She referred Savitri to the nearby District Hospital were MTP and Family Planning services were available.

Savitri and her husband visited the District Hospital Kamalapur. Dr. Gupta at the Hospital explained to the couple about MTP and also talked in detail about the contraceptive options available following MTP and when Savitri could start using a method. Savitri agreed to have an IUCD inserted following MTP.

Questions

- What contraceptive options should Dr. Gupta discuss with the couple?
- What methods of contraception can Savitri choose following MTP?
- When do you think Savitri can start using combined oral pills and IUCD following MTP?
- Would you take any specific precautions in a case of a natural abortion in comparison to MTP?
Overview of Family Planning in Uttar Pradesh

Infant Mortality Rates in Uttar Pradesh

Unmet Need for Family Planning by Selected Characteristics

Estimated Number of Abortions

Estimated Number of Abortions 1991

Source: Jhams and Voss, 1992

Unmet Need for Family Planning

What is Unmet Need?
Overview of Family Planning in Uttar Pradesh

Need for FP Services

- Reduction in death rates has reduced need for large families based on need for income support.

- Reduction in infant mortality has reduced need for large families based on need for child rearing.

- Female illiteracy rate has increased.
Maximising Access and Quality

Receiving Contraceptive of Choice Increases Continuous Use

Unmet Need for Family Planning in Uttar Pradesh

Temporary Methods: Knowledge of Correct Use
Unmet Need for Family Planning

The Big Picture

Family planning workers can have a dramatic impact on increasing the number of FP clients and in changing perceptions about FP.

Source: International Institute for Population Sciences 1980

Unmet Need for Family Planning
Combined Oral Contraceptives (COCs)

COCs: Objectives
- Effectiveness
- Mechanisms of action
- Benefits/limitations
- Health benefits
- Warning signs
- Common side effects
- Instructions for use
- Safe sex practices

Types of COCs

COCs: Mechanisms of Action
- Suppress ovulation
- Reduce sperm transport in Fallopian tubes
- Change endometrium
- Block cervical mucus (prevent sperm penetration)
COCs: Contraceptive Benefits

- Highly effective when taken daily (1-2 pregnancies per 100 women during first year of use)
- Effective immediately if started by day 7 of menstrual cycle
- Pills examination not required prior to use
- Do not interfere with intercourse
- Few side effects
- Convenient and easy to use
- Can stop use easily
- Can be provided by trained medical staff

COCs: Health Benefits

- Decrease menstrual flow (lighter, shorter periods)
- Decrease menstrual cramps
- May improve acne
- Regulate menstrual cycles
- Protect against ovarian and endometrial cancer
- Decrease benign breast disease
- Prevent ectopic pregnancy
- Protect against some causes of PID

COCs: Limitations

- Only moderately effective in typical use (1-2 pregnancies per 100 woman-years)
- Require everyday use and regular resupply
- Births in use effects common
- Rare serious complications
- Least appropriate when breastfeeding
- Do not protect against STIs and other STDs

Who Can Use COCs

Women:
- Of any reproductive age
- Of any parity including nulliparous women
- Who want highly effective protection against pregnancy
- Who are breastfeeding for months or more postpartum
- Who are postabortion ($1000 or less or less than 7 weeks)
- With amenorrhea
- With severe menstrual pain or heavy periods
- With a history of ectopic pregnancy
Who Should Not Use COCs

Women who:
- Are pregnant (known or suspected)
- Are breastfeeding (within 6 months postpartum)
- Have unexplained vaginal bleeding (with spotting)
- Have active liver disease (renal failure)
- Are age 35 and smoke

COCs: Conditions Requiring Precautions
- High blood pressure
- Diabetes mellitus
- Migraines
- Depression
- Breast cancer
- Cannot remember to take pill every day

Failure Rates: Perfect vs Typical Use

COCs: Birth Defects

Summary

<table>
<thead>
<tr>
<th>Anomaly</th>
<th>Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>More congenital malformations</td>
<td>No effect</td>
</tr>
<tr>
<td>Congenital heart defects</td>
<td>No effect</td>
</tr>
<tr>
<td>Limb reduction defects</td>
<td>No effect</td>
</tr>
</tbody>
</table>

Source: Brucker et al 1988

COCs and Benign Breast Diseases

Summary

<table>
<thead>
<tr>
<th>Condition</th>
<th>Effect of COCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fibroadenoma</td>
<td>65% decrease</td>
</tr>
<tr>
<td>Cystic Disease</td>
<td>33% decrease</td>
</tr>
<tr>
<td>Breast Lumps</td>
<td>42% decrease</td>
</tr>
</tbody>
</table>

Source: Sakala 1991

Fertility and Maternal Health Advisory Committee

Conclusions from literature on breast cancer:
- There is no association between oral contraceptive use and breast cancer.
- Some of the studies showed that particular subgroups may be at increased risk; however, other large studies have shown no such associations.

Source: United States Food and Drug Administration 1994

COCs: Risk of Acute Pelvic Inflammatory Disease

Overall, COCs decrease the risk of pelvic inflammatory disease by 50%.

Source: Reis 1992
COCs: Menstrual Blood Loss and Anaemia

- Decreased menstrual blood loss (20 ml versus 30)
- Prevent iron deficiency anaemia (39%)
- Improvement of existing iron deficiency anaemia

Source: World Health Organization

COCs: Rumours and Facts

- Women need to take a break from the pill after some period of time.
- Oral contraceptive pills are safe to use
- The pill will cause miscarriage.
- The pill works to prevent ovulation and fertilisation.
- COCs increase the risk of cancer.
- COCs cause heart problems.
- COCs do not cause any heart problems.

COCs: Rumours and Facts

- COCs cause hypertension.
- COCs can cause an elevation of BP which returns to normal when COCs are stopped.
- Use of COCs may cause infertility.
- Clients from the same level of fertility after stopping COCs as they did before starting.
- COCs may cause birth defects.
- Risks of birth defects are the same for people who do not use COCs.

When To Start COCs

- Days 1 to 7 of the menstrual cycle (day 1 is preferred)
- Anytime during the menstrual cycle when you can be reasonably sure you aren't pregnant
- Breastfeeding: after 6 months
- Non-breastfeeding: after 1-2 weeks
- Postabortion (permanently or within first 7 days)
COCs: Common Side Effects Which May Require Management

- Amenorrhea
- Spotting and bleeding
- Nausea/dizziness/vomiting

COCs: Client Instructions

- Take 1 pill each day, preferably at the same time of day.
- Take the first pill on day 1 to 7 (day 1 is preferred) after the beginning of your menstrual period.
- 28 day periods: when a packet is finished start a new one immediately.
- 21 day periods: when a packet is finished wait one week (7 days), then begin a new packet.
- If you miss within 30 minutes of taking your pill, take another pill or use a back-up method if you have one during the next 24 hours.
- If you forget to take 1 pill, take it as soon as you remember, even if it means taking 2 pills on 1 day.

COCs: General Information

Tell the client:
- Nausea, dizziness, and breast tenderness, headaches and spotting are common during the first three cycles and then usually disappear.
- Certain medications (steroids and most antiepileptic drugs) may reduce the effectiveness of COCs. Client should tell her health care provider if she starts any new medication.
- COCs do not protect against STIs, including HIV/AIDS. Condoms should be provided as needed.

Warning Signs for COC Users

A. Abdominal pain
C. Chest pain (severe), cough, shortness of breath
H. Headache (severe)
E. Eye problems (pain, redness or blurriness especially with near vision)
S. Severe leg pain (calf or thigh)
Who Can Provide COCs

- Medical officers
- Staff nurse
- ANMs/LHVs
- Pharmacists
- Community health workers

Reproductive Health Risks in Perspective

<table>
<thead>
<tr>
<th>Death due to</th>
<th>Numbers (per 100,000 women per year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>1.9</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1.8</td>
</tr>
<tr>
<td>COC use (users)</td>
<td>1.4</td>
</tr>
<tr>
<td>Automobile accident</td>
<td>1.3</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>1.1</td>
</tr>
<tr>
<td>OHSS</td>
<td>1.0</td>
</tr>
<tr>
<td>COC use (nonusers)</td>
<td>0.7</td>
</tr>
</tbody>
</table>

Cardiovascular Disease and COCs

<table>
<thead>
<tr>
<th>Condition</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myocardial infarction</td>
<td>No increased risk</td>
</tr>
<tr>
<td>Coronary vascular accident (stroke)</td>
<td>Minimal increased risk</td>
</tr>
<tr>
<td>Deep vein thrombosis/ pulmonary embolism</td>
<td>No increased risk</td>
</tr>
</tbody>
</table>

COCs: Common Side Effects Which May Require Management

- Breakthrough bleeding and other irregularities (5-10%)
- Nausea (2-6%)
- Weight gain (< 5%)
- Headaches (< 5%)
- Mood changes
- Breast tenderness

Source: Branch (1991, revised 1993)
COCs: Morning-After Pills

Mechanisms of Action:
- Alters endometrium (reduced proliferative-secretory pattern)
- May block ovulation
- May alter tubal motility

(Risk Factors):
- < 1% failure rate when used correctly

Safety:
- No long-term problems in nearly all women
- Hormone (and morning) mood common
- Short-term side effect (nausea to somnolence)

Adams et al. 1992

---

COCs: Instructions for Use as Emergency Contraception

Step 1: Take four low dose pills (or two high dose) of oral pills within 72 hours of unprotected intercourse.

Step 2: Take four low dose or two high dose pills 12 hours later.

Step 3: If next expected menstrual cycle is missed, contact service provider to check for possible pregnancy.

90-95 mg etonogestrel
50 mg or 70 mg etonogestrel
Condoms

Who Should Use Condoms?

People who:
- Are at risk of sexually transmitted OTs or other STIs
- Need a contraceptive method immediately
- Need a temporary method while waiting for a
  long-term method
- Need a back-up method while using another method
- Have more than one sexual partner even if using
  another method
- Are breastfeeding
- Are occasional intercourse
- Need to avoid methods that have systemic effects
- Are prone to premature ejaculation

Types of Condoms

- Latex:
  - Four...
**Condoms: Contraceptive Failure Rates**

- British Family Planning Association 1979 data
- U.S. Couples (Family)

**Frequency of HIV Seroconversion with Condom Use Among Prostitutes**

- Kenya, 1985-1986

**Condoms: Contraceptive Benefits**

- Effective immediately
- No method-related health risks
- No systemic side effects
- Available in community shops
- Inexpensive
- No prescription or medical exam necessary
- Used when another method is not available
- Can be used as backup to other methods (e.g., IUDs, see next page)

**Condoms: Health Benefits**

- Only family planning method that protects against AIDS and other STIs (e.g., HIV, HSV)
- May increase time to ejaculation
- May help prevent cervical cancer
- May increase male involvement
CONDOMS

Condoms: Limitations

- Requires use with each episode of intercourse
- High failure rate if not used correctly and with every act of intercourse
- May reduce sensitivity of penis
- Condoms must be many in quantity in intercourse
- Adequate storage and reactivity must be available
- Long-term use not advocated
- Disposal of used condoms may be a problem

Who Should Not Use Condoms

- Couples in which pregnancy would pose a serious health risk or the drink
- Couples who are allergic to latex
- Couples who need a highly effective method of birth control
- Couples who want a long-term contraceptive method
- Couples who want a method not related to intercourse
- Couples not willing to use currently and with each act of intercourse

Condoms: Common Side Effects Which May Require Management

- Allergy or irritation
- Condom broken or breakage suspected (before intercourse)
- Condom breaks or slips off

Condoms: Breakage Rate

Breakage rate is approximately 0.9 per 100 users during vaginal sex.
Condoms: Client Instructions

- Use new condom with every act of intercourse.
- When available, use a spermicide with the condom.
- Keep an extra supply of condoms on hand. Do not store them in a warm place or they will deteriorate and may leak during use.
- Do not use petroleum jelly or lubricants for a condom. They damage condoms as well. If lubrication is required, use saliva, vaginal secretions or spermicidal jelly.

Condoms: Instructions for Use

Carefully open the package so the condom does not tear. Do not unroll condom before putting it on.

Condoms: Instructions for Use

If not circumcised, pull foreskin back. Squeeze tip of condom and put it on end of erect penis.

Condoms: Instructions for Use

Continue squeezing tip while unrolling condom until it covers all of penis.
Condoms: Instructions for Use

After ejaculation, hold tip of condom and pull penis out before penis gets soft.

Condoms: Conditions Requiring Precautions

- Latex allergy in either the man or the woman
- Couple in which pregnancy is medically contraindicated (e.g., cerebral or renal disease)
- Couples where the man is considered an unsuitable user of condoms

Who Can Provide Condoms

- Medical officers
- Staff nurses
- ANM/ASHVs
- Pharmacists
- Dus
- Community health workers

Male Condom: Rumours and Facts

- May come off or get stuck in vagina
  - Very unlikely, but can be removed easily with fingers
- May burst during intercourse
  - Rarely breaks during intercourse
- Cause gas or other systemic ailments
  - Has no systemic effect on either the man or woman
- Cause an allergic reaction
  - Local allergic reactions to latex are quite rare
Male Condom: Rumours and Facts

- Condoms may cause impotence.
- Condoms do not cause impotence.
- Condoms have a very high failure rate.
- Condoms are reasonably effective if used properly.
- Condoms cause cancer of the cervix.
- Condoms help prevent cervical cancer.
- Condoms can be reused.
- Each condom should only be used once.

Other Barrier Methods

- Diaphragm
- Female condom
- Cervical cap
- Spermicide-based (e.g., Today, Dettol)

Spermicides: Benefits

- Provide some protection against STI/HIV
- Safe, easy to use
- Available over-the-counter
- Can be used without partner’s knowledge
- Ideal short-term method
- User-controlled

Spermicides: Limitations

- High failure rate (7–22%)
- Can reduce spontaneity
- Can be messy to use
- Can cause irritation, itching
- Possible rare allergic reaction
- Resupply
The Toll of Sexually Transmitted Diseases (STDs)

Globally, up to 15% of reproductive-age adults are infected with an STD each year.

Reducing the Toll of STDs

- Develop and use quick, simple and accurate ways to diagnose and treat STDs.
- Make effective services available.
- Treat people with STDs.
- Encourage people to avoid STDs.

What are Genital Tract Infections (GTIs)?

GTIs are those genital tract infections usually transmitted through sexual contact.

Importance of GTIs

- One of the most neglected areas of health care (vaginosis, cervicitis and PID)
- Major cause of infertility in both females and males
- Account for up to 40% of gynaecological hospital admissions
- Cofactor in HIV and HBV transmission
CONDOMS

Common Causes of GTIs

<table>
<thead>
<tr>
<th>Cause</th>
<th>Vaginal Discharge</th>
<th>Urethral Discharge</th>
<th>Oral or Anogenital Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacteria</td>
<td>Vaginal</td>
<td>Urethral</td>
<td>Oral or Anogenital</td>
</tr>
<tr>
<td>Chlamydia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trichomonas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gardnerella</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

GTIs: Presenting Problems

Clients suspected of having a GTI usually present with one or more of the following problems:
- Vaginal or cervical discharge
- Genital ulcers (or enlarged glans/bulbocavernosus)
- Lower abdominal pain (female)
- Genital pain (males)

Problem-Oriented Approach to Managing GTIs

- Simplified approach for diagnosing and treating GTIs developed by WHO
- Guidelines based on client problem (e.g., vaginal discharge) rather than causative agent (microorganism)
Infection Prevention (IP)
Everyone's responsibility

Risk of Disease Transmission

Risk of Disease Transmission

Practices for Reducing the Risk of Hepatitis B and AIDS Transmission

Between clients and staff:
- Handwashing
- Gloves (service provider and cleaning staff)

Practices for Reducing the Risk of Hepatitis B and AIDS Transmission

From contaminated objects:
- Proper waste disposal (staff and customers)
- Decontamination (staff)
- Cleaning (clients and staff)
- Sterilization (clients and staff)
- High-level disinfection (clients and staff)
**Handwashing Practices**

Steps:
- Use a plain or antiseptic soap.
- Vigorously rub lamented hands together for 15-30 seconds.
- Rinse with clean running water from a tap or bucket.
- Air dry hands or use a clean towel.

**Processing Soiled Instruments and Other Items**

Waste disposal:
- Safely dispose of contaminated items.

Decontamination:
- Wipes, used (soiled) objects, water to cleanse plaque, hair and PVA.

Cleaning:
- Mechanically removes most lipids to 90% microorganisms.

Sterilization:
- Destroys all microorganisms (including endospores).
- High-level disinfection (HLD): Destroys all bacteria, viruses, fungi, parasites and some endospores.

**Effectiveness of Methods for Processing Instruments**

<table>
<thead>
<tr>
<th><strong>Method</strong></th>
<th><strong>Bacteria</strong></th>
<th><strong>Viruses</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>HLD</td>
<td>99.99%</td>
<td>99.99%</td>
</tr>
<tr>
<td>Sterilization</td>
<td>99.99%</td>
<td>99.99%</td>
</tr>
</tbody>
</table>

*Time decontamination and cleaning required*

**Processing Soiled Instruments and Other Items**

Waste disposal:
- Before removing gloves, place contaminated same (glove or color) in non-porous container (with a lid) or plastic bag.
- Dispose by incineration or burial.
Photo: Puncture-proof box

Photo: Burning waste

Photo: Simple Oil Drum Incinerator

Processing Soiled Instruments and Other Items

Disinfection:
- Place instruments and reusable gloves in 0.5% hypochlorite solution after use.
- Soak for 10 minutes and rinse immediately.
- Wipe surfaces (sinks, tables) with chlorine solution.
**Preparation of Chlorine Solution**

Make 0.5% chlorine solution by dissolving 3 heaped spoonfuls (15 gms) of 35% bleaching powder in a litre of water.

---

**Photo: Bottle of Bleach, Plastic Bucket and Gloves**

---

**Photo: Placing Used Instruments into a Bucket of Bleach**

- 2 photos

---

**Photo: Gloved Hands Immersed in Bleach**

- 3 photos
Infection Prevention

Photo: Remove the Gloves by Inverting Them

Photo: Gloves in the Chlorine Solution

Photo: Clinic With Two Buckets Next to Exam Tables

Processing Soiled Instruments and Other Items

Cleaning:
- Wash with soap solution and water.
- Scrub instruments to remove debris.
- Thoroughly rinse with clean water.
INFECTION PREVENTION

Photo: Toothbrush

Photo: Protective Attire

Photo: Cleaning Contaminated Instruments

Accidental Exposure of HBV Infected Blood

.00000001 ml
Infection Prevention

Processing Soiled Instruments and Other Items

Sterilisation:
- Steam (autoclave)
- Chemical

Standard Conditions for Sterilisation
By Pressurised Steam

Steam sterilisation:
- 121°C (250°F), 15 lbs/sq. inch pressure
- 30 minutes for unwrapped items
- 45 minutes for wrapped items
- Allow all items to dry before removing.

Boiling Tips
- Always boil for 20 minutes in a pot with a lid.
- Start timing when the water begins to boil.
- Do not add anything to the pot after boiling begins.
- Air dry before use in storage.
Preparing an HLD Container

For a container:
- Seal (at small) or fill a clean container with 0.5% chlorine solution.
- Seal for 20 minutes.
- Pour out solution. (The chlorine solution can then be transferred to a plastic container and reused.)
- Rinse thoroughly with boiled water.
- Air dry before use.

IP: Rumours and Facts

- Preparing a disinfectant is essential.
- Ensure that the time for preparing a disinfectant is not too long.
- Dipping in Sani-Cloth or Lysol is adequate for inpatient areas for nurses.
- Neither Sani-Cloth nor Lysol are suitable for disinfection or disinfection.
- Counterspace for storing bottles is a good infection prevention practice.
- Use of containers for storing or rinsing of bottles may increase disease transmission.

IP: Rumours and Facts

- Preparing a disinfectant is a useful but not truly important step in preparation for reusing them.
- To ensure that the time for preparing a disinfectant is not too long, all items should be disinfected and then cleaned.
- It doesn't matter how long items remain in boiling water as long as the water is sufficiently boiling when the items are placed in the pot.
- In order to achieve high-level disinfection, instruments or other items must remain in boiling water for 20 minutes.
- Only contamination by large amounts of deadly fluid can cause infection with HIV/AIDS or Hepatitis B.
- Minute amounts of bodily fluids can cause infection.

PHOTO: Summary

- IP Icon from Handbook
Intrauterine Contraceptive Devices (IUCDs)

Types of IUCDs

<table>
<thead>
<tr>
<th>Types</th>
<th>Effective Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copper T 2008</td>
<td>3 years</td>
</tr>
<tr>
<td>Siggia</td>
<td>5 years</td>
</tr>
<tr>
<td>Norgestrel 2000</td>
<td>5 years</td>
</tr>
<tr>
<td>Multigest 250</td>
<td>3 years</td>
</tr>
</tbody>
</table>

IUCDs: Mechanisms of Action

- Interferes with reproductive process before fertilization
- Interferes with ability of sperm to pass through uterine cavity

IUCDs: Contraceptive Benefits

- Highly effective (5-9 pregnancies per 100 women during first year of use)
- Effective immediately
- Long-term protection
- Does not interfere with self-introversion
- Does not affect breastfeeding
- Immediate return to fertility upon removal
IUCDs: Contraceptive Benefits

- Few side effects
- After follow-up visit, only need to return to clinic 6 months
- No supplies needed by client
- Can be provided by trained nonphysician
- Inexpensive

IUCDs: Risk of Ectopic Pregnancy

Users versus Nonusers

<table>
<thead>
<tr>
<th>IUCD users</th>
<th>Nonusers</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5% pregnancy rate of which 20% are ectopic</td>
<td>70% pregnancy rate of which 1% are ectopic</td>
</tr>
<tr>
<td>1,000</td>
<td>1,000</td>
</tr>
<tr>
<td>3 pregnancies 1 ectopic</td>
<td>800 pregnancies 8 ectopic</td>
</tr>
</tbody>
</table>

IUCDs: Limitations

- Pelvic examination required
- Screening for GTIs recommended
- Increased PID risk if at all for GTIs or STIs
- Requires trained provider for insertion and removal
- Need to check for strings after every menstrual period
- Increase menstrual bleeding and cramping during first few months of use

IUCDs: Limitations

- May be spontaneously expelled
- Rarely (1/1,000 cases) perforation of the uterus may occur during insertion
- Does not prevent or ectopic pregnancies
- Does not protect against GTIs and other STIs (e.g., HIV, HSV, etc.)
Who Can Use IUCDs

Women of any age or parity who:
- Want highly effective protection against pregnancy
- Want long-term protection against pregnancy
- Are breastfeeding
- Are postpartum and not breastfeeding (insert immediately or after 6-8 weeks)

Who Should Not Use IUCDs

Women who:
- Are pregnant (known or suspected)
- Have unexplained vaginal bleeding (until evaluated)
- Have multiple sexual partners or whose partners have multiple sexual partners
- Have active genital tract infection (vaginal, cervical, PID)
- Have cervical stenosis
- Have had a previous IUCD expulsion or failure
- Are allergic to copper
- Are allergic to polyurethane
- Are allergic to Lippes Loop or ParaGard

Who Can Use IUCDs

Who Should Not Use IUCDs
IUCDs: Conditions Requiring Precautions

- Severe menstrual pain
- History of previous ectopic pregnancy
- Symptomatic vascular heart disease
- Severe anemia

IUCDs: Mean Monthly Menstrual Blood Loss

When To Insert IUCD

- Days 3-7 of the menstrual cycle
- Anytime during the menstrual cycle if reasonably sure the client is not pregnant
- Breastfeeding: 4-6 weeks or 6 months if using LAM
- Postpartum and not breastfeeding:
  - Immediately following delivery
  - During first 48 hours postpartum
- 4 weeks or more postpartum
- Postabortion (provided no evidence of pelvic infection)
  - Immediately or within the first 7 days

IUCD Insertion: Withdrawal Method
IUCDs: Common Side Effects Which May Require Management

- Amenorrhea
- Cramping
- Irregular or heavy vaginal bleeding
- Missing strings
- Vaginal discharge or suspected PID

IUCDs: PID Incidence Rate

IUCDs: Return to Fertility Among Parous Women

Problems with IUCD Use

<table>
<thead>
<tr>
<th>Problem</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>No problems</td>
<td>81.0</td>
</tr>
<tr>
<td>Difficulty</td>
<td>8.2</td>
</tr>
<tr>
<td>Heavy periods</td>
<td>5.5</td>
</tr>
<tr>
<td>Extension bleeding</td>
<td>2.1</td>
</tr>
<tr>
<td>Pain/Discomfort</td>
<td>3.4</td>
</tr>
<tr>
<td>Other</td>
<td>9.9</td>
</tr>
</tbody>
</table>

Number of IUCD Users: 126

Note: The figures may vary as more than 10% of reports might have problems that could not be recorded.
IUCDs: Client Instructions

- Return for check-up after the postinsertion menarche.
- During the first month after insertion, check the strings twice weekly.
- After the first month check the strings after menarche.
  - lower abdominal cramping.
  - pelvic or intermenstrual spotting.
  - pain after intercourse (if your partner experiences discomfort during sex).

IUCDs: Client Instructions

- Return to your provider if you:
  - cannot feel strings.
  - feel hand part of the IUCD.
  - expel the IUCD, or
  - miss a period.

IUCDs: General Information

- Effective immediately.
- Expulsion rates highest during first few months postinsertion (15%).
- There may be some bleeding or spotting the first few days after insertion.
- Menstrual bleeding commonly heavier and longer during first few months after insertion.

IUCDs: General Information

- May be removed any time according to client wishes.
- Tell client:
  - What type of IUCD she has.
  - When it should be removed.
- If possible, provide a card with this information or talk.
- IUCDs do not provide protection against HIV.
  - If either partner is at risk, also use condoms.
Warning Signs for IUCD Users

- Late period with pregnancy symptoms
- Persistent or heavy lower abdominal pain, especially if accompanied by hot feeling, fever or chills, other symptoms suggesting possible pelvic infection
- Stringy mucus or slight pull on the string tip of the IUCD can be felt
- Sexual relations with more than one partner

Outcome of Accidental Pregnancy With Copper T IUCD

<table>
<thead>
<tr>
<th>Pregnancy outcome</th>
<th>N</th>
<th>Percent</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous abortion</td>
<td>66</td>
<td>33.0</td>
<td>16</td>
<td>32.5</td>
</tr>
<tr>
<td>Ectopic pregnancy</td>
<td>5</td>
<td>4.6</td>
<td>2</td>
<td>4.6</td>
</tr>
<tr>
<td>Miscarriage</td>
<td>2</td>
<td>1.6</td>
<td>1</td>
<td>2.0</td>
</tr>
<tr>
<td>Total</td>
<td>73</td>
<td>100.0</td>
<td>20</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Texas, South and West 1976

IUCDs: Return Visit

Instruct client to return to provider:
- After 6 weeks to check strings
- At any time she is concerned about a problem
- For routine reproductive health care

Who Can Provide IUCDs

- Medical officers
- Staff nurse
- ANM/LHVs
IUCDs: Immediate Postplacental Insertion

- Special training and general counseling needed
- No additional risk of infection, bleeding or perforation
- Convenience for client
- Cost effective

Postcoital IUCD Insertion

Mechanisms of Action:
- May prevent fertilization by interfering with sperm transport or function
- May prevent implantation by altering fetal or endometrial environment

Mechanisms:
- 97% failure rate

Safety:
- No adverse fetal effects (should be removed if pregnancy not prevented)
- Not recommended for women at high risk for STDs unless other methods not acceptable or available

IUCDs: Instructions for Use as Emergency Contraception

Step 1: Insert IUCD within 5 days of unprotected intercourse.
Step 2: If no period within 14 days, consult clinic or service provider to check for possible pregnancy.

IUCDs: Rumours and Facts

- IUCDs can travel up into abdomen or head.
- Even if perforation occurs, IUCD remains in the vicinity of uterus.
- IUCDs cannot cause weight gain or weight loss.
- IUCDs do not cause a change in appetite.
- IUCDs can cause a variety of symptoms.
- IUCDs do not have any systemic side effects.
- IUCDs cause fetal malformations.
- IUCDs may cause miscarriage if pregnancy occurs.
IUCDs: Rumours and Facts

- IUCDs may cause cancer.
- IUCDs do not cause cancer.
- A rest period is needed for copper IUCDs.
- IUCDs can be replaced as soon as their effective life is finished.
- IUCD strings can interfere with intercourse.
- Properly trimmed IUCD strings do not interfere with intercourse.
LACTATIONAL AMENORRHOEA METHOD

Lactational Amenorrhoea Method (LAM)

Normal Menstrual Cycle

Physiology of Lactational Amenorrhoea

LAM: Contraceptive Benefits
- Highly effective (2–3 pregnancies per 100 women during first 6 months)
- Effective immediately
- Does not interfere with intercourse
- No physical side effects
- No medical supervision necessary
- No supplies required
- Free
LACTATIONAL AMENORRHOEA METHOD

LAM: Contraceptive Benefits
- Bridge to other contraception
- Build an emotional culture and regime practices
- Support breastfeeding and nursing patients
- Postpones use of sterilize until 6 months in women

LAM: Health Benefits
For child:
- Passive immunization
- Best source of nutrition
- Decreased exposure to pathogens in water, other milk formulas, or on utensils

For mother:
- Decreased postpartum bleeding

LAM: Limitations
- Breastfeeding pattern may be difficult to maintain
- No STD or HIV protection
- Duration of method limited
- Only useful for breastfeeding women

Who Can Use LAM
- Women:
  - Who are fully breastfeeding on demand
  - Whose babies are less than 6 months old
  - Whose breast have not returned
LACTATIONAL AMENORRHOEA METHOD

Who Should Not Use LAM

Women:
- Whose menses have returned
- Who are not fully breastfeeding
- Who are more than 8 months postpartum

LAM: Conditions Requiring Precautions

- When regular supplementary feeding begins (replacing a breastfeeding meal)
- When menstruation begins
- Baby does not suckle frequently (>4 hours between feedings during the day, >6 hours during the night)

LAM: Client Instructions

- Breastfeed:
  - 8 to 10 times/day
  - At least once during the night
  - <6 hours should pass between any 2 feedings
  - If feeding solids food, LAM is no longer effective
  - If amenorrhea returns begin using condoms and return to the clinic for another method

Who Can Counsel About LAM

- Physicians
- ANMs/LPHs
- Staff nurses
- Dads
- Community health workers
LACTATIONAL AMENORRHOEA METHOD

Who Can Use LAM?

Any postpartum woman is eligible:
- If successful breastfeeding is established and plans to continue breastfeeding.
- Nearly fully breastfeeding women:
  - Exclusive breastfeeding is not required
  - Minimal supplementation is allowed

LAM Algorithm

1. Have your periods returned?
   - Yes: Begin another method of contraception
   - No: Maintain breastfeeding for infant health
2. Are you supplementing regularly or allowing long periods without breastfeeding?
   - Yes: No additional contraception necessary
   - No: Begin another method of contraception

Other Contraceptive Options for Breastfeeding Women

First choice
- Non-hormonal methods:
  - Condoms
  - IUDs
  - Male and female sterilization
  - Natural family planning (NFP)

Second choice:
- Progestin-only methods:
  - Depo-Provera
- Intrauterine devices
- Methods containing hormones:
  - Combined oral contraceptives (COCs)
LAM: Rumours and Facts

- Partial breastfeeding will prevent pregnancy.
- Only full breastfeeding will prevent pregnancy.
- Clients who have assumed estrogens are protected.
- Resumption of menses signifies that a client is no longer protected.
- Clients with certain diseases cannot breastfeed.
- There are few medical contraindications to breastfeeding and use of LAM.
**NFP: Mechanism of Action**

**Safe period method**

For contraception:
- Avoid intercourse during the fertile phases of the menstrual cycle when conception is most likely.

For conception:
- Plan intercourse near ovulation typically days 14-16 when conception is most likely.

---

**NFP: Contraceptive Benefits**

- Can be used to avoid or achieve pregnancy
- Non-hormonal related side effects
- Few systemic side effects
- Irreversible return to fertility
- Inexpensive
- Increases family involvement in family planning

---

**NFP: Health Benefits**

- Improved knowledge of reproductive system
- Promotes closer relationship between couples

---
NFP: Limitations

- Effortless, depends on willingness to follow instructions
- Considerable training required to use correctly
- Requires a sexual partner (coercing)
- Requires abstention during fertile phase
- Requires daily record keeping
- Does not protect against HIV and other STIs (e.g., HPV, syphilis)

Who Can Use NFP

- Any reproductive age
- Any party including a non-virgin woman
- Couple with religious or philosophical reason for not using other methods
- Unable to use other methods
- Couple willing to abstain from intercourse for more than 7 times each cycle
- Couple willing and motivated to observe, record and interpret fertility signs

Who Should Not Use NFP

- Women:
  - Whose age, parity or health problems make pregnancy a high risk
  - Women who have recurrent infections (breastfeeding, menstruation and abortion)
  - With irregular menstrual cycles
  - Whose partner will not cooperate (alcohol) during certain times in the cycle

NFP: Conditions Requiring Precautions

- Irregular menses
- Persistent vaginal discharge
- Breastfeeding
NFP: Client Instructions

Safe period method

- For conception:
  - Have intercourse during fertile days.

- For contraception:
  - Calculate your fertile period.

NFP: Client Instructions
Postabortion Contraception

Scope of the Problem in India

- 0.8 per 1000 abortions are illegal in UP each year
- 0.1 per 1000 abortions are legal in UP each year
- ~10,000-30,000 women die from complications of abortion each year
- 26-39% of all maternal deaths are caused by septic abortions
- 3% of women in UP have an unmet need for FP

Source: Ranga, Griffith, and Zhang (1992)

Estimated Number of Abortions

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Abortions</th>
<th>Induced Abortions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>11,465,000</td>
<td>8,711,000</td>
</tr>
<tr>
<td></td>
<td>Uttar Pradesh</td>
<td>1,456,000</td>
</tr>
<tr>
<td></td>
<td>1,133,000</td>
<td></td>
</tr>
</tbody>
</table>

Source: Dhallen and Katz (1992)

Elements of Postabortion Care

Emergency Treatment
FP Counseling & Services
Other Reproductive Health Services

Postabortion Care

Scope of the Problem in India

Estimated Number of Abortions

Elements of Postabortion Care
**Postabortion Contraception**

**Importance of Starting FP Services Immediately**

- Increased risk of repeat pregnancy by 10%.
- Contraception may occur up to day 11 postabortion.
- 75% of women will have ovulated within 6 weeks postabortion.

**Postabortion Contraception: Which Methods to Use**

- All methods are acceptable provided that:
  - Counselling and education are given.
  - Clients are prescribed for precautions.

**Providing Postabortion Contraception**

<table>
<thead>
<tr>
<th>Method</th>
<th>Timing</th>
<th>Effectiveness</th>
<th>Side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implant</td>
<td>Immediate</td>
<td>Effective</td>
<td>Low</td>
</tr>
<tr>
<td>IUD</td>
<td>Immediate</td>
<td>Effective</td>
<td>Low</td>
</tr>
<tr>
<td>Post serum</td>
<td>Immediate or delayed</td>
<td>No induction</td>
<td>No</td>
</tr>
<tr>
<td>Oral contraceptives</td>
<td>Immediate or delayed</td>
<td>No induction</td>
<td>No</td>
</tr>
<tr>
<td>Buccal system</td>
<td>Immediate or delayed</td>
<td>Low</td>
<td>No</td>
</tr>
</tbody>
</table>

**Elements of Postabortion Care**

- Linkages with other reproductive health services.
  - Essential for improved reproductive health.
  - Essential to women's standard of care.

---

**Importance of Starting FP Services Immediately**

- Increase risk of repeat pregnancy.
- Contraception may occur up to day 11.
- 75% of women ovulate within 6 weeks.

**Postabortion Contraception: Which Methods to Use**

- All methods acceptable with counselling and education.
- Prescribe precautions.

**Providing Postabortion Contraception**

<table>
<thead>
<tr>
<th>Method</th>
<th>Timing</th>
<th>Effectiveness</th>
<th>Side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implant</td>
<td>Immediate</td>
<td>Effective</td>
<td>Low</td>
</tr>
<tr>
<td>IUD</td>
<td>Immediate</td>
<td>Effective</td>
<td>Low</td>
</tr>
<tr>
<td>Post serum</td>
<td>Immediate</td>
<td>No induction</td>
<td>No</td>
</tr>
<tr>
<td>Oral contraceptives</td>
<td>Immediate</td>
<td>No induction</td>
<td>No</td>
</tr>
<tr>
<td>Buccal system</td>
<td>Immediate</td>
<td>Low</td>
<td>No</td>
</tr>
</tbody>
</table>

**Elements of Postabortion Care**

- Linkages with other reproductive health services.
  - Essential for improved care.
  - Essential to women's health.

---
Examples of Other Reproductive Health Services

- Treatment of genital tract infections (STIs)
- Cervical cancer screening for women over age 30-50
- Infertility services
- Fertility awareness (e.g., rhythm, temperature, combination, management of existing medical conditions)

Postabortion Contraception: Rumours and Facts

- Women need rest following abortion—Rumour: Rest is not needed.
- Fertility returns quickly—Rumour: Contraception should begin immediately.
- Postabortion IUCD insertion leads to increased bleeding.
- Risk of bleeding is no greater following postabortion insertion.
Postpartum Contraception

Postpartum Contraception: Breastfeeding Women

Timing of Method Initiation for Breastfeeding Women

1. Delivery
2. Hospital stay
3. Home

If delivery in hospital, cessation of breastfeeding for 3 days. Consider contraceptive option for breastfeeding at 3 days. If breastfeeding is discontinued prior to 3 days, consider contraceptive option immediately. If breastfeeding is delayed, consider contraceptive option at 3 days.

*If breastfeeding stopped for any reason for 3 days, contraceptive option can be reinitiated.

Source: P4 1994

Postpartum Contraception: Nonbreastfeeding Women

Timing of Method Initiation for Nonbreastfeeding Women

1. Delivery
2. Hospital stay
3. Home
4. 1 month

If delivery in hospital, cessation of breastfeeding for 3 days. Consider contraceptive option for breastfeeding at 3 days. If breastfeeding is discontinued prior to 3 days, consider contraceptive option immediately. If breastfeeding is delayed, consider contraceptive option at 3 days.

*If breastfeeding stopped for any reason for 3 days, contraceptive option can be reinitiated.

Source: P4 1994
Progestin-Only Injectables

Types of Progestin-Only Injectables
- Depo-Provera (DMPA):
  - 150 mg of depo-medroxyprogesterone acetate given every 3 months

Progestin-Only Injectables: Mechanisms of Action
- Regulate ovulation
- Reduce amounts transported to fallopian tubes
- Change endometrium
- Thicken cervical mucus (prevent sperm penetration)

Progestin-Only Injectables: Contraceptive Benefits
- Highly effective (5.2-1 pregnancies per 100 women during first year of use)
- Rapidly effective (< 24 hours) if started by day 7 of menstrual cycle
- Intermediate-term method (1 to 2 months per injection)
- Pelvic examinations not required prior to use
- Do not interfere with hormones

Progestin-Only Injectables

Types of Progestin-Only Injectables

Progestin-Only Injectables: Mechanisms of Action

Progestin-Only Injectables: Contraceptive Benefits
Progestin-Only Injectables: Contraceptive Benefits

- Do not affect breastfeeding
- Few side effects
- No supplies needed by the client
- Can be provided by trained nonmedical staff
- Contains no estrogen

Progestin-Only Injectables: Health Benefits

- May decrease menstrual cramps
- May decrease menstrual bleeding
- May improve acne
- Protect against endometrial cancer
- Decrease benign breast disease
- Decrease ectopic pregnancy
- Protect against some causes of PID

Progestin-Only Injectables: Limitations

- Changes in menstrual bleeding pattern
- Irregular bleeding/spotting likely in initial months
- Weight gain (1-2 lb) is common
- Prevents intrauterine pregnancies better than ectopic pregnancies
- Re-supply must be available

Progestin-Only Injectables: Limitations

- Do not protect against STIs and other STDs (e.g., HIV, HIV/AIDS)
- Must return for injections every:
  - 3 months (Depo-PMS)
  - Return to fertility may be delayed for about
    3-6 months on average after discontinuation
**Who Can Use Progestin-Only Injectables?**

Women of any reproductive age or parity who:
- Desire effective, reversible method
- Are postmenopausal or not breastfeeding
- Are breastfeeding (no weeks or more postpartum)
- Are postpartum
- Are smokers (any age)
- Do not accept irregular bleeding or amenorrhea

**Who Can Use Progestin-Only Injectables?**

**Progestin-Only Injectables: Use in Breastfeeding Women**

- May increase quantity of breast milk
- Has no effect on:
  - Initiation or duration of breastfeeding
  - Quality of breast milk
  - Growth and development of infants
  - Long-term growth and development of children through adolescence

**Who Should Not Use Progestin-Only Injectables**

Women:
- Who are pregnant (known or suspected)
- Have uncorrected vaginal bleeding (until evaluated)
- Who cannot tolerate any changes in their menstrual bleeding pattern, especially amenorrhea
- With active or recent cardiovascular disease
- With present or past history of breast cancer
- With liver tumors (hepatoma and hepatitis)
**Progestin-Only Injectables**

---

**Progestin-Only Injectables: Conditions Requiring Precautions**

- Active liver disease (viral hepatitis)
- Heart disease
- Stroke (current)
- Depression
- Breast lumps

---

**Progestin-Only Injectables: Timing**

Initial injection:
- Day 1 to 7 of the menstrual cycle
- Anytime during the menstrual cycle when you can reasonably sure the client is not pregnant
- Postpartum
- Immediately if breastfeeding
- After 5 months if using LOR
- Postabortion: immediately or within first 7 days

Refills:
- OCPs, up to 4 weeks early or late

---

**Progestin-Only Injectables: Side Effects Which May Require Management**

- Amenorrhea (absence of vaginal bleeding or spotting)
- Vaginal bleeding or spotting
- Headache
- Nausea/stomach/coning
- Weight gain or loss (change in appetite)

---

**Progestin-Only Injectables: Client Instructions**

Return to health clinic for an injection every:
- 3 months for OCPs
**PROGESTIN-ONLY INJECTABLES**

**Warning Signs for Progestin-Only Injectable Contraceptive Users**

- Delayed menstrual period after several months of regular cycles
- Severe lower abdominal pain
- Heavy bleeding
- Pus or bleeding at the injection site
- Migraine (vascular) headaches, repeated very painful headaches or blurred vision

**DMPA: Return to Fertility**

![Graph showing return to fertility](image)

*Women who stopped using contraception to become pregnant.*

*Source: Basile et al.*

**Cancer and DMPA Use**

**Summary of worldwide literature**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>No association</td>
</tr>
<tr>
<td>Cervical</td>
<td>No association</td>
</tr>
<tr>
<td>Endometrium</td>
<td>Reduced</td>
</tr>
<tr>
<td>Ovary</td>
<td>No association</td>
</tr>
</tbody>
</table>

**Progestin-Only Injectables: Common Misconceptions**

**Fact**

DMPA can be used safely in clients with:
- Diabetes mellitus (insulin or oral hypoglycemic dependent)
- Hypertension (asymptomatic and untreated)
- High blood pressure (including vascular problems)
- Smoking (veryagic)
Progestin-Only Injectables: Common Misconceptions

Fact

- DMMA can be used safely in clients with:
  - Surgery (with or without prolonged bed rest)
  - Venous or arterial disease (excluding symptoms)
  - Venous thromboembolic disease (bood clots)

DMMA: Infection Prevention Recommendations

- Use antiseptic solution to prepare the injection site (washes area first if poor hygiene)
- Use sterile DMMA vial (150 mg per vial)
- Use sterile (or high-level disinfected) needle and syringe

DMMA: Infection Prevention Recommendations

- After use, disinfect all needle and syringe and other:
  - place in puncture-proof container for disposal, or
  - clean and final process by sterilization (or high-level disinfection)

DMMA: Common Side Effects During First Year of Use

- Irregular bleeding
- Amenorrhea
- Minor weight gain
- Headache
- Mood changes

DMMA: Infection Prevention Recommendations
DMPA: Management of Amenorrhoea

- Amenorrhea
- Evaluate for pregnancy, especially if amenorrhoea occurs after period of regular menstrual cycles.
- If no problem found, do not attempt to induce bleeding with COCs.

DMPA: Factors Affecting Acceptance of Menstrual Changes

- Need for contraception
- Reaction of the partner to menstrual changes
- Interference with sexual or daily activity
- Religious constraints

DMPA: Management of Irregular Bleeding

- Prolonged spotting (> 5 days) or moderate bleeding:
  - Amenorrhea
  - Check for gynecologic problem (e.g., cervicitis)
  - Short-term treatment:
    - COCs (20-40 mg EE) for 1 cycle, or
    - Danazol (up to 400 mg for 1-2 days)

DMPA: Management of Prolonged or Heavy Bleeding

- Carefully review history and check hagemoglobin (if available).
- Check for gynecologic problems.
- Short-term treatment:
  - COCs for 1 packet† or
  - Mifepristone (up to 600 mg/W) x 1 day
DMPA: Management of Prolonged or Heavy Bleeding

If bleeding not resolved in 3-4 days, give:

- 2 COCs per day from one packet followed by 1 pill per day from one packet, or
- high-dose estrogen (50 µg EE COC, or 1.25 mg conjugated estrogens) for 10-14 days
Voluntary Surgical Contraception for Women

Contraceptive Method Mix of Currently Married Women

Female Voluntary Surgical Contraception: Types of Procedures

Tubal Ligation: Mechanism of Action

By blocking the fallopian tubes (cutting [Pomeroy] or rings) sperm are prevented from reaching ovum and causing fertilisation.
Photo: Minilap

Photo: Tubal Ring

Tubal Ligation: Contraceptive Benefits

- Highly effective (0.3-1 pregnancies per 100 women during first year of use)
- Effective immediately
- Permanent
- Does not interfere with breastfeeding
- Does not interfere with intercourse

Tubal Ligation: Contraceptive Benefits

- Good for client if pregnancy would pose a serious health risk
- Simple surgery, usually done under local anesthesia
- No long-term side effects
Tubal Ligation: Health Benefits

- Decreased risk of ovarian cancer (exact mechanism unclear)

Tubal Ligation: Limitations

- Must be considered permanent (not reversible)
- May interact later
- Small risk of complications
- Requires specialist physician (gynaecologist or surgeon for laparoscopy)
- Does not protect against STIs and other STIs (e.g., HIV, rubella/CMV)

Tubal Ligation: Client Issues

- The client has the right to change her mind anytime prior to the procedure
- A standard consent form must be signed by the client for the procedure
- Appropriate consent is not required
- In mobile programmes (e.g., camps), counselling and follow-up should be the same as at fixed sites and all recommended selection criteria should be followed

Who Can Use Tubal Ligation

- Age ≥ 22 and ≤ 45
- Married and whose spouse is living
- Any parity, including multiparous women
- Want highly effective, permanent protection against pregnancy
- Breastfeeding (within 48 hours or after 6 weeks)
- Postpartum (within 3 days) or immediately postpartum
- Certain they have achieved their desired family size
- Understand and voluntarily consent to the procedure
Who Should Not Use Tubal Ligation

- Pregnant (except following MTP)
- Acute pelvic or systemic infections (until resolved or controlled)
- Cannot withstand the surgery
- Uncertain of their desire for future fertility
- Cannot give voluntary informed consent

Tubal Ligation: Client Instructions

- Keep the operative site dry for 2 days.
- Resume sexual activity as tolerated (except return to normal activity within 7 days).
- Avoid sexual intercourse for 1 week. If intercourse is required, use a barrier method.
- Avoid heavy lifting for 1 week.
- For pain, take 1 or 2 acetaminophen (e.g., Tylenol) every 4 to 6 hours.
- Schedule a routine follow-up visit between 7 and 10 days after the surgery.

Warning Signs for Tubal Ligation Clients

- Fever (greater than 38° C or 100.4° F)
- Dizziness or fainting
- Persistent or increased abdominal pain
- Bleeding or fluid coming from the vagina
- Signs or symptoms of pregnancy

Tubal Ligation: Conditions Requiring Precautions

- No living children
- Significant medical problems
Tubal Ligation: Side Effects
Which May Require Management

- Wound infection
- Pain at infection site
- Postoperative fever
- Bladder, intestinal injuries (very rare)
- Hemorrhage (subcutaneous)
- Gas embolism with laparoscopy (very rare)
- Subcutaneous emphysema
- Superficial bleeding (skin edges or subcutaneous)

Problems with Tubal Ligation
Uttar Pradesh
1992-93

<table>
<thead>
<tr>
<th>Problem</th>
<th>Medical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>11.4</td>
</tr>
<tr>
<td>Nausea</td>
<td>3.1</td>
</tr>
<tr>
<td>Vomiting</td>
<td>1.1</td>
</tr>
<tr>
<td>Temperature instability</td>
<td>0.3</td>
</tr>
<tr>
<td>Pulmonary embolus</td>
<td>0.3</td>
</tr>
<tr>
<td>Urinary dysfunction</td>
<td>0.3</td>
</tr>
<tr>
<td>Menstrual disturbance</td>
<td>0.3</td>
</tr>
<tr>
<td>Weakness</td>
<td>0.3</td>
</tr>
<tr>
<td>General weakness</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Tubal Ligation
Regret
Insufficient (about 8%) but inadequately studied in developing country settings
- Risk factors:
  - Young age
  - Low parity
  - Change in marital status
  - Sexual dissatisfaction
  - Death of a child

Female Voluntary Sterilisation:
Common Medical Barriers

- Age restrictions (young and old)
- Parity restrictions (less than two living children, no male child)
- Spousal consent
- Provider bias
  - Who can provide:
    - Specialists only
    - Physicians only
Tubal Ligation: Rumours and Facts

- Tubal ligation causes weakness, weight gain/weight loss and other medical problems.
- Tubectomy is a safe procedure with rare minor side effects. It does not cause weight change or other medical problems.
- Tubal ligation causes gas.
  - The gas used during the procedure is gone within 48 hours.
- Tubal ligation is reversible.
  - Recovery of sterilization procedures is generally unsuccessful. Tubectomy should be considered permanent.
Voluntary Surgical Contraception for Men

Types of Voluntary Surgical Contraception for Men

Vasectomy:
- No-scalpel
- Scalpel

Vasectomy: Mechanism of Action

By blocking the vas deferens (ejaculatory duct) sperm are not passed in the ejaculate.

Vasectomy: Contraceptive Benefits

- Highly effective (98-100% protection per 100 women during first year of use)
- Permanent
- Does not interfere with intercourse
- Good for couples if pregnancy would pose a serious health risk to the woman
- Simple surgery done under local anesthesia
- No long-term side effects
- No change in sexual function (no effect on libido or hormone production by the testes)
Vasectomy: Limitations

- Must be considered permanent (not reversible)
- May regret later
- Delayed effectiveness (2 months or up to 28 ejaculations)
- Risks and side effects of minor surgery, especially if general anesthesia is used
- Requires trained physician
- Does not protect against GTIs and other STDs (e.g., HBV, HIV/AIDS)

Vasectomy: Client Issues

- The client has the right to change his mind anytime prior to the procedure.
- A standard consent form must be signed by the client for the procedure.
- Specific consent is not required.
- In multiple procedures (i.e., same, counseling and follow-up should be the same as at first site and all postprocedure infection prevention protocols should be followed.

Who Can Use Vasectomy

- Men who:
  - Not age < 50
  - Non-smoker effective, permanent contraceptive method
  - Whose consent has been fully explained
  - Good health and voluntarily consent to the procedure
  - Are certain they have achieved their desired family size

Who Should Not Use Vasectomy

- Men who:
  - Are uncertain of their desire for future fertility
  - Cannot withstand surgery
  - Do not give voluntary consent
Vasectomy: Conditions Requiring Precautions

- No new children
- Symptomatic heart disease or other heart condition
- Diabetes, diabetes mellitus, severe anaemia
- Ovarian disease
- Local skin or wound infection
- Other medical problems

Vasectomy: Side Effects Which Require Management

- Extensive swelling
- Haematomas (scrotal)
- Wound infection

Vasectomy: Client Instructions

- Wear scrotal support, keep the operative site dry and rest for 2 days.
- If comfortable, you may resume sexual intercourse in 2 or 3 days, but delay sexual activity if you are uncomfortable. Remember to use condoms or another family planning method until you have ejaculated at least 20 times.
- Avoid heavy lifting and hard work for 2 days.

Vasectomy: Client Instructions

- For pain, take 1 or 2 aspiragen tablets (acetaminophen, ibuprofen or paracetamol) every 4 to 6 hours and apply ice packs.
- Return after 1 week for removal of non-absorbable stitches. (If no stitches or if absorbable stitches were used to close the skin, there is no need to return unless there are problems.)
- Come back for semen test 3 months after the operation if you wish to have proof that the vasectomy is completely effective.
Warning Signs for Vasectomy Clients

- Bleeding or fluid coming from the incision
- Very painful or swollen scrotum
- Fever (greater than 38°C or 100.4°F)

Male Sterilization: Current Technology

No-scalpel vasectomy

- Failure rate:
  - 0.2-0.4%
- Complications (overall < 3%):
  - Hematomas
  - Infection
  - Epididymitis
- Mortality rate:
  - < 0.001%

Vasectomy

No-scalpel vasectomy method:

- Developed in China
- Introduced in India in 1991
- Uses specialized instruments (not graspers
  and is hand-feeding) and standardized
  technique
- Has fewer complications than standard
  vasectomy method
- Uses same splicing techniques as standard
  vasectomy method

No-Scalpel Vasectomy:
Short-Term Complications

<table>
<thead>
<tr>
<th>Source of</th>
<th>Total</th>
<th>Death</th>
<th>Death</th>
<th>Source of</th>
<th>Total</th>
<th>Death</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>12/7,741</td>
<td>0.00</td>
<td>1,626</td>
<td>China</td>
<td>12/7,741</td>
<td>0.00</td>
<td>1,626</td>
</tr>
</tbody>
</table>

Source: Li et al 1995

Male Sterilization: Current Technology

Vasectomy

No-Scalpel Vasectomy:
Short-Term Complications

<table>
<thead>
<tr>
<th>Source of</th>
<th>Total</th>
<th>Death</th>
<th>Death</th>
<th>Source of</th>
<th>Total</th>
<th>Death</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>12/7,741</td>
<td>0.00</td>
<td>1,626</td>
<td>China</td>
<td>12/7,741</td>
<td>0.00</td>
<td>1,626</td>
</tr>
</tbody>
</table>

Source: Li et al 1995
Problems with Male Sterilisation

Uttar Pradesh 1992-93

<table>
<thead>
<tr>
<th>Problem</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>2.5%</td>
</tr>
<tr>
<td>Spermicide in semen</td>
<td>2.5%</td>
</tr>
<tr>
<td>Pain in testicle</td>
<td>0.2%</td>
</tr>
<tr>
<td>Testicle enlargement</td>
<td></td>
</tr>
<tr>
<td>Loss of sexual power</td>
<td>0.5%</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Failure to get married</td>
<td></td>
</tr>
<tr>
<td>No. of additional vasectomy</td>
<td>10%</td>
</tr>
<tr>
<td>No. of vasectomy patients</td>
<td></td>
</tr>
<tr>
<td>Success rate (percent)</td>
<td></td>
</tr>
</tbody>
</table>

Source: Reproductive Health Service Centre and International Research Institute for Population Affairs, 1992.

Vasectomy

Long-term reproductive health effects

- Prostate cancer: no scientific evidence of increased risk
- Sperm is cleared from semen by the body in 7-10 days
- No evidence of increased risk of infection
- No effect on sexual function

Source: CDC 1991

No-Scalpel Vasectomy: Technique

Press the tips of the ringed clamp on the scrotal skin overlaying the right vas

Source: Bekeles et al. 1992

No-Scalpel Vasectomy: Technique

Lowering the handles of the ringed clamp to elevate the vas

Source: Bekeles et al. 1992
No-Scalpel Vasectomy: Technique

1. Piercing the skin with the medial blade of the dissecting forceps.

2. Spreading the tissues to make a skin opening twice the diameter of the vas.

3. Planting the wall of the vas with the tip of the lateral blade of the dissecting forceps.

4. Releasing the ringed clamp before elevating the vas with the dissecting forceps—ringed clamp open, but still in place.
No-Scalpel Vasectomy: Technique

Grasping a partial thickness of the elevated vas

No-Scalpel Vasectomy: Technique

Puncturing the sheath, with one tip of the dissecting forceps

No-Scalpel Vasectomy: Technique

Opening the dissecting forceps to strip the sheath

No-Scalpel Vasectomy: Technique

Ligation
Vasectomy: Rumours and Facts

- Vasectomy cannot reverse and usability is not
- Vasectomy does not cause any adverse effect
  response.
- Vasectomy does not cause impotence and loss of libido.
- Vasectomy does not affect a man's sexual capability.
- Vasectomy is reversible.
- Several studies confirm vasectomy is generally
  uncontrollable. Vasectomy should be considered
  permanent.
Withdrawal (Coitus Interruptus)

Withdrawal is a traditional family planning method in which the man completely removes his penis from the woman's vagina before he ejaculates.
Contraceptive Technology Update Workshop
for Medical Officers in Uttar Pradesh

Contraceptive Technology Update Workshop: Goals and Objectives

- Update contraceptive knowledge and practices relevant to family planning service delivery
- Strengthen abortion prevention practices at PHCs
- Strengthen counseling skills
- Identify and resolve technical and programmatic issues relating to family planning service delivery at the PHC
- Design a plan for sharing "Lessons Learned" with staff at the PHC